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In Sickness and in Health

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IN RECENT DAYS doctors have become the targets of considerable anger. The reasons given for this anger are varied, ranging from the charge that not enough people are being given proper medical care to the complaint that doctors fail to react to patients as individuals. It is safe to say that among almost all parties to this debate, process has become confused with product. Since most people would agree that the product of medical care is health, it seems at first glance obvious that the process of medical care should be primarily concerned with the eradication of disease. There is, however, more to it than that; but in order to define the process of medical care with any kind of precision, one must attempt first to cut through a fog of confusion about these matters in which facts are often inextricably bound up with personal feelings, and both facts and feelings must therefore be taken into account.

The process of care—this is the first of a number of distinctions I shall be making in this essay—involves latent as well as manifest functions on the part of both doctor and patient. The manifest function of the doctor is the cure of disease: the making well of the lungs in pneumonia, the heart in heart attacks, etc. The latent function is healing, a mysterious process that makes well the *man* who owns the lungs or heart or kidneys. This distinction implies in turn—what I believe to be the case—that there is a difference between disease in an organ of the body and the illness of the whole man. In the following pages I shall use the word “illness” to mean what the patient feels when he goes to the doctor’s office, and “disease” to mean what the patient has after leaving the doctor. Disease, then, is something an organ has; illness is something a man has.

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IN ALL cultures people go to their doctors because of how they feel—uncomfortable, unpleasant, unusual. Even when a patient goes to the doctor with pneumonia, for example, he is not going because he “has” pneu-

monia but because he feels sick, feverish, has a cough or perhaps chest pain; the doctor “gives” him pneumonia to explain these feelings. In our society today, when we speak of disease we generally mean a disturbance of the organs or body fluids characterized by structural alteration or biochemical change. But we have also come to behave as though where no such alteration or change occurs, there is no illness: nothing, that is, to justify a visit to the doctor. When someone in our society is ill, in other words, he tends to assume that he has a disease. Yet this assumption is, I think, culturally derived; certainly it is not true of every culture. In primitive cultures, for instance, when someone is ill—unfit, unable to do—neither he nor the person from whom he seeks help has a concept of illness or disease that resembles our own. Nevertheless, in all cultures a framework exists which can explain the illness and often supply an effective remedy—effective because whether among Indians, Irishmen, or Americans, no medical practitioner who fails to return his patients to a feeling of health can hope to last long.

The Navajo Indians, to cite a specific example, have been exposed to Western medicine for about a hundred years, and in recent years the exposure has been quite intensive. But the Navajos have chosen to retain a concept of illness which is part of their own religion and culture: the function of the Navajo medicine man is still defined as bringing in good and driving out evil. Yet the Navajo concept of illness is neither primitive nor irrational: it was perhaps best explained by a medicine man, who was also a tribal leader, in a statement before a meeting of white physicians at Fort Defiance, Arizona, in 1955: “There are some things which we medicine men know the white doctor is better able to cure than we, such as appendicitis and tuberculosis; we have given up on these. Then there are such things as snake bite, which both the medicine man and the doctor can cure, each using his own method. But there is still a third kind of illness which only the Navajo medicine man can cure—for example, a person might have lightning illness, caused by his being nearby when lightning struck. You white doctors wouldn’t know that person is sick and so it wouldn’t occur to you to treat that person. But, in the Navajo way of thinking, it is just as impor-

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tant to treat him as it is to treat the person in pain with appendicitis."*

Other examples abound to show that there is unfitness in one form or another in every culture, but that it is presented to healers in different ways—ways that are congenial to the culture in which it occurs. In our culture the only form of unfitness acceptable to physicians is disease, that is, the alteration of body fluids. I believe, however, that we too have disabilities that are not specifically connected to disease, but that until very recently remained hidden in symptoms of disease and were treated by doctors in their more generalized role as healers of the sick. (I am not speaking about the so-called psychosomatic illnesses, in which a physical symptom can be traced to a specific unconscious conflict.) What has happened within the last generation, and for the first time ever, is that the dream of curing disease, and hence of creating profound changes in age-old disease patterns, has become more and more a real possibility. Yet medicine's technological success has created severe strains: illness and disease have come to be separated; patients now wander about disabled but without a culturally acceptable mantle of disease with which to clothe the nakedness of their pain, and doctors tend to define their role more narrowly, seeing themselves as curers of disease rather than as healers of the sick.

