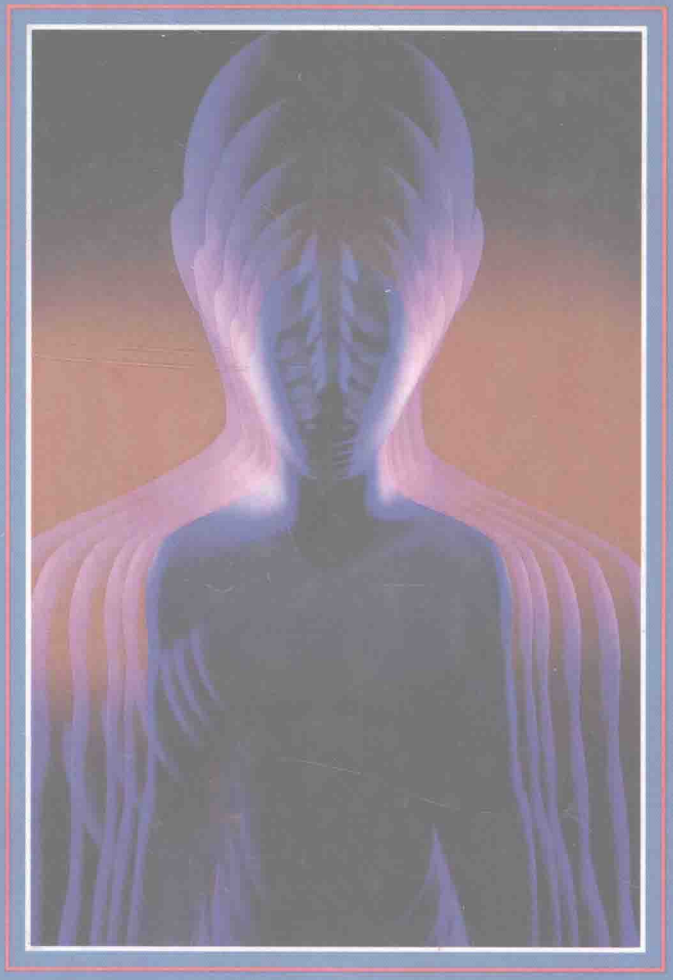
ISSUES & TRENDS IN HEALTH



Rick Carlson, J.D. & Brooke Newman

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by
Rick J. Carlson, J.D.
and Brooke Newman

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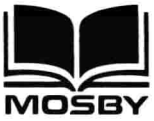

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Rick J. Carlson, J.D.

Rick Carlson has worked as a consultant in the health policy, health futures, and health promotion fields since 1968. Currently, he is the President and Chief Executive Officer of the Primary Prevention Program and PHCard Systems, as well as president of The NewHealth Group, a consulting firm based in New York and Aspen, Colorado.

He has served as chairman of the California Governor's Council on Wellness and Physical Fitness, was the first director of the California Trend Report Project sponsored by the Naisbitt Group, and was invited to be a Visiting Fellow at the center for the Study of Democratic Institutions in Santa Barbara, California.

He also has organized, through the Rockefeller Foundation, the University of California Medical Schools, the Blue Cross Association of America and Institute of Medicine of the National Academy of Sciences, a series of major public policy conferences on issues related to medical care and the promotion of health. As a member of the Institute of Interdisciplinary Studies, he became one of the prime architects of the Health Maintenance Organization program, drafting legislations that initiated the HMO movement across the country.

Mr. Carlson has written several books on health and human services, including *The End of Medicine, The Dilemmas of Punishment, The Frontiers of Science and Medicine,* and *Medicine & Future Directions in Health Care.* He currently is writing a book entitled *New Health.*

Mr. Carlson received his Juris Doctor degree from the University of Minnesota in 1965.

Brooke Newman

Brooke Newman has worked as an editor, researcher, and freelance writer since 1966. She has written articles for magazines and newspapers, and has worked at Simon & Schuster and Time-Life Science Books. She was a contributing author of PLEASURES (by Lonnie Barbach) and worked with Leon Uris on JERUSALEM.

A 1966 graduate from Sarah Lawrence College, she went on to do graduate work in architecture at the School of Environmental Design, University of Colorado. Most importantly, however, she is the mother of four children and the wife of Rick J. Carlson. They live in Aspen, Colorado.

To Nikos, Samantha, Blue, and Joey, without whom this book would have been done a year earlier.

PREFACE

We are entering a new and interesting period in human evolution, especially in the more developed countries of the world, where we have become preoccupied not only with the control and treatment of disease, but also with the maintenance and enhancement of health. This was altogether to be expected from the success of measures for the control of disease, especially the infectious diseases and those resulting from poor nutrition, both types of which can be controlled by improvements in hygienic conditions and other basic requirements for health. The successes achieved by such means have been advanced further by the biomedical sciences and by greater attention to the avoidance of risk factors and to ways and means for avoiding the stress associated with the way of life that prevails in the twentieth century.

