October 2011 Issue | Mark McIntosh, MD -Clinician Roundtable, Part I

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We're here today in a very special environment to talk about lifestyle medicine, which has kind of now moved up onto the marquee. Actually there are now even textbooks on lifestyle medicine. *Lifestyle Medicine* is the name of a text authored by Garry Egger and Stephan Rossner.[1] I've met them; they are medical school professors at Southern Cross University in Sydney, Australia. This book outlines kind of the manifesto for how lifestyle medicine could be integrated within the scope of traditional medicine, both in primary care and in specialty medicine.

INTERVIEW TRANSCRIPT

Mark McIntosh, MD
October 2011

Clinician Roundtable Introductions

I'm very fortunate, as I sit here today, to talk with leading experts from a variety of different backgrounds about their impressions of what lifestyle medicine really means. How does lifestyle medicine interrelate with things like functional medicine, or integrative medicine, or good medicine in such a way as to deliver improved patient outcomes?

Around the table, we have the president of the Institute for Functional Medicine, Dr. David Jones. We have the person who has been a sports medicine expert and worked with athletes for the better part of 40 years and has a family practice clinic that is focused on preventive and functional-related medicine, and that's Dr. Graham Reedy. We also have Dr. Jay Lombard, a psychiatrist/neurologist from New York, who has a rich background in integrating all sorts of things, from very traditional acute care (psychiatric care) into aspects of wellness-focused medicine. We have Dr. Jim Weiss, who is a leading expert and a clinical success story in integrating lifestyle medicine into his diverse general family medicine practice, which he shares with a partner. We have Dr. Ken Browning and his wife, Sandy, who have very successfully integrated First Line Therapy (lifestyle medicine) into their practice in Riverside, California. Dr. Kristi Hughes from Minnesota, who has been a leading proponent, advocate, formulator, and developer of lifestyle medicine programs. We've just had join us Dr. Mark McIntosh. This is quite an esteemed panel of individuals representing all sorts of different backgrounds.

If we can, let's have ground rules of using sound bytes because we are on a limited time. We love the content, but we want to cut down the speeches as much as possible. David, maybe I could start with you,

in that we go back 30 years in our experiences in this field. What does lifestyle medicine mean to you in your mind?

What Does 'Lifestyle Medicine' Mean?

Differentiating Lifestyle Medicine From Public Health Guidelines

DJ: Well, when you talk about lifestyle medicine, you put medicine on the back end of what, in the past, has been thought of as public health. When you look at the national guidelines—whether for asthma, or atherosclerotic heart disease, or metabolic syndrome—all of them start with the admonition that you start with lifestyle intervention, and yet those interventions are not taught to any of us that graduate from medical schools. It reminds me of the article in JAMA where Dr. Halsted Holman actually apologized to the graduates of Stanford Medical School.[2] He's an emeritus professor at Stanford Medical School, and he basically apologized that they had prepared their students for 20{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of what they would see, which is acute medical disease, and that they should be preparing them for chronic illnesses. With chronic illness is the issue of lifestyle medicine, and that's beyond the public health issue of diet and the four food groups, etc., etc.

Lifestyle medicine is about finding a personalized way of applying the science of nutrition, the science of exercise and movement, the science of sleep and restorative activities, the importance of relationships, and resiliency and stress. The science behind those is incredibly deep and robust, and how you apply that to the individual patient is what makes that a medical--not a public health--issue. That's my response to the importance of lifestyle medicine. It's the next level of intervening with outcomes that are usually thought of the domain of the public health officer. It's the domain of the primary care physician, and specialists in certain areas. And it's recognized. I mean, it's in every national guideline, and yet it's not taught. It's one of those things that everyone knows is true, but there hasn't been education. We could get into "Where's the money?", but that isn't where we're going tonight. The money should be there because every time they do a face-to-face test between lifestyle interventions versus drugs/families of drugs, lifestyle is much more powerful. It's an absolute black mark on medicine that they deny the importance of that in the first step of intervention for the problems that we see 70 to 80{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of the time in our offices.

JB: That's a great segue. Thank you, wonderful introduction. Let's switch to Dr. Reedy. Graham, I know you come very heavily from a sports and activity focus as it relates also to the construction of lifestyle medicine. Can you tell us a little bit about how you might weigh in on this topic?

How Physicians Communicate

GR: I think that we're trained, as professionals, to tell everybody what a professional we are and to convince them that we are. There is a concept I think that I have especially learned more recently: that we, as physicians, have medi-speak. We have a lot of medical sounds. It has been said that in our medical training, there are some 13,000 or 14,000 new words that we learn. Those new words that we learn we tend to try on people, and consequently we do not listen very well. There is a form of medicine that we talk about. It has been said we have a tell-ask-tell sort of thing: Tell me your problem, ask me one

question which has one answer, and then tell them again what I think the answer is. We have not been ask-tell-ask, which means: How can I help you? How can I be a part of this? Not: You are scheduled for what you are scheduled for, but how can I help you today? What is your immediate problem as you sit here in the waiting room, which may have changed from how it was when you came driving here? So the ask-tell-ask is help us not have medi-speak.

