Editors' Comments

Tom Janisse, MD, Editor-in-Chief

1998-99 Strategic Planning

The Editorial Team and members of the Advisory Board of *The Permanente Journal* met in February for 1998-99 strategic planning. Although the group discussed many subjects in detail, I would like to highlight three important strategic intents.

Our work first focused on review of the *Journal's* mission statement. We asked, "Did the original statement adequately speak to our mission on the basis of what we learned in our first year of publication?" and "Could we enhance or clarify our mission?" While we did confirm our mission, we also sharpened the language to reflect the growing understanding of "Permanente Practice" subsequent to the formation of the Permanente Federation and the significant number of interactions now occurring among clinicians across the country.

Our revised mission statement reads:

"*The Permanente Journal* is written and published by the clinicians of the Permanente Medical Groups and Kaiser Foundation Health Plan to promote the delivery of superior health care through the principles and benefits of Permanente Medicine."

This commits the *Journal* to superior health care—the first phase of our national brand strategy and promise to members, and identifies the major strategic capability to accomplish this—"Permanente Medicine."

The second strategic focus was our primary audience and customers—the clinicians of Kaiser Permanente (KP). One of our attempts to understand clinician needs will be through the reader survey you will find in this issue. Please respond and help us bring you the value you seek when you hold the *Journal*, view it, and read it.

Our third strategic focus was to better understand and improve the key routine business processes for a medical journal: the performance of our editorial team, article generation, peer review process, issue layout and graphics, printing, distribution channels, and communication with our readers. We will be visiting more of you across the country this year at clinical and research conferences and facility meetings to learn about your successful practices and encourage you to write and submit your best work to your *Permanente Journal.*

In summary, our strategic planning focused on enhancing our core product, ensuring that it continues to define Permanente Medicine and helps to diffuse innovation—those most successful and best practices—into each Region, ultimately improving our care of our members. The cost to do this—for each Region's PMG to support our 1998 budget through allocation based on the number of clinicians in each Region—will be $9.02 per copy.

Alternative and Complementary Medicine

Alternative and complementary medicine suddenly appeared in the awareness of those in traditional medicine in 1993 with David Eisenberg's finding that one third of American people use some type of "alternative" medicine.

Permanente clinicians exhibit a high interest in this area through their questions, attendance at educational sessions, incorporation of alternatives into their practice, and even development of integrative alternative medicine programs. Lydia Segal, from the Mid-Atlantic PMG, who authors an article in this issue, is developing an integrative program after more than a year of exploration, analysis, and the creation of a business case.

When planning *The Permanente Journal* in 1996, we convened KP focus groups to assess the needs of Permanente physicians. These groups said the *Journal* is where they would look for information on alternative medicine. The publication of this article addresses that recommendation.

Transpersonal Phenomena

While we learn about these more recognized alternative therapies—acupuncture, chiropractic, massage therapy, and naturopathy—which appear to be on the frontier of medical care, research exists on other "alternative" processes called "transpersonal phenomena"—intuition and intention. Research on transpersonal communication has previously been relegated to the field of extrasensory perception. However, I believe these processes of information transfer are common in our daily practice, though either largely unrecognized or disregarded as ineffectual when seen through the scientific lens of objectivity. Communicating by intuition and intention resides at the core of our effective interactions with patients. At times we may describe intuition as clinical judgment, a hunch, or a feeling and describe intention as bedside manner, or simply caring. Our intuition about our patients' illness and our intention for them to get well may be more potent diagnostic and therapeutic tools than we now appreciate. While further studies are ongoing to explicitly substantiate the benefit of these transpersonal processes, we can apply them now in a simple manner. To improve intuition, listen. Often our cognitive noise drowns out another person's voice. We don't hear well because we are too busy thinking. To improve intention, consider that caring for another may effect healing in them. Just your sincere interest in a person's well-being, in the clinical setting of a visit, can motivate them to improve their health and could alter their physiologic response to illness.

