Health Promotion: Principles and Clinical Applications

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PART THREE: ISSUES AND RESOURCES

15. Medical Activism

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Preventive medicine is an arcane science. Although its epidemiologic basis has been well documented, it remains a subject more easily talked about than clinically applied. Health promotion, on the other hand, requires *doing*—and pitifully little has been done. An activist extension of preventive medicine, health promotion involves "in-the-streets" education of the public at large as well as in-the-office teaching of patients.

Put in these challenging terms, there is understandable discomfort, skepticism, and even resistance on the part of most physicians when it comes to initiating health promotion efforts. For that matter, why should the responsibility (or onus) of health promotion fall to the physician in the first place? Wasn't he trained in techniques of diagnosis and treatment? Certainly, health promotion does not appear to be time-effective or cost-effective to the busy practitioner. Besides, what third party payer reimburses for "knowledge imparted?" In a miracle cure age, how will the patient in the office expecting at the very least a prescription or a procedure respond to valuable time given over to "just talk?" And what could the physician really be expected to do or say that the patient (or the community) hasn't seen or heard a million times before?

Yet a physician's voice can make a difference. William Osler, one of the greatest bedside clinicians of all time, campaigned vigorously against tuberculosis. This campaign involved everything from pleas for improved housing in Baltimore to testimony before U.S. congressional committees, and it moved American efforts against the disease off dead center.

Ironically, the readers of this book are likely to be the very ones who have been previously well motivated in the area of health promotion—although no less frustrated than other physicians by the variable outcome—and probably the ones least likely to require extensive review of health promotion theories and techniques. But like any skill one wishes to keep well honed and up to date, training in the art of health promotion never ends. Whether in planning and implementing health promotion programs for a medical or hospital setting, in schools, at the work place, on television or radio, or throughout the community, the joy and excitement lie in developing unexpected, positive, and innovative ways to call attention to even the most staid, "good-for-your-health" topics.

IMPEDIMENTS AND INCENTIVES

Within the medical profession, incentives for health promotion have never been strong.

Much of what has gone on in hospitals and physicians' offices in the name of preventive medicine and health promotion has concerned an array of expensive diagnostic screening tests and fancy behavior modification treatment programs, an incomplete—but highly remunerative—approach to the primary prevention of illness. Far from stepping up its involvement in health promotion, organized medicine may even be backing off, as evidenced by a recent statement of the American Medical Association commenting on proposed national health planning guidelines for the Department of Health and Human Services[1]:

> It is stated that the principal health problems for adolescents and young adults are violent death and injury (resulting from accidents, homicide, and suicide), sexually transmitted diseases, unwanted pregnancy, alcohol and drug abuse, and emotional problems. These problems are the result of factors over which the physician and other providers of health care have little or no influence.

Fielding[2] has described the outcome in the public psyche of medicine's technologic self-legitimization: "Turning inward to ourselves [in the search for a disease-free status], our lifestyles, social values and the social system which sustains us are rejected as paltry and pedestrian substitutes for impressive edifices, computer printouts, and medical jargon that add the desired mysticism to the patient-health professional relationship."

Meanwhile, prevention nihilists have sounded the death knell for health promotion.[3-5] They cite as proof the medical advances that research has produced, in contrast to the pamphlets, posters, and palaver they perceive as the sole outcome of the prevention "movement." Some even wonder whether an emphasis on health promotion—which they perceive as paternalistic coercion—is unethical![6,7] Promising miracles and breakthroughs, and buoyed by the wealth of financiers and government grant givers they have impressed, researchers call for "wars" on individual diseases by means of the test tube, catheter, CAT scan, artificial organ, and transplant. Pressured by a system that demands them to publish or perish, medical school faculty members forsake the classroom for the laboratory. Because medical training acculturates students to believe that health promotion is intellectually simplistic and lacking in glamor, even the most public-spirited students and physicians begin to regard this field as ineffective do-gooding. At the same time, new techniques of treatment and diagnosis are readily adopted regardless of how needlessly repetitive they may be.

An even more disturbing element than the active "nay sayers" are the physicians, medical students, and other health professionals who have such a simplistic notion of health promotion that they consider themselves to be prevention advocates even when they do nothing more than hand the patient a pamphlet (which, more often than not, they haven't read). Part of the reason that more physicians do not learn to take time to provide their patients with appropriate, personalized health-promoting information and skills is that they have never actually learned how to communicate in a straightforward, nontechnical way. While doctors-to-be are tested on very minute details of the rarest diseases, they are seldom if ever examined on how well they can communicate to a patient what the patient ought to know, or if they know when a patient hasn't understood the explanation. Consequently, students gradually back off from health promotion; they fear failure, and knowing they lack the skills, they would indeed fail.

A first step toward enhancing the enthusiasm for physicians for health promotion would be to remind students that although they feel at the bottom of the medical totem pole, there is really less of a gap between their first day in medical school and their first day in clinical practice than between their last day in college and their first day in medical school. That is to say, society has invested in them the role of doctor—teacher—from the first day of classes. The student can choose to *play* doctor by practicing mechanical techniques or can *be* a doctor throughout medical school by imparting knowledge to those in the community who

lack an understanding of healthful lifestyles.

The problem-oriented medical record did introduce a specific, documented patient education portion of the patient's medical record. Even this advance does not remove patient education from the on-the-way-out-the-door-any-questions?-so long! portion of the encounter. Patient education—the essential first step toward health promotion—is the process of translating and imparting technical knowledge, reinforcing positive lifestyles, and exploding myths. Whether or not we are aware of it, patient education is part and parcel of everything we do—every syllable, every gesture, every facial expression, perhaps even our exemplar role in the community—and not just a separate, distinct portion of the physician-patient encounter or medical chart. Ideally, it is through a core content of well-rehearsed, up-to-date information—individualized to the patient, like any dose of medication—by which physicians can expand their health promotion efforts to the community. Such activity can in turn help create a climate of support for the physician's efforts in the office setting. At its most advanced level, health promotion aims for the entire community, not just for those at risk for various illnesses. Health promotion messages aimed at everyone will reach and may help those at risk but will also reinforce the positive value system of those not at risk. Health promotion should not be regarded as simply problem-oriented. In spite of McLuhan's astute observation that the media is the message, too many health promotion efforts have honed in on grandmotherly admonitions with little thought to public perception of health information.

It is folly to believe that reversing adverse health lifestyles can be achieved through the efforts of physicians alone. That would be akin to expecting the nation's crime problem to be solved solely by the police (physicians, for that matter, can become involved in crime prevention, too) or the multifarious problems plaguing American schools to be solved solely by teachers. Health is as much a social problem as a medical one, and societally promoted problems such as cigarette smoking and alcohol abuse ought to be more seriously addressed by groups other than physicians, bureaucrats of health-planning agencies, entrepreneurs, faddists, and prohibitionists.

However, physicians themselves ought to be in the vanguard of redressing societal health problems by helping to institute a social support system in the community at large, while continuing to educate patients in the health care setting. Unfortunately, too much of health education has been relegated to less sophisticated (albeit often more articulate and enthusiastic) ancillary personnel—ostensibly in the interest of freeing the physician for "more important" tasks—persons who may be less successful than the physician because they lack the doctor's "mystique." The consensus of several public surveys, including a Louis Harris poll, suggests the physician is the most desired source for public health information.[8]

Unless the physician is willing to step out of the context of the clinical setting—either merely to look around and steep oneself in the events and images of the day-to-day world in which nonphysicians live or actively to call attention to the preventable nature of so many of the problems the physician sees each day—the medical profession will only serve to legitimize its contemporary role in society as technological miracle worker, not its other traditional (and, I hope, future) roles as teacher and advisor.

