

The Center for

Mind-Body Medicine[®]

Science. Training. Community. Outreach.

Report on The Healthcare Community Discussion

Sponsored by
The Center for Mind-Body Medicine
December 30, 2008

Recommendations Respectfully Submitted by
James S. Gordon, M.D., Founder and Director

The accents and the perspectives were as varied as the 30-person group—men and women from their early 20's to early 80's, blacks and whites, Asians and Hispanics, healthcare professionals, businesspeople and policy wonks, the wealthy and the barely getting by. Still, remarkably, as each of us spoke of our greatest health care concerns, common themes, common understandings, common solutions emerged.

Healthcare is “too expensive,” said the first speaker, an FDA scientist calling up other countries’ statistics. “My neighbor,” a currently unemployed old friend, ventured, “gets \$2600 a month in disability and pays \$1500 for her insurance. How can you live like that?” “My daughter and her husband,” an active-duty Army colonel told us, “are actually getting divorced so Medicaid will cover my grandchild’s surgical bills.” “We are,” concluded a former high Clinton administration official, a serious man suddenly sad, “the only advanced country where people without insurance go bankrupt.”

Everyone agreed that catastrophic care after a car accident or in a surgical or medical emergency was often excellent, but that the model of swift and decisive intervention had been long misapplied. “We have a ‘sick care’, not a health care system,” a black family physician told us, to a general nodding of heads. “I can’t bill for obesity or smoking cessation.” The current system, everyone agreed, often reimburses for expensive treatments of questionable value, instead of supporting preventive and self-care approaches. Small businesses, including doctors’ offices, we heard, cut services and raise fees to meet the escalating costs of their own employees’ healthcare—“It’s more than 15% a year,” a second family physician, who’d brought his budget with him, told us. Anxiety about health and coverage, our participants said again and again, contributes to the illnesses that demand coverage, and keep poorly covered people from seeking the help they need. The costs mount out of control while our national health grows worse—we spend far more money, our group

Board of Directors

James S. Gordon, M.D.
President

Donald de Laski, J.D., C.P.A.
Secretary / Treasurer

Honorable Lane Evans
Ambassador Marc Grossman

Ann Hoopes

Dennis J. Jaffe, Ph.D.

John Jeppson III, J.D.

Mary Lynn Kotz

Robert Schwartz

Board of Advisors

Jeanne Achterberg, Ph.D.

Rudolph Bauer, Ph.D.

Herbert Benson, M.D.

Janet Bickel, M.A.

Joan Borysenko, Ph.D.

Barrie Cassileth, Ph.D.

Robert Coles, M.D.

Larry Dossey, M.D.

James A. Duke, Ph.D.

Joel Elkes, M.D.

Jon Kabat-Zinn, Ph.D.

Michael Lerner, Ph.D.

Isabel Letelier

Dean Ornish, M.D.

Kenneth Pelletier, Ph.D.,
M.D. (h.c.)

Candace Pert, Ph.D.

Harold E. Puthoff, Ph.D.

Rachel Naomi Remen, M.D.

Archbishop Emeritus
Desmond Tutu, O.M.S.G.,
D.D., F.K.C.

John E. Upledger, D.O.

Jan Walleczek, Ph.D.

Director

James S. Gordon, M.D.

5225 Connecticut Ave., NW, Suite 414 Washington, DC 20015
tel. 202-966-7338 fax 202-966-2589 www.cmbm.org

members said with pain, incredulity, and outrage, live far less long and have far higher rates of infant mortality than just about any other industrial society.

Still, in spite of the pain, disappointment, and the frustration that providers, patients, and policy makers have all repeatedly experienced, that they still feel, there was, all around the circle and throughout the evening, a sense of promise and a feeling of hope in the room. Everyone deeply appreciated that the opinions of the American people were finally being asked for and that their voices would be heard. This time of crisis in our national health care, we agreed, can be an opportunity for profound change in the structure and the content of our healthcare, a time to eliminate the waste and “collateral damage” of our current system and to cut its killing costs, an opportunity to create a health care system devoted to people, not profits.

At the end of the evening, I summarized the most robust recommendations that were emerging from the rich soil of our conversation, the ones we would make to the Obama-Daschle team. Here they are.

