ABSTRACT. The dysfunctional consequences of the Cartesian dichotomy have been enhanced by the power of biomedical technology. Technical virtuosity reifies the mechanical model and widens the gap between what patients seek and doctors provide.

Patients suffer "illnesses"; doctors diagnose and treat "diseases". Illnesses are experiences of discontinuities in states of being and perceived role performances. Diseases, in the scientific paradigm of modern medicine, are abnormalities in the function and/or structure of body organs and systems. Traditional healers also redefine illness as disease: because they share symbols and metaphors consonant with lay beliefs, their healing rituals are more responsive to the psychosocial context of illness.

Psychiatric disorders offer an illuminating perspective on the basic medical dilemma. The paradigms for psychiatric practice include multiple and ostensibly contradictory models: organic, psychodynamic, behavioural and social. This mélange of concepts stems from the fact that the fundamental manifestations of psychosis are disordered behaviours. The psychotic patient remains a person; his self-concept and relationships with others are central to the therapeutic encounter, whatever pharmacological adjuncts are employed.

The same truths hold for all patients. The social matrix determines when and how the patient seeks what kind of help, his "compliance" with the recommended regimen and, to a significant extent, the functional outcome. When physicians dismiss illness because ascertainable "disease" is absent, they fail to meet their socially assigned responsibility. It is essential to reintegrate "scientific" and "social" concepts of disease and illness as a basis for a functional system of medical research and care.

In 1649, there appeared a treatise by Rene Descartes on 'The Passions of the Soul' which was to play a major role in medical ideology. At one and the same time a devout Catholic and a scientific rationalist, the French philosopher sought to reconcile the need to deal with the body as machine, to celebrate the soul as divine and yet to acknowledge the intimate interrelationship between body and soul. His ingenious solution, very much in the mechanical mode, was to seat the soul in the pineal, a tiny body whose position astride the ventricular system, much like a rider on a horse, subjected it to bodily influences and gave it means to effect body movements through the agitation of the ventricular fluid.

"... That part of the body in which the soul exercises its functions immediately is ... the most inward of all its (the brain's) parts, to wit, a certain very small gland which is situated in the middle of its substance and so suspended above the duct whereby the animal spirits in its anterior cavities have communication with those in its posterior, that the slightest movements which take place in it may alter very greatly the course of these spirits; and reciprocally that the smallest changes which occur in the course of the spirits may do much to change the movements of this gland ... (pp. 345–346) ... The whole action of the soul
consists in this, that solely because it desires something, it causes the gland to which it is closely united to move in the way requisite to produce the effect which relates to this desire . . . " (Descartes 1951: 350). The Cartesian schema was a stroke of scholastic genius; it legitimated the study of the body as mechanism by the science of physiology and preserved the soul as the domain of theology.

As has so often happened in the history of ideas, what was at its inception liberating became in time restricting. The Cartesian disjunction freed biology (and thence medicine) to turn its full powers to the elucidation of physiological and pathological mechanisms in an epoch when natural science was able to develop methods and concepts for investigating only such matters. Yet the very success of the enterprise, most particularly in the past half century, has caused soul or mind to recede so far into the background of contemporary medical thought as to yield so narrow a perspective on problems of patient care as to seriously hamper the physician's efforts to provide that care (Engel 1967). I refer here not so much to the insufficient attention given to psychiatry within the medical curriculum, although that is not an unimportant problem, as to the altogether inappropriate conceptualizations of illness provided for the student in his or her medical education. In the United States, this view was crystallized in the Flexner report (Flexner 1910), a document which set the conditions for both the flowering of what is best in American medicine and the proliferation of the difficulties that now beset it on every side. The prodigious accomplishments of the new biology, institutionalized as the fundamental science to be applied in medical practice, further reified the Cartesian mechanical model. Working models of the disease process determine the data that physicians gather, inform the ways in which 'facts' are integrated into a diagnosis, and circumscribe the boundaries of interventions designated as therapeutic. The momentum of the technological imperative to do what we have the virtuosity to do (without pausing to consider whether it is worth doing) drives the physician's hand and brings him increasingly into conflict with what the patient seeks from him (Eisenberg 1976). Moreover, what has been called the new morbidity (Haggerty et al 1975) — with functional disorders and chronic illness displacing acute infections as the predominant challenges to the medical care system — is not only unresponsive to technology, but is in significant ways worsened by it. The ability to salvage congenital anomalies and to prolong vegetative existence with cardiopulmonary bypass machines and other devices raises questions of meaning and quality in life which strip away the illusion that technology is value-free (Eisenberg 1975).

