Introduction

Will we ever attain ethically sensitive health care?
As things stand:

1 Health care lacks a coherent philosophy of purpose.
2 Beneath the surface, different rationales compete for ascendancy.
3 Many practitioners recognise that health care is more than medical therapy.
4 However, the great bulk of health care remains medically focused.
5 Overburdened with technical tasks, most health professionals rarely catch more than a fleeting glimpse of the richer possibilities.

If we are ever going to do better than this we must openly acknowledge that health care is fundamentally a moral task.

In the midst of crisis

The health world is so conceptually disoriented it seems it may never achieve its moral potential. Mostly we just bumble along – continually troubled by territorial squabbles and inadequate resources – blind to the intellectual challenge that must be met if health work is to become all it can be.

Despite its practical successes, health care lacks a coherent account of its purpose. All notions of health (and so of what health care is meant to accomplish) stem from social values. Not everyone favours the same set of values, consequently different accounts of health care purpose co-exist. But which of them is the true version? Which form of health work is most ethically justifiable? Which interpretation of health ought to guide health policy and practice? How can we reach a philosophically secure decision about the aims of health care? These are fundamental questions – the crisis will carry on until they have been comprehensively addressed.
This conceptual crisis has not appeared overnight. Nor will it be resolved quickly (if ever), though there have been important developments during the past four decades. The British National Health Service (NHS), for instance, has become more open to non-medical innovation and medical schools are increasingly keen to offer students a wider and more intellectually demanding education.

These and other forces are subtly challenging the traditional view that medicine has an exclusive right to define the nature of health care.

**Landmarks (1988)**

Landmarks stand out in this potential health care revolution. Among the most prominent are:

- The rise in the popularity of alternative methods of treating disease and illness, several of which clash with traditional medical theories of disease.
- Growing interest in holism and holistic medicine.
- Acknowledgement by some clinicians that medicine must reassess the nature and causes of disease, and realistically contemplate the extent to which medical interventions are effective.
- Recognition, in medical education and beyond, of the importance of ensuring meaningful communication between doctors and patients. Many medical schools now emphasise how important it is that doctors genuinely understand patients’ worries. Modern schools teach that doctors should be warm, approachable and empathic, should be able to engage in clear dialogue and – where appropriate – be capable of encouraging and helping patients to cope with their problems themselves. Of course, correct diagnosis and appropriate prescribing are as important as ever, but this shift is fundamental nonetheless – it is an expansion of the traditional medical understanding of the point of health care, and it has wide ramifications.
- Increasing awareness within the medical profession that the role of clinicians in health promotion is – at least potentially – less significant than that of politicians and environmentalists.
- Impetus to include training and examinations in ethics for medical undergraduates.
- Pressure from nurses to drag nursing courses away from the old idea of training in technique towards the additional goal of providing students with higher education in an academic setting. Of course nurse education must produce skilled and competent nurses; however, the ‘new nurse’ is a thoughtful carer armed with sufficient knowledge and experience to form her own judgements at work.

**Landmarks (1998)**

The above landmarks remain, but change is slow. The health world’s inability to embrace a philosophy of health means that some events which looked like landmarks in 1988 were of little significance.

In 1988 the medical establishment appeared (to me at least) more flexible than it actually was. Nurses have not been widely accepted as independent practitioners; there
has – with the advent of the health manager – been some change in health service hierarchies, but if anything this has tended to narrow the focus of conventional health care;\textsuperscript{40} health promotion has lost its way, baffled by a blizzard of rhetoric and naive idealism;\textsuperscript{24} and moves to offer health care in the community – too often inspired by the desire to save money – have met with mixed results.\textsuperscript{41} Academics – especially those in secure, tenured employment – might have been expected to lead the way: to dissect, explain and propose theoretically sound improvements to the often blatant irrationalities of the present systems. But too many find it more profitable to go along with the status quo, and just stop thinking when their conclusions begin to sound too dangerous.

\textbf{Landmarks (2008)}

The 1998 edition offered no new landmarks – I was struggling with the slowly dawning truth that change might not come as swiftly as I expected in 1988, as an idealistic, passionate and impatient young man.

