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HEALTH BEYOND THE ABSENCE OF DISEASE: IMPLICATIONS FOR FAMILY MEDICINE

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1. INTRODUCTION

One of the most common observations in a family health center is that the same laboratory result may carry very different meanings for different people. One patient may say, "Doctor, all my results are normal, but I do not feel well." Another may think, "My glucose is slightly high, but I feel perfectly fine." At this point, one of the most enduring questions in modern medicine emerges: is health simply the absence of disease?

At first sight, the question appears simple. In fact, it sits at the center of a broad debate that extends from the philosophy of medicine to public health, family medicine, psychiatry, disability studies, and health policy [1,2]. In contemporary primary care, the family physician is not merely a clinician who measures blood pressure or writes prescriptions. The physician also encounters living conditions, psychological distress, family relationships, economic hardship, ageing, and the social environments in which illness is experienced [3-6]. A person is not only a collection of organs, and modern concepts of health increasingly acknowledge this.

This paper considers how different understandings of health can inform everyday family medicine. It focuses on the assessment of disease, daily functioning, patient priorities and the circumstances in which care takes place. The contribution is to bring these concerns together within the continuing relationship between the patient and the family physician, and to consider their relevance across different health systems.

This is a conceptual perspective rather than a systematic review. The discussion draws on selected work on health, illness and functioning, together with family medicine and primary health care frameworks. Sources are considered according to their relevance to clinical assessment, patient priorities and access to care. The domains in Table 1 organise the discussion and are not intended as an exhaustive classification. The clinical example is hypothetical and is used to illustrate clinical reasoning.

1.1 THE RISE AND STRENGTH OF THE BIOMEDICAL MODEL

Biomedical assessment remains essential in family medicine. It helps clinicians identify disease, estimate risk and select treatment. However, disease measures do not fully describe how a patient feels or functions. Blood pressure or HbA1c may improve while daily life remains difficult. Conversely, a person living with chronic disease may retain good function and consider their health acceptable. These differences matter when treatment goals are discussed [2].

1.2 DIVERSIFICATION OF HEALTH MODELS

Throughout the history of medicine and public health, different theoretical models have been used to explain health and illness. These models shape not only how disease is understood, but also how patients are evaluated, how health systems are organized, and how the physician-patient relationship is constructed. Table 1 summarizes major models relevant to primary care.

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Table 1: Comparative summary of selected models of health and illness

Domain	Main perspectives	Question in the consultation	Practical implication
Disease and risk	Biomedical and biostatistical approaches	What disease or clinical risk needs attention?	Assess disease, risk and treatment needs
Illness experience and priorities	Biopsychosocial, person-centred and cultural approaches	What is troubling the patient, and what matters to them?	Agree on priorities and discuss treatment options
Function and adaptation	Functioning, capability and positive-health approaches	What can the patient do, and where is support needed?	Include daily activities and participation in care goals
Social conditions and access	Social determinants and equity perspectives	What makes care difficult to obtain or follow?	Address practical barriers and coordinate available support
Environmental conditions	Ecological, One Health and planetary-health perspectives	Which exposures or living conditions are relevant?	Include relevant environmental risks in prevention and care planning

Table note. These domains overlap and are grouped here according to their relevance to family medicine consultations. They are not separate or competing definitions of health.

Each model emphasizes a different aspect of health. Contemporary family medicine often works with a hybrid approach: biomedical reasoning remains essential, but it is combined with biopsychosocial, functioning-based, patient-centered, and public-health perspectives [3,4,7-10].

1.3 THE CONTRIBUTION OF FAMILY MEDICINE

Family medicine brings these concerns together through first-contact care, continuity, comprehensiveness and coordination. A patient may initially present with an undifferentiated symptom rather than an established diagnosis. Further consultations allow the physician to review symptoms, recognise changes in function and understand the patient's family and social circumstances. When several conditions coexist, care also requires decisions about competing recommendations and treatment burden. The combination of these responsibilities over time is central to family medicine [4, 7,11-13]. Continuity also allows uncertainty to be managed over time, provided that urgent problems are assessed and a clear follow-up plan is agreed.

1.4 APPLYING THE APPROACH IN A CONSULTATION

1.4.1 WHY HYPERTENSION IS NOT ONLY BLOOD PRESSURE

Consider a hypothetical 55-year-old patient with hypertension who takes medication irregularly, sleeps poorly and has financial difficulties following the death of a spouse. The patient lives alone. Clinical assessment is needed to establish blood pressure control and identify problems requiring prompt treatment. The consultation should also explore medication access, adverse effects, mood, daily routines and the patient's main concern [3,6,14].

The agreed plan will depend on what this assessment shows. It may involve a treatment adjustment, a more manageable medication routine, support with access to medicines or further assessment of psychological distress. The physician and patient can agree on a clinical goal and a practical goal that matters in daily life **[3,15]**.

At follow-up, blood pressure is reviewed alongside medication use, adverse effects, sleep and daily functioning. If the plan has been difficult to follow, the reasons are discussed and the plan is revised. This makes follow-up an opportunity to assess whether care is workable in the patient's circumstances.

1.5 MENTAL HEALTH AND SOCIAL DETERMINANTS

1.5.1 WHY MENTAL HEALTH MATTERS SO MUCH IN PRIMARY CARE

Mental health problems are often regarded as conditions primarily managed in psychiatric settings. In practice, depression, anxiety, burnout, medically unexplained symptoms, and somatization are common in primary care. Physical symptoms may coexist with psychological distress. Both require appropriate assessment, without assuming that one fully explains the other. For this reason, health can no longer be understood only as the absence of organ dysfunction. Mind and body are continuously interacting, and the primary-care consultation is often where this interaction first becomes visible [1,2,14].

