

1 What Is Health Care?

Health care is not what it seems. Consider a few popular prototypes of medicine.¹

The *House* version: Medicine is a detective exercise in which only logic, instinct, and high-tech investigation stand between health care providers and the identification of the problem.

The *ER* version: Medicine consists of a series of life or death crises that demand swift and dramatic professional intervention.

The *Scientific American* version: Medicine consists of the application of dazzling scientific breakthroughs to improving health.

The *Conspiracy Theory* version: Medicine is a shell game in which mega-corporations exploit human suffering for profit.

The *Marcus Welby* version: Medicine is the way that wise and kindly doctors who know best help patients to get better.

The *Money Pit* version: Medicine is an unstoppable force pushing Western economies to the brink of bankruptcy.

None of these versions is dead wrong. But none is completely right.

Even the *Oxford English Dictionary* falls short. The *OED* defines medicine as “the science or practice of the diagnosis, treatment, and prevention of disease,” which excludes medical attention to normal life events (as occurs in obstetrics, which is usually not focused on disease). Worse, if medicine consists only of the diagnosis, treatment, and prevention of disease, then most of the time, most health care providers are not practising medicine. Instead, we spend our time reassuring patients that they have no disease, or helping them to manage suffering that will never be adequately explained by a disease, or supporting them in

the disability that results from the very limited power of treatment and prevention. If this seems incorrect, or simply too bleak, read on. Health care can be a very powerful endeavour, but first we have to see things as they actually are.



We can try to determine the main activities of health care in two ways. We can measure where we, as a society, spend our health care money, or we can measure how health care providers and patients spend their time. In either case, the evidence leads us away from *House, ER,* and *Scientific American*. If we use money as our standard, the primary business of health care in developed countries undoubtedly is treating chronic disease. This emphasis arises because chronic disease is so common – diabetes, cancer, cardiovascular diseases, and respiratory diseases kill 36 million people a year, which amounts to 63% of all deaths worldwide.² The largest costs to society, however, do not result from people dying of chronic diseases but from people living with them. In the United States, chronic diseases are projected to cost \$47 trillion over the next 20 years,³ which offers some credence to the *Money Pit* version of health care. Among the *OED*-endorsed triumvirate of diagnosis, treatment, and prevention, the majority of this money will be spent on treatment, so “treating chronic disease” is one evidence-based definition of the main business of health care.

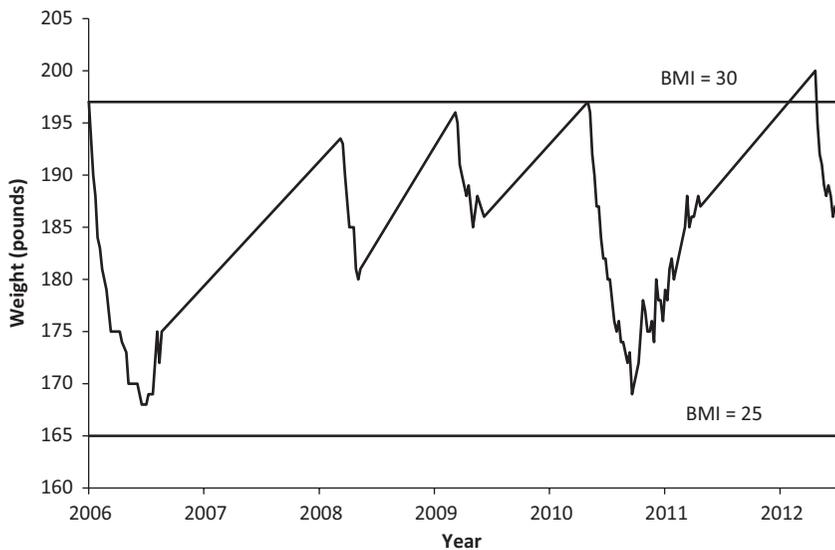
Prevention, on the other hand, *should* be where the money goes. The World Health Organization estimates that up to 80% of heart disease, stroke, and type 2 diabetes, and over 30% of cancers could be prevented by reducing tobacco use, improving diets, increasing physical activity, and reducing the harmful use of alcohol.⁴ The problem is that we don’t know how to do those things very effectively. Habitual behaviour is notoriously resistant to change. Worse, we spend a tremendous amount of effort and money on things that don’t work. Although it is difficult to quantify such things, it seems that when it comes to budgeting prevention dollars, the first instinct is always to bet on the same two losing horses: the naive assumption that educating people about what is harmful will change their behaviour and the related belief that well-informed people tend to act in their own self-interest. Very little evidence shows that these ideas are true, at least when it comes to health.