The second part that comes to great mind for me is the communication. I deeply believe in a study done in some 27 different countries that talked about how communication best occurs. I like a phrase that says, "Everybody communicates, few connect." I really like the fact that then the next part is: How do we not only connect, but how we collaborate as partners in this particular dilemma as a third person? To make the goal a third part of what we are dealing with together as a team? And then we covenant. That means we covenant together to work on this journey to make it worthy of our time (yours' and mine). Not just mine, not just yours': ours'. And that covenant is a critical piece.

And then finally the part that comes to me, I think, that is so important is in the study around these countries it said that it has been found, in over thousands of people, that communication happens only 8{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} by words, 17{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} by tone inflections, and 75{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} by body language. And we're busy becoming a word system. And we're violating the very essence of that. I'd like to hear your thoughts on this around the table because all of you, as far as I know, have heard that sentence. I feel like the biggest thing about integrating lifestyle is to shut up and listen. Be quiet, and not convince somebody how smart I am, but to talk about what excitement I get in a "get to" world, not a "got to" world.

JB: Beautiful, thank you. Dr. Lombard—Jay—from the subspecialty area that you represent (the neurology/psychiatric area), often dealing with very critically emotionally ill patients?

Physicians Have Become Disassociated From Patient Contact

JL: The brain-based perspective. By the way, I would want you to be my doctor, because something that I try to stress to residents in training is the key component of communication and listening with an unbiased and completely open way of hearing from the patient's perspective: what actually they are suffering from as opposed to us trying to contextualize it in our categorical (as opposed to dimensional) models of disease. I think we are really at a very critical stage in medicine right now. For those of us that have been in academia recently, I think that we can all talk about with dismay what we see (or at least what I see personally) as almost an autistic-like healthcare delivery system in which a physician almost completely disassociates from patient contact. Histories and reviews of systems are given by ancillary health practitioners, not by physicians themselves. Forms are filled out with questionnaires, and lab tests are looked at, and MRI scans and radiological procedures are done without any real involvement or interaction between the patient the physician.

Our esteemed moderator here, Jeff Bland, had said something many years ago that really struck me—I think it was in my first year of residency—which was that "We've taken the sacredness out of medicine." And that sacredness of healing is about the relationship itself between physician and patient and we can't neglect that. I think where we are as a society—not just in health care but I think in all aspects of our

current society—is that we think of problems as being one-dimensional in terms of how to fix them. This is obviously a recipe for disaster. Lifestyle medicine, I think, offers us the ability to change a paradigm, to look more at a patient-centric way of intervening.

The last thing I want to say, since I am a neurologist and the brain is one of my favorite organs (not the only one, but…), is that if you think about change and how difficult it is for people to change behavior, behavior change occurs really only occurs in two ways: to avoid pain or to move towards pleasure. If we hold out that basic principle about how our brain operates and use it to improve compliance or ways of engaging our patients in more healthy lifestyles, I think that principle can go a long way in understanding how to improve the delivery of such a complex network of health care.

JB: Thanks, beautiful. That was some real news to use—some very pithy gems. Jim—Dr. Weiss—you know, you made an interesting transition in your career from many years in subspecialty (a very successful practice—into this more general area. Tell us a little bit about that transition.

JW: Yes, I'm a board-certified pulmonologist and I'm board-certified in internal medicine as well, and for the first 16 years of my practice I did a lot of ICU medicine, or as I call it "end-of-life" medicine. About 8 years ago I made the transition because I wanted to prevent people needing what I was doing. It has been a long journey. I have certainly learned a lot over the last 8 years. When I made the transition the natural thing was to do primary internal medicine, and I found myself counseling people. I knew lifestyle changes were the backbone, but I didn't know what it meant or what to do, and so I found myself writing in the plan "diet and exercise," and I began to question myself and think, "What does that really mean?" I started investigating, which I guess has led me to this table today.

Prevention of Chronic Diseases

For me, lifestyle medicine is really about two things. It's about not only prevention, but I'm really struck by the data about how well you can treat these chronic diseases, and I think that has to be of paramount importance to all practitioners, whether they are MDs or DOs or NPs or whatever. And the other thing for me is it is about healthy gene expression and the use of multi-modalities. Frankly, my interest is nutrition, but I certainly understand the concept of exercise and—I know there are MDs here in this room, but I'll say the word out loud, which I typically don't use—meditation, as well. It's really multi-modality for healthy gene expression.

JB: I think you are in the right group to use the word "meditation." These are kindred spirits.

JW: No, no—here I understand, but in other groups I hesitate to say that.

