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Health, environment and chronic diseases: bioethical aspects

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INTRODUCTION

The sanitary reality of Brazil is always more determined by demographic and epidemiological transition as factors that currently configure the health conditions of the population, for centuries aggravated by social exclusion. The combination of chronic diseases with poverty creates a context of extreme vulnerability that requires, in addition to adequate clinical care of the individual, intersectoral policies of collective nature in that individual sociability environment.

The health system is not prepared to handle the larger number of people with chronic diseases, because it is organized to face acute events. The current clinic to treat acute aggravations is not adequate to support people with chronic conditions, dependent on the longitudinal course of life affected by chronic disease and the context in which that life unfolds. Therefore, it is necessary to consider another clinical paradigm to have resoluteness in the care of people with chronic conditions (Mendes, 2012).

This new clinic will depend on a more refined and complex understanding of health itself. What does having health mean in a situation of chronic conditions? First, health cannot be thought of as the opposite of illness. Following the tradition of Canguilhem (2009) and Illich (1981), it can be said that the possibility and the very fact of getting sick is part of being healthy. Therefore, it is necessary to define health as the ability to cope with illness and react to it. This ability belongs to the person affected by the disease, but the activation of this capacity depends largely on the environmental conditions of his sociocultural context. These conditions identified with different natural, symbolic, psychological, economic and social resources of the sociability environment of who is chronically ill, allowing him to live life with quality, dealing with the chronicity determinations of his conditions. Thus, health in a chronic situation demands to be considered and managed in relation to the subjectivity of the person affected with chronic illness and her environment for integration and social coexistence.

This interface between health and environment offers new ethical challenges for the professional in this sector. These challenges are guided by two principles: first, you do not take care of someone individually without due attention to the collective conditions surrounding that individual; second, effective care cannot be dissociated of care and management, because this creates the conditions for that to act effectively. Responding to the challenges depend on the consideration of these two principles.

AMPLIFIED VIEW OF HEALTH AND CLINIC

The sanitarian context of the gradual increase of chronic diseases in the Brazilian population imposes rethinking entirely the way to treat and clinically monitor this cases and the way of conceiving what health is. Chronic conditions, on the one hand, are a theoretical challenge to achieve a better definition of health and, on the other, a practical challenge to build a new clinical model for these cases, no longer based on episodic care for acute events but on longitudinal follow-ups, where chronic illness is a biographical element of the individual existential itinerary.

If, in chronic conditions, the disease becomes part of one's existence, so the quality of life and health need to include this element in their understanding, because it is part of the biography. Chronic disease means a disturbing element in the way of living life, with which it is necessary to learn to cope. It is not about adapting to this element, but finding ways to react to the disruptive consequences. It is about losses that need to be compensated for not only being able to deal with them as well as to live life with the highest possible quality and health in that situation. In this sense, health is the ability to react and handle disturbing factors that disrupt life, finding ways and devices that enable quality and meaning of life amid losses and weaknesses.

Two categories, one taken from biology, autopoiesis, and another from psychology, resilience, can help understand this capability.

The biologists Maturana and Varela (1997) revolutionized the understanding of living beings when they proposed the definition of their identity not from morphological characteristics, but from their autopoietic organization. Any living system is configured as autopoiesis, because it is able to rearrange its components in a new organization, when disturbed. In this sense, autopoiesis is the ability of every living being to react. Therefore, life fundamentally identifies itself with autonomy. What characterizes a living being are not its components or the sum of them, but the very way to organize them due to its autopoietic capacity. The living thing dies when he loses this ability, because he cannot cope with the disorder resulting from the environment to which is attached.

The human being has a more complex autopoietic organization because it is a biocultural being provided, at the same time, of language, and consciousness. Thus, human autopoiesis means a complexification of the ability to reorder its components in a new organization. Health means autopoiesis; disease, an attack on autopoietic organization; and death, the total loss of this capacity. Therefore, health cannot be defined or characterized simply by the presence of certain components, but by the ability to reorder these components into a new existential organization. In humans, the autopoietic organization has a complexity that encompasses the somatic, psychic, social and spiritual dimensions. However, as happens with all living beings whose autopoietic capacity is closely connected and dependent on the ecosystem in which it lives, in humans, similarly, the biocultural autopoietic capacity withdraws from its ecossociocultural context the resources to reorder into a new existential synthesis, when the natural path is disturbed.

In psychology, resilience means to recover, to go forward after the occurrence of a fact that disturbs life. It means first to resist the negative consequences of this fact, trying to overcome its effects, to go on living the best way possible. It implies that the person traumatized overlaps the disturbing fact and reconstitute.

