1969 1970

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.

I

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" pneumonia 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 observation 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

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* 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.

the 1830's, was responsible not only for modern water supplies and sewage, for sanitary laws and departments of health, but for our entire attitude toward cleanliness and health. It is this attitude, now so deeply ingrained in our culture, which wards off disease much more effectively than legal regulations, chlorine in the water, and the like.

First propounded in the late 1800's, the germ theory of disease marked another important beginning in the history of medicine: the supplying of scientific answers to questions concerning disease causation. It had of course been known for a long time that an infectious principle existed—that is, that there was some unidentified matter which provided the means for transmitting diseases—but all sorts of odd notions were jumbled in with this concept, including moral judgments that connected the acquisition of a disease with a person's bad character or intemperance. For scientists, however, such deplorable inexactitude ended with the discovery of bacteria as a cause of disease. An exactness of formulation was born—one cause, one disease—which is only now, with our increasing awareness of the existence and significance of multiple causation, beginning to weaken its hold on medicine.

Somewhat earlier than the development of the germ theory of disease, a German pathologist named Virchow set forth an explanation of the cellular basis of disease. In essence, his theory states that there are structural changes in all diseases at the cellular level and these changes are specific for each disease. Taken together, then, the germ theory and the cellular basis of disease have determined our present definition: diseases are entities in which structural change takes place and for which unique causes can be found. For all its incredible advances, medicine in its most recent phase has added only the idea of biochemical change to this basic definition.

The true age of cure, however, may be dated from the development of the sulfonamides in the 1930's. From that time on, the growth of effective therapy has been exponential. Today, the effectiveness of the modern physician can be described in superlatives: in treatment as well as in diagnosis, technological progress has made the neophyte physician of today far superior to the experienced specialist of a generation ago. The tools are indeed magnificent, the drugs fantastically effective, the electronic technology a wonder to behold. And yet, in the midst of this hyperbole we still find it necessary to ask—what has gone wrong?

II

THE HISTORY of medicine has been dominated by three lines of inquiry that can be paraphrased in question form: *what?*, *why?*, and *what can we do about it?* Illness, however, is a special phenomenon. It has both objective and personal aspects, and thus these three questions have both objective and personal meanings. Although the search for definitions has always been essential as a basis for further inquiry, it is clear to anybody who has ever been ill that the definitions that have emerged, cast as they are in terms of structural and chemical change, form an incomplete picture of illness. Similarly, the question "Why?" asked by the person who is ill is really the question, "Why me?" and is of greater dimension than the same question when asked by the medical researcher, whose germ theory of disease offers only a partial, if vitally important, answer. And since the final step, the development of cures, is contingent upon knowing the *what* and *why* of disease, it is clear that cure will be directed only *against those objective manifestations of illness that our science has defined as disease.* Thus, curing the disease will be effective in resolving the illness to the degree that the illness is explained by the disease. In those cases where all the symptoms and disordered feelings that make up illness are explained by the disease, as in streptococcal sore throat, then the cure of the sore throat will resolve the illness. But in a case like tuberculosis, where disordered feelings, disconnection from society, and numerous other ramifications are pervasive, curing—killing the tubercule bacillus—represents only part of returning the patient to health.

The following examples may make the relationship between disease and illness clearer. Through most of our adult lives most of us have a disease called arteriosclerosis. We are, for the large majority of that time, not ill from it. Similarly, hypertension and diabetes exist through most of their natural history without associated illness. On the other hand, it is possible to have illness without disease. (While hypochondriasis may leap to mind here, it probably represents a less common example.) We do not feel well; we have symptoms. Sometimes we take these feelings to the doctor and are reassured that we have no disease; more often we are given diagnoses like low blood pressure which, although they do not represent the presence of disease, make us think that our symptoms are honorable. And often we just feel ill for a few days until the feeling passes without a visit to the doctor. What those feelings of illness are and what motivates them are subjects beyond the scope of this essay, but it can be said with assurance that the problem they represent is very real: in research on the common cold, for instance, it has been found that whereas many of the volunteers who are given infectious material develop a cold, a significant proportion of the control group who are given non-infectious salt water *also* develop a classical cold, indistinguishable from the infectious type. Finally, illness and disease can coexist; as we have aready seen, during most of the world's history and for most of the world today, that is probably the most common situation. (Even here, however, things are not so simple. The huge infant and child wastage of the

underdeveloped countries derives largely from the diarrhea symptom complex—63 per cent of all deaths in the age group one to four in Egypt. Yet despite repeated attempts, it has been impossible to demonstrate that one bacterium or virus is responsible; the symptom complex seems rather to result from a mixture of problems of hygiene and nutrition.)