Experience suggests that self-interest and information are very weak forces for change. Let’s look at a case example of the common phenomenon of managing diet, exercise, and weight. Will is a clinical

nutritionist, an expert in healthy consumption. Have a look at the graph that illustrates the fluctuations in Will's weight over six years (Figure 1.1). The record starts with a weight of 197 pounds in May 2006. Will had just been diagnosed with mild hypertension (high blood pressure) and decided to try to lose weight to help keep his blood pressure under control. The 197 pounds on Will's frame equalled a body mass index (BMI) of 30, which is considered high enough to pose a long-term health risk. Motivated by the knowledge that a BMI of 30 and hypertension are both cardiac risk factors, Will started recording his weight and adjusting his diet.

Interventions to help people to lose weight fail about 80% of the time (more often than that if you keep track for more than a year). This failure happens not because most people doubt the health risks that come with obesity or are unaware of them. Certainly in Will's case, there was no knowledge gap to overcome. However, Will did have to think about what to change and how to maintain the change. The best evidence about weight-loss programs says that the ones that work share some common features: a low-fat diet, some degree of increased activity, and a record or diary of food intake.⁵ Since the program advocated by

Figure 1.1 Will's weight over six years



Weight Watchers meets that description, Will joined. He also told his family doctor, his wife, and a couple of friends and family members what he was doing, to help him to keep on track.

Scanning the graph shows us that Will succeeded for a while, then quit trying for a while, then tried again, and repeated the pattern four more times. The graph also illustrates some other things. The long straight-line ascent from one period of lower weight to the next peak represents many months when he was not even weighing himself; he had abandoned the entire project. Also, notice that each peak of weight is a little higher than the last. This pattern is typical for weight loss and gain in someone who is overweight – it says less about Will than it does about the phenomenon of trying to reverse habitual behaviour. In particular the weight curve illustrates how difficult it is to reverse a pleasurable behaviour when change requires effort and the behaviour’s adverse consequences are far in the future. Will’s knowledge that he would be healthier if he weighed less is a minor part of the forces determining the shape of Figure 1.1.

For examples of more successful behaviour change in the service of public health, consider the relatively recent increase in seat belt use and decrease in smoking. Increasing the use of seat belts took decades and was largely driven by legislation. Fines for flouting the law were not very effective; it took the addition of driver’s licence demerit points, the threat of curtailing freedom, to accomplish the change. The prevalence of smoking has been reduced from over 40% in 1955 to about 20% now, through an extensive, multifaceted effort that has included not only public education but also changes in public policy, pricing, and the availability of effective individual treatments to support smoking cessation.⁶ After all these measures, however, the prevalence of smoking has been more or less constant for the past decade.⁷ We seem to have run out of ideas.

These are the first vexing aspects of health care. It is rarely a sprint and much more often a seemingly perpetual marathon – which is to say that health care is not usually about identifying and curing acute diseases but rather about managing the impact of chronic ones.⁸ Beyond that, we are much better at treating chronic diseases (which almost never means “curing”) than we are at preventing them. It makes perfect sense to prevent the diseases that show every sign of being preventable and of crippling our future economy – we just don’t know how.



If we put aside the question of where society spends its health care dollars and instead look at how health care providers and patients spend

their time, chronic disease remains prominent, but the discussion gets more complicated. Take the providers in the department where we work, for example. Not too long ago, in an effort to increase access to treatment for people who were being underserved, we decided to look at the data regarding patients' visits to see how we were spending our time. Most of us were quite surprised to discover that as a group we spend almost 70% of our time seeing 13% of our patients. That is a lot of effort and expertise being directed towards a relatively small group of people. The people in that 13% have chronic diseases, to be sure, but so do most of the other 87%. Disease alone isn't what drives this pattern of intense use of health care workers' time by relatively few people. Something else is going on.

Because we work in a department of psychiatry, it could be that our practice is not representative of our colleagues' practices in other areas of health care, but it turns out that our situation is, in fact, the norm. High health care use is one of the forces that the Institute of Medicine has identified as creating a "quality chasm" in contemporary health care.⁹ Even in emergency departments, which would seem on the surface to be geared towards the care of acute medical needs rather than chronic concerns, heavy users or, colloquially, "frequent flyers," are recognized as a major drain on resources that are best suited to acute care.¹⁰