To sharpen discussion, I will set forth a somewhat overstated contrast between lay and professional perspectives without attempting to provide fully comprehensive and logically exclusive definitions (Fabrega 1972). What matters
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for our purposes is the headlines, rather than the fine print, if we are to confront the major conceptual barriers to a responsive health care system.

To state it flatly, patients suffer 'illnesses'; physicians diagnose and treat 'diseases'. Let me make clear the distinction I intend: illnesses are experiences of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems. I will employ this semantic distinction in the discussion that follows, though I acknowledge that illness and disease are synonymous in contemporary English usage.

Illness and disease, so defined, do not stand in a one-to-one relationship. When disease is extreme, as in diabetic ketoacidosis or in the terminal stages of malignancy, its pervasiveness makes illness inevitable. However, disease may occur in the absence of illness: the person with hypertension may be asymptomatic and therefore unconcerned when the physician who measures his blood pressure becomes alarmed; he may stop taking the prescribed medication because it makes him 'ill', even though he is told it will mitigate his 'disease'. Only when the hypertension leads to congestive failure or hemiplegia will the person become a patient and agree with his doctor that he is sick; even then the agreement may be limited to a common perception that a problem exists which each is likely to formulate in quite different terms.

Similar degrees of organ pathology may generate quite different reports of distress, differences determined by culture, expectation and setting. Zola (1966) has described strikingly different complaint patterns in Italian and Irish patients with 'objectively' similar medical conditions. Beecher (1956) has noted the greater reliance on morphine analgesia among civilian accident victims than among military battle casualties with comparable traumatic injuries. Calin and Fries (1975), in a systematic follow-up of 'healthy' blood donors positive for the histocompatibility antigen HLA-W-27 (an antigen previously identified as a marker for ankylosing spondylitis), found that about one-third of these ambulatory and undiagnosed individuals had symptoms of inflammatory disease and X-ray findings pathognomonic for the clinical entity. Here we confront the variability not only of disease expression in a genetically susceptible population but also of the medical index of suspicion for its diagnosis in the face of the ubiquity of chronic low back pain (also present in 10% of the control donors without W-27 who were simultaneously surveyed).

These few examples must suffice to illustrate the variability of the experience of illness in the presence of ascertainable disease of comparable severity. The other side of the coin is the problem of illness in the absence of detectable organ pathology, for which conversion hysteria provides a convenient paradigm. Its recognition is as ancient as Egyptian medicine (19th century B.C.); the term we still employ stems from Greek medicine (5th century B.C.). The regnant theories
of its cause have changed from wandering of the uterus through demoniacal possession to psychological determination (Veith 1965). More importantly, its prevalence and its phenomenology have changed pari passu with the changes in ideas about it (Chodoff 1954). Rather than reviewing this historical evolution in detail, let us take a moment to consider the patients so meticulously studied by Charcot at the Salpêtrière (Guillain 1959). Whatever his patients’ initial complaints, by the time they had been shown repeatedly to the attentive medical audiences who flocked to his celebrated lectures, they came almost uniformly to exhibit all four phases of Charcot’s ‘major hysterical crisis’ in the course of their medical acculturation. This presents, in microcosm, a culture-bound syndrome emerging from the interaction between the professor and his clientele (Munthe 1930). Let it be clear: the patients were ill before they saw Charcot; what changed was the patterning of the symptoms; in a way, doctor and patient shared a folie-à-deux. He expected what they produced; they came to produce what he expected. It was the evolution of the clinical syndrome that had been altered, not its initiating pathogenesis. That had anteceded his intervention; yet his ideas, as they interacted with lay belief systems, in turn became part of the common culture. With culture change, the flamboyant manifestations of hysteria have diminished sharply in frequency (Chodoff 1954). Epidemics (Smith and Eastham 1973; Sirois 1973) in susceptible, usually rural, populations are still occasionally reported. The less dramatic and more diffuse psychosomatic syndromes have not only replaced the anaesthesias and paralyses of yesteryear as culturally constructed and legitimated responses to life stress but have also come to constitute a major fraction of medical practice (Stoeckle et al 1964).

