COMMENTARY

A Conversation on the Future of Health Care: Integrating Lifestyle Medicine—Part One: Understanding the Concepts

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Abstract

In response to personal and institutional history and articles published in *The Permanente Journal,* this article begins a conversation based on the premise that health care will only reach its full potential with the integration of traditional medical care, which relies on the application of pharmacologic and surgical intervention after the development of illness, and *lifestyle medicine*, the use of optimal nutrition and exercise.

Introduction

This commentary is in response to articles in *The Permanente Journal* during the last seven years and to personal experiences and observations during a career that has often traversed the "road less traveled."

The premise of this conversation is that health care will only reach its full potential when two existing paradigms are integrated: 1) Traditional medical care relies primarily on the application of pharmacologic and surgical interventions after the development of illness. It is based on reductionism, which can be characterized as relying on the smallest details in biologic pathways for interventions but ignoring the larger context of the causes of illness. 2) Lifestyle medicine (LM) is primarily the use of optimal nutrition (a whole foods, plant-based diet) and exercise in the prevention, arrest, and reversal of chronic conditions leading to premature disability and death. It looks in a holistic way at the underlying causes of illness.

Background

Three other issues must be addressed to place the above in perspective: During their training, physicians and other health professionals receive little or no education in nutrition, nor do they in their subsequent careers.

At a meeting of 25 active and retired Medical Directors, I asked how many individuals had read the 3 books that serve as the bedrock of the science and understanding of LM: *The China Study,*[1] by T Colin Campbell, PhD, and Thomas M Campbell II; *Prevent and Reverse Heart Disease,*[2] by Caldwell B Esselstyn Jr, MD; and *Dr Neal Barnard's Program for Reversing Diabetes,*[3] by Neal D Barnard, MD. Out of a possibility of 75 affirmative responses, only one responded yes.

The initial submission of this commentary was reviewed by 8 professionals. Each was asked to respond to the question of having read *The China Study* or having seen the LM film *Forks Over Knives*.[4] Six responded; so out of a possibility of 12 affirmative responses, there were 2.

My personal contact with health professionals has yielded the same level of response.

Vision, Intention, and Means

To implement a change, there must be a linear progression that can be summarized by the acronym VIM: vision, intention, and means. My goal here is to address vision and intention. Comprehensive implementation will not be possible without a thorough understanding of these two steps. My comments herein will address understanding the concepts. Implementing the concepts will be for a future consideration.

The concepts and public awareness of LM are now sufficiently mature to warrant serious consideration of the proposed integration. Some will object by saying, "We're already doing these things." Farmers' markets, bicycle riding, suggesting exercise, and other activities are important, but what is needed is a coordinated, comprehensive LM approach for health care staff and patients.

In what follows, I outline the journey that has led to an interest in a paradigm integration and conclude with some ideas on how to achieve increased awareness and an ongoing conversation about the importance of LM in health care.

So, how did a physician in the specialty of obstetrics and gynecology ever develop an interest in LM?

African Experience

Having worked in primary care for seven years in Malawi, East Africa, I have been exposed to the contrasts between our Western health issues and those of a population living a simple life with a primarily plant-based diet. This has led to several insights.

In my medical experience in Africa, Western chronic illnesses—for example, obesity, coronary artery disease (CAD), type II diabetes, osteoporosis, and cancer—were relatively rare. This leads to an appreciation of crosscultural disease incidence analysis, revealing how aberrant disease prevalences are in the US. Why are we so different? Why do we have a CAD death rate in the US equivalent to losing the passengers on two and a half Boeing 747s daily? Why are the healthiest individuals, as outlined in the *National Geographic* article "The Secrets of Long Life,"[5] found in Okinawa; Sardinia; and Loma Linda, California? How does our increasing incidence of crippling chronic illnesses relate to the standard American diet?

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I was fortunate to have been working in Malawi when the problems of Marasmus and Kwashiorkor were being addressed in a preventive (rather than therapeutic) manner by the introduction of a porridge weaning food made from ground dried corn, white beans, and peanuts. The normal transition of weaning was to a corn starch diet. Vision and intention were used by a very wise Dutch nun who had worked for more than 40 years with the local population. Laurel and Hardy films, the *Our Gang* series, and other silent films were shown on suspended bedsheets in the villages; a nutrition lecture was given; and the weaning food samples were provided and subsequently stocked in the local markets. This completed VIM, and these two scourges were no longer part of our daily rounds.

Individuals lived out the motto "Be healthy by choice, not by chance" as they began to experience improvements in the 70% of their health that was directly under their control. This occurred outside the medical model.

Pritikin and Kaiser Permanente

Step forward to the next experiences. While I was a physician with the Permanente Group in the 1970s, one of our cardiologists made me aware of the Pritikin Longevity Program, which relied on nutrition and exercise as therapeutic modalities for the treatment of many of our chronic health conditions (eg, obesity, hypertension, diabetes, CAD). Pritikin and his staff gave a demonstration of his approach at the San Diego Medical Center. His demonstration and a review of his results strongly suggested that an organized LM program could, in some cases, offer an alternative to treating symptoms. Because this comprehensive, expensive program was conducted in a domiciliary setting, its potential for application in a traditional medical model of care seemed limited.

I had a desire to test the waters about the interest in such an approach, so I called upon some of the pioneering giants of the Permanente Medical Groups to tap their collective wisdom. Sidney Garfield, MD (physician founder and first Medical Director of Kaiser Permanente); Morris Collen, MD (founder of the Kaiser Permanente Division of Research); Ray Kay, MD (founder of the Southern California program); and Nathan Pritikin agreed to meet. They spent a day sharing their roles in the development of health care. What Pritikin shared was something far outside the traditional medical paradigm and sparked quite a discussion. As the group separated there was an expression of, "If only we had known each other earlier!" Unfortunately, the time to formally introduce LM had not yet arrived.

