

HEALTH: TWO IDOLATRIES¹

Insofar as medicine is concerned, it would not be good to reject this gift of God [i.e. the medical science] merely because of the bad use some people make of it. [...] On the contrary, we should bring to light the extent to which these people are corrupted.
Saint Basil the Great, *The Longer Monastic Rules* (55, 3, PL 31, 1048).

It has become classical to oppose two conceptions of health, in relation to two types of medical practices, or even two approaches to the human body. Simplifying, I shall call the first conception *objectivist* and the second one *naturalist*,² epithets that will become clear later. The different terms available in English to designate a state of unhealth allow me to give a hint at this distinction. The English language has three different terms whose meanings are quite distinct and which can be contrasted with the poverty of French's single term *maladie*.³ In English, *disease* refers to the malady as it is apprehended by medicine; *illness* signifies the malady as experienced by the patient; *sickness* suggests a state of malaise rather than of malady or, more precisely, a social representation of the malady, if one follows Jean Benoist's analysis of the American contributions to the anthropology of health and disease.⁴

The first model of health is linked to an objective conception of disease (disease-object), the second one to subjective (disease-subject) and social (disease-society) conceptions. Does such an opposition make sense? Do we have to adopt one of these two conceptions or, in a borderline case, can we have a mix of both?

I. THE TWO CLASSICAL MODELS OF HEALTH AND DISEASE

One needs to have a clear understanding of the fundamental distinction underlying the two classical models of health and disease in order to understand my argument. Hence, I shall clarify this distinction, propose three arguments that confirm it, and offer a path towards overcoming some of its problematic aspects.

A. The Objectivist Model of Health

Two points need to be clarified from the very beginning. On the one hand, even though the biomedical model that shall be described here is currently dominant, it is neither taught nor reflected upon as such, *in actu signato*. It is rather part of a common unconscious representation conveyed through medical studies and practiced by medical staff, especially those working in hospitals, and remains the implicit point of reference of medical teaching and practice. On the other hand, the predominance of this model does not imply exclusivity. As I shall argue below, patients as well as doctors transgress this model all the time, a fact that shows its insufficiency *in actu exercito* and calls for another approach to health.

According to the model we are dealing with, health is an observable and quantifiable characteristic of the human body. It is reducible to a certain number of biological parameters. For instance, a healthy body has between 4 and 5 million red blood cells (half a million less for women), a potassium level between 3.5 and 4.5 milliequivalents per liter, and a weight (W) in kilograms such that the result of the fraction W/S^2 will be between 18.5 and 25 (where S indicates the size measured in meters). With values below the given range, we consider the body to be too thin; values above it indicate excess of weight; and an index above 30 points toward obesity, with the ineluctable consequences it implies.

In other words, according to this model, health presents the following four characteristics:

- 1) It is *objective*, in the sense that it refers to external data and not to subjective feelings. Consequently, the criteria of health can be universalized and normalized since they are not linked to individual representations. The American anthropologist Byron Good, who at the beginning of the 1990s was called to evaluate Harvard's medical programs and who met personally with students for several weeks, reports the following remark by a medical resident: "We are not here simply to make people tell their lives. As professionals, we have learned how to transcribe phenomenological descriptions of behavior into physiological and pathophysiological processes" (Good, 1998, pp. 174-175).
- 2) It considers the body according to the (macroscopic and microscopic) morphology of its organs and the physiology of its different functions. Added to the first characteristic, this second one signifies that the

health of the organs and of their functions is measured through *quantifiable*, statistical criteria, which can be normalized and regarded as the object of science. The body, Didier Sicard notes, “is more and more absent from medicine, and is present only if medicine offers it objective parameters, images or numbers” (1999, p. 157).

- 3) It is *somatic*, which means that it considers only the body, independently of the external environment and the psyche.
- 4) It is *invariable*, i.e., independent of the history of the subject and, therefore, independent of any eventual responsibility (cf. Genard, 1999). The biomedical model of health considers these parameters at a given time and is therefore able to say whether or not the body is healthy; independent of its future evolution. If I observe a blood sugar level of one gram between meals, I can certify that it is normal and then healthy.

Since the first of these characteristics commands the other three, I have labeled this conception of health “objectivist,” the suffix stressing the partiality of such a perspective. This point has been well summarized by Leriche’s famous saying: “health is life in the silence of organs”. The objectivist model of health is based on a vision of the body that I would sum up in two features: *passive* and *fragmented*.⁵ As a matter of fact, the first characteristic of a body that can be objectivized is its quantification; what Descartes would have named its extension. But extension is a passive characteristic; activity is a qualitative property. Therefore, to stress measurability is to make oneself blind to the dynamisms supporting the human body. On the other hand, what is extended is dividable, decomposable into parts.