This chapter will attempt to move the physician beyond the boundaries of conventional health vocabulary and to stimulate an awareness of what is going on in the patient's world. It will also suggest ways in which the physician can participate in community-wide health promotion efforts. Essential to this latter activity will be a look at potential allies and blockers of health promotion coalitions.

WHO ARE THE BLOCKERS?

The major myth of health promotion is that everyone favors it, like motherhood and apple pie. In fact, there are both soft-spoken and vociferous opponents of health promotion

throughout society. If health promotion is perceived as do-gooding by the public, then it will not receive very much meaningful support. If it is safe, easy, nonthreatening health promotion, the public will pay it lip service. The socially acceptable, albeit heretofore largely ineffective, voice of health promotion is the imperative ("Get your blood pressure taken!" "Don't smoke!" "Buckle up!") not unlike the authoritarian, motherly commands each child grows up hearing ("Eat your spinach!" "Drink your milk!" "Wear your galoshes!").

There is a more ominous side to health promotion when one considers the segment of the public whose profit and self-interest depend on the encouragement of risk-taking, health-demoting behavior. As White[9] points out: "Life-style modification, if it is to be successful, will adversely affect the pharmaceutical industry, the tobacco industry, the alcohol-products industry, the food-products industry, and the automobile industry." I would add the insurance and hospital industries as well as the news media, the latter through loss of advertising revenue.

One other set of blockers within the health field itself deserves mention: the new breed of mostly well-meaning faddists who have skewed health promotion (via bestsellers and talk show appearances) toward a largely profit-oriented, upper middle class, suburban value system: the stereo-earphoned-jogging, beansprout-growing, megavitamin-munching, health-food-hawking, wellness seminar set. Implicit in this movement is an idea that one must pay to gain good health, usually through special secret dietary regimens named after one doctor or another. Often the word "holistic"[10] is used, as if to suggest that conventional medicine in no way reflects an outlook of the total person. Now that doctors are free to advertise without fear of disapprobation, the terms "family care," "nutrition," and "holistic" are cropping up in advertisements in the Yellow Pages and in newspapers.

To see just how much of a challenge lies ahead, one has only to visit the employee cafeteria at any work place—even hospitals—during a coffee break or lunch time. All the elitist talk of wellness obviously hasn't reached the common man, who smokes three or four cigarettes and drinks three or four cups of coffee in lieu of going outside for some fresh air. Gray[11] postulates that the failure of preventive medicine lies in the inability of health promoters to communicate linguistically with the very working class populations who most would benefit from lifestyle changes. Sociologically, he adds, "it may be that preventive medicine fails because it is projected by the middle class and is therefore rejected by the working class."

Certain aspects of health promotion are far easier to design and implement than others. Worden[12] called attention to "popular and unpopular prevention." Tackling illicit drug use among teenagers is popular prevention, as are jogging, fun runs, and stress seminars. In other words, who would possibly oppose them? There is no one in society overtly urging us to use LSD, angel dust, or marijuana, unless we want to make too much out of rock music lyrics, or articles in *Rolling Stone* or *Playboy*. No one is telling us *not* to exercise—apart from television's wanting us to sit in front of the set to watch athletic competitions and cheerleaders rather than participate in sports. Jogging threatens no one with lost sales. Rather, it creates a market for expensive running shoes and designer warm-up suits. Similarly, no one is urging us in so many words *not* to eat low-cholesterol foods—although through advertising, hamburger and other fast food chains try very hard to make sure our children will eat their products, which generally contain high levels of cholesterol, calories, and salt. Certainly, no one is telling us *not* to get our blood pressure taken. People who haven't the slightest idea what blood pressure is but who become scared will generate revenue for hospitals, doctors, and manufacturers of antihypertensive medication, not to mention the inventors of shopping center blood pressure machines. The more prudent approach to counteracting hypertension—the limiting of salt in the diet—has not been attempted on a societal basis, perhaps because that would move into the realm of unpopular

prevention. In other words, would a major health promotion effort to limit salt in processed foods meet with support of the food industry or their principal beneficiaries, the mass media?

It is not difficult to figure out other examples of unpopular prevention. "One of the first duties of the physician," wrote Osler, "is to educate the masses not to take medicine." Discouraging the use of over-the-counter drugs for every symptom would be considered by the pharmaceutical industry a very unpopular form of prevention. Yet, as Worden points out, such consumer safety education would remind us that we are all drug consumers living in a culture saturated with drugs, not merely a narrow band of exotic illicit drugs.[12]

Cigarette smoking and alcohol consumption are responsible for many more preventable deaths than any other risk factors, yet efforts to curtail them are regarded as moralistic. As the most powerful advertisers, the tobacco and liquor industries effectively prevent prevention efforts from ever starting. The Advertising Council, described in *Charity USA*[13] as the "do-good non-profit arm" of the advertising industry, "places about $600 million worth of advertising annually for causes ranging from the prevention of forest fires to the promotion of the sales of Savings Bonds" but has never touched America's number one preventable cause of poor health and high medical costs—cigarette smoking. In short, 30 years after the first conclusive evidence showing the relationship between cigarette smoking to lung cancer—now the leading cause of cancer death in men and, by 1983, likely also to be in women—the tobacco industry spends $1 billion each year to promote the brand-name imagery of sophistication, beauty, machismo, and athletic prowess, while the federal government under the Carter administration spent less than $400,000 to counteract smoking and is budgeted for even less under the current administration. Was it appropriate for the American Medical Association to agree at the time of the release of the *Surgeon General's Report on Smoking* in 1964 to accept $10 million from the tobacco industry to study the relationship between smoking and health for another 15 years? In all but a handful of state legislatures, the industry has been successful in killing legislation restricting smoking. One false assumption on the part of lawmakers and the public alike is that tax revenues are beneficial. In fact, expenditures for the care of those with cigarette-related diseases are several times greater than tax monies.[14] While the Seagram's company urges readers of the *Wall Street Journal* to "know your own limit" each Christmas and New Year's Eve, its advertising throughout the rest of the year suggests that the alcohol products it manufactures are part of social success and good times. Liquor store chains work hard to kill legislation to raise the drinking age.[15] It is only when a drunken driver runs over a child that public outrage flares. Even then, most governmental fiscal allocations go to finance alcohol rehabilitation centers, as if society has given up on getting drunks off the road or preventing abuse of alcohol to begin with.

HEALTH PROMOTION IN THE SOCIETAL CONTEXT

The first essential component of a true health promotion effort is communicating a sense of proportion of the major killers of our society. One can choose a popular or "safe" aspect in which to get involved—from cracking down on marijuana sales to television violence abatement—but one should know the relative numbers of people affected by each problem. The five leading causes of death are cardiovascular disease, cancer, violence (accidental or otherwise), respiratory disorders, and digestive diseases. In terms of preventable risk factors related to most of these conditions, cigarette smoking and alcohol abuse stand out. Lest one so easily believe that the public "has heard it all before," consider the outcry by chain-smoking workers over "cancer-causing chemicals" in the workplace or indignant, cigarette-puffing parents furious over learning that there may be small concentrations of asbestos in the insulation of school classrooms (see Chap. 2).