1. **We need a coherent, rational system of National Health Care, a single-payer system that, without demeaning and destructive bureaucratic obstacles, meets the needs of all Americans.** This recommendation was supported by successful, stressed-out health professionals and beleaguered parents, by self-styled liberals and conservatives, and by policy analysts who months ago believed it was “off the table” of political discussion. In spite of any complexities in its creation, it was regarded as the “only sane” remedy. Indeed, one of our participants, a former head of mental health services for the Veterans Administration, pointed out that a majority of US physicians and nurses already favor such a plan.

The crucial task, we felt, was to examine the available models—Medicare, government employees’ insurance, and military health in the United States, and the national systems of other developed countries—and create one that was most beneficial and suitable to our population: a system that facilitated more free choice than the current one, and eliminated demeaning bureaucratic inquisitions while insuring universal coverage and cutting costs. Though all participants regarded insurance companies as obstacles, the chief proponents of profits over peoples’ welfare, all felt it was imperative that their employees be retained as workers in the single-payer system or retrained for other careers, especially in healthcare.

2. **Whatever model of universal care is chosen, it must be grounded in a profoundly different point of view and practice from the current one, one in which prevention is as important as treatment and in which self-care and mutual help are understood as fundamental to both prevention and treatment.**

This means that education about psychosocial and economic factors in health and illness and practical instruction in the use of nutrition, exercise, stress management, and mind-body approaches must come to be seen and practiced as the true primary care. These effective and inexpensive practices—“breathing, moving, learning how to shop,” as one mother of three put it—must be used wherever possible prior to more side-effect burdened approaches like surgery and drugs, as well as along with them. All of our group believed that this approach was absolutely essential to cost savings as well as our national health; that it should be mandated as primary care.

We realized as we listened to several military participants that we have much to learn from the Armed Forces’ emphasis on comprehensive fitness programs which include mental, emotional, spiritual, social, familial, and financial, as well as the physical, aspects of health.

This approach to wellness and prevention does not, we believe, require economic incentives and penalties as many have insisted —carrots and sticks. It can be grounded in an entire system which helps people who have felt discouraged and disrespected and alienated to become actively engaged in their own care. I and other clinicians in the room reported that when we treated our patients with respect, taught them techniques they could use to help themselves, and provided the kind of practical, emotional, and social support they needed to sustain the changes they decided to make, health care miracles were possible. Many of us, including The Center for Mind-Body Medicine staff (and many of our professional trainees), have found this approach to be highly successful with populations that are often regarded as recalcitrant and incapable of self-care, including the low-income, chronically ill elderly; delinquent adolescents; HIV-positive ex-prisoners; and war-traumatized children and adults. Respected and treated as equals who are capable of understanding and helping themselves, offered the opportunity to use tools to live healthier and fuller lives, the vast majority respond—and so will the vast majority of all Americans.

- 3. Integrative approaches to healthcare must be adopted as the standard of care and rigorously studied.** This means including in National Health Care whichever forms of helping and healing—whether previously described as conventional, complementary, or alternative—have proven to be most effective and making them available to all Americans in comprehensive and individualized programs: meditation and medication, acupuncture and surgery, group support in sustaining programs of self-care as well as individual diagnosis and consultation in designing them.

4. **Transforming the selection and education of health professionals.** The health professionals who will sustain and embrace this new commitment to comprehensive care, self-care, wellness, and prevention, must be imbued with idealism and humanitarianism, with a primary devotion to science in the service of people, to patients, not profits. To train and support them, we must create a system which provides a free professional education with an emphasis on wellness, self-care, and prevention as well as biomedicine, and, in return for it, require compulsory public service for all physicians, nurses, and other health professionals.

This system would foster the selection and education of the most committed, gifted, and dedicated healthcare providers regardless of financial background. It will give all health professionals both a scientific understanding of the therapeutic power of self-care and prevention as well as a profound personal experience of these approaches. It will emphasize character, commitment, and genuine concern for others equally with academic achievement.

5. **The transformation of the health of our population must begin with our children.** In this process, the Department of Education must be understood as a central agency in health promotion and disease prevention. Current school health programs are largely negative—“don’t smoke, don’t drink, don’t have sex, etc. etc.”—and largely ineffective. The school wellness curricula that all states have been ordered to develop are a good first step. They need to be taken far more seriously, closely examined, and carefully implemented. True and comprehensive wellness—including exercise, nutrition, stress management and self-expression—must become a central part of all school curricula and of the lives, and the teaching and learning experience, of all school personnel and of the parents of school children. Those who are teaching self-care must themselves learn and practice it, and the homes that children live in must support their children’s efforts to help and care for themselves.