Yet even when illness and disease coexist, it is possible to demonstrate the distinction between them, as the following anecdote makes clear. An elderly man, widowed for four months, had become sloppy in his clothing and personal habits, although he continued working at his job. His appetite was poor. He caught a cold which persisted, and then a bad cough. After about two weeks he developed a fever, was found to have pneumonia, and was admitted to the hospital. Despite apparently adequate therapy and an initially good response, his fever persisted and he remained listless. He told his doctor that he didn't care what happened to him and would just as soon be dead. The doctor delivered a scathing lecture to him based on the patient's lifelong moral and religious beliefs. The next day the old man was obviously better. On the day after that, free of fever and almost free of cough, he signed himself out of the hospital; he was furious at his doctor. The case is not unique.

The rise of scientific medicine, whose methodology and philosophy have tended to deny the existence of that which cannot be measured, has contributed to blurring the distinction between illness and disease. The latter point is perhaps best understood by looking at the growth of psychiatry during this century. The contributions of Freud must be counted as a major medical advance: Freud showed us, for the first time in a systematic way, the presence and many of the operations of the unconscious mind; he made clear, in an undeniable manner, the influence of early childhood experience on subsequent behavior; he introduced a mode of therapy comparable to no previous way of making people feel better. Our world has changed because of these revelations, and we shall never go back. Yet we argue about many Freudian concepts and the illnesses described by them as though they hadn't been around for over fifty years, and we argue about them because they do not fit any concept of disease that has evolved since Hippocrates (although the influence of emotions on bodily change had been appreciated even before Hippocrates). These concepts cannot be quantified; there is no structure to be examined under a microscope, no chemical to be found altered in a blood test. Naturally, there are other reasons why doctors find it difficult to accept these ideas, but at least in part the professional objects to them because they are so "soft," so difficult to measure, and so at odds with the received philosophy of disease.

But if there appears to be a real difference between illness and disease, is there a similarly clear-cut distinction to be made between healing and curing? To begin with, it is important to realize that although one must divide these functions in order to understand them, such a division is really artificial. Rarely will cure be effected without the accompaniment of at least partial healing; similarly, at least nowadays, healing is usually accompanied by cure. For the sake of discussion, however, curing may be defined as *returning a diseased part to functional integrity, or destroying or stopping a disease process.* For bacterial diseases, that means killing the bacteria; for endocrine diseases, such as thyroid disease, it means slowing down an overactive gland or replacing the deficiency of thyroid hormone in an underactive gland. Removing a diseased gall bladder is curing, as is replacing a defective heart valve. And so on. A pill can cure.

Healing, on the other hand, is *returning the whole person to fitness, to health, to a state where he can go and do.* According to this definition, an amputee is returned to health, though he remains an amputee, when he *feels* healthy. Somebody who has had a stroke, though he may limp for the remainder of his days, may feel healthy. Conversely, even after his limp is gone he may feel forever threatened and unfit and thus be forever ill. The active process of healing includes the functions of comfort, support, understanding, motivating, drawing on the "nature" of Hippocrates, the "healing force" of Sydenham, or the "phlogiston" of the 17th-century vitalists. Healing, in other words, is a highly personal phenomenon.

The way I have stated the distinction between healing and curing may be acceptable to many, but the descriptive terms unfortunately offer little insight into the process. For example, while a pill may cure, it may also have healing powers, no matter how it is dispensed. Thus, healing is not something dependent solely upon the healer; it is, rather, a process that draws upon something within the patient. We go to the doctor to get better, and in so doing, we equate illness with disease; when told of our disease, we expect to get better when the doctor cures us. Generally speaking, the doctor sees the situation in the same way. For that reason cure is the doctor's manifest function. The other process, healing, is not on our minds; we do not think about it, and, generally speaking, neither does the doctor. But it occurs, even if it is outside our awareness—latent, in other words.