One way to confront the opposition to health promotion and to win greater acceptance for it among the public is to define the basis for it. Health promotion applies all that we have learned in medicine to prevent the next generation from falling into the same traps we did. The basis of health promotion lies in the primary prevention of illness. Rewarding and exciting health promotion efforts can be geared to elderly and middle-aged populations, but the most socially beneficial efforts will aim at children and adolescents.

Far from being ineffective, health promotion can be successful out of proportion to the effort put in—if it is done with clear objectives. Most health promotion efforts fail, but so do most advertising campaigns for new products. In trying to explain why seat belt safety campaigns have failed, why the prevalence of drug abuse seems to have risen among teenagers, and why cigarette smoking has dramatically increased among teenage girls and women in spite of all the health warnings, apologists within the health field say such things as, "That's human nature," "People are always going to take risks," or, worst of all, "It's their lives, and we can't interfere with people's personal lifestyles."

PROMOTING HEALTH PROMOTION

Clearly, physicians need to turn to other fields in order to respond to the detractors of health promotion. I suggest subscribing to *Advertising Age,* the *Journal of Advertising Research,* the *Harvard Business Review, Consumer Reports, FDA Consumer,* and the *Wall Street Journal,* through which one can learn how business goes about selling its ideas to the public. It doesn't take much studying to realize that seat belt safety campaigns have failed[16] because they haven't been sold correctly. The problem is, public service campaigns are not truly designed to succeed in improving public lifestyles, but rather to show how clever the advertising agency is before it moves on to its next public service campaign. Public service announcements, the freebie, *sine qua non* of do-good health promotion efforts, are not run frequently or at predictable times, unlike those advertisements for which one pays. To put it in other words, were there one ad for seat belt use for every ten automobile ads and using celebrities, the message would get across more memorably. But while frequency of advertisements is important, a *comparable* number of ads (to the promoted adverse health behavior) probably isn't necessary. The major reason that cigarette advertising is no longer on television is because of the very success of the health promotion counteradvertising effort in 1967–1970. Government-mandated counteradvertising that ran in only a tiny fraction of the time allotted to cigarette commercials was successful in cutting the expected sales of cigarettes by upward of 30% in three years.[17] It was the cigarette companies who couldn't stand the heat of competition of health promotion. They pulled their own ads off the air—over the objections of the broadcasters—in order to see the number of mandated counteradvertisements vanish. In the decade since cigarette advertisements have been off television, teenage smoking has risen because of the successful, unopposed advertising campaigns in the printed media, retail stores, billboards, sporting events, jazz festivals, etc.[18]

One can only conclude that the leading health educator—by virtue of its appeal to consumers to buy filtered, low tar brands (and, by implication, safer brands)—is the cigarette industry. It has been described as "selling death"[19] in the guise of safety. A brilliant counteradvertisement of Britain's Health Education Council suggests that switching to a low-tar cigarette is "like jumping from the 36th floor instead of the 39th."

Consumer Values and Perceptions

How does this industry succeed so well? Perhaps because it cares enough about the consumers of its product to study them. It hires the best psychologists, the cleverest advertising people, and the top media experts. It aims at everyone in order to reach the highest possible market share of consumers.

Thus, while the Marlboro man looms menacingly over our highways, we in the health field—not to mention parents, teachers, and counselors—are regarded as the real authority figures! I believe this is due to our naivete and our inability to let go of a staid, self-legitimizing health vocabulary. The folks on Madison Avenue are constantly creating new images and combinations of words with which to sell products. While absurd claims are made for the advantages of one medication over another, health professionals are asked to provide more "proof" that smoking (or anything else involving a profitable commodity) is really harmful. Health professionals must begin thinking in a brand name world. Patients don't smoke 800 degrees worth of hot, foul-smelling, overpriced, chemical-laden tobacco and paper. They proudly purchase Marlboros. They *are* Marlboro cowboys. What truck driver smokes Virginia Slims? Yet is the latter brand any less lethal?

The first step for the physician who wants to deal effectively with the problem of cigarette smoking (as a metaphor for all preventable health problems) is to set aside the mumbo jumbo lingo of pack-year histories and to begin studying the brand name imagery of consumer cigarette advertising. We need to examine the symbolic role of cigarettes in our society and not be misled by assertions that, after all, they relieve tension. In fact, cigarette smoking probably reinforces a stress cycle. Above all, cigarettes are cosmetic products. They're part of our uniform, and people will accord us attention if we use them and act sophisticated. The challenge of health promotion on a one-on-one level is to individualize our approach (a 15-year-old girl can't be spoken to in the same way as a 45-year-old executive) by appealing to the values that most matter to the person.[20] On a community-wide level, we can portray the nonpurchase (and thus money saving) of adverse health products with good looks, sexiness, and popularity—not just some abstract commodity called "good health"—in much the same way as cigarette advertisers do.[21] Good health promotion efforts ought to consider avoiding the term "health" entirely. How does one sell a product to a person who already thinks he has it?

Physicians also need to perceive themselves as just as much victims of advertising as their patients, not only in terms of consumer goods but also pharmaceutical products. Not wishing to be behind the times in our prescribing practices, doctors are just as susceptible as patients to claims of miracle cures. There is a direct correlation between advertising dollars poured into a campaign for a medication and the number of prescriptions written. Although there is widespread concern about the overprescribing of minor tranquilizers, diazepam (Valium) and chlordiazepoxide (Librium) remain high on the list of prescribed drugs, and advertising for them has not diminished. If we've heard all about these drugs from the manufacturer, why do we need to be reminded of them by advertisements in nearly every issue of most major medical journals? As leading sponsors of continuing medical education, drug companies may be inhibiting a health promotion orientation.

A disturbing trend is the advertising of former prescription drugs on television. One pharmaceutical company employs a respected actor, E. G. Marshall, to sell Maalox.

Doctor figures also promote other allegedly health-related products. For instance, Robert Young, long identified with the television role of Dr. Marcus Welby, has been called upon to sell a coffee product in such a way as to suggest that it is healthful. The term "preventive medicine" has even crept into some advertisements for pharmaceutical products, a gross misuse of the English language.

Just as the vocabulary of diagnostic and therapeutic medicine has changed over the years, so the vocabulary of health promotion must keep pace with the changing vernacular. Medicine has a lot to learn from the success of Madison Avenue in selling products.

Costs

The very cornerstone of health promotion is that "it pays to advertise." Health promotion cannot succeed on a large scale until those who support it put their money where their

mouth is, beginning in their own offices. In a survey of 150 South Carolina physicians,[22] most thought the office waiting area a potential place for health education, yet almost no one spent a dime on health education materials. In contrast, most spent in excess of $100 a year on commercial magazine subscriptions.

One of the most widespread myths among health professionals is that the voluntary health agencies are working closely together with the common goal of wiping out such problems as cigarette smoking. In reality, the charities compete for donations and spend only a small amount on health promotion.[23] Although American charities utilize public service time, they generally do not spend money on advertising space. Most charitable fundraising efforts are aimed at attracting support for research, as typified by this advertisement in the obituary pages of the *Chicago Sun-Times:* "End suffering. Give to cancer research." The assumption that physicians need begin their health promotion involvement by volunteering their services to an established health charity is not necessarily true. The health charities originated as a means to help the medical profession allay public anxiety about certain diseases. Many of these charities have become national organizations that coordinate local groups. The best charitable health organizations are those in which local citizens play a greater role than paid staff.

