

The Birmingham News

VIEWPOINT:

To cure heart disease, medical community must target prevention

By ALAN BLUM

"Heart disease treatment cost might triple by 2030."

Accustomed to reading health stories in The News about promising medications and advances in diagnostic and therapeutic technology resulting from research at our universities and medical centers, I was struck by this sobering headline in the Jan. 27 edition. Highlighting the urgent need to curb the unhealthy behaviors that cause heart disease, the story quoted an American Heart Association spokeswoman as calling for "early intervention and evidence-based public policies."

A laudable goal, to be sure. But a significant, unspoken obstacle to the success of preventing heart disease is the failure of medical schools and other health professional schools to teach students how to champion lifestyle change for patients and their families in the clinic, classroom and community settings.

The foremost measure to prevent heart disease from happening or heart attacks from recurring is the avoidance of cigarettes. The health and economic toll taken by smoking is devastating: an estimated 300,000 deaths each year from heart disease caused by smoking in the U.S. and as many as 6,000 such deaths in Alabama -- or six times the number of motor vehicle fatalities.

It has taken far too long -- nearly half a century from the publication in 1964 of the surgeon general's report on smoking and health by Alabamian Dr. Luther Terry -- to see a significant decline in the rate of heart disease, though still not the cost of treating it. That's because most of the decline in deaths from heart disease has been the result of secondary prevention -- saving the lives of heart attack victims in high-tech coronary care units and trying through expensive medications and intensive rehabilitation to keep those who have had a heart attack from having another one. Primary prevention, which means never having a heart attack in the first place, has taken a back seat in the medical school curriculum.

For all the lip service paid by academia, health officials, medical societies and health insurers to the importance of curbing smoking and other killer habits, not a single medical school in this country has introduced long-term, continuity-of-care experiences for medical students throughout all four years of training, with the aim of a reduction of lethal lifestyles.

Ending bad health habits takes time, faith, patience and perseverance. Without the trust built on long-term relationships with patients and their families, it is far more difficult for doctors and other health professionals to coach them toward healthier behaviors.

Medical education has evolved into hopping from one separate, specialized area of the hospital to another every month or two, from pediatrics to surgery to obstetrics to psychiatry, which seldom provides an opportunity to get to know patients. And when we really don't know our patients, we tend to compensate by ordering more tests, the cost of which we do not know, either.

Medical students rarely get to see the lasting impact they can have on peoples' lives. They thrive instead on the undeniable thrill of assisting in an operation on a diseased heart, helping run a cardiac resuscitation code in the emergency room, or selecting a blood pressure medication for a patient from among numerous options.

The result is that while graduating medical students can recite the causes, diagnostic tests and treatment strategies for failing hearts and clogged arteries, they are largely devoid of experience in enhancing patients' ability to prevent heart disease by stopping (or never taking up) smoking, losing weight, exercising or even relaxing. Yet, even first-year medical students could have as big an impact on patients' health as their professors

if they were given the chance to acquire and hone the skills of listening to and communicating with patients.

Merely providing a prescription for a well-advertised, high-priced, and only modestly effective medication for smoking (or a nicotine-replacement product that a patient can already buy over the counter) is woefully inadequate when unaccompanied by skilled counseling, which is taught poorly, if at all, in medical school. Small wonder that fully half of patients who smoke say they have not been counseled by their doctors on how to stop.

The same neglect of smoking cessation and prevention is found in continuing medical education courses on heart disease for physicians, as evidenced by the dozens of CME brochures I have received from medical schools across the country in my three decades as a family doctor. In a recent program for a five-day CME course titled "Coronary Atherosclerosis Prevention and Education," hosted by a renowned cardiology department at a medical school in a neighboring state, none of the nearly 40 lectures and workshops was devoted to educating patients on smoking cessation and relapse prevention, or to strategies for tobacco use prevention in the community. In contrast, there were many presentations on diagnostic tests and invasive procedures, which are more technically challenging, intellectually gratifying and remunerative.

For all its public hand-wringing about the tobacco pandemic, the American Heart Association itself is missing in action on smoking in the CME courses it sponsors. And although the AHA has adopted a policy position calling for ending the sale of tobacco products in pharmacies, it continues its long-standing commercial relationship each February with the national drugstore chain Walgreens, a leading seller of cigarettes, for its American Heart Month fund-raising promotion.

Although we should be proud of the technological and pharmaceutical advances that have prolonged the lives of heart-attack survivors, medical schools and other institutions must now devote far greater attention to reducing the development of heart disease in the first place. Considering the prediction of triple the cost of heart disease care in less than 20 years, we really have no other choice.

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