EDITORIAL

DISEASE AND ILLNESS—CURING AND HEALING

A long time ago I came into possession of one of the series of paintings that Bausch and Lomb had commissioned, probably around the midpoint of the last century, tracing the history of eye care in the United States. My picture is entitled *Eyes Examined in the Early Days of Professional Eye Care.* Another picture in the series, depicting an earlier time, shows glasses being dispensed in a jewelry store. My picture gives no doubt that the examination is being conducted in a professional office.

The artist captured the difference extremely well. In my picture both doctor and patient are dressed in the style of the early 1900's, and the then state-of-the-art optometric tools are evident: an ophthalmometer (not a keratometer) is prominently displayed as is a trial lense set, a reversed Snellen chart, an astigmatic sunburst chart, along with several posters depicting various aspects of the eye. The patient, a distinguished looking gentleman, is seated with his hands grasping the ends of the arms of the chair in a relaxed manner, while the doctor is performing retinoscopy. There is no phoroptor and consequently there is uninterrupted space between the patient and doctor. They are face to face, each fully aware of the other.

I have long interpreted this positioning as an integral part of a special relationship between the two, one that has been increasingly lost in all of the health care professions. At least part of the price paid for providing today's more advanced level of care, because of increased knowledge and technology, has been a diminution of this doctor-patient interaction. In spite of some lip service to the contrary, patients are increasingly perceived as objects harboring diseases, and in the interest of "professionalism" the doctor is primarily concerned with the disease, and less with the person. Indeed, the typical picture of today that characterizes optometric care shows the patient seated behind a slit lamp, phoroptor, or with electrodes attached to areas of the head.

Galland [1] has termed the current model of medical, and I might add mainstream optometric, care as "biomedical." It is disease based in that the patient brings one or more problems to the physician who correlates the description of symptoms, the medical history and clinical testing findings in order to generate a list of possible diseases. A differential diagnosis can then be made. Once this is determined, an appropriate treatment regimen follows. In optometric education, this scenario has come to be known as the "problem based curriculum."

While this model is apparently consonant with today's world of cost containment and managed care, it has serious shortcomings. Galland cites a study [2] showing that in a large sample of patients seen by general internists, some 74% were left with no medical or psychiatric diagnoses to explain their entering symptoms, i.e., the reason they sought care. In the everyday world, the clinician who limits her practice to the biomedical model basically has two options when this occurs: she can tell the patient there is nothing wrong or refer the patient to a "specialist." Neither of these actions usually provides patient satisfaction. Galland accounts for this very real inadequacy of the biomedical model by suggesting that because it is totally focused on disease, it neglects the other equally important aspect of patient care, namely, illness.

While the distinction between these two entities is not always crystal clear because of the mind-body interactions in sickness and in health, Spiro [3] provides a practical difference between the two. He conceptualizes *disease as what the doctor sees and finds*, while *illness is what the patient feels and suffers*. In operational terms, when the practitioner finds sufficient evidence that a disease is present, he must treat it in accordance with the standard of practice. When there is insufficient data for the diagnosis of a disease, the doctor can cease his active

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involvement, as described above, or elect to treat the illness. This latter action is not something to be taken lightly: the doctor must make a conscious decision to extend the role of "curer," for which he was originally trained, to that of a "healer."[1] This extension is a willingness to recognize the statement I've either heard or read that "while doctors seek the cure, patients seek care."

Some health care practitioners never elect to grow in this direction. Healing is a concept that generally was addressed minimally, or not at all, in their professional education, the didactic portion of which is based on the scientific method, and the clinical portion in curing. Further, to become a healer requires practitioners to make a commitment to develop what Rogers [4] has termed "a helping relationship" with their patients. This in turn requires, among other things, that the patient perceives the healer as trustworthy, consistent, dependable, not judgmental or threatening, and willing to truly listen to and encourage and facilitate meaningful two way communications. Essentially, the initiative in this relation is for the doctor to show respect in order to earn respect.

It is probable that the distinctions made in this editorial regarding disease and illness on the one hand and curing and healing on the other are not in the minds of many health care providers. Nevertheless, they are important concepts since success in today's health care environment presupposes that the practitioner be an expert curer when appropriate, a caring healer when appropriate, and often to function simultaneously as both. The former role indicates competence in the basics of the profession (the science), while the latter signifies a willingness to develop meaningful and lasting relationships with patients (the art). Patient satisfaction and loyalty in today's very competitive health care market is enhanced when the clinician is neither exclusively a curer nor a healer.

References

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