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«Spezifische Wirkungen» im historischen und kulturellen Wandel · 'Specific Effects' Undergoing Historic and Cultural Transition

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What Counts as Disease? – Rationales and Rationalizations for Treatment

Key Words

Nosology · Disease as a bodily phenomenon · Disease as social strategy · Mental illness · Medical interventions

Summary

Disease is a fact of nature. Diagnosis is an artefact constructed by human beings. The core concept of disease is a bodily abnormality. Literally, the term 'disease' denotes a demonstrable lesion of cells, tissues, or organs; metaphorically, it may be used to denote any kind of malfunctioning, of individuals, groups, economies. Classic nosology was descriptive, based on somatic pathology. The diagnostician sought to anticipate and approximate the pathologist's findings at autopsy, that is, identify the patients's bodily lesion/disease and its material cause (etiology). For example, the term 'pneumococcal pneumonia' identifies the organ affected, the lungs, and the cause of the illness, infection with the pneumococcus. Contemporary nosology is strategic, based on economic, legal, social, and other interests (unrelated to disease as somatic pathology). The diagnostician seeks to secure reimbursement for medical services, legitimize treatment, justify defining undesirable behavior as disease, and so forth. For example, diagnosis-related groups provide bureaucratic rationale for reimbursing medical services by third-party payers; psychiatric diagnoses provide legal-scientific rationale for treating mental diseases as if they were brain diseases; and so forth. Formerly, diagnoses encoded the objectively verifiable condition of the patient's body (diseases). Today, diagnoses rationalize the health-care policy of the body politic (methods of controlling costs and compensating physicians). We are witnessing the transformation of nosology from the medical-scientific classification of disease as somatic pathology, into the medicalized justification of social policy as 'health care' or 'treatment'.

Schlüsselwörter

Nosologie · Krankheit als körperliches Phänomen · Krankheit als soziale Strategie · Mentale Krankheiten · Medizinische Interventionen

Zusammenfassung

Was wird als Krankheit betrachtet? Logik und Rechtfertigung von Behandlungen

Krankheit ist ein Teil der Natur. Die Diagnose ist etwas Künstliches, von Menschen Gemachtes. Das Grundkonzept von Krankheit ist eine körperliche Abnormalität. Wörtlich bezeichnet der Begriff «Krankheit» eine nachweisbare Läsion von Zellen, Geweben oder Organen, metaphorisch wird er zur Beschreibung jeder Art von fehlerhaftem Funktionieren von Individuen, Gruppen oder Ökonomien verwendet. Die klassische Nosologie war deskriptiv, basierend auf der somatischen Pathologie. Der Diagnostiker versuchte, sich an die durch eine Autopsie erhaltenen Ergebnisse des Pathologen anzunähern, sie zu berücksichtigen und so die körperliche Störung des Patienten (Krankheit) und ihre materiellen Ursachen zu identifizieren (Ätiologie). Beispielsweise bezeichnet der Begriff «Pneumokokken-Pneumonie» das betroffene Organ, nämlich die Lunge, und die Ursache der Erkrankung, nämlich die Infektion mit Pneumokokken. Die heutige Nosologie arbeitet strategisch und berücksichtigt ökonomische, gesetzliche, soziale und andere Interessen (steht aber nicht in bezug zur somatischen Pathologie). Der Diagnostiker versucht, die Bezahlung der medizinischen Leistung abzusichern, die Behandlung zu legitimieren, die Definition unerwünschten Verhaltens als Krankheit zu rechtfertigen, usw. So ermöglichen in die Diagnostik involvierte Gruppen eine bürokratische Rationale für die Erstattung der Kosten von medizinischen Dienstleistungen durch Dritte; psychiatrische Diagnosen sorgen für die gesetzliche und wissenschaftliche Berechtigung zur Behandlung von mentalen Krankheiten als handelte es sich um Krankheiten des Gehirns usw. Früher beinhaltete die Diagnose den objektiv verifizierbaren körperlichen Zustand des Patienten (Krankheiten). Heute setzen Diagnosen die Gesundheitspolitik der Gesetzgeber durch (Methoden, um die Kosten zu kontrollieren und die Ärzteschaft zu finanzieren). Wir sind Zeugen des Übergangs der Nosologie von einer medizinisch-wissenschaftlichen Klassifikation von Krankheit als somatische Pathologie zu einer medizinisch verbrämten Rechtfertigung von Sozialpolitik als «Gesundheitsfürsorge» oder «Behandlung».

