IN SEARCH OF ANSWERS

An internationally-recognized authority on stress, Dr. Paul Rosch says changes in the relationships between health care consumers, physicians and health care professionals require the medical arena to retool for the future.

"The major roads and routes that physicians and American medicine have been traveling are approaching several detours, if not crossroads. The reasons for this are varied and stem mostly from changes in relationships between doctors and patients."

— Paul J. Rosch, M.D., FACP
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Dr. Paul Rosch, president of the American Institute of Stress, has been on the cutting edge of medical practice for some 30 years, having worked with Dr. Hans Selye, the founder of the modern stress concept, and Dr. Flanders Dunbar, who introduced us to the term "psychosomatic." In his work with stress, Rosch has long held that the quest for health involves the integration of "a sound mind in a sound body," an approach familiar to those grounded in the health promotion philosophy.

The author of numerous articles on stress in both professional and lay publications, Rosch has written and been quoted extensively on changing trends in medical care delivery.

"At present there are obviously more questions than answers," Rosch wrote once in his newsletter, *Practical Stress Management*, and the search for some of those answers provided a focal point for a recent interview.

OPTIMAL HEALTH: There seem to be endless sources of health information today, much of it obviously conflicting. How can we more efficiently get good health information to the public?

ROSCH: It depends on what you mean by good health information. In the past 10 years a variety of changes have taken place in the delivery of health care and in attitudes about health and these have greatly altered the physician/patient relationship. One of these is that patients frequently get information about medical advances as fast or faster than their physicians do. For example, it's common practice for a newspaper like *USA Today* or the *New York Times* to report the latest findings from the *New England Journal of Medicine*, which many physicians don't even subscribe to.

I think even more importantly we're seeing a growing wave of consumer wariness about the unknown and long-term side effects of drugs and, along with that, a move toward natural pathic methods of health enhancement. Physicians, unfortunately, have usually not been trained in such things as nutrition, exercise and stress reduction as part of their medical school curriculum, and as a consequence a whole variety of other health professionals, entrepreneurs and even charlatans have come in to fill that void. In truth, there are often no clear-cut answers to what constitutes the best health information.

OH: If there are no clear-cut answers, what then?

ROSCH: I think we have to take an honest approach and say, "Look, we don't have all the answers." You have to also appreciate the individual's potential for self-healing. The power of the placebo phenomenon is increasingly being recognized — that a certain number of individuals undergoing any kind of treatment may benefit from it simply because they feel they're in control of the situation. While it's not possible to define stress scientifically, one thing that is clearly very distressful is a sense of being out of control.

OH: Doesn't the placebo phenomenon threaten the role of the physician?

ROSCH: It certainly could to some extent. Much of the physician's efficacy has derived from that very phenomenon. Treatments that were used 100 years ago would be considered worthless quackery today, and yet people kept going to physicians, so obviously they were getting some benefit. Much of the power of the old-time physician, of the shaman or witchdoctor, had to do with the patient's faith in his prescription or healing powers.

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Today the aura of the god-like physician is rapidly disappearing and, with it, so is the physician's power in that sense. That belief has been transferred in many ways to other areas such as macrobiotic diets and aerobic exercise and it's sometimes difficult to determine whether the benefits derived from those activities are a function of those specific modalities or of some nonspecific placebo effect.

OH: So what does the physician's role become, then?

ROSCH: I think the physician has to be responsible in terms of recognizing the limits of medical knowledge and to help guard the patient against charlatans who are going to prey on his fears and ignorance.

OH: Could you give me an example of that?

ROSCH: I think we see it in our own area. There are a number of legitimate and promising stress-reduction programs in place, but the problem is that anyone can claim to be a stress specialist. Even health professionals often have difficulty discriminating between authentic efforts and those that are primarily spurious. That's why the American Institute of Stress was founded — to provide such a resource.

OH: The problem seems to be that the so-called quacks can make more glamorous claims than the responsible person. How do you overcome that?

ROSCH: It's difficult to. I think the Federal Trade Commission can exercise certain responsibilities. Also, ethical publications certainly shy away from advertising that is clearly fraudulent. But there's a fine line between quackery and things the medical community does not accept, but which will ultimately be shown to have some therapeutic value. A good example of that might be biofeedback or acupuncture. You know, 15 years ago such approaches had very little medical recognition. Now it's been shown that both can be effective for certain conditions. The great danger there is that enthusiastic practitioners may recommend them when they are not appropriate.