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"I am puzzled about which questions we are asking and what answers we seek. How to get it down? Why did it go up?"

By describing these processes it is not my intention to demystify and undermine the magical and personal aspects of healing. My main point here is that, as clinicians begin to see medicine changing to incorporate new complementary therapies and as we feel a growing distance from our training, intuition and intention are actually at the core of traditional medical practice. Recovering their value in our Permanente Practice will place us at the frontier of future medicine.

Prevention Through Attention to Behavioral Medicine

What the alternative dialogue prompts is an evaluation of how we usually do things. In my mind, one basic assumption of traditional medicine is that "disease happens." We believe disease happens in response to genetic, physical, infectious, and environmental factors largely out of our control. In reacting to disease, we identify symptoms or signs of disease, diagnose the disease, and then treat the disease with chemical, physical, or surgical interventions. To improve this current approach, some clinicians now emphasize prevention and population-based care. We look to find disease sooner (early diagnosis), treat it faster (immediate access and therapy), treat it more consistently (guidelines), and both look for and treat disease in more people (population-based care).

I am puzzled about which questions we are asking and what answers we seek. In concert with the listed approaches, our treatment emphasis appears to be in response to the question, "How to get it down?" We use ACE inhibitors to lower blood pressure, lovastatin to lower cholesterol, and glyburide to lower blood sugar. Instead, I wonder if we should be attending more to the question, "Why did it go up?" If stress elevates our blood pressure, a high-fat diet elevates our cholesterol, and lack of exercise and diet control elevates our blood sugar, how much are we addressing prevention? It's as though we are treating hypertension to prevent heart failure, treating high cholesterol to prevent coronary occlusion, and treating hyperglycemia to prevent retinopathy. We appear focused on secondary prevention.

We may be chasing, with an increasing supply of drugs and clinicians, an unending demand for services that is symptomatic of a system disconnected from the cause of its problems. Within KP it is certainly not increased reimbursement for services that drives this process. Is it a medical model out of touch with our patients' lifestyles? Perhaps it is frustration with the ineffectuality of our recommendations to alter lifestyle. Perhaps it is the way that we deliver these recommendations. Perhaps our members are resistant to our suggestions, are in a state of unreadiness for change, or lack a support system for change. Perhaps it is just too complex. Can there be some answers in the proliferation of the public demand for something alternative or complementary?

John Nelson, a Northwest Permanente internist who supported a case management project for his diabetic patients with difficulty controlling their blood sugar, said after seeing his patients improve, "Physicians, both because of time constraints and training, often tend to focus on the nuts and bolts of disease management and to overlook important psychosocial and lifestyle issues that may have a very profound effect on our patients' health and their ability to follow through with a treatment program."

The article in this issue, as well as the divergent efforts underway across KP's Regions, will add some knowledge and experience to our group's collective practice both to answer some questions and to ask new ones. If we don't have integrated allopathic and complementary medicine soon, at least we may have integrated program learning through our dialogue about alternative medicine in these pages, in interregional groups, or on the Intranet.

Our end is always to better objectify new subject matter, understand and appreciate it, find what is beneficial, sort out what is harmful or of questionable effect, and bring higher value to our members. ❖

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Clinical Contributions

Arthur L. Klatsky, MD, Associate Editor

Once again, we present a varied menu in the **Clinical Contributions** section of this issue. All of the articles should be of interest to a large proportion of physicians practicing in many areas of Permanente Medicine. The article titled "Suppurative Appendicitis: Quality Improvement Study of Disease Duration," by Kirtland Hobler describes a subset of acute appendicitis patients with a different clinical presentation and distinctly less benign course. The article suggests that there is clinical value in recognizing this group, and Dr. Hobler also points out the important (and, perhaps, comforting) concept that quality-of-care assessment—which lumps the "suppurative" subset with all acute appendicitis—may be intrinsically unfair to the physicians involved.