EMPHASIS ON YOUTH

Just as there are no sacred cows in health promotion, so medicine cannot rest on such laurels as the highly publicized drop in cardiovascular mortality over the last 20 years. Mortality figures for 1980 show heart disease to be *increasing,*[24] and women who have been led to believe they've come a long way will be disappointed as their heart disease levels rise. It is not enough to see more people jogging and buying nutritious foods. What is needed is an emphasis on the primary prevention of illness among young people. One of the first pitfalls the health professional falls into is assuming that schools are the best way to reach children and that school boards are all in favor of greater involvement by health professionals. In fact, those who attempt to introduce health promotion into schools often meet resistance.

A more basic problem is that students may well prefer not to be in school, and lectures on health promotion may work in the opposite way from that which is intended. Those who wish to become involved in health promotion should be mindful of the four hours of television the average child watches each day, as well as the two hours of radio he listens to. Health promotion should not regard the student as a passive recipient of health knowledge. Rather, it should involve students in the design of the programs themselves. Too much of health education in schools emphasizes statistics, graphs, and pathology slides. Too little involves the students' contributions.

The one-time presence of a health professional in a school classroom may be little more than a novelty. Physicians should consider *adopting* a class rather than giving an annual talk on venereal diseases, drugs, or any other specific subject. The physician should be available to answer a variety of questions; he can still gear his answers around the material he otherwise would have presented in a lecture, but the effect is one of dialogue. Why, after all, does the physician wish to get involved in school health education? Is it to earn respect in the community and build his practice? Or is it really to go about changing an unhealthy situation?

Teachers themselves *have* been successful with children up to the sixth grade in conveying the dangers of adverse health habits. One would be hard-pressed to find a 10-year-old who doesn't react negatively to cigarette smoking or alcohol abuse. The problem begins, however, among junior high school age children, prime targets of Madison Avenue. This is the best age for physicians to fill the gap, as health education classes diminish.

Twelve-year-olds no longer memorize the commercials for sugared cereals or toys as do their younger brothers and sisters. Instead, they know every word and every superstar in

the commercials for Miller Lite beer or Skoal smokeless tobacco. Because physicians may have less exposure to commercial advertising, they may think it is designed only to sell products. To the contrary, advertising is meant just as much to socialize young people to look forward to using a product or to pretend to use it, e.g., candy cigarettes or, lately, bubble gum chewing tobacco and bubble gum snuff. In addition, advertising aims at nonusers of the product in order to make them complacent about the product and the way in which it is advertised. Tampon ads, for instance, were not permitted on television until recent years. The purpose of such advertising, which obviously isn't designed to sell to every viewer, is to desensitize the public. Naturally, advertising also always offers something positive—often the antithesis of the product itself. It creates an awareness of a problem or insecurity we might not even know we have! And above all, advertising usually offers at least one of the three most important priorities in our society: looks, sex, and money.

Accordingly, the first step toward successful school health promotion on the part of the clinician is to become knowledgeable as to what is going on in the students' world. He should listen to rock radio stations, watch television, read teen-oriented magazines, visit record stores, and attend after-school sports practices or pinball matches. Above all, it is essential to pay attention to the advertising imagery as much as to the song lyrics or other fads. The next step is to bring this imagery to the classroom, in the form of slides, tapes, and magazines (high-school age boys' favorite magazine isn't *Boys' Life;* rather, I've found, it's a toss-up between *Playboy* and *Sports Illustrated*).

Problem Orientation

The health professional's first inclination is to be problem-oriented in the approach to school children. That is, if the objective is to discourage smoking or drug abuse, the temptation is to show pathologic slides. Such a unidimensional scare tactic has only a limited effect. The most sobering pictures become abstract and less meaningful as time goes on. Fear of death or disease should not be the first choice of appeal to those who have little concept of vulnerability. The physician's world should be brought into the classroom as part of health promotion, but it can more easily succeed if done by juxtaposing advertising imagery to reality. Thumbing through a copy of *Sports Illustrated* and pointing out how photographs of athletes are placed opposite ads for cigarettes and alcohol products allows students to see the hypocrisy first-hand. Ridicule is also a powerful motivator, as can be seen in classroom games in which students are asked to parody advertising campaigns for harmful products. The use of advertising imagery demands a suspension of belief in the phrase "peer pressure." This is a jargon term that has somehow been retained in our vocabulary, like "pack-year history." Peer pressure can be bought, signed, sealed, and delivered on Madison Avenue, as any candy or toy maker or rock music impressario will corroborate.

Parents

A second myth to discard is that parental modeling is responsible for most of teenagers' adverse lifestyles. Parents are not much more savvy—and in many instances far less so—about the origins of their own belief systems than are students. To gain the advocacy of parents and allay anxieties in a blame-oriented society, health promoters need to look at the origins of problems rather than join the panic over the end result. Parental concerns revolve around drug abuse, a serious problem but one that does not exist in a vacuum. Drug abuse is promoted in our society, be it by the rock music industry or by advertisers in publications teenagers read. Risk taking of all kinds is actively promoted and undermines parental prerogatives. In order to show how drug abuse is promoted, health promoters need to point to the encouragement of drug use by people of all ages.

When asked about his smoking marijuana, the teenager may be copping out by mentioning his parents' smoking or taking tranquilizers, but he is absolutely correct. Until adults

acknowledge their own hypocrisy, they will not succeed at preventing drug abuse among teenagers. For parents to be content that their children are dipping snuff because at least they're not smoking—or smoking cigarettes because "it's not marijuana"—is shameful. Going after drug paraphernalia "head shops" is a valid objective, but the tendency may be to blame the paraphernalia or the marijuana while overlooking the overt appeals of more socially acceptable advertisers to take risks.[25-29] The cigarette, alcohol, and motorcycle industries represent a far greater organized threat to teenagers, but because they are so obvious, we practically ignore them.

A Carry Nation prohibitionist reaction will not work in the 1980s. What may work is the economic boycott. In 1978 a group of nurses in Virginia, aghast over the test market promotion in their state of Chelsea, a beverage that was packaged like beer and contained a small amount of alcohol but was advertised to teenagers, informed store owners that they would not buy any products in stores that carried Chelsea. The product was pulled from the shelves, never to return. In essence, parents, teachers, school administrators, and students all need to be educated about the origins of drug abuse and the proper proportions of the killer habits. Physicians must learn the difference between popular and unpopular prevention and not take the easy route. The bottom line is to treat the public as fellow consumers, not patients, and to speak in consumer-oriented, everyday language, not in medicalese.

In our highly sophisticated medical world, we spend hours each year discussing such entities as juvenile rheumatoid arthritis and juvenile onset diabetes, tragic illnesses which affect a mercifully small percentage of the population. Meanwhile, we shrug our shoulders at what I would call "juvenile onset drug abuse, alcohol consumption, and cigarette smoking," problems to which 100% of adolescents are susceptible after years of socialization in the media.

