

EXPERT PANEL DISCUSSION

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Rosanne Rust, MS, RDN, LDN, Arthur Frank, MD, Steven N. Blair, PED,
and Michael Parkinson, MD

American College of Lifestyle Medicine Expert Panel Discussion: The Treat the Cause Movement*

Editor's Note: The following expert panel discussion was recorded on October 27, 2013 as the opening session of the American College of Lifestyle Medicine Annual Convention.

Participants were the following:

- James M. Rippe, MD—Moderator
- Wayne S. Dysinger, MD, MPH—Lifestyle Medicine Expert
- Rosanne Rust, MS, RDN, LDN—Nutrition Expert
- Arthur Frank, MD—Obesity Expert
- Steven N. Blair, PED—Exercise Expert
- Michael Parkinson, MD—Insurance and Prevention Expert

Dr Rippe: The *American Journal of Lifestyle Medicine (AJLM)* is proud to play a role in bringing together these diverse experts in multiple areas of lifestyle medicine to discuss the “The Treat the Cause Movement.” Our goal at *AJLM* has always been to provide a platform for serious, evidence-based discussion on how issues related to lifestyle impact on both short- and long-term health and quality of life. We recognize that expertise in this area resides in many

places and covers numerous bodies of literature. In our expert panel, we are delighted to have individuals with expertise in multiple areas related to lifestyle medicine. Let me briefly introduce our panelists. Each of them is a leading expert in his or her field with numerous accomplishments. I will only briefly highlight several of each of their qualifications:

Rosanne Rust, MS, RDN, LDN is a registered, licensed nutritionist with over 25 years of experience in clinical and community nutrition, and currently works as a nutrition communications consultant.

Dr Arthur Frank is a world-renowned expert in the field of weight management and obesity treatment.

Dr Steven Blair is Professor in the Departments of Exercise Science and Epidemiology and Biostatistics at the Arnold School of Public Health, at the University of South Carolina and a widely quoted expert in the area of physical activity and exercise.

Dr Wayne Dysinger is the Chair of the Department of Preventive Medicine and Director of the Family and Preventive

(Lifestyle) Medicine Residency at Loma Linda University. He is also Medical Director of the Lifestyle Medicine Institute.

Dr Michael Parkinson is the Senior Medical Director of Health and Productivity for the UPMC Health Plan and WorkPartners overseeing employer strategies to improve health and competitiveness. He is the former President of the American College of Preventive Medicine (ACPM).

Dr Rippe: The first question is for Rosanne Rust. In the area of nutrition, what do you see as the major issues that impact on the field of lifestyle medicine?

Ms Rust: As a registered dietician, it is clear to me that diet therapy plays an extraordinary role in wellness and disease prevention. Obesity, for example, is a significant issue both in the adult and pediatric populations. The family unit is a key to intervention. While we talk about specific foods and which diet is the best, it is most important to understand the totality of our behavior, including the way we eat, how we eat, and how we teach our children to eat.

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Thus, behavior is a critical issue in nutrition.

Dr Rippe: Dr Frank, in the area of obesity, what do you see as the major issues related to the field of lifestyle medicine?

Dr Frank: A number of issues related to obesity seem particularly compelling and obligate our attention.

First, the culture around us has a generally negative and stigmatizing view of obesity. It does not see obesity as a medical problem and tends to blame the patient for indifference, bad eating habits, and willful misconduct. There is abundant evidence that obesity is largely related to abnormal metabolism and only a small fraction of the disease is related to patient behavior.

Second, we need to have a cultural shift in the public thinking, and also among patients and health professionals, that obesity is a disease. This shift is not simply for administrative purposes, but primarily to enable us to undertake its management with the same intensity we would apply to other chronic medical problems.

Third, we accept that we must get the patient involved in the management of the disease. There should be no expectation that modification in thinking, a diet, a pill, or a surgical procedure will solve the problem. The patient is not fully responsible for having the disease, but is substantially responsible for its management.

Fourth, we must shift away from seeing this as a trivial or cosmetic problem. We, and the patients, have to see this as the serious disease that it is with all of the complex issues that arise from it.

Fifth, is the complex issue of the maintenance of weight loss. We have to find better ways of helping patients with the continued management of this disease just as we do with patients in the management of diabetes, hypertension, or cardiac disease.

Sixth, we must also find a better way of dealing with cost issues in weight management and weight maintenance because without some sort of more

rational way of dealing with costs there is no way that health care professionals can be compensated for their time, skills, and knowledge.

These are issues that are suffocating the management of obesity making it extraordinarily difficult to sustain proper care. We must deal with these issues because they are the heart and soul of so many other problems.

All of these factors deal with lifestyle issues. Management of this complex disease with its life-altering implications is surely going to involve substantial changes and will need all the help that can be provided by skilled and experienced experts in lifestyle management.

Dr Rippe: Dr Blair I am sure it was music to your ears when the American Heart Association, my professional organization, declared that physicians should counsel patients about physical activity. How does physical activity interact with lifestyle medicine?