The shifting pattern of symptoms among military neuropsychiatric casualties provides another illustration of the shaping of the response to stress by culture which channels overt expression into explicit syndromes of illness. What DaCosta had described as ‘irritable heart’ or ‘neurocirculatory asthenia’ among soldiers in the American Civil War had been reified as ‘disordered action of the heart’ by British physicians at the time of the First World War. By the Second World War, cardiac symptoms, though still prominent, were less exclusive; the congeries of symptoms were reformulated in such diagnostic categories as ‘battle fatigue’ or ‘combat neurosis’. Concomitantly, conversion symptoms (blindness and paralysis) were less often encountered in the Second than the First World War (Baker 1975).

The point of interest here is not the terminology but the changes in the observed manifestations, in which other symptoms had displaced the cardiac ones from the centre of medical attention. Indeed, in the Second World War, military psychiatrists noted the local character of prevalent clinical syndromes; that is, there were differences in the patterns observed at different fronts.
Moreover, the course of illness was observed to alter as the mode of management was changed. Prompt treatment near the front and rapid redeployment resulted in far less chronicity than when neuropsychiatric casualties were shipped back to distant hospitals (Medical Department, U.S. Army 1974). What remains enigmatic is the relationship between official military figures and the actual prevalence of casualties. Factors like unit morale, effective leadership and specific battle conditions, as well as modes of management, influence incidence as well as course. To an unknown extent, we face a problem in classification; that is, the same constellation of signs and symptoms can be ascribed to medical causes (for example, cardiac malfunction), they can be regarded as instances of cowardice, or they can be labelled combat neurosis. It is also likely that actual rates of casualty are a function of the behavioural options which shared belief makes available to the community. Now that neurasthenia, a concept from Western medicine widely adopted in China and Taiwan (A. M. Kleinman, personal communication), is no longer an officially tenable diagnosis in the People’s Republic of China, it would be most instructive to know what – if any – syndrome of illness has replaced it as a mode of response to stress.

If conversion hysteria serves as a convenient example of ‘illness without disease’, it also provides an apparent contradiction to the thesis that, for contemporary medicine, disease is organ pathology. Hysteria is to be found in the official medical classifications of ‘disease’. In part, its tenure is a heritage of the past when it was the province of neurology; in part, it may be supposed by some to yield its secrets one day to more sophisticated biomedical research into its pathogenesis. However, it is precisely hysteria as a prototype of the ‘myth of mental illness’ that has been singled out by proponents of labelling theory (Szasz 1964) for use when they criticize physicians for ‘medicalizing deviance’. Moreover, for many physicians, the so-called functional disorders represent problems of uncertain legitimacy and continuing debate over such concepts as malingering or secondary gain (misuse of the sick role, in sociological terminology).