My disillusionment over conventional health systems’ blindness to simple philosophical truths became catharsis when my best friend died from cancer in 1998 – as can be seen from my final editorial for \textit{Health Care Analysis} (reproduced with permission from Springer Netherlands).\textsuperscript{42}

\textbf{Death’s moral sting}

Yesterday my first friend died. He was 7 and I was 5 when we met, 42 when he was obliterated by an aimless cancer. His devastated wife is left to raise their two young girls alone, while the rest of us struggle to find any sense anywhere any more.

Death forces contemplation in a way nothing else can. Why am I still alive? Is there any meaning in this brutal world? How should we live in the face of nature’s arbitrary slaughter? Does anything matter? We ponder these crushing questions as best we can, until life’s mundane masquerade anaesthetises us again.

In the medical world death is commonplace. Staff become used to it. It is part of the job, to be dealt with along with everything else. It is never easy, but where death is routine it is impossible to experience every fatality as deeply as I feel the loss of my friend. Health workers have to stay in sight of the humdrum or become overwhelmed.

But death and suffering can become so familiar that they lose their moral sting. There is a dilemma here: to survive emotionally it is necessary to distance oneself from a constant stream of tragedy and torment. But once it becomes normal to stand apart from other people’s anguish one’s sensitivity is at risk.

After 14 years working with health professionals – the last six of these as editor of \textit{Health Care Analysis (HCA)} – I fear that many in conventional health care overprotect themselves from the vale of tears, often at great cost to patients, to whom suffering is never commonplace.

I have countless examples. I describe a few below – some from my teaching practice, others from my editorial life.

(Continued)
Student investigations

Each year, when examining fifth year students’ powers of ethical thinking, I ask for reports of ‘ethically interesting situations’ encountered in clinical departments. As a result I have a box full of evidence that clinical competence and human sensitivity can be worlds apart.

Student 1: Secrets in oncology

‘In the oncology clinic my role was observational. I met Mrs K, 32 years old, who had metastatic breast disease and was receiving palliative care. During the interview it became apparent to me that the patient didn’t realize that the treatment option was not a cure and that she would die of her disease in the near future. After she left I raised this issue with the consultant, who replied “I don’t tell them if they don’t ask me”.’

Student 2: Informed consent in ENT

‘A diagnosis of malignancy had been made by means of a needle biopsy from a metastatic node in an elderly man’s neck. The clinical director asked the patient what he knew of his condition. The patient told him he was anxious to know because nothing had been said. The director told him he had “a serious growth in his neck” and nothing more regarding prognosis or treatment. It struck me that everyone knew exactly what this man had except the patient himself. He had even received intensive investigation – the needle biopsy – without being told what was being looked for.

I find this situation interesting from the point of view that the law says that for any procedure there must be informed consent – which obviously wasn’t obtained prior to the needle biopsy.’

Student 3: MS = poor quality of life?

‘My case involves a 38-year-old woman who had multiple sclerosis (MS). She was living independently at home, with some help from her husband. She walked either on crutches or a “walker”. She came to hospital with peritonitis – nothing to do with her MS.

She consented to an operation to wash out her abdomen and reconnect her bowel. She was very sick (septic) afterwards, unable to converse – the doctors wanted to move her to the intensive care ward. The intensive care consultant refused to take her on the ground of her MS – she said they do not accept people for intensive care who will not have a good quality of life afterwards (referring to the MS).

The patient stayed on our ward and died 2 days later.’

Student 4: He’s a no-hoper anyway

‘A 28-year-old Maori man presented at A&E with a chest injury following a car crash in which he was driving drunk. He had a small pneumothorax which didn’t warrant treatment and was discharged to the police. The next day he was gaoled. In frustration he pushed his hand through a pane of glass, requiring readmission. A routine chest X-ray showed a complete deflation of his left lung which required urgent reinflation. The registrar inserted a chest drain, but thought it would make a good teaching case and got his colleagues (a registrar and a house officer) to insert, remove and reinsert the chest drain twice more.

This was a huge ethical issue for me. The registrar justified his actions by saying, “Well, he was a no-hoper anyway.” But I knew it was wrong. However, it was only through deliberation that I understood why.’
Death’s moral sting  (Continued)

Student 5: Public bad news

‘I was in an ENT clinic with eight of my fellow medical students one Friday morning. We were expected to go around to various rooms in the outpatient clinic, examine each patient and talk to them (I should mention that there was a consultant in the corridor yelling at anyone who wasn’t in a consulting room with a patient).

