



A contribution towards health

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KEYWORDS

health, health promotion, quality of life, wellbeing

1 | BACKGROUND

What is health? The question is being asked 60 years after the proposal of the first definition.¹⁻³ With the passing of such a long period of time when it seemed to have become accepted, with the usage, citations and attempts to adhere to it, and the theoretical speculation implemented and flourishing around it,⁴⁻⁶ there would now appear to be a change of course. Questions about the definition of health are being debated now by a scientific community comprising voices that are asking such a question anew.^{4,5} And what exactly is it that at this very moment is causing us to consider such a change of course? An analysis of the literature produced in recent times shows the need to specify a way in which we will be able to speak of health in the face of a change in the overall epidemiology and the proof of the impossibility of a biological condition free of the risk of being affected by the disease.^{1,6-10} One limit of health definition proposed in 1948^{2,7} concerns how verifiable the complete satisfaction of such a condition can actually be. Moreover, the 1948 definition implies that, in the presence of a diagnosis or even therapy, the physiological readaptation given by the allostatic system^{11,12} or the capacity for self-management, are not considered. Finally, the definition does not allow for the possibility of detaching oneself from the clinical aspects.¹³ Thus, the reported issue with the 1948 definition lies in the description of health as if it were a state: the concept of health is conceived as hypostasis, that is reification.¹⁴ Recent commentaries above-cited underline that if health were actually a state, it would constitute a synonym for physical state

and, firstly, there would be no need for an ad hoc definition which differs from the one that allows for the identification of a primary morphological and functional state pertinent to the organism. In the second place, analysis of the periphrasis 'state of wellness' reveals that it considers two distinct levels at the same time: one level concerning the empirical state ('state') and one level concerning the hypothetical theory about this state (what 'well' means). Therefore, the character of the state is attributed to a construct which is subjectively shared (wellness), thus making health as a state: it is an epistemological leap that makes the definition potentially unachievable.^{6,15}

As we are reminded by Canguilhem,^{11,12} a good physical state or illness are body conditions: illness is identifiable at the moment in which there is a dysfunction with respect to the surrounding environment, and physical state can be defined within the description of the subjective functioning and parameters of an individual. But the physical state can neither be taken as standard nor as normal, since physical dimensions can be part of individuals' lives and since there are also remarkable competences for managing the pathological state of these dimensions.

Therefore, not even in the hypothetical definition of health as a sole body condition, the above-cited health definition can be considered exhaustive since it would need to allow for the variability of physiological adaptation.^{12,16} If health were a state, in the organism, there would be peculiar health parameters existing regardless of their identification. These empirical conditions would be present and would persist independently of the observers' being

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still unaware of it, as it happens when there is a cause determining a pathological state.^{16,17}

2 | CAN HEALTH BE PRESENT INDEPENDENTLY OF THE OBSERVER?

Since health cannot be identified with a state and it does not stand opposed to the state of illness,¹⁸ health takes shape according to the observer.¹⁹ Since it is not a dichotomous state (present/not present), health is currently considered as self-perceived and it is defined by the observers at the moment in which they are dealing with it and it is located on a continuum.

Epistemological reflection here specifies: health perception is situated on a level of conceptual realism where the reality in question is generated by the knowledge categories utilized to describe it. This shift from the observed to the observer allowed to highlight previous limitations.¹³ Thus, how health is being generated becomes the key in any study undertaken here. Specifically, health is a construct, defined on the basis of language used; therefore, health is defined by the discursive modalities used to describe it.^{20,21} When patients speak of health and describe it, health becomes reality, constructed by means given by language. So much so—as we are told in the most recent literature²—that if until recently someone described himself/herself as being 'healthy' only if he/she had no pathological state, now there is agreement on the fact that this diagnosed person can be defined 'healthy', although not in a state of integrity on the functional physiological level. He/she can be 'healthy' even if not meeting the terms of the definition of theoretical medical integrity from a 'physical, psychological, and social' viewpoint.^{1,22}

A further shift in the definition of health occurs as soon as it is identified as wellness. In this way, the construct of health is defined using another construct, wellness, to express it. Since it is a construct, it needs to be defined in order not to fall into the domain of common sense, too. In fact, there is a risk of both getting into a never-ending vicious circle (defining a construct through another construct and so forth). Furthermore, there is a risk of allowing any definition in ordinary language and thus making health no longer a scientific term, but rather a 'debatable' term: paradoxically as if everyone could give their own definition of 'pathology'. Moreover, through this vagueness and imprecision, we are in danger of 'harking back to a time of clinical impotence', once epitomized by pain in the medical field,^{1,6} with the result that the definition of 'health' becomes unworkable and can no longer have any practical application.

