TRENDS & Ideas

MEDICAL RESEARCH

The Effect of Diet and Lifestyle on Coronary Heart Disease in Women

Illustrations by Sim Gellman

A study reported in the *New England Journal of Medicine* traces the correlation of incidence of coronary heart disease and changes in lifestyle and diet in more than 85,000 women from 1980 to 1994. The results showed a decline in the incidence of coronary heart disease due to reduction in smoking, improvement in diet (such as decreased red meat and high-fat dairy product consumption), and an increase in the use of postmenopausal hormones. However, the study also found that the increasing prevalence of obesity, due in part to increased dietary glycemic load (high intake of refined carbohydrates) did slow the decline in incidence.

The study looked at the contribution of the variables individually to the change in incidence of coronary heart disease. A 13 percent reduction, therefore, was attributed to a reduction in smoking; 16 percent of the decline was explained by improvement in diet; and an increase in postmenopausal hormone use accounted for another 9 percent decline. On the other hand, the increase in body-mass index explained an 8 percent increase in the incidence of coronary heart disease in this cohort.

The authors of the study admit that it is unclear how much of the decline in mortality rate is due to a decline in incidence and how much is due to improved survival. However, the large sample, high rate of follow-up, and detailed data allowed them to examine over time how changes in diet and lifestyle might account for the trend in decreased incidence. And while the decline in incidence was slowed by the national trend to increased obesity, the findings do point to the importance of diet and lifestyle in the primary prevention of coronary disease.

PHYSICIAN-PATIENT RELATIONSHIPS

The Dichotomy of Hope and Truth

The right of a patient to know the truth about his or her condition, even if the prognosis was bad, grew out of the surge in social forces of the 1960s (civil rights, feminism, and autonomy movements), reports Delia O'Hara in *American Medical News*. However, with medical training focused on technical intervention, Kenneth Iserson, MD, an emergency department physician, notes that many physicians dread "the D-word" and, when faced with having to communicate bad news, will often delegate to least senior staff members or insulate themselves with jargon, euphemisms, or brusqueness.

Medical schools have begun to address the need for training physicians in the skills of compassion. Fifteen years ago, Susan Tolle, MD, director of the Center for Ethics in Health Care, Oregon Health Sciences University, Portland, developed an in-house program to train interns on how to deliver bad news. Most interns are called on to use these skills immediately upon leaving the program, says Tolle.

While most patients want to maintain hope, they also want to be informed about their illness. "We have to disentangle hope from the idea of a cure," says Robert Buckman, MD, physician and author. Patients must be directed to realistic goals—spending time with family, getting affairs in order, preparing for a good death. Buckman offers advice on delivering bad news:

- Talk to the patient in person and in a comfortable, private place.
- Find out how much the patient already knows and determine his or her emotional state.
- Find out how much the patient wants to know.
- Give information such as diagnosis, treatment plan, and prognosis in small chunks.
- Respond to patient's feelings.
- Plan what can be done and what the patient will need.

Providing patients with information cannot be a "one size fits all" approach, cautions Timothy Quill, MD, internist and professor of medicine. Physicians must appreciate the transition in people's lives that bad news represents and take care in how they deliver it.

MEDICAL RECORDS TECHNOLOGY

Storing Medical Records Online

Several Internet start-up companies are banking on consumers' growing interest in taking control of their personal health records, reports Joan Raymond in *American Demographics*. Several dot-coms have entered the marketplace, selling convenience, security, and control of medical data through sites such as eMD, WebMD, CapMed, WellMed, HealthMagic, and PersonalMD. These services compile their customers' medical records and store them at a password-protected cyber "warehouse" in an attempt to eliminate the need for hospitals and other providers to track down important data in the tangled health care system.

PersonalMD, for example, offers customers free access to their medical records, including electrocardiograms, radiographs, and reports, via storage at their web site or through an automated faxing system. One hundred thousand people have already registered with PersonalMD.

