



## It's All About the Benjamins — An Interview with Dr. Dean Ornish



Dr. Dean Ornish

**D**r. Dean Ornish is a true pioneer of healthcare reform in the United States. For the past 28 years he has, in a highly pragmatic and systematic manner, established and promoted the efficacy of a comprehensive diet and lifestyle-based approach to managing and reversing heart disease. A radical departure from the prevailing drug regimens and surgical interventions, Dr. Ornish's approach is a model of healing that is not only safe and effective but ecologically and economically sustainable, as the following three articles will show. (See page 24 for an overview of his Program for Reversing Heart Disease and Page 27 for an look at the Preventive Medicine Research Institute.)

We are grateful to Dr. Ornish not only for his tenacity as a pioneer, but for the model of healthcare reform that his work lays out for us. As Dr. Ornish shared with us in a recent conversation, he encountered many obstacles in developing and sharing his work—from doing the initial research to prove the validity of the approach, to finding ways of helping people to make and maintain real changes, to convincing insurers to cover the program. Counteracting inevitable creeping cynicism with hard work and good humor, Dr. Ornish found ways to overcome these significant challenges. His most recent, and perhaps most powerful contribution yet, is that his Program for Reversing Heart Disease and other evidenced-based comprehensive lifestyle change programs are now on the cusp of being covered by Medicare. This is momentous: for the first time in history, Medicare may cover a medical intervention that is nutrition and lifestyle-based.

The following interview is excerpted from a conversation we had with Dr. Ornish at his offices at the Preventive Medicine Research Institute in Sausalito, California in January, 2005.



**Dr. Kreisberg:** *When you started out, your program was considered quite radical. I'm sure in some circles, it still is. Can you tell us about your approach to getting the program established in the medical community?*

**Dr. Ornish:** I started this work in 1977 when I was a medical student. I used to think if we just did good science that would change medical practice. In retrospect, this was a little naïve. I have come to understand that the primary determinant of medical practice is not just science, but reimbursement. I would add that the primary determinant of medical practice is not its effect on the environment, but reimbursement.

It's not that most doctors are primarily interested in money, but instead that the entire system is designed to reimburse drugs and surgery. Therefore, the journal articles are funded by ads for drugs and surgery and the medical schools get much of their funding from those same sources. So, if you're trained to use drugs and surgery, and you are reimbursed to use drugs and surgery, you will tend to use drugs and surgery. It's the way the system is set up. We physicians tend to do what we get reimbursed to do and we get trained to do what we get reimbursed to do. So by changing reimbursement, we change both medical practice and medical education.

For example, last year \$30 billion was spent on bypass surgery and angioplasty. But no randomized trial to date has shown that angioplasty prolongs life or even prevents heart attacks. And bypass surgery has shown to be effective in only 2 to 3 percent of people, and they tend to be the people with the most disease. And yet it hasn't made a dent in how medicine is practiced because these approaches are reimbursed. And the same is true for many other things we do as physicians. So my colleagues and I

here at the Preventive Medicine Research Institute spend time doing good science, because it is important, but it is not sufficient. And I used to think it was.

**Dr. Kreisberg:** *So if the science isn't sufficient, what approach did you take?*

**Dr. Ornish:** It became clear that what we needed to do was change insurance company reimbursement. So I went to insurance companies and asked them, "Would you pay for this preventive approach? We have study data that shows its efficacy." And they said "No, we won't. We don't pay for diet and lifestyle, that's prevention." And I said, "What's wrong with prevention?" They responded that it might take years to see the benefit, and since 30 percent of people change insurance companies every year, why should they spend their money today for some future benefit which, even if it occurs, someone else is going to benefit from? And I said, because it is the right thing to do. And they would shuffle and look away.

So then I took another approach: "Not only can this be prevention, but this can be an alternative treatment for select patients right now. For every man or woman who would have undergone a bypass and can safely avoid it by changing diet and lifestyle, you save \$30,000 immediately. Real dollars today, not just theoretical dollars years later."

And they replied, "Well, that sounds great in theory, but people can't change their diet and lifestyle. Your program is way too hard. If we pay for it, we will end up paying for their bypass anyway and the cost will go up rather than down." By then we had 20 years of research, because this was in the early 90s. And I said, "We have already shown that people can do it. Look at our data." And they said, "You live in California. It's an altered state. This will never play in Peoria."





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Finally, in 1993, Mutual of Omaha agreed to pay for our program. They were the real pioneers. That made front-page news around the country because it was the first time any major insurance company paid for something that was considered alternative.