Here, the requirements of the scientific approach converge with those of biotechnology. Indeed, *technical manipulation requires fragmentation*.⁶ This is particularly clear for two new techniques, namely the transplantation of organs⁷ and the sequencing of the genome.⁸ This is the reason why the objectivist model and the anthropology of the passive body lead to maximizing the place of technique and minimizing the role played by the organism.

The most evident consequence of this objectivist approach is to dispossess the subject of his pathology and those who look after him of their compassion. “Medicine formulates the human body and the disease in a culturally distinct way” writes Byron Good (1998, p. 150). Anne Fagot-Largeault, medical doctor and philosopher, speaks of a “tradition of hardening. As if the contact with human suffering was creating a

compensatory need to keep oneself at a distance, or even to laugh the suffering off" (see an interview of Fagot-Largeault in Canto-Sperber, 1998, p. 102).

While psychologists detect here a self-protective mechanism designed to cope with an omnipresent culpability (cf. Naquet, 1998, pp. 57-69), philosophers decipher it as an encounter between an anthropology of the objectified body and an objectifying look that abstracts the humanity out of the subject. I shall exemplify this point with a personal anecdote. During my residency in nephrology at Tenon, we admitted a patient with severe renal insufficiency due to septic shock; he had been saved *in extremis*. Finally, on the day he left the hospital, we went to his room. We were visiting the patients that day; significantly, almost all of the previous "medical visits" took place in the non-resident medical student room, with only the medical chart. The patient, deeply conscious of the fact that he had escaped death thanks to the technical skill and zeal of the medical staff, began warmly to thank the attending physician. Tears even came to the patient's eyes. The attending physician quickly left the room, mumbling incomprehensible words. A bit more and he would have asked the nurse to prescribe a lachrymal dryer for the patient! I had the impression that this doctor was, for the first time, meeting a sick person, and not merely a disease.

B. The Naturalist Model of Health

Holistic approaches to health did blossom during the first decades of the 20th century. In order to maintain health or promote recovery, some physicians emphasized the role of nutrition, thermal cures, stays at the mountain, and sanatoria that offered the advantages of rest, pure air and sun. Along with these approaches, the so-called 'natural remedies' also became very popular (i.e., all the remedies that can be obtained from traditional medicinal plants). During the 1920s, naturopathy developed thanks to a polygraphic doctor, Paul Carton.⁹ Supported by a national association and a journal, this synthetic doctrine is based on a semi-vegetarian diet and some physical and mental exercises, all tinctured with hermeticism.

The evolution of nouns is interesting. For three-quarters of a century, different medical approaches, among which homeopathy is the most famous, were ignored and marginalized by official medicine. Later, during the 1970s, they were termed *alternative* medicines. It was a *de*

facto acknowledgment of their specificity, but in a dialectic and discriminatory way; the epithet *alternative* implies a mutual exclusion, in such a way that to accept conventional medicine automatically means to disqualify the other forms, and *vice versa*. At the beginning of the 1980s, the less polemical term *complementary* therapy was proposed. Today, we speak of *integrated* therapy, an adjective that expands the field of the therapies we used to consider appropriate only for functional patients (sometimes called also "mild medicine") to the more serious problems of contemporary medicine.¹⁰

Another model, defining health as an inner state of harmony of the body in relation to its environment, its psyche, and its history, has also been contrasted with the objectivist model. Such a conception of health is opposed point by point to the four properties of the objectivist model described above:

- 1) Health is here a *subjective* characteristic: to *be* healthy is to *feel* healthy, not only in the negative sense of not experiencing anything disturbing, but also in the full, positive sense of feeling well, peaceful and ready to act at the same time, with a body that answers to what is asked without complaining. Health here takes the body-subject into account, i.e., the actual experiences of the body.
- 2) It corresponds to a *quality* of life that can neither be reduced nor analyzed in parameters objectifiable. To use Canguilhem's categories (1966, 1992), health does not belong to "normality" (which is quantifiable) but to normativity, that is to say, to value. Does the Latin *valere* not testify to the deep relationship between health and value?
- 3) Health is an *entering into relation* with the other of the body, still internal to the person, namely the psyche, as well as with the external other of this other, namely the environment and society.¹¹ Thus, health becomes not *normality* but rather *norm*: capacity to cope with the environment.
- 4) It is *historical*. The health of a person is inscribed within a history. Even though after the treatment and convalescence the patient might recover *ad integrum* the health he used to have, the pathology is part of his memory and his experience will not leave him uninjured.

Analogously to the way in which I characterized the objectivist conception of health above, this new vision of a healthy being can be described as based on a representation of the body, here *active* and *unified*. If health is a value, it is because it is a capacity of the body. The insistence on the dynamics proper to the organism leads to *minimizing* or

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