

The Critical Theoretical Perspectives and the Health Care System

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Abstract

Background of the study: The goal of healthcare system is to achieve a well-organized, safe and holistic patient care. However, the existing healthcare system of today remains fragmented and complex (St. Meld. Nr.47, 2008-2009). Hence, it is still unable to meet the patients' complete integrated health care needs; and at the same time patients often experience extraneous disappointments due to unnecessary delays, disputes and complications (St. Meld. Nr.47, 2008-2009). **Aim:** The aim of this literature study is to show how critical theoretical perspectives influence the healthcare system through professional practitioners, institutional strategies and research methodology and/or policy; in order to meet the complete needs of the patients and guarantee health care services of quality and safety. **Result:** Health care is a set of complex phenomena that involves a vast of objective theoretical and scientific knowledge; professional's subjective ability to properly apply such knowledge; and a system of interaction that can ensure a well-coordinated, sufficient, efficient and safe health care service. There are three emerging levels of developing culture in health care that are addressing the health care needs of human beings today: 1 Professional level (provision of critical health care through professional's subjective synthesis of knowledge; 2 Institutional level (provision of critical institutional multidisciplinary health care through facilitated socially construed team coordination); 3 Academic level (provision of critical academic health care through interdisciplinary research generating objective knowledge with ideological policies and approach). **Conclusion:** Critical theory embraces the scientific traditions that advocate proper objectivity and subjectivity in a manner that social construction of health care becomes more appropriate, effective, and complete. Critical perspectives in health care transform the system into an integrative multidisciplinary model that provide a more thorough patient care, which brings about emancipating social changes at the three levels of health care system. Critical competencies facilitate holistic-oriented, trustworthy and safeguarding individual professional independent practice, regulatory institutions and ideological academy.

Introduction

The goal of health care system is to achieve a well-organized, safe and holistic patient care. Health care involves varied distinctive disciplinary knowledge of professionals contributing to the completion of an aspired integral quality care. It also involves interactions between them that are framed within an existing system and/or structure. Although there is a continuous and progressive developments in the existing health care system of today, health care services remain fragmented and complex (St. Meld. Nr.47, 2008-2009). Hence, it is still unable to meet the patients' complete integrated health care needs; and at the same time patients often experience extraneous disappointments due to unnecessary delays, disputes and complications (St. Meld. Nr.47, 2008-2009). Health care needs of human beings comprise the complexity involving the integral aspects of human life including physical, psychological, emotional, social, and spiritual needs.

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A common characteristic among people experiencing serious illness and trauma is anxiousness, because they are cognitively and emotionally weakened (Grimen, 2010). The combination of feeling helpless, lack of technical competence and emotional disturbance make the patients vulnerable (Parson, 1979 iGrimen, 2010). Patients who have previous undesirable experiences in health care suffer from anxiety, unnecessary stress and confusion. Previous research showed that patients, especially the elderly, could suffer from confusion in connection to surgery (Andersson, Gustavsson, & Hallberg, 2001). Later, confusion has also been linked to increase complications, prolonged hospital confinement and mortality after surgery (Galanki, Bickel, Gradinger, von Gummenberg & Forstl, 2001). Murphy (2006) asserts that care management should be holistic, because patients have an inter-relatedly complex psycho-physiological and social need. However, the unique knowledge of health care professionals from diverse disciplines has limitations and is non-sufficient to meet the complete needs of individual patients, unless the professionals will work together as a team to complement and supplement each others' critical knowledge and competencies. This is because professionals/scientists were taught, trained and cultured within their corresponding distinctive disciplinary tradition (Kuhn, 1970) that has a restricted perspective.

