Encouraging the Practice of Preventive Medicine and Health Promotion

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I MUST CONFESS AT THE OUTSET that I have never spoken publicly on the subject of preventive medicine before, and I do not consider myself by any stretch of the imagination to be an expert in this field. I suppose I was asked to speak at this meeting in part because of my total ignorance of the subject. In certain ways ignorance can be useful. As one begins to think about the problems of an unknown field, one tends to ask important basic questions that may not have been adequately faced by the experts who have lived with the problem for a long time. I do not know that I have correctly identified the important issues, but I have tried to think about how preventive medicine relates to what I have learned about the teaching and practice of internal medicine in more than 30 years of experience as a member of a medical faculty. My comments are offered with full realization of my lack of expertise in preventive medicine, but with the hope that they may be useful in stimulating further discussion.

The stated purpose of this symposium is to see what can be done to foster the teaching of disease prevention and health promotion in medical schools, with the object ultimately of making physicians more committed to the methods of preventive medicine in their everyday office practice. I am totally in sympathy with this objective, but I think we need to realize that the undergraduate medical curriculum is likely to have less influence on medical practice than graduate training and that either kind of education—undergraduate or graduate—is likely to be less influential than a host of other social and economic factors that determine the behavior of physicians and their patients. So the first point I would make is that no modest, achievable change in the undergraduate or graduate phases of medical education will do much to change the way medicine is practiced in this country unless we also make much more important changes in the system of health care and the nature of the society into which physicians go out to practice. I will come back to this point subsequently.

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Physicians' Attitudes Toward Prevention

At present, there are many reasons why most physicians and most patients are not very interested in primary preventive medicine. From the physician's point of view, perhaps the most obvious of these reasons is that third parties reimburse little or nothing for counseling, screening examinations, checkups, and other forms of primary prevention. On the other hand, procedures, diagnostic tests, and other specialized services are reimbursed relatively generously. The inevitable result is that physicians in practice concentrate on procedures that are reimbursed and tend to neglect the personal services that are not. After all, no economically rational physician would be inclined to spend much of his time doing things for which he incurs an economic penalty.

A second reason for lack of interest, hardly less important than the first, is that all medical practice is oriented toward the recognition and treatment of disease in the sick patient. Primary prevention, on the other hand, deals with people who are well, or at least who think they are well, and it attempts to modify behavior or environment, or to identify the early asymptomatic evidences of disease. The practice of medicine traditionally begins with a patient consulting a physician about a problem for which he seeks relief or reassurance. That is the historical function of medicine and it is supported by a vast universe of hard, biological knowledge and technology. Physicians have been educated in this system, and they and their patients are familiar with it. That system and those expectations and attitudes are not going to change very much no matter what we do. Therefore, I think we will have to recognize that preventive medicine now and for the foreseeable future is going to be seen by both physicians and patients as something peripheral to the central body of medical practice.

Furthermore, while it can be an integral part of medical practice, much primary prevention does not

even require a physician. Nurses, physicians' assistants, and other nonphysician health workers are often quite capable of providing primary preventive services and can do so more cheaply than physicians. Of course, many primary preventive measures involve public education, sanitation, environmental protection, or occupational safety—areas in which a major share of the responsibility is borne by government and social agencies other than physicians or other individual health workers. At any rate, even if they could be reimbursed for their time, many physicians would feel that it would be inappropriate for them to devote much attention to primary prevention or health promotion, since some of it can be done as well and more cheaply by less highly trained health professionals, and other aspects are best handled by government or other social agencies.

Two-thirds of American physicians are specialists of one kind or another and are simply not oriented toward preventive medicine except as it may relate to the diagnosis and management of specialized problems in their fields. The other third, family physicians, general internists, and general pediatricians, are, as I have said, discouraged from doing much primary prevention because it takes so much time and it is so poorly reimbursed as compared with the more specific diagnostic and therapeutic interventions.

There are many other reasons why most physicians are not as interested in prevention as they are in diagnosis and treatment. For one thing, prevention has no immediate payoff in terms of professional satisfaction. The prevention of disease or disability is not nearly as tangible or as satisfying to a physician as are the identification of existing diseases and their successful management. For another thing, patient satisfaction is also likely to be greater, since a healthy patient who remains healthy is not nearly as grateful to his physician as is the patient who is relieved of anxiety or discomfort by the successful management of his complaints.

