The Idea of Health: A Philosophical Inquiry

Judith A. Smith, R.N., Ph.D.
Head, Family and Community Section
Program Director
Community Health and School Health
School of Nursing
University of Pennsylvania
Philadelphia, Pennsylvania

THERE IS A NEED to clarify the idea of health because it plays a central, directive role in every phase of nursing and medicine. It defines the objectives of nursing and medicine with different conceptions of health, directing practice toward different targets or goals. This article attempts to resolve the seemingly unrelated, multiple, and ambiguous views of health into several distinctive concepts, followed by a discussion of their general structure and interrelationships.

METHOD OF PHILOSOPHIC INQUIRY

The method of testing ideas in philosophic inquiry is that of critical discussion. In science, the testing of ideas takes the form of testing hypotheses. The major difference between philosophical inquiry and empirical science is that experiments are not performed in philosophic inquiry. The available literature is searched for fundamental ideas on the topic, the funda-

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mental ideas are analyzed, and the ideas are extended. Philosophic inquiry thus provides the basis for scientific experiments.

In this case, the literature was searched for fundamental concepts on the nature of health. On the basis of these tentative investigations of the literature, all of the various conceptions and ideas of health can be resolved into four distinctive types.

Despite the varied meanings of health, it was recognized as having one formal significance, namely, one extreme of the health-illness continuum. A continuum is an unbroken sequence of things arranged so that between any two points there is always an intermediate point. The variations between conditions of health and illness are smooth. There are no discrete points. Health then becomes a comparative term, rather than a classificatory (either/or) term. "A comparative concept allows for a 'more or less': it provides for a gradual transition from cases where the characteristic is nearly or entirely absent to others where it is very marked."[1(p54)] Thus it is possible to speak of more or less health, of an individual being healthier at one time than at another time, or of one individual being healthier than another. Such a comparative concept provides an effective basis for admission to and discharge from hospitals. Conspicuous presence of signs and symptoms of serious disease is the basis for hospital admission; significant decrease in their severity results in discharge from the hospital.

Therefore the concept of health involves a "scale" or gradation of health or illness. The structure of the gradations depends on what human traits or conditions are evaluated. The different ways of structuring such health-illness continua or gradations are called models of health. The word *model* in this context pertains to the ways in which the continuum is conceived.

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Health is also a relative term. People are judged healthy when measured against some standard or ideal of health. The models in this article constitute standards of health. The conclusion of who is healthy will differ depending on the standard, that is, the model of health used.

MODELS OF HEALTH

The various ideas on the nature of health can be divided into four models: (1) eudaimonistic, (2) adaptive, (3) role-performance, and (4) clinical. They were chosen because of their significance as directive ideas in the restoration and preservation of health. They also play a significant, even if implicit, role in the writings of many important contemporary researchers. The discussion of these four ideas is presented in the context of a critical examination of the writings of representative authors viewed as leaders in their fields.

Eudaimonistic model

The eudaimonistic model comprises several views of human nature that extend the idea of health to general well being and self-realization. This viewpoint is found in aspects of ancient Greek medicine and in the moral philosophies of Plato

and Aristotle. A significant modern representative of this conception of health is Maslow.[2-5] The idea of health developed in the writings of Maslow expresses an ideal of human nature and personality. It is the ideal of persons who can measure up to their wisest and their best aspiration. The best aspiration is one that is directed to fulfillment and complete development. That which is developed is the intrinsic potential. Health is the condition of actualization or realization of this potential.

Thus illness within this context is a condition that impedes or prevents self-actualization because the cure of a physiologic condition does not complete the task. A health professional then has to attempt to assist the individual toward self-fulfillment.

Within the context of this model, the health extreme of the continuum is viewed as exuberant well being. In contrast, the illness extreme is conceived of as enervation and languishing debility. Maslow's viewpoint is an attempt to redirect thinking away from a mechanistic view of people that assumes everything can be explained by seeking antecedent causes, toward a holistic view where the characteristics of wholeness, unity, and individuality become assumptions on which the nature of humanity is explained.

Adaptive model

The analysis of the adaptive model derives from a study of the writings of Dubos.[6-8] The idea of health developed in the writings of Dubos is based on a generalized conception of medicine that includes but extends beyond the study and treatment of diseases. The adaptive model of health appears in Dubos's books as an important directive idea uniting the aims of preventive and therapeutic medicine. Health is the condition of the organism in which it can engage in effective interaction with its physical and social environment. The characteristic mode of this interaction is adaptive behavior. Thus disease is a failure in adaptation; it is a breakdown in the ability of the organism to cope with certain changes in its environment. Medical treatment aims to restore this ability so that the organism can once more function using its own adaptive mechanisms.

According to this conception, even when individuals have been freed of disease, they may still not have attained health. They may still fail in effective social functioning. Privations of food, wholesome air, recreation, and education may confront them with hostile, challenging environments with which they cannot cope and to which they are unable to adapt. For Dubos this condition also marks the absence of health.