Dr Blair: Well, not very much unfortunately, but it should! Physical inactivity in my view, is the biggest health problem of the 21st century. Perhaps it is second to something but it is a huge problem. If you go to Google and put in "physical inactivity" and see how many hits you get and then put it "obesity" and see how many hits you get, you probably get 30 times more hits for obesity than physical inactivity. We included this in an Editorial called "Call to Action to Physicians" to try to get doctors to pay more attention to physical activity. One of the reviewers of the editorial said "Well, that's just Google. Who cares about Google? What about PubMed?" We looked at PubMed and found 40 times more hits for obesity than for physical activity. There is no question we have an obesity epidemic and we really don't know what's causing it other than positive caloric balance. Many people have said that the obesity epidemic is due entirely to people eating too much because physical activity hasn't changed. If they mean self-reported leisure time physical activity, from NHANES (National Health and Nutrition

Examination Survey) surveys, that has been fairly flat over the past 30 years. But is there anyone who doubts that occupational physical activity has declined substantially in the United States over the past 50 years? Tim Church's research group published a paper on that a couple of years ago. He reported a decline of 140 calories per day in occupational activity in men and 120 calories per day in women. These are more than enough to explain the obesity epidemic. We also published a paper on household management energy expenditure among American women over the past 45 years and showed a decline of ~1800 calories per week in. So don't keep telling me "it's only a matter of eating a healthy diet." That is important, but unless you measure physical activity or fitness properly I think you're taking a wrong direction. Even in leading scientific journals, the concept of "physical activity" and "fitness" often do not appear in articles. This is a serious mistake.

Dr Rippe: Dr Dysinger you have been a leader, really a pioneer, in the area of lifestyle medicine. What do you see as the major challenges facing the entire field?

Dr Dysinger: One of the challenges is simply being recognized as a discipline within medicine. The challenge will start to go away as people understand what lifestyle medicine is, recognize the term, and understand the modalities of lifestyle medicine such as nutrition, physical activity, stress management, and weight management. The other big challenge is the finances. How do lifestyle medicine practitioners get reimbursed for lifestyle medicine practices in the same way that physicians are reimbursed for coronary artery bypass grafting surgery or gastrointestinal procedures? We need to find more opportunities for different models of reimbursement in lifestyle medicine. It remains an enormous challenge to establish financial mechanisms to provide lifestyle medicine counseling for our patients and get reimbursed in financially viable manner.

In addition, we have already discussed sustaining lifestyle change. We know how to change lifestyles. We know how to do that quite well. It is well documented that we can change people's behaviors in the short term but sustaining those new behaviors is not as well documented. We must document that. We also need a change in our culture and society away from being obesogenic and toward supporting healthy lifestyles. Our society currently is really an anti-lifestyle medicine culture. It does not encourage physical activity or healthy eating. We have to look at how we incentivize society and culture not just in the United States but worldwide. The chronic disease epidemic is moving rapidly through the world. Those will be the biggest challenges.

Dr Rippe: Dr Parkinson you have played a significant role and continue to consult in the insurance industry. How do you see the future of lifestyle medicine as it relates to the Affordable Care Act or to insurance in general?

Dr Parkinson: First let me say that it is great that American College of Lifestyle Medicine has decided to hold its annual conference inside the political bubble that is Washington, DC. There is a lot of political rhetoric being attached to "health care reform." In fact, many of these elements were at least conceptually in place when the HMO (health maintenance organization) movement began. The science and data analytics weren't as mature, but we attempted to change the financing of health care from an episodic service type of reimbursement to something called "global capitation." Currently, you do not use the words "global capitation" inside the political beltway. But that, in effect, is what an Accountable Care Organization (ACO) does. The ACA, which stands for the Affordable Care Act, is hardly affordable and it is certainly not sustainable because it does not treat the root cause of disease in any significant shape or form. Don't get me wrong. There are some good aspects of the ACA since it provides incentives that employers can use to improve healthy

behaviors. There are attempts to standardize evidence-based clinical preventive services and uniformly cover them. There is some commitment to funding innovative pilots and shared decision making with patients, but there is really nothing in the ACA legislation which addresses lifestyle medicine—particularly the clinical practice of optimizing behavior change to treat established disease.

I personally believe that the term "lifestyle medicine" is problematic. Our goal should be for every patient around the world to use healthy lifestyle behavior choices to prevent, treat, and reverse chronic conditions. In my institution I call that "optimizing behavior change in clinical practice" because that's the way I get the attention of internists and family doctors in the health care system I work in. I am cautiously optimistic that we will be able to get out of what I would call our "fee for service tin cup mentality" that is, "just pay me more for my services and I will be able to address behavior change." CMS (Centers for Medicare & Medicaid Services) is not interested in paying any professional or any individual *more* money nor are institutions going into ACO arrangements interested in that. They are interested in shared savings and payment models that are new and innovative which leverage technology. If a person or resource is not needed to produce a desired outcome at lower cost, so be it.

There are also numerous innovative models in the employer and entrepreneurial space, such as concierge medicine, direct pay models for comprehensive preventive care, and direct primary care retainer-based practices which are rapidly developing. These new models are particularly disruptive and could become challenges to the status quo—with or without the ACA. For example, there are numerous patients who will choose to pay \$95 a month for direct access to a physician when needed and essentially use their cell phone as their initial "medical home." They really are disconnected from "organized medicine" and they

don't really care what the American Academy of Family Practice or "organized medicine" thinks or says. I believe we are a tipping point that is pivotal. We must make the case through the eyes of the consumer, the family, and the citizen, who are voting with their feet and their money that we meet their needs and improve their lives. They must see value in what lifestyle medicine practitioners are committed to and deliver—and we have to be willing to do it "their way—on their time and money." Advancing the goals of lifestyle medicine, I do not believe, will come from "on high," that is, from CMS or from the ACA.

