Curing and Healing: Two Goals of Medicine

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Abstract
This chapter will begin by signaling potential problems with the dichotomy between curing and healing. It continues to explore three different ways of thinking about the dichotomy: rational vs. irrational, the meaning of curing and healing as experienced by patients and practitioners, and the relationship between curing and healing in the practice of medical care. It is argued that while the distinction between curing and healing is not a universal one, as it is based on a Western distinction between disease and illness, both curing and healing require taking responsibility for the well-being of the vulnerable patient.

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Introduction

Curing and healing are two categories that appear central to the practice of medicine. And yet given the variety of healthcare systems, practices, and beliefs present in the world and the universal problem of illness and vulnerability, there is some doubt as to the validity of the distinction between the terms. This is the central problem that organizes the remainder of this chapter. In it the problem of the dichotomy between healing and curing will be explored, as well as the uses and meaning attached to these categories.

The Problem

Being ill and in need of medical assistance is a universal human experience. At times, we all need specialized help in order to make us better. What is different is the way a health-related problem is approached in various cultural contexts and the explanatory models of illness that are present. Once attempts at self-curing or perhaps self-healing are exhausted, one will presumably contact a specialist. In a provincial small British town, one probably will pay a visit to the general practitioner, who will prescribe some medicine and a course of action fitting with the Western medical tradition. In an isolated indigenous community in the Amazon, one will probably turn to a traditional healer or a shaman, who will provide the sick with herbal medicine and perhaps perform a healing ritual. In a multicultural city such as Hong Kong, one will face a choice between Western medicine and traditional Chinese medicine and depending on circumstances and personal beliefs will choose accordingly. Assuming the specialists approached are successful in their endeavors to help the patient and the patient feels markedly better or better still – recovers completely – ask yourself this: is it fair to say that the GP cured his patient and the shaman healed his? Now, try an experiment and say: The GP healed his patient, the shaman cured his. Are you completely happy with the swap of the terms? Assuming you live in the West and work for a Western company, would you be comfortable saying to your employer – “I am fit to work, my doctor healed me completely.” Maybe not. And it is interesting why not. And would you trust a healer as much as you would trust a doctor? But now ask yourself this – is there an essential difference between the accomplishment of the GP and that of the shaman? Both were successful; both patients were made better; the problem was solved. Perhaps the source of some of the discomfort one might feel in swapping the terms, or using the word “heal” in a formal Western context, lies not so much in the difference between “healing” and “curing” but in what we consider to be proper medicine. Perhaps the GP was successful because she employed the principles of scientific, evidence-based medicine, whereas the shaman was just lucky, and his actions, despite existing system of beliefs in the given part of the Amazon, were groundless, especially from a Western point of view, “healing” being some fuzzy concept, free from common sense, and an efficacious practice. But if we so lightly discount non-Western medical systems and traditional healers as medicine proper,
then why the problem of “healing and curing as two goals of medicine”? Is not “curing” enough? And if we do not disregard non-Western medical traditions and accept that indeed traditional healers have the basis to help their patients, cannot we just use the terms curing and healing interchangeably in the context of non-Western medical practice? Perhaps the processes of curing and healing are two sides of the same coin – namely, making the patient better (see also Hutchinson et al. 2009).

Three Approaches

There are three broad ways to approach the differences between curing and healing. One is to focus on the difference between rational Western medicine as opposed to nonrational healing lying outside of medicine and the problem of defining “medicine” as a scientific practice. The second is to consider what the terms might mean to the people experiencing curing and healing as patients or as practitioners of medicine broadly understood. The third possible approach is to explore the terms not so much by contrasting them but by analyzing the relationship between curing and healing in the context of the relationship between patients and practitioners. This last approach will be briefly considered in the section “Curing and Healing as Two Aspects of Medical Care.”

Let us first turn to the first approach.

1. The distinction based on curing grounded in rational Western medicine and irrational healing may be presented in the following manner. Bear in mind this does not take into account ethnographic evidence relating the process of becoming a healer and non-Western explanatory medical models, and which is why in presenting the argument the focus is on “faith healing”:

Contemporary medicine as a rational system of knowledge and practice is governed by laws of science and is evidence based. The results of actions based on that system are predictable and repeatable and work regardless of cultural context. Curing comes about as a result of applying appropriate medical knowledge and practice to the medical problem at hand. Medical practitioners, thanks to an organized and thorough system of education, know and can usually explain and provide evidence for why certain actions bring about a cure and why they occasionally fail to do so.