JB: So Ken, you and Sandy have done just a masterful job of converting your clinic into a place I would call an oasis of lifestyle medicine. Tell us about that transition and what drove you or encouraged you to make that transition?

From Treating Conditions to Helping People

KB: Like Jim, I was very traditional, board-certified, in my case, in family practice. I did a high-powered residency with the Air Force at Fort Warden, Georgia, so I came out being able to do all these amazing

critical medical things. I did OB for a number of years. I went through a transition of private practice to groups and finally came back to private practice. And I woke up one morning and it dawned on me (and I look around this room and there is a lot of maturity in this room, and so I think it is a product of age, experience, journey): I'm not making a difference in anybody's life. I've seen enough colds, and I've seen enough flus, enough UTIs, but what was I really doing with my passion?

About this same time, we moved from a group back into a 1902 heritage house, which is very welcoming and patients love it. As Jeff says, it is an oasis in the medical world. I had patients asking me, "You know, Doc, I take horse chestnut," or "I take glucosamine for my knees so I can play golf," or "I take this, I take that." "How does that mix with my medication?" And I had to be honest with them: I had no clue. But I heard this so often that I realized I needed to find out. So it was just a stroke of luck that I called somebody who put me in touch somebody who put me in touch with somebody. We spent months courting, as I like to call it, because this was new language. This was a whole new world for me. I went through a couple of lifestyle educators. I was banking on them to hold me by the hand and lead me on my way, and one day at my doorstep was Chris Katke, who is the lifestyle educator extraordinaire in the world. We'd sit around in the mornings and I like to say that I'd have a cup of coffee and he wouldn't because he's the purist, and we would solve all the problems in the world. You know what I'm talking about: How do we do this and how do we do that? I often say that I was so stupid I didn't know what I didn't know, and that I shouldn't be able do what we started to do, and all we started to do was do lifestyle medicine. We started doing FLT before it was FLT, and it's been a great journey.

JB: Sandy, how about you? You have shared this journey. You have been a local spokesperson, working through the patients. Has it been a transition, as Ken described it, for you?

SB: Certainly. The transitioning was tricky, but I think what really kind of powered it was realizing that we were helping our patients—his patients—by giving them really simple usable tools, and then them having the results they were looking for. You were talking about avoiding pain and working towards pleasure. Well, a lot of people were motivated by the conditions that brought them in and were actually being vocal about wanting something other than another prescription, and were given some things that they could pretty easily implement, starting day one. And that kind of just fed on itself.

JB: Did you find from your experience that word of mouth became kind of a transition force to change your practice? As people had success they went and talked to other people and suddenly you started getting the Dr. Browning reputation of where to go?

KB: At first it was like pulling teeth because this was 8 years ago and the public was not as aware as it is today that there are alternatives out there to just giving a slew of prescriptions. I was also very shy when I first started. My confidence level was not high. Nowadays I'm accused being "House-ian" (Greg House, from TV). Because I will tell people and I'll just get in their face. I mean, I will read their personality and such, but I will get into their face and say, "This is what you need to do. I will write you a prescription or 10 prescriptions if that's what you want, but in this office we don't do that. We're going to teach you how to eat. We're going to teach you how to eat a modified Mediterranean diet, and how to do it 5 times a day, and you're going to get control back of your life. How does that sound?"

When I always ask my new patients, "How did you find me?" "So and so sent me" or "I heard about you." And that makes the journey with them much easier because I'm not having to start from square

one.

JB: So Kristi this is a great segue to you because a lot of what we're talking about was pioneered by you and Lyra Heller in the form of FirstLine Therapy (FLT). Tell us about your journey on this whole revelation process.

Empowerment: Helping Patients Take Control of Their Health

KH: Well, it has definitely been a process, there's no question, and a journey (a heck of a journey). As someone already commented, we were doing lifestyle medicine before it was called lifestyle medicine and I think that's a really interesting review, when you look back over this last decade. If I were going to summarize lifestyle medicine in one most important term, I would use the word "empowerment." Empowerment for the patient. It is a joy to be able to hand that locus of control back over to the patient with knowledge. It is an honor to be in a relationship with a patient. I would state that's probably the second most important thing that's taking place in lifestyle medicine: everything is about relationship. It's relationship to self. It's relationship to your provider, your coach, your doctor. It's about your relationship to food, your relationship to want to move your body or not move your body. And so I would say empowering the patient, really encouraging them to come full circle.

In a non-demeaning way, to me it is so comparable to managing the transition of bringing a little person from age 2 until age 5 or 6 because you have to teach skill sets. You have to teach ways in which that person will come to that discovery on their own, and they don't realize that you guided them to realize, "I want to eat more legumes in my diet, I need more color in my diet, I need to get up and move my body because it's the right thing for me." So to really bring yourself to the other side of the table and get out of the advice giving and to the empowerment position. I think that's probably the greatest privilege of doing lifestyle medicine.

