Education

IN LIFESTYLE MEDICINE

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Navigating the Uncharted Waters of a Lifestyle Medicine Fellowship

Abstract: *Lifestyle medicine (LM) is now recognized as a first-line treatment and disease reversal program for many chronic diseases. More providers are encouraged to prescribe lifestyle treatments, yet lack of training, inadequate time, and poor reimbursement hinder many physicians from actually following through, and few LM specialists are available for counsel or referral. With great strides in resolving these dilemmas, the American College of Lifestyle Medicine has created standards and competencies, and the American Board of Lifestyle Medicine will be holding its first exam for certification in LM in October 2017. Still no residency or fellowship program exists to train providers to become LM specialists. This article describes one physician's journey through an unaccredited fellowship in lifestyle medicine at Black Hills Health and Education Center under Dr John Kelly, founding president of the American College of Lifestyle Medicine. Highlighting the differences of her lifestyle medicine training from her prior primary care and preventive medicine training, the author advocates for the formation of an accredited LM training program in intensive lifestyle medicine interventions.*

Keywords: fellowship; education; lifestyle medicine

The field of lifestyle medicine (LM), though ancient, is young in its voyage across modern medicine. Its course is still being charted as it navigates an ocean of rising paperwork, crashing alarms, and relentless deadlines. The purpose of LM as Dr David Katz, founder of the True Health Initiative, defines, "adding years to life and life to years," can be a North Star in those endless white caps, guiding LM practitioners like starry constellations—led venturesome sailors long ago.¹

Many health care providers are now encouraged to prescribe LM due to the

Lifestyle Medicine are rallying a crew, but education and therapies are inconsistent and no accredited residency or fellowship program exists to cultivate the greatly needed homogeneous and adept LM experts.^{5,10,11} This article is a sketch of the my own voyage across the uncharted waters of an LM fellowship that is to be used with the wisdom and experience from others to create a map hopefully navigating to new accredited LM training programs.

In 2015, after completing residency in family and preventive medicine at Loma Linda University, I moved back to my

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success of early voyagers who invested their lives' work in developing effective disease reversal programs that changed worldwide treatment guidelines.^{2,9} Unfortunately, lack of training, inadequate time, and poor reimbursement hinder many physicians from actually following through, and few LM specialists are available for counsel or referral.⁵ Organizations like American College of Lifestyle Medicine (ACLM), Lifestyle Medicine Education Collaborative, and the American Board of

home state of Indiana where I planned to work at Cummins LiveWell Center (LWC), the new employee lifestyle medicine and primary care center for Cummins Inc. When construction delayed the opening of the LWC, somewhat serendipitously and almost miraculously, the contracts, medical licenses, and travel arrangements fell into place within weeks for me to join Dr John Kelly, MD, MPH, and founder of ACLM, for fellowship training in LM. Cummins Inc. sponsored my fellowship

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from October 2015 to February 2016 at Black Hills Health and Education Center in South Dakota. The length of the program was 5 months simply because construction on the LWC was completed at that time.

Upon arriving at the 250-acre campus with its orange cliffs and ponderosa pines, Dr Kelly and I quickly set out to finalize the details for my training. With his expertise and my feedback, the following educational goals were created. By the end of the fellowship I would

1. Complete the 11-day intensive treatment program as a patient
2. Finish the American College of Preventive Medicine (ACPM)/ACLM LM Core Curriculum modules
3. Be the lead physician of an 18-day program using Dr Kelly only as a consultant
4. Review 3 to 4 landmark studies in LM each week
5. Complete a research project with a publishable manuscript
6. Teach the physician-led patient education lectures on heart disease, diabetes, epigenetics, and neuroplasticity
7. Assist in creating LM workflows and guidelines for the LWC
8. Be involved with physicians in the community and outside educational lectures advocating for LM

Dr Kelly also created several assignments for me to complete before, during, and after the fellowship to assess my knowledge and critical thinking.