Doctors of medicine for instance is objective in giving care in the sense that their profession is a specific form of scientific endeavour, tracing human pain and suffering that is biological in nature (Paley, 2002). Doctors of medicine tend to prioritize the patient's bio-physiological needs, and they find it necessary and desirable to place a certain emotional distance between themselves and their patients (Paley, 2002). On the other hand, nurses provide health care on the grounds of their ideology that emphasizes the subjective capacity to be sensitive to human sufferings, to empathize, and to develop the full-fledged virtue of compassion (Bloom, 2005). They focus on providing psychological care that starts from acceptance, respect, understanding, moral support, etc to mental or behavioural therapy (Vetlesen & Nortvedt, 1997). In recognition to the objective and subjective needs of the patients, to the social processes involved in the health care system, and to the limitations of professional perspectives; critical competencies among individual practitioners, collaborative team members and researchers has become a crucial necessity. To meet the patients' holistic needs, it is pivotal to cultivate professional competencies in doing proper critical analysis, decision-making and interventions. In this connection, I will study and describe how Habermas' distinction between the objective perspective, the subjective perspective and social world has influenced the health care system. First, I will present the critical theory of Habermas; second, I will identify and describe the critical world of health care (objective, subjective and social); then lastly, I will show how critical theory has influenced the health care system through professionals, institutional policies and academic pursuits in health care sciences.

The Critical Theory of Jürgen Habermas

The critical theory of Jürgen Habermas distinguishes the reality in three dissimilar points of view: The objective perspective that regard all natural, social and subjective item/theme as a subject **matter**; the subjective perspective that include the inner world of feelings, ideas, opinions and attitudes; and the social world that does not simply exist, but is construed and legitimated (Habermas, 1999). These perspectives are non-contradictory, but rather complementary and supplementary with each other. Habermas' critical theory therefore covers elements of three reality domains in our modern world that are interconnected with each other. Based on the critical theory of Habermas, I will now identify, distinguish and describe what could be viewed as an object, subject or a social world within the health care system.

The Objective world in Health Care

The objective world in the health care system encompasses the diverse sciences or professional knowledge, including knowledge of the actual patient cases or organizational routines wherein said knowledge is to be applied. This embraces generalized scientific and theoretical knowledge that has brought about clarity, structure, regularities and predictabilities to our understanding **of/about** patient conditions such as bio-physiological needs, pathological diagnoses, treatment and rehabilitations. This also covers factual and context-specific patient information, procedural communication, technical and practical routine, standardized interventions, organizational system and strategies, rules and regulations, professional ethical ideology, institutional policies, governing jurisprudence, etc. In health care, objective theories, scientific knowledge and generalized principles serve as the main core and measurement for quality assurance and patient safety. Patient safety is an important part of quality regime in every health care service, and encompasses avoidance, prevention, and limiting undesirable incidence and risks (Aase, 2010).

The Subjective World in Health Care

The subjective world includes those personal factors that belong to the patients and/or health care professionals, which could have a direct impact on the health of the patient and the health care processes and services. The patient's personal values, beliefs, culture, tradition, language, level of knowledge and understanding, and other individual subjective experiences have significance in their own health and in the health care services that they receive. It is therefore important for the professionals to acknowledge how and why these subjective patient experiences play a role in being able to meet their needs and in providing them the deserved safety assurance. The World Health Organization (Longtin, Leape, Sax, Sheridan, Donaldson & Pittet, 2010) and the Social and Health Ministry of Norway (Sosialhelsesdirektoratet, 2006) recognized that subjective experiences are crucial to patient safety therefore they recommended that patient must participate in the health care processes. Patient participation means that the person using the health care service should be an active participant in planning and deciding about their own care, treatment and/or rehabilitation from the very start and until the health care goals have been achieved (Sosialhelsesdirektoratet, 2006). Through patient participation subjective factors that have significance in patients' health care and treatment can be revealed. Hence, patient participation as a strategic concept emphasizes the patient's role in their own health situation to enhance patient safety when the patient is receiving any form of individualized treatment or health care service (Longtin, Leape, Sax, Sheridan, Donaldson & Pittet, 2010). In Norway, patient participation is embodied as an aspect of quality, and a priority issue in National strategy for quality in social- and health care system (Jenssen, 2009).

