

THE VALUE OF DISEASE, ILLNESS AND SYMPTOMS

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One of the most pervasive messages in modern advertising, both public and private, is that good health is something to strive for. Thus, the condition of our bodies and how the medical fraternity can impact on us is never far from our thoughts. Central to this interaction between doctor, patient, and society is a core group of terms that frame our discussions of sickness and health. Of particular interest to philosophers of medicine, the way we use and recognise the differences between these terms has implications for how we decode the medical encounter. In this essay, three terms, disease, illness, and symptoms will be analysed to develop an argument for the continued separation and appreciation of them as distinct, although imbricated, concepts crucial to the performance of modern medicine.

There is a proliferation of medically oriented shows on television, from the drama of *Grey's Anatomy* to the phenomenally popular *ER* and the slapstick *Scrubs*. Each night, we anticipate how Hugh Laurie will unravel the *disease*, an old lady deal with her *symptoms* and watch the nursing staff manage the *illnesses* of the unwell. These terms - 'disease,' 'illness,' and 'symptoms,'- are central to the medical encounter, providing the framework for understanding sickness and health. Of particular interest to philosophers of medicine, the way we use and recognise the differences between these terms has implications for how we decode the medical encounter. In 1975, Christopher Boorse suggested that the difference between 'disease' and 'illness' was that diseases were discrete physical entities without normative value, whereas illnesses were conditions which might include diseases and have normative value (Boorse, 1975). This conclusion suggests that illness, by having normative value attached to it, is important in a purely relative sense. However, I believe that, in order to maintain a robust understanding of the medical encounter, we should regard these terms as important because they perform different roles.

This essay will describe the differences between the concepts of disease, illness, and symptoms, framing them in two ways; the first is in the nature or focus of each term. Disease, illness, and symptoms refer to different objects and are known by different means – disease by learning, symptoms by experience. In the context of medicine they are used to refer to the same object, the sick patient, but they vary in the focus and manner of description. The second difference is the power relationships that are invoked by the concepts and are subsequently responsible for directing the performance of the clinical encounter as well as the social response to the sick person. The final section will outline two interesting ways to view and understand the differences between the three terms. The first, by examining Annemarie Mol's analysis of the hospital 'performance' of atherosclerosis and the other, by analogy to an argument in the philosophy of mind. It will be concluded that disease, illness, and symptoms are separate concepts which operate on a tier of power and derive meaning through the interplay of their connotations.

Terms of the Medical Encounter

Intuitively, hospitals are pro-active types of places: you go when something is wrong, the doctor pokes and prods at you, and you are treated, and then (hopefully) dismissed with a clean bill of health. Although there may be different kinds of logic operating for different doctors in any one encounter (Mol, 1998) the ideal effect of visiting a hospital or medical centre is to feel better. Thus, it makes no sense to talk about disease or illness without first understanding the concept of symptoms. They prompt the visit to the doctor, thereby providing the initiating role in the medical encounter.

Symptoms – The Language of Disease and Illness

Rene Leriche said that health is *life lived in the silence of the organs*¹, in other words, we live life when we do not notice our bodily processes. It is when these processes malfunction and we can monitor them that sickness and health become obvious concerns. A racing heart signifies exertion, a runny nose means a head cold, a tender knee signifies a nasty bruise and so on. Symptoms demonstrate the potential for disease because they are the markers of illness and in the clinical setting they are like the language which communicates between the two separate concepts of disease and illness. Symptoms gain their epistemological weight by being part of the lived experience of illness. Without symptoms of some sort, there would be no reason for anyone to go to the doctor. Even hypochondriacs, who often go to the doctor for no reason, *think* they have symptoms which motivates them to seek professional care.