6. **We must create a sane alternative to the current overpriced, counterproductive, indeed, destructive system of malpractice insurance.** This new option would separate financial compensation for patients from re-education and punishment of health professionals and hospitals. A national fund would fairly compensate those who have been injured by medical and hospital error (the vast majority of whom, according to a number of studies in New York and elsewhere, do not sue and are not compensated) in a way similar to workman’s compensation. Instead of perpetuating the destructive narrowness of “defensive medicine,” this new approach would provide genuine re-education for erring physicians or—if their offenses warrant it—bar them from practice. This kind of system, which is being successfully used in such countries as

Norway and New Zealand, must be investigated and refined to meet US needs.

7. **We must remove the baleful influence of the insurance and pharmaceutical companies on healthcare quality and its cost, and make industry serve, rather than exploit, Americans with health needs.** This includes eliminating health insurance companies from the health care equation. They are formed for profit rather than service, and each year add hundreds of billions of dollars (\$350 billion according to Physicians for a National Health Plan) of administrative costs, executive pay, and shareholder profits to our health care bill. This measure would require retraining and re-deploying the several hundred thousand managers and workers in the insurance industry—equipping those who are genuinely interested to provide health care and health education.

A national system of health care should have and use its bargaining power to ensure true competitiveness among pharmaceutical manufacturers and thereby significantly lower costs. Elimination of the influence of direct-to-consumer advertising—deplored by health professionals as well as patient advocates at our meeting—would further lower costs as well as reduce unnecessary, propaganda-driven drug-prescribing and drug-taking.

8. **We must develop a research program which serves the needs and priorities discussed above, one which helps set the agenda for our nation's health, rather than one that uncritically reflects a narrow biomedical perspective.** The NIH's 30-some billion dollar budget must be put to the best possible use, with a far more significant percentage—up from the current 2% to perhaps 20%—explicitly dedicated to studying the effectiveness of prevention, self-care, and wellness. An additional 20% of the budget needs to be shifted away from the single intervention studies—one drug or one procedure—on which NIH grants focus, to the study of comprehensive, integrative and individualized programs of care for the chronic illnesses that beset our population and consume our health care dollars, approaches that appear to be likely to produce the best results—for example, nutritional, mind-body, and exercise interventions for arthritis, heart disease, and chronic pain; chemotherapy along with nutritional therapy, acupuncture, herbs, and group support for cancer. Finally, 10% of the budget that is allocated to single intervention studies should be awarded to research on non-patentable approaches, including mind-body therapies, herbal remedies, therapeutic dietary programs, acupuncture, musculoskeletal manipulation etc. etc.

9. **We must recover the ancient philosophical perspective, in which the highest quality healthcare is seen as promoting personal, emotional,**

social, and spiritual fulfillment, and we must develop programs that manifest this perspective. The military's health care may be more effective than most civilian care because it has allegiance to and is implemented in the service of a greater mission—the defense of our country. A similar and perhaps even more life-affirming spirit—one of enhancing our collective national life and of providing service to our fellow citizens—can be called on and mobilized for civilian health care.

10. **A White House Office of Health and Wellness.** As we surveyed the changes we were recommending, it became clear to our group that a small but powerful agency at the highest level of our government was required to ensure continued responsiveness to the ongoing and changing health needs of Americans. Therefore, we recommend that a White House Office of Health and Wellness be established. This office (which would in some ways be similar to the White House Offices of Science and Technology and Drug Policy) would ensure that government bureaucracies (including any required for National Health Care as well as the NIH, the Departments of Education, and Defense and the Veterans Administration) are accountable to a vision in which service to all Americans is paramount. The White House Office would help ensure ongoing active engagement of our population in their own care and in shaping the kind of care that will most effectively, humanely, and economically meet all our needs.



Participants in CMBM's Community Health Care Discussion, 12/30/08

**The Center for Mind-Body Medicine is a 501 (c)3 organization.
Your tax-deductible donations are much appreciated.**