Dr Rippe: Rosanne Rust, you belong to what is perhaps the largest professional health care organization in America—The Academy of Nutrition and Dietetics. What is controversial within that organization? How are we going to combat magazines that tell us every month of the newest "super food" and get people back to implementing what we already know about good nutrition?

Ms Rust: There are certainly a number of controversies within the nutrition profession. I have always tried to be balanced and realistic in my counseling of patients. My personal philosophy is that you have to treat people based on their lifestyle, income, the ability they have to provide food for their families, and also within their cultural and religious backgrounds. Within the dietitian community, there is some controversy about what is the "best diet." I don't advocate a diet. That is, I don't advocate one diet for all. I will not convince my patients to become vegan if they are not already interested in that and neither will anybody else. Everyone has their own personal preferences, tolerances, and cultural background. Certainly there are evidence-based nutrition guidelines that should be considered as the framework of healthy eating, but it's the job of the nutrition counselor to determine how this framework can be successfully worked into an individual's lifestyle.

Another area of controversy has been sugar. Sugar has been in the news and

has received a great deal of focus over the past few years. Some investigators have argued that fructose and sugar are evil. There was even a recent issue of *National Geographic* with a cupcake on the cover! I found it very ironic that a cupcake could represent our geography but to me it is clear that there is not one ingredient or one food that is causing the obesity epidemic or other health problems that relate to populations internationally. Obesity represents a long-term support issue that takes time and there is no one magic bullet. There is not one food or diet plan someone can follow for the rest of their life and there certainly is not one ingredient to blame.

Other controversies include whether you should eat organic or not organic, whether you should avoid gluten or not or be on a high-protein diet. Back to my original statement, it is important to emphasize behavior so that people understand what healthy eating is. I am sure that if we did a survey, 8 out of 10 people would say that they are supposed to eat fruits and vegetables and not consume too much fat and that plant-based diets are good. But actually implementing this, in most people's lives, is a completely different issue that involves behavior changes. We have to also place a higher value on nutrition in our society. We have to value the idea of doing the right thing for our bodies and get our patients to value that too.

Dr Rippe: There was an excellent article published by the American Heart Association in a scientific statement about implementing the American Heart Association Guidelines.¹ The basic thrust of the article was that the emphasis had to be more on implementation rather than developing new guidelines.

Ms Rust: Yes. Let's just work on those basic guidelines. It is helpful to improve people's diets if even in just a small way. For example, we could not possibly consume all the fruits and vegetables that we are supposed to be eating according to the Dietary Guidelines for Americans² or the American Health Association.¹ There simply are not enough fruits and

vegetables being grown for everyone to consume those amounts. It is really important to make people's lifestyle and diets better than they currently are and move them in the right direction. For example, research shows that small amounts of weight reduction can have a huge impact on health. So let's not shoot for perfection. Let's shoot for some advancement.

Dr Rippe: Dr Frank, certainly there are areas of controversy in the obesity world. What are the tops ones that come to mind for you?

Dr Frank: People are always looking for "the perfect diet." They say to me, "Tell me which diet I should be on. Which weight loss diet works best?" We have weight loss diets, weight loss doctors, weight loss pills, weight loss books. You go to the bookstore and there are 50 different diet books. And patients say, "Which one is the best one? Which one should I use?" And I say, "It probably doesn't make a lot of difference which one you use." Unless the diet is basically a type of lunatic extreme kind of process most diets patients follow will enable them to lose weight. The trick isn't following them, it is sustaining the follow-up and managing that in a long-term way.

I tell patients to find a way to eat healthfully and find a diet that they can stay with and maintain. They have got to think of this process as sustaining the diet for a long period of time—essentially indefinitely. There are always going to be variations and no one is going to be perfect but it must be viewed as a long-term process. Short-term interventions are basically useless. We've got to find a way of preventing people from losing and regaining weight 5 and 10 and 15 times. We've got to get a way of enabling people to maintain their weight, which involves changing behaviors. It depends on changing lifestyle; it depends on awareness, it depends on patients sustaining the ability to pay attention to what they are dealing with and to do it continuously. It isn't the diet that is going to make a difference. It isn't the physical activity that is going to

make a difference. It is the whole way of life that is going to make a difference and this must be done in a sustaining way.

Dr Rippe: Dr Blair, you have been doing a study called "The Energy Balance Study."³ Could you tell us a little about this?

Dr Blair: As I have already indicated, I do not think we really know the cause of the obesity epidemic. We have, however, been engineering movement and energy expenditure out of our everyday life. As I have already indicated, there are marked declines in household management energy expenditure, occupational energy expenditure, and so on. But we don't really have good studies and good data on energy balance where we have measured in free-living individuals, the intake side of the equation and also measuring energy expenditure. We are doing this to assess energy balance in our current study of 430 young adults who are overweight or obese. We measure resting metabolic rate after an overnight fast, energy expenditure by an arm band which correlates very well with doubly labeled water data and also gives data on intensity. Our research subjects wear an arm band for 7 days. We also do 3 random, 24-hour dietary recalls during this time. We repeat all these measures every 3 months and at 1 year collected data on 200 individuals using doubly labeled water. The outcome measures are weight and body composition, which is determined by DXA (dual-energy x-ray absorptiometry) scans. So we are putting together a database on energy balance that will let us test several hypotheses. We will have data to determine if people are gaining weight and/or changing body composition and which people are eating more calories or expending fewer or some combination. It is important that we have some actual data in this area instead of simply going with people's opinions. Right now, we have no compelling evidence that Americans are eating any more now than they did 30 years ago especially if we look at calories per kilogram per day. It is

possible that the obesity epidemic is due to people eating more. Maybe it is, but I have not seen data to support this.

