



## *Debating Point*

### **The Artificial and Elusive Demarcation Between Health and Disease**

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#### **Introduction**

Health and disease are normally seen as the poles of a continuum, and it is widely supposed that an objective demarcation line exists at some point along the spectrum. But the dividing-line between health and disease is artificial. It is a man-made distinction, not a natural one. In reality no distinct line can be drawn between health and disease since the meaning of these terms varies according to cultural, social, economic, anthropological and medical factors. Thus there are many possible lines of demarcation, each of which is drawn to serve particular ends.

And this fact has far-reaching social and economic consequences. If the dividing-line between health and disease is artificial then neither health nor disease are self-evident conditions, but states which have to be claimed.

#### **Different Perspectives**

The 'sociocultural perspective' and the 'medical perspective' on health and disease are usually differentiated as follows.

##### *The Sociocultural Perspective*

The 'sociocultural view' of health and disease defines health and disease, at least in part, according to prevalent cultural values and social standards.<sup>1</sup> While the details of these values and standards vary between cultures, in general social groups judge health and illness against standards of adaptation. Thus categories of health and disease are created in two main ways: by reference to broad cultural norms (ethical, philosophical, and religious traditions) and by reference to the prac-

tical coping capacities of individuals.<sup>1</sup> But, of course, both forms of assessment are open to discussion. Should unwanted pregnancy be considered a form of disease? Should alcohol and smoking addiction be thought of as forms of deviant and punishable behaviour, or as conditions which need medical care? Coping capacities may be influenced by such factors as personal attitude, social environment, financial resources, and family life.

In individualised, permissive and wealthy societies views of health and disease tend to diverge markedly from those found in insulated and poor communities. Dubos relates a well-known example<sup>2</sup> of an Indian tribe in which a particular skin disease was so prevalent that 'the diseased' were considered normal and the 'non-diseased' ill. As Dubos noted, health and disease are not entities but concepts used to characterise a process of adaptation to the changing demands of life and the changing meanings we give to living. If this is true then the 'sociocultural perspective' cannot offer an absolute demarcation between health and disease. Is medicine able to provide a more definitive account?

##### *The Medical Perspective*

Generally speaking, it is possible to distinguish between two medical concepts of disease: the 'empirical' and the 'conceptual'. Through the centuries these two concepts have developed into firmly established doctrines, each of which has many supporters. These doctrines can be traced to the ideas of the rival medical schools of Cos and Cnidos (islands which lie 20 kilometres apart in the Aegean sea) which flourished during the 5th to the 2nd centuries B.C.

The Coan\* or empirical conception is best exemplified by Hippocratean writings.<sup>3</sup> In his books the famous doctor gives a detailed description of the patient: the general impression he makes on the doctor, the patient's stools, the colour of his vomit: and also describes the context of the patient's life—his social circumstances, the climate, prevailing winds, his housing, and so on. From these aspects the Hippocratean method is to form a prognosis based on the doctor's experience, and to prescribe natural ingredients as remedies. No specific diagnosis is made. The diagnosis *is* the patient's condition: Mr Smith is ill.<sup>4</sup> The Hippocratean description is clearly patient rather than disease oriented, and modern readers are not able to make any recognisable diagnosis from these descriptions.

By contrast the Cnidian school insists on a clear definition of a disease. Given that typical configurations of symptoms and signs are said to constitute general 'disease categories', a new patient-case can be diagnosed by correlating the presenting symptoms with those of a predefined disease.<sup>5</sup> This, of course, is the forerunner of the disease descriptions found in current medical textbooks. In fact, the Cnidian school was the first to attempt to systemise and classify diseases into a taxonomy.

### Theory Makes a Practical Difference

It makes a great difference to the resulting medical judgement whether the diagnosing doctor is a follower of the empirical or the conceptual doctrine. The empirical doctrine allows the doctor to diagnose the presenting condition in terms of a unique combination of symptoms and signs (a descriptive diagnosis) whereas the 'conceptual' doctor must identify the condition by 'fitting it' into a predefined taxonomy of diseases.

The freedom inherent to the empirical approach is particularly welcomed in family medicine and primary health care. But this is a less precise form of medicine, and diagnosing particular symptom presentations observed in unique individuals can bring the empiricist into conflict with those authorities which demand an unequivocal statement about the 'health status' of a

patient. Consequently, in order to minimise conflict, the empirical doctor is forced to make use of codes that are part of the official nosology, while trying to avoid rigidity as far as possible (and thus will tend to mix—often uneasily—the empirical doctrine with the conceptual).