I began my training with the “patient experience.” Though I viewed myself as already fairly healthy, exercising regularly 3 to 4 times a week, eating a lacto-ovo-vegetarian diet with infrequent fish or chicken, I was still pleasantly shocked by the change I saw in my own body. With the switch to a plant-only diet, adding in 15 minutes of resistance training a day and regular sleep, my total cholesterol dropped 19 points in 15 days (168 to 149 mg/dL). I also lost 3.5 pounds and a couple inches off my hips and waist. I had not expected to see any change, especially the drop in already normal

cholesterol by eliminating eggs and dairy from my diet.

After understanding the interventions from a patient’s perspective, I then joined Dr Kelly to run the next 4 programs. During that time, I saw 20 patients that enrolled in the medical program (included appointment with physician twice a week) for 11 to 18 days. Average age was 55 years; 60% were females. The most common diagnoses were hypertension (50%), diabetes (50%), high cholesterol (45%), and depression (40%). On average, we saw a drop in total cholesterol by 18 mg/dL without starting any new cholesterol-lowering medications but rather stopping 3 patients’ prior prescriptions. Weight dropped by an average of 3.5 pounds. Beck depression scores improved from an average of 23 (moderate depression) to 9.7 (minimal to no depression). Patients left encouraged, many of them tearful as they shared about “getting their lives back.” This was my first medical rotation in 8 years of training where every patient was helped, the side effects made people feel better, and diseases were reversing.

Though my dual residency program at Loma Linda exposed me to outpatient LM clinic visits and intensive lifestyle change group visits, I had rarely reduced medications and had never stopped them. Patient adherence was poor, and I finished my residency thinking LM changes took months to be even minimally helpful. Nevertheless, I knew it was the best long-term prescription from my education, medical articles I had read, and conferences I had attended.^{4,7} Working with Dr Kelly, I assisted in tapering down medications on almost every patient treated. My LM counseling did not change drastically, but the adherence to the treatment did. I had underestimated the power of lifestyle interventions because I had never seen the intensive effects produced when prescribed with adequate dosing.

In some ways, before my fellowship, it was as if I was a physician learning how to treat diabetes only from the outpatient perspective. I was aware of what the textbook said, but I had never

been the intern in the intensive care unit (ICU) titrating an insulin drip for a disorientated patient with ketotic breath and a chilling ABG (arterial blood gas). It is in the ICU where insulin’s true power to bring someone back from the deathly grip of ketoacidosis is revealed. My training in LM had not yet included this essential ICU perspective, and it felt like a check mark on a flow chart, not the exhilarating rush of a rescued life.

I became acutely aware of the “rescued life” sensation as my fellowship ended. The final assignment was to compare the LM treatment plan we prescribed for 2 particular patients with a standard medical treatment plan. Patient 1, MM, a Hispanic matriarch struggling with depression, increased her walking from 30 seconds consecutively to 30 minutes in 3 weeks as her arthritis pain and diabetes came under control even while taking less medication. If I had managed her illnesses according to standard family medicine guidelines, I would have started 3 new medications with one having potentially devastating immunosuppressive side effects. Patient 2, WS, owned a motorcycle shop and bought shotguns for birthday presents. He presented with a congestive heart failure exacerbation. He left our program 20 pounds lighter and off 3 of his medications. WS continued with a plant-only diet after finishing the program in February 2016, and by November 2016, he had lost 50 pounds. With traditional family medicine treatment, he might have needed a brief hospitalization for IV Lasix and 4 new maintenance medications. This tough motorcyclist left teary eyed and hopeful about his future. I too felt rescued, but with an unsettling feeling in my chest. I could no longer practice medicine without intensive lifestyle interventions.

In March 2016, I joined Premise Health who runs the LWC. Our clinic goal is disease reversal through lifestyle changes. Since the fellowship, I am confident LM therapies are the best evidence-based treatment that exists for chronic disease and anything less would be subpar medicine. My training helps

me better counsel on how to make dramatic lifestyle changes and taper medications down or off as changes are made. Personally, I have continued eating a plant-only diet with the occasional special event and regular resistance training, 2 areas that had previously been very intimidating.

With this sketch of experience and the constellation charts from many others, we can create an accredited training program empowering providers to become competent LM specialists, capable of prescribing a therapy that can prevent, treat, and reverse disease. We can train the new recruits, stay the course, and reach our destination of true health, “years to life and life to years,” for our patients and ourselves.¹

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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