On the professionals' perspective, subjectivity in health care service may concern their personal value, behaviour and attitude. Analysis of unwanted incidence and unnecessary errors suggests that the common causes of surgical failures often come from behavioural factors rather than lack of knowledge and technical expertise (Paterson-Brown, 2010). Every complex social situation, institution or event is the result of a particular configuration of individuals, their dispositions and understanding of their situation (Watkins 1959 in Lukes, 1968). Furthermore, professional subjectivity involves the professional's individual ability to properly apply professional ideological baseline, and theoretical/scientific knowledge in meeting the objective and subjective needs of the patients. Elements of ideology influence the carers' actions, behaviours and attitudes that manifest knowledge content, because practitioners may conduct their functions based on their professional ideology (Geuss, 1981).

The Social World in Health Care

The construed social world in the health care system is the structured process of interactions among or in between health care professionals and patients. Social interactions involve both the objective and subjective world of this system. It is about actual communication, collaboration, and other activities that involve socio-professional relationships. However, professionalism is not simply an application of scientific knowledge in practice or in a patient-professional health care setting; it also demands moral, political and legal discretion (Grimen, 2010). Patient safety and professionals' work satisfaction depends on how health care is organized (Lindwall & von Post, 2009), because competent clinical performance is conditioned by time, space and circumstance. According to Svensson and Karlsson (2010), putting leadership control and effectiveness before professional competence can be a source of criticisms. The tension between ideal and reality can cause problems, and this applies to all social institutions (Tranøy, 2007). Any institution with strategic organization that aims primarily for economic gain may result to enormous consequences, both for the patients who may suffer from trauma or for the professionals who may suffer from guilt. In 2007, 127,416 cases of possible faulty surgery was reported in UK, and 1136 of these were related to wrong patient details, wrong surgical site and mistaken surgery (Paterson-Brown, 2010). Neglecting potential instances of patient safety in favour of economic advantage should be resisted in all levels of clinical and administrative leadership (Paterson-Brown, 2010).

At the clinical area, the recognition of interplay between patient participation and patient safety is probably the most significant social paradigmatic change in health care system today. The subjective ability of professionals to properly apply their knowledge and the standardization of patient participation play an important role in building an organizational activity that may reduce complications, morbidity and mortality rate. Reduction of unwanted incidence and unnecessary injury will require changes on many levels within a health organization (Paterson-Brown, 2010). The limited knowledge provided by distinct sciences in health care can be strengthened through a critical stance. A critical stance is an essential attribute of the fundamental sense of science literacy (Yore et al, 2004). To strengthen the professionals' subjective ability to apply knowledge upon serving the society, health care seems to transform into a three-level critical knowledge system.

The Transformation of Health Care System Today

Health care continues to grow in complexity due to advancement in technologies of care and increased availability of medical information for clinicians and patients (Sibbald et al., 2013). Paradoxically, as a reverse consequence, health care needs in general also drastically increases. To address the rapid changes and development in health, health care and health sciences, concepts like knowledge synthesis (Kim, 2000), multidisciplinary (e.g. Sylvia et al, 2011), interdisciplinary (e.g. Jacob et al, 2013; Sibbald et al, 2013), holism (Kim 2000), etc have been dominating the academic, institutional and individual professional activities. It is believed that complex and persistent health and social problems can be more effectively addressed by integrating research expertise and scholarship from diverse range of disciplines (Clarke, Hawkins, Sadler et al, 2012). There are three emerging levels of developing culture of what I will call critical unitary scientism in health care that are addressing the health care needs of human beings today: 1 Professional level (providing Critical professional health care); 2 Institutional level (providing Critical Institutional health care); 3 Academic level (providing Critical academic health care).

