SUMMARY
DERIVED FROM CONSIDERATION OF THE SUBJECTIVE FACTS

---

1. The efficiency of the medical services depends primarily upon diagnosis.

2. The primary diagnostician is the sufferer.

3. Therefore the primary diagnosis depends upon the subjective state of disease.

4. The sufferer, however, is guided to seek treatment, not by his subjective state of disease, but by consciousness of social incapacity.

5. There may be a wide lapse of time between the sufferer's diagnosis of disease and his diagnosis of social incapacity.

6. The professional diagnostician is concerned with the objective facts, i.e. the disorders, which underlie the disease of the sufferer.

7. A toothache may produce more *disease* than the most dangerous cancer. There is no necessary parallel between the degree of disease and the nature and severity of any underlying disorder.

8. The sufferer is too often content to have the disease alone alleviated, even when a cure is available for the underlying disorders.

9. Disorders do not always cause disease; they may remain masked by a sense of well-being.

10. Well-being, like disease, can be associated with any form of disorder.

11. Well-being, like disease, has varying degrees. The most exuberant sense of well-being may be associated with the most serious disorder.

12. Well-being completely discounts for the individual the importance of any manifest disorder.

13. Well-being deceives not only the individual but also the casual observer, however well trained in diagnosis.

14. It is not, as in disease, the unwillingness of the sufferer to seek treatment which keeps the disorders underlying well-being from the medical services, but well-being itself.

15. Therefore well-being must be studied if we are to find a way out of this impasse.

16. Hence the recognition of well-being as a cloak covering every kind of disorder is of primary importance.

17. As it would be hopelessly impracticable to apply every available test to exclude each and every known disorder, a test must be found for the detection of well-being.

18. This can only be done through a study of well-being itself, not of the disorders that underlie it.

19. This implies a comparative study of well-being and health.

20. Our hypothesis to be tested is that the sense of well-being is the consequence of the effectiveness of the process of compensation in the body.

21. This effectiveness of compensation may be costing the body dear because it is being maintained at the expense of extravagant wear and tear of the compensating organs.

22. Compensation is brought about by the adaptative function of the organism turned into a defensive measure and is carried on at the expense of the reserves of action and function. It is thus a spending or wasting process.

23. The adaptative function of the organism is in health directed to the digestion and synthesis of the external material and the conditions of the environment. Health is thus a process, not a state. It is a cumulative as opposed to a spending process, not defensive but acceptive.

24. On this hypothesis it may be possible to direct experiment and observation towards a comparative study of the physical processes of health and well-being respectively.

25. This research work demands suitable material, so the major problem still remains: how to collect and retain families suitable for observation and research?

An analysis of some of our experiences in this attempt and of some of the difficulties attending it, is presented. At the date of presentation of this report, time, and that only

because time means money, seems the one factor threatening progress of this study.

G. Scott Williamson, M.D., Ch.B. Edin.
Innes H. Pearse, M.D., B.S. Lond.
Anni Noll, Dr. med. Heidelberg.
R. Bolton, B.M., B.Ch.
H. A. H. Howard, B.Sc. Lond.
Lucy Crocker, B.Sc. Wales.
(*Sec.*) Mary Langman.

APPENDIXES