**Dr. Kreisberg:** *What was it they were paying for? Tell us a little bit about the program itself.*

**Dr. Ornish:** The Program for Reversing Heart Disease is a year long. We trained a team of people for each demonstration hospital that would run the program. This team included a cardiologist, an exercise physiologist, a registered dietician, a stress management specialist which was really a yoga and meditation teacher, a nurse case manager, a program director and a clinical psychologist. Mutual of Omaha reimbursed the hospital for the cost of the program. And what they found after three years was that almost 80 percent of the people who were told that they needed a bypass or angioplasty were able to avoid it by making diet and lifestyle changes as a direct alternative. And as a result, they saved almost \$30,000 per patient in the first year, which is huge. Over time, 40 insurance companies began paying for this program.

**Dr. Kreisberg:** *This sounds like a huge success.*

**Dr. Ornish:** It is and it isn't. The real tipping point is up and coming. After many years of hard work, Medicare agreed to run a demonstration project a few years ago. This month (January, 2005), Medicare is holding a formal hearing called the Medicare Coverage Advisory Commission Hearing to review our data. This will help them make the national coverage decision. We are asking them to do this not as a branded, Dean Ornish program, but as a non-branded, non-proprietary, generic program. We just want to give

it away. And so anybody that has a program based on what we have done or can present their own evidence that their program can reverse heart disease will be eligible for reimbursement.

We now have over 2000 patients who have gone through our three demonstration projects which have shown bigger changes in diet and lifestyle and better clinical outcomes and greater cost savings by far than have ever been shown in similar diet and lifestyle interventions. We have also shown in our randomized trials—ironically, using very high-tech, state-of-the-art measures—that we have been able to prove the power of this very low cost, low-tech and, in many ways, ancient intervention.

I am hopeful that this will happen. And if it does, it will be the real breakthrough. If Medicare pays for this then most of the other insurance companies will as well and, as I mentioned earlier, we doctors do what we get reimbursed to do and we get trained to do what we get reimbursed to do, so if Medicare makes this a covered benefit, then it will change both medical practice and medical education.

And it was a good lesson to me that not only do you have to have good programs and good science, but it has to be financially self-sustaining.

**Dr. Kreisberg:** *Does the reimbursement from Medicare go to the hospital?*

**Dr. Ornish:** Yes. This is part of why it has been so difficult to get Medicare to consider this program. They have never done anything like this. We are asking them to pay for it as a program, not as individual components where the dietician bills for their time and the exercise physiologist bills for their time, but as a defined program for a defined price for a year. For anyone who is eligible. Right now they are paying for it for 1800 patients as part of our demonstration



program, but as a defined benefit it would be for any Medicare beneficiary with heart disease.

**Dr. Kreisberg:** *Many existing cardiologists are already trained in a certain way, and certain personalities are drawn to the technology of medicine. What you are doing is quite different for that group of people, culturally. Have you found any tension in current cardiologists adopting this?*

**Dr. Ornish:** No, on the contrary. Most of the medical directors at our programs are interventional cardiologists that make their living doing angioplasty. So this isn't competitive with that. In other words, I try to build bridges, not to burn them. And so we don't go to cardiologists and say we are right and you are wrong and you should do this and not that. We say look, even if a patient needs an angioplasty, they still need to change their diet and lifestyle to avoid having another one, otherwise it is like mopping up the floor because the sink is overflowing and you haven't turned off the faucet. You get a new set of problems and side effects. As they begin to do it and see how powerfully people begin to improve they realize for selective patients that they can do this instead of an angioplasty. So it is both an alternative and an adjunct. And so presenting it in that way we don't polarize or alienate or antagonize people.

But it is also true that many cardiologists realize that what they are doing is incomplete at best. So there is a real interest in these kinds of approaches. But the problem has been that people have to make a liv-

ing. And with managed care taking the approach of forcing doctors to see more and more patients in less and less time, it is frustrating for everyone. Because if you only have eight minutes to see a new patient, you don't have time to talk about their diet or their exercise or their kid on heroin or the problems in their marriage or anything. You basically have time to listen to the heart lungs, write a prescription for Lipitor, and you're off to the next patient. It is very unsatisfying for both doctors and patients. So what I have found is that there is a real hunger for this among conventional cardiologists and physicians. A lot of people went into medicine because they wanted to help people. So we are really trying to create a new model of medicine that is both more caring and compassionate and more cost effective and competent by addressing the more fundamental causes of why people get sick rather than just literally or figuratively getting a bypass. And we found a lot of receptivity to that.

**Dr. Kreisberg:** *In your model is the actual visit longer? Is it more in-depth and do (doctors) spend more time with the patient?*

**Dr. Ornish:** Yes and yes. The doctor acts as quarterback here. The doctor doesn't have the time and the training to teach people about these things. But if the doctor says, look, you have heart disease and you have to do something about it. And we go through the different therapeutic options—bypass and angioplasty, traditional drugs, we can change diet and lifestyle, or some combination of those. We go over the risks and



Even if a patient needs an angioplasty, they still need to change their diet and lifestyle to avoid having another one.



benefits and says whatever you choose, I am here to support you. And then if they are interested in diet and lifestyle, then I have a whole team of people you can work with. And if they choose that, they come four hours a week, so it is a lot of time. But the doctor doesn't have to personally be there. He or she is the quarterback who oversees it.