To understand how these changes have come about, we must keep in mind that our way of conceiving of disease, the rational-scientific basis of medicine in which we have justifiable confidence, is also in large part bound up in our specific Western cultural circumstances. We have always had explanations for things and we have always believed those explanations to be correct. Indeed, one of man's more constant characteristics is his faith in "the facts of today," whereas, if there is one thing we should have learned from the history of science, it is that over the course of time our most cherished scientific beliefs turned out to be frail reeds.

LIKE so much of Western culture, our system of medical explanations derives from the Greeks. Hippocrates, who was born about 460 BCE, is called the father of modern medicine primarily because he introduced direct observation as a basis for the diagnosis and therapy of disease and rejected a system of medicine that was wholly dependent on magical-religious beliefs. In his long life this acute observer described, classified, and suggested rational therapies for large numbers of diseases—many with lasting accuracy. (While we tend to remember the acuteness of his observations we tend to forget that throughout his writings Hippocrates also demonstrated a recognition of, and respect for, the unknown healing forces of nature.)

The medicine that followed Hippocrates and the Greeks came to depend less on careful ob-

servations than on authority and dogma. Although some anatomical knowledge, based upon animal dissection, was added to the body of information inherited from the Greeks, a climate of religious superstition prevailed for centuries, and little real progress was made in the conquest of disease. As late as the 18th and early 19th century infant mortality was rampant, with infection, and its foster-parent malnutrition, underlying the carnage. But infection did not stop in infancy; diseases we dismiss lightly today, the ordinary contagious diseases of childhood, were then commonly fatal. Young adults died of pneumonia, streptococcal infections, and the nonspecific diarrheal diseases. Epidemics of bubonic plague and smallpox were common (the great plague of London in 1665 killed 68,000 people); these diseases did not merely sweep through in fatal waves, they remained in constant residence, the plague-bearing flea jumping lightly over the enormous gap between rich and poor.

The rush to the cities brought on by the Industrial Revolution made matters even worse: the slums were crowded beyond belief; there were no toilets and no running water; lice and hunger and filth were everywhere; sewage ran in the streets. Modern travelers to India are shocked by similar scenes that, nevertheless, represent a distinct improvement over London or Paris in the 18th and early 19th century. The diseases with which we are more familiar today—cancer, ulcer, appendicitis—were also present, and they, too, were often fatal, especially since surgery was limited in practice by the unacceptable pain it entailed and the danger of infection. The methods of the physician, rarely effective, consisted mainly of bleeding, and the administering of purgatives and emetics. It is no wonder that in the midst of all this disease and death, mankind looked to God for surcease, for, in truth, neither doctors nor medicine were of much help.

By the middle of the 19th century, however, mankind began to be lifted out of disease.† Although no cures were as yet available, the development of preventive medicine marked the beginning of improved health for the populations of Europe and America. Vaccination was probably the first step in this process, but the great sanitary revolution was even more important. This revolution, which was begun by laymen in England in

* K. Deuschle and J. Adair, "An Interdisciplinary Approach to Public Health on the Navajo Indian Reservation: Medical and Anthropological Aspects," in *Annals of the New York Academy of Sciences*, vol. 84, pp. 887-905, 1960.

† The scientific basis, to be sure, had begun to be laid long before. In the late 1600's, Sydenham, following the tradition of Hippocrates, had stressed the importance of knowing the natural history of disease and had begun to write accurate descriptions of various kinds of illness. Others followed Sydenham, so that by the early 1800's diseases were well-catalogued—an essential step in the development of treatment and a precondition for the systematic teaching of medicine.