An especially effective means of talking to parent groups as well as students is to use advertising taped off the television and radio and cut from magazines and newspapers. A discussion of nutrition can get very dull, indeed, unless it is pointed out how our very concepts of nutrition are being confused by advertising. Several snack food makers, for instance, are beginning to appeal to parents by coopting the words "vitamin-packed," "nutritious," or "healthy."[30] Hostess cupcakes advertisements feature a concerned mother who chooses only this "nutritious" product for her children's snacks. Fritos corn chips actually includes a listing of nutrients, along with comparisons indicating that one bag equals a cup of milk in calories and to two slices of bread in salt! Soda companies are appearing more frequently at school board hearings to urge retention of vending machines. They are also increasingly sponsoring high-school sporting events, as breweries are stepping up their sponsorship of college sports. In getting across an appropriate message of moderation, the health promoter should not deny permission to use a product. Cokes and MacDonald hamburgers are *fine* at a baseball game, but *not* a dozen times a week, as all too many teenagers are doing.

School

School has not been an especially creative environment for health education. Fortunately, more emphasis on values and decision making is entering curricula. Not all decisions advertisers ask adolescents to make concern risk-taking behavior. But it is fascinating to see how the advertising of one product plays on that of another. Cheryl Teigs, whose image has appeared in advertisements for Virginia Slims cigarettes for years, now advertises various brands of cosmetics in publications aimed at teenagers and preteenagers. Xerox urges advertisers to sell lipstick and other cosmetics in its Student Group magazines with the slogan: "Not all 12 year olds do their coloring on paper." *Teenbeat* magazine for young girls tells its advertisers: "Get 'em while they're young . . . when they're forming buying habits now . . . at the tender ages of 12, 13, 14, and 15." The editorial content of the maga-

zine, squeezed between upward of 30 pages of cosmetic advertising, is geared to just two values: looks and hero worship. There is almost never anything that offers teenagers ways to become involved in their communities and to have positive accomplishments outside of school. Thus teenagers may not be willing allies in the effort to promote health in the community because they don't really understand what it is. Asked whether they ever did any volunteer work after school, a group of Miami teenagers responded, "What's that?" Such social retardation, which may be the result of so few incentives for meaningful community service, is at least as disturbing as the well-publicized waning of literary and mathematical skills. Adolescents have had their social value system, not to mention the English language, "preempted" by the narcissistic words and images "brought to you by" Madison Avenue. A key to turning around the bad situation is not just to listen to the complaints of adolescents, but also to challenge them to get involved in local coalitions of teachers, physicians, ministers, and businesspersons that are open minded and gutsy enough to tackle problems at their site of origin and not merely at the more visible end stages—in short, health promotion of the community at large is the difference between do-gooding and really doing well. Do the alcohol, cigarette, and motorcycle industries go to high-school assemblies once a year to pass out pamphlets on the dangers of *not* drinking, smoking, and driving? To the contrary, they are there right outside of school on billboards, in magazines in the school library, on televised sports events and other youth-oriented activities, and on popular giveaway items from t-shirts to Frisbees.[31] The processed food industry has actually hired dieticians to give one side of nutrition in schools.[32] Unlike medical science, advertising science has long since discovered the difference between do-gooding and really doing well in the communities it is called upon to "serve."

In spite of generating enthusiasm and imagination, health promotion advocates may harm their own cause if they fall into one or another frequent traps. One such pitfall is what Wardon calls the "definition of a failing program," namely, the upright but wrong-headed attitude that "if we only save one person from drug abuse, it will be worthwhile." At the other extreme is the academic emphasis on measuring effectiveness of a health promotion effort. Making school-based (or inclusive, as part of community-wide efforts) health promotion as effective as possible is a commendable ideal,[33] but one that can easily detract from the implementation of many programs. At every stage in health promotion programs, proponents are asked to prove the effectiveness of the effort. Too much of health promotion is devoted to the measurement of short-term behavioral change. Rather than suggest that a given series of health promotion activities prevented the onset of adverse lifestyles, proponents should point to the number of students who continue to become involved in the ongoing health promotion effort. A failed program is one that does not spark continued attention and participation but serves only to justify the existence of a grant or the guilt-ridden need to "do something, anything." The way to succeed with children is not only to go to schools but also to work with them in the community in such a way as to make them feel important and worthwhile. To supplement a "rap" on drug abuse or cigarette smoking, the physician might invite students to the hospital or office to see casualties first hand. To this end, the prescient physician will also attempt to create an enjoyable, challenging, educational environment in the health care setting.

THE MEDICAL ENCOUNTER

The Physician's Office

In what way has the physician created a health-promoting atmosphere in the office? Is the waiting room airy and well lighted? Is the furniture fluffy and chic, or does it provide good back support? Does the receptionist or nurse smoke? Is the patient always greeted by name and with a reassuring smile? Has the physician

personally read and selected the health education materials he makes available to patients? Is the guiding force behind the design and decor of the office a practice management course instructor, an interior decorator, or the health-conscious physician? Are the latest news and fashion magazines displayed, or has the physician chosen those publications that promote healthful lifestyles? *Runner's World,* boasting of its refusal to accept cigarette advertising, has encouraged physicians to subscribe specifically in order to supplement the health education of patients in the waiting room. On the other hand, *Better Homes & Gardens,* which accepts between 15–20 full-page color cigarette advertisements in each issue, has attempted to portray itself as a health-oriented publication ideally suited to the physician's office and has a special discount subscription price for physicians. Asked to explain the contradiction, *BH & G*'s publisher wrote to me that he hopes "those people who do not smoke will turn past the cigarette ads." The physician loses a golden opportunity to create a healthful environment by not scrutinizing such magazines for their misleading and antihealth advertising. Canceling subscriptions to such publications—informing the publisher of the reason—might set the ball rolling toward change in publishing policy. On the other hand, clipping and displaying the misleading ads for all patients to see, or stamping across each antihealth advertisement something like "THIS AD IS A RIP-OFF," might enhance an office waiting room positive health strategy.

Sources of Health Information

An overlooked area of history taking is inquiring about the patient's ongoing sources of health information. During my medical training, which included caring for people from a broad range of socioeconomic levels, I was amazed at how many people turned to the *National Enquirer* each week. Rather than laugh at this or shrug it off as intellectually demeaning, I began reading it to keep ahead of my patients! The *Enquirer* has a circulation of over 5 million. Moreover, it is not just about macabre stories of slayings and psychics. As much as 50% of some issues is given over to articles on health. Obviously, it is a principal source of information about self-improvement, as is a similar publication, the *Star.*

Unfortunately, the formula for the articles is simple and predictable: an imminent breakthrough, a medical conspiracy to keep a wonder drug from the public, a crash diet, or simply the promise of living to be 100. "Exclusive—World's Top Cancer Doctors Say . . . WE'RE WINNING THE WAR AGAINST CANCER—Exciting New Breakthroughs Will Save Millions"; "Top University Study Reveals DRINKING IS GOOD FOR YOU"; "Doctors Claim Amazing Diet Pill Will Let You Lose Weight & . . . LIVE UP TO 20 YEARS LONGER"; "Top Heart Specialists Reveal Easy Plan to . . . CUT YOUR RISK OF HEART DISEASE IN HALF"; "Thousands of Greedy Doctors and Druggists Dispense Dangerous Pills to Drug Abusers"; "Scientists Develop Superdrug to Cure All Diseases—Safely." As if these distortions aren't disturbing enough, most of the color advertising pages are for cigarettes. The rare editorial content that deals with smoking will almost invariably tout a breakthrough in treatment or cure, except for nutritional preventive measures such as eating carrots to prevent lung cancer.