A backup occurred. Either students had to be in a room in numbers in excess of four or out in the hallway being told off by the consultant. Many students responded to this by walking into any room where they saw other students, presumably assuming some sort of global consent from the patient.

Eventually a young man, his mother and grandmother were in a room being told about his cancer and his treatment options with no fewer than 15 other people crowded in. At one stage the grandmother offered a student her chair. It was accepted, even though this meant that the grandmother had to leave the room.’

These passages are true and unexceptional. Every year 20–30% of students divulge similar experiences.

It is surely obvious that in each case if the doctor had been the patient he would not have wanted to be treated in this manner. He would want information, he would want his doctor to be aware that ‘quality of life’ is a subjective judgement, he would want to be protected from pressure and ridicule. He would want kindness, compassion and empathy, and if he did not receive these he would want to know why.

So why are some doctors so unable to respond to visceral human needs? What is so hard about imagining oneself on the receiving end? We are all going to die, we all feel pain, almost all of us will become ill – and we will all need care then. What is so hard about giving it when one can?

Two worlds

Since HCA began in 1992 I have been painfully aware that the journal makes no difference to what happens in health care’s name . . . papers that are written in the hope they might change something are studied by few if any practitioners:

[This] frustrating experience is a product of two worlds which do not meet. One world is the still cloistered domain of academia, where intelligent ethical analysis is possible but practically useless. The other is the evermore utilitarian world of practice, ruled by politics and money and nowadays often openly scornful of careful reasoning.

Of course this is not an absolute divide. Not all health professionals are as insensitive as the doctors in my students’ reports, and considerate plans are sometimes put into practice. However, it is undoubtedly not the case that increasing academic interest in health care ethics has made the difference its protagonists assume. If anything contemporary health systems have become more inhuman than they used to be.

They have certainly become more managed and as a result more prone to the pseudo-scientific fancies taught in management schools. We are, for example, inundated with glossy material proclaiming that someone or other is ‘working towards’ mental health, when almost everything in psychiatric work is directed at the control of mental illness. Drug companies chase profits unashamedly. Governments obsessed by rising costs (i.e. soaring prices caused by the selfish pursuit of commercial profit) hand over health care planning to accountants, a profession not primarily renowned for its kindness. Precedent is allowed to hold sway over

(Continued)
Death’s moral sting  (Continued)

evidence\textsuperscript{49} as powerful interests strive to remain in control. Health care is increasingly regarded as a business, as it always has been in countries outside northern Europe. (‘The customer does not need to know any more than you want him to,’ is as much ethics as the health care tradesman needs to know.\textsuperscript{50}) Academics and practitioners alike fall into camps\textsuperscript{51} in which nothing other camps say can possibly change their minds.

None of what I’m saying is the remotest bit scientific, I admit, and there are counterexamples. However, I doubt there are enough to dent the general case that our basic human experiences are being devalued. A system supposed to cater for them has become so insightless that patients are disappearing in a smog of technical efficiency. The desire to manage health systems as if they are essentially the same as business corporations – and to do so in a way that fosters anxiety and secrecy in employees – means everyday callousness is obscured so long as the required outputs are produced at the right cost. In turn, the lack of humanity of many of those at the top of coal-face hierarchies feeds a system where caring for suffering people is not seen, is not rewarded and is even discouraged if it is considered too expensive.

The answers

It is not difficult to say what ought to be done to change this frequently obscene situation, yet much of what is needed is apparently politically impossible. In order to achieve a humane health system governments should:

- Remove personal financial incentive for service provision
- Fund a comprehensive public system through progressive general taxation
- Employ salaried staff, professionally remunerated and contractually forbidden to practice privately
- Prohibit all inducements to health professionals from commercial companies, including all advertising
- Pass laws to ensure that all policy decisions are made openly by publicly accountable decision-makers
- Distinguish human helping from business dealing by developing or adopting a clear and practically explicit philosophy of practice\textsuperscript{24}
- Encourage continuing public discussion of this philosophy
- Educate health care students broadly, in the humanities as well as the sciences
- Insist on in-service training in comprehensive ethical analysis\textsuperscript{52}