In turn faith healing can be said to lie outside of the rational. Healing comes about as a result of applying through prayer and laying on hands of a supernatural, mysterious power that cannot be explained, taught, or rationally acquired. The healer heals but does not know why he can heal, how his gift works. In a case of miraculous faith healing, one focuses on the persona of a healer, where as in the case of curing, one focuses on a system of knowledge and practice. The results of thus understood healing are unpredictable, are unrepeatable, and from the point of view of Western medical practice are accidental. There is no causal connection, unless one takes into the account the placebo effect, between the actions of a healer and the state of health of his patient. From the point of view of
Western medicine, faith healing is a potential source of harm and should be discouraged.

There are of course problems with this argument. Most of these center on recognizing Western medical system as the only valid scientific system there is and, by definition, better than any alternative. This Eurocentric point of view might make us blind to what non-Western medical systems have to offer both in terms of healing and curing, especially that healing cannot be reduced to “faith healing.” Moreover, non-Western medical systems do not necessarily have the distinction between illness and disease on which it will be argued the dichotomy between curing and healing is largely based. But if the difference between the terms does not boil down to the difference between the rational and the nonrational and Western and non-Western, where does it lie? Let us turn to the second approach to the difference between the terms and focus on what it means in terms of the experience of being cured or healed.

2. It is sometimes said that one cures a disease and heals an illness, where simply speaking illness is the personal experience of being unwell, shaped in part by one’s culture, place in society, and personal circumstances and the disease is the underlying organic, physical cause of being unwell (Cassell 2004, 2012; Lerner 1994), and together, disease and illness describe a sickness. From the differences between illness and disease follows another important dichotomy, namely, the difference between pain associated with a disease and suffering associated with an illness (Lerner 1994). All those elements have an impact on the place and role of the medical practitioner (or practitioners) and the patient in the process of getting better.

Imagine for a moment that the practitioner is a firm believer in the biomedical model, with its focus on curing the disease. This approach is said to limit the involvement of the patient in the process of getting better: the patient is interviewed, various tests are performed, diagnosis is given by the physician, and a course of action is prescribed – it might consist of further tests, or taking some form of medication, or some more advanced treatment performed by the physician or a whole medical team on the patient, with limited contact between the patient and at least some of the individual members of the team (e.g., the patient will probably not see or talk to the radiologist analyzing complex USG or tomography images or the person analyzing blood samples). In short, things are done to the patient (Milstein 2005), and the patient is expected to comply with the action prescribed. Can this approach be valid and successful? Certainly, provided one is dealing with relatively simple matters that are easy to resolve: a straightforward case of appendicitis or some simple infection easily treated with a series of antibiotics, easy to diagnose, and easy to treat. It is worth remembering during this thought experiment that while many good physicians also take into the account the needs of their patients as human beings with specific social circumstances, worries, and resources, healthcare systems in developed countries tend to focus on the underlying organic causes of medical problems, simply because it is easier to put a price tag and a time frame on the treatment required.
And yet to focus entirely on curing a disease might not be sufficient to make a patient completely better, simply because patients, apart from having a disease, are also part of a wider sociocultural fabric, which makes them react to being unwell in a specific manner and which also makes them attach a particular meaning to the episode of being unwell. Patients not only feel pain, they also suffer. And while a pain killer might be sufficient to deal with physical pain, it might not be sufficient to deal with suffering. This is where healing comes in. As argued by Egnew: “Healing is the personal experience of the transcendence of suffering” (Egnew 2005: 258).

Given the definitions of illness and disease, it is debatable whether humans ever experience disease as such. Being aware of being unwell is already a part of the cognitive, emotional, cultural, or even spiritual experience of being ill. And therefore a physician’s focus on curing a disease might not be sufficient to deal with the problem, especially if we are dealing with a chronic or incurable condition. Healing on the other hand is said to take into the account the human condition and experience of being unwell, including social, cultural, historical, and economic factors (Crandon Malamud 1991; Finkler 1994; Waldram 2000). But what exactly is healing and how is it achieved? It is said that healing is a process that promotes health and restoration of balance between mind and body (McGlone 1990: 77–84). There is no agreement among academics as to what exactly the process entails, but the following elements appear in various accounts and definitions of healing (e.g., Glaister 2001; Hutchinson et al. 2009; Egnew 2009):

(a) Healing actively engages the patient.
(b) Healing is multidimensional.
(c) Healing is creative and meaning making.
(d) It leads to restoration of balance and the acceptance of status quo.
(e) Healing process can involve a whole group of people. The problem does not have to be an individual one. Neither the healed nor the healer needs to be an individual.

Let us briefly explore these elements of healing also in relation to the concept of curing.