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Disease, according to the 'Oxford English Dictionary' (OED) is 'a condition of the body, or of some part or organ of the *body*, in which its functions are disturbed or deranged; a morbid *physical* condition' (emphasis added). Diagnosis, in turn, is 'the determination of the nature of a diseased condition ... also, the *opinion* (formally stated) resulting from such investigation' (emphasis added). Disease and diagnosis are in large part, but not exclusively, medical concepts, and the foregoing definitions reflect a medical bias.

Nosology – the classification of diseases – depends on the identity and interests of the nosologist. Patients, physicians, and third parties (relatives, insurance companies, the state) have different interests in, and agendas about what *ought to count* as disease-and-treatment. Patients want relief from illness and suffering. Pathologists want to identify the disease responsible for the patient's bodily disorder (and the cause of his death). Practicing physicians want to treat patients rationally, relieve their complaints, and collect a satisfactory fee for their services. Third parties – relatives, insurance companies, the state – want many different outcomes, such as saving the patient's life, letting him die, providing a maximum of expensive treatment, refusing to reimburse the cost of treatment of non-disease, and so forth. The differences that divide these parties are matters of self-interest, not matters of fact or reasoning; hence, they cannot be resolved by evidence or logic. We can acknowledge these differences and arbitrate the conflicts among the contestants; or we can deny them and pretend that decisions sanctioned by a politically irresistible combination of Medicine and the State are, and ought to be, 'valid' for all 'rational' participants.

Disease: Bodily and Mental

The core *medical* concept of disease – and, by implication, of diagnosis – is a *bodily* abnormality (I use the terms 'disease' and 'illness' interchangeably). Literally, the term 'disease' denotes a demonstrable lesion of cells, tissues, or organs. Metaphorically, the term may be used to denote any kind of malfunctioning, of individuals, groups, economies (for example, illegal drug use, violence, homelessness); the term 'mental disease' – the criterion for which varies among psychiatric authorities depending on the practical interests they seek to advance – typically refers to some sort of behavior that is 'unwanted', either by the subject himself or by others (for example, panic reaction, attention deficit disorder).

Extending the criterion of disease from malfunctions of the human body to malfunctions of the human mind introduces a fatal infection into the materialist-medical definition of disease. The mind is not a material object; hence, it can be diseased only in a metaphorical sense [1]. However, once we accept the fiction that mental illness is a real disease, we are compelled to accept the diagnoses of mental illnesses as the names of real diseases, despite the fact that the criterion for what counts as a mental disease has nothing to do with the criterion for what counts as a bodily disease.

In 'Psychiatric Diagnosis', Donald Goodwin and Samuel B. Guze, two of the most respected psychiatrists in the United States, state: 'Classification in medicine is called ‹diagnosis›' [2]. This is wrong. The medical classification of diseases is called 'nosology', not 'diagnosis'. The authors also misuse the word 'disease'. They write: 'When the term 'disease' is used, this is what is meant: A disease is a cluster of symptoms and/or signs with a more or less predictable course. Symptoms are what patients tell you; signs are what you see. The cluster may be associated with physical abnormality or may not. The essential point is that it results in consultation with a physician' [3]. In other words, disease, according to these authorities, is *not an observable phenomenon*, but a social relationship. (If this is true, the absence of physicians would protect people from getting sick.) What makes this assertion especially remarkable is that it is asserted by psychiatrists many of whose so-called patients do not want to be 'patients' and do not want a consultation with a *psychiatrist*.