OH: I know you are not in agreement with those who say that smoking is a major cause of heart disease, that you say stress is really the cause.

ROSCH: Well yes, I think that's quite clear now. The whole concept of risk factors is really based on the Framingham Study. Now what did the Framingham Study do? It started 40 years ago to look at people who had heart attacks and see what about them was different from people who did not. What they found was that there were certain risk factors — diabetes, being overweight, having high blood pressure, smoking too much, having high cholesterol — that were associated with heart attacks. Then they said, OK, if what we're saying is correct, we should be able to predict who's going to have a heart attack based on an amalgamation of those risk factors. And that turned out to be fairly accurate.

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Finally they said, OK, all we have to do to prevent heart attacks is cut out smoking, lower cholesterol and lower blood pressure. A seven-year, $115-million study called MRFIT (Multiple Risk Factor Intervention Trial), accomplished those objectives, but there was no significant reduction in heart attacks. In fact, a subset of hypertensives treated with diuretics had a higher mortality rate than the controls. On the other hand, reducing Type A cardiac-prone behavior has been shown to be 50 percent effective in reducing heart attacks and the use of beta blockers has been 26 percent effective. The point is, that association never proves causation. The link between cigarette smoking and high cholesterol and hypertension is probably that they're all manifestations of Type A or coronary-prone behavior and when you modify that behavior, those problems are diminished.

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OH: I know you're not saying smoking is good for you, but are you saying that people who emphasize antismoking campaigns for heart disease as opposed to antistress education are doing a disservice to the public?

ROSCH: No, I think they're doing a service in terms of the fact that it's a recognized health hazard as far as the lungs are concerned. But I do think it's not correct to claim that if you stop smoking you won't have a heart attack. The facts don't support that. I also think it's irresponsible to recommend across the board that salt intake should be severely restricted to prevent or treat hypertension. Part of the problem is that the major funding for medical research is heavily subsidized by the pharmaceutical industry and their primary interest is not in natural approaches but in the bottom line — they want to sell their products.

OH: If that's true of the pharmaceutical industry, is it also true of the medical profession and the health care industry?

ROSCH: Well, if you think about it, really, medicine is the only profession that's in business to do away with itself, theoretically. But you see we have two issues here that have always existed in medicine. If you go back to the ancient myths of Hygeia and Asclepius, the followers of Asclepius felt that the duty of the physician was to treat illness. The followers of Hygeia believed the role of the physician was to prevent disease. There's always been some oscillation between those two viewpoints. They should not be mutually exclusive, but I think the real problem today is that our definition of health is a negative one. We tend to define health as the absence of illness, but that makes no more sense than defining peace as the absence of war. We're technically at peace with the Soviet Union, but I don't think that best describes the nature of our relationship with that country. More and more individuals are acknowledging the inseparable relationship of mind and body in the pursuit of optimal well-being. They are now seeking advice not on how to get well, but how to get better. Unfortunately, doctors have not traditionally been trained in that orientation. You can't even find the word health in the index of any major medical journal.

OH: As you say, the ideal of the medical and health care profession is to promote health, but realistically, there's a bottom line for everyone. Who's going to pay for that? The insurance industry?

ROSCH: I think they will. You're seeing more and more evidence of the cost-effectiveness of stress-reduction programs, for instance, in industry. Fiscal intermediaries and large corporations are recognizing that this has great payoffs.

OH: How far away are we from this ideal situation, where everyone is working on the principle of health care rather than illness treatment?

ROSCH: Well, I don't know. I think we're probably a long way from it. Our health care system today is a misnomer — it really is a sickness-cure approach. You have to have a lot more education, starting in the schools. Too many patients are influenced by television commercials to believe there's a pill for everything. A patient comes to you with a headache and you want to sit down and get at the cause so it can be prevented, but he doesn't have time for that. He says, "Hey doc, give me a pill." They deliver their bodies to your office like they deliver their cars to the garage, often with not as much concern. We try to instruct young physicians into getting at the cause of disease from a prevention viewpoint, but it's not going to be successful if the patient has no appreciation of the value of that approach. Another problem is that insurance companies don't reimburse for cognitive skills, for thinking or caring about a patient, so there is little financial incentive for a physician to spend a great deal of personal time with the patient. We have all kinds of doctors and all kinds of patients. What's required is a mass educational approach, a redefinition of health and emphasis on the individual's ability to control his or her own destiny.

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