From the professional perspective, McConnell claims that “**sickness** (disease) and **health** (wellness) are words that refer to the actual presence or absence of disease and do *not* refer to symptoms, signs” (McConnell, 2007, p. 6)². Symptoms are a separate entity to disease but they are the starting point for a causal hypothesis. Symptoms are defined as “complaints reported by the patient or by someone else on behalf of the patient and are [a] part of the medical history” (McConnell, 2007, p. 5). They are initial evidence of malfunction as noted by the *sufferer*, they are subjective and categorised as deviations from the normal ‘feel’ of the body. It is an important concept because it captures the way that the body demonstrates malfunction and shows the sufferer that there is something amiss. As Boorse points out, “normal is the natural. The state of

¹ Rene Leriche quoted in Canguilhem, G. (1989) *The Normal and the Pathological*, New York, Zone Books.

² Original emphasis

an organism is theoretically healthy” (Boorse, 1975, p. 57). The aches and pains of a cold or the uncomfortable heat of a fever are symptoms and they are part of the subjective experience of illness; they are the intermediary which guides discussion between the doctor speaking the language of disease and the patient, speaking the language of a sufferer.

Illness – The Embodiment of Symptoms

The concept of illness expands the notion of symptoms by extending it to the patient as the object of suffering. *Symptoms* are felt by the object of suffering, the patient, but the notion does not include the extra layer of social and personal meaning which seems to be inherent in the word itself. Arthur Kleinman articulates the distinction best when he says that “by invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering” (Kleinman, 1988, p. 3). Illness is a holistic term, more robust than symptoms but more vague than the scientific, objective, universal concept of disease, which will be discussed next. Illness is that part of disease which is not articulated by scientific definition and thus, “it should be of no surprise that the suffering of people can be only imperfectly mapped to a set of objective disease ideal-types” (Aronowitz, 2004, p. 71). Illness is the patient experience as a whole, the social, economic, and political consequence of disease.

As mentioned above, one part of the progression in the medical encounter is diagnosis and this is dependent upon both concepts of disease and illness. The purpose of diagnosis is to define a scientific cause for the ailment (disease) and provide a “description of the patient as a *sufferer* of a particular disease process” (Chiong, 2001, p. 89)³ The concept of illness relies on the patient, the sufferer for its epistemological roots. The meaning of illness is embedded in the lived

³ Emphasis added.

experience, it is “intimately related to notions of one’s sense of self” (Lupton, 1995, p. 79). As a subjective notion, illness lends itself to personal anecdote and the power of suggestive expression. Since most of us have, at some point, suffered from some kind of illness, we can empathise with an ill person and bring meaning to someone else’s pain.

Disease – The Underlying Cause

The last concept, disease, is highly focussed on scientific principles and is used to maintain the objectivity of medicine. Indeed, Engel asserts that in terms of health care and determining the type of disease ailing the patient, “the concepts that guide inquiry are objectivity, a-historicity, a-culturicity, a-emotionality, and universality” (Engel, 2008, p. 25). Disease is thus set apart from variable and subjective properties; it is a concrete and specific term which applies to a definite entity. Again, Kleinman articulates the notion well: “disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice” (Kleinman, 1988, p. 5). Unlike the ideas of illness and symptoms, the patient is not the final object of scrutiny and investigation, it is the ‘disease entity’ that is being sought-out and treated. Disease has science as its underlying epistemological foundation and has a more rational, objective and impersonal flavour.

Understanding disease as an independent, dispassionate concept allows it to be a suitable object of medical attention and inquiry because it can be dealt with like a problem that “applies indifferently to organisms of all species” (Boorse, 1975, p. 56). Theoretical disease entities thus operate to affect normal processes indiscriminately, producing the suffering and symptoms of a patient via the operation of a specific causal process. This has the effect of liberating disease from the complicated, unmeasurable and subjective experiences of illness (Engel, 2008). Unfortunately,

it can also prevent the doctor from viewing the patient as a whole entity, thereby hindering their ability to deal with the entire array of concerns which the patient might present. It was recently noted in the *New York Times* that some physicians found it particularly difficult to treat the elderly who had multiple conditions. Under the normal paradigm of medicine, their illnesses needed to be broken up and divided into “collections of malfunctioning body parts” (Carpenter, 2009). However, this increases the risk of harmful drug interactions and does not account for the fact that the elderly may not be in a position to afford copious amounts of drugs, and still be able to remember the correct combinations. The overall achievement of the disease concept is to reduce the form of a suffering human to an array of systematised and mechanised biological functions that are attacked by discrete entities resulting in dysfunction. The three concepts differ in their focus and epistemological underpinning. Symptoms and illness arise from a personal and subjective knowledge base. In addition, illness considers the extra, emotional and experiential element of sickness while disease is concerned with the objective entity which is responsible for dysfunction.