A practitioner who works on healing an illness ought to engage with the ill person, in order to assist him in regaining the feeling of being in the right place and the right time as to his body and mind. However, it is said that healing is not something done to the patient but something that takes place within the individual with the help of his active participation, through the patient’s commitment to doing what is required to heal (Glaister 2001: 64; Levine 1987; Mulloney and Wells-Federman 1996). Five steps in healing have been identified that are signs of active participation: awareness, appraisal, choosing, alignment, and acceptance (Scandrett-Hibdon and Freel 1989). The engaging aspect of healing can be contrasted with curing, which is seen as primarily doing something to the patient
Yet this may be an overstatement. Under normal circumstances patients undergoing a cure in the context of Western medicine are not passive, as the phrase would suggest. For the most part they are actively engaged in the whole process, starting with the decision to visit the family doctor, complying or not with the doctor’s advice (this is especially true in relation to lifestyle changes recommended or taking prescribed medicine), and finally the decision to terminate further treatment. Perhaps what matters in the understanding of the difference between curing and healing is not so much the factual engagement and participation of the patient in the process of getting better in the context of curing and healing but how that difference is constructed and perceived by patients and practitioners alike. In the case of healing as an element of alternative therapies in the West, patients tend to perceive healing rituals and activities as ones that engage them, while they see the doctor-patient relationship in the Western medical tradition as one riddled with power inequality and requiring passive compliance on their part (McGuire and Kantor 1998: 201).

Healing can be seen as multidimensional, especially if one sees healing as achieving a balance between various dimensions of the people undergoing the healing process, namely, the physical, emotional, mental, social, or spiritual (Glaister 2001: 64). In that respect healing is markedly different from a definite cure leading to an absence of a disease. The multidimensional aspect of healing means that the absence of disease is neither sufficient nor necessary for healing to occur. What matters is the acceptance of the status quo, coping with and integrating the demands of one’s illness or disease (Coward and Reed 1996) and its aftermath. Consider the case of a woman undergoing treatment for breast cancer. First, she needs to adjust to the situation of being seriously ill and deal with the chemotherapy, its side effects, and their consequences in day to day life, as after all apart from being ill, she remains a daughter, mother, partner, and a woman. Even if following mastectomy and chemotherapy she is declared to be free of cancer, it will take more than that before she feels whole again. She, for example, needs to learn to accept herself without a breast or with reconstructed breasts. Also, a brush with a serious life-threatening disease might demand psychological and social adjustments and reevaluation of one’s life (see also Dobkin 2009). Those elements are important parts of the healing process and lead us onto the next point, namely, that healing is said to be a creative and meaning-making process – in order to make sense of one’s illness or even approaching death, one needs to give it meaning (Good 1994). The meaning might be created by the person undergoing healing, or it might be developed with the help of the healer (Egnew 2009).

The meaning-making aspect of healing points to another major difference associated with the dichotomy of curing and healing, namely, that the aim of curing is restorative, while healing is transformative (Hutchinson et al. 2009: 845). By curing one eradicates a disease or corrects a problem. One “removes” the changes caused by the sickness, and brings back the patient, as far as possible, to the ideal, healthy starting point. By healing one brings about a change in the patient, whether by changing his attitude to illness, by creating a new meaning in his life, or by
giving him or her greater sense of integrity and place in the world following an illness or while facing approaching death.

It is worth remembering that the healing process can stretch beyond the individual healer and the individual in need of assistance. At first glance this is not such a great difference from curing in the context of Western medicine. On the one hand the curing process can involve a whole medical team, and on the other it does not need to focus on a single individual. Such is the case of treating STDs or other venereal infections, where relevant practitioners prescribe medicine for both partners, or large-scale medical emergencies, where a whole population is the focus of medical activities and surveillance, such as in the case of the Ebola epidemic in Africa. However, in the case of the healing process, ethnographic evidence suggests that what is at stake is not so much the well-being of a collection of individuals but the well-being of the whole community bound by specific social relationships (Katz 1982; Vermeylen and van der Horst 2007: 179) or a family or kinship group (Turner 1967). Arguably, what is being healed and strengthened are the relationships between people. Whether healing is focused on individuals, the whole community, or specific relationships within, it depends on the social and cultural construction of self (Scheper-Hughes and Lock 1987).

