A conversation with
KENNETH R. PELLETIER:
SOUND BODY, SOUND MIND

by Joe Flower

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Introduction

For much of mainstream medicine, the body is a machine, and the job of doctors is to fix its parts. For Dr. Kenneth R. Pelletier, a human is a whole system -- not only a whole, complex body system, but a complexity of body, mind, and spirit, which is itself a node in a larger complexity of family, work, community and environment. When he and a few others began preaching this "holism" in the 1970s, they formed a tiny and easily dismissed minority within the halls of medicine. Two decades later, they are a growing minority, and they are far from tiny or dismissable.

Dr. Pelletier himself is now a Clinical Associate Professor of Medicine at the Stanford University School of Medicine. As director of the Stanford Corporate Health Program, he and his team work collaboratively on health in the workplace with 20 major corporations, including American Airlines, AT&T, Bank of America, Levi Strauss, IBM, and Xerox. Starting with the international best seller *Mind as Healer, Mind as Slayer* (1977, revised 1992), he has produced seven major books, including *Holistic Medicine: From Stress to Optimum Health* (1979), *Longevity: Fulfilling Our Biological Potential* (1981, revised 1991), and *Healthy People in Unhealthy Places: Stress and Fitness at Work* (1984). At the same time, he has written over 200 professional journal articles in behavioral medicine, health promotion, and psychoneuroimmunology.

His latest book, *Sound Mind -- Sound Body: A New Model for Lifelong Health*, grows out of an intriguing study funded by Laurance S. Rockefeller which Pelletier undertook in 1988. Pelletier's premise was simple: if we want to know about health, we should study health, not just pathology. Over a period of five years, he interviewed 53 prominent people who represented prototypes of optimum health, searching for what they had in common, looking for the keys to a healthy life.

The results were sometimes startling, and often carried a kind of wisdom. If they are taken seriously, they give us a profoundly different vision of the mission and place of medicine and of healthcare in society.

The publication of the book gave me an opportunity to catch up again with Pelletier, whom I have known for over a dozen years. I encountered him first when I worked with Robert Schwartz at the Tarrytown Conference Center, when we were members of Schwartz' "Tarrytown 100," and later when I was researching a history of the Esalen Institute as a catalyst in shifting the mind of medicine.

He took cappuccino with me and Patrice Guillaume (my partner in the Change Project, as well as my wife) in the vast mid-morning quiet of the dining room at the Claremont Hotel, that great white Victorian pile in the Oakland hills, the bare survivor of the great fire. Our view started 40 feet below us and rolled on across Berkeley and the Bay to the City and the Golden Gate.

The long three-way conversation bounced from mutual acquaintances, to chaos theory to the nature of change, to sailing the open oceans, churning up piece after piece of his findings, uncovering their implications, and forging links between them and the other visions we have unfolded here. We circled particularly around the multiple meanings of health, healthy family, and healthy community, and came back to the deep roots of health in the mind and the community.

Pelletier:

Alice asked the Cheshire Cat: "Would you tell me, please, which way I ought to go from here?" To which the cat replied with a smile: "That depends a good deal on where you want to go."

No journey begins without a destination. If health is our destination, it's important what we mean by "health." Once we have a model of health, then we can ask what are the preconditions in the individual, in the family, in the community, in the environment, and in the medical care system that gets us to that destination.

Right now we are oriented toward disease. We ask, "What does an individual need to do to avoid disease? What are the things that communities need to do to reduce violence? What are the things that hospitals and doctors need to do to treat disease?" These are excellent questions, but they are very limiting.

We need a course correction. The whole medical care system has lost its sense of its destination. We are no longer certain of the purpose of health care.

What is health?

We have no body of knowledge about the best that we can expect of a person -- physically, mentally, spiritually, or emotionally. If we can begin to find out what that looks like for an individual, then we can ask, "What kinds of social and environmental preconditions do we need to foster that rather than impair it?"

By the time I got to the end of this study, no definition more limiting than this seemed adequate: Health is a life lived well and fully, a life involved with other people, and with self-exploration of the emotions, the mind, the body, the spirit, and the world around us.

