From the Editor

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Chronic diseases and cancer

We now live with illnesses and disabilities from which we used to die

(Sir Cyril Chantler[1])

Recognition that a disease is chronic or lifelong affects our perception of its consequences and dramatically alters the requirements for its management. The description of cancer as a chronic disease by Professor Sikora in his College Lecture[2] must have precisely this effect. Cancer is increasingly a disease of wealth leading to greater longevity, and rates are rising chiefly in developing countries as prosperity improves. Screening techniques are becoming available, and by attention to lifestyle issues and the use of drugs, the disease progression in many forms of cancer can be restrained even when they cannot be cured. Near patient testing is sometimes feasible and life expectancy is increasing. Cancer has achieved the status of a chronic disease.

Diabetes closely fits this description of a chronic disease and there are many parallels. It was fatal until the first patient with Type 1 diabetes was treated with insulin in 1922. Now there is growing recognition of Type 2 diabetes as a major world health problem with huge implications in developing countries where its increase will be spectacular. Indeed it is expected that the world-wide number of patients will rise from 135 million in 1995 to 300 million in 2025. The need for resources for diabetes care alone is hard to calculate. And now cancer rates and those for other chronic diseases are also increasing. Indeed, Professor Chamberlain in her Bradshaw Lecture observed that 'the modern NHS will be increasingly not about the cure of isolated disease episodes, but about the amelioration of chronic disease'[3]. The sheer numbers of patients with chronic diseases together with the complexity and cost of management requires a fresh approach. What can be done?

Patients with chronic diseases unlike those with acute illnesses have to make choices – informed choices. They need to understand the risks and benefits of accepting or not accepting advice on management, as well as the magnitude of these risks and benefits. There are issues regarding lifestyle and medication which need to be discussed. Uncertainty enters this framework because guarantees of sustained health can rarely be given. A patient with well treated hypertension may still die from a stroke, or one with diabetes from cancer. It is against this difficult background that the 'empowered' patient must make major decisions. Yet meaningful and accurate information such as the 'number needed to treat' formula is often difficult to present and the comprehension of risks and benefits poorly understood. Indeed patients' acceptance of treatment in relation to statistical benefit varies widely as described by Trewby *et al* in their paper on page 527 of this issue of *Clinical Medicine*[4]. These observations add increasingly to our concerns when advising patients what they can do. Once again, new strategies are needed.

Patients with chronic diseases need education: they need to understand their disease and its management. Delivery of appropriate and useful education is however a huge undertaking for increasing numbers of patients with complex diseases. Trials of new approaches to the management of Type 2 diabetes are therefore important, using the model of therapeutic patient education described by Assal[5,6]. Group patient education comprises not only discussions regarding the disease and its implications, but also provides and monitors the skills needed for its management, eliminating the need for routine individual consultations. Quality of life issues, which do not necessarily equate with achievement of biomedical benefits are addressed, and patients have the opportunity to decide together the setting of goals, changes of attitude and beliefs, and gain at the same time the ability to act in response to monitored

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results. The process makes them independent and gives them support from fellow sufferers. Early trials have demonstrated the acceptability of this approach as well as improvements in measures of diabetic control[6].

Therapeutic patient education schemes need not be undertaken by established doctors or specialist nurses. They provide an ideal opportunity to introduce novel strategies using specially trained Health Care Practitioners as suggested by the recent working party report from this College on *Skillmix and the hospital doctor – new roles for the health care workforce*[7]. These schemes could in due course be rolled out to meet the needs of the multitude of patients with chronic diseases both in our own environment and in developing countries, where various attempts are already in progress to deliver health care to remote communities[8].

Improved education and understanding brings with it the power to reject advice, whether in relation to lifestyle changes or the use of medication. It is often suggested that health professionals fail to understand the needs of their patients leading to high levels of 'non-compliance', and indeed it is well known that many diabetic patients do not take their medication or adhere to an appropriate diet. Yet informed choices carry responsibilities, and when patients reject advice, they need to understand the potential adverse consequences. When things go wrong, they can be guilty of contributory negligence.

Chronic diseases will dominate health issues in the twenty-first century and cancer has joined their number. Not only are new clinically and cost-effective approaches needed, but perhaps it is time to change the name. Colloquial use of the word 'chronic' implies something very bad, severe or grave. And many for whom English is not their first language may not comprehend its true meaning at all. 'Lifelong diseases' might express with greater clarity exactly what we mean.

References.

1 Chantler C. The second greatest benefit to mankind? *Clin Med* 2002;**2**:544-53.
2 Sikora K. The impact of future technology on cancer care. *Clin Med* 2002;**2**:560–68.
3 Chamberlain A. Advances in rehabilitation: an overview and an odyssey. *Clin Med* (in press).
4 Trewby PN, Reddy AV, Trewby CS, Ashton VJ *et al*. Are preventive drugs preventive enough? A study of patients' expectation of benefit from preventive drugs. *Clin Med* 2002;**2**:527–33.
5 Assal JP, Golay A. Patient education in Switzerland: from diabetes to chronic diseases.*Patient Educ Couns* 2001;**44**:65–69.
6 Trento M, Passera P, Bajardi M, Tomalino M, *et al*. Lifestyle intervention by group care prevents deterioration of Type 2 diabetes: a four-year randomised controlled clinical trial. *Diabetologia* 2002;**45**:1231–9.
7 Royal College of Physicians. *Skillmix and the hospital doctor: new roles for the health care workforce*. Report of a working party. London: RCP, 2001.
8 Alemu S, Watkins VJ, Dodds W, Turowska JB, Watkins PJ. Access to diabetes treatment in Northern Ethiopia. *Diab Med* 1998;**15**:791–794.

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