Under the conditions of this model, the health extreme of the continuum is that in which the organism maintains flexible adaptation to the environment and interacts with the environment with maximum advantage. Conversely, alienation of the organism from the environment and failure of self-corrective responses are model indicators of the illness extreme.

Role-performance model

Many people base their concept of illness and health on the role-performance model. The analysis of this concept of health was based on a study of some

treatises of medical sociology and some of the work of Parsons and others.[9-13]

Adequate role-performance appears to be a common-sense criterion of health. Thus sickness is an incapacity that prevents people from "doing their jobs." If nothing in a person's condition impedes the effective performance of his or her role, then he or she is in a healthy condition. This popular criterion also seems to guide the health policies of military and industrial administrations.

It is assumed that the relevant role is the one in which the person earns or otherwise receives income. However, a person has many roles. The examination of this model therefore entailed role analysis.

Performance as a model of health is further complicated by the emergence of role conflicts. Effective performance in one role may preclude adequate performance in another, raising questions concerning relative values and hierarchies of needs. In this model the health extreme of the continuum constitutes performance of social roles with maximum expected output; the illness extreme is failure in performance of one's role.

The role-performance model provides a minimal conception of health. Evidently persons able to perform adequately in their occupational roles may fail to achieve the self-actualization of Maslow's model or the adaptive facility of Dubos's. They may also fall short of the clinical model in that they may be physically ill even though able to fulfill their central roles.

Clinical model

A clinical model was explored through clinical models of modern medicine.[14-21] Most people who consult a physician are in pain or are experiencing some more or less acute abnormal condition of the body or mind. The responsive practice of the physician seeks to alleviate or eliminate the pain and to free patients of the derangements and the malfunctioning of their organs which constitute or contribute to their illness. Thus the focus of medical practice becomes primarily the elimination of morbid physical or mental conditions and relief from any concomitant pain. When relief is attained and the symptoms of disease are no longer present in the body or mind, medical therapy has completed its task. The patient is restored to "health."

The health extreme of this model is the absence of signs or symptoms of disease or disability as identified by medical science. Conversely, conspicuous presence of these signs or symptoms is a model indicator of the illness extreme.

But from the fact that diagnosis reveals no symptoms or signs of derangement in people, nothing can be inferred concerning their vigor, vitality, zest, stamina, or capacity to perform their accustomed roles. In this respect the functioning of the human body is analogous to the operation of a complex machine. The effectiveness or efficiency of the machine may vary widely. There may be a great difference between that condition of the machine in which it and its several parts are *merely* functioning without derangement and the condition in which it functions at optimum effectiveness.

Is the optimization of the body and mind system as viewed within this context within the scope of medical practice? Or does the concern of medicine stop with

the elimination of disease? Perhaps further improvement towards an optimum condition entails considerations which transcend medicine and have to do with a lifestyle. Health is a moral and political problem as much as it is a medical problem.

GENERAL STRUCTURE AND INTERRELATIONSHIPS OF THE FOUR MODELS

The aim of this article is the identification of each model and not primarily the advocacy of any one as preferable over the others. However, one outcome of the inquiry has been the recognition of the progressively inclusive character of these four concepts of health. The eudaimonistic model of health embraces the concerns of the other three and presents a model of health care resembling the comprehensive ideal of ancient Greek philosophy.

The models of health can be seen as viewing individuals within broader and broader contexts.

The four models of health presented here can be viewed as alternative ideas of health, although they are not mutually exclusive ideas. The adoption of one model does not preclude the adoption of the other models of health, although the degree of emphasis put on each model may differ. But they can also be viewed as forming a scale—a progressive expansion of the idea of health. The models of health can be seen as viewing individuals within broader and broader contexts.

The narrowest view, the clinical model, views individuals within the boundary of their skin. They are seen as physiologic systems with interrelated functions. Health within this context is viewed as the absence of signs and symptoms of derangement within the physiologic system. Illness constitutes signs and symptoms of disease, derangement, or malfunctioning of the body or mind. This constitutes a negative conception of health because it emphasizes the idea of illness, not health.

This model suggests the characteristics of diseases. If a person does not have the diseases then he or she is considered healthy. The physician's job is to certify the human organism as physiologically sound. The physician has little concern for what happens to the patient outside of the office.

Nevertheless, the clinical model is a fundamentally important conception because it is a minimal conception of health. Within the context of the clinical model, a person who has the signs and symptoms of disease can never be considered healthy, regardless of how productive or creative he or she is. If a person is considered healthy, even though signs and symptoms of disease are present, then another standard of health is being used.

The other models of health add requirements to this idea of health because they do not focus on clinical illness, but rather concentrate on the more positive qualities of life. Thus to be healthy one has to at least meet the standards of the clinical model. But these standards are not enough if some positive aspects to health are to be introduced.