Power Relations in the Medical Encounter

An interesting way of framing the difference between the three terms is to examine the power differential that exists between them when they are invoked. Power relationships are not foreign to the medical encounter; watch any hospital drama on television and you will immediately notice the hierarchy of power operating amongst doctors, nurses, and patients. However, it is not only the common social roles that dictate the differential but also the power inherent in the theoretical concepts central to the medical enterprise. The context of the doctor-patient relationship is part of the medical ‘encounter’ and in this environment; it is not the authority of

the individual doctor that is invoked. Rather, it is the meaningful interaction between the concepts of disease, illness, and symptoms which generates much of the social dynamic.

As Lupton argues, “a power differential is not necessarily considered a negative part of the medical encounter; power is viewed as necessary to facilitate the needs and expectations of both patient and doctor” (Lupton, 1995, p. 117). In light of the expert knowledge which the doctor is assumed to have, it is hardly surprising that there is a difference in the social and political weight of the doctor’s opinion over the patient’s. As argued above, ‘disease’, ‘illness’, and ‘symptoms’ have differing objects of focus and epistemological foundations. These terms thus have contingent and intrinsic power levels inherent in their commonly understood meaning.

The Professional Advantage

In the doctor-patient relationship, it is fairly obvious on which side of the encounter each of the concepts apply; disease is the realm of the doctor, illness the concern of the patient and symptoms the means by which the two may start a dialogue. Inherent in the disease concept is the rational and objective power of the scientific enterprise. Thus, not only does the doctor have years of professional education and training, but they may also claim the ‘truth’ of science as the epistemological foundation of their discourse.

Disease is part of the specialised world of science and learning medicine “involves learning the traditional biomedical knowledge, but also learning how to talk and interact with patients, how to evaluate this talk and how to talk about talk” (Hydén and Lumma, 2007, p. 23). The doctor (generally) holds authority over the patient who will most often communicate the problem in terms of their subjective experience of illness but it is uncovering and treating disease that is

the productive portion of medicine. Disease is the focus because it is transferrable; it can be understood by a range of people and dealt with in a consistent manner. In terms of the medical interview, where the patient will explain their illness in terms of symptoms and their subjective feelings, the doctor must “perform the medical interview in almost the same way irrespective of the actual patient, the type of medical problem, the specific situation or context” (Hydén and Lumma, 2007, p. 23). It is instrumentally useful to use abstract, neutral concepts because then groups of people may establish a repertoire of mutually understandable content without requiring first-hand experience of an individual complaint. By contrast, communicating symptoms to a friend or colleague, without them having experienced similar feelings, may elicit sympathy but no valuable advice, assistance, or empathy.

As Kathryn Hunter argues, “a malady cannot be understood nor therapy effectively prescribed unless the patient’s experience is captured accurately and translated into a recognisable medical version” (Hunter, 1991, p. 138). Thus, a doctor’s power is derived from their ability to translate the subjective into the objective, to measure unmeasurable quantities and turn them into salient elements of a diagnostic hypothesis. Bodies malfunction for a reason and it is expected that, because of the universal nature of disease, the underlying cause of dysfunction should be there for the physician to find and address. This is not to imply that all the power of the medical encounter is held on the side of disease and the doctor, rather that the common interaction of the two constitutes the predictive strength of the theory of disease.

