From the Editor

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Chronic disease

'The real essence of great portraiture of all time is the artist's eternal interest in the human figure, character and emotions, in short in the human drama.'

(Mark Rothko, Artist)

Doctors charged with the care of people with chronic disease are uniquely privileged to observe the evolution of human emotions and drama, often over many years. The continuity of care by individual physicians enables them to accumulate 'knowledge of the patient's history, values, hopes and fears' which will 'provide better care than a similar doctor who lacks such knowledge'.[1] However, as Sir Cyril Chantler observed in his 2002 Harveian Oration, 'we now live with illnesses and disabilities from which we used to die'.[2] Consequently the number of patients with an increasing range of chronic diseases has risen dramatically, to an estimated 17 million in the UK. It is clear that traditional, long-term care with individual consultations for all such patients is no longer a viable reality. Will this loss damage patient care, or might new modes of practice actually enhance their well-being as well as delivering a more effective service?

The needs of people with chronic long-term disease range from those of the few with highly complex and often multiple medical problems at one end of the spectrum, through a greater number who require specialised medical care, to the majority, perhaps 70 to 80%, who need support for self-care. Delivery of care to such large numbers of people requires teams who can provide and teach the necessary skills, working for the most part in the community with complete integration across primary and secondary boundaries. Sensitive leadership and above all mutual trust are needed in developing such programmes. It is encouraging that several specialties, such as diabetes, asthma, dermatology and others, have already developed imaginative schemes for care. Yet at the same time, resources are needed for secondary care facilities for patients with complex problems, as well as for research and education. They must not be damaged.

Motivation – both of patients, who in the short term may not always perceive the benefits of life style changes and other treatments, and of health professionals delivering care – is critical for success. For patients, achievement of agreed goals creates encouragement to persevere with treatment.[3] Incentives for professionals are probably also best achieved by feedback: benchmarking provides individual centres with information which shows their standing in relation to other centres across the UK, enabling them to improve their own standards if they are unsatisfactory. Benchmarking for COPD,[4] asthma,[5] myocardial infarction[6] and stroke,[7] established by the Clinical Evaluation and Effectiveness Unit of this College, has already been shown to result in better overall care across the nation. On the other hand, the financial incentives that have been proposed have fickle effects and discourage professional behaviour.[8] Government too should trust its health professionals.

Novel approaches to care are needed. Treating patients in groups, for example, may have some advantages over individual consultations. Evidence suggests that such group programmes, at least in patients with type 2 diabetes, result in better perceived health, together with improved control despite using less medication.[9] It has also been shown that enhancing motivation using variations of cognitive behaviour therapy and motivational interviewing can also result in better control with reduced pharmacological interventions.[10] Furthermore, as reported by McKee and Nolte in this issue,[11] nurse-led clinics can be more effective than traditional physician-led care. Effective outcomes have been described in the management of a range of conditions including chronic

obstructive airways disease, asthma, heart failure, and diabetes. Overall there is growing evidence that chronic disease management programmes improve the outlook for a wide range of disorders.

McKee and Nolte also examine the influence of healthcare systems on the management of chronic disease in different European countries.[11] They describe the decline in mortality from common treatable conditions in many European countries, in stark contrast to the situation in the USA where the probability of dying from such conditions is much higher. They observe that systems of healthcare can either enhance or impede programmes of care for patients with chronic disease. The English National Service Frameworks, for example, 'require a degree of integration that seems unimaginable in Germany' where, at least until recently, reimbursement of physicians discouraged an integrated team approach. What is needed now is a generic model for the care of people with chronic disease.[12] There is much interest in the chronic care model developed in the USA,[13] and this College, jointly with the Royal College of General Practitioners and the NHS Alliance, has recently published an important report on commissioning services for chronic disease management in the NHS, advocating above all the establishment of joint clinical governance arrangements in the organisation of integrated care.[14]

There is an inevitable conflict between the efficient delivery of the technical needs for managing chronic disease by a range of skilled personnel on the one hand, and the human needs of our patients which should be addressed by individual medical consultations. Since the attitudes of patients range from a total life-long obsession with illness at one end of the spectrum to complete indifference at the other, it is only within the medical consultation that the narrow confines of guidelines, which may introduce a spurious certainty, can be interpreted for the individual patient. Of course, ultimately both sides of care are needed: systems of care can both enhance the quality of life and reduce mortality, but the skill of the physician is still required to synthesise often imprecise information and help patients to make their decisions and choices in the face of uncertainty.

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