Dr Rippe: Dr Dysinger, the concept of lifestyle medicine comes under attack both from people who have unproven theories about lifestyle and health and also from serious professional organizations such as the American Heart Association who would appear to want to co-opt the concept. For example, the AHA Council that I sit on used to be called “The Council on Nutrition, Physical Activity, and Metabolism.” Now it has just changed its name to the “Council on Lifestyle and Cardiometabolic Health.”⁴ How will the lifestyle medicine movement address these issues?

Dr Dysinger: You’re right that in the area of lifestyle medicine there are people who would take lifestyle medicine and move it into integrative medicine, or functional medicine. These concepts may initially seem scientifically based but at times spin off into some unproven, non-evidence-based ideas. Then there is established medicine or established nutrition, who base their approach on long-held beliefs and long-held practices which may not be working since we certainly are having more and more chronic disease and not less. There is a certain hesitancy to move in a new or different direction at this point, even in the scientifically proven arenas that comprise lifestyle medicine.

Let me give you a specific example. Several years back there was a McDonald’s restaurant that wanted to move into the community that I live in and we said “no, we don’t really want a McDonald’s restaurant in our community.” We believed that the easy choice should be a healthy choice, not an unhealthy choice, but there was great controversy and pressure there. People said we were taking away their freedom by not allowing them to make choices. The point, however, is not taking away choice. The point is making the easy choice the healthy choice. I really think that if lifestyle medicine is going to meet its potential and help reverse the chronic

disease epidemic, we have to make the healthy choice the easy choice. That is true for food, as well as for exercise and physical activity. We have to make climbing the stairs easier than going on the elevator. We have to make choosing fresh fruits and vegetables easier and more economical than choosing the more calorie dense foods. So I believe that pressure relates to issues that everyone is trying to solve within the lifestyle medicine movement.

Dr Rippe: Dr Parkinson, I was struck by your comments that the Affordable Care Act is really not affordable at all and doesn’t really address fundamental changes in behavior. How are we going to do that and how is the insurance world going to play a positive role in that?

Dr Parkinson: Let me first clarify my comment. The nature of American democracy, as much as we may decry it, is still probably the best system of government the world has seen and maybe ever will see. Unfortunately, as I learned after 20 years in the service in the military, anyone who thinks that “single payor” is not political, or is not influenced by major economic forces, is pretty naïve. Our federal health care brokered system that now directly or indirectly finances the majority of medical spending is effectively governed by an elected board of supervisors: Congress. Up until very recently, the largest single contributor in PAC (Political Action Committee) money to Congress were the financial institutions. It is no secret what happened to the financial industry over the past 10 years as they took a tumble. Who does that leave at the top? That leaves the medical industrial insurance complex. So the hospital industry, the insurance industry, the pharmaceutical industry, to a lesser degree the medical industry, and the device companies, together now comprise the largest single contributor to Congress. The ACA represents what is essentially a political solution to what is at its core, inherently a lifestyle problem. It’s really no surprise that the ACA doesn’t address lifestyle medicine or the

true causes of disease, disability, premature death, and excessive costs. The ACA in many ways builds on an ineffective and inefficient health insurance model using new processes to buy insurance—with health care premiums and overall costs, which are roughly double the cost of health care anywhere in the world. And it also guarantees everyone can buy that insurance with generous subsidies. There seems to be a lot of politics around whether the consumer going to the Healthcare.Gov Web site to purchase ACA coverage sees his/her subsidy first—or the true cost of the actual premium first. However, if 80% of health care costs are related to choices we make and environments in our homes, our schools, our worksites, and our communities, we really shouldn’t care who processes the medical claim; or if there’s a 3-, 5-, 10-, or 25-tiered formulary. In many ways, the root causes of chronic disease and the true costs in excessive medical and pharmacy costs remain obscured by the ACA and current insurance models.

Tomorrow morning I leave very early to go to Appalachia. I will meet with people drilling natural gas in Kentucky and West Virginia. My message to them is—look at each other and help each other make health care affordable. It is not your employer’s health care benefit. It is yours. And it’s not a “benefit”—you paid for it in a lower salary. And it really is in your hands and those of an enlightened provider who partners with you to improve your health and address the root causes of your disease and the many medications you may be taking. If your physician or provider helps you and your family to live healthier, great. If not, find another doctor. And make sure you use ALL means at your disposal to help you in your journey. It may be a cell phone app, it may be someone in your church, its more-than-likely one of your buddies in the company. Behavior change isn’t inherently “medical.”