The growth in size of a population of older individuals and all that this implies, not to mention the liberation of youth and the possibility of making wider choices throughout life, creates a need for this guide for the perplexed which Brooke Newman and Rick Carlson have so ably put together. They and the contributors to this volume reflect a wide array of points of view and approaches for use by those who seek a source of information and guidance in their active, responsible participation in protecting, maintaining and enhancing their own health.

The day may come when it will be said that we are experiencing an epidemic of health to which this book has contributed.

by JONAS SALK, M.D.

CONTENTS

PART I A FRAMEWORK FOR HEALTH

1 THE NEW HEALTH REVOLUTION

Rick J. Carlson, J.D. has worked as a consultant in the health policy, health futures, and health promotion fields since 1968. Currently, he is Special Adviser to the Primary Prevention Program and PHCard Systems, as well as president of The New Health Group, a consulting firm based in New York and Aspen, Colorado.

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This book has an uncompromising premise: the health field has changed so dramatically in the last 10 years that most of what we know about health and medicine today is obsolete and increasingly irrelevant.

A second premise is almost as crucial: much of what we are learning about health casts the individual as the central actor in the pursuit of health (though not so much as "holistic" medicine purists and "wellness" faddists might think). Hence, unlike more traditional times when everyone depended upon the family doctor for guidance, what the individual knows today is far more important and far more likely to lead to a healthy life.

Essentially the health field is undergoing a radical shift that will affect medical practice and research. Individuals will be profoundly affected in the ways they seek better health care, as will the health institutions. This shift will have far-reaching effects on the American economy, too, touching the individual, the neighborhood, the community, and larger institutions, including government. Finally, this shift will affect many of our social interactions as people live longer, treat disease more effectively, and respond to new health practices.

Remember back a dozen years ago. What kinds of questions were you asking about health? How important was your health? What kinds of health problems faced you, your family, and your friends? What were you doing about them?

What was your hospital like? What types of services and programs did it offer? Did you have health insurance? Was the cost of medical care an issue?

What problems did you solve on your own without a physician? Did you believe everything your family doctor told you? What about this "holistic health" stuff? Had you heard about health promotion and wellness? Had you heard the term *immune system*?

You probably didn't ask any of these questions in 1975. Few people really cared enough then to formulate such questions, much less to find the answers. But do you care now? If you do, what has happened in the last 12 years to make you care? Have any of the following occurrences since 1975 affected your personal health practices?

- The National Cancer Institute has published reports and sponsored conferences on the relationships between diet and nutrition both in preventing and treating cancer.
- The National Institute on Heart, Lung, and Blood Disease published new guidelines in 1984 for the treatment and prevention of hypertension which encourage nonpharmacological approaches, emphasizing physical fitness, nutrition, and stress control.
- The holistic health revolution emerged, flowered, then disappeared, as much from indifference as suppression, *because* it served its purpose in stating the obvious and in reminding many practitioners of truisms they were neglecting.
- The Institute for the Advancement of Health was founded in 1983 with a prestigious board and the mission to "further the scientific understanding of how mind-body interactions affect health and disease."

Since 1975, the health promotion movement has become a decided reality, with community programs emerging daily and with more employers developing or expanding employee programs at the worksite. "Wellness" programs abound, particularly in hospitals, and behavioral medicine programs flourish as mind-body links in health and disease are explored. New "prevention" centers have appeared, most prominently at the Pasteur Institute in Paris.

Consumers are changing longstanding habits in response to new health information (see the Gallup Poll results in *American Health*, March, 1985) and the self-help industry, which exceeded $17 billion in sales in 1983, is rapidly approaching the $30 billion mark. Health food restaurant franchises are opening throughout the United States, and the hottest new field in biomedical research is psychoneuroimmunology, which purportedly studies the relationship between emotional, psychological, and neurological states, and the body's immune system and capacity.

Investor-owned health care companies and HMOs are growing to the point where some have become prime candidates for corporate takeover. Hospitals have been merging, and offering new services, including birthing centers, women's health programs, sports medicine programs, "urgi-care" and "surgi-care" facilities, and health promotion and fitness programs. Holding companies are springing up to permit diverse corporate initiatives in the name of health.

These are fairly impressive events. I doubt that anyone could have forecast more than a few of these events in 1975. In fact, whenever I am asked, "What are the new ideas coming along in the health field?" I reply, "What more do you want?"