The new model of health and healthcare that arises from this study is one that recognizes, first, that there are practices that individuals can and should undertake.

Second, we need to make judicious use of appropriate care, whether traditional or alternative, when health fails, which it does for all of us at some point.

Third, we need to look at the psychosocial and physical context in which any medical practice and any personal behavior is imbedded -- the family, the community, and the physical environment.

Until you have all three dimensions and look at their relative contribution, you have an approach, but you don't have a comprehensive model of true health.

Holistic vs reductionist

We have traditionally defined health in a much more physical sense, in reductionistic, mechanical, and biological terms, in terms of surviving cancer, preventing heart disease, or coping with arthritis. We have done that both on the biomedical end of the continuum and even on the supposedly holistic side.

There is nothing holistic about many practices that are called "alternative" or "holistic." An

acupuncturist, an herbalist, or a homeopath can be as reductionistic as any allopathic physician or surgeon that I have ever encountered. There is nothing inherently integrated, comprehensive, or holistic about an alternative practice that falls into the same trap -- the single factor panacea -- be it pharmacology, surgery, homeopathy or acupuncture. If you fail to take into account the multiple internal and external influences on health, you don't have a really comprehensive approach to health.

No antagonism

The search for the preconditions of health is not antagonistic to the best of allopathic care, or any other form of care. The Western biomedical model is absolutely the best model in the world for tertiary care and the management of extreme trauma. There is no question about that. People come from all over the world to the United States like a mecca to seek out that form of care.

The problem is that we have taken an excellent system for the management of trauma and acute crisis, and misapplied it to chronic conditions. We have also ceased to apply it conservatively, where it is clearly dictated. For example, we have an $8 billion dollar per year business, and growing, in coronary bypass surgery -- of which perhaps 20 to 30 percent is really necessary, and not preventable. For that relatively small percentage we should have the best coronary intervention programs we can possibly have. We should also pay attention to the prevention of the other 70 to 80 percent of coronary heart disease, to free up the money so that anyone who truly needs a bypass procedure would be able to have it. Now we don't do that.

This is not just about attitude. Mainstream medicine tends to dismiss much of the work that attempts to address the preconditions of health by labelling it "the power of positive thinking." And the more extreme advocates of alternative care want us to shun everything except the visualization or "power of the mind" model. Neither point of view is accurate. Attitude is one of more than twenty dimensions of health.

Healthy people

We set out to study health by talking to people whose lives seemed healthy. I started my research agnostically -- I didn't know if I would find anything. I started with the question: "What are the minimal prerequisites by which you would judge a person healthy?" We ended up with three minimal criteria for picking candidates to interview: First, that they be recognized by their peers as accomplished in their field. We did not want "drop-outs," but people immersed in the strains of daily life and career. Second, that they adhered to certain practices in order to sustain their level of health. Third, that they perceived themselves to have a mission or purpose in life beyond the maintenance of their health and their personal financial well-being.

What we did not do was pick a list of people who were paragons of health in the conventional sense -- the Jack LaLannes of the world. As an example, my original list contained two people that I did not end up talking to for reasons of logistics. In my mind I had Bruce Jenner on one end of the continuum -- an Olympic athlete who for most people would represent an optimum state of health. On the other end was Stephen Hawking, the quadriplegic astrophysicist. By biological, reductionistic standards this is not a healthy person, but I felt that any definition of health must include both of them.

Similarly, you often find remarkable children, dying at a very early age of leukemia or some congenital abnormality, who express a state of consciousness and love, a state of being in the world and giving to others, that to me is health. I felt that whatever constituted health had to incorporate those children, too.

I don't have the answers, even after doing the study, but I have a lot of questions about our glib assumptions about what health is and is not. It's not so easy for me to answer that any more.

Health certainly is not the fifty year old movie star trying to look twenty. That is a beautiful

biological vehicle but it's not health necessarily. It is not enough to have a tight butt and good biceps and the right cholesterol. Sorry, that is not all there is to life.