Remember death’s moral sting

But above all the answer is never to forget death’s moral sting. There are two ways to go. The dominant path just now is to become progressively numb in the face of stupid policy, arrogant practice and relentless human annihilation. The alternative – immeasurably more noble, and our saving grace – is to feel death’s moral sting all the time. It is all around us. The solution to health care’s failings is to use human suffering to provoke humane thinking. Death can make us dull, or it can reawaken us to the importance of every single human interaction every single minute. If death has a lesson it is that life is short, precious and every last bit of it matters to someone we can touch now.

To the memory of Andrew John Richardson (‘Rickers’) 1955–1998
The 2008 edition has no new landmarks either – however, the controlled anger of my editorial has grown into a quieter, practical realism: yes, the medical establishment holds as much power as ever; yes, philosophically empty habits will continue to shape health care’s future BUT change will come too, and with the advent of new communication technologies is now a lot more likely than it used to be (as you can see from Chapter Eleven).

**The health world is changing**

The idea that it is desirable to provide health care solely according to clinical priorities (ignoring social and moral aspirations) is under pressure. Medicine has dominated orthodox health care because of its high social status and hefty financial muscle, and because its practitioners have privileged knowledge. But although health work appears as controlled by medicine as ever, beneath the surface inspirational conceptual and practical developments are taking shape, even though the majority of health workers are still not aware of them.

**Thomas Kuhn’s theory of paradigms**

Thomas Kuhn’s theory of paradigm change is a handy way to illustrate this (though I do not claim that paradigms are real). Kuhn was interested in the history of scientific research. He investigated the attitudes and beliefs of research scientists and found that for most of the time – usually for their entire careers – most scientists have common aims, accept the same standards and procedures, and embrace shared criteria of success. They engage in what he calls ‘normal science’, where they try to solve ‘puzzles’ – or technical difficulties – within an accepted tradition. Occasionally scientists are faced with a crisis that causes them to question the most basic assumptions of their research tradition. When this happens what was thought to be bedrock can turn to quicksand, and everything is thrown into uncertainty.

During a paradigm change events and results of experiments are observed for which the current set of explanations (the present paradigm) is unable to account, a phenomenon accompanied by a growing perception that the existing way of seeing things is inadequate. This perception – that ‘there is something profoundly wrong about the theoretical framework in which we are working’ – can develop into an intellectual crisis resolvable only by redefining the entire project. Such redefinition is impossible until the most politically powerful researchers have become convinced it must be done.

**A classic example of paradigm shift**

The change in perspective when Newton’s theory of mechanics was superseded by modern physics is often cited as a classic example of a paradigm shift or scientific revolution. Newton’s theoretical structure was applied fruitfully for over two centuries. However, as developments in technology both demanded and facilitated increasingly precise
measurements and predictions, Newtonian mechanics was found not quite accurate enough. It was discovered to be impossible to increase accuracy further within the tradition. Instead Newton’s mechanics was supplanted by another theory, which explained the evidence in a radically different way. This was not a steady progression but a dramatic upheaval – a remarkable revolution in thinking. The implication of this for our understanding of the nature of science is immense since it calls into question the ‘common-sense’ that science is a steadily accumulating body of public knowledge about reality.

After studying similar historical examples it seemed to Kuhn that ‘common-sense’ is mistaken, and that spectacular changes in direction can and do take place within well-established research disciplines, even those that have achieved considerable practical success. Newton’s stature as a scientist and original thinker is unshakeable, yet modern physicists no longer build on his physical theories. Good research can be done that produces fundamentally mistaken hypotheses, so progress in science cannot only be a matter of adding to existing work. Sometimes accepted theories and wisdoms have to be rejected. And this process can happen in all research traditions, not just in natural science.

Many philosophers disagree with Kuhn, arguing that it is both arbitrary and melodramatic to call a series of explicable developments a ‘revolution’. Some critics point out that if the history of science is studied with care there are always strands of continuity to be found.55

While Kuhn’s theory of paradigm change clearly does not provide a complete explanation of the growth of scientific thought, it is nevertheless illustrative to explore his idea in relation to contemporary health care. To do so is inevitably to over-simplify, but it can help show how the idea of paradigm change might encourage a more complete appreciation of health care change.