Healing Without Curing

Healing is sometimes said not to necessitate a cure in the biomedical sense (e.g., Glaister 2001: 64). It is argued that getting better in terms of a patient’s self-assessment can be achieved by better coping with sickness and a restoration of balance, both achieved through the process of healing. This process sometimes requires that the point of balance is shifted and that what is restored is not so much the previous status quo but a balance resting on a new understanding and acceptance of self in the world. This is particularly the case of people coping with chronic diseases and those nearing the end of their lives. The easing of suffering is achieved through gaining acceptance of the situation, giving it meaning, and adapting.

Curing Without Healing

Hypothetically, curing, in the biomedical sense, can also be achieved without healing. This is especially so in cases where the patient is not aware of being sick and of having a disease. In such cases the problem might be diagnosed by some routine testing during, say, a health check and easily treated, without giving the patient the time to consider herself unwell. Perhaps a good example of this is a case of mild vitamin D deficiency. Before diagnosis, symptoms associated with it, if at all noticed, might be blamed on the time of year, overwork, etc. but might not be connected to one’s health. Another type of situation in which one might be dealing with a kind of curing without healing is one in which from the biomedical point of
view the problem is sorted or managed as well as possible according to current medical knowledge, with any physical symptoms being well taken care of, without the patient regaining their sense of well-being and balance. This might be, for example, the case of a woman recovering from stab wounds inflicted by her partner during domestic abuse incident. Her physical wounds might be cured, but she might, as argued by Erickson (2007: 10), never feel truly healed. That is, in spite of a successful cure, her quality of life continues to suffer (see also Eisenberg 1977).

Curing and Healing as Two Aspects of Medical Care

For all the importance attached to the distinction between curing and healing in Western medical practice and thought and philosophical and anthropological work on both Western and non-Western medical systems, it is worth remembering that each and every medical system is a cultural system (Rhodes 1996) and each involves elements of both curing and healing. Indeed, it may be argued that the distinction between curing and healing is overstated as is the dichotomy between illness and disease. Cassell (1976) points out that the very notion of an organic disease as a cause of a sickness is the central concept in the Western medical model. The notion that a malfunctioning body is what makes a person feel ill lends itself to the formulation of the distinction between curing and healing, where we cure the disease and heal the person. But what happens in contexts where there is no concept, or only a limited concept of disease as a cause of a sickness, and where the explanatory model of illness is completely different from the Western one? In such a context, the distinction between curing and healing is unlikely to be valid. If the sickness is believed to be caused by an invasion of evil spirits, or witchcraft, or upset ancestors there, the medical practitioner needs to take culturally appropriate action to deal with the problem, and that is not identical to dealing with a disease. And even within the Western context, Waldram (2000: 606) argues that healing an illness and curing a disease are not separate, unrelated aspects of the treatment of sickness. As argued by Lown (1999: 313): “Whereas the medical transaction is largely concerned with curing a disease, the patient craves to be healed. The object of the patient’s art is to have the doctor incorporate healing in the process of curing.” This is apparent, for example, in the effect the interaction between patient and physician has on how one judges the efficacy of treatment. Consider how in the biomedical system the patient’s self-assessment of how he or she is feeling following treatment is taken into the account in order to judge the effectiveness of the curative treatment. Similarly, a physician’s positive proclamation on the effectiveness of treatment may lead to an improvement in the patient’s subjective well-being (Waldram 2000: 607). This suggests that despite doubt as to the validity of the dichotomy between curing and healing, it is worthwhile to explore the relationship between the two processes as they are understood in the Western context.
Conclusion

Caring for a patient, whether we focus on curing or healing, involves many different aspects: from defining and accepting the person as a patient in need of treatment, diagnosing them, and treatment proper. Also, even in the Western biomedical context, the patient is not necessarily an individual: it can be a group of related persons or a group of people with a similar condition involved in group therapy. Bearing in mind that the line between curing and healing may be blurred, it is important to remember what the two concepts have in common, especially when translated into practice: improving the well-being of the person (or even persons) in need, noticing and defining their problem, and taking care of them – in short taking some responsibility for the patient’s well-being. Without this, one cannot speak of either curing or healing or indeed of medicine.

Summary Points

- The dichotomy of curing and healing relies on the dichotomy between disease and illness.
- It can be argued that the dichotomy of curing and healing is not universally valid as the dichotomy between illness and disease is not universally recognized.
- Presenting curing as rational against irrational healing is a mistake, as medical systems throughout the world rely on varying explanatory models, making different actions rational in different cultural settings.
- The curing and healing dichotomy can be seen as diametrically different in terms of their aims. The first being restorative, while the second transformative.
- The patient is seen as passive in the process of curing and actively engaged in the process of healing.
- The dichotomy of curing and healing is useful at the level of analyzing the relationship between the medical practitioner and the patient, particularly in the Western context.

References

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