Indeed, patients may have to be exhorted or persuaded, sometimes even against their will, to give up unhealthy habits and adopt a health-promoting lifestyle. In this sense, the traditional roles of physician and patient are changed when physicians practice preventive, rather than diagnostic and therapeutic, medicine. In the traditional relationship, a patient seeks a physician's help because he is ill, or is worried that he may be ill. The physician, in attending the patient, is providing a service that the patient feels he needs, and in a substantial percentage of cases the patient will ultimately come to believe that the service has been of some benefit to him. With preventive services, however, most patients do not seek out the physician but must be persuaded to do so by the argument that they will benefit in the long run from the preventive encounter. They rarely can be sure that they have in fact been helped. Some patients, of course, ask for checkups or other preventive services and are grateful when their physicians can reassure them that they are healthy. In most cases, however, patients are likely to receive primary preventive care with about as much enthusiasm and gratitude as they would a fire drill.

Although I have said the practice of preventive medicine changes the traditional roles of physician and patient, I do not mean to imply that there is anything inappropriate or unethical about the situation. On the contrary, I believe that physicians have an ethical obligation to do what they can to prevent disease and promote health, which is no less compelling than their obligation to diagnose and treat disease. I will discuss this again subsequently, but I mention it here only to make the point that the preventive role is, in certain ways, more difficult for both physician and patient than the more traditional diagnostic and therapeutic role.

Need for Incentives

If we are to make preventive medicine and health promotion more attractive to physicians and patients, we will have to give them both more incentives. Physicians will have to be paid more for the time they spend in preventive activities, and they will have to be persuaded that such activities are not only cost-effective but appropriate for physicians as opposed to nonphysician health personnel. Patients, for their part, will have to be persuaded that they stand to benefit in the long run from prevention and health promotion.

Patients will also need a health insurance coverage that at least includes preventive services and possibly even goes beyond mere coverage to offer some financial incentive, such as reduced premiums, for conscientious adherence to health promoting practices. How would a pro-competitive approach to health insurance affect this goal? If people are given vouchers or fixed subsidies with which to purchase insurance from competing prepaid groups, will they opt for those more expensive plans that provide preventive services in addition to the minimal diagnostic and therapeutic services? I would guess that the poor and the near poor probably would not, unless, of course, preventive services were required by law. In a competitive medical marketplace, those with limited incomes, if offered a choice between saving money and preventive health services, would almost certainly opt for saving money.

Thus, if our government wishes to encourage pre-

vention and health promotion in a competitive market, it will have to make certain that all approved insurance plans are required to include coverage of specified preventive services. The mere offering of such services will not suffice, because cost-conscious provider groups would have no incentive to persuade their members to use preventive services. Even if we assume that preventive medicine and health promotion activities are cost effective, they are not likely to be so in the short run, when the economic survival of the provider group is being decided. It seems clear to me, therefore, that there will have to be considerable regulation and oversight of the services delivered by the HMO provider groups if preventive practices are to be implemented on a broad national scale.

This leads me to observe that the goal of promoting price competition in a free medical marketplace as a means of controlling costs will probably conflict with the goal of promoting preventive medicine. The marketplace, after all, is a mechanism for satisfying wants, not needs. Consumers seeking the lowest premium, and many would be in that category, are not likely to want preventive services, and provider groups seeking to cut their costs are not likely to be anxious to offer such services either. The net result, as I see it, is that prevention and health promotion will have to be encouraged by government initiatives that either mandate these services or provide strong economic incentives for their use.

Public education is important under any system of health care; it would be particularly so in a system that emphasized preventive medicine. In the last analysis, people will have to be motivated to want what they need, to demand preventive services from their health providers, and to assume personal responsibility for following through. Considering how resistant many Americans are to the educational efforts of government, the task of persuading the public to act in its own best interests sometimes seems almost impossible. It is certainly made easier when the scientific evidence is unequivocal, for example, as in the case of cigarette smoking and cardiorespiratory disease. This brings me to a consideration of what the medical profession ought to be doing in this field.

Physicians' Responsibilities

It seems to me that physicians have at least two clear moral responsibilities here: first, they have an obligation to get at the facts of disease prevention insofar as possible. Although there is strong scientific evidence to support some of the current tenets of preventive medicine and health promotion, we are still woefully ignorant about many of the most important questions. It is the medical profession's responsibility, aided by its colleagues in public health, epidemiology, and biostatistics, to carry out the critical studies to determine what we can rely on in the way of strategies for prevention and health promotion. However, in our understandable enthusiasm for the growing but still modest body of evidence that prevention really will work, we must be careful not to overreach ourselves and assume more than we know. We should require strong evidence before intervening on a broad scale to modify the behavior of our patients. In many areas, we certainly need much more data than we now have. We tend to be overly optimistic about the health benefits of some of the preventive and health promoting strategies that are now popular. Much of what we do know—certainly, not all—is based on relatively soft evidence. We have to be honest about that, just as we should be critical in our examination of new evidence and unrelenting in our efforts to develop a better information base. The task of developing more information about prevention is one in which the medical profession must lead.

