

Editors' Comments

A Tribute to Women

Tom Janisse, Editor-in-Chief



You are holding the first of two Women's Health issues; the second will be published in the Fall. There was such a large response to our call for articles that the Editorial Team decided to publish the best articles in two successive issues. As you read these research studies, programs, initiatives, and systems innovations, and view the paintings, photographs and other visuals, you will learn much that is transferable to all of your patients. We are privileged as an organization to have women so prominent and successful in the fields of clinical medicine, research and leadership to be able to present such exemplary knowledge, practice, and wisdom. This will be of great benefit to ourselves, our members, and our communities both local and national. Congratulations to the women we feature and to the women we serve.

Women's Health Center

The concept of "Women's Health" as a realizable future alternative to conventional health care for women exists only by understanding several key components and by achieving a new perspective. Primarily, enhanced care for women will not be achieved by erecting a new building to house a Women's Health Center. Neither will it be achieved through an institutional icon; through advances in technology; through tertiary services; through expanded well-analyzed data sets; through singular or insular treatment approaches delivered by an impersonal scientist; or through advancements in traditional medical science. Clinicians will, however, be more sensitive to women and will exhibit enhanced communication and relationship skills.

In our process to describe the future, we must first ask women what they want and listen to them, before we mistakenly build a future on the basis of our current assumptions about them from a biomedical model. What women have suggested so far in focus groups of members, in meetings of clinicians, and in the recent literature looks and sounds alternative. A spectrum of approaches and activities are necessary from convenience to holism. Focus first on common needs and concerns. Deliver services close to home, in one place. Don't make a woman drive all over town to each specialist's office. Care should be multidisciplinary and delivered or coordinated as much as possible at one visit in a women's health module. For example, just as two surgeons from different departments arrange their time to perform an operation and look into the belly together, two specialists could arrange a visit to look into a woman's health concern together. In a variation of this scenario, some would even prefer a group setting with other women to socialize and exchange stories and advice. And it is important to remember that women's health begins when they are young girls. Compartmentalizing their care within department boundaries is artificial and better serves providers of care than recipients.

Kaiser Permanente has been developing the "capability" of delivering advanced women's health care for several years. This capability—a connected set of activities and competencies—resides in our integrated system and in people and processes. It represents a women's health "center" that exists in many sites; through many services; in many relationships; and in the attitudes, perspectives, and interpersonal skills of many clinicians and ancillary providers. This will be a center "without walls" as exemplified by the personal health knowledge a registering medical assistant will have by accessing a woman's electronic medical record in any facility.

The woman, as individual, will be "the center" of her health care. The center will not be a structure into which she seeks service. It will be a primary care center rather than a tertiary care center. A primary care doctor and team will lead the coordination of her care. She will not receive expert medical advice at the end of a long string of visits that have ignored psychological, social, behavioral, familial, or environmental factors. These will be assessed initially as "emotional vital signs" and be taken with the physical vital signs.

When clinicians recommend that geriatric women go to the local health club for exercise, we will recognize their loss of dizziness, improved balance, less painful knees, and normalizing blood sugar as advanced health care practice rather than an off-handed suggestion about which medical science doesn't concern itself. We will recognize that the social encounter she had with several other elderly women was one of the most potent components in improving her physiology, because she learned that others have similar maladies and that they have overcome them with simple methods they taught her. As well, she will be versed in self-care through easily available education, materials, printed and electronic resources that are readily accessible, carefully researched, and reader-friendly.

Clinicians will consider alternative options and will recognize cultural diversity and preferences. Similarly, quick referral by her primary care physician to an acupuncturist for relief of chronic nasal congestion, or to a massage

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therapist for lumbar strain, or to a naturopath for an herbal tea to help her sleep will become common practice and be recognized as advances in women's health care.

As we continue to develop the women's health center capability as a program, and it becomes increasingly recognized, the women in our preferred market segments will stay with our system, and others will join us. Because these women make many of the health care decisions for their family, we gain their husbands and children as members. These women will influence other women with whom they are friends, in their neighborhoods, in their churches, in their gatherings, and in their workplaces. Women will also influence their husbands, fathers and sons to appreciate a more holistic, balanced approach to their treatment.

In this discovery and creation process, impersonal medical care will become personal health care. ❖

Women's Health: Permanente Medicine

Lee Jacobs, MD, Associate Editor, Health Systems



I was reminded again at a recent Infectious Disease meeting of the global importance of women's health.