1. Professional Level

In this level, critical professional health care is provided through professional's personal synthesis of knowledge. In caring science, Kim (2000) introduced the theory of knowledge synthesis based on critical theory of Habermas. Knowledge synthesis of Kim shows four spheres of knowledge: a.) The generalized sphere, b.) The situated hermeneutic sphere, c.) The critical hermeneutic sphere d.) The ethical/aesthetic sphere. These four spheres represents the objective knowledge content utilized by caregivers. In practice, each professional subjectively elicit personal knowledge, draw situational/circumstantial specific knowledge and they access public knowledge.

a.) The generalized sphere is inferential and focuses on the generalizable knowledge. The knowledge in this sphere provides foundation for general understanding, systematic explanations and predictions through objective validation. Natural sciences for instance enable the professionals to predict, understand and explain phenomena concerning normal human anatomy and physiology, disease pathology, medical treatments, etc; technical and technological sciences allow professionals to deliver safe health care service through qualified and accurate use of technical device or equipment; and knowledge of organizational, managerial and legal laws guide professionals to structure their duty in practice and guarantee quality and patient safety. b.) The situated hermeneutic sphere is referential and refers to the knowledge that can give us insights, appreciations, sensibility and understanding. This sphere is about acknowledging subjective meaningful human experiences that is lived within a situational context between patients and professionals. In meeting the patients, awareness and appreciation of patients' subjective perspective helps the professionals to be aware of the prejudices governing their own subjective understanding. The patients' view must be acknowledged so it can be isolated and valued on its own (Gadamer in Austgard, 2012). This is so, because a misunderstanding of the care recipient's needs may result in unhelpful responses (Abraham & Shanley, 1992). Several factors that affect health, diseases and healing are of social and of cultural nature (Grimenog Ingstadi Grimen, 2010). In this respect, empowerment becomes necessary. Empowerment is a form of social care because it rejects alienation, sustain self-esteem and promote self-actualization (Stang, 1998). Alienation means that a person may feel strange among her/his environment, her life or herself/himself. It means that one is not in the position of controlling her/his own destiny because of other powerful influence such as people, organization, etc (Rotter in Stang 1998). If we are to understand about particular case, we need to understand the culture-specific aspect with reference to a more universal aspect (Shweder, 1990). c.)

The critical hermeneutic sphere is transformative, and refers to the knowledge of interpretation, critique and emancipation. It is dialogical and informative knowledge that depends on the use of language. This elucidates knowledge of mutual understanding through interpretation; hermeneutic understanding through fusion of horizon; and emancipatory through autonomy and responsibility. Health professionals for instance should be able to communicate with patients, understand their life situation, and sort out the factors that have an impact on their health, diseases and healing (Grimen, 2010). Communication as a tool for gathering objective and subjective information is two way. To be able to gather information from the patients, health care professionals are required to inform the patients about the services they give and orient them about their possibilities. One has to encounter the knowledge, so that it can be a part of one's universe (Collins, 2009) of possibility.

Informing patients about possibilities can assist them in making their own choices about their care as well as how they want to participate in their own change process ((Rogers 1970 in Butcher, 2006). Patients will most unlikely involve themselves in decisions that concern medical knowledge and clinical expertise, but studies revealed that thorough information give patients strength to trust themselves and come with a decision that only themselves would ever know (Longtin et al., 2010). d.) The ethical/aesthetic sphere is desiderative, and refers to knowledge regarding the general and specific normative standards of caring practice. It determines what is desired, normatively expected and aspired in practice. This sphere illuminates professional and humanistic ideology to do what is best for the patients. A "call to duty" means the responsibility to do work that is for some greater good (Butcher, 2006). Knowledge synthesis reflects the **subjective competencies** of professionals in critical analysis, decision-making and in applying their objective theoretical/scientific knowledge drawn from four different spheres. However, because science is just a quest for understanding (Roscoe, 2010) or simply an attempt to understand, explain, and predict the world we live in (Okasha, 2002); there is a possibility that the knowledge we arrived at is not a reality and/or knowledge we applied to are not appropriate to the situation. Through critical ability, professionals may question the objective knowledge and structures, and at the same time enable them to generalize that subjectivity such as individual patient's experiences is an important aspect in giving care.