Goodwin's and Guze's assertion that mental illness need not be associated with physical abnormality is contradicted by other psychiatric experts who claim that *all* psychiatric diagnoses name somato-pathological conditions. For example, Allen Frances, the chief architect of the American Psychiatric Association's internationally influential '*Diagnostic and Statistical Manual, DSM-IV*', states: 'The special features of DSM-IV are ... elimination of the term 'organic mental disorder' because it incorrectly implied that other psychiatric disorders did not have a biological contribution' [4]. In other words, the scores of mental diseases manufactured by adding the suffixes 'phobia' and 'philia' Greek or Latin terms – such as agoraphobia and zoophilia – are all real (bodily) diseases [5]. (Biological) psychiatrists assert that all mental diseases are brain diseases and that advances in our understanding of the functioning of the brain will provide irrefutable proof for this assertion.

- The diagnosis of a bodily illness – say, sarcoma – is the operative word that justifies a physician's admitting to a hospital a patient who wants to be in a hospital and consents to being admitted to one.
- The diagnosis of a mental illness – say, schizophrenia – is the operative word that justifies a psychiatrist's admitting to a mental hospital a person who does not want to be in a mental hospital and refuses to consent to being admitted to one.

Linguistic considerations help to illuminate the differences between bodily disease and mental disease as well as between disease and diagnosis. A competent user of English does not attribute motives to diseases and does not call a motivated action a (bodily) 'disease'. For example, we do not attribute motives to a person for having leukemia; do not say that a person has reasons for having glaucoma; and would be uttering nonsense if we asserted that diabetes has caused a person to shoot the President. But we can and do say all of these things about a person with a mental illness. One of the most important philosophical-political features of the concept of mental illness is that, at one fell swoop, it removes motivation from action, adds it to illness, and thus destroys the very possibility of separating disease from non-disease and disease from diagnosis.

The proposition that one of the functions of the idea of mental illness is to conflate the differences between disease and diagnosis and define disease as 'treatability' is clearly displayed in the prevail-

ing definition of addiction. Alan I. Leshner, director of the National Institute on Drugs abuse, which is a part of the National Institutes of Health, states: 'The essence of addiction [is] uncontrollable, compulsive drug seeking and use. This is how the National Academy of Science's Institute of Medicine, the American Psychiatric Association, and the American Medical Association all define addiction. ... It is important to emphasize that addiction as defined here can be treated' [6].

Medical diseases are *discovered* and then given a name, for example acquired immune deficiency syndrome (AIDS). Mental diseases are *invented* and then given a name, for example attention deficit disorder. The validity of this generalization ought to be obvious to any careful observer of modern medicine.

Diseases are physico-chemical phenomena or processes, for example, the abnormal metabolism of glucose. The disease qua somatic pathology is the abnormal metabolism; the diagnosis, 'diabetes', is its name. Somatic pathology is diagnosed by finding physical abnormalities (lesions) in bodies, not behavioral abnormalities (misconducts) in persons. Disease qua somatic pathology may be asymptomatic (for example, hypertension). Changing the official classification of bodily diseases cannot transform non-disease into somatic pathology, or somatic pathology into a non-disease.

Mental diseases are the names of personal conduct, unwanted by the self or others. The disease qua psychopathology and its diagnosis/name ('panic reaction') are one and the same thing. Psychopathology is diagnosed by finding behavioral abnormalities (misconducts) in persons, not physical abnormalities (lesions) in bodies.

Disease qua psychopathology cannot be asymptomatic. Changing the official classification of mental diseases can transform non-disease into psychopathology, and psychopathology into non-disease (for example, smoking from a [bad] habit into 'nicotine dependence', *and* 'homosexuality' from a perversion into a non-disease and civil right).

Diagnoses are disease-names, much as Christian (first) names are person-names. Nowadays, we routinely give disease-names not only to somatic pathology (real or bodily diseases), but also to behavioral pathology (psychopathology or mental diseases). Indeed, *if we propose to treat (mis)behavior – as a matter of law or social policy – as if 'it' were a disease*, we are *expected* to call it a 'disease' (for example, 'substance abuse'). Not surprisingly, we diagnose mental illnesses by finding abnormalities (unwanted behaviors) *in persons*, not abnormalities (lesions) *in bodies*. That is why forensic psychiatrists 'interview' criminals called 'patients' (who often do not regard themselves as patients), whereas forensic pathologists examine body fluids (whose source may even be unknown to them).