The article titled "Written Instructions and Compliance with Return Visits for Reading Mantoux (PPD) Skin Tests in a Large General Pediatric Practice" by Harold Farber is a reminder of the ubiquitous nontechnical problems which beset medical practice. In this era of highly-technical medicine, too many persons assume that all difficulties can be overcome, but front-line, busy clinicians know better. The problem here is patient noncompliance. The disappointing result of this experimental attempt to improve an abysmal rate for reading of the Mantoux test is an object lesson in this regard.

George Longstreth's article, "Relation Between Physical or Sexual Abuse and Functional Gastrointestinal Disorders," is a learned, data-based discussion of a provocative and possibly controversial topic. Comments from readers about this or any article would be welcome.

Finally, this issue includes a Perspective article from the July 1943 *Permanente Foundation Medical Bulletin* entitled "Fat Embolism" by Bernard Gray and Nathan Meadoff, with commentary by Jerry Schilz, Chief of Orthopedic Surgery at the Kaiser Permanente Baldwin Park facility. Fat embolism had become a major, relatively newly recognized problem with the increase of traumatic injuries during WWII. It is fascinating to see what progress has been made and sobering to realize how incomplete our current understanding of this problem remains. ❖

Health Systems Management

Lee Jacobs, MD, Associate Editor

This issue, **Health Systems Management** has contributions from Kaiser Permanente (KP) authors covering several topics that I'm certain you will find interesting. Addressing this edition's System Challenge is Lydia Segal's article, "Complimentary and Alternative Medicine Comes to Kaiser Permanente." With her article, she opens the door to a controversial topic that I'm sure will provoke a valuable dialogue.

Sherilyn Kam and Scott Brooks introduce an exciting new study correlating KP employee commitment to customer satisfaction, and eventually to financial performance. While similar linkage studies in the banking industry suggest a high correlation, this is a landmark study for health care and for KP specifically. Over the years a tremendous data pool of KP results will be compiled enabling extensive study. I would anticipate updated reports from this group at least annually.

Barney Newman's group provides the small and mid-sized Permanente Groups with several very helpful guidelines on integrating a teaching program in their article, "A Strategy for a Permanente Academic Partnership in a Small Medical Group." Involvement in teaching programs is beneficial not only for those in the Permanente community who enjoy teaching, but also provides an opportunity to assist the local academic institutions in providing students and residents with the best kind of ambulatory experience—the Permanente Practice experience!

Peter Juhn et al, from the Federation's new Care Management Institute provides an excellent foundation for future Health Systems Management studies in their article, "Care Management: The Next Level of Innovation for Kaiser Permanente." Nothing could be more "physician friendly" than the concepts this group describes. Especially noteworthy are the strategies they present on implementation—probably the most critical step if we are to integrate these programs into our health care teams.

Finally, Michael Chaffin, the Medical Director from the Hawaii Permanente Medical Group, presents his thoughts on the role of the partnership as the characteristic best distinguishing KP from our competitors.

I hope you enjoy these contributions in the Health Systems Management section. As in the past, the extent of dialogue in the Permanente community depends in large part on your response to these and future articles. ❖

External Affairs

Scott Rasgon, MD, Associate Editor

Three articles in the **External Affairs** section by Don Parsons, Dennis Flatt, and David O'Grady in the opening comments refer to the movie *As Good As It Gets* and the reference in it to HMO care of asthmatic children. The audience response referred to represents the public's image of poor care in HMOs created in the media that is completely opposite of what occurs in the Permanente Medical Groups. *The Permanente Journal* is one way to get the message out to differentiate us from all managed care and to show how we offer superior care—often being the leader and innovators in the health care field. Many examples of the high quality of Permanente Medicine appear in the issues of the *Journal* already published and many more will appear in future issues.

Linda Kotis speaks to our social mission in her article on our program to help insure uninsured children in California. The article about Ohio Permanente Medical Group's new Medical Director illustrates his vision for the future. The last two articles again help differentiate us from other managed care organizations and reflect our social mission. ❖