

Moore, M.D. *Managing Diabetes, Managing Medicine. Chronic Disease and Clinical Bureaucracy in Post-war Britain*. Manchester: Manchester University Press. 2019. 320pp. £25.00. ISBN 978 1 5261 1307 8.

‘Managing diabetes, managing medicine’ by Martin D. Moore is a historical monograph on the developments in managerial medicine in post-war Britain, viewed through the lens of changes in diabetic care. Diabetes is presented a paradigmatic chronic condition that triggered a change in concerns in healthcare management away from acute trauma and infectious diseases and towards continuing care of chronic maladies associated with longer living and lifestyle changes. Moore’s elaborate engagement with shifting understandings of diabetes and evolving systems of clinical and state control offers an optic for studying the development of wider bureaucratic clinical care since the 1940s. This is the decade where the analysis begins.

The establishment of the National Health Service (NHS) in 1948 marked a historical change in healthcare structures against the backdrop of novel comprehensions of chronicity. Moore observes that the following three decades saw the control of diabetes as, largely, the domain of hospital care. However, from the 1950s onwards, a multitude of gradually introduced innovations hinted at changing boundaries for diabetes diagnosis and treatment and the relocation of some diabetic care away from the hospital and towards the community. Nonetheless, structured primary diabetic care was rare in the 1960s. General Practitioners were looked down on by senior hospital clinicians, which was indicative of role hierarchies within healthcare. It was not until the 1970s that diabetic care was formalised as the responsibility of primary clinicians, thanks to a combination of interventions from charismatic consultants and political reforms in 1974. This had implications for doctors’ professional project and the wider professional management of medicine.

Further developments which reinforced a move towards national forms of management that Moore compellingly evaluates in the second half of the book include the creation of managerial technologies in structured and shared care schemes, the formalisation of diabetes management as a public health problem and politicisation of national structures of healthcare governance. The solidification of integrated systems of structured care in the direction of

managed medical practice is explored through an array of micro-, meso- and macro-topics: from a greater focus on medical records and the implementation of audits, through the central government's interest in retinopathy as a diabetic health concern, to the importance of international conditions and British neoliberal politics promoting professional self-interest and market efficiency in medicine.

With its fine analytical detail grounded in thorough research that draws on academic journals, newspaper articles, oral histories, interviews and archival research, the book will capture the interest of historians of medicine, health economists, health service researchers, healthcare management and public management academic and practitioners and critical sociologists interested in the formation of medical professions. The focus in understanding the professional and political context of diabetes control is on doctors, to the exclusion of nurses and patients. However, it feels that this empirical selectivity was necessary given the objective of the book to present doctors as active participants in the development of managed medicine situated at the intersection of state-run healthcare reforms and clinicians' professional projects.

Further testimony to the depth of Moore's research is in the detail of his analysis of how an array of diabetic complications informed changes in managerial medicine. As an academic studying relationship-based wound care, I was particularly impressed to see Moore acknowledge the challenges of foot ulcer care in his account of the management of medicine. Foot ulcers tend to be omitted from social and cultural discussions of diabetes, but Moore makes room for subtle acknowledgements of the dangers of diabetic foot complications and the critical role of chiropody (podiatry)¹ in managing diabetic care.

Moore ends his monograph of 'contemporary history' of professional management of diabetic care by proposing that the structures of professional clinical management are here to stay. Reading this in August 2020, when the world was grappling with risks of a second wave of a highly infectious respiratory disease Covid-19, shown to pose unique risks to people with diabetes (Apicella et al., 2020), I could not help but wonder about the implications of the pandemic for the management of medicine in a resource-stretched healthcare system. Of

¹ The evolution of the role of chiropody in foot ulcer care and a rise in degree-level training has led to some chiropodists now being referred to as podiatrists.

course, Moore could not have predicted the coronavirus outbreak. He cautiously notes that a “[h]istorical perspective may provide useful context and points of departure for prognostication, but drawing definitive conclusions from history is something of a fool’s errand” (p.253). The NHS will operate under a pandemic mode for months if not years to come. An incremental thought-provoking question for contemporary historians of medicine emergent from Moore’s excellent monograph is, “What does the coexistence of infectious and chronic diseases mean for the continuity of managerial systems of medical care?”

Anna Milena Galazka

Cardiff Business School,

United Kingdom

@AnMilG

References:

Apicella M, Campopiano MC, Mantuano M, et al. (2020) COVID-19 in people with diabetes: understanding the reasons for worse outcomes. *The Lancet Diabetes & Endocrinology* 8(9): 782–792. DOI: 10.1016/S2213-8587(20)30238-2.