- Anthrax is a disease, regardless of whether anyone recognizes or interprets it as such. It is a 'biologically constructed' disease. It can, and does, kill its host.
- Attention deficit disorder is a disease only if it is authoritatively interpreted as such. It is a 'socially constructed' disease. 'It' cannot kill the patient.

In the case of bodily illness, the clinical diagnosis – that is, the disease-name attached to the patient – is a hypothesis, typically confirmed or disconfirmed at autopsy (by the so-called pathological diagnosis). The aim of the traditional clinical-pathological conference was to emphasize the distinction between these two different kinds and meanings of diagnosis. The pathological diagnosis *is* the disease.

In the case of mental illness, the clinical diagnosis – that is, the disease-name attached to the patient – is the only kind of diagnosis there is. In psychiatry, there is no clinical-pathological conference: it is not possible to die of mental illness or find evidence of mental illnesses in body fluids or tissues. In the absence of a pathological diagnosis, the clinical diagnosis – the so-called 'psychopathology' – validates its own disease status. The term 'alcoholism', for example, functions as both a phenomenon and its name; diagnosis and disease are one and the same thing.

Physicians and scholars writing on medical matters no longer distinguish between *discovering* a bodily disease and *inventing* a mental disease. Perhaps they are not aware of the differences. Or, if they are, they may consider acknowledging them a hindrance to their agenda, which usually is to construct or deconstruct one or another 'mental illness', not to clarify the concept of illness. For example, Mikkel Borch-Jacobsen, a philosopher of psychiatry, calls the propaganda for the reality of multiple personality disorder 'the making and marketing of a disease' [7]. This is wrong. Multiple personality disorder is not a disease; it is a diagnosis [8].

I have long maintained that we ought to restrict the definition of (literal) disease to demonstrable bodily lesion (with the pathologist as the final arbiter of what counts and does not count as a lesion/disease). This definition may be regarded as the gold standard of illness. It is an apt analogy, for two reasons: 1) in each case, the standard is fixed (not amenable to manipulation by parties with special interests); 2) both standards are now anachronisms (paper currency [unbacked by gold] has everywhere replaced gold as legal tender; (mis)behavior is everywhere routinely diagnosed as disease [typically attributed to a 'chemical imbalance in the brain']). Routine use of the terms "disease" and "diagnosis" to refer to both sick bodies and sick persons renders much of the debate about illness-and-treatment – especially the treatment of so-called mental diseases, the uses of placebos and so-called alternative treatments, and self-medication with recreational and illegal drugs (tobacco, marijuana) – not merely inconclusive but incoherent.

- If the physician addresses disease as somatic pathology, the direct or primary goal of treatment is ameliorating or curing the disease that causes the patient's symptoms (suffering). The desired (normalizing) response of the body, measured by objective methods, is the sole criterion for the efficacy of the intervention. Subjective improvement in the patient's well-being is the dividend paid by this investment. Treatment aimed directly at making the patient feel better, but without normalizing the disease process, is called 'palliative'.
- If the physician addresses disease as psychopathology, the goal of treatment and the criterion for its efficacy depend on whether the subject is a voluntary or involuntary patient.

  If he is a voluntary patient, the direct or primary goal of treatment (psychotherapy) is to make him feel better. The subjective response of the patient is the sole criterion for the efficacy of

the intervention. If he is an involuntary patient, the direct or primary goal of treatment (civil commitment and coerced drugging) is to make others feel better (about the patient or about being relieved of him). The subjective response of others (psychiatrists, relatives) is the sole criterion for the efficacy of the intervention.

- If the physician medicates the patient with a placebo, or the individual medicates himself (with legal or illegal drugs), the direct or primary goal of treatment is to make the patient or oneself feel better. The subjective response of the patient/self is the sole criterion for the efficacy of the intervention. The objective improvement of bodily processes (if any), observed by the physician (and other medical experts), is the dividend (if any) paid by these investments.