My argument thus far has stressed the discrepancy between disease as it is conceptualized by the physician and illness as it is experienced by the patient. To that I have added an emphasis on the way the patterning of illness is influenced by medical concepts as they permeate the general culture – which is something that has, of course, always been the case. Practitioners of the healing arts have existed for as long as professional functions have been specialized in human society. In a recent excavation of a Neanderthal burial site, a skeleton some 60 000 years old was found close to pollen grains from eight flower species, seven of which are still extant and known for their medicinal properties (Solecki 1975). This unlikely botanical clustering suggests bouquets purposefully gathered and laid down at the interment of a medicine man or shaman.
Whether or not healers appeared on the scene quite so long ago, medical lore is integral to every existing human culture (Leslie 1976). With the historical evolution of a people, the healer, initially a repository of folk tradition, becomes highly specialized. He is ‘called’ to his role by personal experiences or attributes that set him off from others; he may be apprenticed to older practitioners and undergo a period of intensive preparation; he acquires arcane knowledge and the gift of communicating with the gods and spirits. Because he must expose himself to, and overcome, the dark forces that produce illness, he is deemed to possess great powers. The principal social functions of the medicine man reside in his ability to diagnose, to prescribe ritual actions designed to overcome illness, to cast a prognosis, and to legitimate the mysteries of death (Kleinman 1974). He names and explains just as we name and explain, though he and we employ very different explanatory systems. All belief systems (and we must acknowledge that this includes our own) are culture-bound. They make little sense out of context despite their persuasiveness to those brought up to share the same frame of reference. They change as the society which generates them changes — and as specialization of professional function permits the development of bodies of learned knowledge. To the extent that these new conceptions become common property, they may displace, merge with or simply coexist by the side of older lay beliefs, despite what appear to be logical incompatibilities. In developing countries, patients quite regularly employ the services of health practitioners of widely different persuasions, sometimes consecutively and sometimes simultaneously, as if to leave no source of relief untapped. Within such a society, as one moves from the low, usually preliterate healing tradition through the ‘high’ tradition (formal, scholarly and élite) and finally to imported Western medicine, one observes widening gaps in shared belief, in social class and in effective communication between patient and practitioner (Kleinman 1975). This is more readily recognized in an exotic context; that is, when it occurs in another country. We ignore, at peril to our understanding, the extent to which American patients seek out marginal practitioners (Firman and Goldstein 1975) and obtain as much (or as little) relief as orthodoxy is able to provide for such chronic disorders as low back pain (Kane et al 1974). What besets the Western physician is a difference in degree and not in kind from what troubled his predecessors.

However, the very limitations of their technology kept indigenous healers more responsive to the extra-biological aspects of illness, for it was chiefly those aspects they could manipulate. Our success in dealing with certain disease problems breeds the ideological error that a technical fix is the potential solution to all. It would be absurd to suggest that we should forego the power of Western medicine in deference to shamanism. It is essential to enquire how we can expand our horizons to incorporate an understanding of illness as a psycho-
logical event. Indeed, our worship of restricted and incomplete disease models can be viewed as a kind of ritual or magical practice in itself.

To what extent can we anticipate help from psychiatry in resolving these dilemmas? Of necessity, psychiatry has retained a greater concern than other fields of medicine for subjectivity and social context; the reasons are intrinsic to the specialty. The inherent nature of its clinical problems centre on distress and disturbed behaviour; other practitioners refer to it patients with ailments that stubbornly refuse to respond to conventional biomedical measures and patients whose behaviour is viewed as problematic for the health care system; the disorders it treats are peculiarly sensitive to psychosocial interventions; the epidemiology of psychiatric problems strongly implicates social influences as concomitant if not causal variables. Yet I must acknowledge at the outset that psychiatric theories reflect the conceptual confusion that afflicts the rest of medicine. If I venture to sketch their main outlines, it is because psychiatry has available to it a more catholic if incomplete and inconsistent set of concepts. In this sense, it may provide fruitful leads for a more comprehensive theory of medicine.

In what convenient follows, I will focus on the psychoses. They provide the most convenient bridge to other medical disorders, in that the disease–illness dichotomy remains a central preoccupation. The concepts of the psychotic process that provide the paradigms for psychiatric practice include multiple and manifestly contradictory models (Lazare 1973): the organic or medical model – genetically based aberrations in biogenic amine metabolism; the psychodynamic – developmental and experiential in origin; the behavioural – maintained by environmental contingencies; and the social – disorders of role performance. This potpourri of doctrines stems from the fact that psychosis manifests itself in disordered behaviour. With full recognition of its physiological roots, behaviour is simultaneously a function of developmental history and interpersonal context.

The medical model of psychosis is as ancient as the monograph ‘On the Sacred Disease’ attributed to the Hippocratic corpus. It affirms “And men ought to know that from the brain and the brain alone arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs and tears . . . By the same organ we become mad and delirious, and fears and terrors assail us . . . and dreams and untimely wanderings . . . All these things we endure from the brain, when it is not healthy . . .” (Hippocrates 1886). This view reached its apogee in the 19th century with neuropathology triumphantly ‘explaining’ general paresis. When the confident expectation that other psychiatric disorders would reveal themselves under the microscope failed to be fulfilled, the disease model was supported by only a hardy few, to be revived within the past two decades by
the discovery of psychotropic drugs, new evidence for genetic diatheses, and neurochemical findings. Those psychiatrists who follow the medical model pay close attention to signs and symptoms as the foundation of differential diagnosis because it is the identification of the clinical entity that enables the doctor to predict the expected course and to determine the appropriate treatment. Drugs and electric shock, measures directed at the somatic matrix, are the keys to management; psychosocial measures are adjunctive. Both implicitly, by the medical character of the treatment given, as well as explicitly, in the explanatory models provided, the patient is led to believe that he has a disease, similar to other diseases, for which he need feel no culpability. A good patient, however, is expected to follow the medical regimen. The diagnosis legitimates the sick role but simultaneously confers responsibility for compliance.