Will the ACA make American business and communities more competitive globally? Will it effectively address poor health, excessive medical costs, and lost

productivity? While I think there are good initiatives in the ACA, we must double down in our homes, our schools, our communities, our worksites. Lifestyle medicine practitioners are pioneers and I thank you for your leadership. But I urge you to look locally while we deal, through our professional organizations and other venues, with national concerns. I was President of ACPM, and had the privilege of working closely with Liana Lianov, current ACLM President, and Dr Eddie Phillips from Harvard, on some of these big issues. It is clear that there are vested bureaucracies that don't change very rapidly. But we have had a few wins. For example, Ornish-like programs can now be reimbursed under Medicare, that's great—but it only occurs after a person has had their CABG (coronary artery bypass graft) and from a health insurance perspective, at a very steep cost.

Two years ago there was a shot not heard anywhere in the world! Medicare policy stated that you don't have to have heart disease before we will pay for obesity counseling from a physician and, in addition, that physicians could have nutritionists in their offices to help with this. The patient had to show progress toward goals over a specified period of time. But reimbursement was provided BEFORE the onset of disease for obesity. But to my knowledge, no system in the country has dramatically taken this approach and yet in one way or another, our professional organizations had lobbied for this policy change for years. We wanted that, but it hasn't seemed to have taken hold.

Dr Dysinger: Because they only pay \$18 per visit.

Dr Parkinson: There you go.

Ms Rust: And they didn't include registered dietitians as nutrition providers!

Dr Parkinson: I will tell you, anyone who studies politics, understands that there *is* a global budget for health care already in effect. When cuts come there will be a real battle to preserve money and turf. The medical/industrial

community is often very aligned with academic medical communities—and as mentioned, there are many powerful groups who remain committed to preserving as much of the status quo as possible. So the ACA is a big deal but I don't want us to think somehow, because we now have universal access to health insurance, that we have fundamentally addressed the true causes of poor health and excessive costs. We have got to continue fighting as best we can.

Dr Rippe: I would now like to open this discussion up to the entire panel and ask how we close the gap between what we know people should be doing and what people are actually doing in terms of physical activity, weight management, nutrition, and other aspects of positive lifestyle. How are we going to close the gap between what is actually happening and what we think should be happening? How are we going to address the problem that 80% of health care costs are driven by what we do in our daily lives?

Ms Rust: We first have to approach people as individuals and help them take small steps toward their goals. As a dietitian, I can tell you that when the obesity legislation went through, my profession was completely stymied that we weren't included (in terms of the ability of a registered dietitian to bill directly for obesity management). This is about 50% of what we do! Lifestyle change is what we do! We have to find a way to either offer support to our patients or help them make changes. People cannot be counseled on diets simply by giving them a piece of paper. That is not nutrition counseling. We need to offer people support because lifestyle medicine involves a long-term process. For example, if a patient is overweight, has high blood pressure, and metabolic syndrome, they are not going to be able to make drastic changes. The first thing that we need to do is establish rapport with them so that they will buy into following our advice. We cannot mandate that people will be motivated—they have to motivate themselves. If a patient comes to me eating fried chicken

and processed food, and is going to a fast food restaurant every day, I may suggest that they cut that down to 3 days a week rather than trying to take away their entire lifestyle. Gradually I add in better behaviors. It is also important not to focus on what patients should *not* be doing, but rather on what they should be doing, asking them to add good behaviors.

Dr Rippe: Dr. Frank?

Dr Frank: We must also include the issue of public policy. While we interact with our patients, we also need to change public policy. We need to change the culture we live in. We can change school programs and educational content. We can change food labels. We can change farm subsidies. We can change tariff policies and we can do a lot of useful things if we have the determination and potential will to do it. These will allow us to change the environment we live in. We can change taxes, we can create bicycle paths, we can enforce running and walking programs. We are not doing those things, but they are important to changing lifestyle. These things will enable us to facilitate lifestyle changes. It must be more than each of us individually working with our patients. The patient also lives in a community in which these things are possible and these things are reinforced.

Dr Rippe: Dr. Blair?

Dr Blair: A year or so ago the National Academy of Sciences released a draft document titled "Science Education in the United States." It was a 600- or 700-page document. I downloaded the PDF and I typed in the "find" box "physical activity" and got the response "term not found" I then typed in the "find" box "behavioral science." Again, "term not found." I then typed in "nutrition." Again, "term not found!" Now I am not opposed to physics, chemistry and mathematics but can you seriously tell me that in our big, affluent country with our huge educational system, there is no place for behavioral science to help students learn how to make these

lifestyle changes that we have all been talking about? This is insanity!

I also want to reinforce what Rosanne Rust said, that we are bombarded with craziness in the media. Go to the supermarket, go to the magazine rack and look at the front covers, and on about 80% of them, you will see beautiful, slender, supermodel, partly clothed women. Occasionally you will see a guy with six pack abs. On the cover then is: “buy my book,” or “follow my diet,” “follow my exercise program and you will look like me.” This is out there all the time. How do we deal with it? I think we need something like FDA regulations or a Good Housekeeping Seal of Approval to validate how programs actually work. I believe Dr. Frank said 50 books in the bookstore were based on diets. In the *New York Times* every week there is at least one diet book in the top ten and maybe occasionally a physical activity book, but are any of them valid? Were any of them written by people that actually know something about the science? I don't know how we are going to deal with this. It is certainly much harder now with the Internet than it was when we just had hard copies of books but I think as lifestyle medicine, physical activity, and nutrition professionals, we need to think about how to try to manage this.