The important difference between bodily disease (lesion) and mental disease (behavior) is not that one is a value free biological fact, and the other a value-laden social construct. Both are value-laden social constructs. Prizing health more highly than illness, however defined, is a value judgment. The crucial difference between bodily disease and mental disease is that what counts as a bodily disease is based on a judgment of how the *body* ought to function, whereas what counts as a mental disease is based on a judgment of how the *person* ought to function. For example, presbyopia may or may not be classified as a bodily disease, and homosexuality may or may not be classified as a mental disease.

If we fail or refuse to distinguish between literal and metaphorical diseases, we confuse and deceive ourselves and others not only about the differences between literal (somatic) treatments (influencing the body), and metaphorical (mental) treatments (influencing the person), but also about the differences between *medical treatments* (for example, performing an appendectomy for acute appendicitis), and *medical interventions* (for example, performing an abortion terminating a healthy but unwanted pregnancy).

Not every discomfort and pain a patient feels or complains about to a doctor is a symptom of disease; nor is every medical procedure that a physician performs to make a patient feel better a treatment. By ignoring these distinctions, we conflate the concepts of disease and diagnosis and confuse being a patient (a social role) with having a disease (lesion). Persons called 'patients' may or may not have diseases; persons who have diseases may or may not be patients [9]. To be sure, there is method in this madness too. By failing to distinguish between diseases and diagnoses, complaints and lesions, treatments and interventions, we have created a veritable pharmacotherapeutic utopia – a medical fairy-land where there are treatments even for non-diseases.

A Brief History of the Concept of Disease

Like everything in the world, the concepts of disease and treatment have a history. In so-called primitive societies, dangerous spirits lurked everywhere, especially near the dead. Thus, for a long time, people avoided examining corpses. Hippocrates had not the faintest idea about what is inside the body. Aristotle believed the heart is the seat of the intellect. The anatomical fantasies of the ancients were systematized by Galen (2nd century, A.D.), the most famous physician of antiquity.

One of the most absurd conceits of modernity is the belief that our sick forebears were utterly bereft of 'medical help'. The opposite is closer to the truth. Minor maladies, such as colds or small wounds, were viewed as natural and treated with a vast array of herbal medicines, while major maladies, such as the plague, were attributed to supernatural sources and treated by prayer and sacrifice to the gods.

We tend to forget that Christianity is not only a faith of redemption; it is also – in this respect quite unlike Judaism or Islam – a 'faith of healing' (body and soul). Jesus is more than a prophet; He is a Divine Physician. For centuries, Christians were satisfied with regarding sickness as punishment for sin, curable by means of prayer, repentance, sacrifice, and the aspersion of holy water by a priest, the representative of an all-forgiving deity. Everyday life was replete with proof of the efficacy of these 'miraculous' cures. Shrines with powers of healing sprang up all over the Christian world. Even today, more than 5 million pilgrims visit Lourdes every year.

As the influence of religion declined and the prestige of science rose, the views of sufferers and healers about disease-and-treatment began to diverge – slowly at first, with great rapidity in our day. For a long time, neither patients nor physicians had a clear idea about the nature of disease; it was simply a danger and a discomfort to be relieved as best possible. Self-medication with herbal remedies – foremost among them opium, alcohol, and tobacco – became the sufferers' main defense against illness and pain. As professional healers became more proficient in operating on the body, some became 'barber surgeons', others experts in 'prescribing' diets and medicines (usually to induce 'purgation' of the body of presumed toxic substances causing the illness). The latter theory-practice metamorphosed into premodern medicine's panacea, namely, bloodletting. Those who believed in these interventions worshiped them as cure-alls; those who did not, dismissed them as quackeries.

The birth of anatomy as a medical enterprise is attributed to Vesalius (Andreas Witing, from Wesel on the Rhine), a physician and professor of anatomy at the University of Padua who, in 1543, published 'De humani corporis fabrica'. Although the book was a great success and Vesalius was widely admired, many physicians bitterly attacked him for disrespecting Galen. Vesalius gave up anatomy, burned his notes, and retired to the role of court physician to reigning royalty. In the sixteenth century, the Church began to authorize the dissection of executed felons. Although physicians participated in this enterprise, the great Renaissance artists, especially Michelangelo and Leonardo da Vinci, must also be counted among the true fathers of anatomy.