The Social Aspect of Sickness

The second and well documented aspect of the medical encounter is the social power which is invoked in discussions of sickness and health. Parsons, in his paper *Illness and the Role of the*

Physician: A Sociological Perspective argues that “illness is not merely a ‘condition’ but also a social role” (Parsons, 1987, p. 151). The subjective nature of illness means that much of the social power is the result of empathy from other members of the community. If you are sick, you demonstrate symptoms which both the doctor and your peers can interpret (in their own particular ways). The ‘sick role’, as Parsons calls it, means that “the sick person is, by definition, in some respect disabled from fulfilling normal social obligations, and the motivation of the sick person in being or staying sick has some reference to this fact” (Parsons, 1987, p. 148). Thus, the usual obligations which are part of living in a community are suspended until the sufferer can return to normal function. Arguably, the ‘sick role’ derives its meaning and power from the interaction of all of the concepts put together. Symptoms are evidence of illness and illness is generally caused by some kind of disease. Borrowing from the authority of science, the sick role pardons the sufferer from normal social obligations because it is the result of a disease entity – an abstract, (mostly) neutral concept⁴.

In the medical encounter, both doctor and patient have a tacit understanding of the roles they are expected to play. It would not make sense to go to the doctor in the first place if this was not the case because doctors “can or should provide ‘answers’ to the patient’s problems, and both can be frustrated when this expectation is not met” (Chiong, 2001, p. 90). The flip-side of the exemption provided by the sick role is that in the social sphere, the ailment you suffer from must fall under an appropriate medical category to entail special treatment. Social power is harnessed when moral weight is brought to an issue and finds consensus in the general populace and as Boorse points out, “illness is merely a subclass of disease, namely, those diseases that have

⁴ It should be noted that the sick role cannot be applied so easily to chronic conditions or conditions which are regarded to be self-inflicted, e.g. chronic fatigue syndrome or lung cancer as the result of smoking.

certain normative features reflected in the institutions of medical practice” (Boorse, 1975, p. 56). Thus, there are two environments where social forces are influenced by the nature of the terms disease, illness and symptoms; externally to the medical encounter and internally.

Two Different Ways to Understand Difference

The nature of the disease concept – scientific, rational, and objective – allows it to operate as a framework for the other two ideas to secure themselves against. However, disease would not be an interesting topic of discussion if it did not affect anything. As an abstract concept, something which disturbs normal function is interesting but not interesting enough to be as robust and developed as the term is in medical philosophy. The striking thing about these concepts is their interplay and the different levels of knowledge which operate during the medical encounter. Here, I will present two ways of understanding the difference between each of the concepts and how their meanings interact to produce a coherent experience. The first example will analyse all the terms together and see how they operate in a practical setting, and the second example will focus on the disease/illness distinction.

The In-House Study

In McConnell’s *Nature of Disease*, atherosclerosis is defined as a

lifestyle disease related to smoking, lack of exercise, obesity and a high-fat diet. Atherosclerosis is characterised by chronic inflammation, scarring, and cholesterol deposits in large and medium-size arteries. ... Atherosclerosis accounts for about one third of deaths in the industrialised world (McConnell, 2007, p. 277).

To describe the disease, the definition includes the size of the arteries that are affected by ‘atherosclerosis,’ the kinds of effects it will have on the arteries, as well as some ‘risk factors’

which do not directly cause the disease but are 'related' to it. In an effort to understand this disease, Mol undertook a study to see how the treatment and understanding of atherosclerosis was actually 'performed'⁵ in a teaching hospital in the Netherlands (Mol, 1998).

In summary, the most interesting thing that Mol reported was that the diagnosis of 'atherosclerosis' connotated different things to different kinds of doctors, and elements of diagnosis and treatment were viewed differently at a hospital in another part of the city. In terms of the first dispute between different *kinds* of physician, she notes that "in the clinic, one could say, atherosclerosis *is* claudication. While in the department of pathology, atherosclerosis *is* a microscopically enlarged thickening of the vessel wall" (Mol, 1998, p. 147)⁶ In both cases, atherosclerosis is the focus, it is the disease entity but it is practically viewed through the lens of a discipline. 'Claudication'⁷ and 'thickening of the vessel wall' produce the same feelings or *symptoms* in the ill patient, an experience of pain when walking over one hundred metres, but the description and the medical term, cannot produce a full understanding of atherosclerosis.