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1.6 IS HEALTH REALLY ABOUT FEELING WELL?

The World Health Organization's classical definition is well known: health is not merely the absence of disease or infirmity, but a state of complete physical, mental, and social well-being [16]. This definition was important because it moved medicine beyond a narrow disease model. At the same time, it also creates conceptual difficulties. Who is ever in a state of complete well-being? Is constant happiness possible? Is ageing a normal process or a disease? Can a person living with a chronic condition still be healthy?

For these reasons, many authors now prefer to understand health less as perfection and more as the capacity to adapt and self-manage in the face of social, physical, and emotional challenges [2,14]. A person living actively with diabetes, a worker using a prosthesis, or an academic with multiple sclerosis who continues a meaningful and productive life may reasonably experience themselves as healthy. Health is therefore not exhausted by the absence of disease; it also includes adaptation, function, participation, and meaning [17].

1.7 PREVENTIVE MEDICINE AND THE ROLE OF THE FAMILY HEALTH CENTER

Changes in health models have increased the importance of family health centers. A health system focused only on treating established disease will struggle with rising diabetes, obesity, uncontrolled hypertension, and mental health problems. Preventive medicine is therefore not a secondary activity but a core function of primary care [3,4,11].

Vaccination, cancer screening, pregnancy follow-up, child development monitoring, chronic disease follow-up, smoking cessation counseling, and lifestyle guidance are central activities in family health centers. A contemporary understanding of health is less concerned with waiting for disease to appear and more concerned with reducing risk, strengthening resilience, and maintaining function before disease becomes disabling [3,4,11].

1.8 HEALTH EQUITY AND DIFFERENT PRIMARY CARE SETTINGS

The same care plan may be feasible in one setting and difficult to follow in another. Medicine costs, transport, working hours and the availability of follow-up can affect what patients are able to do. For refugees and migrants, language and administrative barriers may create additional difficulties. These circumstances need to be considered when treatment plans are agreed [3,18].

In the hypertension example, irregular medication use may partly reflect difficulty obtaining treatment. Advice alone will not remove this barrier. Depending on local resources, care may require help with medicine access, coordination with other services or involvement of community health workers. Family physicians cannot resolve all social problems, but they can identify barriers and contribute to a coordinated response [3,4,9].

Health research consistently shows that the conditions in which people are born, grow, live, work, and age have a major influence on health [5,18]. Poverty, education, employment security, air pollution, access to healthy food, housing, and social support are all linked to health outcomes. Family physicians recognize this at the level of individual encounters: some patients cannot afford their medication, cannot eat regularly, cannot find a safe place to exercise, live alone, or lack social support. For this reason, modern health policy cannot be limited to building hospitals. Health is also a matter of social policy, education, urban planning, working life, and environmental policy [4,5,9,18].

1.9 IS AGEING A DISEASE?

One of the most interesting debates in health models concerns ageing. Is ageing a natural process, or should it be treated as a biological deterioration requiring medical intervention? Modern medicine increasingly avoids viewing ageing only as inevitable decline. The concept of healthy ageing has gained importance, especially as populations live longer and chronic multimorbidity becomes more common [14,19].

The aim is not merely to extend life expectancy, but to preserve intrinsic capacity, functional ability, participation, and quality of life. Family health centers are crucial for older adults because many live with several chronic diseases, polypharmacy, loneliness, mobility limitation, and cognitive changes at the same time. These realities cannot be explained by biology alone [4,14,20].

1.10 IS THERE A SHARP LINE BETWEEN HEALTH AND DISEASE?

Perhaps the most important answer is that, in many situations, there is no sharp boundary between health and disease. Prediabetes, mild hypertension, subclinical depression, and mild cognitive impairment all occupy grey zones. Human health is often not black and white, but a spectrum. Family health center practice stands at the center of this spectrum, where risk, symptoms, function, values, and context must be interpreted together [2,4,14,21].

This paper presents a conceptual approach rather than an evaluated intervention. Its usefulness in routine consultations remains to be studied. Implementation will also depend on consultation time, staffing, continuity and the availability of other services.

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2. CONCLUSION: HEALTH IS A HUMAN STORY

Health is a multidimensional human experience. It cannot be adequately understood solely through laboratory results, radiological images, or biochemical values. Contemporary medicine increasingly understands the person through biological, psychological, social, cultural, and environmental dimensions. Family medicine is one of the most visible fields in which this broader understanding is practiced, because the family physician encounters not only disease but also the patient's life story.

In family medicine, disease control is one part of assessing health. Daily functioning, patient priorities and access to care also matter. Continuity allows these concerns to be reviewed together as circumstances change. A broader understanding of health becomes clinically useful when it leads to care that patients can understand, obtain and follow.

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CONFLICT OF INTEREST

None declared

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AUTHOR CONTRIBUTIONS

HY: Conceptualization, methodology, analysis, writing—original draft

DATA AVAILABILITY

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EQUATOR CHECKLIST

Not applicable

AI STATEMENT

No generative AI was used for data collection, data analysis, interpretation of findings, or generation of scientific conclusions. Only Table 1 was generated with ChatGPT.

ETHICAL CONSIDERATIONS

Ethical approval was not required as this study did not involve human participants, personal data, or confidential information.

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