Next on the scale is the idea of health as

role-performance. This is an advance beyond the clinical model because it adds social and psychological standards to the idea of health. Persons need to be not only physiologically sound in the clinical sense but also socially fit. The role-performance model, although not rejecting the clinical conception of health, conceives the idea of health in a wider perspective, involving the complex of social relationships and functions into which people enter because of their roles. From this viewpoint, people who find their social niche and fulfill their social roles adequately are healthy. Role-performance failure can mean illness, even if people are clinically healthy. They fail because they have not developed adequate social and psychological traits. Yet this model is also limiting because it can lead to a routine, inflexible, and mechanical idea of health. Change can create problems in adequate role-performance.

The adaptive model is more expansive than the other two but incorporates them. People within this context have to be not only physiologically healthy and perform their roles adequately, but they must also show adaptive behavior—creative adjustment to changing circumstances through growth, expansion, and creativity. The routine, inflexible life of the role-performance model is an insufficient standard for health in this sense. The adaptive model generalizes the idea of people and health by viewing people as adaptive systems in relation to their social and natural environment.

The most comprehensive and expansive conception of health is the eudaimonistic model. The eudaimonistic conception of health extends the idea of people and their health to embrace capacities and activities in cultural enterprises. Maslow described the ideal as the self-actualizing, fulfilled and fulfilling, and loving personality. Thus the eudaimonistic model is the most comprehensive because it embraces the three preceding models in the series.

From another viewpoint, these four conceptions of health appear as four ideals of humanity. The clinical model views individuals as physiologic systems and the role-performance model views individuals as elements in the social fabric. The adaptive model sees the ideal individuals as flexible, effective participants in a challenging environment they are capable of meeting by means of their adaptive resources. Finally, the eudaimonistic conception is an ideal of the civilized, cultured person who has the capacity for continuous growth, the refinement of sensibilities, and creativity.

IMPLICATIONS OF THE MODELS OF HEALTH

Health is a directive aim in the practice of health professions. Four significant directive ideas of health have been identified. Thus four different targets at which the nurse can aim have been provided. Nurses will direct their practices in light of whatever model is adopted. Each model, that is, each target, leads to different goals.

The differences among the four models of health do not entail opposition; all four have a certain fundamental validity in relation to human needs and aspirations. Nevertheless, there are certain significant differences in outlook and emphasis. In this respect the clinical and role-performance models on the one hand and the adaptive and eudaimonistic models on the other hand appear in different perspec-

tives. Both the clinical and role-performance models seem to focus on the maintenance of stability; they may be said to aim at physiologic and social homeostasis. In contrast, the adaptive and eudaimonistic models are oriented toward change and growth.

The distinctive nursing role under the adaptive and eudaimonistic models

Increasing attention is being focused on the distinction between the medical care of the clinical model and what is called health care. It is becoming increasingly recognized that medical care is not synonymous with health care. Or, to put it less paradoxically, there are different kinds of health care depending on the model of health on which they are predicated. What has been traditionally designated as *medical care* is oriented toward what is here called the *clinical concept of health.* The difference between this and the other models of health is, in one respect, a matter of range of concern and activity, with the clinical model being the narrowest.

However, a patient's life is part of a complex set of relations that are not covered by the clinical model. Problems affecting the quality of life may demand almost equal attention in the other models of health.

The care of health has come to be seen in a wider context, embracing behavioral and environmental factors. In contemporary society there is an increasing interest in personal behavior, lifestyle, genetic and biologic traits, and the social and natural environment. The study and the regulation of these is now recognized as an indispensable element in modern health care. Health care can no longer be confined within the limits of the clinical model. To see an individual's well being as not merely incidental and peripheral to a humane society but as the indispensable element of modern health care is to adopt the eudaimonistic model of health.

Conceiving health on the adaptive or eudaimonistic models means a vast expansion in the area of health care into regions that are not traditionally regarded as the concern of the health professions. These two models make the quality of life the major concern of the health professions. However, increasing attention has been given to them recently. For example, concern for the development and preservation of a congenial salutary environment is implicit in the adaptive model. Similarly, certain aspects of individual life have come to be seen as newly recognized factors in health. Among these may be included stress on the job, the failures and frustrations of life, and the alienation from social strata that provides opportunities for rewarding careers. In other words, under the eudaimonistic model, failures in achievement and self-fulfillment are also seen as assaults on health. Thus this model views the availability of opportunities for growth in education, in vocation, and in emotional maturity as important issues for health professionals.

Assuming responsibility for the quality of life means a corresponding change in education. Nurses have to be taught to stop thinking only clinically and to start thinking in terms of the social philosophy underlying the adaptive and eudaimonistic models. Nurses as key figures in the delivery of health care would become the guardians of the quality of life in the community.

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