But why should it be latent? Illness is a primitive state of disordered sensations, a state which, in its helplessness, in the threat it poses to the individual's sense of omnipotence, and in its loosened connections to the world outside, is reminiscent of infancy. Indeed, there is much about illness to make us think that the sick person functions in large part on an infant's preverbal level.

Thus, awareness of the healing function is often absent not only because of the psychological mechanisms of repression and denial, but because the sick person seems to operate more in terms of primitive body language than in words.

The regression I have been describing is further enhanced by the failure of reason. The disordered sensations of the sick person may be so unfamiliar that he cannot comprehend them in terms of prior knowledge or experience. No conceptual framework available to him can explain completely, or even satisfactorily, what is happening to him, and all his thoughts only serve further to expose him to the unknown. Inner omniscience having failed him, he constructs solutions that lead to further questions he cannot answer. His explanations become more primitive, often they involve self-blame in an attempt to keep the process rational, but ultimately they threaten to overwhelm him altogether.

WHAT DOES a healer do? In essence, he forms a safe bridge between the very different worlds of the sick and the well; he uses the omnipotence with which he is invested to restore the patient's belief in his own indestructibility, and he offers the patient a surrogate control of the world when the latter's own mechanics of control have been disrupted by disability. The healer removes illness from the realm of the unknown and places it in the realm of reason and the known. (It does not matter what system of reasoning the healer uses, so long as it is culturally congenial to the patient.) Often enough neither the healer nor the patient is aware of this interaction between them; sometimes, indeed, the sensations involved may even be repressed by the patient in order to prevent conscious recognition of his helplessness.

The fact that behavior associated with illness is basically the same in different cultures, as well as in the classical myths of mankind, suggests that the healing function is one of vital importance. Therefore, if the art of healing has been diminished by technical progress, change must occur to redress the balance. As a physician, I believe that healing should remain the province of physicians, but the recent rise of T-groups, sensitivity-training sessions, Esalen-type institutes, and the like—all of which can be seen as substitutes for the kind of healing that used to be primarily associated with the role of the physician—testify to the possibility of the need being satisfied elsewhere.

One should be aware of the great risks involved in such ventures, in which the healing function of medicine is undertaken without the knowledge and discipline that medicine brings to that function, and without medicine's sense of continuing responsibility to patients. Nevertheless, the insight that lies behind the establishment of such extra-medical practices is a valid one: technical advance has brought us to the state where healing and curing have become separated. The tools of the modern doctor have allowed him to hide behind his effectiveness in curing disease. Curing, which involves primarily intellectual skills, is a much easier task to perform than healing, which imposes a greater emotional burden and responsibility on the physician. It is only natural that he should avoid something that imposes such a cost, especially when he is unaware of what he is failing to do. For what the doctor does that is now "wrong" is something better than what he ever did before. But, in fact, the physician is not simply doing something better now, he is doing something different—now he can cure directly, whereas before he could not. I do not mean that the power to cure directly necessarily diminishes the healing function. Surgeons, who cure effectively, now as they always have, are *themselves* the modality through which cure is effected, and their role as healer is harmonious with their role as curer. This was true of physicians in general for the entire history of medicine prior to the present generation. When they made someone better, *they* made him better; they were directly involved in the cure.

But now it is the penicillin that cures pneumonia, and the physician knows it. In addition, he knows that no matter who had given the penicillin, it would have been just as effective. Whether or not the patient senses this change—I believe that increasingly he does—the modality of cure has become external to the physician; as a person, the doctor has begun to give way to something that works better than he does. It is as if a new, more effective medicine man had come to town, and the old medicine man were retreating. (The new medicine man—the efficacy of drugs—has the added advantage of a lot of favorable newspaper publicity.) When a healer believes less in himself as the agent of cure than in the things he uses, it is only natural that his effectiveness as a healer will itself become diminished.

Another factor that has contributed to upsetting the balance between illness and disease has been the technical revolution in diagnosis. The yearly check-up is meant to reveal disease before it has a chance to produce illness. On the other hand, the so-called multiphasic health-screening programs, which are semi-automated check-ups, have produced many findings usually associated with disease but whose significance—because they are found so "early"—is doubtful. A doctor often does not know whether to tell his patient about the findings, or what to tell him to do about them. Yet despite the general lack of knowledge, the multiphasic health-screening techniques, now in an experimental or at least a youthful stage, are going to be a major presence before long.

