

## Book

### A history of chronic diseases

Dividing diseases into acute and chronic is an old medical device. The English physician Thomas Sydenham (1624–89) differentiated “Acute [diseases] meaning those of which God is the author, chronic meaning those that originate in ourselves”. *Mutatis mutandis*, Sydenham’s dictum, is a summary of modern medicine, with chronic diseases defining everything else by exclusion. Nevertheless, as George Weisz argues in his cogent analysis in *Chronic Disease in the Twentieth Century: A History*, the notion of a chronic disease is a construct, not a “natural” category. There are simply too many exceptions. Tuberculosis and leprosy are communicable diseases, the largest category of “acute” afflictions, but they are hardly acute in their natural histories. Some cancers, chronic in most classifications, can often appear quickly and be generally treated effectively. (Choriocarcinoma and testicular carcinoma are examples.) Cervical carcinoma can be communicated. The term non-communicable diseases is fuzzy around the edges.

The 19th-century evolutionary philosopher Herbert Spencer reputedly advised people seeking longevity to acquire a chronic disease and nurse it. (He lived for 83 hypochondriacal years.) Spencer’s quip was consonant with Victorian metaphors of people having finite amounts of energy and dying early after burning their candles at both ends. It fits less well with the American chronic disease initiative in the 20th century, Weisz’s centre of gravity in this book. Unlike advocates in the UK and France, Weisz’s other two countries of analysis, chronic disease officials in the USA viewed the issue as one of early treatment and life-long prevention, and not simply the consequences of old age.

The USA’s age spectrum during the first half of the 20th century was lower than that of Europe, and insurance companies in the New World

unsurprisingly noticed that keeping their clients alive longer reduced death premiums. They consequently pioneered periodic physical examinations assuming that earlier diagnosis could lead to increasing life expectancy, and decreasing payments. In that, insurance companies were simply responding to an ancient medical trope about the impact of diagnosis on disease outcome. The companies also used entrance examinations, to screen out bad risks and set premiums appropriately.

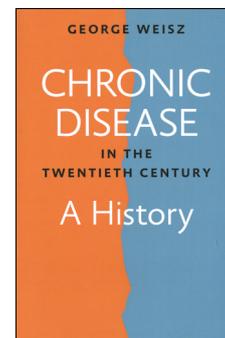
**“Weisz shows beautifully that concern with chronic diseases is hardly new, but that medicine and society have yet to provide humane and effective solutions to the problem.”**

The American chronic disease movement attracted a good deal of attention from epidemiologists and public health experts, many of liberal persuasions who tied their investigations into programmes for medical care reform. To that end, they needed information about the nation’s state of health, and Weisz scrutinises a number of surveys in the middle decades of the 20th century. These sought to uncover the extent of chronic illness within all age groups. Some surveys were funded by medical charities, but others resulted from lobbying by municipal or state officials, or were initiated centrally by the Public Health Service and other national agencies.

The USA had an “NHS” long before the UK, but the American acronym stood for National Health Survey, and although it gathered a great deal of useful information, it led to few changes in the structure of American health care. After World War 2, the Committee on Chronic Diseases (CCD) continued to put the issues surrounding chronic diseases within the national health agenda.

The cynic might argue that surveys or committees are substitutes for action, and Weisz’s analysis of the many American instances in the chronic disease field hints at the truth of this. To be sure, there were a number of local initiatives with positive outcomes. Several chronic disease hospitals pioneered vigorous rehabilitation programmes for those with strokes, polio, or the consequences of accidents or war wounds. The Veterans Administration throughout this period (and beyond) had a reasonable record in caring for the victims of the wars in which the USA was involved. For the rest, the American Medical Association has ever been committed to a fee for service model for medical care, and most hospitals were wary of too much central intervention. The consequence of the USA’s campaign to deal with chronic diseases has been many important changes but no structural breakthroughs.

What counted as a “chronic” disease varied over the decades. Heart disease and cancer have regularly featured, and earlier formulations of the problem emphasised “rheumatism” and other inflammatory joint disorders. Serious injuries and congenital disorders were generally included. Tuberculosis, often a chronic disease and of continuing relevance, hardly appears, and most American surveys removed mental disorders from their gaze. When dementia was included in chronic disease analyses, it was invariably of the senile, old-age variety. Diabetes, now a commonly cited example, was absent from many earlier concerns, partly because type 1 diabetes was quickly fatal before insulin turned it into a chronic disease, and type 2 diabetes was less prevalent (or less noticed) a century ago. Chronic renal failure, although common, was more resistant to effective medical intervention before the coming of dialysis and renal



**Chronic Disease in the Twentieth Century: A History**  
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transplantation after World War 2. Although the condition was singled out for federal legislation of entitlement in 1972, it remains almost an also-ran in Weisz's account.