I started out to interview these individuals without knowing if there were any common elements in these people's lives. Probably the single most striking finding was that there is a clear developmental continuum that grew from the early inner experience of the person -- a private, intimate, usually traumatic experience very early in life -- to what we see later in life, in their sixties, seventies, eighties, and even nineties, of the most outer, public expression of altruism. That continuum seemed to define health -- not a particular biological state, but a developmental life cycle, a continual process of growth that has its moments of crisis, and its moments of joy and ecstasy as well, evolving and expressing the life fully and well lived. It's almost a Whitmanesque definition of health, but I am hard pressed to come up with anything that better describes this optimal state.

These people have had it all -- physical traumas, emotional crises, life-threatening diseases, divorces, financial setbacks, anxieties. No one is spared the travails of life. But they have learned to optimize those experiences, to transform them, to have a sense of the necessity of giving to others.

I do not believe that trauma is a precondition for optimal health. However, in the course of this project, this was a major surprise -- virtually every one of them at a very early age had had a major traumatic event: incest, physical abuse, near-death incidents, life-threatening disease. The prevailing model is that trauma in childhood inevitably leads to adult disability, that when you are sixty years old you can still blame the fact that you had an alcoholic father who beat you at the age of three for the reason that you are now an alcoholic.

The study simply says that childhood trauma is not inevitably destructive. It can lead to a breakthrough rather than a breakdown. There were several things that made the difference. When this trauma occurred the children weren't developmentally very sophisticated, and everything got stripped away. The parent was often the cause of the trauma, either by perpetrating it or by their absence. So the children had nothing. And all of them described that, having had all of this stripped away, they felt something inside -- an irreducible, transcendant, unharmed inner strength.

Secondly, it seemed to be critical that the trauma be confirmed by someone out in the world, by a significant other who helped the child -- a teacher, a minister, a parent, a brother, or a sister who verified what happened. Without that affirmation, it is difficult for a person to build that sense of inner strength into a positive transformation. The confirmation from a significant other person seemed to be a turning point.

It is the essence of psychotherapuetic interventions that we can revisit early traumas and transform them. So at minimum, the message of the study is: "Yes, there was a trauma, 50 years ago, 60 years ago, and you may not have done it right. You may not have adapted well, for any number of reasons. You may have guilt, but there are methods now to revisit that, to transform it and move on." The individuals that I interviewed are perhaps only unique in that they had this second ingredient, the confirmation by the significant other. But there is nothing that we have found that is not accessible to any individual, and to anyone who has charge of children.

You can help a child in trauma by simply affirming that whatever they are sensing inside, there is this something irreducible inside of them right now, that you can feel, that isn't harmed, that will grow. Confirming that may be the most salutory thing we can do. And that is often not done. You do not even have to know the nature of the trauma. You just have to love the child.

It can be learned

This skill of dealing with crisis as a challenge can be learned. Every single person pointed out that they had first learned to cope as a young child, and then refined that skill over the course of

time.

The most basic starting point seemed to the ability to enter into a state of quiet mental equilibrium, to withdraw from the external events. This point of equanimity would allow them to get a perspective on what was going on so they didn't keep repeating the same destructive behavior, so that they could look objectively at their own life.

Having looked objectively at their own life, they could begin to make some decisions that were different, to say, "Okay, tomorrow I am not going to eat 5000 calories a day. I'm going to eat 3,000." And they could have the consistency to carry that out, minute by minute and hour by hour, day by day. There is nothing magic about that.

Most of us, when we are traumatized, become filled with anxiety. These individuals have a very transient period of diffuse anxiety. They acknowledge it, they say, "Oh my God, this is terrible." Denial is not part of their game. They are brutally honest. But they also have the ability to cut through that, to say, "Now what?" They get to that next step much more quickly, with more honesty and more clarity than most people. It's a kind of learned courage.

What it means for health care

By studying these individuals who embody health, we can come to some conclusions about the social, political, and economic systems designed to maintain and foster health. The image of health that the study gives us implies a need for profound changes in healthcare.

If we accept the implications of this new model, we need a new kind of health care professional. If this is an approximation of health, then it places infinitely more emphasis on the psychosocial influences, on early life and development, and therefore on prevention.

