



The Mystery of Positive Health and Family Medicine: Theories and Data

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Abstract

If one wants to live, if there is something for which one wants to live, the will to live becomes a powerful force to fight the disease. The powerful will to live is intensified by the desire to create something, to discover something, to achieve something. A large number of patients who go from office to office are never improved, whatever treatment they receive. They complain about many and varied ailments. They feel weak; others can not sleep; some have pains in the legs, shoulders or back; others feel nervous and downcast. But if a disease is cured, the sick person can always somehow produce another. However, countless people carry out their work without fatigue if encouraged by enthusiasm and are interested in what they do. Physical illness is often something like an adjustment to the difficulties of life. It is a costly adaptation; but there are times when you really need to get sick: it is a truce in the struggle to reorganize your forces or to find new perspectives. There are two ways to get out of a situation that causes emotional tension: fight or flee. In almost all the difficulties that arise in life, it is not the external situation that makes us fail, but internal forces that we have not taken into account. Situations that have no possible solution are rare in life. Generally, we fail to discover the solution because it is one that we are not willing to accept: to make a positive adjustment.

Keywords

Resilience; Social capital; Empowerment; Patient activation; Doctor-patient relationship

–“This is indeed a mystery,” I remarked. “What do you imagine that it means?”

–“I have no data yet. It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts”

Sir Arthur Conan Doyle. *A Scandal in Bohemia*.

There is a large amount of data and studies about the disease and its processes, but we know almost nothing about health, about people who never fall ill and die peacefully, while they sleep, at 90 years old. We do not know what they eat, how their families are, how much exercise they do... It is a mystery. That is, we do not know anything about them that may be associated with their good health. We know behaviors and risk factors related to the onset of illness, but its absence is not sufficient data that can be associated with good health or positive

health. These behaviours -or their absence: not smoking, not eating fats ...-, are called “healthy” only because they are associated with a reduction in the risk of becoming ill, and therefore they must be seen as derived from the concept, that is measures, of negative health [1,2].

However, the approach of “risk factors” [tobacco, alcohol, cholesterol, hypertension...] and disease continues to dominate the attention of contemporary medicine and epidemiology. Health is not a product of medical services or the medical industry. Positive health is not the absence of disease, and can be achieved through rewarding work, fresh air, healthy food, love, healthy housing, joy, social relationships, solidarity, literature, music, to be sitting in the sun looking towards the horizon, to be free. Positive health is true well-being: feeling capable and fit, with its physical, mental and social dimensions in a balanced way [3].

It is an admitted fact and that it is experienced in the day-to-day practice of general medicine that many patients are sick, but at the same time they are healthy [positive health: ability, well-being]. General Practitioners [GPs] are also familiar with the fact that patients often die “when they want”, when they have solved pending issues, when their lives no longer make sense. The biomedical loss of organic function is not necessarily equal to the inability to adapt and to live normally. Positive health is different from biomedical health. Positive health is the capacity of possession or appropriation by the human being of his own body; as the ability to integrate health / disease into the autonomous project of life that each one has forged.

Does health depend on external and internal structures that make possible the full use of all resources? Is not the health problem a biological problem but a social one? Have we been poorly educated regarding the superiority of biomedical explanations aimed at the disease and the determinants of the disease, to the detriment of social factors? It’s a mystery!

The dominant view is that premature death is due to cancer and heart disease, while the alternative view that the main causes of death are lack of social support, poor education and economic deprivation is almost ignored. Because of this dominant vision, large amounts of money are directed to technological development, although they only achieve modest results, and nevertheless it would take research to assess the effectiveness of the existing care system and the non-medical influences on health. There remains a persistent gap in health outcomes between wealthy and poor countries. Basic measures such as life expectancy and infant and under-five mortality remain divergent, with preventable deaths being unacceptably high, despite significant efforts to reduce these disparities [4].

The biomedical orientation of medicine tends to think that it is the only thing in the world. We forget that traditions, political and cultural forces, personal resources, etc., they influence health, as well as the role of the doctor and the way in which we practice it. Even in the sociological view of health, the idea that everything has an external cause to the individual, which is manipulable, curable, is another underlying form of reductionism. The scientific community consolidates the evidence that certain limits are being reached in the response capacity of medicine to the health needs of patients, which may be due to the concept of health and its determinants that dominate health systems, focused on the biological interpretation of

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the disease and that do not provide remedies for the non-biological determinants of health such as poverty, stress, social support and self-esteem, and it is urgent to investigate other paths of alternative production of health services [2].

Thus, we are faced with other concepts and variables with which to work, promote, measure and evaluate. That is, obtain data to build theories. Some of them are:

The sense of coherence (a way of perceiving life and the ability to successfully manage the infinite number of complex stressors encountered in the discourse of life) which is the capability to perceive that one can manage in any situation independent of whatever is happening in life. It is defined as a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence. Sense of coherence reflects a coping capacity of people to deal with everyday life stressors and consists of three elements: comprehensibility, manageability and meaningfulness; That is (a) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (b) the resources are available to one to meet the demands posed by the stimuli; and (c) these demands are challenges, worthy of investment and engagement [5,6].

Resilience. It has been described as the ability to withstand bad things happening to you without the expected devastating outcomes [7].

Social capital. It has been defined as the resources available to individuals and groups that are part of a network. This definition is valid both from an individual point of view and as a collective, and it is a unique and distinct entity from the traditional psychosocial factors of social support, depressive symptoms, and self-efficacy [8,9].