These firms believe the time is right to offer such web services. According to Cyber Dialogue, an Internet market research firm, in 1999 24.8 million Americans searched the web for health and medical information—up from 17.1 million in 1998. They predict this number of web-savvy, health-conscious people will grow to 33.5 million by the end of 2000.

However, roadblocks for these companies are significant—including consumer wariness, issues of control, and industry regulation. Almost 75 percent of adults are concerned that these sites would share personal information with third parties without permission, according to a survey by Cyber Dialogue. Nearly 60 percent fear the sites might be vulnerable to computer hackers.

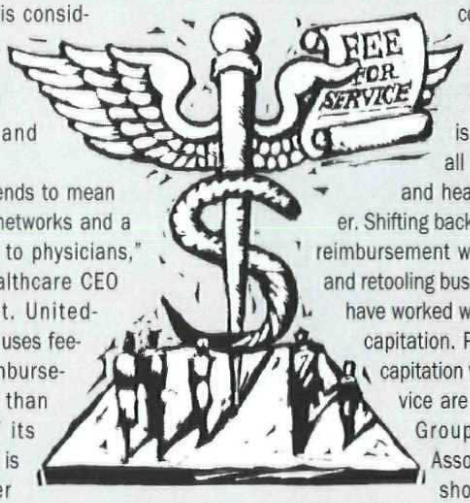
Control of medical records is also an issue. Who has final say over the use of these records—the patient, the physician, or neither? Whether physicians and other health care providers will accept patient-created records is a matter of debate. In addition, these start-up companies will need to follow the myriad rules and regulations of the health care industry to comply with federal law.

Still, advocates hope that their investments—$1 billion in venture capital in 1999—will pay off. "The medical record is at the center of the entire patient experience," says Graham Pallett, a principal at Deloitte Consulting. "Once people get over the fear of loss of privacy, you'll see more adopters, the same way consumers adopted the ATM: [from] 'Nope, don't trust it' to 'How can I live without it?'"

PHYSICIAN REIMBURSEMENT

Fee for Service Rebounding

Although not yet a significant trend, signs are beginning to emerge that insurers are rethinking capitation and taking another look at discounted fee-for-service reimbursement, writes Julie A. Jacob in *American Medical News*. Capitation, being paid a flat rate per patient no matter what the treatment, is considered by many physicians to be impractical for business and patient care.



"Capitation tends to mean a narrowing of networks and a transfer of risk to physicians," says UnitedHealthcare CEO Jeannine Rivet. UnitedHealthcare now uses fee-for-service reimbursement for more than 90 percent of its contracts. Rivet is not alone in her thinking: Cigna HealthCare of Colorado, Blue Cross and Blue Shield of Florida, and PacifiCare Health Systems are all switching back to fee-for-service reimbursement for some of their physician contracts. "[Capitation is] not the one-size-fits-all strategy that we have long purported it to be," admits Ben Singer, spokesperson for PacifiCare Health Systems.

The reasons for switching back to fee for service have less to do with satisfying physicians than with pure economics. Some insurers are dropping capitation because their analysis has shown that paying claims on a case-by-case basis is cheaper for them than paying physicians a flat rate. In addition, it is simpler to administer one standardized fee-for-service contract than to negotiate individual capitation contracts with several medical groups.

This new trend is not popular with all physician groups and health plans, however. Shifting back to fee-for-service reimbursement will entail revising and retooling business models that have worked well in the world of capitation. Plus, statistics on capitation versus fee for service are unclear. Medical Group Management Association statistics show that although the percentage of medical groups with some capitated contracts is rising, the revenue that is derived from these contracts is going down.

Despite the fact that some insurers are taking another look at fee for service, capitation will not disappear any time soon. As Robert Trinka, vice president of Aon Healthcare Insurance Services in Miami, notes, "When capitation works, it's a great solution. It just isn't the universal solution that many people hoped it would be."