Resilience is the ability to develop well to continue projecting into the future despite destabilizing events, difficult living conditions and sometimes-severe trauma. It is the universal human capacity to deal with, overcome, learn or even be transformed with the inevitable adversity of life. This protection capability allows one to deal with the harmful effects of an adversity and overcome them. This involves trying to turn bad situations, traumatic moments and difficult and inevitable life situations in new perspectives to go on living with meaning (Manciaux, 2003).

Resilience is a subjective capacity. However, it does not mean in any way an innate overcoming ability of a gifted someone that is independent of the environment, but an aptitude possible by family and social environment to handle frustrations, where that individual lived mainly in the early his life and whose capacity remains dependent on his sociability context, from which he drains the symbolic resources to overcome the negative effects of stressful events.

If health in the context of chronic conditions needs to be understood as the autopoietic and resilient ability to handle disturbing factors and reacting to them, the clinic needs to be rethought to allow the emergence of another model of therapeutic care to people afflicted with chronic diseases. This clinic will have to include the dimension of accompanied self-care, for which the chronic patient is fully monitored so he can assume the self-care of his chronic condition.

Two factors underpin this new model: the uniqueness of human illness and the context/environment of sociability of becoming ill. The chronic condition of a diabetic or hypertensive cannot be treated universally, because each case is unique, clinically speaking. That is why it is necessary a special attention to this uniqueness to understand the biographical subjective experience of illness and the way of dealing with the consequences of becoming ill. This is the basis for a pact between the professional and the user of the therapeutic itinerary agreed between the two and in need of periodic reviews and renegotiation. Only with care and strengthening the motivation potential and accountability of the chronic disease patient, it will be possible to achieve the goal of self-care, which will be continuously monitored by the professional staff of primary care.

However, it is not enough to have singular care of people with chronic conditions without, at the same time, a look and a consideration for the environment/context of his sociability, because that is where the chronically ill find resources and devices, from biopsychic to symbolic-cultural, to deal with the consequences of its chronicity. This environment/context ranges from the family sphere and neighborhood to the socio-environmental space of the neighborhood and the social and political situation of the historical moment. This ambience explains the social and cultural determinants of the illness experience and of the understanding of its limits and requirements.

Thus, for example, diabetics and hypertensive patients are advised to diet and exercise. However, the economic difficulties to buy food and the disregard for its symbolic and social significance, rooted in deep family traditions, frequently make these prescriptive advices fail. Therefore, it is necessary to engage the very familiar surroundings so there is effectiveness. Chronic ill must receive incentives from their family circle and their social support network to assume his self-care. Another example are physical exercises, which require an enabling environment for its realization. Most people with chronic conditions live in neighborhoods without adequate space to walk or structures to work out. In this sense, the incentive for people to articulate through their neighborhood representations to demand the government the construction of these spaces is part of the monitoring of their chronic conditions.

These local contextual determinants fall into a broader context, that is the environment as a place of social and environmental sustainability and social reproduction of life. This environment sets the standard of living, including sanitation, recreational areas, housing in unpolluted areas with respect to air and water and security measures against violence, so that people can enjoy a satisfactory state of health. Without these minimum conditions, it is impossible the monitoring and the resolute self-care of chronic patients that focus effectively on improving their morbidity. Thus, one cannot think health and subsequent care of these people without including, in monitoring, his sociability context and living environment.

Territory, environment and health

Today, basic health care is more organized and related to the adjoined territory of the population attended by a particular health team. In this sense, the territory is one of the axes of primary care, but, for that, it is important to understand what territory means in its relation to health. Territory may have an administrative meaning of spatial organization of accountability. In this understanding, the territory is something external to health and is only for administrative purposes of the system. However, if territory means the symbolic and social appropriation of a geographical area as ambience of sociability for a particular human group, so it is closely associated with the health conditions of that population.

This geographical space thus constituted is the place of construction and operation of community social support networks that inhabit this proper territory. Being part of this space of daily sociability of a group determines the identity of its inhabitants and define the skills to participate in networks and access services offered by this symbolic social space.

If the social determinants shape the health situation of a social group, then health is essentially linked to the social space that sets these determinants and enables the emergence of social support networks and coexistence. Therefore, a full understanding of health will include the spatial conditions for the social reproduction of life or the promotion of quality of life, because the social space provides the support, resources and tools to respond to any disturbance of the vital balance. Thus, health is resilience or responsiveness, depending primarily on collective environment, which constitutes the geographical space.