Finally, technical advance has wrought a drastic change in illness patterns. I have previously discussed in these pages how the loss of the realistic threat of premature death among the young has caused great problems. The threat is no longer

death but life, stretching out in vast reaches and demanding to be filled with meaning and return. The infectious diseases that previously caused so many deaths in the young have virtually ceased to exist (with the proviso of course that our freedom from those diseases is only as stable as our society). But disability among the young has *not* ceased. The ranks of the disabled now include the unhappy, the misfits, the alienated, the drug-abused, the underachievers, and others who suffer the illnesses stemming from a misalignment between themselves and their society.

IT MIGHT BE argued that while disability of the kind I have just described is a sad phenomenon, it should be of no concern to the physician because, unlike disease, it cannot cause death. Consider, however, the following table, which lists the probability, in percentages, of an individual's dying in the next ten years. Only the five leading causes of death are given.

WHITE MALE, AGE 10	%
1. Motor Vehicle Accidents	.30
2. Drowning	.07
3. Accidents due to firearms	.04
4. Suicide	.04
5. Leukemia	.03
Total probability of dying within 10 years	.88

WHITE MALE, AGE 15	
1. Motor Vehicle Accidents	.60
2. Suicide	.09
3. Drowning	.07
4. Homicide	.05
5. Accidents due to firearms	.04
Total probability of death from all causes within the next 10 years	1.44

WHITE MALE, AGE 20	
1. Motor Vehicle Accidents	.58
2. Suicide	.13
3. Homicide	.06
4. Drowning	.04
5. Aircraft accidents	.04
Total probability of death from all causes within the next 10 years	1.58

WHITE MALE, AGE 25	
1. Motor Vehicle Accidents	.38
2. Suicide	.15
3. Arteriosclerotic Heart Disease	.10
4. Homicide	.06
5. Chronic Rheumatic Heart Disease	.04
Total probability of death from all causes within the next 10 years	1.62

As can be clearly seen, diseases are no longer the primary causes of death in the young. But, on the other hand, death from automobile collisions, homicide, suicide, and perhaps even drowning should not be regarded wholly as accidental in nature; it is becoming increasingly apparent that they often represent self-determined destructive acts—in other words, a form of illness or disability clearly not associated with disease defined as structured or biochemical change.

But are these things the province of physicians? Last year I recorded a series of interviews in rural Jamaica and in New York City, asking the "simple" question, "What is a doctor's job?" The following quotations are illustrative of the responses I received. The first interview is with a fifty-five-year-old New York City woman, hospitalized for investigation of the rheumatic heart disease that was disabling her.

Interviewer: "What is the doctor's job?"

Patient: "To keep me alive. Want me to go on?"

Interviewer: "Yes."

Patient: "All right. Because especially now, we don't have Gods any more really and truly. Hardly anybody believes in that. So the doctor's job is one that never existed—far beyond any of the others. There were some Gods that were all of these things, and there was Jesus. Because you had another world. But since we don't believe in it any more, the doctor is now God.

"Anyway your life consists not of confronting sudden death really—like at the end which we understand—but the threats which are all around us all the time—which we don't understand. . . .

"But all the things you appreciated in God, essentially what were they? So even if you let the blood out like the Aztecs, it was to give more life. Now the doctor is the only remaining thing to prevent you from, like, the things around you. Science does it in a limited way."

Interviewer: "Why does science do it in a limited way but the doctor doesn't?"

Patient: "Because the doctor is a personal thing, a personal confrontation."

The next interview is with a forty-year-old man in a small mountain town in Jamaica, West Indies. He is very poor, owns half an acre of land, and has nine children:

Interviewer: "What do you mean by sickness?"

Respondent: "Is a thing you feel—a pain. And another type of sickness, which is poor. Poor is a sickness. You look at your kids around you, and you gots no money, you don't know no means to get food for them . . . is one of the greatest sickness in the world.

