Deaconess Hospital

Department of Surgery
George L. Blackburn, M.D., Ph.D.
Chief, Nutrition/Metabolism Laboratory
Cancer Research Institute

New England Deaconess Hospital
194 Pilgrim Road
Boston, Massachusetts 02215
(617) 732-8543-44

Associate Professor of Surgery
Harvard Medical School

February 23, 1990

Henry Blackburn, M.D.
Professor and Director
Division of Epidemiology
Stadium Gate 27
611 Beacon Street, SE
Minneapolis, MN 55455

Dear Henry,

It was a pleasure to meet you and get to know more about the roots of the Blackburn Family particularly the relationship to the Douglases.

Enclosed is a couple of editorials I have written recently and the U.S. Preventive Health Task Force Report and a copy of the minutes of the first meeting of our Center for the Study of Nutritional Medicine. As I told you, I was highly impressed with your community based plan to empower the community leaders to take charge in the task of public health program. I hope that we can work together on some of these projects in the future. As I told you, I am hoping to get Chick Koop to take a leadership role in this task.

I certainly will plan to visit you on my next trip to Minneapolis and hope you will do the same if you come to Boston. Nothing would please Susan, my wife, more than to have you stay with us.

Best personal regards.

Sincerely,

George L. Blackburn, M.D., Ph.D.

GLB:jl

Enclosures

Deaconess
Hospital

Department of Surgery
George L. Blackburn, M.D., Ph.D.
Chief, Nutrition/Metabolism Laboratory
Cancer Research Institute

New England Deaconess Hospital
194 Pilgrim Road
Boston, Massachusetts 02215
(617) 732-8543-44

Associate Professor of Surgery
Harvard Medical School

To the Editor: Regarding your recent Sounding Board — *The Future of the American Health Care System*[1] — we would point out the conspicuous absence of any discussion of the responsibilities of the recipients of such care.

All Americans must play a more active role in their own health care. While Shortell and McNerney emphasize patient satisfaction, functional health status, and achievement of treatment objectives, no criteria are described for promoting patient-provider interactions aimed at preventive as well as therapeutic medical care. The relevance of such criteria is supported by the U.S. Preventive Services Task Force: of the seven major conclusions reached, the first and foremost dealt with the importance of personal health practices[2]. The Task Force estimated that by adopting healthier lifestyles, Americans would prevent 40-70% of the 12 million years of productive life lost each year in the United States.

Lifestyle changes also offer a more cost-effective approach than do pharmacotherapies. For example, the long-term costs involved in drug treatments for mild to moderate hypertension range from $11,000-$61,000 over twenty years[3]. However, it is well established that dietary intervention can produce a 10 mm Hg and a 9 mm Hg drop in systolic and diastolic blood pressure, respectively. Patients who achieve a ten-pound weight loss and who maintain certain behaviors — a 25 g decrease in fat intake, a reduction in dietary sodium, and an increase in leisure time and physical activity — can control their blood pressure throughout their life[4,5].

Indeed, the Surgeon General recommends a similar nutritional and lifestyle regimen for the control of five major chronic diseases[6]. We[7] and others[8,9,10,11] have reported the many benefits associated with the consumption of a low-fat diet, including the reduction in body mass index; in risk for atherosclerotic and other cardiovascular disease; in risk for hyperinsulinemia, hypertension, and other chronic disease; and in risk for certain cancers (breast, colon, ovarian, endometrium, prostate). By adding

exercise and relaxation techniques to a healthy diet, even more benefits could be realized. Finally, the promotion of nutritional hygiene in a group setting shifts the burden from the physician (to provide a pill or other quick fix) to the patient, who will receive support from other group members.

In line with other successful programs, we put forth to Blue Cross/Blue Shield of Massachusetts a preventive medicine plan for which, at the outset, each party would pay one-third of the cost (the recipient of the coverage, the provider, and employer/third-party payer, *i.e.*, BC/BS). As the provider successfully implemented behavior change (with no dropouts), they would be reimbursed for their cost. To recipients who successfully met certain health outcomes by maintaining basic lifestyle changes (*e.g.*, smoking cessation, reduced alcohol intake, consumption of low-fat, high-fiber diet, increased physical activity, stress management), the employer/ third party payer would in turn refund 50-100% of their cost, depending on the efforts made to remain healthy.

Although Shortell and McNerney do not discuss the option in their guidelines, they would be well advised to add the use of incentives — for consumers and for health-care providers — to their list of financial considerations. Americans would be given a tangible, immediate motive rather than a philosophical, long-range recommendation to change their diet and health habits, and physicians would be motivated to improve their productivity, quality of care, and involvement in preventive medicine. This type of health program would educate the public as to their individual responsibility for their own health and to foster the doctor-patient relationship in a more positive light as well.

Sincerely,

George L. Blackburn, M.D., Ph.D.

1 Shortell SM, McNerney WJ. Criteria and guidelines for reforming the U.S. health care system. *N Engl J Med* 1990; 322:463-466.

2 Lawrence RS, Mickalide AD, Kamerow DB, Woolf SH. Report of the U.S. Preventive Services Task Force. *JAMA* 1990; 263:436-437.

3 Edleson JJ, Winstein MC, Tosteson AN, Williams L, Lee TH, Goldman L. Long-term cost effectiveness of various initial monotherapies for mild to moderate hypertension. *JAMA* 1990; 263:407-413.

4 Insull W, Henderson MM, Prentice RL, *et al.* Results of a randomized feasibility study of a low-fat diet. *Arch Intern Med* 1990; 150:421-427.

5 Grimm R, Neaton J, Elmer P, *et al.* Treatment of "mild" hypertension study(TOMHS): blood pressure results through 18 months (abstract). *Circulation* 80(4):II-301, October, 1989.

6 U.S. Department of Health and Human Services, Public Health Service. *The Surgeon General's Report on Nutrition and Health.* DHHS (PHS) Publication No. 88-50210. Washington, DC: Government Printing Office, 1988.

7 Blackburn GL, Kanders BS. Medical evaluation and treatment of the obese patient with cardiovascular disease. *Am J Cardiol* 1987; 60:55G-58G.

8 Wood PD, Stefanick ML, Dreon DM, *et al.* Changes in plasma lipids and lipoproteins in overweight men during weight loss through dieting as compared with exercise. *N Engl J Med* 1988; 319:1173-1179.

9 Hypertension Prevention Trial Research Group. The Hypertension Prevention Trial: three-year effects of dietary changes on blood pressure. *Arch Int Med* 1990; 150:153-162.

10 Buzzard IM, Asp EH, Chlebowski RT, *et al.* Diet intervention methods to reduce fat intake: nutrient and food group composition of self-selected low-fat diets. *J Am Diet Assoc* 1990; 90:42-50.

11 Stamler R, Stamler J, Gosch FC, *et al.* Primary prevention of hypertension by nutritional-hygienic means. Final report of a randomized, controlled trial. *JAMA* 1989; 262:1801-1807.