

Lifestyle Medicine: A Primary Care Perspective

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“Patients don’t change.” The memory brought back uneasy feelings as I recalled the admonitions given by several of my medical school attending physicians. “Don’t waste your valuable few minutes on counseling; better to use medications, which we know work.” A few years later, in residency clinic at a community health center, I met Rosa (name has been changed). At age 45, she struggled with hypertension, depression, and obesity; her blood work that day added prediabetes to the list. Rosa had a stable job and intact family, but felt overwhelmed by her health problems. She tried dieting countless times, only to regain more weight than she had lost. Previous primary care physicians told her she needed to lose weight, but to that end, she had not been offered any realistic solutions.

During our first visit, I helped Rosa assess her strengths and weaknesses, resources, preferences, and stage of change. Then, collectively, we came up with an action plan. She decided to attend our shared medical appointments (SMAs)—group visits to help overweight and obese patients with risk factors for cardiovascular disease make healthy lifestyle changes.¹ During these visits, Rosa spoke with others who had similar health conditions, participated in health and wellness activities, and learned to set achievable goals. She especially enjoyed the stress reduction sessions, exercise classes, and cooking demonstrations of quick, inexpensive, healthy meals.

In addition to SMAs, Rosa learned about culturally appropriate, healthy foods from our dietician and safe exercise techniques from our physical therapist. Armed with the information and skills needed to make healthy lifestyle changes, Rosa felt empowered. She began exercising several times per week at a community gym. Her husband took charge of cooking meals and made healthy lunches for her to take to work. When her work schedule made it difficult for her to continue attending the SMAs, our medical assistant arranged for her to have a “buddy” who was also trying to lose weight. They held each other accountable and provided much-needed camaraderie on the road to health.

In 12 months’ time, Rosa’s hemoglobin A1c returned to normal and her weight stabilized at 15 pounds less than it had been at our initial visit. Her mood and blood pressure improved, so she was able to stop taking medications for both depression and hypertension. She continued to eat healthily and exercise. Inspired, her husband also began exercising. Seeing Rosa and her family become healthier made our care team feel proud that we had been part of the transformation.

Rosa’s story illustrates the power of lifestyle medicine. While the specialty of preventive medicine is well known to physicians, lifestyle medicine is elusive for many. Lifestyle medicine is defined as “the systematic practice of assisting individuals and families to adopt and sustain behaviors that can improve health and quality of life.”² The first textbook on this subject was published in 1999, and the certifying board, the American College of Lifestyle Medicine, convened its first meeting in 2004.³ In 2007, the American College of Preventive Medicine Board of Regents decided to become actively involved in lifestyle medicine, and convened a panel of experts in 2009 to develop 15 evidence-based competencies for practicing physicians.² Examples include collaborating with patients and families to develop action plans such as lifestyle prescriptions, practicing and promoting healthy behaviors, and drawing on an interdisciplinary team of care providers.

In 2012, the American Medical Association called for physicians to “acquire and apply these competencies, and offer evidence-based lifestyle medicine interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine.”⁴ However, many primary care physicians find this recommendation challenging to implement in time-strapped clinical practices. Limited training in lifestyle medicine also leaves many providers feeling ill-equipped to counsel patients—especially when they are not living healthily themselves.⁵ Furthermore, most reimbursement models preferentially reward treatment over prevention.

Of the top 7 causes of death in the United States, 5 are largely due to lifestyle-related chronic diseases.⁶ As a consequence, escalating health care costs due to preventable diseases make it imperative that we adopt

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TABLE

Practical Tips to Integrate Lifestyle Medicine (LM) Training Into Existing Medical Curricula

Tips	Examples
1. Host didactic sessions with LM experts	Question and answer or hands-on workshop to learn to write exercise or healthy eating prescriptions
2. Hold LM journal clubs	Review current recommendations and evidence for LM in the care of chronic conditions
3. Facilitate student and resident rotations with LM practitioners	LM-focused clinics or clinics with offerings in stress reduction and healthy nutrition
4. Include risk behavior change, counseling, and health education in standard medical curricula	Motivational interviewing, health coaching, and information about appropriate diet and exercise
5. Support trainee-led initiatives in LM	Medical school LM interest groups
6. Develop and provide affordable resources to help patients implement healthy lifestyle changes	Handouts about local farmers' markets, food security resources, low-cost gym memberships, and community wellness initiatives

strategies to incorporate lifestyle medicine into conventional, treatment-based medical practice. The longitudinal nature of primary care makes it an ideal place to start; however, the full burden of this change need not fall on primary care physicians alone. Effective and efficient practice of lifestyle medicine employs a multidisciplinary team in which physicians are equipped to work as educators, coaches, leaders, and collaborators (TABLE).

In medical school classrooms we learned to tell patients to exercise and eat more vegetables. Our first attempts to convey this one-liner to real patients revealed that limited counseling is not enough. It takes motivation, resources, information, and a lot of work to make lasting changes. However, most medical school and residency programs lack in-depth education about nutrition, physical activity, motivational interviewing, health coaching, and management of multidisciplinary teams. For example, only one-third of medical schools offer a dedicated nutrition course to their students.⁷ In addition, most residency programs lack rotation experiences where lifestyle medicine is modeled, taught, or practiced. Previous studies^{8,9} of internal medicine residents showed that they lacked confidence in basic lifestyle medicine principles, such as prescribing exercise or using behavioral modification techniques.

Seasoned physicians know that patients with cancer, alcoholism, or kidney disease cannot fight their health battles alone. State-of-the-art treatments, networks of specialists, and support groups are available to help them. Why are other lifestyle-related chronic conditions treated differently? While there are a handful of senior clinicians advocating for the integration of lifestyle medicine into patient care, trainees seem to be leading the charge. The past few years have seen an increase in the development of lifestyle medicine interest groups at medical schools where trainees are making strides to integrate lifestyle medicine into their curricula.¹⁰

The rise in obesity in the United States and other developed countries is largely due to a normal human response to an increasingly obesogenic food environment.¹¹ Key factors identified as contributing to obesity include heavily marketed, highly processed foods that are less expensive than their healthier, less processed counterparts, and an increase in sedentary activities.¹¹ Nearly three-quarters of the \$3 trillion spent yearly on health care in the United States is for chronic, lifestyle-related diseases.^{12,13} Escalating health care costs are partially a consequence of these obesogenic factors combined with a treatment-focused, rather than prevention-focused, approach to health care.

In order to afford to care for everyone in society, we need to focus on prevention and create solutions that allow delivery of sustainable, cost-effective health care. One place we can start is by making educational experiences in the field of lifestyle medicine a priority, and optimizing them at every level of physician training. We should take into account, as we continue to increase and refine lifestyle medicine curricula and learning experiences in medical education, that experiential learning theory supports focusing on practice-based experiences rather than relying solely on passive textbook or online content.¹⁴ Understanding lifestyle practices, and how to change them, will move us beyond placing temporary fixes on chronic conditions and help us get to the root of problems driving preventable chronic disease.

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