# Gross National Happiness and Medicine

March 2009

Today most countries define success in terms of economic growth measured as Gross Domestic Production, or GDP. This number represents the total value of goods and services produced within a country's borders in a given year. Interestingly there is a growing movement to define national success in more holistic terms via the concept of Gross National Happiness (GNH).

The GNH movement started in the Kingdom of Bhutan which borders on India and Tibet and is one of the globe's most isolated countries. By 1970 travel and technology had opened its doors to the modern world. King Jigme Singye Wangchuk felt a strong commitment to preserve his country's culture and traditions during this influx of modernization. In 1972 he crystallized this concern around the Buddhist notion that the ultimate purpose of life was inner happiness. He felt the need to define development in terms of personal happiness rather than solely in terms of abstract economic measurements such as GDP. Pursuit of this intention led to his establishment of Gross National Happiness as a primary national objective. In essence, individual happiness was to take precedence over economic prosperity as the nation developed. Quality of life rather than sheer quantity of material production and consumption was to be the ultimate social goal. With this guiding principle the government took measures to preserve the nation's traditional culture and environment, successfully balancing modernization with conservation of Bhutan's ancient identity and traditions. Rampant destruction of the country's environment was avoided. By 2002 their government was spending almost 18 percent of its national budget on education and health care as compared with 2 to 3 percent for China. In 2006 Business Week rated Bhutan the happiest country in Asia and the eighth happiest country in the world citing a global survey conducted that year by England's University of Leicester[1]. The U.S. ranked 23rd, due to "nagging poverty and spotty health care."

Not surprisingly, the Bhutanese concept has spread, moving rapidly from the Indian subcontinent into much of Southeast Asia. The Fourth International Conference on GNH was held in the Netherlands this past November and 25 countries were represented.

What, might you ask, does all this have to do with the current state of healthcare in the USA? As you may have guessed by now, I have a few thoughts on that subject.

Let's look for a moment at our health care system and how we define its success. As a profession we tend to measure our accomplishments in terms of quantity of life as reflected by the vital statistics of life expectancy, infant mortality and maternal mortality. We pride ourselves, as well we should, that life expectancy at birth hit a national high of 78.1 years in 2006. We chafe a bit at the thought that although we spend more money per capita on health care than any other country in the world, our life expectancy ranks #34, tied there with Cuba, Costa Rica and Chile. Then again, our maternal mortality puts us at #35, right in there with Lithuania and Bulgaria, and sadly, infant mortality puts us at #39, tied with Slovakia, Serbia, Thailand and Lithuania. But that's a topic best saved for another time.

Allow me to suggest that when it comes to our profession's value structure, Length of Life (LOL) has become our GDP. And I think Quality of Life (QOL) must become our GNH.

Even as the goals of GDP and GNH are not necessarily mutually exclusive, neither are those of longevity and quality of life. But we all know that sometimes they are. Slavery may improve GDP but would rarely be expected to improve Gross National Happiness. Placing NG tubes in chronic hemiplegic dysphagic aphasic stroke patients may well improve Length Of Life, but few would argue that it improves Quality Of Life. Many people recognize that there are health states worse than death. Even as Bhutan has given higher priority to GNH than GDP, there is a public calling to our profession to manifest the capacity to give quality of life precedence over longevity.

In some areas of medicine we have done well with this. We quit doing yearly screening chest x-rays in smokers when we realized that finding early lung cancer did not improve survival. In fact our well-intentioned efforts to cure this cancer were shown to significantly decrease quality-adjusted longevity compared to those smokers who were not screened. In terms of quality-adjusted life years, our treatment was worse than the disease. Unfortunately we have yet to apply the same wisdom to the use of PSA screening for prostate cancer. Like lung cancer in smokers, we have yet to find a treatment for prostate cancer that is better than the disease in terms of quality-adjusted life years. Many other countries have stopped doing PSA testing in light of this reality. Ours sadly has not. Last month's JAMA article and Cancer Institute article on this subject [2] may help change this.

As a profession we face similar conflict of intention (longevity vs. quality of life) when we attend patients at the end of their lives. There comes a time when disease-directed therapy aimed primarily at prolonging LOL, has need to give way to comfort-directed therapy, whose goal is maximizing QOL. Clearly the public wants this. Clearly many of us in medicine have a hard time making this transition. Thus arose the need for Advanced Directives (ADs) to help patients communicate their end of life requests clearly to their caregivers and families. Yet in most out-of-hospital crisis situations ADs simply don't work. Emergency responders don't have time or opportunity to find and sort through the paperwork. This dilemma has birthed the nationwide POLST (Physician Orders for Life-Sustaining Treatment) project that is now active in over 14 states. Completion of the bright pink POLST form by the patient and their physician creates an easily recognizable set of orders that accompanies the patient from home to hospital to SNF to Board and Care, providing clear direction regarding intensity of medical intervention. This project also came in response to patient demand that we as a profession pay greater attention to quality-focused longevity.

Potential application of the GDP/GNH: LOL/QOL paradigm begs implementation at all levels, from designing specific therapeutic protocols to restructuring the healthcare system as a whole.

Bhutan: The little country that roared. Let us join the chorus.

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[1] Business Week, Europe section, October 11, 2006
URL: http://images.businessweek.com/ss/06/10/happiest_countries/index_01.htm
This British survey compiled data from UNESCO, the CIA, the New Economics Foundation, and the World Health Organization, among others, and concluded that wealth, access to health care, and basic education were the most critical factors in determining happiness.
See more recent related article: Business Week, Global Section, August 20, 2008
URL: http://www.businessweek.com/globalbiz/content/aug2008/gb20080820_874593.htm

[2] New York Times, Health Section, March 18, 2009
URL: http://www.nytimes.com/2009/03/19/health/19cancer.html?_r=1&emc=eta1
The PSA blood test, used to screen for prostate cancer, saves few lives and leads to risky and unnecessary treatments for large numbers of men, two large studies have found.