The psychiatrist in the psychodynamic mode views psychosis as the end-result of the vicissitudes of pathological life experience; that is, of arrested development, distortions in reality perception, impaired adaptive responses. Syndrome diagnosis is almost irrelevant to treatment because its fundamental method is one of uncovering the idiosyncratic past and facilitating its reintegration into new patterns of meaning. The patient's aberrations stem from acting towards persons in his current environment as though they were the important figures from his past. Thus, exploring the relationship between doctor and patient underlies the therapeutic process of correcting interpersonal distortions. In contrast to the conventional medical model of disease and treatment, the patient is enjoined to play a central role in his own rehabilitation. Although he is acknowledged as sick, he holds veto power over his recovery. The very terms employed—flight into illness, resistance, secondary gain, degree of motivation—imply his participation in his illness. The developmental emphasis implicates his family, as does the inclusion of family members in group and family psychotherapy. If the psychodynamic model preserves the dignity of the patient as a free person, it exacts a price in the responsibility it confers on patient and family for causing or contributing to the sickness.

The behavioural model evolved from the application of operant conditioning theory, a contribution from academic psychology, to the management of clinical problems. In this paradigm, abnormal behaviour is learned behaviour; by definition, it persists because other people in the patient's environment unwittingly maintain that behaviour by rewarding him for exhibiting it and by ignoring or punishing him when he deviates from it. There is no 'disease' to be identified and treated; rather there is a constellation of behaviours that require to be changed. What matters are the relationships between output and input: the black box between is not an important focus of interest; subjective self-report is an unreliable guide to its contents and the details of its wiring are indifferent to the output/input analysis. The equivalent of diagnosis is the task of identifying
the rewards that have maintained undesirable behaviours. Treatment consists of
the design of a contingency response programme in which rewards are delivered
only for those constructive behaviours whose frequency is to be increased. So
long as total control can be maintained over the responsive environment, what
the patient thinks is a matter of indifference; it is what he does that counts. And
that can be externally controlled, at least so long as others cooperate. The recent
extension of the behavioural model to biofeedback methods (Miller 1969)
provides a powerful technology with which physiological as well as behavioural
functions can be modified. Non-manipulable motivational elements do, of
course, enter the scene with voluntary patients who must contract to adhere to
the programme. But the behaviourist's client, primarily a responder rather than
an initiator, is analogous to the medical patient who is expected to follow
doctor's orders. This is, at first glance, a curious coincidence; the behavioural
technician specifically disclaims interest in the internal workings of the machine,
whereas these are focal concerns for the biomedical technologist; however, the
identical outcome in the structure of the therapist—client relationship stems
from the shared premise that the forces producing illness exist in spheres apart
from the patient as a thinking and feeling person.