Far from ignoring the *Enquirer,* the physician would do well to study it and similar publications in order to observe how deception is foisted on the public in the service of advertisers' interests. It would be easy to suggest that physicians not cooperate with such sensational magazines. Most already don't. But once an article has been published in a medical journal, there is free domain to take conclusions and implications out of context. Even the California Medical Association used to prepare a regular health column for the *Enquirer!*

Time, Newsweek, and *U.S. News and World Report,* at least one of which is bound to be present in the physician's office, contain anywhere from 5 to 15 pages of cigarette advertising per issue (or 30–60 percent of advertising revenue) and a similar number of alcohol ads.

Since its inception in the early seventies, *Ms* magazine, which purports to be an advocate for women, has run hundreds of pages of cigarette advertising but not a single story dealing with this major killer of women. Perhaps the biggest offender of all is the publisher of *Ebony* and *Jet.* Notwithstanding the devastating toll taken by cigarette- and alcohol-related disease in the black community, the most advertised products in these publications are cigarettes and liquor. Discussions of questionable health practices also abound in many of the so-called consumer publications, and physicians should collect and scrutinize such publications as well as the best-selling "health" books.

The physician's media watch must center on the local media, and the physician should become an active letter writer, to the publisher as well as the editor. Although it would seem that these opinion makers would be natural allies of physicians in the effort to curb health costs and improve community well-being, the sad economic reality is that advertising revenues can create rationalizations for *not* helping out.

Newspapers are masters at the art of popular prevention. They even lead campaigns to halt the dumping of toxic chemicals or to discourage the use of cocaine or marijuana (e.g., series entitled "Marijuana and Your Child," *Chicago Sun-Times,* March 1981) and will certainly run an annual editorial warning of the dangers of cigarette smoking or drunken driving. But *too many* such editorials and investigative reports just might succeed in reducing the consumption of these legitimate big business products that provide lucrative advertising income. There is an excellent opportunity for those who have an interest in community-wide health promotion to point out the disparity between coverage of lesser (but more sensational) causes of death and disease and that of the leading causes. Adolescents are bound to pick up on the hypocrisy of editorials against drug abuse (or high medical costs) while full-page cigarette advertisements run in the sports pages, fashion section, and even the comic page.[34] The *Miami Herald,* which would not accept an advertisement from a physician-led organization challenging a full-page advertisement of the tobacco industry that opposed a clean indoor air ordinance, even accepted an advertisement for a solid gold Quaalude pendant.[35]

Pharmacies that sell alcohol products and cigarettes represent the ultimate hypocrisy.[36] Would a community condone a dentist who dispensed soda, rock candy, and lollipops or a physician who kept a soda machine and beer cooler in the waiting room? A true health care coalition must expect pharmacists to adhere to their self-proclaimed health care role and scrutinize the products they sell. In order for pharmacists to be respected and reimbursed for the dispensing of knowledge and not just of merchandise (including such harmful products as cigarettes, diet "aids," and nasal sprays), a societal reevaluation of the role of the pharmacist is essential. Similarly, the sponsorship of local "health fairs" by drug store chains, often misconstrued to be an outstanding example of health promotion, ought to be looked at more closely. The encouragement of low-cost screening tests appears on the surface to be a good means of identifying persons at risk for disease. A somewhat cynical but not unrealistic view suggests, however, that health fairs tend to attract hypochondriacal (and predominantly elderly) persons who already are receiving medical care. In addition to undermining the role of the personal physician, health fairs may serve to increase the sale of medications and the utilization of medical services. Only ongoing screening programs held in conjunction with county public health departments deserve credibility.

THE WORKPLACE

Industry

Brailey has pointed out that "the logical setting for health-promotion programs is the workplace, where a large segment of the population can be reached on any working day."[37] Community-wide health promotion efforts need to include on-the-job programs. Without promising miracles in reversing adverse life-

styles, proponents can reasonably propose to employers that greater time devoted to health promotion at the workplace may, if done engagingly and nonthreateningly enough, succeed in boosting morale, if not productivity and lowered health costs. The linguistic and sociologic gap between the health-promotion–management coalition and employees is, as Gray[11] noted, the biggest obstacle to success. Inviting a dietician to lecture blue collar workers about nutrition cannot possibly succeed in enhancing employee enthusiasm for healthier eating *unless* the subject can be talked about under a title such as "How to Cut Your Food Bill in Half!" Asking steelworkers to come to a lecture on "How to Quit Smoking" may only raise masculine resistance to "being a quitter." On the other hand, using the social support system of those employees who do not smoke cigarettes may engage the interest of even inveterate smokers. Specifically, were the employer encouraged by local physicians to offer employees cash incentives to all employees who do not smoke, on the basis of the higher health cost and absentee rate of smokers, then the employee would better associate good health habits with financial income.

Unfortunately, although State Mutual Life Assurance Company of Worcester, Massachusetts and a relative handful of life insurance companies have successfully pioneered in offering life insurance to nonsmokers at lower than standard rates,[38] Blue Cross and the rest of the *health* insurance (and fire insurance) industry have been noticeably inactive in this regard.[38] One obstacle is assuredly workers' perception of victim blaming. Bent upon blaming management for laxity in controlling workers' exposure to chemicals or other dangers, unions are refusing to acknowledge the slightest contribution of the individual's own adverse lifestyle. A group of Florida postal workers walked off the job upon learning that asbestos insulation had been used in the building for 20 years. The fact that most smoked cigarettes—a far greater cause of lung disability—did not deter them from suing the Post Office. Equally wrong, management—in an effort to avoid litigation—is trying to focus all blame on smoking and other lifestyle problems. Physician health promoters can play a valuable role in the coming years by serving as intermediaries who call attention to the responsibility of both sides to enhance the health of the working population and their families. Similar techniques to those used in the classroom—especially pointing out the self-destructive lifestyles promoted by Madison Avenue—can be equally compelling at the workplace.

Hospitals

One of the most disappointing working environments is the hospital, whose employees do not seem to be any more mindful of positive lifestyles than employees at any other place of work. We certainly would not tolerate a nurse sitting at her station sipping a bourbon and water, but we blithely ignore the equally demoralizing behavior of cigarette smoking. The Joint Hospital Accreditation Commission has not even responded to the issue of fire prevention (the leading cause of hospital fires is cigarette smoking) other than to issue recommendations to contain fires and install smoke detectors. Hospital gift shops, especially in Veterans Administration medical centers, still profit from the sale of cigarettes. If places of health cannot set a better example for the community, then there is little hope for the success of health promotion.

The fault is that of hospital administrators and physicians who are too busy with their day-to-day revenue-generating business to create a more positive health environment. By and large, hospital administrators work to keep beds filled, not empty. Few hospitals have advertised to the community in a concerted, ongoing campaign about the tenets of good health. One Louisiana hospital has made a token purchase of billboards in order to encourage immunization,[39] but by and large hospital advertising aims only to give itself credit for having available the latest CAT scanners and cardiovascular testing equipment. In short, hospitals are doing a lot of talking about health

care (and disease care) but not health promotion.[40] Hospital administrators urgently need to abandon tokenistic "National Good Health Week" type efforts and begin promoting health on a year-round basis.