After the discoveries of the pioneer anatomists, physicians began to view the human body as a machine whose workings must be better understood, rather than just manipulated – in a style half-magical, half-empirical – in the manner of the herbalists. The stage was now set for the development of the scientific *diagnosis of patients*,

both dead and alive, and of scientific construction of a *classification of diseases*. Rudolf Virchow's publication, in 1858, of 'Cellular Pathology as Based upon Physiological and Pathological Histology' and the great discoveries of the early bacteriologists placed modern medicine on the solid foundation of the natural sciences. Subsequent technological developments led to similar advances in clinical diagnosis. Today, the practicing physician can diagnose disease in the living patient as objectively and almost as effectively as the pathologist can diagnose it at autopsy. The long-standing gap between ante-mortem (clinical) diagnosis and post-mortem (pathological) diagnosis has all but disappeared.

Although medicine is based on science, it is not a science and, indeed, cannot be a science. This is because in practice it impinges on virtually every aspect of human life, from religion and law to economics and politics. Physicians as individuals and medicine as an institution are thus engaged in many activities besides diagnosing and treating patients, such as promoting and protecting public health, helping the administration of the law, assuming the roles of activists in matters of child care, education, criminology, and so forth.

Virchow was well aware of the social-political implications of medicine and enthusiastically supported the idea of the physician as a sort of Platonic philosopher-guide to the politician-king. 'What other science', he asked rhetorically, 'is better suited *to propose laws* as the basis of social structure, in order to make effective those which are inherent in man himself?' [10] Feeling secure in this fallacious premise, Virchow demanded that political power be placed in the hands of the physician: 'Once medicine is established as anthropology... the physiologist and the practitioner will be counted among the elder statesmen who support the social structure. Medicine is a social science ... Let us recall the saying of Lord Bacon that knowledge is power, and be satisfied with nothing less from our great and promising science' [10]. The terrible abuses to which this conception of medicine has led in this century are too familiar to require further comment [11].

The notion that the *practice of medicine* is – or, under 'ideal' circumstances, could be – a 'natural' science, albeit false, appears superficially attractive and plausible. The argument goes like this: As the astronomer studies celestial bodies, the physician studies human bodies; each seeks to understand the material composition and natural function of the objects he studies. The trouble with this reasoning is that the objects of medical practice are *persons as moral agents*, not bodies as material objects. It is true that the human body is composed of parts – organs, tissues, and cells; and these parts – the heart, the lung, the kidney – have 'natural functions'; and that when these natural functions fail, we have diseases, such as asthma, heart failure, uremia. However, when we add up all our body parts, the sum total is not merely a living human body but a living human being – a moral agent. At this point the materialist-scientific approach to medicine proves inadequate. The pancreas may be said to have a natural function. But what is the natural function of the person? That is like asking what is the meaning of life. These are religious-philosophical, not scientific-technical questions. Different religions, different cultures, and different persons offer different answers. The diversity of human values is, of course, no more surprising than is the diversity of, say, human language or custom.

When the physician enters the realm of the meaning of life – and of the control of personal conduct – he ceases to be a medical practitioner, much less a biological scientist. Instead, he dons the robes of the priest, the politician, the judge, the prison warden, and even the executioner, determining the legitimacy of moral values, judging the permissibility of particular instances of personal conduct, punishing misbehavior, and so forth, all in the name of health. Although understanding medicine as a moral and political-economic enterprise does not require the technical sophistication required for understanding it as a materialist science, progress in this area – intrinsically opposed to the dominant ethic and vested economic and political interests – has lagged, and continues to lag, far behind. The disjunction between medicine as science and medicine as politics is intensified by the medicalization of disturbing behavior, misconceptualized as the medical explanation of mental illness.