**The heart of the crisis in health care**

A ‘paradigm shift’ looks like this:

![Figure 20](image)
Paradigm X represents the old consensus, and Y its successor. The overlap symbolises the common ground remaining. So far as the classic example is concerned, Newton and his contemporaries can be thought of as working in Paradigm X. When it was discovered that Newtonian mechanics could not explain some astronomical observations this paradigm was thrown into crisis and a new one eventually assumed dominance. In physics Paradigm Y, which inspired relativity theory, the uncertainty principle and quantum mechanics, was a radical departure from Paradigm X. Many of its basic assumptions contradicted Newtonian theory, although some beliefs were still shared. For instance, the use of logic and mathematics, the demand that all theories should be tested as rigorously as possible, and the terminology of the old paradigm, remained common. In other words, even when a radical shift occurs the two spheres are not totally separate. Some philosophers of science maintain that the shift is neither as neat nor as simple as the Venn diagram illustration suggests, and that it usually makes more sense to think of the new paradigm as encompassing the old one, retaining the ‘falsified knowledge’ and mistaken beliefs, but finding this information of little or no relevance to future work:

**Figure 21** The new paradigm encompassing the old one

**Relevance to health care**

The idea of paradigm change is a helpful analogy in the world of health care. Of course, even this very general idea is not wholly appropriate, since health care is more to do with practice than research, and Kuhn’s interest lay mostly with scientific theorising. Nevertheless there is a partial correspondence.

The present situation in health care might be caricatured like this.
**Paradigm X**

Paradigm X contains the ‘old school’ of health care where health is thought to be nothing more than the state of a person not suffering from disease, illness or infirmity; where the medical profession defines its rationale without consulting those whom it seeks to serve; where the idea of medical education is that as many facts as possible should be crammed by students (who soon come to see their ‘education’ instrumentally – something to be got through to become a doctor); where the idea of providing students with a proper grounding in ethics is seen as pointless – or worse, seen as a threat; where technical decisions are made ‘for the good of the patients’ without patients’ involvement; where patients are used to test the effect of drug treatments in controlled experiments without their knowledge; where patients are not permitted to see their medical records; where the health service is organised in strict hierarchical lines in which everyone knows his or her place; where curing disease through clinical science is the primary motivation; and where measures of success or failure in the care of patients are predominantly quantifiable, emphasising severity of disease, degree of deviation from statistical norms and life expectancy.

**Paradigm Y**

Paradigm Y is the fruition of the developments and initiatives listed (see pp. 4–5 in the First Edition, pp. 23–24 in the Second Edition, p. 2 in this edition), plus other practical improvements. It is based on a different theoretical understanding of work for health – its impetus is the simple idea that people are of fundamental consequence. In Paradigm Y curing disease and illness and increasing the length of life remain important, but are not always as important as increasing the autonomy of those who request or need health care, distributing available resources fairly, education and (at least sometimes) respecting people’s choices even if they conflict with given advice.

Paradigm Y policy-makers understand that health in the richest sense can be more to do with personal freedom than physical fitness. Its health services are organised to ensure all workers have a say in what happens to it; the users of the service are allowed to see whatever has been written about them and, as far as circumstances permit, are involved in all decisions that affect them. The task of enabling people to develop mentally, physically and emotionally – creatively throughout their lives – is a primary motivation (see Figure 22), necessitating a restructuring of most services.

Paradigm Y harnesses web-based technology, not just to improve clinical management systems but to include professionals and patients emotionally and socially. Paradigm Y information systems share values, feelings and human reasoning at least as well and at least as extensively as they share electronic medical records (see Chapter Eleven).

Paradigm Y has not yet crystallised – though its outline is visible to those who know how to look.

**A hidden crisis?**

Many in the health world do not accept Kuhn’s image has anything to do with health care. Any evidence of a conceptual and practical health care ‘crisis’ is at best superficial,
they will say. The conventional position is that there have been some changes of emphasis, and some secondary developments which complement the main body of medical work. But slow evolution hardly constitutes intellectual crisis, and clinical medicine rightly governs health work.