2. Institutional Level

Critical Institutional health care is socially construed and represents Habermas' legitimated social world. Critical Institutional health care provided through unitary science is an institutionalized ethical culture in practice when collaborative professional employees contribute toward a holistic care. Critical Institutional health care is therefore cumulative or a collection of interacting critical professional health care competencies which function within an objective legitimated system. At this level, organizational strategy facilitates collaboration of different practitioners and coordination of integrated care through good leadership employing multidisciplinary perspectives. Thus, enables the institution to develop and provide a complete health care that allows satisfaction of the complex human needs that is conditioned by space, time and scope reality. The interdisciplinary team coordinates and functions through given institutional structures, and the team problem-solving ability is greater than that which could be achieved by a single individual's profession-specific knowledge base (Ruddy & Rhee 2005 in Jacob et al., 2013). For instance, Taylor (2008) asserts that correction of malnutrition has shown to have effects on wound healing, on length of hospital confinement, morbidity, and mortality. To prevent postoperative complications, it was recommended that community health professionals and hospital staff need to be alert regarding the overall health issues of the elderly patient; including assessment of cognitive impairment, nutritional, blood and electrolyte status prior to and after surgery (Stewart, 2011). In this case, the knowledge of complex needs enable us to identify the necessary professional competencies owned by professionals who should comprise the coordinating critical health care team.

For several years, proper coordination of patient care has been considered as a significant factor in the improvement of any health care service (Tjora & Melby, 2013). Unfortunately, it was also proven that professionals have no agreement on the subjective definition of "care coordination" and no consensus on what it entails (Walsh et al., 2011). In a study done in England and Denmark it was revealed that there is lack of clarity about who should perform specific tasks and there is omission and duplication of care coordination activities (Beringer & Fletcher, 2008). It is believed that assessment of patients' objective and subjective needs are rarely included as an essential component of care coordination (Walsh, Young, Harrison, Butow, Salomon, Masya & White, 2011). Researchers have concluded that coordinated care requires far more effort than physicians alone can deliver (Stille et al 2005 in Ehrlich et al 2012). It is believed that effective care coordination or collaboration depends on the capacity to move across multiple professional, organizational and cultural boundaries (Ehrlich, Kendall, Muenchberger, 2012); and this critical culture capability can be institutionalized for a more effective activities. A prominent evidence for unity in science of care is the pursuit to improve collaborative effort, guidelines, interventions and outcomes; through interdisciplinary critical research.

3. Academic Level

Critical scientific/academic research generates theoretical and scientific knowledge that encompasses the objective world in the health care system. Theories are presented in textbooks illustrating many of its successful applications (Kuhn, 1970), while scientific knowledge is published as articles in databases. Academic knowledge provides generalized knowledge and systematic structure or classifications that validates and legitimize sound clinical judgments.

Systematic method for identification, assessment, analysis, and evaluation of risk are necessary foundation of important decisions (Aven, 2007) in professional health care practice. Classifications reflect distinctions inherent in the world, assume determinism (Polit & Beck, 2012), and facilitate predictions. Traditionally theories and scientific knowledge are produced within a discipline, until it was proven that interdisciplinary coercion provides a more sophisticated knowledge and allow a better understanding of complex reality (Kim 2000; Peter et al, 2011; Tappenden et al. 2013; Tjora & Melby, 2013). Interdisciplinary health research is increasingly encouraged and is often a specific requirement for research grants worldwide (Clarke, Hawkins, Sadler, et al., 2012). The Office of Research in Women's Health at the National Institutes of Health in Maryland, USA prioritizes interdisciplinary research to promote institutional change towards best practice (Dornino, Bodurtha, Nagel et al, 2011). Changes to clinical practice were often attributed to new clinical research evidence (Sibbald et al, 2013). In medical education, there is a recurring call for more social science and humanities in the curricular content, because it was acknowledged that biomedical science alone is not sufficient for training of caring and competent health care professionals (Whitehead, 2013). Scientists whose research is based on shared paradigms were committed to the same rules and standards for scientific practice (Kuhn, 1970), therefore they have the easily recognizable limitation. A scientist should draw upon multiple forms of knowledge including natural sciences, social sciences and humanities (Whitehead, 2013). Fusing varied disciplinary perspectives and integrating multidisciplinary research practice can directly influence analysis, understanding, explanation and generation of new ideas in health research (ibid), and consequently in health care system as a whole. Through interdisciplinary research, each critical professional practitioner will gain knowledge and insight that may entirely cover the complex and integrated needs of each patient that is under his/her care. More and more researchers are inclined to interdisciplinary collaboration within and across the institutions, communities and nations. Interdisciplinary collaboration also brings forth creative/innovative ideas and products that have a direct impact on the health and wellbeing of the society