I had the absolute joy of getting to come to medicine through a naturopathic medical background training, and then I found functional medicine immediately right outside of my naturopathic training. To me, this is the only language I know. In a sense I grew up inside of this mindset and for me it's a bigger challenge to step outside and try to look at the challenges because I think lifestyle medicine is common sense. It's so much common sense. It's what the patient is asking for, and intuitively, on so many levels, you just need to give them permission to go there.

JB: Mark, thanks so much for being here all the way from Florida. Mark is at the University of Florida. He is one of our co-investigators and just was one of the lead authors on a big multi-center trial we were involved in. Wonderful papers.[3],[4],[5],[6] Thanks, Mark, and thank you for being here. We're just talking about what each individual thinks, in their mind, lifestyle medicine means to them.

MM: Pleasure to be here.

JB: Nice to have you here, thank you. Emergency medicine seems like almost 180 degrees away from lifestyle medicine, but yet you've done some extraordinary things in segueing these concepts into your practice and into your mindset.

Seeing the Result of Poor Lifestyle Choices in the Emergency Room

MM: Well, I'm still on the journey. Really, spending many nights in the emergency department, you realize that we're done a tremendous job with acute care medicine, but I realized that probably 75 to 80{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of the patients that I would see at night were there because of poor lifestyle choices. I felt like I was at the bottom of the cliff picking up the pieces. If I was just able to build a fix at the top of that cliff, then we could perhaps have true impact and prevent a lot of the things that I was specifically seeing.

The Impact of Corporate Wellness Programs

I really began to delve into the concept: How do we deal with chronic disease? With Dr. Jones as well as yourself I had the opportunity to be introduced to the concept of lifestyle medicine. The way I would really define it is it is really whole-person medicine or patient-centered medicine. The type of medicine I was so used to doing was really physician-centered medicine, and I definitely want to reiterate the point that we are empowering.

At that point, I wanted to ask the question: "How can I have an impact within a university setting—the training of physicians who are residents, and also specifically the staff and physician population?" I moved into corporate wellness. I'm still doing emergency medicine—I can't leave that love—but I realize that corporate wellness is where we spend 40 hours a week. This is where our employees are and our patients (quite often they become our patients). I realize that we can intervene in their lives: how they think, how they work, how they eat, how they move or exercise. It really comes down to the fact that lifestyle medicine. The physiology is really complex, but really the underlying causes of so much of the chronic disease has so many interacting nodes, and it's really looking at how our environment—our work environment, the air we breathe, the food we eat—really washes over our genes and determines whether we have health or whether we do not, and I think lifestyle medicine is really the tool which we can use to change behavior, and really even at the genetic level really have a phenotypic response in a very healthy way. Just the privilege of participating in the multi-center trial just showed me this is really possible, and it is through behavior, and through walking into that room with real intention and interacting with those patients, and determining who they are as a whole person.

JB: Wow, I tell you, this round-robin just once around the table is enough food to feed you intellectually and emotionally for quite awhile. A lot of power words were discussed: relationships, empowerment, intention, collaborate, connection, covenant. How we might work on developing this high-level communication. Being good listeners—active listening is another powerful concept. Jay's concept of how people make decisions on the basis of either avoiding pain or moving to pleasure and how do you navigate through that matrix to use the nervous system as guidance for compliance and adherence. Then this whole concept of really recognizing that late stage disease starts off with altered function, so using the lens to focus on the right things, because if we just wait for pathophysiology we may have missed all sorts of precedents that could have been guides for us earlier.

So with that, David, let me turn to you as one of the longstanding founders and developers of the functional medicine concept. How would you see a differentiation, if at all, between what we call lifestyle medicine and functional medicine? Where do they connect or overlap?

Differentiating Lifestyle Medicine from Functional Medicine

DJ: Well, I think the participants at this table would probably say the same thing, but if you go to the American College of Lifestyle Medicine--if you talk to Colin Campbell, for instance,--lifestyle medicine has a certain degree of one-size-fits-all: that there are certain common foods that we should be eating (that we should do a modified Mediterranean diet is a very common thought), one-size-fits-all in terms of so much exercise each day.

My experience was that I got into this early on because it is pretty obvious that lifestyle—the day-to-day, minute-to-minute choices of my patients—was impacting them in such a way that they ended up with a diagnosis that, by standard of care, I needed to put them on drugs, and I'm sitting at my desk at the end of the day wondering, "Can I keep doing this?" I was seeing the side effects from drugs and wondering if I shouldn't be calling them and saying, "The best thing for your health would be to stay away from me." That literally happened. That's when I went searching and that's when we started working together. That was almost 40 years ago.