Dr Frank: I conducted my own personal survey at the airport. I went to the news counter and there were 27 different magazines on display. Twenty-five of them had, as a feature on the cover, a diet, which was how to lose weight quickly and simply. And they were not all the traditional women's magazines. These were all general magazines and 25 of the 27 had this theme on the cover. Certainly they can't be all talking about the same diet.

Dr Blair: This afternoon after I got here I didn't quite have my number of steps completed. I take 5 million steps per year and I needed to take a little more of a walk today. So I went down to the desk and asked how to get to the Mt. Vernon trail at the nearby Reagan Airport. The person at the front desk said

“you can't walk to the airport!” Well, yes actually you can but that is not what is encouraged.

Dr Rippe: I would like to make a modest proposal. It seems to me the American College of Lifestyle Medicine could become a leader in this area by establishing a series of awards. The ACLM could award the top 2 or 3 fitness books or the top 2 or 3 diet books that are based on good science. It wouldn't have to be money, just recognition that these are good, science-based books. Or perhaps give an award to the Congressman or woman who actually does something reasonable about linking lifestyle medicine to good health. I believe that this would help the ACLM establish its position as the leader in lifestyle medicine.

Dr Rippe: Dr Parkinson, you've said that in the current environment, with the medical, pharmaceutical, industrial device complex it will be very difficult to move lifestyle medicine issues to a higher priority in Congress since these powerful and affluent segments of our society are putting up a lot of PAC money. How do you think we can really bring about change?

Dr Parkinson: Let's be candid, it is all too often about politicians' money machines. But we can make it less of a political issue. In a sense, we all “vote with our feet” every day in our communities, in our dinner conversations and in our practices. So I think the more we make addressing the “root cause” of preventable and reversible disease NOT a federal issue but rather a state issue and local issue, the more progress we may make. For example, the biggest employer, in every community I have been in the past year, is the hospital. The largest single building in most every community in America is the hospital. It is funded by a third-party payment system that is largely already broken.

As I say to employers in Western Pennsylvania, my job is to grow non-health care jobs here. We already have more hospital beds, more facilities, more doctors, more nurses, more

hospitals than probably we need, and if 80% of heart disease, 91% of diabetes, 60% of cancers just don't occur in countries or even US populations that don't have the lifestyle habits that we do in America, why would you ask the medical establishment to fix it for you? This is the message we have to constructively take to our employers, leaders, citizens, and communities—while beginning to constructively partner with the medical leaders “on the ground.” The solutions won't come from inside the Washington beltway.

At its core, this is not inherently a medical issue. One of the issues we have to address is the appropriate role for medical, public health, nutrition, education, spiritual, and physical activity leadership in energizing community solutions to creating health and fixing the current misalignment of incentives.

So here is the “good news” in my mind. The good news is that the ACA will unmask a terrible secret that Americans haven't been told for 70 years since the inception of employer-based health insurance. That is, that health insurance is absolutely, totally unaffordable. Prior to the ACA, we penalized sick people who bought on the individual market. They perhaps uniquely “saw” the true cost of health insurance. Now we are going to see that the average family premium for a family of four is \$16,300—and that is before you self-pay for your considerable deductible, see a doctor or get a single pill of Lipitor (that you wouldn't likely need if you ate healthier and moved more).

Many of the exchange ACA plans will be associated with higher deductible—anywhere from \$1500 to \$5000 to \$10 000. Bottom line: your \$250 per month insurance—subsidized or not—will require you to put in another \$2000 to \$10 000 before you can see a physician and maybe have a co-pay of \$20 or \$50. I see this dramatic and near-term exposure of the true cost of insurance as an opportunity to connect patients and families to the “root cause” of their conditions and pathways to address them via lifestyle medicine.

Even many of the largest employers are moving rapidly and quietly to something called the “private exchange.” You don’t see a lot about this in the news, but you may have seen that IBM’s retirees and companies like Darden and Red Lobster restaurants are saying, “We have had enough of double digit inflation in health insurance premiums. We are going to give our employees a voucher, a check amount, and you go to a private exchange and you buy what you can.” Seventy to eighty percent of the time these employees buy a health insurance plan that is less expensive and less extensive than what the employer provided before. The majority of these plans are consumer-directed health plans, which is something that I helped pioneer here in Alexandria, Virginia at a company called Lumenos. These plan designs address both the epidemiology of disease and the economics of how best to purchase health care. The choices that you make matter to your health and your wallet. By understanding your health and your care, improving your behaviors, and share in all medical decisions, including surgery and drugs, you can improve your health and likely save money. Better health and choices can be rewarded by rolling over account balances year-to-year.

So, most of the plans on the private exchange are Consumer-Directed Health Plans (CDHPs), which you will see growing dramatically. They have been growing at double digits for the past 2 to 3 years. I think this is a great opportunity for lifestyle medicine. For the first time ever, 330 million Americans will begin to realize there is no such thing as a “benefit.” They pay for the benefit in lower salaries, alternative compensation, or job loss. There is no “benefit.” There is no “benefit” from Medicare or Medicaid. We pay for it. Staying healthy and adopting healthier behaviors is the ultimate cost mitigation. So leveraging this powerful message that physical activity, good nutrition, and mindfulness are effective in addressing both disease and costs for you and your family—represents a new opportunity for those committed to lifestyle medicine.