(<http://ec.europa.eu/programmes/horizon2020/en/area/health>). The impact of architecture (Peters, 2008; Knibbe & Waaijer, 2012), technological engineering (Peter et al, 2011), Information and Communication Technologies (Haux et al 2008), etc have been more and more highly acknowledged as contributing disciplines addressing the health care needs of human beings. In research, methodologies grounded on a critical ideology often utilize multiple perspectives and focuses on raising awareness and advocating emancipation in hope for a social change (Polit & Beck, 2012). Research conducted within an ideological framework can therefore be described within a transformative paradigm (Mertens, 2007). This transformation should reflect trustworthy and safeguarding health care service and professional relationship through generalized and objective validating scientific and theoretical knowledge. The professional relationship between health care givers and their patients is characterized by epistemic asymmetry. Epistemic asymmetry means that the professionals manages knowledge that patients/clients does not have, but do need them (Grimen, 2010). This implies that professionals should act in the virtues of integrity, sincerity, credibility, allegiance and dependability. Trustworthiness of the professionals connotes reliability of their knowledge and competence, because patients are in a type of position that is characterized by lack of knowledge and powerlessness (Grimen, 2010). Reliability of validate multidisciplinary knowledge develops through scientific research with ideological constructs (Polit & Beck, 2012), such as through the critical philosophy of Habermas. Some scholars elucidate and articulate the philosophy of the science of unitary human beings within the context of the universe of philosophy (Butcher, 2006). They advocate unitary pattern-based praxis that recognizes harmony in person-environment integrality; facilitating patients' ability to participate knowingly in change. This promotes healing, wellbeing and human betterment in both patient care and research contexts (Rogers 1970 in Butcher, 2006).

Conclusion

"Philosophy should develop and bloom through multidisciplinary sciences, and should embrace the whole scientific civilization, so that nature-, social- and spiritual sciences will grow together with a greater relation to the world" (Schelsky, 1963 in Habermas, 1999). Health care is a set of complex phenomena that involves a vast of objective theoretical and scientific knowledge; professional's subjective ability to properly apply such knowledge; and a system of interaction that aspire to ensure a well-coordinated, sufficient, efficient and safe health care service.

Apart from its complexity, health care is in constant change due to the rapid advancement in medicine and technology, and due to the changing social norms. Paradoxically, the developments in health sciences bring forth the increasing needs and expectations from the society. These health care needs and expectations are also complex and necessitate a collection of diverse disciplinary knowledge from different health sciences. There is a call for a multi-professional collaborative effort in order to meet the health care demands of today's generation through professionalism and good leadership. Critical theory embraces the scientific traditions that advocate proper objectivity and subjectivity in a manner that social construction of health care services becomes more appropriate, effective, and complete. Critical perspectives in health care transform the system into an integrative multidisciplinary model that provide a more thorough patient care, which brings about emancipating social changes at the three levels of health care system. Critical competencies facilitate holistic-oriented, trustworthy and safeguarding individual professional independent practice, regulatory institutions and ideological academy.

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