In this sense, the very services of the health system need to work in coordination with this social space. The effectiveness of access and response to needs will depend on the integration within the daily sociability of users. Only then, it will be possible to detect contexts of vulnerability and collect effective epidemiological data on the health status of that community.

This understanding manifests in the territories of the teams of the Family Health Strategy, defined as a space of everyday sociability of users and not as adjoined territory defined by numerical and administrative criteria. Attention to the environment is one of the features of the strategy and roles of community workers, but that environment is not simply the natural ecosystem, but the space appropriated to social use by actors and projects that have shaped this territory. This appropriation answered often-antagonistic interests, giving rise to environmental conflicts that have outsourced environmental costs that focus the health of users from that territory. This close interaction between health and geographical space requires an ecosystemic vision of one's health, including in his understanding the concepts of development, sustainability and environmental justice.

The development is not identified simply with economic progress, expressed by the GDP, but it means the improvement of social living conditions of the population, producing collective well-being and enabling higher quality of life. The criteria for assessing this improvement provided by development is sustainability and environmental justice. Sustainability means the reproducibility of natural conditions for the permanence of basic biodiversity to create social conditions for the reproduction of life and health. The negative criteria to assess this sustainability is environmental justice, aiming for equity in the use of natural resources and the destiny of damage and environmental costs of this development. The concept of ecological footprint helped to understand that certain countries and social groups spend a lot more natural resources to produce the goods they consume than others do, who express very low levels of consumption. This lack of fairness in the use of resources is very unfair, making development environmentally and socially unsustainable. The backside of this unequal use of resources are the costs and environmental damages this development, destined and pushed, usually, to socially vulnerable populations and environmentally fragile areas, creating spaces of environmental injustice, which affects the lives and health of those who live in it, because it destroys the environment that reproduces their living conditions.

If the chronically ill need to be promoted and sustained in their autonomy in the care and responsiveness in the face of worsening risks, its environmental and social living and sociability conditions conform the context from which they derive the different resources needed for this reaction and this care. Environmental and socially unhealthy contexts do not offer the conditions to assume accompanied self-care of one's chronic condition. To take individual decisions in favor of better quality of life depends on the usufruct of collective contexts of quality of life. This means that the monitoring the chronically ill requires a broader look and an intersectoral concern for environments in which they live and coexist.

Planning as an ethical requirement of clinical and sanitarian accountability

The close relationship between health and environment and the consequent ecosystemic understanding of one's health suggests that is not enough to clinically deliberate with the chronically ill about their therapeutic itineraries, but, at the same time, it is necessary to strategically worry about their collective through planning and intersectoral coordination of environmental and social health conditions in their territory of sociability. In this sense, you do not take care of someone individually without worrying about his feeling of belonging and so the clinical accountability for chronically ill also encompasses a sanitarian accountability for his environment of social reproduction of life. If clinical accountability requires skill to decide the best therapeutic way, the consequent sanitarian accountability requires competence to plan intersectorally the environmental and social conditions for the realization of this care itinerary in chronic situations.

The health professional could say that these conditions are not his responsibility, because his ethical concern is with the clinical care of the chronically ill. However, if the care has to be ethically resolute, not depending on pure good intention, but to achieve results in improving chronic situation so there is real accountability, then the professional cannot use excuses and say that these socio-environmental conditions are not part of his concern of professional ethics. Clearly, changing and improving these conditions are not a direct responsibility of primary care professionals, but as attention is inseparable from management, they need to articulate with the community and the city council health monitoring and management and other sectors of the municipal administration to plan strategies to implement intersectoral action for the improvement of socio-environmental conditions in the territories of its sanitarian responsibility. Therefore, the concern and the articulation of this strategic plan, which focuses on accountability for the ambience territory of the enrolled population, are part of the professional ethical requirements of primary health care (Junges; Barbiani; Zoboli, 2015).

Conclusions

This reflection allows pointing to the thesis that the true complexity is not in the tertiary level of a hospital, as is generally thought, because this level is more characterized by a technological complexity, while the primary level, where takes place the longitudinal follow-up of the chronically ill, responds to the true meaning of a complex biological reality that is defined in its complexity by its interactions with the environment that make it reorganize itself continuously due to its answers regarding changes in its environmental conditions. Thus, the manifestations of chronicity of a patient depend largely on environmental and social living conditions of the patient, which allow him to react or not to risks and assume self-care. Therefore, there is nothing more complex clinically and sanitarily speaking, than accompany longitudinally a chronically ill in health services. This is the great ethical challenge of primary care professionals.

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