The fourth model, the social, emphasizes the individual's role in the social
system. It is the character of his interrelations with the persons who make up his
life space, and that of the social role to which he is assigned that constitute the
source of his disorder. In this context, emphasis is placed on the effect of a
psychiatric label as a powerful mechanism which casts the individual in the role
of patient and generates a set of expectations he is coerced into filling. This
proposition is particularly difficult for physicians to accept; it makes them into
society's gate-keepers and jailers (Zola 1972), in complete contravention of the
professions' self-image of its function as beneficent healer. Yet there are facts
that cannot be swept away. When Pinel in France and Tuke in England at the
end of the 18th century introduced the moral treatment of the insane, they were
considered radicals for striking the chains from the 'violent' insane. Contrary to
the conventional wisdom, the violence of patients diminished rather than
increased once the restraints were removed. The restraints themselves had
generated much of the resistance which was the ostensible justification for their
use. The importation of moral treatment to American shores was criticized on
the ground that American patients were inherently in need of greater restraint
because American society was more anarchic; yet the results of humane care on
overt behaviour of patients were similar to those in Europe. A more recent
example of the pervasive influence of the social field on behaviour is the
identification of the social breakdown syndrome (Gruenberg 1967)—a
behaviour pattern that characterizes the neglected chronic schizophrenic patient.
Superimposed on the initial psychosis is the deadly levelling effect of the
institution as a total society. The observed pattern of behaviour results not from
the 'disease' but from the experience of anonymity and alienation and the
assignment to the role of chronic patient. Contrariwise, the devolution of the
state hospital system in the United States began before the massive use of
psychotropic drugs; the change resulted from reorganization of the system,
altered admission and discharge policies, and the development of community
services. The drugs were, however, instrumental in accelerating and sustaining
that process (Eisenberg 1973). In its most extreme form, the sociological model
places the principal determinants of behaviour entirely in the social field and
leaves little or no room for biological and psychological factors 'internal' to
the patient. To epitomize by analogy, human behaviour in a dynamic social
field may be likened to the movements of iron filings in a changing magnetic
field.

How are we to reconcile these models? Each captures important facets of
clinical reality, yet disregards or even denies others. We lack the equivalent of
Lorentz transformation equations that would enable us to move from one
inertial frame of reference to another. A comprehensive and inclusive general
theory of disease—illness would subsume the relations that hold true within
particular coordinate systems and specify the limiting conditions. That theory
has yet to be written; even then it will be no more than a provisional guide for
comprehending the clinical world.

Models are ways of constructing reality, ways of imposing meaning on the
chaos of the phenomenal world. This is not to deny the independent reality of
that world but to emphasize that it does not present itself to us organized in the
ways we come to view it. The models physicians use have decisive effects on
medical behaviour. The models determine what kind of data will be gathered;
phenomena become 'data' precisely because of their relevance to a particular set
of questions (out of the possible sets of questions) which is being asked. Once in
place, models act to generate their own verification by excluding phenomena
outside the frame of reference the user employs. Models are indispensable but
hazardous because they can be mistaken for reality itself rather than as but one
way of organizing that reality.

Error is compounded when abstractions are reified and diseases are regarded
as things. Virchow (1958) wrote: "Diseases are neither self-subsistent,
circumscribed, autonomous organisms, nor entitites which have forced their way
into the body, nor parasites rooted on it but . . . represent only the course of
physiological phenomena under altered conditions". Even within the definition
of disease as organ pathology, disease is not entity but a relational concept.
From this vantage point, Englehardt (1974) has brought the central issue into
focus: "If disease is viewed as a relation, one can then choose those aspects of
the relation most easily manipulable; that is, most easily treated . . . Theory thus
becomes an instrument of action: one chooses a theory to highlight variables open to easy influence”

In his actual practice, the physician employs what Polanyi and Prosch (1975) term ‘personal knowledge’; that is, he combines ‘tacit’ models of illness with more or less explicit models of disease. If they were to be spelt out and deliberately set side by side, these tacit and explicit concepts would display logical incompatibilities. That they are held simultaneously indicates that clinicians mediate between medical models of disease and popular models of illness just as do the patients who employ concurrently the services of herbalists, shamans and doctors. The resolution of the tensions between contradictory models occurs in practical action. Health practitioners behave differently from what they say they do when they are asked to describe their actions (Kleinman 1975). Closer attention to ‘tacit’ knowledge should enable us to construct more comprehensive clinical models of disease—illness.

My argument for the necessity of a more universal perspective on illness is not an academic exercise in the philosophy of medicine. What we think affects what we do. Biomedical concepts have yielded major dividends for certain classes of disease problems. However, they are not only irrelevant to others, but misleading because they misdirect our efforts. The image of the doctor as technician contributes to the paradox of patients being dissatisfied at a time when the profession considers that its powers are at their greatest. We generate false expectations for cure that lead to malpractice suits when medical fallibility rather than personal incompetence is the issue. Virtuosity in performing too readily becomes an end in itself and blunts sensitivity to purpose. As Burge and his associates (1975) noted in a recent article on the treatment of acute myeloid leukaemia “The present preoccupation with intensive therapy appears to blind physicians to the poor quality of life which their patients lead. The aim of treatment is too often to induce a haematological remission (an irrelevance to the patient) rather than to improve the quality of life.” The modern doctor’s dilemma is a product of our new biological powers. Only when it is possible to delay death does it become meaningful to ask whether it should be delayed. That question did not have to be asked when the best we could do was to diminish suffering, now as then a value most would agree upon.