MEDICAL ORGANIZATIONS

Nor can medical associations go unchallenged as self-proclaimed health promotion advocates. To its credit, the American Medical Association has paid for such advertising messages as "Seven Good Habits Your Doctor Wishes You Had." But where has it placed the ads? In the *Wall Street Journal* and *New York Times,* apparently in an effort to impress those who control business and the media, as well as legislators. The day the AMA purchases advertising time on children's and teenagers' programs will mark a significant breakthrough in health promotion. Local medical associations and auxiliaries have sponsored Tel-Med, a phone-in service that offers two-minute tape recorded messages on a variety of topics. But those motivated enough to call such a service—or write for a brochure—may not be the ones most in need of information. Outreach programs must expand. There is still a long way to go toward ending the telethon mentality of our society, wherein we believe that giving money for research will solve all our ills sooner or later.

There is an urgent need for medical associations to narrow the gap between the vast amount of scientific knowledge physicians have accumulated and the simple, basic information about which the public still hasn't learned. Above all lies the challenge of overcoming the braggadocio attitude of risk-taking individuals, who say "You gotta die of something" or "Everything causes cancer." Exploding myths of cancer means educating the public to understand the proportionate known causes of cancer and the fact that cancer is not a single disease but more than 100 diseases, some of which are totally preventable or curable. Similar effort is needed in explaining hypertension, diabetes, and other complicated diseases made all too fearsome by the media.

LEGISLATION

The reader might think that this chapter has led up to a call for more legislative responsiveness on the part of lawmakers. Unfortunately, legislators seem more responsive to professional lobbyists than to grassroots organizations. A more subtle problem exists. "Politicians are slow and unwilling to act because they represent the people and reflect the public's unwillingness to accept such legislation as that on random breath-testing, on restrictions on advertising, or on increased taxation on tobacco and alcohol."[11] In other words, we cannot regulate and legislate unless we educate.[41] Otherwise, laws will be perceived solely as restrictive or punitive.

Those groups urging repeal of 55 mph speed laws or motorcycle helmet safety laws[42] are motivated by the conviction that their freedoms are being trampled on. They do not perceive harm as happening to anyone but themselves. Of course, society does pay a major share of health bills for these victims,[43-45] and the same is true for cigarette smoking and other lethal habits. In educating the public that everyone is affected, activist forces seeking the enactment of legislation can help their cause through mass media advertising. Two of the most successful public health measures—mandatory preschool immunization[46] and (in Germany and Sweden) revocation of driver's licenses after a single conviction for driving while intoxicated—have had extensive advertising campaigns.

In the case of clean indoor air ordinances (most of which have failed), activists have mistakenly aimed first at private enterprise, by calling for no-smoking areas in restaurants, rather than at the public sector. Since airports, taxis, schools, and transit stations are tax-supported, the activist physician health promoters can campaign to withhold federal, state, and

local funding from airports and the like that do not provide a healthful environment for children. If such legislative efforts fall short, there can always be the power of the economic boycott.

MEDICAL ACTIVISM: THE DOC MODEL

The pinnacle of health promotion, then, is organization. In addition to drawing on a wide diversity of occupational groups, health promotion organizers should mobilize the broadest possible range of ages and ethnic groups. A coalition of teenagers and the elderly, for instance, serves the additional purpose of fostering respect and understanding.

As for groups primarily composed of physicians, the legacy of the 1960s has led to the formation of more vocal and demanding, issues-oriented (as opposed to economically self-interested or mere resolution-passing) organizations such as Physicians for Social Responsibility, a group trying to prevent the outbreak of nuclear war, and Physicians for Automotive Safety.[47-49]

Another notable example of the physician's role as community activist and health promotion advocate is represented by DOC (Doctors Ought to Care),[50] a coalition of health professionals, students of all ages, and other concerned citizens founded in Miami in 1977. Now present in 40 communities around the country, DOC aims to put its money where its mouth is by *purchasing* advertising space with which to oppose the promotion of cigarette smoking, alcohol and drug abuse, poor nutrition, and unsafe driving—problems especially prevalent among teenagers. But the twist to DOC's approach is that it doesn't compartmentalize health problems; rather, it looks at adverse lifestyles as a continuum and proportionately emphasizes the major problems in its campaigns. The basic method behind the advertising is borrowed from the beloved, irreverent *Mad* magazine, namely, satire, ridicule, and parody that appeal to children and teenagers. One of DOC's themes is, "You've coughed up long enough, baby!" DOC advertises a new brand of beer called "Killin' Time" and a whiskey called "Cutty Sank," which features the slogan, "People Like Ships Sail Better When They're Not Loaded." Another advertisement encourages the nursing of infants: "Take Your Baby to the Breastaurant—Home Made, Not Store Bought." Two of DOC's cigarette brands are "Golden Phlegms" and "Arctic Lungs"—"Guaranteed to Make You Cool as a Corpse." Through the sale of its posters and t-shirts, DOC can finance other advertising.

DOC aims to tap the highest possible level of commitment of every health professional to health promotion, be it in the office with an improved health strategy or in the community at large. It is also working with parents, teachers, hospital personnel, business leaders, workers, and, above all, teenagers themselves to help design the programs aimed at adolescents. The theme "SuperHealth 2000" was chosen with the goal of having every American child "leap tall buildings at a single bound" by the year 2000—the buildings on Madison Avenue that send forth antihealth propaganda in the interest of commercialism.

Although individual DOC groups are free to become involved in any activities of their choosing, the unifying use of a common name makes for greater visibility and influence. In addition to producing commercials for television and radio, DOC purchases bus bench advertising (an excellent, inexpensive local publicity medium) and tried—with no uncertain resistance on the part of the outdoor advertising companies—to obtain billboard space. DOC's shining effort has been the organization of a statewide speakers bureau by the South Carolina Family Practice Residents Association. An original DOC radio call-in program in Miami as well as daily television and radio health commentaries (DOC's SuperHealth spot) received national awards from the American Medical Association. DOC's encouragement of high-school and junior high school groups through the sponsorship of student-run conferences and other projects has enabled it to obtain small grants.

Above all, DOC has learned the art of generating memorable and meaningful publicity. More than 100 physicians, medical students, dentists, nurses, podiatrists, and other allied health personnel participated in a series of three "house calls" paid on a cigarette-company-sponsored film festival near a college campus (DOC renamed it the "Benson & Heart Attack Film Series"), a cigarette-company-run tennis tournament (DOC put on its own entitled the "Emphysema Slims Circuit"), and the *Miami Herald* for the purpose of calling attention to the fact that the newspaper circulates 360 million pages of cigarette advertisements in the community it serves each year! DOC maintains active media watch, letter-writing, and guest column efforts. It helps sponsor a rock group, Kirk and Blake, whose original songs include "Emphysema Blues." A DOC comic strip, spoofing advertisements for harmful products and fads, has run in several newspapers (on a paid basis), but most have not permitted it to be published!

DOC is more of a concept than a full-fledged, by-the-book organization. It is a coalition of local groups, with a unifying sense of humor and a sense of purpose, that is trying to uplift local value systems. The beauty of DOC is that its heretical views have been published in legitimate medical journals. Its writings that have appeared in medical journals and daily newspapers have concerned a variety of subjects, including adolescent pregnancy, over-the-counter drugs, noise pollution, motorcycle helmet laws, television advertising and violence, mass transportation, drug abuse, and, above all, cigarette smoking. DOC members have served as consultants to school boards, health systems agencies, hospitals, and local and national television shows, including a special program on water pollution on "Battlestar Gallactica."