A second obligation of the medical profession is to attempt to persuade patients to adopt those strategies that have been proved effective. Physicians must be careful, however, to avoid officiousness and they must not intrude on the freedom of patients to choose their own lifestyle once the facts and consequences are clearly understood. Physicians should be teachers and counselors, not supervisors, policemen, surrogate parents, or bureaucrats.

Removing Barriers

How then can the medical profession and the public be enlisted in the preventive medicine enterprise? Some of my answers will be obvious from what I have already said. In the first place, the economic barriers that now exist to the practice of preventive medicine and health promotion need to be removed. The present fee structure in American medicine is working against the whole preventive medicine strategy. Primary care and family practice are discriminated against, and episodic specialized care and technological procedures are sometimes excessively rewarded. Without some rearrangement of the reward system, which will give more incentives to primary care and preventive procedures, we will never really get anywhere. To make this change will require the cooperation of the third-party payers, including the government, and it will also require the participation and support of organized medicine. This will be a difficult task, fraught with all kinds of political problems, but it is a task that will have to be addressed.

The scientific barriers to physician participation also need to be removed. I have already emphasized how little we really know for sure when it comes to the importance of changing lifestyle and the primary practice of preventive medicine. The things that physicians can feel confident about in this field are relatively few; they may be tremendously important, I recognize, but they are relatively few, and physicians will need to be armed with much more information before they can enthusiastically undertake a large-scale preventive medicine campaign. To generate the needed new information will require many new epidemiologic studies and clinical trials. This is the wrong time for Federal support of the National Institutes of Health to be slackening. If we are going to learn more about how to prevent disease and promote health, we will need more research, not less. Unfortunately the kinds of research we need—prospective epidemiologic studies and controlled clinical trials—are the most expensive of all.

Third, we need to assure that a higher percentage of practicing physicians are in primary care. At the present time, no more than a third of the total practicing physician time is devoted to primary care. The effort to turn that around and get something closer to a 50-50 proportion between specialists and primary care physicians is one that will require the support of government as well as organized medicine. The report of the GMENAC (Graduate Medical Education National Advisory Committee), the first broad-based national effort to look at problems of medical manpower, has not been treated as well as it deserved by either of these institutions. It is unfortunate that GMENAC has been phased out just at a time when we need more information about the patterns of health manpower and when we need more, not less, public discussion of our manpower needs. I would hope that organized medicine, with the support of government, would once again take up the study of manpower problems. There is probably a slow trend toward the expansion of primary care at present, but it is so slow that when one considers the increase in the total number of physicians, we undoubtedly will end up in the next decade with a vast oversupply of specialists. This is not going to be conducive to the practice of preventive medicine and health promotion.

Fourth, the public must be informed and motivated to use preventive medicine and health promotion techniques. To do this will require the combined efforts of government, the media, and the medical profession. The two recent reports to the public from the Surgeon General on health promotion are an excellent start in the right direction, but they only scratch the surface. We will need a lot more government initiative in this area; the media need to be unremitting in their concern for this issue and the profession has to become more involved.

Fifth, in agreement with the theme of this meeting, I do think that we should try to modify undergraduate education. However, I tend to be not only skeptical about the value of such modifications, but very conservative about the extent of the modifications that are needed. There is no question in my mind that we do need more curriculum attention to social and preventive medicine, and to the disciplines of epidemiology and biostatistics. However, I believe that the growing body of knowledge in these fields will, and should, also be incorporated into all aspects of medicine. Many schools will find it useful to have a separate department that concentrates on the teaching of social medicine and the principles of epidemiology and biostatistics, but I think it would be a mistake to sequester all the teaching of preventive medicine into a separate department. That would ensure its isolation from the mainstream of medical education and medical practice. Preventive medicine and health promotion should be an integral part of the practice of medicine in every field, and the valid facts and concepts in these fields should be woven into the teaching and the practice of every specialty of medicine. But that will not happen any faster than the growth of new convincing, science-based information which demonstrates that preventive medicine works. No amount of rhetoric, no amount of exhortation, will change the fact that we must have hard evidence that preventive medicine and health promotion are really effective. When that evidence becomes available, it will inevitably be incorporated into the body of medical practice.

Finally, as we attempt to apply principles of health promotion and preventive medicine, it is important that we consider the society in which physicians and patients live. There are many aspects of our society that are unhealthy. Poverty, poor housing, malnutrition, environmental pollution, industrial hazards, unsafe automobiles, the commercial promotion of tobacco, alcohol, and junk food consumption, and the ready availability of handguns and illicit drugs are all examples of social factors that predispose to injury and ill health. They are part and parcel of the social structure of our society, and we must honestly face the fact that we cannot expect major changes in health-related behavior without changes in many aspects of our society. A government interested in preventive medicine and health promotion will have to deal with these problems if it wants to maximize the benefits of the preventive approach.