By this model, a team of health care providers would have to truly fuse of the best of alternative care with the best that we have in Western Medicine, along psychological, and social skills, even ministerial, religious, spiritual counseling skills.

There are existing models of this, both in the United States and abroad. This isn't fairy tale speculation. For instance, the Kellogg Foundation for many years funded innovative projects that created such teams. They usually functioned out of churches or community centers, and included at minimum a physician, a nurse and a minister.

There are other such models in the US. There are clinics within the National Health System in Britain that are given exemption from the ordinary reimbursement schedules so that they can incorporate alternative practices -- and very often they are housed in churches.

Getting outside the individual

The model clearly recognizes that the preconditions of health do not reside in the individual alone. On the other hand, neither is the individual a helpless victim of the psychosocial and physical environment. We need to focus on the individual in the context of the family, the community and the physical environment.

This sounds abstract, but in reality there are specific steps that you can take in each of these domains that take this abstraction and make it very real.

For example, there are now a growing number of community-based coronary prevention programs in the United States: Pawtucket, Rhode Island; Minneapolis, Minnesota; and five cities within California. That was the "Five Cities" project that was conducted at Stanford by Dr. John Farquhar and his colleagues beginning nearly 15 years ago. It demonstrated that when you intervene in a total community rather than trying to focus on individuals at disease status, you lower the rate of disease. And you do it more efficiently, less expensively, than if you let people consume fat, smoke, be sedentary, and then try to manage the resulting heart disease.

So we know that you can intervene, that you can influence a geographic area to become more optimally healthy. That's a very important finding, and we have yet to really make use of it. We will. I think we are going to have to.

Once you change the financial incentives from "the more disease you treat, the more money you make" to "here is a finite amount of money, within which you need to manage both prevention and treatment," the game changes 180 degrees. I don't think we recognize how powerfully these incentives have flipped. It's going to take three to five years to fully realize it. It is as astounding for us in healthcare as the Copernican discovery that the earth was no longer the center of the universe. It is that deep a shift of perspective -- and what follows from it is a whole different way of delivering health care.

The hospital of the future

We have spent about two years in a strategic planning group working with the Stanford University Hospital, trying to envision the hospital of the future.

The hospital of the future will have tertiary care. It will have great trauma care. If I'm in an automobile accident the last thing I am going to do is meditate. I'm going to want a very good trauma center to save my life.

There is plenty of disease and trauma to go around. Hospitals are not all going to go out of business. But 25 to 40 percent of hospitals in the United States are excessively bedded, and overstaffed -- they are going to close, period. We are going to have fewer hospitals, with the really good ones will continuing excellent tertiary care.

The hospital of the future is going to reach out into the community. For example, East Palo Alto, in Stanford University Hospital's backyard, has had the highest murder rate in the United States. The hospital realized that most of the gunshot and trauma injuries in East Palo Alto end up the Stanford University Hospital Emergency Room, at great uncompensated cost. So the hospital had great incentive to reach out and begin to apply what we know about how you organize communities to East Palo Alto, from violence prevention to counseling on sexually transmitted diseases and drug abuse, to do what it could to enhance the health of the total community in a geographic area.

The hospitals, clinics and health networks of the fuutre will form direct alliances with large corporations, or with groups of small employers that will function like large corporations, with direct contracts for finite amounts of of capitated money to care for whatever comes up in that population. The responsibility will no longer be just on the individual to keep healthy, or the company, while the responsibility of the hospital is to take care of you when you are sick. Instead, the individual, the hospital and the company will have a fused, convergent responsibility.

As soon as you even ask the question: "What is appropriate care?" then you are inherently creating an alliance between the hospital, the community, the government, and the people, because everyone has a vested interest in the same outcome, which is "prevent what you can and treat what you must."

There will be a different relationship between tertiary providers and insurance carriers. Insurance carriers' actuarials used to be busy calculating how to increase the premiums next year to make a profit. And hospitals were busy treating as much as they could, to bill the insurance companies, to get as much money as they could. That's over.