**Dr. Kreisberg:** *Do you have plans to extend the work to conditions other than heart disease?*

**Dr. Ornish:** We are about to publish the first randomized, controlled trial that shows that the progression of prostate cancer can be affected through diet and lifestyle. We presented the preliminary findings at the Annual Scientific Meeting of the American Urological Association.

We focused on heart disease initially because we have the randomized control data, we have cost data, we have medical effectiveness data, and it is still the number one cause of death and cost for Medicare, so if they can do it in this area it will be a much smaller step to have them do it for other illnesses as more data becomes available, even for prevention. There is a whole range of chronic diseases that could benefit from a diet and lifestyle approach—diabetes, hypertension, obesity, arthritis, prostate, breast, colon cancer to name a few.

**Dr. Kreisberg:** *What is the core of the effectiveness of your approach?*

**Dr. Ornish:** Emotional stress has been shown to increase the risk of almost all diseases, so anything that reduces the risk of that can help prevent those diseases. I have spent a lot of time with the same group of patients over many years doing these studies and I have asked them, "Why do you smoke, why do you overeat, why do you work too much, why do you abuse yourself

in these ways?" These behaviors seem so maladaptive. They say, "Dean, you don't get it. These behaviors are very adaptive because they help get us through the day." And for many people that is more important than worrying about living a few months longer. As one person said, "When I get depressed, I eat a lot of fat. It coats my nerves, it numbs the pain." Another said, "I have 20 friends in this package of cigarettes and they are always there for me. Are you going to take away my 20 friends?"

There are lots of ways that people have for bypassing or coping with pain, either literally or figuratively. But to me the pain is always the teacher, it is the messenger, it is saying listen up, pay attention, you are not doing something that is in your best interest. So we find that one of the reasons that we are able to motivate people to make such big changes is that we are looking at the deeper levels at what motivates that behavior. And that is really important, because otherwise, it is very hard for people to make even small changes.

But when you make big changes, most people find that they feel so much better so quickly it reframes the reason for making those changes from risk factor adoption and prevention—which is really boring for most people—to feeling better. If you make big enough changes, your brain gets more blood so you think more clearly. Your heart gets more blood, your sexual organs get more blood, so for many people those become choices worth making not just to live longer, but to live better.

**Dr. Kreisberg:** *I would like to go back to the origins of this conversation. So institutionally, it ends up being about the economics—you realized you had to get it paid for.*

**Dr. Ornish:** It is, like the rappers say, all about the Benjamins.



**Dr. Kreisberg:** *Is that true on the patient level as well? Do patients need to have it paid for?*

**Dr. Ornish:** Most people can't afford to do this. It costs \$7,200 or a little more than that per year. It is more than most people can afford to pay for out of pocket. Then again, if people had to pay for their own bypasses and angioplasties, there would be a fraction of them performed as well.

**Dr. Kreisberg:** *But if someone is paying for them to go, why would they stay with it?*


**Dr. Ornish:** People on this program feel better not just physically, but in these deeper levels that are harder to measure but are often more meaningful for people. If you talk about prevention, it is really hard. So we don't talk about prevention. Instead, I talk about feeling better and having more energy and having a better sexual function and looking better and feeling better and weighing less and rediscovering inner sources of peace and well being and joy. That is ultimately what matters to people. If you live longer, great. But if you get hit by a truck it doesn't mean that you wasted your time. So many patients have told me, "Even if I don't live longer, I would still continue this because I know how much better I feel when I do it."

And the sense of community that is created is very powerful. The support groups initially started as a way for people to share recipes and shopping tips and compare running shoes, and so on. But in the very first study I did back in 1977, I realized that I had unwittingly created this sense of community

and that is very meaningful for people. Community is a basic human need that often goes unfulfilled in modern life because of the breakdown of the social networks that used to provide this.

**Dr. Kreisberg:** *It is powerful work you are doing and those of us interested in medical reform are grateful. Do you have any words of advice?*

**Dr. Ornish:** Things that are worth doing often take a really long time and they are hard to do. I am cautiously optimistic at this point. I am more optimistic than I have ever been, let's put it that way. And I have to be because it is so easy to be cynical otherwise.

Most people have no idea how hard it is to do the work we do. I'm not complaining. It is part of the challenge, it is what I do for fun. It is very hard to get funding to do studies like this because it doesn't take the traditional approach. It is hard to get them published, because they are held to a different standard. It is very hard to get insurance companies to pay for this, it is extremely hard to get Medicare to pay for this, but these are all things that are worth doing. That's what makes this approach financially viable. So while we are talking about what makes medicine sustainable, it is all about the Benjamins. 

But to me the  
pain is always  
the teacher,  
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