These critics might be right – Paradigm Y may turn out to be nothing more than wishful thinking. However, it is worth remembering that during his investigation into the history of scientific research Kuhn noticed that during the ‘crisis period’ – the time when two paradigms are competing for ascendancy – only very few people recognise that a transition is taking place. Some may suspect a revolution, but it is only with hindsight that the true extent of the crisis becomes apparent.

It would not be too surprising if the current foment were to escape the attention of busy health workers absorbed in particular tasks. There is little enough time for them to reflect on changes even within their own disciplines. Standing back to take a view of health care as a whole can appear impossible to those daily involved in dealing with the many distressing obstacles that hinder patients. And it is necessary to learn of a great many disparate developments to have anything like an informed understanding of what is going on. As with political revolutions, for all of us working during the transition, it may only be when the dust has settled that we will see the complete picture.

**The gestalt-switch**

Kuhn uses a further image to back his claim. He argues that the change of perception that happens when an individual notices he is working in a new paradigm can be likened to a ‘gestalt-switch’, an idea derived from the Gestalt school of psychology which flourished at the start of the twentieth century.57
The gestalt-switch is famously illustrated by showing that an arrangement of lines on paper can be seen in different ways. The pictures in Figure 23 might be either a duck or a rabbit, and either a vase or two faces, according to what we think we are seeing.

There are two points worth noting here: first that the theories we have about what we are observing help us make sense of what we observe, and second that it is necessary to have a relevant theory in order to make sense of anything. Kuhn’s insight was to extrapolate this idea into the realm of science where if we hold one theory (say Newtonian mechanics) we ‘see’ the evidence in one way, yet if we hold an alternative theory (say the new theory of physics) we ‘see’ precisely the same evidence in a different way.

It is – I hope – not over-stretching the point to develop this line of thought in a way germane to the future of health care. The theories we hold about our everyday work – the subjective theoretical framework in which we each operate – obviously affects our interpretation of the world, and what we do in it. Health workers’ understanding of their practice affects both their performance and their attitude towards those for whom they are caring. So – since a great variety of subjective understandings exist – it is surely important to make them overt – to reveal them to their holders as they really are (which is what the Values Exchange and Health Exchange try to do – see Chapter Eleven). Once this is routinely done, health workers will see that beliefs they take to be self-evident are not obvious at all (they will see a range of plausible alternatives) and it may then also be possible to shape future developments to correspond with the foundations theory of health, by highlighting the most creative interpretations of health work.

**Health workers can create future change through present practice**

What health workers do now – in everyday practice – is instrumental in bringing about the future of health care.

We are constantly faced with choices which may shape our destiny. Our paths are limited by what we have done, by our talents, our education, our circumstances and the historical era in which we live, but we almost always have some choice about what to do, what to believe, how to act towards others and what to say. Even in circumstances where our choices are restricted, alternatives are usually open to us. For instance, a
teacher may have no choice but to teach a class of disinterested and unruly teenagers, but still have significant options about how best to deal with them. And even where choice appears totally limited we can at least choose between doing and not doing a thing. We can create ourselves, more than we think. And just as we can create ourselves, through our actions we can create conditions in which other people are better placed to create more fulfilled versions of themselves too.

To bring about the paradigm transition, it is absolutely crucial that health workers not only speak of ‘positive health’ and ‘empowering’ but act according to richer ideas of health. If the new paradigm is to triumph, health workers who want it to be reality must ensure they are true to themselves, and that their actions match their beliefs.

**Disease or health? The greatest frustration**

The gestalt-switch analogy also helps explain the central, frustrating tension which is currently preventing the paradigm shift. Gestalt-switch difficulties can be overcome, and the way to do it is to display and explain both options simultaneously. This should not be so difficult. Do you want to see just the one thing – either a duck or a rabbit – or do you want to be able to say, ‘I see them both. Now I can make up my mind which I prefer’?