Complete Health Improvement

Thirty years later, my wife and I were introduced to CHIP (Complete Health Improvement Program, www.chiphealth.com), developed by Hans Diehl, PhD, who had been the epidemiologist and education director at Pritikin. His idea was to bring LM into the local setting, where people could experience a program in their own town and have local support afterward. We became Directors in presenting CHIP in our community, and after seeing our participants' results we knew that an LM program could be incorporated into a health care system. Individuals lived out the motto "Be healthy by choice, not by chance" as they began to experience improvements in the 70% of their health that was directly under their control. This occurred outside the medical model. For those of us who are "age enhanced," an additional saying was encouraging—"Die young as late as you can!"

The Permanente Journal

Now, let's bring in *The Permanente Journal* and track its articles on LM. I saw the first mention of LM in the Fall 2006 issue (volume 10, number 3). Let's review the articles.

There was a book review[6] of *The China Study*[1] outlining the results of the largest nutritional study ever undertaken, under the direction of three universities—Cornell, Oxford, and Beijing. This study showed the health advantage of a whole foods, plant-based diet.

Additionally, there was an article in the Health Systems section: "A Conversation with Marion Nestle, PhD: Straight Talk About Obesity, Nutrition, and Food Policy,"[7] sponsored by the Kaiser Permanente Institute for Health Policy. It is useful to review the last question posed to Dr Nestle and her answer: Question: "Is the health care industry doing anything that's particularly useful in terms of promoting nutrition and healthier lifestyles?" Response: "Hmmm. Good question, but I can't think of any examples. The health care system is designed for treatment, not prevention, and until there's a way to make prevention pay, nobody will talk about it or do anything about it. KP [Kaiser Permanente] is the only game in town where prevention pays. Your organization benefits if people are healthier, but I can't think of any other institution in America where that is true. This gives KP a rare privilege and a responsibility, and if you don't take full advantage of it you will be missing a rare opportunity."[7] My, but that was seven years ago.

In culling through the traditional articles in that issue, I was able to identify 20 applications of LM, without one mention of this approach in the articles. The awareness was not there yet.

Now jump forward through a hiatus of seven years to *The Permanente Journal,* Spring 2013 (volume 17, number 2), and under Special Reports you will find "Nutritional Update for Physicians: Plant-Based Diets"[8] (www.thepermanentejournal.org/issues/2013/spring/5117-nutrition.html.) This is a must-read for physicians. For those who ask for evidence of the efficacy of a plant-based diet, please refer to the 46 references cited.

Finally, in the Fall 2013 (volume 17, number 4), issue of *The Permanente Journal,* there is a review by me[9] of Colin Campbell, MD's most recent book, *WHOLE—Rethinking the Science of Nutrition.*[10] It addresses the reasons why a whole foods, plant-based diet has been so difficult to implement.

Implementing Lifestyle Medicine

Now, let's consider some ways understanding the concepts of LM can be implemented.

The first is a suggestion for *The Permanente Journal.* Perhaps the time has come to dedicate a section in each issue to the subject of LM. A possibility could be to consider the authors of "Nutritional Update for Physicians: Plant-Based Diets"[8] as a core group from which to solicit evidence-based publications in this field.

The next suggestion is to initiate some simple steps to bring health care professionals and employees to a deeper level of understanding of LM.

Start by showing the film *Forks Over Knives*[4] (ie, nutrition versus the scalpel) at all the Medical Centers. This film tracks the careers of Drs Campbell and Esselstyn and their scientific and clinical experiences with a whole foods, plant-based diet. Two individuals are followed through their improvement in health achieved by LM. This film is relevant to both medical professionals and lay individuals. Through our CHIP program, we arranged for a free public screening in our community, and 450 individuals attended. At the conclusion of the film there was a standing ovation. One participant was scheduled for bypass surgery in 4 days. His cardiac surgeon, after reviewing our LM approach, agreed to this alternative, and surgery was cancelled. After the CHIP course, the individual and his spouse lost a combined 110 pounds, and there have been no cardiac symptoms. At a program cost of $350 for the couple, this was a good return on investment.

Make available at all centers copies of 1) *The China Study,*[1] 2) *WHOLE—Rethinking the Science of Nutrition,*[9] 3) *Prevent and Reverse Heart Disease,*[2] and 4) *Dr Neal Barnard's Program for Reversing Diabetes*.[3]

Develop and begin to promote Web sites that will continue the educational process. I will reference two, hosted by recognized scientists: http://pcrm.org/health/cancer-resources is a division of the Physicians Committee for Responsible Medicine, with many resources and links, and at www.drmcdougall.com you will find extensive coverage of health topics and recipes.

The final suggestion is to have regional symposia, open to physicians and other health professionals from all specialties. LM has applications in many specialties. There are multiple individuals and resources waiting for an invitation to bring an expanded awareness.

Conclusion

Final words in this conversation: The integration of the two mentioned paradigms should be considered from an individual perspective and a Kaiser Permanente program perspective. If you personally use the resources outlined, you will be well down the path of understanding the concepts of LM and the goal of integration, and you may even find an improvement in your health.

When a conceptual maturation has developed, a comprehensive next step can be considered: implementing the concepts of LM. ❖

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In the Future

The doctor of the future will give no medicines, but will interest his patients in the care of the human frame, in diet, and in the causes and prevention of disease.

— Thomas Alva Edison, 1847-1931, American inventor and businessman