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Social factors in the gender perspective in health

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The 1948 WHO document containing the well-known definition of health as bio-psycho-social wellbeing sparked a heated debate when it was published, as numerous sides were aware of the implementation difficulties it would entail. This position was based on the development of the discipline and its scientificity based on the observation of an ill body, which, from Descartes onwards, had separated the body from the mind and the patient from his/her living conditions.

This perspective therefore implied, in practical terms, a revision of the traditional clinical approach and of the very concept of health, such as the absence of disease. It did not include the social factors influencing our environmental context and behaviours, and our cultural models, and consequently, our daily experiences.

Despite this evocative element and the objective considered relevant still today, i.e. the therapeutic result, the term "quality of life" meets with the same opposition when the profession is exercised, even with significant theoretical contributions. This sort of impermeability is justified on the one hand by a presumed a-scientificity of the data to be used and, on the other, by the requests deriving from the privatisation of and by the resource cuts in the healthcare system[1].

Surely in the face of such immobility a certain organisational inertia needs to be examined, marked as it is by delayed and inadequate answers. At the same time, the need to review interpretative frameworks in favour of the paradigms needs to be supported. These go from the multidimensionality of the health category to providing a suitable definition of both the interpretative keys and tools.

Conversely, if the complexity of reality is crammed into the method set out to understand it, not all variables can be taken into due consideration; therefore, the risk is the same one identified by Kuhn in "The Structure of Scientific Revolutions" where he argues that "What a man sees depends both upon what he looks at and also upon what his previous visual-conceptual experience has taught him to see."

In other words, what is needed is an epistemological review of the disciplinary statutes where, to date, barriers have been erected, areas of contamination have been created and the acquisition of new knowledge may be the result of porous exchanges, of reflections that allow for the development of shared, critical paths in universities where obstacles were raised, and which are now widely questioned.

Merton[2] has focused on the idea of historically and socially produced science, on the fact that even a datum considered objective is the result of a construct, meaning that the crystallisation of criteria can determine the prescriptions, prohibitions, preferences and directions allowed in the research, which legitimise the institutional values and accredited methodologies adopted by the scientific community.

In the case of positivism, the exclusion of the observer's assessment on behalf of a presumed objectivity has, in the words of Oliver Sacks, excluded a 'who' as well as a 'what', i.e. an actual person in medicine, as no subject is present in the meagre history of clinical cases.

Gender medicine has suffered from the same slow form of penetration, in addition to the difficulty of interpreting this term when used as a simple synonym of 'sex'. Precisely for this reason, as stated repeatedly, it is not so much about medicine, even if the latter is gender-specific, but rather about the gender perspective in health when it comes to promoting a field of research that follows a multi-factorial model and includes all indicators involved in the process, thereby avoiding what has been defined as "social biologization"[3,4].

The multidisciplinary concept of health and the category of gender

Consequently, if it is correct to shift from a bio-medical approach to a broader scenario, then it is also necessary to shift interest towards a holistic idea of psychosocial wellbeing, thus overcoming the dualities that have divided the body from the mind and the individual from his/her daily life. In this way, numerous elements and related causes are considered relevant in a renewed concept of health, ranging from environmental quality to food consumption, from individual behaviours to safety in the workplace[3].

It follows, from an integrated and non-reductive perspective, that gender can proffer a heuristic value to bypass the so-called neutrality of science. According to said neutrality, males are perceived as an invariant, a performative structure that actually leads to a natural form of female subordination, not only in terms of citizenship rights but also in terms of visibility and recognition as fully-fledged subjects with differences.

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To elaborate a new epistemological position, we need to examine the cognitive methods and overcome the 'organic, hierarchical dualisms ordering discourse in the West'. Indeed, it is in the overlapping of nature and culture that the term gender is used as a synonym for sex, a mistake we continue to make in medicine, which results in us losing those important aspects of this category that can help us to better understand the phenomenon, assuming the category is used according to its meaning as a social construction of biological differences.

This means that with the full declination of this perspective, we can see what was previously attributable to the perseverance of axiomatic cultural models, deriving from a practice of dominion, and expound the processual dimensions that still today lead to inequalities between the two sexes, in terms of roles, relationships, expectations, obligations and behaviours that are considered culturally appropriate. On the one hand, we are dealing with disadvantages deriving from both the dynamics of power, the availability of material resources and disparities in welfare systems*, as well as dominant values and beliefs in the public sphere; and on the other hand, a destiny that from the attribution of the essential maternal function reproduces the traditional and asymmetric management of domestic chores and care-giving activities[3,4]. Conditions, therefore, that have been historically assigned to different identities and reproduced by the socialization processes and educational models deriving from the very characteristics of sexual belonging and the social implications that these entail.

Based on such assumptions and in order to overcome these dichotomies that have characterized positivist scientific thinking, our contribution, from a theoretical perspective, is to refute the ontological premise of the objectivity of observation, which has excluded other points of view, and re-define paradigms capable of initiating a dialogue among open methodologies, and to address the complexity of the elements present in the health system, which is interpreted as a complex process and not just as the absence of disease**. To quote an eloquent metaphor by Merton[2], 'Medicine is at heart a polygamist', i.e. medicine is married to a number of sciences from which contributions and visions are derived to build a dynamic category of health that takes into account many possible dimensions, including these three terms and their multi-faceted meanings: disease, illness and sickness. By looking at gender differences from another point of view, we can reveal concealed horizons of an important articulation of knowledge that can help us to improve the effectiveness of therapeutic interventions. If we introduce this concept in our work, we will be expanding the field of common reflection and leaving behind the Universal Subject, meaning we can compare inclusive categories and opposing dichotomies, which have characterized our way of thinking for some time now.

Therefore, to respond to the question 'what can sociology do for medicine and vice versa?' i.e. what kind of osmosis can we create amongst types of knowledge, we have to look to the introduction of multidisciplinary keys. These models can be used to develop more inclusive theories and practices in the medical field and help identify the multifarious connections between the two disciplines and broaden our gnoseology (philosophy of knowledge). This results in the overcoming of the exclusive control exercised by a physician in favour of other professionals with whom reflections and cognitive objectives can be shared to improve the quality of not only the services offered but also of the success of the treatment.

Indeed, the critical reflection on the definition and classification of diseases, considered scientific but instead strongly influenced and founded in the historical context and the cultural climate that produced them, highlights how gender differences have been codified within an exclusively male community that perceived female inferiority and subordination as natural. Many of the diagnoses were, in fact, based on an ideological approach, and little attention was devoted to the aetiology, the numerous and possible explanatory variables, thus forgetting the social and psychological causes of the afflictions of women.

There is a risk that this historical delay may persist in the prevention, diagnosis and treatment of diseases if theoretical efforts do not become a part of the profession in practice.

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* The Italian welfare system is based essentially on the concepts of work and compensation, flanked by the Catholic vision of subsidiarity, i.e. the importance of the family and social policy (Esping-Andersen, 2009).

** To unravel the threads that bind people to their cultural environment, the widespread *mentality* needs to decipher the past and question the founding core of scientific conjecture by refuting the ideology of objectivity, by exposing the constraints that symbolic structures exert on intellectual attitudes and, consequently, subvert the influence of social roles on the production of science (Merchant, 1980; Armstrong, Pederson, 2015).

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