From the time of the first healers, patients came to them to seek relief from discomfort and dysfunction. They found what they sought and they honoured the provider. Symptom relief under medical care is the commonest outcome for most episodes of illness. Historically, this bonus to medicine as craft has been a plague to medicine as science. The benefits patients obtained have been attributed to the procedures in fashion rather than to the social dynamics of the medical encounter. With the growth of experimental sophistication in clinical trials, such benefits have been labelled ‘placebo’ effects: that is, sources of
variance that complicate experimental design. ‘Placebo’ has become almost an epithet suggesting charlatanism rather than a marker for an extraordinary and quite fundamental characteristic of good medical care. Of course, we need controls in clinical trials if we are to evaluate new remedies. But we ought equally to seek an understanding of our therapeutic heritage rather than disdaining it, as the ‘hard’ scientist does, or being deceived by it, as many practitioners are.

Curt dismissal of ‘placebo effects’ is symptomatic of the widespread contempt in which psychotherapy is held — as though it were ineffective because no one brand has been shown to be clearly superior. What has hounded research in this area has been the effectiveness of psychotherapeutic methods in abating symptoms. When two-thirds of a comparison group reports itself improved, a new mode of treatment will need remarkable powers indeed to generate a significant difference (Luborsky et al 1975). More appropriate is a reversal of the traditional paradigm (the search for differences) so that just those common attributes which underlie the generally good symptomatic outcomes can be identified. It is only when changes in social effectiveness (in contrast to changes in symptom scores) are examined that it becomes possible to demonstrate gains from psychotherapy over and above those resulting from medication (Weissman et al 1974).

The therapeutic benefit derived from the medical presence, I contend, is evidence for the mediating role of psychosocial factors in the genesis and maintenance, as well as repair, of the experience of illness. In a given case, these factors may hold the centre of the stage or be peripheral to the main drama. They are never absent in the ill person until consciousness lapses; even then, they continue to operate in the responses of family and community. For most of their history, healing theory and practice have responded to psychosocial factors in symbolic and tacit ways; what is called for now is systematic social and behavioural research in medicine, supported by resources comparable in magnitude to those we have so profitably devoted to the biomedical enterprise. There can be no pretence that the psychosocial field yet possesses methods of like investigative elegance and power. Equally, there need be no reason to doubt our ability to fashion such methods once we acknowledge how crucial they are to understanding contemporary health problems.

Medical care is a complex social process, embedded in the cultural matrix and laden with values. Critics warn us of the harzards of technical iatrogenesis (Illich 1975); let us be similarly alert to the potential for psychosocial toxicity (Fox 1976). Symptom relief can be purchased at too heavy a price; not only may the identification of a malignant process be delayed but both doctor and patient may become captives of a misleading mystique. The outcomes that matter are long-range as well as episodic. Is the patient wiser after the transaction: that is, more proficient at self-care or more dependent on the doctor as anodyne? Both
modern and traditional medicine share that hazard. If cure is in part a function of belief, how shall we prepare the practitioner for conveying confidence while retaining the private scepticism necessary for an investigative attitude?

Problems of ethics abound. We cannot deliberately fabricate belief systems and practices for experimental study. It is precisely here, however, that research into cross-cultural medicine may prove particularly illuminating (Kleinman 1974). We can take advantage of 'natural' cultural variation to compare and contrast outcomes. The chastening discovery that other theories of disease, and practices based on them, can produce benefit helps to free us from medical ethnocentrism (Eisenberg 1975). Once illness is reconceptualized as a disruption in an ongoing biosocial matrix, we will be less likely to pursue disease as a thing-in-itself. The chase after that will o’ the wisp recalls a remark attributed to Gertrude Stein. Commenting on a nondescript American town, she said “When you get there, you discover there’s no there there!”

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NOTES

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