"That makes mad, it sometime eats your brain. If you don't not good enough, you run off, you mad . . . go asylum. Sometime you have plenty men that hang, of his home problem."

IF THESE, and other disabilities of our time, are not the province of physicians, in whose province

do they fall? The knowledge and understanding necessary to heal these illnesses and reduce these disabilities are not presently available, but the same could be said of other illnesses throughout the history of medicine. The problem now is that many physicians are reluctant to turn from the easy task, the cure of rapidly disappearing diseases, to the difficult tasks presented by modern disabilities.

III

We might pause here to examine more closely some of the current criticism of American physicians, criticism which I believe can be better understood in light of the distinctions I have been attempting to draw. Criticism of medicine has probably been around as long as the profession. In part it attests to the high nature of the calling, to the fact that when all is said and done doctors are only men confronting the mysteries of life, and the role demanded of them is simply too large for ordinary mortals. However, the current criticism is different: more intense, more specific, and possibly more justified. It can best be understood by dividing it into criticism of bulk services and of individual services.

The essence of the criticism of bulk services is that there is a large unmet need for medical services in the United States; that the services provided are very, very costly; and that the distribution of services is uneven, so that the poor who have the greatest need get the least aid. The attack, which is manifestly correct as stated, comes not only from laymen but from physicians as well, generally members of the academic community, medical administrators, or the relatively new group of physicians engaged in so-called social medicine. This last group has been in the forefront of the fight for prepaid medical plans such as HIP in New York or Kaiser-Permanente on the West Coast, as well as similar attempts to increase the efficiency, decrease the cost, and spread further the available medical services. The social-medicine concept, now adhered to by most critics of bulk services, emerged relatively early in the century in an attempt to extend "private" medical services, not charity, to the less advantaged. The original demand was that medical care be made a basic right of the individual and hence the responsibility of society. Now we pretty much accept it as that: the "new" criticism has to do with the failure of the medical profession to meet its "accepted" responsibility. I put quotation marks around the word accepted because doctors as a whole may not agree that medical care (their services) is everyone's basic inalienable right. That is to say, they would probably concede, if the distinction were presented to them, that curing—the banishment of disease—might well be such a right, but that healing is a contractual arrangement that puts personal demands upon the doctor, demands that cannot easily be made the basic right of another. In any case an argument is difficult to conclude constructively when one side—the critic—assumes the existence of responsibility and the other side does not—especially when neither side is arguing about the same responsibility. Thus the real question is not whether the right to health maintenance exists—it would be hard to deny the right to freedom from disease—but, rather, how we can discharge that responsibility without destroying the latent function of medical care and thus leaving other, equally important, needs unmet. (One of the striking facts about this group of critics, including the physicians among them, is that most have never practiced medicine and hence they view the interchange between doctor and patient as primarily related to disease. Practicing physicians as a rule know very well that it is not so simple as that.)

The essence of the criticism of individual services—the second category—is that physicians have become impersonal and "don't care anymore." This kind of criticism is also on the rise, and has been since the Second World War. During this period the profession has been increasingly concerned about its "image." (Conveniently, physicians have an organization to do their worrying for them—the American Medical Association. All things to all people, the AMA is much too complex a phenomenon to be dealt with here. However, I would, as a physician, be in a bad way without it. It has helped elevate me and my colleagues to our present technical eminence. It draws on itself slings and arrows meant for individual doctors. And if things seem to be going too well, it always seems capable of making some outrageous political goof to stir up the pot again. In short, it has done more to improve physicians, medical schools, and hospitals, worried more about the doctor's image and done more to damage that image than any other institution. It should be remembered that the AMA is an organization of practicing physicians. Some of its paradoxes are the paradoxes of the practice of medicine itself.)

Apparently, doctors have good reason to be concerned about their image. "Unconcerned"; don't care"; "not committed"; "not dedicated"; "cold"; "don't take time"; "don't listen"—these, to say the least, are not the qualities one would associate with the ideal doctor. Criticism of this kind is essentially not concerned with that aspect of medical care which I have defined as curing—most people, on an individual basis, are happy enough with their physician's ability to cure—but rather with the more latent activity of healing. Hence the lack of specificity in the complaints; since, as I have noted, the healing function itself often occurs without awareness or language, it is not easy for a patient to articulate precisely the meaning to him of its absence.