Functional Medicine Offers Powerful Tools

The personalization of lifestyle medicine is the next step, and knowing what the difference is. The core diet—you say the Mediterranean diet, but what if the person has, say, metabolic problems versus toxicity problems versus endocrine problems versus…and the list goes on. How do you create an architecture that can take these concepts of lifestyle and physiology and marry them to the patient in such a way that it has a very specific and focused application? And that's why some of the people in lifestyle medicine say, "Well, this functional medicine stuff is just too complex." Well, I'm sorry. If you do lifestyle medicine, you'll get 60 to 70{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of people better, because the marketing to keep them imprisoned in very bad habits is very effective. If you can get them out of those habits of eating the wrong way, and sitting on the couch and watching football games, and being more interested in their rotisserie group versus taking care of themselves, you'll get 60 to 70{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of those people better. But it is that other group that, as physicians, it's a very focused issue of how do you apply these powerful tools so I know from the specific kind of genetic testing, from questionnaires, from getting to know the patient, that they need something tweaked in their relationships, in their stress, in their diet? That's the specific functional application that is very personalized and takes it to another level. I deal with almost all my patients rather than 30{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} because they come in and they are already on some kind of diet that they have read is good for them, and they're already exercising, and they're already doing the basic issues of looking at their lifestyle, but how do you focus that so it affects them, and it is different than the same dog-and-pony show you do with everybody else?

One of the big issues in lifestyle medicine is this: How is this different than public health? It is different from public health if you have an architecture of thinking methodology for making it specific to their needs. If you don't, you are doing lifestyle public health measures. In my mind, lifestyle medicine and functional medicine are the same thing, but in the minds of people that I talk to that are experts in the area of lifestyle medicine, we do something different because I spend time doing things that they think are too specific and too complex. I make it too hard. Well, complex problems require complex thinking. I mean, you just can't do one-size-fits-all. I think, in terms of the actuality of lifestyle medicine versus functional medicine, our particular approach takes it to that next level. Yes, all of those measures that we're talking about in terms of standard lifestyle medicine teachings, those are part of the formula and the relationship

that one emerges in my clinic when you bring that specificity to that patient, and then you let them choose because you understand the different doorways they can walk through. That's looking at their specific functional issues. So that's the way I see it and I see it when I talk to practitioners that have a different kind of approach. What we are teaching is complex, but the human organism is complex.

JB: Good, thank you. "Complex" is a good place to segue to Dr. Reedy, who has 50 patients waiting in his waiting room that he's going to see over the course of the day. It is having been in that environment I can feel the sense of complexity that must work through his nervous system. Graham, from your experience, what are the barriers that you've encountered in introducing these concepts successfully in a general practice?

"When All Else Fails, Ask the Patient"

GR: I have the advantage that the only patients in the office exercise, exercise, exercise. So that culls herd. In the northwest that means that if the milk's not milking, then I'm sorry, love, you're gone; the cow's not there anymore. So we've culled the herd in terms of people that want to be well, people that already want to be there. Then from that particular group we have built on asking a set of questions. There is a great quote they said to us in medical school by wise people: "When all else fails, ask the patient." So I will oftentimes say, "You came in and we had you scheduled for this, and this, and this. What would you say, of the things you are most concerned about, is the biggest concern?" It is to teach my staff, because the staff is a key person—in the front, they do the check in and they've got the computer and such. I oftentimes start the staff by saying, "This is a lifestyle practice. Listen to the words not said. Listen to the phrases that they feel. Listen to what it is you think they want to say but are afraid to say. And what you'll do is they may not tell you, but you'll open a door where they may tell me, and that way we're doing it together." And then I have a staff person with me, as well as computerized records, in the room the entire time. So if I say, "These are the things it seems to me that you are saying to me and what you want most. Is that correct?" And I love one statement I heard not long ago that said: The average physician time with a patient in front of them before the doctor interrupts is 17 seconds. Given that, it has been shown by studies that if you merely listen for two minutes, then 75{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of what the visit is about will be told to you, and about 25 to 50{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} of the solution will come from them, not me. And in that regard, it's as though if I then feel that they are making headway, I validate them and when they walk out, they feel they've been heard, but more than that they feel valued as a person. If that does happen, then they feel that, "You're stressed as much as me," and so there is a reason to put them there. We put the patient at eye level, never on an exam table. The computer's here, I'm here, they're here. Never, ever, anything in between. I'm touching all the time. My patients say, "I've never seen anybody touch so much." Not inappropriately, but what I'm trying to do is to find a way to get the connection. You can't and to make them open the door to lifestyle change unless you find the connection. And then finally I'll say: "Of all the things you said to me, I want you to go home, and these are three things I heard. I'm not really sure that's what your three things look like. So what I would like you to do is go home, I would like you to write them out and then bring them back. And then in some situations I may do what he does and I may sit them on my chair facing myself and say, "So, I have this problem. What are your top three solutions?" And by giving a paradigm shift, I give them the responsibility. I make people as smart as me. I tell them, "You're just as smart as me. I just learned 13,000 words you haven't heard of before. And the thing is that doesn't make me smart, that just makes

me stuck. I'm narrow. I'm very, very narrow." So, involvement is a technique I use.