The growth rate in the health care industry over the last 12 years has been unprecedented and is largely due to a fundamental change in the way people think about their health. Bernie Tresnowski, president of the Blue Cross and Blue Shield Association in 1985, was asked by *The Wall Street Journal* why people were spending less time in hospitals. He replied "The movement [of consumers] out of hospitals and into new places and forms will continue. . . . The underlying reason it will happen is that this is what people want." (February 27, 1985)

In 1975 I wrote *The End of Medicine*, a book that launched a debate that continues today about

the role of medical care. Ten years ago health was considered the consequence of good medical care. Today, as important as medicine can sometimes be, we know that health is far more than good medicine.

In *The End of Medicine*, I suggested that radical, even revolutionary, change would occur in the near future. The changes that are occurring today are the result (as are all truly profound changes) of shifts in the way we perceive things, of deep conceptual change. In 1975, some of these new ideas about health had just begun to crystallize. We had begun to think, if not necessarily to act, holistically about our health. We had begun to recognize (or more accurately, to remember) the critical role of the individual and of the capacities of the mind, attitude, and emotions. We began to see that medicine that treated only the physical symptoms of a patient whose illness resulted from stress, was medicine that in far too many cases could only palliate that illness. Only then did we begin to see that such medicine was a very costly enterprise, given the limited recovery it could produce.

Today we are in the midst of a revolution launched by changing ideas and articulated at the level of institutional change. The health care system is fiercely competitive. Hospitals are merging with national firms. Insurance companies are offering health care, and hospitals and clinics are offering insurance plans.

Changes in medical care are the result of changing attitudes and values—not mergers, acquisitions, and hot new marketing schemes. Most of what's happening at the organizational level in health care is the result of turf wars, "my organization is bigger than your organization," the adult male's equivalent of adolescent locker-room comparisons.

And yet, what are the consequences of these changing values and attitudes? What real difference will it make to the person interested in his or her health in 1995? If the "health seeker" in 1975 had known what was in store in the next decade, what an exciting set of opportunities could have been anticipated. Even on a more pragmatic level, what if the health-conscious investor in 1975 had had a few bucks to invest in a small company proposing to film Jane Fonda doing aerobic exercises?

The changes yet to come in the health field are much more dramatic than those occurring in the last 12 years, as truly revolutionary as those changes were. We have just barely begun to learn the new ways of health. As we continue our passage away from the highly mechanistic views that shaped our modern medical system, we will enter very new and different terrain.

Take Care was recently opened in Seattle by Group Health Cooperative of Puget Sound, one of the oldest and largest HMOs in the country. Group Health realized that with all the interest in self-care, a retail health store in a commercial shopping area might work—and it has. In the first 6 months of operation, Take Care revenues were way ahead of projections and might even be higher if the medical staff at Group Health allowed the store's management to sell vitamins and minerals, always a staple of consumer self-health wants. With the success of the first outlet, Group Health is already planning two more stores in Seattle, and has firm plans to franchise Take Care across the country.

As another example, theories about nutrition have changed dramatically in the 1980s. In the 1970s, any suggestion that nutrition had any connection with the onset or treatment of cancer would have been met with incredulity or, more likely, derision. But in June 1985, the American Cancer Society placed an ad in *American Health* magazine entitled "A Defense Against Cancer Can be Cooked up in Your Kitchen." The ad advised readers that a diet high in fiber, rich in vitamins A and C, and low in nitrites, salt-cured foods, and animal fats would help prevent cancer of the colon.

This book covers a spectrum of change. But there is one clear constant: In virtually every instance, the issues and topics addressed by contemporary commentators places the individual at the center of the health scene. Governments, communities, groups, health care providers, and

(increasingly) employers do play very important roles. And undeniably, for some individuals, their responsibilities for their health are of less importance at given times—indeed, for the very poor and dependent, obtaining a decent livelihood is the central health issue, and any talk of personal responsibility for health is unrealistic at best and small and mean in any event.

Still, for the majority of us, the choices we make and the lives we choose to lead will determine our health. And this is the realization that is at the core of the New Health Revolution.

2 A VIEW OF HEALTH PROMOTION

Norman Cousins has written 16 books, including *Anatomy of an Illness, Human Options,* and *The Healing Heart*. For more than 25 years he was editor of *Saturday Review*. He is currently on the medical faculty of UCLA.

People are not machines. Neither are physicians mechanics. The interaction between patient and physician begins with confidence and respect—confidence by the patient in the physician and respect by the physician for the imponderables that can represent a vital fraction in any equation of treatment and recovery.

In his final piece for *The New England Journal of Medicine*, editor Franz Ingelfinger wrote: "If we assume that physicians do make patients feel better most of the time, it is chiefly because the physician can reassure the patient or give medication that is mildly palliative."

In a sense, every patient-physician relationship is a psychosocial venture. It is as erroneous to deny or disparage a role for attitudes in healing as it is to contend that they are an alternative to competent medical attention. Just learning about the fact of severe illness can sometimes create feelings of helplessness, hopelessness, anxiety, and panic, with well-known physiological penalties. The wise physician recognizes the need to provide emotional support for the environment of treatment. The physician cannot guarantee that his approaches will work, but what is of greatest concern to the patient is that everything possible is being done on his behalf.