Dr Ornish has run multiple programs that emphasize physical activity, nutrition, and mindfulness. And employers are increasingly attuned to an expanded definition of “health and fitness.” For example, the new president of the World Bank, Dr Jim Yong Kim, came to that position from Dartmouth. About a month prior to this conference he arranged for senior executives at the World Bank to participate in a daylong session of mindfulness training. Twenty Buddhist Monks came to the World Bank and asked each executive to ponder the question: “What is your purpose? What is important to you? Are you tuned into your environment?” The Bank provides healthy options in its cafeteria. Employers are way ahead of the medical and hospital community in this regard. Way ahead. If you have an enlightened employer who still offers health insurance in your community, take a day off and ask them to teach you about how they create health in the workplace—and touch the home and community as a result of their leadership and example.

Dee Edington, who has written so persuasively on this topic has said somewhat tongue-in-cheek, “I got it all wrong. It’s not about individual’s changing behavior, it is about changing the environment and individuals will respond to it.” So my point here is let’s not overmedicalize the route to achieving our ultimate goal—a healthier America. Lifestyle medicine may be most effective when it grows organically at the local level in partnerships with leading employers, groups, and select health care delivery organizations “at the local level.”

Dr Rippe: Dr Dysinger, how are people who want to make a career in lifestyle medicine going to be able to play a role? Where do they get trained? What do they do? What are the nuts and bolts that will allow people who want to pursue a career in lifestyle medicine to become leaders in this area?

Dr Dysinger: We need to make a lot of changes in how we go about health professional training. We have hours and hours of pharmacology in our medical

school curriculum, yet very little on nutrition. We need to change some of those things and it needs to happen both at the medical school level, at the residency level, and at the CME (continuing medical education) level. These are the kinds of things that the American College of Lifestyle Medicine is working on.

I was just at a conference a few weeks ago where the AAMC was represented, the AMA was represented, the NIH was represented, the National Board of Medical Examiners was represented, and other leaders as well. The whole purpose of the conference was to explore how we can change medical school education around lifestyle medicine. Clearly, we have to engage in these kinds of initiatives.

We need to also focus on the area of maintenance. We know how to change health behavior. We know how to do it rapidly in intense therapeutic lifestyle change kinds of programs. We also are learning how to do the small steps that Rosanne was talking about. We need to do a better job, however, of teaching ourselves how to accomplish these small steps and take our patients through it step by step. I think one of the biggest gaps that we have is in the maintenance programs. To give an example, if I have an alcoholic who is admitted to a residential facility, and I discharge that alcoholic without putting him on a maintenance program that included multiple Alcoholic Anonymous meetings per week and a psychiatric and other very intense follow-up, and if I don’t tell that alcoholic that he/she needs to be doing this for the rest of his/her life, I would be in danger of committing malpractice. But every day we have people who come to us and we do not put them on a lifelong maintenance program for obesity or for diabetes or for other chronic diseases. Much of this has to do with the lack of good maintenance programs. We do have maintenance programs like Weight Watchers and Overeaters Anonymous. There are programs out there but we haven’t developed a standardized, replicated, good maintenance program for lifestyle

medicine. So I believe our challenges align more in the area of maintenance than they are in initial health behavior changes.

Dr Rippe: I would like a plug for the American College of Lifestyle Medicine to become more inclusive. The ACLM conference is done in collaboration with the American College of Preventive Medicine. I know that ACLM also has a relationship with the American College of Sports Medicine. I don't know about the Academy of Nutrition and Dietetics, but it seems to me that ACLM ought to be bringing to the table not only physicians but also big, powerful nonphysician organizations who offer their own expertise such as in the area of nutrition. At my research laboratory, we employ 5, full-time MS, RDs, all of whom are much more knowledgeable in the area of nutrition counseling than I am. I also employ exercise physiologists and they have more extensive background and expertise in this area than I do. So it seems to me an opportunity for the ACLM is to take that leadership position and bring to the table not only these other professionals that I have mentioned but also individuals who are expert in mindfulness meditation, behavioral medicine, psychology, and so on. For example, when I asked for a show of hands in our audience of 250 people at this roundtable discussion, I only noticed 3 to 4 members of the Academy of Nutrition and Dietetics and a similar number of exercise physiologists. ACLM has an opportunity to bring together a summit in this area.

Dr Frank: I am a physician and I have been practicing for about 40 years and I have been dealing with weight management for all that time. It has occurred to me on multiple occasions, and over a long period of time, that much of what I do ought not to be done by me, but by other people. What we have done is medicalize a lot of problems and we have medicalized obesity. Fortunately, our program at the George Washington University School of Medicine had gotten large enough so that we could have a professional staff

with diverse skills doing a variety of things. They have skills that I don't have. We had counselors, psychologists, behavior therapists, exercise therapists, and dietitians and they do what they do better than I can do it. They do it with much more skill and, for better or for worse, at less cost. Unfortunately, we have medicalized problems that really should be shifted back to nonmedical personnel because they can do it better. They have better skills, better experience, and a different perspective than most physicians dealing with specialized problems.

Dr Blair: In the audience that we are speaking to tonight we only have 3 or 4 exercise scientists. Thus, in the areas of nutrition and exercise science we have a very small contingent.