On the basis of indications outlined in the Declaration of Alma Ata (1978), carrying out a study of what has taken place in the 35 years since it was made, Habersack and Luschin²³ discovered that the definition, from which public policy on the subject of health emanates, can be seen to be disconnected from any possibility of attaining 'health'. The authors also claim that health defined as 'complete physical, mental, and social wellbeing' is itself unpursuable to a large extent and leads to the creation of an economic and social division. The Declaration of Alma Ata was followed by the Ottawa

Charter,²⁴ which attempted to resolve the issue of the unworkability of the 1948 definition, specifying the roles (which are also political) involved in dealing with health.

The 'Human Fact Sheets' and the United Nations Special Rapporteur's work on the Right to Health are operative attempts of application of these definitions.^{25,26} Therefore, this subsequent step taken on an international level highlights the fact that health cannot be univocally defined and, the 'highest level of health', can be considered in a different manner, belonging to a specific context and depending on the criteria that are subjective, social, cultural, and, therefore, also historical. If decisive steps are not taken in this direction, the definitions of health 'leave most of us unhealthy most of the time'²⁷ and the following formation of public policy cannot be said to be effective.^{23,27,28} This is the state of the art of matter.

3 | A THEORETICAL KNOWLEDGE BASIS FOR HEALTH

In the face of this analysis, there is a need for a definition that is both rigorous and founded on an adequate epistemological basis.¹ Since perceived health alludes to the system of a historical–social reality, built by social norms,⁵ there is no basis for distinguishing a normal from a pathological state and in light of this an abnormal opposed to normal state risks to be counterproductive in patient's health perception and self-evaluation. The relationship between physical state—the organic dimension—and health can be expressed in terms of the interaction between what is generated by the disease and what is generated by the competences of the person who may present a pathology,^{29,30} meaning that health is narrated in ordinary language. A definition of 'what health is' cannot, therefore, be prior observation or be independent of the manner in which health is discussed. Indeed, health is defined at the moment when the different roles interact to deal with the theme or topic of health—health professionals, patients, and the community—using ordinary language to define the reality. Reflecting this intersubjectivity health can be conceptualized as a dialogic process.³⁰ This makes it possible to take pragmatic action regarding health on a community level and not only in ideal terms, involving all the various roles in that particular context of interaction that have a share in the responsibility for health.³¹ Thus, the intervention to promote health can generate and trigger resources, activating those who receive the intervention and no longer remains inactive, and all of this can be achieved through a networking process through which the various roles converge around a single objective. Thus, health can be described as a configuration generated in the context of a dialogic process which foresees pathologies and/or implications of actions on the organic level as well as on the level of interaction in the community. There is not a normative 'limit' of a maximum attainable level of self-perceived health or a level completely divorced from health in which we cannot speak of health, indeed self-perceived health still continues to exist as a process. Recent literature has shown³¹ that, as far as pathology is concerned, it is not entirely possible to eliminate etiopathogenesis



nor attain total eradication of pathogenic agents. Conversely, we can achieve patient care. Treating pathology constitutes a minimum level of promoting health where, in the continuum of health on a scale of varying degrees of health, the absolute extremes of certain/indisputable presence and total absence of health rules out and creates interactive, changeable processes. In this way, self-perceived health and physical condition cannot overlap; furthermore, the misleading interpretation of health as exclusively empirical perception is no more passable.

Therefore, in the current state of the art, a nomothetic criterion is being applied to perceived health, whereas the criterion should be something else. If we consider the types of agents of a pathology (chemical, physical, genetic, viral/bacterial) and appreciate the fact that these, rooted in the very living environment of the anatomic-functional unit, can neither be avoided nor entirely eliminated but rather must be considered ever-present: a situation of the complete good medical state cannot be given. Where it is not possible to outline a complete good sanitary condition, the intervention process can be directed at responding to the maintenance of an allostatic equilibrium. In this regard, Windelband distinguished between an idiographic science in opposition to nomothetic science^{32–35}; beyond this opposition since health is studied both by sciences with idiographic and nomothetic approaches, in the sphere of health the principle cannot be other than interactive. The interactive principle appears effective regardless of what is known of the event or agent. Thus, there can be health promotion even in the absence of certainty of the causative agent about the cause of that event and, therefore, predictability of the effects. Within a framework according to health, the minimum level is possible when there can be no cure for the pathology but only therapy. Indeed, even when the prognosis is very poor or there is no disease remission or the disease is terminal, patient's health can be always improved.

