FROM THE ACLM

President's Desk

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Back to Basics

Abstract: *Non-drug therapy should be foundational to our treatment plans. These should be evidence-based. Drug based therapies rely heavily on randomized controlled trials while the evidence many lifestyle interventions relies more heavily on epidemiological studies. Both have weaknesses and strengths. Medicine needs a system for evaluating evidence that recognizes the strengths of both types of studies and includes some common measure such as Number Needed to Treat (NNT) and Number Needed to Harm (NNH).*

Keywords: non-drug therapy; lifestyle medicine; evidence-based medicine; bias

I did my residency in the early 1980s at a small hospital situated in a wealthy neighborhood in the western Chicago suburbs. One of our residency faculty members was a “volunteer” who rode the train out from downtown Chicago one day a week. All of us young doctors respected Don Bennet. Not only was he generous and polite but he was, at least to us, a VIP. Don had earned first a PharmD and built a successful career. He then had gone back to school and earned an MD. Now he never really “practiced” medicine, but he freely shared that he got the degree to help him understand how the clinicians mind thinks.

Dr Bennet, as we called him, was head of the *Drug Evaluations* section of the American Medical Association (AMA) and, as such, was chief editor of the annual

reference of the same name. At that time the AMA decided that physicians needed a less biased source of information on medications than the industry-written, *Physicians Desk Reference (PDR)*. From Dr Bennet we learned to appreciate and avoid, as much as possible, the biases that industry brings to scientific process. As time progresses it has become even clearer that there has been clear effort to distort the publishing of scientific truth as well as to buy the integrity of researchers, clinician, and the professional associations.¹ But I digress. That subject is better left for another time.

When “Doctor Bennet” lectured us young doctors he used a Socratic rather than a didactic format. He would present a patient something like this,

Then would come the question, “What do you want to do for her?”

A resident would answer, “Acetaminophen?”

Dr Bennet would shake his head.

Another resident would volunteer, “Ibuprofen.”

Again the shake of the head.

And we all sat there thinking, “Surely he doesn’t want us to prescribe a narcotic? What does he want us to say? I’m stumped.”

Then “Doctor Bennet” would say, “What is the nondrug therapy?” He wanted us to prescribe nondrug therapy foundationally and consider carefully the medication benefits as well as the potential negative effects. Something similar occurred in every one of his

Treat the body well, it will
often heal itself.

Mrs Jones is a 48-year-old female who comes into your office complaining of pain in her knees and hips when she gets up in the morning, slowly getting worse over the last 12 to 18 months. The pain usually lasts for 15 to 20 minutes, slowing down her morning routine, and then dissipates until she finds herself sitting for a length of time—like her driving commute or sitting at her work desk. And each time the pain would last for a few minutes and then go away.

“lectures.” As I remember it, I fell for his “trap” every time. But by the end of residency the concept had sunk deep into my medical thinking and I continued an aggressive quest for simple, lifestyle-related, nondrug therapies for the diseases I treated.

In those days I had never heard the term “Lifestyle Medicine.” But I have come to understand that I was being taught the basic principles of this now blossoming discipline. Principles like, “Treat the cause, not just the symptom.”

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As a practicing physician, I know there is a place for pharmacotechnology and procedures but none of these should displace the preeminence of the basics of nondrug therapy for if we “Treat the body well, it will often heal itself.”

Clarity

Lifestyle medicine is a relatively new term that is defined in different ways by different folks. In an attempt to normalize and clarify the concept, several have taken a stab at creating definitions. Here are an illustrative few:

- In 2008, the leadership of the American College of Preventive Medicine, Mark Johnson and Mike Barry, defined lifestyle medicine as a defined scientific approach to decreasing disease risk and illness burden by utilizing lifestyle interventions such as nutrition, physical activity, stress reduction, smoking cessation, avoidance of alcohol abuse, and rest.²
- The website of the American College of Lifestyle Medicine currently defines it this way, Lifestyle Medicine involves the therapeutic use of lifestyle, such as a predominately whole food, plant-based diet, exercise, stress management, tobacco and alcohol cessation, and other non-drug modalities, to prevent, treat, and, more importantly, reverse the lifestyle-related, chronic disease that's all too prevalent.³
- It maybe that the Wikipedia definition,⁴ borrowed from a recent article summarizing the thoughts of several American Heart Association (AHA) committees will become the standard definition. The AHA defined Lifestyle medicine as a branch of medicine dealing with research, prevention and treatment of disorders caused by lifestyle factors such as nutrition, physical inactivity, and chronic stress.⁵

Similarities are present but all are focused on finding and applying healthy

lifestyle choices to primary, secondary, and tertiary prevention of chronic disease. They are all saying essentially the same thing. They all recognize the importance of applying nondrug therapy first for most chronic diseases. Don Bennet would be pleased.

And we, as a specialty, are carving out a niche in modern medicine that strengthens and matures these basic principles. I am pleased to be part of the American College of Lifestyle Medicine (ACLM) movement.

Complexity

Most seem to understand that lifestyle medicine encompasses the choices we make in our life that affect our health but there is less clarity as to the identity of the best choices. Lack of clarity comes from, among other things, our own biases and conflicts of interest, the cumbersome scientific process, or even an unawareness of the research that has already been done.

Recognizing and questioning our own biases and conflicts of interest should be a basic skill that all of us practice. It is so easy for personal financial gain (the retirement fund drug company stock, for example) to distort patient care practices. The evidence shows that a low-calorie, plant-based diet may reverse type 2 diabetes,⁶ but I do not even tell my patients about it because, “nobody will do that” with a subtext that says, “I would/could never go plant-based.”

The scientific process has made significant progress toward defining healthier choices but there is still much to be clarified. Confounding this process is the difficulty, if not impossibility, of ethically performing, on human subjects, the double-blind, randomized controlled trials (RCT) that would define them uncontroversially for a skeptical scientific community.

At present, our pharmacotechnology is tested and retested with large numbers of placebo-controlled, randomized trials while the lifestyle interventions (especially dietary) draw much more heavily from a few large prospective epidemiologic trials.

It is not that there are no RCTs in lifestyle medicine it is just that they are expensive and harder to randomize and motivate. Many lifestyle factors cannot ethically be put to long-term blinded RCTs in human subjects. For the present we are often left depending more on the prospective epidemiologic trials, which have another set of problematic, yet I would argue, manageable biases. But fortunately the effect size of many nondrug treatments are high, so the results tend to be statistically strong even though the studies are smaller and/or for relatively shorter duration.

Both the RCT and prospective epidemiologic trials have weaknesses⁷ and strengths and both can teach us more about nondrug therapies. Neither should exclude the other. Both should inform or treatment recommendations

A Potential Solution?

Obviously there is more work to do in this area. In my heart I know that Don Bennet would be pleased with the efforts that have gone into identifying and demonstrating the power of these lifestyle-related nondrug therapies. While we have organizations doing systematic reviews like the US Preventive Services Task Force or the Cochrane Group, they rely solely on RCT data and seldom reference to the other levels of available evidence.

I would like to see an evidence evaluation system that combines and clarifies the evidence we have from both of these research tools along with basic science research. As I see it, one of ACLM's tasks as a change agent is to gather together all the evidence and make it easy to understand. Practitioners and the public need a manageable way to compare the relative effectiveness of both drug and nondrug therapies.

One way to do this would be for the organization to develop and maintain a catalog of treatments with number needed to treat and number needed to harm. This would be helpful even if the numbers were given in ranges. Is there any one of our members with the time, energy, and expertise who would

like to take up this important task? ACLM is a passion-driven, volunteer organization of health professionals like you looking to make a positive difference. Let the staff know if you are interested and thanks for joining with us as we bring positive change to the world of healthcare.

Don Bennet would be proud.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. **AJLM**

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