JB: Yes, I really notice that in your practice. The people that are there, no matter the age, be it high school athletes or weekend warriors or aspirants in middle age, they all have a common bond of being on this journey with you, and feeling as a participant, but with a good guide. It's not like a journey that you are wandering off with a scout and they have no cartography, so there is a guidance principle that goes on there that is very solid, right? It ties itself to something that is both sacred and substantial. I think that's an interesting way of thinking about lifestyle medicine. And by the way, that concept of the 17 seconds to make a snap decision, that comes from the book, How Doctors Think, which was written by the Harvard Medical School professor.[7] It talks about the linear, Cartesian, Baconesque way that we train people to think: we train out of them reductive reasoning and we train into them rote reasoning and memorization. I think that that kind of breaks the pattern, which is—as has been said by all of you—more of a web than a single bullet. It's more of an interconnected web than a single explanation.

Jay, you've been in the medical school teaching environment, you've been in the clinical trauma unit, you've been in private practice, you've been an educator, you've an author, you've been a scholar, you've been on a spiritual journey. How does all of this interesting mosaic and texture weave itself into the relationship that you have with your patient? I would imagine it's very different than a traditional neurologist or psychiatrist.

JL: I think it's hard to follow Graham because I think what Graham says is really quite a powerful role model for physicians to follow. I think that everybody here shares this concept about the importance of relationship and healing. I know when I am very effective as a healer it is because I'm completely present in that interaction that is occurring, even if it is only two minutes. It requires us to sort of step out of ourselves and into the perception of who that person is that is coming to see us who is ill. Again, I love the analogy that you gave about sort of changing roles and having the patient themselves be the problem solver. I think it's a brilliant technique to engage patients in.

Illness is More Than Just a Physical Disorder

One of the things I think that we all have to understand, and this is again maybe a brain-centric approach, but we have to understand that illness in many ways reflects not just a physical disorder, but really an existential or spiritual disorder as well, and that all illness can be seen as a reflection of both a physical disorder and also an emotional or mental disorder. Unless we address that in our toolbox, if you will, to understand the driving forces that create illness based upon a person's perception of themselves—their relationship with themselves, the relationship that they have with their spouse, their children, with their community? Those are key elements of a healing process that we've neglected to really discuss in current western paradigms of medicine. Those sometimes are the most important elements. Sometimes it's just really a matter of a patient being heard for the first time. I can't tell you how many times someone will break down and start crying just because it is the first time they were actually ever listened to. It's not rocket science. There is a famous quote from, I think, Cecil's Textbook of Medicine: "The secret to care for patients is to care for patients." It's not that complicated. But we forget the basics.

Kristi, I'm sort of the opposite of you. I grew up outside of functional medicine or whatever words you want to put on it. I think that if we look at some of the obstacles that I see from a sociological perspective in terms of adoption of some of the common sense things that we're talking about here, some of them are

really economical. We have to really understand that there are cost barriers that are very real. We've created sort of a medicine which is really accessible only to people who can afford it. For this to be a transformational type of medicine for society, we have to find ways of making it more economically scaled to all comers, not just people who are able to pay out of pocket for it. That's something I think that we should be cognizant of.

JB: Some really good pearls there, and I think that's a good segue to Dr. Weiss. Jim, as you've made this transition from pulmonology over into a more health promotion/wellness-based practice, how did you handle the economics? How do you deal with the reimbursement to services? Is it something that you are still modeling? Is there an approach that you've seen that makes sense?

Support Staff is Very Important to Success

JW: I'm blessed to have the second best lifestyle educator. Insurance reimburses for my time, and also reimburses for my lifestyle educator's time, assuming that you follow the proper prescriptions. I want to tag onto something David said: It's absolutely true that it has to be personalized. I haven't been doing this for 40 years, I've been doing it less than 8. My lifestyle educator has a different personality, so there are certain patients who connect with me and I work with them. I try and give them the time they need. I have a practice style that's really designed for that, which is a benefit. And I listen to those patents. There are other patients who connect better with Stephanie. Initially—I'm catching up to her now—but initially, she frankly had a better understanding of the supplements, etc. We are talking about a paradigm shift in medicine. For a classically trained physician who has no clue it takes time to learn.

In my office, we try and keep it as low cost to the patients as possible. The one stumbling block is the cost of the medical food or the supplements, but I have had very little pushback against that. My experience—I'm in southern California—is this is what the population there wants. They don't have to be super wealthy to be willing to reach into their pocket to pay for the medical food or to pay for the fish oil, etc. They know that they are going to be healthier, which is absolutely spiritual and existential, and potentially have their healthspan approximate their lifespan. That's very important. That's what people want. It's a question of priority. There are some people who won't reach into their pocket for it, and it makes it harder to help them. But I have not had a problem getting people to pay for it. Granted, I'm in an affluent area of the country. I don't know what it would be like in other places.