Dr Parkinson: I do want to say that I see some potentially positive developments on the horizon. I would urge lifestyle medicine practitioners to think within your local health care system and your local community about how you might agitate, catalyze, and stimulate change. I do not see any type of significant cost control on the horizon except for the one that no one considered—it is not in the ACA. It is to get healthy! It is true that as we stand up Accountable Care Organizations, we will have better analytic tools and new ways of understanding data, including health assessment data, claims data, laboratory data, behavioral data than we did in the mid 1970s or 1980s when HMOs first got started. We need effective, scalable programs that will help people change their behaviors and we need them fast. We don't really need, or have the luxury of doing, a 2-, 3-, 5-, or 10-year demonstration project. Doctors are coming to me right now. We have 6000 physicians and 50 000 employees. One of the cardiologists in our system came to me and said "Mike, I can't do this anymore. Why in the world would I be putting in devices for people with afib without addressing the root cause of their big flabby hearts—obesity? Give me something that I can partner with them to help them be accountable to lose

weight. And if you're not willing to try, well, frankly, you're not my patient anymore."

So I believe we are at a tipping point—whether it is in surgery, or in bariatrics, or in cardiology, or in pulmonary medicine, where some of our subspecialty colleagues in the medical world are beginning to say, "This is crazy! The disease I am seeing is overwhelmingly lifestyle related." But we have to serve them up something that can be leveraged across multiple conditions and settings. I believe the majority of doctors will not embrace lifestyle medicine if it means they must perform face-to-face counseling. But they *will* embrace what ACSM, other organizations, and AHRQ have shown, which is brief 2- to 3-minute messages to write the prescription for behavior change, provide referral to a supporting resource, and create the expectation in for follow-up and continued support and engagement. In that sense, leveraging the "power of the white coat" to create meaningful support and build expectations of improved health behaviors within a system of care is "scalable" lifestyle medicine.

We need to approach the prescription for behavior change with the same amount of gravity that we do for medication adherence. Think about the support that a patient typically receives at a dedicated Coumadin Clinic at the hospital. Optimizing the patient's understanding, self-care, system, and physician expectation of mastery is the goal. This is the type of "prescription for wellness" model we are trying to build at UPMC. Whether or not it's "lifestyle medicine," I won't comment. But it begins with the competencies defined as "lifestyle medicine" by the joint medical specialty organization consensus convened by ACPM several years ago and published in *JAMA*. It is, however, a model that the medical care system is looking for that hasn't been developed yet. As ACOs evolve, I hope you see such systems-based models growing. Right now most doctors don't believe in ACOs, don't know what an ACO is, and parenthetically, don't necessarily believe in "medical homes" either.

For the most part, ACOs, for the immediate term largely come down to one and only one thing—keep Mrs Johnson, who has congestive heart failure, out of the hospital. She must be kept out of the hospital for at least 30 days. I think lifestyle medicine has a huge role to play in this area but we have to articulate specifically what it is and how it might work.

Dr Blair: We have to learn how to deliver interventions to the masses. Look at the Finnish Diabetes Studies, the Look AHEAD trial—they did have pretty good success over 4 to 5 years. It is not 4 or 5 decades, but the point I am making is that we have evidence to do these interventions that last more than a few weeks. The example I like to use is social media. It seems to me that social media and iPhones got people on the streets of Tripoli to protest dictatorships. I think it should get them on the street to Washington to take a walk! This line of research is starting to bubble up, where people are using these kinds of approaches to change behaviors. We will never have enough nutritionists and kinesiologists who are skilled in behavioral change techniques. There will never be enough of them to deal with the millions of people who need these interventions, so let's deliver lifestyle medicine by using modern technology, social media, and so forth. This is a hot new area, but the current research in the past few years is, I think, encouraging. We should be pushing this.

Dr Rippe: I remember one of my great teachers in medical school said something very simple to me. "Nobody likes to be sick." Now maybe people don't know they are sick. Most surveys suggest that people who don't have cancer, heart disease, or some other chronic illness think they are well because they do not have a chronic disease. But they are not as healthy as

they should be and they are not using their health as a performance tool. Members of the American College of Lifestyle Medicine are leaders in this field. It is important that all of us tell the medical student that we see on rounds to go back to their patients and tell them that they are going to give them a physical activity program or that they are going to put them on a weight loss program and give them a specific one or have them seen by a nutritionist. It was Margaret Mead the famous sociologist who said "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."⁵

So the American College of Lifestyle Medicine is currently small by standards of some of the large subspecialty groups like the American Heart Association, but it is a group of people who can truly change the world. That is how the world will change—by small groups of passionate people who care.

Dr Dysinger: Just to add to that, 2 years ago at the first American College of Lifestyle Medicine meeting, there were 50 people. Last year there were twice that many—a little over 100 people. This year we have 250 people at the conference! The American Heart Association cannot say that they have doubled their attendance every year for the past two years.

Dr Rippe: I would like to thank the members of the Expert Panel for their insightful comments on the current state and future of lifestyle medicine. If I may close with a personal anecdote. I happen to edit two major textbooks. One is the major intensive care unit textbook in America⁶ and the other is the major lifestyle medicine textbook.⁷ Unfortunately, each edition of my ICU textbook outsells my lifestyle medicine textbook 20 to 1! Before I die, I want that to be reversed. It is organizations

like the American College of Lifestyle Medicine and the passionate people who have attended this conference that are going to make that happen. Thanks again to our panelists for a wonderful, inspiring, evidenced-based conversation and to our audience for your passion and commitment to lifestyle medicine. Together, we can and will change the world! **AJLM**

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