From the Editor

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Changing perceptions of disease

Perceptions of disease determine both the approaches to treatment and the attitudes of society. Where uncertainty exists, and no effective treatment is available, approaches to disease are usually influenced by prevailing societal attitudes. Resolution of uncertainty by scientific discovery can therefore upset the existing order.

Medieval Christian society regarded many diseases as due to the sinfulness of man, and treatment was delivered according to this perception. Leprosy was a punishment for the sin of lust and sex, Christ healed by forgiving sins, and St Bernard of Clairvaux (1090 to 1153), perhaps wisely at the time, taught that 'to consult physicians and take medicines befits not religion and is contrary to purity'.[1] It is logical then that the principal role of medieval physicians in Europe was often that of priest and confessor.[2] Even now, many societies regard epilepsy as the consequence of a curse, making it difficult to convince sufferers that anticonvulsants might offer effective treatment.

AIDS was a new disease of the 20th century. It was at first seen as the 'gay related immune disease'[3] attributed to 'sinful' behaviour and associated with guilt: its sufferers were outcasts. There was no known cause and no effective treatment. Professor Pinching in his perceptive article on page 78 of this issue[4] compares this situation with that of chronic fatigue syndrome/myalgic encephalitis (CFS/ME) which is still without any demonstrable cause; immune and other mechanisms remain unconvincing, and its psychiatric origin is disputed, especially by sufferers.[5] Modern medicine has failed to discover cause or treatment and perceptions remain confused. Indeed, AIDS and CFS/ME once had much in common in that perceptions were determined by society and the citizen became the expert. CFS/ME has been politicised.[6]

Discovery of the HIV virus provided a biomedical explanation for AIDS: perceptions of AIDS and CFS/ME then drifted apart. Professor Pinching observes that biomedical solutions 'provide some anchorage against shifting constructs of illness, of which perhaps CFS/ME is one of the most evident current exemplars'.[4] Thus, whilst perceptions of AIDS have completely changed, medical and social issues around CFS/ME remain unresolved leaving its status unchanged. Similar considerations have applied to other conditions such as Gulf War Syndrome or the association between MMR and autism.

Understanding disease changes with discoveries in science leading eventually to changing attitudes in society. Yet society at times perversely views the scenario differently from science: thus South African politicians have spurned the concept of HIV causing AIDS, and some patients at one stage opposed standard double-blind trials for new HIV treatments. In the case of CFS/ME, the value of evidence-based treatment by behavioural therapy for CFS/ME has been denied by some patient groups.[5] When William Harvey in the 17th century described the circulation of the blood 'the whole theory of medicine was destroyed, along with its power to convince, and the principal therapeutic technique of the time was made a nonsense of'.[7] Even after major scientific advances, perceptions of disease, often deeply ingrained in society, may evolve very slowly indeed. Perhaps it was ever thus.

References

1 Porter R. *The greatest benefit to mankind*. London: Harper Collins, 1997, pp 84–110.
2 Rawcliffe C. God, mammon and the physician: medicine in England before the College. *J R Coll Physicians Lond* 2000;**34**:266–72.
3 Porter R. *The greatest benefit to mankind*. London: Harper Collins 1997, p 594.

4 Pinching AJ. AIDS and CFS/ME: a tale of two syndromes. *Clin Med* 2003;**3**:78–82.
5 Sharpe M. The report of the Chief Medical Officer's CFS/ME working group: what does it say and will it help? *Clin Med* 2002;**2**:427–9.
6 Wesseley S. Reported in Shenker GN, Blake DR. Understanding pain: the enigma of pain and suffering. *Clin Med* 2002;**6**:574–7.
7 French R. Harvey, clinical medicine and the College of Physicians. *Clin Med* 2002;**2**:584–590.

PETER WATKINS