SUSTAINABLE MEDICINE

With sustainability being such a trendy catchword these days, do we really need to add medicine to this already crowded field? In his best seller *The Omnivore's Dilemma,* Michael Pollan reminds us that "unsustainable" means: **Sooner or later it must collapse**. By almost any criterion, the current American medical system is unsustainable. We've all heard the statistics: health care costs increasing at double the cost of living (now 16% of the GNP) yet our health ranked below all other developed countries, close to 50 million Americans uninsured. Yes, we desperately need a sustainable medicine.

How is sustainable medicine different from health care reform? Politicians, policy-makers and think tanks are trotting out massive plans to "save" the system, but almost all of these plans focus on changing the way we pay for health insurance and increasing access. While both of these are desperately needed, they will not make our system sustainable, because they fail to examine the fundamental attitudes and philosophy behind medical practice, and unless these are addressed, legislated health care reform will have about as much success as campaign finance reform.

THE THREE PRINCIPLES OF SUSTAINABLE MEDICINE

1. Medicine must strive towards the *long-term goal of promoting and sustaining health*.
2. Medicine must be *economically sustainable*.
3. Sustainable medicine requires a *personal, collaborative, long-term doctor-patient relationship*.

Regarding the *long-term goal of promoting and sustaining health*, doctors all too often feel pressured to alleviate acute symptoms by prescribing drugs, and this frequently leads to the overuse of antibiotics, pain medicines, and antidepressants. Concern has been raised recently that indiscriminate ordering of CT scans is exposing patients to dangerous cumulative doses of radiation. And fragmented care from multiple specialists often leads to polypharmacy, especially among geriatric patients. So while an internist is prescribing a drug to treat osteoporosis, a psychiatrist or urologist may be prescribing another drug which increases the risk of falling.

Although we have powerful drugs to reduce blood pressure, lower cholesterol, and treat diabetes, and can surgically bypass blocked coronary arteries, there is near unanimity among public health experts that these conditions are largely caused by poor lifestyle choices, which conventional medicine has done a very poor job of successfully addressing. Early detection measures, such as PSA and cholesterol screening, Dexa scans and mammograms, certainly have value, but they are not a substitute for true health promotion. In fact, family practice can sometimes feel as if it has been reduced to a checklist of all the recommended screening tests and immunizations.

Economic sustainability means there must be a dedicated attempt to bring annual health care cost increases down to a level commensurate with general cost-of-living increases. But government mandates will never accomplish this because the American public will not accept bureaucratic control over access to the latest procedures and technology. Rather, it has to come from a fundamental change in attitude. Unless we appeal to factors other than just economics, there are very few incentives for the patient or physician to control costs. Rather the opposite: physicians make more money when they order tests, and feel as if they are less likely to be sued for negligence, while patients, fearful of disease yet angry at the insurance companies, are happy for the reassurance that they think negative test results will give them, and eager to "get something" out of the outrageous insurance premiums they pay. All doctors know that we order many unnecessary tests and procedures. But if, for example, a CT scan for every minor concussion has become the standard of care in my area, why should I stick my neck out in this litigious society and not order one?

That's why what we need is a fundamental change of attitude. Just as we all have an individual moral duty to reduce environmental pollution and global warming (even if we can afford a gas-guzzler), so must we likewise be committed to cost containment, even if we ourselves have excellent medical insurance. This does not mean the renunciation of medical progress, only the realization that it must have limits.

The little secret that most doctors know (but never admit) is that appropriate cost containment leads to better, not worse medical care. How can this be? Here are two examples, drawn from my daily life as a family physician:

- A patient with abdominal cramps and diarrhea calls the office after hours. The on-call doctor suspects an intestinal virus, but *just to be sure*, especially as he doesn't know the patient, he sends her to the emergency room. The ER doc also suspects an intestinal virus, but orders a CT scan of the abdomen *just to make sure* it isn't appendicitis. The CT is read as normal except for a possible growth on the liver, clearly unrelated to the current symptoms. Although it is theoretically possible that a malignancy has been fortuitously discovered, the overwhelming likelihood is that this is a harmless incidental finding. Nonetheless, the patient will be subjected to expensive, painful, and perhaps dangerous confirmatory procedures, only to be told: "I'm so happy to report that it was nothing." Ironically, the relieved patient—who has been subjected to far more discomfort, worry, and risk than her condition warranted -- is thrilled not only with the result, but also with our "wonderful" medical system. (Unless she had to pay for the scan!)

- A busy doctor orders a Lyme disease test even though the patient's vague aches and pains are not consistent with that diagnosis. The patient has requested this test, and the doctor figures that in any case it can't hurt *just to make sure*. The test comes back equivocal (as they often do) and the doctor, *just to make sure*, elects to treat with antibiotics. The patient, now convinced that he has Lyme disease, does not improve with the first course of antibiotics and ends up being treated for months or even years with antibiotics for a disease he never had. In addition to their cost, these unnecessary antibiotics carry risks of their own, including potential compromise of immune and gastrointestinal function. Perhaps even more harmful, the patient now is convinced he has a chronic illness, with often devastating psychological and sociological consequences.

The first two principles of sustainable medicine are likely doomed to failure without the third, namely *a personal, collaborative, doctor-patient relationship*. Impersonal care from large groups and emergency facilities is frequently unsatisfying for doctor and patient alike. We must return to groups that are small, locally-owned, and socially embedded in the community. The doctor should live near his or her patients and be seen in non-medical situations – Little League games, school events, at the food market and cultural events. The practice must strive to promote long-term doctor-patient relationships, where patients know who their doctor is, even in a group practice. When a trust relationship is built up, there are fewer unnecessary trips to the emergency room, fewer CMA (cover-my-"behind") tests run, and an atmosphere is established where the fear of lawsuits is not a major (or *the* major) determinant of decision-making.

This requires a major shift back towards having the primary care physician play a central role in health care. But just putting the primary care physician in charge does not guarantee a personal and collaborative relationship. In fact, many family doctors have found that they make more money, especially with large HMO practices, if they see a huge volume of patients and refer out anyone who has a problem which takes more than five or ten minutes. It's hard to imagine that this makes for a very satisfying professional life. In fact, job satisfaction, about which so many doctors complain endlessly, along with the increasing imperative to control runaway costs, might just provide the motivation for the sea-change which sustainable medicine is calling for.

Given the powerful forces in opposition, does sustainable medicine have a chance? Here we may perhaps take heart from recent changes in agriculture. Although agribusiness still produces almost all the food in America, witness the tremendous recent rise in farmers' markets and CSA's (community-supported agriculture cooperatives), resulting even in a popular new concept: *locovore*. Many people have become convinced that developing a closer, more personal relationship with small-scale farmers and gardeners in their community results in healthier, better-quality, affordable food, and yields environmental benefits as well.

For many years, especially during the 1960's and '70's, the organic whole-food movement, which arose out of concern for personal health, and the environmental movement, whose focus was the health of the planet, remained largely disparate and on the fringes of mainstream thought. It is only fairly recently that these two have come together, united by the powerful rubric of **sustainable agriculture**, through which the mutual interdependence of individual and planetary health has become manifest. Is it too much to hope that **sustainable medicine** may some day soon serve as a banner to unite patients longing for better health care, practitioners tired of assembly-line medicine, and public policy makers looking for solutions to the health-care crisis?

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