JB: Ken, let's ask you the same question. I know in Riverside County you probably have a very mixed socioeconomic population of patients (from my experience in Riverside). You probably have a wide array of differing abilities to have discretionary income available. How does that influence how you deliver the program?

Balancing a Practice with Managed Care and Lifestyle Medicine Patients

KB: Riverside is a very blue collar area (Riverside, San Bernadino, that whole area). I'm still trying to figure this out. My practice is still heavily laden with managed care. We all know the joke or the one-liner that you have five minutes to spend with the patient. Every patient that I see, even if it is mom-brings-in-Joey-with-an-earache, I throw something out there about wellness. I throw something out there about lifestyle medicine, about how we're different. They walk into the office and one of the first things they see is our natural pharmacy. That spurs questions. I search for ways to open dialogue with patients,

whatever that may be. Typically, I will throw out these tidbits on the five- or seven-minute visit (whatever it make be), and then finally a hook is set, and that seven-minute visit becomes 20 minutes or a half hour, right? Then you're behind. But it gets my passion going because I just so much love that aspect of medicine because finally we can give people tools to prevent or even get their lives back so that they can have a great life. They can have a healthy life. They can have an abundant life.

What we do with our HMO patients (probably 30{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} are HMO), I work with them when I can and I send them up to see my lifestyle educator for their co-pay. Business-wise, that's not real sound, but if it is about getting people well, then that's what you do, with the hope that they will go out and tell their friends and tell their family and more people will come and more people will come. My experience with the PPOs and Medicare is if you bill it correctly (or hopefully what you believe is correctly—in the spirit of correctness), they pay okay. They pay okay. For the physicians out there that are wondering, "Can I make a living doing this?" Yes, you can. Yes, you can. But you have to get creative. You have to pay more attention to what's going on with your people.

Graham, I love what you said. I've heard it before but I haven't heard it for a long time. I appreciate what you said. Just shutt up and listen. We're all kind of designed—especially the male part of us—as what? We're fixers. "Tell me what's wrong and I'll fix it." For some things—emergency room medicine—that would be perfect. For critical medicine that would be perfect. But in the folks that just come into our office, they may not even know what's wrong with them until they can get it out, voice it, so thank you for that.

JB: Ken, you know, we've had the privilege (many of us) to see some of the videos of your patients. There are several that have just struck me deeply. They are kind of like mental images etched on the inside of my neurons that, when I get tired and wonder what I am doing, I remind myself of these experiences. I'm reminded of the one of the high school teacher that you had that was transformed. I think at the end he looked at the camera and he said, "I thank Dr. Browning and Chris, my lifestyle educator, for saving my life." How do you value these? How do you put a return on the investment on those kinds of comments? They are very, very powerful. I really appreciate your patients sharing those things. They are the most powerful learning tools, when we see these personal transformations occur.

DJ: It is so different than sitting at your desk looking at the list and reviewing the number of side effects from the medicines that you give them. The difference in my life from sitting at the desk and saying, "I've either got to quit this profession or I've got to go out and find different answers because I can't live with this." And now what happens when you engage and something emerges from that context of healing that is bigger than you instead of being smaller than you.

KB: In our office we call it, "We do the happy dance."

JB: That's a good visual metaphor. So Kristi, a lot of these principles we're talking about are the tradition of natural medicine and naturopathic medicine, so maybe that's why it is so deeply in your DNA. I'm sure you get questions because you're educating all sorts of different disciplines about "How can you be so presumptuous to tell people that are believing in pharmacology as solutions to these issues that lifestyle medicine would be a successful different approach?" How do you manage through that?

Remove the Obstacles to Healing

KH: At first, do no harm. I think it's really the oath that we've taken. And what is so powerful in lifestyle medicine, which you experience within the first couple of months of truly doing it and living it, and you see it in patient care and patient results as often the most powerful is helping the patient identify or flag their obstacles in their healing path. What is it that is holding them back from healing? Just that identification alone. Is it your job? Is it where you live? Is it your home? Oh, you've got lead in your well water; you didn't know. So, the first step for me in lifestyle medicine is to identify those triggering events. You know, if we're going to talk about a functional medicine model, it is triggers and triggering events in your ATM (antecedents, tiggers, mediators) model: What is triggering the disease or has triggered the episode? With lifestyle medicine, number one: remove the trigger, remove the obstacle.

