Lifestyle Medicine: A New Paradigm Embedded in Osteopathic Principles

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Dr Drozek practices lifestyle medicine as a specialist on a referral basis.

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The headline read, "Doctors Are The Third Leading Cause of Death in the US, Killing 225,000 People Every Year" in July 2000.[1] The article went on to explain that this statistic resulted from flaws and unintended consequences of our current system of medical practice. A recent article in *The BMJ* affirmed that this finding is still true today.[2]

Two-thirds of the US population is overweight or obese, and more than half have diabetes or prediabetes.[3,4] As discussed in *The BMJ* article, our current approach to medicine, in which we focus on pills and procedures, doesn't seem to be the answer. Should we as osteopathic physicians be concerned? Is it time to consider a different approach? Instead of becoming more like allopathic physicians, is the timing right to reassert our osteopathic heritage and focus again on what made us distinct? How many of us even know the tenets of osteopathic medicine (*Figure*)?[5]

May I suggest that we examine the relatively new specialty of lifestyle medicine as a refresher course on what the application of osteopathic principles can do? The American College of Lifestyle Medicine[6] defines lifestyle medicine as follows:

> 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.

Lifestyle medicine perfectly aligns with osteopathic principles, recognizing the whole person and the body as a unit with intrinsic healing and health maintenance capabilities when provided the right environment, one that is focused on healthful food, activity, stress management, and other healthy lifestyle practices. It recognizes that the function of human beings is closely bound to our structure; what we feed it; and what we do with it. The literature demonstrates these principles through studies by people like Dean Ornish, MD; Neal Barnard, MD; and many others who have used rational treatment (as opposed to splitting chests or performing bariatric surgical procedures on children) to reverse and prevent heart disease, diabetes mellitus, cancer, and many other chronic lifestyle-related diseases.[7]

1. The body is a unit; the person is a unit of body, mind, and spirit.
2. The body is capable of self-regulation, self-healing, and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

Figure.
The tenets of osteopathic medicine.[5]

In 2012, the AMA House of Delegates acknowledged the concept in a resolution that urged physicians to…

> acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based *lifestyle medicine interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease* within clinical medicine [italics added].[8]

The 15 competencies identify skills and attributes that physicians should possess in 5 key areas: leadership, knowledge, assessment, management, and use of office and staff.[9]

When is lifestyle medicine appropriate? I suggest that it may be appropriate almost all of the time. Instead of prescribing a proton-pump inhibitor for symptoms of gastroesophageal reflux disease, risking the unintended consequences of kidney damage, osteoporosis, and dementia, why do we not focus on diet instead? When discussing a screening colonoscopy, why do we not also talk about avoiding processed and red meat and increasing the amount of fruits, vegetables, whole grains, and legumes in the diet? The list could go on and on. What

about our patients with dyslipidemia, high blood pressure, angina, diabetes, overweight or obesity, autoimmune disease, or cognitive impairment? Each of these conditions can be effectively managed with lifestyle medicine approaches[7] that would avoid the overuse of pills and procedures and simultaneously reduce health care costs.

But where do we find the time to incorporate lifestyle medicine? It is much like practicing osteopathic manipulative medicine. We must determine to serve the best interests of our patients, even though the economic, time, and systemic pressures work against us. Like osteopathic manipulative medicine, we should all be trained in lifestyle medicine. We should apply it to some degree in our practices, regardless of our specialty. We should also have lifestyle medicine specialists—physicians with a focus and specialized skills—on a referral basis, especially for complex cases.

Our profession needs to be at the forefront in promoting and lobbying for health care reform that focuses on health rather than disease. We should be encouraging our politicians to not only develop policies that promote wellness, but to also support those policies with funding through reimbursement for providers who keep our society and its workforce well.

The time is right for a new paradigm—a lifestyle-focused approach to health care. We cannot practice business as usual. We can't afford it. We can't sustain it. We can't survive it.

The time is right for the osteopathic medical profession to reassert our founding principles and take the lead in researching, developing, promoting, and applying the practice of lifestyle medicine. It is in our DNA! (doi:10.7556/jaoa.2016.101)

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Correction

The *JAOA* and the author regret errors that appeared in the following article:

Wright WF. Cullen sign and Grey Turner sign revisited. *J Am Osteopath Assoc*. 2016;116(6):398-401. doi:10.7556/jaoa.2016.081.

On page 398, in the statement "Cullen and Grey Turner are names for common physical examination signs of abdominal wall hemorrhage, also known as *rectus abdominis subfascial bleeding*," the portion "also known as *rectus abdominis subfascial bleeding*" should have been deleted. Also, on page 399, the statement "An important distinction is that neither Cullen nor Grey Turner intended these signs to be indicators of intra-abdominal pathology" should have appeared as, "An important distinction is that Cullen and Grey Turner intended these abdominal wall bleeding signs to be indicators of intra-abdominal pathology."

These changes will be made to the electronic versions of the articles online. (doi:10.7556/jaoa.2016.102)