the aid of psychotherapy, leading to subsequent success with behaviour therapy. Because of the lack of theoretic application to many of a patient's problems, the need is for a combined approach to ascertain the relevant factors involved and to specify goals for treatment. The present trend is for the two disciplines to move closer together. Many psychotherapists are acquiring skills in behaviour therapy; many clinical psychologists are recognizing the role of covert factors and are inclining towards psychotherapy. Far from the psychiatrist interfering in treatment in which the psychologist is expert (Eysenck, p 18), there is little reason why a flexible collaboration cannot be created.

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THE CONCEPT OF DISEASE

DEAR SIR,

Professor Kendell (*Journal*, October 1975, **127**, 305–15) has argued the most interesting thesis that disease should be defined as that which decreases fertility and increases mortality, but excludes 'purely cultural factors determining who lives and dies'. Since man is biologically a cultural animal—his culture being a major determinant in individual and species survival—this is a curious position. Kendell is forced to the arbitrary exclusion of cultural factors because he has confused two questions. These are the scientist's question and the practitioner's question.

The scientist, the passive outsider, may ask, 'What factors reduce fertility and increase mortality?' His answer will clearly encompass cultural factors, including the efforts of doctors. The practitioner, the active insider, may ask, 'Whom should doctors treat?' The answer will depend upon doctors' competence and optimism and their given role in a community. The group treated will continually change as doctors' competence and the community change. Their role is subject to continual negotiation, as is the role of, say, psychologists, social workers and so on. The answer to the second question is specific to time, place and culture.

The answers to the two questions will *not* be the same. We may use the term 'illness' in one or other answer, or neither, just as we wish, but we may not, as Kendell does, confound the two and use a partial answer to the scientist's question to try to answer the practitioner's question. Logically it is wrong, practically it could be disastrous.

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DEAR SIR,

Professor Kendell's address (*Journal*, October 1975, **127**, 305) encourages us to rethink our concepts of disease. Briefly, he finds it difficult to define disease and advocates in its place the concept of 'biological defect'. While appreciative of his thoughtful contribution, I am more in agreement with the customary definitions of disease and the morbid process than with his position; the customary definitions are rarely challenged by their critics, they are simply ignored.

Disease stands for 'absence of ease' (Oxford English Dictionary)—the patient's subjective awareness that there is something wrong, covered by the clinician with the term 'symptom'. The lack of ease, or symptom, is the discerned result of the underlying morbid process. The patient is usually, but not always, aware of his disease; discernment is increased by screening devices. The symptom must not be confused with the underlying morbid process.

The morbid process of disease is well defined in most adequate medical dictionaries (e.g. Butterworths). It results essentially from one or more noxious agents acting on a structure, setting up dysfunction in it, and releasing coping devices to restrict and repair the damage, which, if they fail, cannot be prevented. The power of the coping devices varies with individuals and populations. The noxious agent can be psychic or somatic; the structure can be the psyche or the soma; the morbid process can be psychic or somatic. Indeed psychic trauma can lead to somatic