In business, this result is called the 80/20 rule: around 80% of sales come from 20% of clients. In health care, however, our goal is not to "increase business" but to distribute a limited resource for the maximal benefit of all. What is it about the 20% of patients that accounts for the disparity in their use of health care resources? First, it is worth dismissing some possible explanations that often come up before people look at the data. The 20% are *not* highly privileged in their access to health care services. Neither does disease severity account for high use; it *isn't* simply that we spend a lot of attention and resources on the people who are the sickest. Instead, when we examine the data about high use of medical resources what we find are that high users are consistently characterized by two things: health care providers find interactions with them to be "difficult," and these patients are likely to have some form of mental illness, most often depression or anxiety.¹¹ Some other characteristics vary a little between health care settings. In primary care settings, high users are very likely to have multiple physical symptoms that can't be explained by physical disease processes. In emergency departments, heavy users are often struggling with addictions. In specialists' offices high users are usually either people suffering from

the symptoms that are the currency of that specialty but without the expected underlying biological disease (e.g., non-cardiac chest pain in the office of a cardiologist or irritable bowel syndrome in the office of a gastroenterologist), or people with identifiable disease processes who are experiencing anxiety about their disease that is out of proportion to its severity. We will soon see that these apparently different situations are all just variations on a theme.

That difficult interpersonal encounters are a consistent marker of patients with high use is one of the more direct indications that the forces underlying vexing health care are often relational. The difficulty lies *between* the patient and the provider. A “difficult patient” is one that a health care provider walks away from feeling something that she finds hard to tolerate – like anger, fear, helplessness, or hopelessness.¹² And the frustration is usually mutual.

So, another vexing truth about contemporary health care is that most health care providers do not feel well trained or confident in managing difficult interpersonal problems, and yet the evidence suggests that doing this is how we spend a large part of our time.



As much as high use drains fiscal and human resources, underuse is also a problem. In this case, the trouble is that people who avoid medical interactions excessively, or who lack access to health care, do not receive prompt attention to health concerns when they arise. The usual assumption (which has not been tested as thoroughly as one would hope) is that attending to problems early prevents them from getting worse and that ignoring them leads to bad outcomes and complex, expensive care. The example that comes to mind is of discovering a lump and dealing with it promptly rather than letting it grow into an untreatable cancer.

A second way in which underuse increases the burden of disease for individuals and its cost to society occurs when a person who is managing his or her health in isolation has a chronic disease. This situation may be the most expensive form of underuse.¹³ A couple of examples paint the picture. First, think of a person with high blood pressure. Treating hypertension is fairly easy and not very expensive compared with the treatment of other medical conditions. At the same time, high blood pressure is usually invisible – it has no symptoms – and so it is an easy problem to *avoid* treating. Unfortunately, the cost of untreated hypertension can be quite high over the long run. A person who is not

monitoring and treating her high blood pressure is at risk for problems that have a very large impact on quality of life and health care costs, especially stroke and heart attack.¹⁴

As another example, diabetes is a chronic disease that often requires high maintenance to keep it under control. Making lifestyle changes, monitoring food intake and exercise carefully, monitoring blood glucose, and, for some, adjusting insulin doses in response to these variables is a complex and demanding regimen. Collaborative cooperation between patients, their families, and health care professionals helps to manage the complexity. On the other hand, a person who ignores signs of illness and prefers not to see health care professionals (let alone follow their instructions) is at a disadvantage. From an interpersonal perspective, a person who takes self-reliance to an extreme while also avoiding collaborating with or depending on others will find it harder to manage diabetes effectively. Evidence supports this notion; people with this interpersonal style have significantly worse control of their diabetes.¹⁵ This result is further evidence of one of the core theses of this book: understanding patterns of interpersonal relationship style shines a new light on the problems of vexing health care.

We have sketched out an image of Western health care that is frustrating, to say the least. Put bluntly, the costliest parts of medicine involve the chronic treatment of preventable diseases that we don't know how to prevent; much of health care providers' time is dedicated to interactions that are unsatisfying to both providers and patients; the common reasons for which patients need intensive management go beyond the diseases that providers feel they are experts in treating; and access to effective, affordable, and timely care is compromised by both extraordinarily high and low users of health care resources. Finally, and worst of all, many health care providers don't seem to notice or acknowledge that this is what it is like to practise their craft. The "quality chasm" of vexing health care cannot be rectified if providers and patients treat each frustrating impasse as an anomaly that is due to individual deficits, such as difficult patients or bad clinicians. Making changes requires changing peoples' behaviour, providers and patients alike. And there we hit another roadblock – we can't change behaviour if we start from the premise that our best tools will be logic and information. To find a solution, we need a new way of understanding the problem.

To build a new approach to vexing health care, we want to find a way to *adapt health care to the relational needs of individual people*. We want people who are experiencing intense and unmet needs for support

and reassurance to feel supported and reassured. We want health care providers who feel as if they cannot exercise their expertise when they are caught in a frustrating no-win interaction to feel skilled not only at “diagnosing, treating, and preventing disease” but also at relating to the people they are trying to help. We want people who are reluctant to see health care providers at all to live healthy lives in spite of their disinclination to take on the role of patient. We want personalized medicine for whole people. Creating that is what this book is all about.