Education

IN LIFESTYLE MEDICINE

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Shifting the Paradigm

Abstract: *Current medical education lacks significant training in the principles and practices of lifestyle medicine. In this column, I describe my journey to lifestyle medicine, lifestyle medicine education, and what it is going to take to shift the educational paradigm away from the current model to one that is focused on nutrition and lifestyle behaviors and that is both accessible and effective.*

Keywords: lifestyle; medicine; education; online; healthcare

When I made the decision to go into medicine at the ripe old age of 5, my only perspective was that of the rural, family physician. I had been to the emergency department, at least twice, by that age for stitches but do not remember that, of course, so the Rockwellian vision it was. By the time I was a fourth-year medical student, my love for medicine had been tarnished by the inability to actually cure anyone. I found that my internal medicine rotations were tedious. Every hospitalized patient had the same list (or variation of said list) of chronic diseases: diabetes, congestive heart failure, chronic obstructive pulmonary disease, and depression. Rounds were tedious because we spent hours and hours, checking labs, perseverating over the numbers, and then adjusting medication dosages up or down or

stopping some drugs and starting others to tweak those numbers to optimization. It did not work. They did not get better.

That experience propelled me into Obstetrics and Gynecology. I liked the well-demarcated edges of it. There was an alpha and an omega to each patient. Pregnancy . . . baby. Bleeding uterus . . . hysterectomy. I could “cure” people. However, as I began my practice, I realized that I could not escape those chronic, incurable diseases. Insulin resistance and diabetes were causing

Unfortunately, my peers did not share my enthusiasm for this new-found knowledge and declined to change the way they practiced medicine. After all, if heart disease and diabetes really could be prevented or reversed with diet and exercise, then why did they spend all that time and money in medical school learning something else!? Exactly. Why did any of us do that?

It was at this point that I decided to leave my practice for the academic world. It seemed to me that the only

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infertility and dysfunctional bleeding. Hypertension, diabetes, and obesity in pregnancy were leading to all sorts of bad pregnancy outcomes, and morbid obesity was making it harder and harder to operate on patients. There had to be a better way to practice medicine and help people.

When I discovered lifestyle medicine, it was as if a thousand puzzle pieces of medical information I received in medical school (and another 500 that I did not learn) all came together in my mind to create a picture of how to help people restore their own health. It was my moment of serendipity!

way to solve the health care crisis we face in this country was to shift the paradigm and train the next generation of providers differently. Lifestyle medicine must be the core of what we do rather than a cursory recommendation for the asthmatic to quit smoking on his or her way out the door with prescriptions for an inhaled steroid and a rescue inhaler.

But how? As the Director of the Institute for Human and Planetary Health at Doane University, I have been given the opportunity to create continuing medical education (CME) courses in lifestyle medicine. The challenge with a

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project like this is that in a meta-analysis of 99 trials and 160 interventions, the measures most effective at demonstrating a change in physician performance are those that include patient reminders, patient-mediated intervention, and outreach visits. Conversely, formal CME conferences or activities without practice-reinforcing strategies, have relatively little impact.¹ In addition, what we know about learning is that, according to the Cone of Learning by Edgar Dale, after 2 weeks we tend only to remember 10% of what we read, 20% of what we see, and 30% of what we hear. However, by adding interaction and a dynamic presentation that retention rate can increase to as much as 70%.² In addition, e-learning technologies have been shown, in diverse medical education contexts, to be at least as effective as traditional instructor-led methods.³ So to work, I went!

All this information was the impetus for creating online CME courses that include interactive, dynamic content with lifestyle treatment protocols for common, chronic diseases, behavior change and coaching education, a series of real patient cases, and practice models for lifestyle medicine. The protocols are meant to address the lack of practice-reinforcing strategies in many CME activities.

Similarly, we stepped outside the typical voiced-over PowerPoint presentation by utilizing a software tool, called Articulate 360, to create custom, interactive lessons that are easily accessible from any type of device in order to increase retention rates.

Course 1 starts with an in-depth discussion of the principles of oxidative stress, the microbiome, and epigenetics. These 3 principles, we are finding more and more, affect nearly all chronic disease processes, including diabetes, heart disease, and cancer. The next 3 lessons focus on how lifestyle behaviors and our environmental exposures affect oxidative stress, the microbiome, and our genes. The second week of Course 1 and both weeks of Course 2 focus on specific

diseases, disease processes, and lifestyle treatment protocols. I was inspired by the systems approach in Dr Greger's book, *How Not to Die*, and I owe him a debt of gratitude for all the review of the literature he and his team have done and continue to do. Reading and comprehending the research is something I am accustomed to but wading through the mind-blowing numbers of papers that have been published, and continue to be published daily, is entirely another task.

Course 3 is focused entirely on behavior change strategies and coaching. Physicians are largely ill-equipped in this subject area and I am no exception. However, all practitioners could benefit immensely from some basic coaching skills. For this material, I have employed the services of a talented young health coach who also happens to teach various health-related courses at our institution in addition to having been a CHIP facilitator.

And finally, Course 4 includes all things practice related. During my time on the planning committee for the annual American College of Lifestyle Medicine conference, the feedback we received, nearly continuously, was, "I know the evidence for lifestyle medicine and I believe it but how do I DO this!" There is a deafening cry from those in medicine who understand the impact of lifestyle medicine on their patients' lives to know how to get away from the 40 per day, 7-minute office visit. This course is designed to help.

Creation of each individual lesson is more time consuming than I ever could have fathomed. Each lesson is highly referenced with an average of 100 references per 15-minute lesson. The other piece, that often goes unrecognized for us book-nerdy types like me, is the IT side. I have a team of instructional designers, helping with effective pedagogical strategies and instructional technologists, doing their video magic. The human and financial capital required for a project like this cannot be understated.

We are in the middle stage of completion of this project, and I am confident that it will be good. It will be effective, timely, and, I believe, useful for those who take the courses. Seeking feedback from peers has been important. Some really smart people that I respect have been very encouraging, but they have also given honest feedback. It is hard to ask how to make any project better because it means more work! But ultimately we end up with a better product. All that being said, any project can always be better. However, better can sometimes be the enemy of good. I have already identified things that I would do differently next time and items that will be addressed at the time of update.

So, back to tedious. I always knew, yet am rediscovering, that much of life is tedium. So many of the tasks that, as Dr Michael Greger says, "just have to be done" are tedious. I have, in this new and most satisfying mission, chosen to focus not on the tedium, the obstacles, the setbacks, but on the continued exciting journey that I have every hope will play some, if ever so small, role in helping end one of our national tragedies, our diseased people who deserve better. Patch Adams said, "If you focus on the problem, you can't see the solution. Don't focus on the problem." I wake up every morning determined to focus on the solution. So many very talented and dedicated people hold my hand along the way.

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