Some of the more prominent insurance carriers, including Aetna, Blue Shield, and Prudential, are already developing totally new relationships with hospitals and practice groups, to have more prevention. They are now on the same wave length. This shows the overwhelming influence of capitation.

Finally, we are used to thinking of health care being delivered one on one, or in groups, within the walls of an institution. That's over. We are going to see a greater use of a variety of methods of telecommunication. There is some great research going on showing that you can modify risk factors, reduce cost, and improve health by mail. But the biggest impact is going to be through telecommunications. We'll use telephone-plus-mail delivery systems, and interactive television and computers. That allows you to reach retirees, and rural communities. It allows a small community in an area that does not have a very good tertiary care facility to literally access Stanford or a Harvard or wherever the high quality tertiary care is going on. The community will be partially geographic and partially defined by the outreach capability of telecommunications.

The hospital of the future can be done within a capitated plan. It is still profitable. People still get to do what they like doing. Some doctors have no interest in prevention. Other professionals love it. There is still plenty of disease to go around, and there is plenty of prevention to be done. The hospital can be a focal point if it transforms itself into an entity that works with the community that is geographically nearby, that works directly with the companies and the insurance providers, and that reaches beyond its boundaries through telecommunications.

American healthcare needs to go through a painful transformation. But it can be done systematically. You can go from thinking, "I think it's a good idea, but I'm not sure" to "Here is the blueprint for implementation in a series of systematic steps." That's entirely possible. There is no mystery as to how to do that.

Capping percent of GDP

People are afraid that somehow hospitals, or insurance companies, will be disadvantaged by the reforms that we see coming. Everyone is fearful of capping the percentage of GDP. But I think it would be a great idea. Because an estimated 30 to 40 percent of what we spend right now is excessive, inappropriate and unnecessary. That's $300 to $400 billion per year.

My objection to every proposed national plan is that none of them even try to control the unnecessary, inappropriate, costly utilization that spends both money and lives due to unnecessary procedures. Every penny of the most comprehensive program that would involve the community and the hospital could be accomplished within a zero-based budget that simply paid more attention to appropriateness of care.

This idea that universal coverage is inherently more expensive is utter and total nonsense. The $300 billion that we waste each year on inappropriate treatment is more than enough to care for every underinsured person in the United States.

There is plenty of data there to show that we can deliver more health at less cost right now.

Altruism

My study of healthy individuals showed that altruistic work is related to people's ability to overcome life-threatening crises. The people I talked to focused outside themselves. But I believe that an altruistic focus may actually be good for an organization, as well. Focusing beyond its own survival paradoxically can help an organization adapt and survive better.

A number of large insurance companies, for instance, now are redefining their missions. They now see themselves as part of the health provider system, as opposed to the administration and reimbursement systems.

For the first time, with this change from fee-for-service to capitation, an insurance company has a vested interest in managing the burden of disease. You could call an insurance carrier's mission of restoring and sustaining health altruistic. Clearly it is a mission outside of itself. The evidence is

excellent that for those carriers, hospitals, and companies who define their mission in that way, the economic benefit is enormous.

Every individual in this study defined his or her mission as something beyond themselves -- which had an enormously positive financial impact. Fulfilling the mission was lucrative. They didn't set out to earn a lot of money. They set out to convey a message, to make a difference, to take on a cause, to challenge an assumption. As a result, they became financially successful, but that wasn't their purpose.

One executive at AT&T defined his purpose within AT&T: "To promote global communication. To enhance our understanding of each other. All the rest is dial tone." When hospitals and insurance carriers begin to believe and to act as though their mission is outside of themselves, then the systems begin to fall into place.

Start here

The Tao says, "the journey of a thousand miles begins with a single step." It doesn't matter, quite honestly, where you begin. You can begin with a community violence or conflict resolution program. The California Wellness Foundation is funding a program like that, for example, between the Bloods and the Crips with the Los Angeles Police. You can start there.

You can start with an environmental concern, removing contaminants that are conducive to birth defects from the environment. You can start with the hospital. The hospital is a perfectly good place to fulcrum the community-based model, to be the hub for environmental, physical and psychosocial initiatives. It is a great place from which to network out in the telecommunications system to reach people who can't be physically within that domain.