The Concept of Disease and the Politics of Treatment

A hundred years ago, physicians were, rightly, therapeutic nihilists: There was little chance that the patient would benefit from the physician's efforts at treating him. Today, physicians are, wrongly, therapeutic utopians: Although patients now benefit from countless effective preventive and therapeutic measures, they still fall ill with incurable diseases, suffer, and die. The effort to eradicate disease and suffering due to disease – especially if the concept of disease is expanded to include the problems of everyday living – is a quixotic quest.

The public, even more than the medical profession, is in the grips of the delusion of a utopian medicine. One of the results of this medicalized view of life is the erroneous belief that diagnoses *logically* define and *morally* justify treatment. Although this sounds reasonable, it is not. In a free society, *medical treatment is contingent on, and justified by, the patient's consent, not by the physician's diagnosis.* In the absence of consent, the law considers treatment – even medically beneficial and correct treatment – assault and battery. To constitute 'treatment', a medical intervention must be not only genuinely remedial, it must also be wanted and consented to by the patient.

However, as modern democratic societies raise medical care above personal liberty as the supreme *political good* – that is, as they embrace what I have called the Therapeutic State – their customs and laws replace the Rule of Consent with the Rule of Benefit. The result is that in the Therapeutic State, treatment is contingent on, and justified by, the physician's diagnosis of the patient's illness and the physician's 'prescription' of the proper intervention for it [12, 13]. The patient who disagrees with the expert's judgment and recommendation runs the risk of being declared or treated as 'incompetent' or 'insane'. The conflict between justifying treatment by consent and by diagnosis is the source of most problems now viewed as issues of patient competency. The fact that these are mu-

tually irreconcilable criteria is masked by attributing to psychiatrists the expertise to 'diagnose' incompetency.

The point I wish to make here is simple, but is often overlooked. Diagnoses/diseases do not receive or reject treatment; nor do they pay for medical services or receive such services at the expense of the taxpayer. These attributes belong to persons. Justifying reimbursement for treatment by diagnosis – exemplified by the American policy of basing payment on diagnosis related groups (DRGs) – is premised on the erroneous assumption that the relief of illness is a purely scientific-technical matter; and, more specifically, on the assumption that, for the same diagnosis/disease, prince and pauper ought to receive the same treatment. In real life, prince and pauper are usually offered different treatment options for the same diagnosis/disease. Moreover, even if both were offered the same options, each would make a different choice, reflecting his particular outlook on life and values. This is just one of the problems created by making reimbursement for treatment dependent on diagnosis. 'The greatest danger with DRGs', observes one candid physician, 'may result from linking monetary gain to the classification system, an idea supported by the current literature' [14]. The corrupting influence of making the reimbursement of physician's services dependent on patient diagnoses is too obvious to require extensive documentation. Physicians take refuge in the view that everyone 'has something' that can be diagnosed and joke about scattering 'confetti diagnoses' across billings forms. Another physician puts it even more bluntly: 'The sicker *you make* a patient look, the more money you get' [15].

These developments are the inexorable results of interposing a bureaucracy between doctor and patient and giving it the duty and the power to determine the cost of the treatment. Whether out of ignorance or necessity or both, the bureaucrats confuse diagnoses with diseases, and ostensibly identical disease-entities with the subjective values different people attach to seemingly identical treatments. However, the hypochondriac and the stoic place very different values on medical interventions. Although they may 'objectively' suffer from the same disease, the former values medical services more highly than the latter and seeks more of them [16].

The considerations I have advanced have important, but troubling, implications for health care politics and policies in advanced societies. In the United States, prevailing and proposed health care policies endeavor to secure two mutually contradictory goals: They seek to protect the patient from shouldering the full cost of his medical care and, at the same time, to preserve the patient's self-determination as a decisive element in the therapeutic situation. To make matters worse, they try to reconcile this contradiction – which is hardly a secret – by predicating treatment-authorization and reimbursement on medical diagnosis which, in turn, is conflated and confused with "objective disease." The fact remains that the patient does not pay for his own care, yet has a vital interest in his right to accept or refuse treatment; whereas the payer (insurance company or the government) has no interest in the patient's health or rights, but does have a vital interest in minimizing health care costs and paying only for what it regards as the effective treatment of a bona fide disease.