**Clarification of meaning is crucial**

Clarification of meaning can make a real difference to what is done. If work for health is only taken to mean work to cure disease then the implications for practice are massively different from those that follow if work for health is taken to mean ‘liberating all human potential to the fullest degree’. In an earlier book, various meanings and theories of health were discussed, among them the views that ‘health is a state of complete physical, social and mental well-being, not merely the absence of disease, illness and infirmity’; the theory that health occurs when disease is absent; the theory that a person is healthy if she can perform her normal social function; and the theory that health is a strength – an ability to cope with or adapt to the problems life throws in people’s paths. These theories are not fully compatible with each other. They will not gel into a coherent whole without contradiction. For example, a person might have a disease (and so be unhealthy according to one possible meaning of health) and yet still be able to perform her normal social function (and so be healthy according to an alternative meaning of health).

The analysis offered in *Health: The Foundations for Achievement* revealed a common theme beneath the various theories. This is that work for health is always designed to remove obstacles in the path of biological, intellectual, emotional and creative human potentials. The *Foundations* argument is that health is a richer idea than commonly supposed – health is to do with human flourishing, not merely the absence of disease. Effort against disease can be genuine health work, but it is not the whole story.

Once you understand the *Foundations* analysis it is very hard to see why this is not completely obvious to everyone. For example, consider the hypothetical job title ‘Health Promotion and Disease Prevention Officer’. No-one would dispute that this title makes
sense, so everyone should be able to see that the use of two separate terms – ‘health promotion’ and ‘disease prevention’ – implies different meanings.

Much of the ambiguity in health studies has come about (and remains) because this major distinction seems invisible to most people. Forward-looking authors writing about health frequently introduce nebulous ideas like ‘positive health’ and ‘well-being’ to indicate that health is not one side of a see-saw counterbalanced by disease and illness. But then, having glimpsed one picture momentarily – having realised that the duck can also be a rabbit – even the most radical health promotion visionaries slip back into the old habit of discussing how to decrease disease and illness.

Health writers and workers caught in the trap fleetingly realise that health is to do with fulfilment, but then they hit a daunting mental block. As soon as they begin to consider how this fulfilment can be made concrete, they fall under the spell of medicine again, hurtled backwards as if attached to a piece of elastic stretched as far as it can go.

The basic problem is that health is still habitually thought of from a point of reference that begins with disease. This is such a powerful idea that almost everyone seems to think that when talking about health you must necessarily refer to disease, illness, handicap and injury sooner or later – or else you cannot be talking about health at all.

Health promoters continually insist that health is more than the absence of disease and illness, yet their official work is almost entirely directed at preventing disease and illness. Having experienced a fleeting insight into the fullest sense of health the very next thought of the ensnared health educator is always something like, ‘How can I persuade this person to adopt the kind of habits which will make him less prone to becoming ill?’ Certainly, if a health educator can achieve this particular goal then she stands a good chance of enhancing a person’s life in general (for instance, if the person who is the target of the persuasion avoids a stroke as a result then this will prevent a wide range of obstacles, not just brain damage per se). But the trouble is that constant emphasis on ameliorating disease and illness in the name of health embalms a central mistake – the continuation of the unreflective assumption that preventive and curative medicine is the best means of helping an adult person to become more of what she could be. Yet of course it is not. Health is not only a matter for medicine and can be created and improved in numerous ways for which medicine has no brief.

**Summary**

Chapter One is not much different from the way it was 20 years ago. It still argues:

1. The health care world does not have to be the way it is – despite the engrained tradition, status and money involved. There are better ways to think about and practice health care.
2. The purpose of health care is not immutable. The idea that health is nothing more than the opposite of disease is just one amongst several meaningful inspirations for health care practice.
3. Within establishment health care there is much activity that draws on richer theories of health. Some of it even contradicts strictly medical goals.
Summary (Continued)

4 If enough of this ‘deviant’ activity can rise to the surface there will be a paradigm shift, or at the very least more and more people will begin to think of health care differently, and will come to expect additional support from their health carers

5 It is up to those health workers who prefer a richer, autonomy-based ethos, to express the new paradigm in what they do. Pretty much everything hinges on how health workers think and act right now.

The next chapter is an attempt to accelerate change by showing that ethics is the key – it simply makes logical and ethical sense to see human autonomy as the heart of health care rather than to think curing disease, injury and handicap is all there is.

Health work is moral work. Consequently, by making clear the range and importance of the moral content of health work, by bringing what already exists to the fore in its proper focus, it should be possible to bring about the most desirable form of the new paradigm. Ethics is the key to the formation of health work’s new era.