In spite of the "variety of 'atheroscleroses' performed" (Mol, 1998, p. 162), the physicians still maintain the power balance in the doctor-patient relationship and even question the reliability of a patient's report that he only has 'minor difficulty walking,' preferring to refer to the test results which indicate he should not be able to walk at all (Mol, 1998, p. 150). The examples highlight the fact that the performance of disease is clearly informed by both the hierarchy of power implied by the concepts of disease, illness and symptoms, but is also adjusted in practice to suit

⁵ Here, performed is used to refer to how different doctors understood the disease 'atherosclerosis' as well as the kinds of interactions that this disease caused amongst physicians, students, and patients. The primary concern was not necessarily the textbook definition; instead, it is the way that the textbook definition is interpreted in a practical situation.

⁶ Original emphasis.

⁷ Claudication is difficulty walking or limping.

the subjective or objective nature of the concept. A theory of disease produces many facts about 'atherosclerosis' while the subjective report of 'minor difficulty' may be adjusted for clarity by interpreting objective test results.

The Philosophy of Mind Knowledge Argument

In the philosophy of mind, there is an argument against physicalism known as the 'knowledge argument'. It is designed to show that "the material or physical story about us is not the complete story about us because it leaves out the sensory part" (Braddon-Mitchell and Jackson, 2007, p. 134). Like the concept of disease, it aims to reduce things to more fundamental properties, in this case, physical things. Thus, physicalism and disease are analogous concepts, although not exact, the philosophy behind each of them is quite similar and generates many of the same objections. The knowledge argument is as follows: Mary is a brilliant young girl, stuck in a monochromatic room (Jackson, 1997)⁸. She has both the ability and the inclination to gain all knowledge; she knows everything that can be known about anything physical. Finally, she is released from her monochromatic room and is given a red rose. The knowledge argument says that when Mary sees this red rose, she learns something new and different to all the things she previously knew about red. She now *knows* the experience of red, implying that "certain facts about experiences are nonphysical" (Güzeldere, 1997, p. 37). Admittedly, this is an intuitively forceful argument and I think, is somewhat similar to the illness/disease distinction.

Science might claim to know everything about the body and physiology, pathology and biology can explain all the facts about disease, but this neglects the subjective, experiential element of disease. When disease affects a human, it is an illness and takes on different kinds of

⁸ The knowledge argument presented here is a summary of Braddon-Mitchell and Jackson's re-telling.

qualities which are different to scientifically descriptive, conceptual explanations. Illness involves a lived experience, like the act of seeing red for the first time, although the concept is grounded in the scientific/physicalist ideology, it is not wholly captured by it. This is the fundamental difference between the concepts of disease and illness and explains why it is instrumentally and intrinsically useful to understand the two terms as related but distinct. Although there are suggestions that it would be easier in the philosophy of medicine to sweep these sometime problematic concepts under one umbrella term (Danner Clouser et al., 2004)⁹ but it seems that this would not solve the ultimate problem of understanding their difference or use this disparity in a productive way. If you accept that there is a difference in common usage, it is valuable to try and understand how it operates.

Conclusion

Meaning is produced in the medical encounter by respecting the differences between the concepts of disease, illness, and symptoms, and in practice adjusting for their bias. The three terms operate in a tier system with each one feeding meaning to the other. For the concepts of illness and symptoms, social power and acceptance are contingent on legitimations from the 'rational' concept of disease; illness means little socially without medical/scientific justification. In contrast, the concept of disease, borrowing its social power from science, does not require the justification of illness or symptoms; it has enough epistemological weight to stand alone. Symptoms can be dismissed as psychosomatic or proof of malingering, disease cannot. Illness captures the distinct personal, experiential quality of sickness and disease is a useful medical

⁹ Here, Danner Clouser et al suggest that 'malady' be used as the group term for other concepts like 'disease,' 'illness,' and 'injury'.

concept. Each term is most productive when it is kept distinct but we must realise that each concept acquires meaning in context of the other. If philosopher's of medicine wish to merge the terms of bring them under a blanket concept, it will be difficult to maintain the robustness of each idea.

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