Physician Competencies for Prescribing Lifestyle Medicine

Liana Lianov; Mark Johnson

JAMA. 2010;304(2):202-203 (doi:10.1001/jama.2010.903)

http://jama.ama-assn.org/cgi/content/full/304/2/202

Physician Competencies for Prescribing Lifestyle Medicine

Liana Lianov, MD, MPH
Mark Johnson, MD, MPH

THE LEADING CAUSES OF DEATH FOR ADULTS IN THE United States are related to lifestyle—tobacco use, poor diet, physical inactivity, and excessive alcohol consumption.[1] US residents with these risk factors have plenty of room for improvement—including those who are asymptomatic and those living with chronic disease. Health behaviors could greatly influence future health and well-being, especially among patients with chronic disease. However, only 11% of patients with diabetes follow accepted dietary recommendations for saturated fat intake,[2] and 18% of patients with heart disease continue to smoke, barely better than the general population's smoking rate.[3]

The enormous potential effects of health behavior change on mortality, morbidity, and health care costs provide ample motivation for the concept of lifestyle medicine, ie, evidence-based practice of assisting individuals and families to adopt and sustain behaviors that can improve health and quality of life. Examples of target patient behaviors include, but are not limited to, eliminating tobacco use, improving diet, increasing physical activity, and moderating alcohol consumption.

Effectively motivating patients to change behavior can be a frustrating and difficult challenge. Merely encouraging patients at the end of an office visit to attempt such changes yields limited results. Success requires the development of specific healthy lifestyle action plans in partnership with patients and intentional follow-up in subsequent visits. For example, one study showed that when physicians provided structured counseling to sedentary adult patients, followed by a health educator booster call, the total length of the weekly walking exercises increased by 5 times that of patients in the control group who received standard care.[4]

Even though the most widely accepted, well-established chronic disease practice guidelines uniformly call for lifestyle change as the first line of therapy,[5,6] physicians often do not follow these recommendations. For instance, obese patients are advised to lose weight only 36% of the time during regular examinations, a proportion that improves only slightly to 52% if a patient already has obesity-related comorbidities.[7] Furthermore, only 28% of smokers reported that health care professionals had offered them assistance to quit smoking in the past year.[8] Findings such as these reveal 2 important facts: Physicians cannot ascribe the entire responsibility for inadequate lifestyle changes to their patients, and clinicians must accept some responsibility for deficiencies in the quality of health care. Acknowledging the crucial role of environmental and community factors in creating and sustaining inappropriate health behaviors does not eliminate the duty of physicians to assist patients in making health behavior changes.

Physicians also have cited inadequate confidence and lack of knowledge and skill as major barriers to counseling patients about lifestyle interventions.[9] Among the 620 respondents in a survey of family physicians, only 49% felt competent prescribing weight loss programs for obese patients.[10] Even though changing unhealthy behaviors is foundational to medical care, disease prevention, and health promotion, a physician's trusted relationship with the patient must be augmented whenever possible by family support, an interdisciplinary health care team, and community organizations and agencies (BOX).

To begin to address the identified gap in physicians' armamentaria, a group of representatives from primary care medical specialties and other interested medical professional societies met and developed suggested lifestyle medicine competencies for primary care physicians.

Further work continues in developing curricula, training materials, evaluation, and system-based practice tools and performance measures to help physicians achieve these goals. Although these suggested competencies were developed largely to guide continuing medical education activities for primary care and preventive care physicians, many of these individual competencies have relevance for all spe-

Author Affiliations: American College of Preventive Medicine, Washington, DC (Drs Lianov and Johnson); Jefferson County Public Health, Golden, Colorado (Dr Johnson); and Berkeley HeartLab and Department of Public Health Sciences, University of California, Davis (Dr Lianov).
Corresponding Author: Liana Lianov, MD, MPH, University of California Davis, PO Box 1461, Fair Oaks, CA 95628 (llianov@bhlinc.com).

Box. Suggested Lifestyle Medicine Competencies for Primary Care Physicians

Leadership

Promote healthy behaviors as foundational to medical care, disease prevention, and health promotion.

Seek to practice healthy behaviors and create school, work, and home environments that support healthy behaviors.

Knowledge

Demonstrate knowledge of the evidence that specific lifestyle changes can have a positive effect on patients' health outcomes.

Describe ways that physician engagement with patients and families can have a positive effect on patients' health behaviors.

Assessment Skills

Assess the social, psychological, and biological predispositions of patients' behaviors and the resulting health outcomes.

Assess patient and family readiness, willingness, and ability to make health behavior changes.

Perform a history and physical examination specific to lifestyle-related health status, including lifestyle "vital signs" such as tobacco use, alcohol consumption, diet, physical activity, body mass index, stress level, sleep, and emotional well-being. Based on this assessment, obtain and interpret appropriate tests to screen, diagnose, and monitor lifestyle-related diseases.