Empowerment. It is defined as a process that can facilitate control over the determinants of health of individuals and population as a way to improve health. Empowerment as an ongoing process, knowledge is power, having an active role, communication and interaction between patients and health care professionals, support from being in a group, religion and spirituality, and gender [10-12].

Patient activation, which describes the skills, confidence and knowledge a person has in managing her/his own health and health care [13].

But, is there solid evidence that these variables are attributes or indicators of good health? Are they related to healthy behaviours that promote or contribute to positive health? How do they affect basic biological processes, such as brain activity, endocrine function, and immune reactions? Is there an approach to general interactions between biomedical and sociological variables in a framework of systemic integration and exchange relationships? Is the classical epidemiological chain of agent-environment-host obsolete? What are the causal roots of good health and positive health? How does positive health affect the practice of family medicine and how does it apply in daily consultations? Well-being is not measurable in the way that bio-medical science requires [14]. Empowerment is core to health promotion; however, there is a lack of consensus in the wider literature as to how to define it and at what level it may occur [15]. Little research has been performed on health outcomes of interventions aiming to increase patient participation in general practice visits among patients suffering from symptom-based complaints; the results of many research are non conclusive; the quality of the trials has been weak, possibly due to the complexity of the concept. This weak quality may explain the lack of conclusive results [16].

But on the other hand, we have some data. Lack of social support and somatic health problems is associated with psychological distress. Social support acts as a health mediator [17]. Social relationships substantially contribute to the explanation of socioeconomic status differences in subjective health [18]. Stronger social relationships are associated with a 50% increased chance of survival, and this effect is similar for both "functional" [e.g., the receipt or perception of receipt of support within a social relationship] and "structural" measures of relationships [e.g., being married, living alone, size of social networks] [19]. Low neighbourhood social capital and low general social trust are associated with higher rates of psychosomatic symptoms, musculoskeletal pain, and depression. Individuals with low general social trust have more than three times increased odds of being depressed, three times increased odds of having many psychosomatic symptoms, and double the odds of having many symptoms of musculoskeletal pain [20]. Further, the prevailing biomedical ethic of care engenders a mere 'fix-it' approach, which focuses on the clinical treatment of the disease and neglects the role of patients in the process of care [21].

How can we fix things? How should we live to achieve the best that is in us, to achieve maximum success and happiness? The answer, probably, is that we must cultivate the will to live. But, how can a positive approach to health care be built in the daily practice of family medicine? An approach that allows the GPs to focus on the "strengths" of the individual / patient, rather than on the weak and risk factors, to help a positive plan to be adopted in the face of the difficulties of the people; a plan who allow restoring the meaning of their lives, which makes them feel able to solve the difficulties. How can strategies be defined and implemented so that health returns to daily life, that it springs from that daily life?

While the concept of positive health is consistent with the philosophy of family medicine, it is largely unclear what behaviours or interventions comprise the promotion of positive health in practice. Because positive health can be associated with multiple benefits, including better health, it is up to GPs to become familiar and incorporate this concept into their practices. However, although family doctors advocate, in theory, empowerment in patient care, they often fail to realize it in practice [22]. Meanwhile that more data is obtained, and theories can be completed, some actions by family doctors are already advisable:

First of all, we must learn that our patients get out of the inevitable difficulties of life with the least possible impairment of their emotional health. Many measures of emotional relaxation that we choose are harmful because they are evasive. Protect emotional health with the same care with the protection of physical health, and fully develop our capacity as human beings. If one really strives to live, one should not be afraid to die [1]. A new concept of Diagnosis, Currently, the "diagnosis" can disempower people rather than help them. It is hard to imagine cardiologists, psiquiatricians or endocrinologists debating whether medical diagnosis has enabled or labelled their patients. Here is an input from family medicine. Family medicine contributions to the enablement of patients lie in both the past and the future outside of the development and use of diagnostic classifications. To enable a person is to empower her, to support her in exerting her capacities [23].

Person-centred care. Over recent years the push for health care to become more person-centred has been mounting, with increasing attention being paid to the importance of people's experiences of care, and to supporting them to manage their own health [13].

Continuity of care: Chronic care received consistently over time can positively affect health status, and benefit patients with low activation [24,25].

Doctor-patient relationship: Primary care setting is critical to having a sustained relationship between patients and physicians in order to enhance patient engagement [26].

Healthy coping interventions: The recent literature provides support for a variety of healthy coping interventions in diverse populations, including chronic diseases self-management education, support groups, problem-solving approaches, and coping skills interventions for improving a range of outcomes; cognitive behaviour therapy and collaborative care for treating depression; and family therapy for improving coping in youths [27].

Patient participation in the consultation process: Patient-targeted coaching, educational materials, and communication skills have a substantial impact on communication, and so, there is a benefit to diagnosis and management of patient conditions [28].

Patient self-report: Patient self-reports are a more powerful predictor of outcome than were traditional biologic measures, such for example anti-DNA antibodies in rheumatic patients. So, self-management which emphasizing patient participation should be incorporated in family medicine consultations [29,30].

However, there is still a lack of data to conclude the theory and solve the mystery [31] of how to understand and promote positive health in family medicine consultations. Many studies to date lack statistical power or methodological rigor. Future research should suggest operational measures to be applied in consultations. Especially, general practitioners must generate evidence within their practice configuration [32].

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