It would be absurd to say that patients should not be given the best that medical science has to offer in view of the possibility that patients may feel angry or deceived if medical treatment hasn't worked. For the same reason, psychological bolstering should not be withheld out of fear that patients may react adversely if the downward course of the disease is not halted. In any case, medical science and psychological support go hand in hand. Guilt feelings are far more likely to occur when things that should have been done are not done. It is commonsensical to believe that most patients have a better attitude when they have a partnership with their physicians than when they feel sidelined and helpless.

Paying attention to a patient's emotional needs and to the quality of life; helping the patient to mobilize his inner resources when confronting a difficult challenge; creating an environment in which the physician can do his best; relieving feelings of panic and helplessness; being mindful of the needs of family and friends—all these come under the heading of psychosocial and psychological factors.

In the course of my assignment to lecture to students at the UCLA School of Medicine on the "medical humanities," the sessions producing the most intense discussions concerned patient-physician relationships. Resource materials for such discussions were far from skimpy and included such teachers and philosophers of medicine as Montaigne, Sir William Osler, Oliver Wendell Holmes, Francis W. Peabody, Lawrence J. Henderson, Walton Hamilton, Hans Zinsser, William Carlos Williams, Richard Selzer, and Walter Cannon. One thing in particular, however, troubled me about the exchanges as they progressed. The discussions were lively enough, but it became apparent that many of the students tended to regard the entire area of patient-physician relationships as soft. They seemed reluctant to attach appropriate importance to the physician's communication skills, to medical ethics, or to the circumstances of a patient's life. Certainly they were justified in regarding as primary the measurable information yielded by diagnostic technology or textbook approaches to treatment, but it was also important to consider the factors that affected patient cooperation and confidence. Even if we couldn't readily quantify compassion or communication skills, was it at least possible to gain increased respect for these aspects of medical practice? Why shouldn't a broad cultural background be regarded as essential in the practice of medicine?

I brooded over these questions, then I realized I needed additional evidence, if only of a suggestive nature. Accordingly, I undertook a mailbox survey in the Westwood, California, area on the general subject of patient-physician relationships. We distributed about 1000 questionnaires not far from the UCLA campus.

The questionnaire was accompanied by a letter stating its purpose—namely, to stimulate discussion among medical students about the way patients select and appraise their doctors. Participants were asked to give their answers or opinions to three questions: Had they changed their physicians in the past five years, or were they considering changing now? Why had they changed or why were they thinking of changing now? Did they have any suggestions to make about the education of medical students?

Altogether 563 responses were received—an unusually high figure, we were told by polling experts, considering that the questions called for written answers and the respondents had to supply their own postage and address their own envelopes.

We turned the responses over to the department at UCLA that, with the aid of computers, tabulated such materials. In due course, we received a survey report.

In presenting the report to the students, I was careful to emphasize the curbstone and informal nature of the survey, underlining the fact that it was in no way to be regarded as scientifically constructed or statistically significant. It was undertaken mostly for the purpose of supplying us with rough clues about patient's attitudes. Certainly, the base was much too confined for the survey to be considered remotely representative of patients as

a whole. It was made clear to the students that the replies came from a single neighborhood that was up-scale in education, professional status, and income (a fact that seemed to impress some students who intended to go into practice).

The most striking fact emerging from the survey was that 85% of the respondents either had changed physicians in the past 5 years or were thinking of changing for reasons other than relocation, the physician's retirement or death, and so forth.

Only 25% of those who had changed physicians cited incompetence on the part of the physician as the reason for doing so. It was clear that competence was taken for granted. A medical diploma and an ability to meet other requirements appeared to offer adequate assurance of capability. Why, then, did they change physicians? The bulk of the respondents changed for a wide variety of reasons having to do with the style or personality of the physician, including poor communication skills, office atmosphere of clutter or disorganization, inability to reassure the patient, and personal habits or characteristics (e.g., smoking, obesity, or lack of cleanliness).

In presenting the results of this survey to medical students, I reminded them that within the next decade the United States will have a surplus of 40,000 to 50,000 doctors. Laws of supply and demand will create an increasing respect for approaches and values now described as "soft." The net effect of the survey is that I now have little difficulty in gaining serious attention for the wide array of factors that go into a strategy of treatment. And, now that psychoneuroimmunology is attracting increased attention in academic circles, a far more auspicious environment exists than before for discussing the factors surrounding illness and medical practice. The question is not now—anymore than it has been—whether physicians should attach less importance to their scientific training than to their relationships with patients, but rather whether enough importance is being attached to all the factors involved in effective patient care.