Management Skills

Use nationally recognized practice guidelines (such as those for hypertension and smoking cessation) to assist patients in self-managing their health behaviors and lifestyles.

Establish effective relationships with patients and their families to effect and sustain behavioral change using evidence-based counseling methods and tools and follow-up.

Collaborate with patients and their families to develop evidence-based, achievable, specific, written action plans such as lifestyle prescriptions.

Help patients manage and sustain healthy lifestyle practices, and refer patients to other health care professionals as needed for lifestyle-related conditions.

Use of Office and Community Support

Have the ability to practice as an interdisciplinary team of health care professionals and support a team approach.

Develop and apply office systems and practices to support lifestyle medical care including decision support technology.

Measure processes and outcomes to improve quality of lifestyle interventions in individuals and groups of patients.

Use appropriate community referral resources that support the implementation of healthy lifestyles.

cialties. Physician educators at both the undergraduate and graduate medical education levels should consider incorporating the relevant lifestyle medicine competencies into education and training programs. Each medical specialty is encouraged to review these competencies and adopt and adapt them as appropriate.

Financial Disclosures: Dr Lianov reports that the American College of Preventive Medicine, of which she is a board member and Dr Johnson is president, received unrestricted educational grants from Procter & Gamble and Lifestyle Center of America to host a Blue Ribbon Panel Meeting on Lifestyle Medicine Competency Development at American College of Preventive Medicine headquarters July 27-28, 2009. Dr Lianov also reported that she is employed by Berkeley HeartLab.

Previous Presentation: The ideas and recommendations presented herein are derived in part from the Blue Ribbon Panel Meeting on Lifestyle Medicine Competency Development.

Additional Contributions: We are grateful to the professional societies who sent representatives to the competencies development meeting in July 2009. They were Michelle May, MD, and Herbert Young, MD, MA, of the American Academy of Family Physicians; Woodie Kessel, MD, and Edward L. Schor, MD, of the American Academy of Pediatrics; Rebekah Wang-Cheng, MD, of the American College of Physicians; Saul Levin, MD, MPA, of the American Medical Association; Paul R. Fowler, DO, JD, of the American Osteopathic Association; Wayne S. Dysinger, MD, MPH, of the American College of Lifestyle Medicine; and Edward Phillips, MD, of the American College of Sports Medicine. Joan Sabaté, MD, DrPH, of Loma Linda University also participated in the meeting as a content expert. James Rippe, MD, of the Rippe Lifestyle Institute and Joan Sabaté, MD, DrPH, of Loma Linda University also participated in the meeting as content experts. None of these participants received compensation. In addition to the panelists, special thanks to American College of Lifestyle Medicine for its leadership in the development of this initiative, to Karen Sauvigne for assisting the consensus development, and to David Shih, MD, MS, for conducting the literature review and initial draft development and to Michael Barry, Certified Association Executive, for reviewing the manuscript.

Additional Information: The American College of Preventive Medicine and American College of Lifestyle Medicine have endorsed these competencies.

REFERENCES

1. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA*. 2004;291(10):1238-1245.

2. Eilat-Adar S, Xu J, Zephier E, O'Leary V, Howard BV, Resnick HE. Adherence to dietary recommendations for saturated fat, fiber, and sodium is low in American Indians and other US adults with diabetes. *J Nutr*. 2008;138(9):1699-1704.

3. Soni A. *Personal Health Behaviors for Heart Disease Prevention Among the US Adult Civilian Noninstitutionalized Population, 2004*. Rockville, MD: Agency for Healthcare Research and Quality; March 2007. MEPS statistical brief 165.

4. Calfas KJ, Long BJ, Sallis JF, Wooten WJ, Pratt M, Patrick K. A controlled trial of physician counseling to promote the adoption of physical activity. *Prev Med*. 1996;25(3):225-233.

5. National Heart, Lung, and Blood Institute. *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*. December 2003. http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf. Accessed April 26, 2010.

6. American Diabetes Association. Standards of medical care in diabetes—2010. *Diabetes Care*. 2010;33(suppl 1):S11-S61.

7. Stafford RS, Farhat JH, Misra B, Schoenfeld DA. National patterns of physician activities related to obesity management. *Arch Fam Med*. 2000;9(7):631-638.

8. Partnership for Prevention *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*. Washington, DC: Partnership for Prevention; August 2007. http://www.prevent.org/images/stories/2007/ncpp/ncpp%20preventive%20care%20report.pdf. Accessed April 26, 2010.

9. Huang J, Yu H, Marin E, Brock S, Carden D, Davis T. Physicians' weight loss counseling in two public hospital primary care clinics. *Acad Med*. 2004;79(2):156-161.

10. Foster GD, Wadden T, Makris A, et al. Primary care physicians' attitudes about obesity and its treatment. *Obes Res*. 2003;11(10):1168-1177.