The DOC example is a major step forward. It shows that in taking an unabashedly activist role in health promotion, the physician can delight in being a teacher and exemplar instead of some semidivine (and aloof) miracle worker. Miracles have nothing to do with health promotion. What health promotion requires is time, enthusiasm, and faith in people and in oneself. Sadly, it also involves an awareness of the fact that strong vested interests are working to resist any change in the status quo upon which they do not have prior approval. Well-paid legislators, health officials, hospital administrators, businesspersons, physicians, and school officials readily acknowledge (and even employ) the power of commercial advertising to sell people products and services they do not necessarily need. Yet many of these people will actively block efforts to bring health promotion out from the shadows of do-gooding pamphlets and public service announcements in order to fight fire with fire. While pointing indignantly to the ethical implications of "telling people how to behave," they ignore the fact that advertising does it day after day with little self-restraint.

A principal motivating emotion of anyone truly interested in getting involved in health promotion is anger. Seeing how preventable, premature illness is actively promoted in our society, one should respond not unlike the television commentator in the film "Network": "I'm mad as hell, and I'm not going to take it anymore!" One must also be mindful of the great magnitude of preventable health problems—individually and taken as a whole—as well as of the fact that many major health problems are also social problems that demand a concerted effort by a broad coalition. Similarly, many social problems, such as racism, illiteracy, and juvenile crime, need to be better addressed by health professionals. Unless we begin to shift the emphasis away from a research and miracle cure mentality and toward an environment of health promotion and preventive medicine, twentieth century America will most assuredly be looked back upon as that unfortunate time when, for all its technologic marvels, it sold itself to death.

REFERENCES

1. American Medical Association statement to the Dept of Health and Human Services, March 2, 1981, re: Proposed National Guidelines for Health Planning, Federal Register 45-FR 78552, Nov 25, 1980.

2. Fielding JE: Health promotion: A notion in search of a constituency. *Am J Pub Health* 67:1082–1085, 1977.
3. Hackman H: Prevention: The golden myth of American medical care. *Modern Med* (April 15, 1978), 11–41.
4. Freireich EJ: Is cancer prevention better than cure? *JAMA* 242:2783–2784, 1979.
5. Eisenberg L: The perils of prevention: A cautionary note. *N Engl J Med* 297:1230–1232, 1977.
6. Wikler DI: Persuasion and coercion for health: Ethical issues in government efforts to change life-styles. *Millbank Memorial Fund Quart/Health and Society* 56(3):303–336, 1978.
7. Freedman B: The case for medical care, inefficient or not: The ethical costs of preventive medicine. *Hastings Center Report* (April 1977), 31–40.
8. Urich VC: The physician's role in health education and promotion. *Michigan Hosp* 17(1):6–8, 1981.
9. White LS: How to improve the public's health. *N Engl J Med* 293:773–774, 1975.
10. Relman AS: Holistic medicine. *N Engl J Med* 300:312–313, 1979.
11. Gray JAM: The failure of preventive medicine. *Lancet* 2:1338–1339, 1977.
12. Worden M: Popular and unpopular prevention. *J Drug Issues* (summer 1979), 425–433. (NB: *The Journal of Drug Issues* is essential to any library of health promotion materials.)
13. Bakal C: *Charity USA,* New York, New York Times Books, 1979, p. 321.
14. Luce BR, Schweitzer R: Smoking and alcohol abuse: A comparison of the economic consequences. *N Engl J Med* 298:569–571, 1978.
15. "Big Daddy's lobby helps to kill bill on drinking age." *Miami News,* April 17, 1979.
16. "Fatal auto crashes found rising with refusal to use safety belts." *New York Times,* January 11, 1981.
17. Warner KE: The effects of the anti-smoking campaign on cigarette consumption. *Am J Pub Health* 67:645–650, 1977.
18. "Special events add flavor to cigaret wars." *Advertising Age,* December 8, 1980.
19. Whiteside T: *Selling Death,* New York, Liveright, 1971.
20. Blum A: Butting in where it counts. *Hosp Physician* 16(4):22–35, 1980.
21. Blum A: Medicine vs Madison Avenue: Fighting smoke with smoke. *JAMA* 243:739–740, 1980.
22. Unpublished survey by the author, 1979.
23. Medical charities and prevention (editorial). *Br Med J* 1979(2):1610.
24. "U.S. death rate increased 3% in 1980, estimates by Metropolitan Life show." *Wall Street Journal,* March 3, 1981.
25. "Head shop battle raging." *Atlanta Journal,* January 24, 1978.
26. "Children, in test, buy drug trappings freely at 'head shops.' " *New York Times,* March 30, 1978.
27. "Parents declare war on 'head shop' industry." *Chicago Sun-Times,* November 4, 1979.
28. "National parent unit to fight drug abuse." *Miami Herald,* May 9, 1980.
29. Newman SH: "Parents vs marijuana." *New York Times,* June 12, 1980.
30. "High-potency vitamin advertising swings upward." *Advertising Age,* March 12, 1979.
31. Gift-horse with nicotine-stained teeth (editorial). *Lancet* 2:880, 1978.
32. Draper P, Griffiths J, et al: Three types of health education. *Br Med J* 1980(2), 493–495.
33. Rogers, KD: Making school health education effective. *Am J Pub Health* 71:526, 1981.
34. "Newspaper execs' goal: Boost youth readership." *Advertising Age,* January 31, 1977 (newspapers are actively encouraging the use of newspapers in current events and home economics classes).
35. Advertisement in *Miami Herald,* November 25, 1976.
36. Schroeder SA, Showstack JA: Merchandising cigarettes in pharmacies: A San Francisco survey. *Am J Pub Health* 68:494–495, 1978.
37. Brailey AG: The promotion of health through health insurance. *N Engl J Med* 302:51–52, 1980.
38. Cowell MJ, Hirst BL: *Mortality Differences Between Smokers and Non-smokers,* State Mutual Life Assurance Company of America, Worcester, Massachusetts, 1979.
39. Elrod JK: It pays to advertise—even in health care. *Forum Med* 2(8):1082–1085, 1977.

40. Roberts L: Perils of prevention. *N Engl J Med* 298:747, 1978.

41. In this regard, there are few finer documents than that of Lalonde J, *A New Perspective on the Health of Canadians,* Ottawa, Information Canada, 1974.

42. Perkins RJ: Perspective on the public good. *Am J Pub Health* 71:294–295, 1981.

43. Baker SP, Teret SP: Freedom and protection: A balancing of interests, *Am J Pub Health* 71:295–297, 1981.

44. Watson GS, Zador PL, Wilks A: Helmet use, helmet use laws, and motorcycle fatalities. *Am J Pub Health* 71:297–300, 1981.

45. Personal liberty versus common sense (editorial). *Lancet* 2:567–568, 1980.

46. Middaugh JP, Zyla LD: Enforcement of school immunization law in Alaska. *JAMA* 239:2128–2130, 1978.

47. Fleming TC: Activism: A double-edged sword. *Postgrad Med* 68(6):16–18, 1981.

48. Physicians for Social Responsibility, PO Box 144, Watertown, MA 02172.

49. Physicians for Automotive Safety, 50 Union Avenue, Irvington, NJ 07111.

50. DOC, 3942 Willowwood Road, Martinez, GA 30907.