The continued increasing AIDS incidence for women in the United States is striking. Especially alarming is the worldwide statistic that out of 16,000 new HIV infections each day in 1997, 40% were women. How about the fact that the cumulative number of children orphaned by AIDS worldwide is 11.2 million? How discouraging is it to see the continued high incidence of perinatal transmission of HIV from mother to infants in other countries when we know that with treatment it is preventable? We have documented evidence that breast-feeding increases the transmission of HIV to infants, but third-world mothers are placed in a Catch-22 since the death rate from diarrhea is so very high if they don't breast-feed.

Certainly women's health in the United States and around the world, especially related medical, social and ethical issues, deserve special attention. For that reason we are dedicating the next two issues of *The Permanente Journal* to this very important topic.

It is not just a popular topic-of-the-month. No, it is right at the core of Permanente Medicine as we are always seeking to better understand the evidence-based approach to the care of a population of people. Too often the women's health focus in the community is based solely on economics. Such is not the case for Permanente.

In the Health Systems section of this edition, we present several articles on women's health that are representative of the type of work that is taking place throughout Kaiser Permanente. Dr Jill Steinbruegge shares personal observations on women's health and then presents the challenge to Permanente Medical Groups to address the gender gap in leadership. Dr Rhoda Nussbaum's introductory commentary and her article summarizing the work of the Women's Health Task Force in Northern California sets the agenda for the articles that follow. Dr Philip Tusso's article on an estrogen replacement anchors this issue with articles on breast cancer and mobile mammography to follow in the second part of the series on women's health issues which will appear in Fall 2000 edition of *The Permanente Journal*.

I hope you enjoy your reading of the work that your Permanente colleagues are doing. As always, we invite your articles and comments for future publication. ❖

Coming in the next issue ... Focus on Women's Health—Part 2

Uterine Artery Embolization for the Treatment of Uterine Fibroids

Perimenopausal Mood Problems

Sex Differences in Coronary Hospitalizations

Mobile Mammography: Providing Service to the Hard-to-Reach Woman

Improving Breast Care

In the Shadow of Obesity—Part 2

... and more



Letters to the Editor

To the Editor.—I enjoyed reading the Spring 2000 issue of the *Journal*, especially the Editor's Comments. I would like to speak in more detail about another article on page 57 entitled "Emergency Contraception Research and Demonstration Project." As a member of the Ethics Committee at Kaiser Permanente Santa Clara, I think a more accurate description of the effects of the hormones administered to the patients in the study is necessary. Attempts at contraception after intercourse with hormone therapy could potentially block the sperm's passage through the cervix, prevent sperm migration to the ovum in the distal Fallopian tube, or prevent sperm capacitation (cleavage to and penetration of the ovum). Studies show that, at peak phase during ovulation, it takes an average of 90 seconds for the sperm to penetrate the cervix and another four to five minutes to reach the distal Fallopian tube with capacitation following a short time later. Due to the usual delay in taking emergency contraceptive pills (ECP) none of these potential effects would take place in a timely fashion. Use of the hormones would, however, increase the transport time of the embryo to the uterine cavity by reducing tubal motility and prevent implantation of the embryo into the uterine wall. Wyeth's data on the estrogenic component of the ECPs do not demonstrate any convincing evidence that ECPs prevent ovulation in this situation. In spite of ACOG's recent change in terminology, conception takes place at fertilization, usually in the distal tube, and not at implantation. I agree that ECPs will reduce the number of unplanned pregnancies from unprotected intercourse but what the patient has the right to know is that this is not a contraceptive but an abortifacient effect of ECPs. As with other medications, procedures, and treatments, the patient has a right to—and we have a legal and ethical obligation to—informed consent.
Dave Hammons, MD
Kaiser Permanente, Santa Clara, CA

In Reply.—Dr Hammons correctly describes the several mechanisms of action of hormonal EC. These mechanisms are described in the Provider Service Manual, in the patient information brochure, and in the Healthphone script developed by the Project.

The Provider Service Manual contained the following statement (p. 4) about these mechanisms of action:

"...since some people will consider interference with a fertilized, not yet implanted egg as an induced abortion, the potential mode of action must be made clear to all members who might elect this treatment." (p. 4)

and the following recommendations to providers (p. 6) about counseling:

"Due to various definitions of pregnancy and abortion, the mode of action should be clearly explained to members as part of their decision-making process." (p. 6)

In the patient brochure, the statement below follows the description of the mechanisms of action of ECPs:

"Because a fertilized egg may be prevented from growing by this treatment, ECPs are considered an abortion by some people. If you would not use a treatment that would interfere with an already fertilized egg, then ECPs may not be a good choice for you."

Finally, providers who considered ECPs to be abortion were permitted to opt out of providing of ECPs.

The EC Research and Demonstration Project was grounded in respect for differences in beliefs about abortion, and took seriously the obligation to provide information about ECPs that would permit informed decision-making.

Diana Petitti, MD
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