### *Elusive Foundations*

'We in medicine are always arguing the question whether 'there is' such a thing as disease and what 'the nature of disease' is, while we have no concept of disease which can form the inter-subjectively controllable basis for such a debate'.<sup>6</sup>

The idea that there is a universally accepted, objective foundation for all disease<sup>7</sup> has faded over time. Different sorts of taxonomy have been

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*'... the empiricist approach to diagnosis can conflict with the demands of official authorities ...'*

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found to be necessary (in order to categorise 'mental illness' and 'physical illness', to give one example). Furthermore, medicine has expanded its boundaries by incorporating not only newly recognised disease but also illnesses defined initially in 'folk lore'—such as the 'common cold', 'cold on the bladder', 'heavy food dyspepsia', 'spice oil diarrhoea', and 'wear and tear of joints'. Newly discovered diseases such as: SID (Sudden Infant Death), MBDS (Minimal Brain Damage Syndrome), PID (Pelvic Inflammatory Disease), Post-natal Depression, IBS (Irritable Bowel Syndrome), ME (Myalgia Encephalomyelitis), and Chronic Fatigue Syndrome, have been included in the nosology, but without a pathophysiological substrate, correct legitimation or proper classification. They are but convenient names without explanatory or predictive meaning.<sup>8</sup>

The result is a very confusing world, a mixture of empirical (Hippocratean) and conceptual (Galenian) views.

### Consequences

What are the consequences of this confusion?<sup>9</sup> The general opinion, and especially that of

\* Originating from Cos.

established social institutions and insurance companies, holds that it is the doctor's job to recognise an illness, confer the 'sick status' on the potential patient, establish priorities, and take the initiative in dealing with the patient's health problems.<sup>10</sup> Western societies have bestowed the doctor with this authority, and he is expected to draw a clear and unambiguous line between health and disease. At present the right to decide lies with the doctor. But, given the theoretical confusion—given that there is no clear demarcation line—should the doctor have this right?

Mechanic<sup>2</sup> calls medicine 'a social institution as well as a technical activity which is shaped by the economic and sociocultural context in which it is embedded'. As a social institution, health care has become a success story (viewed from certain perspectives, at least), but its expansion threatens other social institutions. Enlarging the medical horizon to states of pre-illness (and implementing preventive strategies) does seem to have brought about improved health for younger persons (and decreased infant mortality rates), but this

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*'... it is still widely believed that health care can provide a panacea for the miseries of human life ...'*

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improvement has not been effected for the elder population so far. In 1841 the life expectancy of a 50-year old man in Britain was 20.0 years. In 1976 it was 22.7 years and has changed little since.<sup>11</sup> The successes of antibiotics and vaccines raised high expectations about medical competence in providing health and happiness among the public as well as among medical scientists. Those expectations, however, did not materialise. Nevertheless, it is still widely believed that health care can provide a panacea for many, if not all, miseries of human life.

Within a period of nearly 20 years (1974–1991) the number of patient contacts with doctors in primary health care tripled in The Netherlands. In the same period contacts with specialists doubled. Within a period of just 10 years (1981–1991) contacts with physiotherapists increased by 74% and by 55% with alternative healers. The costs of health care rose from 5.4% in 1968 to over 8.5% of the GNP. As Horrobin has said:

'... these escalating costs have not been accompanied either by equivalent objective therapeutic success or by equivalent rises in patient satisfaction. Our patients die marvelously documented, technologically assisted deaths, but they die in much the same ways and at much the same age as they did in 1960'.<sup>11</sup>

## Conclusion

A number of problems and uncertainties have been raised by this brief review. Although they are well-known in philosophical and social scientific circles they are otherwise consistently ignored. But I call for a wider debate about them. If medicine cannot come to terms with its own confusing terminology and methodology; if medicine cannot stop raising expectations it cannot fulfil; if medicine does not deliberately restrict its boundaries; and if medicine does not take serious steps to explain why it chooses to call some conditions states of health and others states of disease; then the result must be that health policy (which medicine largely continues to direct) will either be simply an arbitrary matter, or will be implemented on the basis of economic arguments. Where everything else is imprecise the discipline that offers precision will triumph. And the evidence of the moment is that this is exactly what is happening.

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