But wherever you start, you must start with individuals. Within the hospital structure, within the insurance industry, within large corporations, I never have the experience of working with AT&T, or IBM, or American Airlines -- although we have worked with all of them for more than a decade. My experience is that I work with a personnel director, a medical director, a hospital administrator, or an insurance senior vice president who realizes that things are changing and says, "I want to know how to adapt my system in a more clever way than my competition, so that I survive."

You need to communicate to the leaders of the hospitals and the insurance systems what's in it for them, personally, in terms of their power base, and their personal financial security, as well as the future economic viability of their company, and the necessity of caring for the people who work for them.

The competitive model -- with hospitals competitive with insurance carriers, and insurance carriers gaming the large companies, and companies hating the insurance carriers because they are trying to get too much out of them -- is over. Anyone who operates on that model, personally or collectively, is dead. The collaborative, cooperative model -- what's in it for you, what's in it for me, let's figure out how we can each get something out of this whether money or something else -- is the future model. That's the long and short of it. It's the future model financially and it's the future model of personal health, with alternative and mainstream care laying down their arms and seeing how they can work together.

It's going to happen. The National Institutes of Health has an Office of Alternative Medicine to responsibly evaluate alternative medicine practices. They funded a series of research projects last year. They have put out a request for proposals for academic medical centers to apply to them for funding. Beginning in 1995 the job of these academic medical centers will be not to do the research themselves, but to train, help, and work with community practitioners in their immediate area evaluate their practices with scientific rigor. Our group at Stanford is in fact applying to be one of these coordinating centers. We are talking to acupuncturists, homeopaths, and Chinese herbalists. Their job is to deliver these services to their patients. Our job is to figure out how to evaluate them rigorously for the NIH Office of Alternative Medicine.

That's remarkable. It's such a clear statement of what the objective is -- to collaboratively bring together what really works in alternative care (because there is a lot of fraud out there), and what really works in allopathic medicine (because there is a lot of fraud there, too). Let's find out what is the best of both worlds and integrate them into healthcare. Now that is a collaborative, non-adversarial model.

I see too many organizations bogging down in the means, the tools and the tinkering, without ever figuring out where they are going. Hospitals have everything at their disposal that they need to make this transition -- but they need to rethink the purpose of the building, of the computer, of the record system, and of the personnel. That's the challenge. Once you define your destination, everything else is easy.

If there is any message for hospital executives, it is to be bold. The old system does not work. If you cling to the old system you are dead, a dinosaur, your hospital is going to close, you are going to lose your job and your employees are going to get fired. Change or die.

This is not a guess. It is not an approximation. It is not crystal ball gazing. There is a decade or more of living, working, breathing, models of hospitals, communities, and corporations, that have successfully integrated the three aspects of individual responsibility, appropriate use of medical care, and attention to the psychosocial and environmental precursors of health. They are health effective. They produce more health than disease, and they are cost effective because it is inherently less expensive.

There is no "trust me" here. This is a performance-based, outcome-based statement: if something doesn't work, scuttle it. I don't care if it's alternative, mainstream or otherwise. If it doesn't produce more health at a reduced or comparable cost it is wrong. Get rid of it. You can set up bench marks to know whether the people you are serving are getting better, and whether you are doing better financially as a result. If it can't pass those two tests, junk it, I don't care how convinced you are that it's right.

Don't be afraid of managed care, don't fear what is coming but embrace it. You can know with absolute and unequivocal certainty that there are road maps, there are models, there are ways of getting there from here.

Let go of the fear. Let go of the digging in with your heels. Move forward. We know how to do it. It can be done. The saber rattling and the fear mongering and the doomsday prophecies are just the empty rhetoric of a system that is dying and refuses to go peacefully.

It's the Nike philosophy: "Just do it." The times demand that we be creative, that we take risk, that we let go of fear. But probably the most formidable thing is that we must let go of old assumptions that we know how things work. We don't. That's a certainty. We really don't. We have to move forward anyway, without knowing -- and that is what requires vision, and a very special courage.