There are, then, two different criticisms of med-

icine now being voiced. The first complains of the high cost and insufficient spread of medical care, while the second complains of the insufficient warmth and attention of individual physicians' services. Both criticisms seem valid, although each is concerned with a different aspect of the process of medical care.

WHAT IS being done to solve the problems of medical care? At the moment, not much, although one can say with some assurance that change is coming. National health insurance, a basic necessity, will probably be a reality within a few years. Yet if the structure of that insurance is based upon a false understanding of the *process* of medical care, then the insurance will fail to do the job assigned it. Medicaid must stand as a classic example of insurance so designed as to perpetuate indigency, promote dishonesty, and even perpetuate illness. Medicare, on the other hand, has been good medical insurance. But it is becoming increasingly expensive, as it had to do in order to promote better medical care—which means time and service, costly items.

It seems impossible to discuss this whole problem without confronting the extremely touchy subject of money and medical fees. Although physicians are usually paid for their services, our culture insists that they act differently about money from other members of society (except the clergy). They are not meant to care about it; their relationship to money is supposed to be oblique, almost incidental. I myself frankly do not know how important direct monetary payment is as compensation for a physician's services. It is obvious that during the healing process a patient is so exposed, so vulnerable, that it helps if he can maintain some method of control over the actions of his doctor, but for some patients this is a greater personal need than it is for others. In any case, the perceived value of goods or services provided throughout our society is linked to their cost, and it would be difficult to conceive of the link not being extended to physicians' services as well. Physicians are *expected* to do well financially: it is important to our conception of their high status that they succeed monetarily. On the other hand, when they appear to be doing *too* well, they become suspect. Mainly they should be regarded as being motivated by the desire to do good, or, in other words, by their calling—a word that carries connotations of a divine or inward conviction appropriate to the function of the healer. There is nothing divine or mysterious about the desire to make money, and the money-oriented doctor is hence tainted by suspicion of fraud.

Many doctors, especially when they are young, are themselves conflicted about this problem. Some have difficulty asking for payment or charging sufficiently. In the continuing battle between academic and practicing physicians, the academicians have pointed to the higher income of the practitioner as evidence of the latter's moral failure. It is an effective argument because it finds resonance within the practitioners' own inner doubts. But in this battle too, as in so many others, neither side is arguing the real issue—indeed, generally neither is aware of the real issue. Most insurance programs and medical-care programs are unfortunately designed by men who have never practiced medicine, or who have left the practice of medicine after a short time, or a long time ago. They may feel themselves free of the taint of profit motive, and feel that they are driven primarily by a wish to do good for the recipients of the program and to protect those recipients from the greed of the practicing physician. It is frequently less costly, however, in emotional terms, to do good for the masses than to do good for individuals, and the actual motives of these men may be more complex than they care to admit.

I do not mean to deny, however, that the high income of a physician may have a corrosive influence on his work, especially if he derives from it no other reward sufficient to make up for the hard work, minimal leisure, and constant fatigue that are the hallmarks of the practice of medicine. Such a physician often loses respect for his calling, and when he does so money can become inordinately important to him.

In the past, the inner conflict experienced by the physician between the pure demands of his calling and the taint of materialism was partially resolved by the rendering of free services. Many, if not most, physicians took care of patients who were unable to pay. They charged nothing, or charged just enough to allow the patient to feel he was not receiving charity. Before the days of Medicare, many aged patients who were unable to pay were privately treated for little or no payment. Insurance, medical plans, Medicare, and Medicaid have changed all that. Because of the change, many are getting care that never before received it, and there are more who still must be reached. But the benefit is not without its moral price. Free services, freely rendered, may be one way for a physician to reduce that price. Free services cannot be demanded, for then they would be a form of servitude, but when they are given by choice they can have an ennobling effect both on the individual and on the profession he represents.

The problem of fees and reward in medicine is immensely complex. There are so many sides to it, and the issue has become so highly charged, both publicly and personally, that objective discussion has become virtually impossible. (I am sure, for example, that this section aroused real feeling in most readers.) Nonetheless, it is of central importance in planning for the coming changes in the social structure of medical care, and we all stand to suffer from a continuation of the present doctrinaire positions about medicine and money.