As one might expect, diagnoses are most often and most obviously constructed, deconstructed, fabricated, or falsified when they seriously affect the interests of the parties affected – that is, public ideology and the public purse on the one hand, the personal economic or liberty interests of individuals on the other hand. Moreover, although virtually everyone recognizes the systematic falsification of the public diagnoses of Very Important Persons (for example, of President Franklin Roosevelt), few people recognize, and fewer still acknowledge, the systematic fabrication of the diagnoses of persons who commit dramatic crimes (for example, John W. Hinckley, Jr.). In 1982, Hinckley, it may be remembered, tried to assassinate Ronald Reagan. Diagnosed as schizophrenic, he is serving what amounts to a life sentence disguised as treatment in a mental hospital.

Some examples of diagnostic fabrications and falsifications motivated by economic considerations also warrant mention. Explaining the practice of a typical family physician, a reporter writes: 'The visit doesn't get paid if [she] write[s] down depression. Because that's a psychiatric diagnosis. However the doctor knows that if she writes down the diagnosis 'fatigue' instead, she can still see those patients ... and prescribe an antidepressant like Zoloft' [17].

In hospitals, the construction of 'appropriate' diagnoses is usually no longer in the hands of physicians at all; instead, it is in the hands of medical records staff personnel assisted by so-called 'code consultants' whose job is to help 'upcode' diagnoses. A reporter in the Wall Street Journal explains upcoding as 'the practice of upgrading the seriousness of a medical malady by filing Medicare bills under the DRG [diagnosis-related groups] code that will carry the highest price. [The practice] appears to be endemic in the [hospital] industry.' The reporter cites a DRG consultant suggestion for upcoding, for example, from 'simple pneumonia' (worth $2,991) to 'pneumonia, complications' (worth $4,462) [18, 19].

Conclusion

Diseases are facts of nature, whereas diagnoses are artifacts constructed by human beings. Why do we make diagnoses? We have several reasons for doing so: 1) Scientific – to identify the organs or tissues affected and the cause of the illness and thus explain/understand the malady; 2) medical-therapeutic – to reassure the patient that the physician knows what ails him and to aid the physician in selecting the proper treatment for the disease diagnosed; 3) professional – to enlarge the scope, and thus the power and prestige, of a state-protected medical monopoly and the income of its practitioners; 4) legal-social: to justify state-sanctioned coercive interventions outside of the criminal justice system (for example, exonerating certain behaviors performed by certain classes of people which, were they performed by certain other classes of people, would be dealt with by the criminal justice system as opposed to the mental health system); 5) political-economic – to justify enacting and enforcing measures aimed at promoting public health and providing funds for research and treatment on projects classified as

medical; and 6) personal – to enlist the support of public opinion, the media, and the legal system for granting special privileges or inflicting special penalties on persons diagnosed as ill (handicapped, mentally ill, etc.).

Classic nosology was *descriptive*, based on *pathology*. The diagnostician sought to anticipate and approximate the pathologist's findings at autopsy, that is, identify the patient's bodily lesion (disease) and its material causes (etiology). For example, the term 'pneumococcal pneumonia' identifies the organ affected, the lungs, and the cause of the illness, infection with the pneumococcus.

Contemporary nosology is *strategic*, based on *economic, legal, social, and other interests (unrelated to disease as somatic pathology)*. The diagnostician seeks to secure reimbursement for medical services, legitimize treatment, justify defining undesirable behavior as disease, and so forth. For example, DRGs provide bureaucratic rationale for reimbursing medical services by third-party payers; psychiatric diagnoses provide legal-scientific rationale for treating mental diseases as if they were brain diseases; and so forth.

Formerly, diagnoses encoded the objectively verifiable condition of the patient's body (diseases). Today, diagnoses rationalize the health-care policy of the body politic (methods of controlling costs and compensating physicians). We are witnessing the transformation of nosology from the medical-scientific classification of disease as somatic pathology, into the medicalized justification of social policy as 'health care' or 'treatment'.

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