Considering perceived health as a process, it entails the possibility of narrating. The person who has a pathological diagnosis is one of the narrating voices contributing to health narration in the community. In this theoretical and operative position, a disease is not a pervasive category for the role of the patient, it does not exhaust the meaning of health for that patient, and it does not hamper the possibility of being healthy. But exactly through diagnosis and the resultant implications, a peculiar health configuration with its own references and evaluation becomes possible. Thus, in the dialogic concept of health, the various players involved come together in a particular framework, which allows for a variability and constructive plasticity in terms of health, devoid of standardization (since standardization could change when conditions change, as Canguilhem stressed^{11,12}).

4 | CONCLUSIONS

In conclusion, health can be defined as a conceptual reality constructed through the language modalities used to speak of it and is located in a dimension in which processes have relevance, generating reality. Health is a reality but not an entity considered by the naturalist approach,³² since it is configured on the basis of the

gnoseological categories used to know it, meaning ordinary language. In this way, telling about perceived health means considering physiological state (as the empirical level of health), but it does not entirely coincide with ascertaining the physical soundness: narrations about how individuals are feeling already implicitly involves an interaction with their own anatomical–functional unit and generates the possibility of ascertaining soundness. Namely, the possibility of telling about health ('how you are feeling') is intrinsically bound to the medical condition. Therefore, if the anatomical–functional unit is suffering from a pathology, the individual's narration will use and avail of some aspects and issues referring to the medical condition, medical treatments, and resultant effects. This means that health is generated and rests on the interaction which ordinary language makes possible. Thus, using ordinary language to tell how a patient is feeling involves interaction with the other who is listening—and not only with the cultural values and connotations of health.^{36,37} The other is not the anatomical–functional unit, but the one who receives the narration of 'how I am/how I feel' and then renarrates the narration structured through specific modalities. If physical condition belongs to the individual anatomical–functional unit, health pertains to the interaction in the community: it does not belong to, nor it is found in, but rather is generated with interaction and is promoted toward interaction. As a process, health includes the language modalities through which individuals create reality; thus, its rules social norms and how it appears.

The discourse about health is founded on the use of language and by virtue of sharing a discourse which identifies the need to repair a situation, to get rid of the cause of harm, and to proceed to do so. As seen in this contribution, since the good physical condition is proof of the absence of pathological agents, where it is not possible to verify the absence of pathological agents and therefore the cause is not certain or not manageable, the possibility of the description of health is preserved. Indeed, the configuration thus created lies in the definition of health and no longer in that of physical condition. Thus, physical condition is embraced within a discourse which we call health: the narration of health overwhelms physical state and it is not the contrary. Health is the key to managing the cause or managing its absence. Based on the fundamentals of language: when we speak of pathology's cause and this rests on a discourse which has ramifications in the community that uses ordinary language, this use of the language configures the possibility of thinking, organizing community, and managing the interventions. In this sense, we cannot remain on the level of the cause but must move on to the use of what we currently know about the cause, and this is an interactive level. Thus, prevention and cure constitute the first step in reaching health. In the following steps, management of the illness would not be carried out if discourse about health management did not exist.

Therefore, in answering the question 'what is health?', to maintain a certain analytical rigour we find ourselves asking 'how is health constructed?'. The foundation of health on a conceptual epistemological level and the rigour of the reasoning, in the awareness of hypothetical causalism and mechanicism referred to the organism, allows the scientific community to advance in terms of

knowledge and produce further, subsequent questions. May the answers to these questions generate health in the rigorous management of interaction.

AUTHOR CONTRIBUTIONS

Gian Piero Turchi and Eleonora Pinto made a substantial contribution to the conception of the work and wrote the first draft. Luisa Orrù and Antonio Iudici revised it critically. All authors listed contributed to manuscript revision, read, and approved the submitted version.

ACKNOWLEDGEMENTS

Open access funding provided by BIBLIOSAN.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no data sets were generated or analysed during the current study.

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How to cite this article: Turchi GP, Orrù L, Iudici A, Pinto E. A contribution towards health. *J Eval Clin Pract*. 2022;28:717-720. doi:10.1111/jep.13732