And then number two, you go to the foundations of health. You really open up the storyline and say. "Well, what else is holding them back from their healing as it relates to their food choices, their movement, their sleep, their resilience, their relationships, and their social network?" You live it in practice, you see it transform your family's lives, your patients' lives. You see this, and as Dr. McIntosh spoke to, you've seen it in a large group experience as well. And you become a believer in that sense. So through great confidence, through clinical experience.

I think one of the most important aspects of the journey for the clinician who is learning lifestyle medicine is to learn discernment in knowing which program or direction to place the patient. If I were going to take a patient who presented with minimal intra-abdominal visceral fat, who was really holding weight in other areas of the body, or below the waistline, who struggled with weight loss for 20 or 30 years, who didn't have elevated triglyceride levels, and who wasn't suffering with blood pressure concerns, and they walked in the door and they needed lifestyle transformation, I would have to give them a program that would be more targeted and more designed to deal with the underlying causes of their disease. If we're going to come back to the roadmap, for me the map is a functional medicine map that lifestyle medicine lives and exists within: remove the obstacles, identify your antecedents, triggers, and mediators. Remove the obstacles to healing. Next, go to the foundations of health. Deal with the lifestyle medicine concerns. Again, transform the diet. Help move them through behavior modification, and then just step back and watch it happen.

I like to just give it two weeks. Two weeks, four weeks, in eight weeks miracles will happen. And at that point I want to know what's left. And when I can see which symptoms are left or what are the areas or concerns that aren't clearing or moving in the right direction, then I'm going to take a more advanced therapeutic intervention route and apply the systems biology approach to functional medicine. For me, it is so remarkable. It is such a remarkable experience to have the patient come in, sit down, across the desk from you or next to you, and just sob for joy, which is a very different experience from them sobbing from the pain, and thanking you profusely.

Our practice is 95{56bf393340a09bbcd8c5d79756c8cbc94d8742c1127c19152f4230341a67fc36} referral at this point, and I'm either the patient's first choice, or they've been through ten other providers.I chose to go back to the Midwest because there weren't other providers doing this, so I end up with the patients from the functional medicine and the integrative practitioners who don't know where to go next. And I go right back to the basics: What are the triggers? Remove the obstacles. Transform the foundations to health and wellness. And then let's dive into the other areas of pathology. Then we'll look at our

assimilation and our GI concerns, or we'll deal with detox, or we'll move into the endocrine system. But there is just so much power in just giving the body the chance to heal.

JB: The beautiful statement you've made reminded me of conversations that we've all had or listened to with Mark Hyman, who when he was working at Canyon Ranch always would introduce himself as a "resort doc": the doctor of last resort. Because he was the guy at Canyon Ranch that was providing a different kind of medical service than traditional pharmacology.

Mark, you made a comment which I want to follow back up with because I think it's a very, very interesting comment: that you learned a lot by participating in this multi-center clinical trial. Your site was one of the three sites on a metabolic syndrome intervention trial. I'd love to know, as you've had a chance to kind of get away from it a little bit and look back, what did you learn? Other than the data, what was the most impactful for you in the learning experience?

The Macro Level: We Have a Sick Care System, Not a Healthcare System

MM: Probably the major thing that I've learned is that we truly do have a sick-care system and not a healthcare system. By doing the project, most of the participants, most of the people that we enrolled in the study, actually were employees on the floor staff. Actually by implementing the therapeutic lifestyle changes and using the nutraceuticals, we truly had major successes on the campus, and you can see, for those people, their lives transformed. That was extremely powerful to our administration that, you know, we needed to do something different. I'm taking it more to the macro level because what happens now is I have a sick system, not exactly a sick patient. I'm using every opportunity that I can to use the functional medicine model and essentially address the whole system.

From the experience in the clinical trial, now we have moved into developing a whole corporate wellness program. We did not have corporate wellness at our organization. Right know it is hard to do corporate wellness on a personalized level, but a lot of the principles we are using—how to eat well, think well, breathe well, move well—all of those aspects are really coming from this model. So we started corporate wellness, and secondly, within the past year, we developed a physician-directed weight management program. Some of those patients will potentially entertain bariatric surgery, but bariatric surgery is just a tool, and if you don't learn lifestyle changes, you will not have the success. Obviously our hope is that many of those patients will not have to entertain bariatric surgery.

We have also started a palliative care program in the past year. Palliative care: these are the patients who are suffering chronic disease, whether they are being cured or not cured. Once again, the model of whole-person medicine can be applied. So, out of the study we developed a corporate wellness program, physician-directed weight management program, and palliative care within the past two years. It is looking at the macro more than the micro. We're making some steps and that's how I think we are going to change medicine. In the future we'll see the successes from that standpoint and the administration will see it and it will shift down, hopefully, to our physicians and our residents as well. It is a different approach than one patient at a time, but we can see it is taking place.

JB: Very inspiring. Thank you. That's a wonderful collateral benefit from being engaged in a clinical trial. Fantastic. I wish all trials would end up with that kind of revelation in the participants.

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