American medical and public health engagement with chronic disease thus offers a fascinating scenario, and contributed several contemporary features to the rest of the western world. Screening is one instance, although American doctors hardly embraced it wholeheartedly. It took up a lot of time, was generally badly paid, and was far too mundane for most front-line doctors' tastes. Only with the coming of routine multiphasic screening from a single blood sample, and the routinisation of Pap smears and mammography did the idea really take hold. Mass chest x-rays for tuberculosis were in vogue in both North America and Europe for several decades from the 1920s, but their success in prevention was never clearly demonstrated, and by the time effective drugs to treat the condition arrived, the disease's incidence

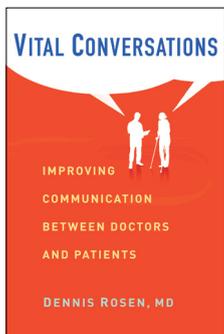
was sufficiently low to discourage continued funding.

Rehabilitation was another innovative aspect of the American chronic disease involvement. Several hospitals integrated departments of physical therapy into their efforts to get the chronically ill or disabled back into the community and at work. The fact that America's concern with chronic care covered the whole spectrum of life was also unusual, and may be the most striking aspect of the movement Weisz analyses. By contrast, British physicians became concerned with chronic disease as an important source of bed blocking. The shortage of hospital beds in the early decades of the National Health Service placed a premium on rapid hospital turnover. Although most people nowadays remember Thomas McKeown (1912–88) for his work on historical demography arguing against the power of medicine to have influenced significantly mortality statistics in the past, the young McKeown did

pioneering research on the impact of the chronically ill on hospital function. Weisz shows that this research, in the 1940s and 1950s, actually fits into McKeown's later concerns with the caring role of medicine. Not only were many elderly people with chronic diseases blocking beds, they could be better off—psychologically, socially, and medically—out of the hospital. That home care, nursing homes, or sheltered accommodation could be cheaper for the state, was secondary to McKeown's humanist vision.

The French, too, came late to confront the issue of chronic disease. This has changed dramatically within the past couple of decades, but Weisz offers important insights into the relationship between ideologies and systems of health care in his three countries. Weisz shows beautifully that concern with chronic diseases is hardly new, but that medicine and society have yet to provide humane and effective solutions to the problem.

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Vital Conversations: Improving Communication Between Doctors and Patients  
Dennis Rosen.  
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## In brief

### Book *Vital communication*

As I go on the morning ward round each day, I'm grateful for the blood tests and the MRI and CT scans. Of course, the many diagnostic tools in my toolbox don't come cheap, and rising health-care costs in high-income countries have led to political and managerial involvement to reduce costs and increase efficiency. In reality, this often means strict targets for time spent with each patient. In our quest for efficiency have we sacrificed communication—the most valuable tool at a doctor's disposal?

In *Vital Conversations: Improving Communication Between Doctors and Patients*, paediatric pulmonologist Dennis Rosen argues that the conversations we have with our

patients can, in fact, serve as an aid in our search for efficiency. It's a seemingly simple idea, but one which could have a positive impact. In a journey of his personal experiences from Israel to Boston, he explores not just the benefits of good communication between a patient and her doctor, but the necessity of it in performing our duties as medical professionals to optimise care. We are reliant on our patients to tell us about themselves—they are, after all, the only expert. Without the information patients provide, tests become obsolete. Medication has no use unless patients adhere to it. Rosen suggests that by changing how we talk to our patients we can reduce hospital readmissions, unnecessary investigations, and

increase medication compliance with the potential of cheaper yet higher quality health care.

As a final-year medical student, I can't help but wonder if my communication skills are at their peak—I have an abundance of time to spend with my patients, no financial targets to meet, and I receive regular training and feedback on this very aspect of my work. I will keep Rosen's excellent book with me next year as a reminder not to let communication lose its place as the diagnostic tools become too many to fit in my box.

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