LIFESTYLE MEDICINE – LIFESTYLE PARTNERSHIP

Anca Hâncu[1], Florin Mihălţan[2],Gabriela Radulian[2]
[1]Lotus-Med Clinic Bucharest, Romania
[2]University of Medicine and Pharmacy „Carol Davila" Bucharest, Romania
Corresponding author:
Florin Mihălţan, Sos. Viilor 90, 0505159 Bucharest, Romania,
E-mail: mihaltan@starnets.ro

Abstract
High prevalence of noncommunicable diseases with their associated costs are related more and more to unhealthy behaviours such as unappropriated diets, lack of physical activity and smoking. Lifestyle medicine is now more and more scientific and with evidence-based fundament. The key in lifestyle change is negotiation and cooperation. Physicians should do more than education, should empower and motivate the patient in planning a healthy lifestyle leading to sustained change.
Keywords: *noncommunicable diseases, lifestyle medicine, diet, physical activity, smoking.*

Abstract
Prevalența ridicată a bolilor noncommunicabile, cu costurile asociate acestora, este legată din ce în ce mai mult de comportamentele nesănătoase, cum ar fi dietele indecvate, lipsa activității fizice și fumatul. Medicina stilului de viață este, în prezent, susţinută de argumente din ce în ce în ce mai științifice, având un fundament bazat pe dovezi. Cheia în schimbarea stilului de viață este negocierea și cooperarea. Medicii ar trebui să facă mai mult decât educație, ar trebui să responsabilizeze și să motiveze pacientul în planificarea unui stil de viață sănătos care să conducă la schimbări susținute.
Cuvinte cheie: *boli noncommunicabile, stil de viață, dietă, activitate fizică, fumat.*

Suboptimal diet, a preventable risk factor in noncommunicable diseases, is very well known to have an impact, however not systematically evaluated in a comprehensive study until now. Recently, a large study has been published, linking the impact of suboptimal diets with noncommunicable diseases mortality and morbidity(1). This study analysis included 195 countries and, by using the comparative risk assessment method, realised an estimation of disease burden attributable to specific dietary factor. Important findings, in 2017, 11 millions deaths and 25 mil DALY's could be attributable only to dietary risk factors. 3 millions deaths are correlated with high sodium intake, other 3 millions with low intake of whole grains and 2 mil deaths with low intake of fruits. In order to have a reference term, smoking is causing 6 millions deaths(2). This comprehensive picture

about unappropriated diet on NCD's mortality and morbidity is highlighting the need for more preventive measures.

High prevalence of noncommunicable diseases with their associated costs are related more and more to unhealthy behaviours such as unappropriated diets, lack of physical activity and smoking. Even behavioural change is recommended as first line of prevention and management for noncommunicable diseases, implementation is still a challenge[3]. Lifestyle medicine is now more and more scientific and with evidence-based fundament, but besides all recommendations, results have not been markedly changed[4] This does not mean changing what we actually recommend, but changing the way of supporting individuals in healthy living. The key for therapeutic lifestyle change should be cooperation and negotiation[5]. Physicians should be a role model and really champions of changing for their patients behaviour.

Unfortunately, evidence suggest that less than 40% of visits for chronic diseases, for example for hypertension are involving lifestyle counselling[6]. The actual focus on short advices on stop smoking, limit salt or lose weight is a missed opportunity to prescribe lifestyle medicine, meaning: exercise, plant based diets, social connection, smoking counselling, stress resiliency, adequate sleep. Behaviour change is very complex and requires an interaction and connection between practitioner and patient. Physicians should do more than education , should empower and motivate the patient in planning a healthy lifestyle leading to sustained change.

The complexity of lifestyle behaviours is strongly supporting the partnership between practitioners and patients. In acute care settings, the “expert approach“ should identify immediately problems, handling them easily, but chronic diseases could be managed more effective by a “coach“ approach[5]. Lifestyle medicine practitioner should be able to change from expert approach to coach approach by listening mindfully, sharing information only when the patient will be ready to understand and receive them, empowering patients to be responsible for their actions and transforming problems in opportunities for learning.

By cooperation with the patient, physician will be a guide for patient in finding solutions for their problems and creating an environment leading patient to self discovery. Extremely important in lifestyle medicine will be that patient will accept the responsibility and goals will result in healthier daily habits. A powerful intrinsic motivation will include the 3 basic principles of self determination: competence, autonomy and connection[5].

Motivational interview should address autonomy, collaboration, compassion and

evocation, patient being the owner of the goal, comprising not only healthy lifestyle outcomes but also disease outcomes, for example glycated haemoglobin decrease for diabetic patients, cough reduction or exacerbation reduction for asthmatic patients or exacerbation reductions for chronic obstructive pulmonary disease patients.

As Mahatma Gandhi said "Be the change that you want to see in the world", practitioners should evaluate firstly their own vision and values, prioritising their own growth mindset. Any patient journey is an unique experience for his own advancement and growth[5]. The strength of language in promoting healthy behaviours is well understood. Not so much has been discussed about "dichotomus thinking" just a form of cognitive rigidity, many patients are already thinking in extreme appraisals as "good or bad", "healthy or unhealthy". These create a barrier to behavioural change which is necessary for treatment success, associated with increased risk of eating disorders and obesity. Grouping foods in healthy or not healthy can act as a barrier for dietary adherence[7]. Instead of using the type of " black and white " terms in categorizing food, more appropriate will be to use terms that indicate a continuum[8] to describe healthy behaviour , which will be helpful to distract patient from all or nothing approach[9]. Practitioners should learn flexibility in thinking as an important skill in supporting patients to sustain and be compliant on long term to healthy behaviours.

Instead of focusing mainly on individual responsibility it would be appropriate to consider the complex cluster of information about genetics, epigenetics, social norms and environmental factors. Subtle negative judgements from health care provider will be reflected in communication with their patients. If the patient feels blamed, will not feel comfortable sharing experiences, information that could be important for healthcare provider in order to be able to help them.

Conversely, if the practitioner believes that genetics is the main factor in causing obesity will give a powerless message to the patient. It is critical that practitioners will discuss lifestyle changes challenges with the patient, taking into consideration both aspects: individual responsibility and factors outside patient control. By mitigating dichotomus language, this approach could be appropriate in healthy lifestyle recommendations. Practitioners are encouraged to recognize dichotomus thinking in themselves and at their patients, too, the language free from stigma is a key in promoting healthy lifestyle. Moreover, focus on individual and not labelling based on adherence to treatment, medical condition, willingness or abilities to engage in lifestyle modification will be reflected in the correlation between attitudes, perception , outcomes and language[10]. Stigma, as described by Link and Phelan[10] results from 5 components: labelling human differences, then stereotyping by linking undesirable characteristics to the label associated, grouping "us versus them", then the person experience stigma and finally the power. Stigmatisation is associated mainly with obesity, but also with other conditions and is linked with worsened clinical outcomes[10].

In order to avoid these stigma, for example, doctors are speaking about their patients as "person with diabetes" or "patient with asthma" or "patient with obesity" instead of diabetic, obese, or asthmatic.

"The use of Language in Diabetes Care and Education" was created by a task force from American Diabetes Association and American Association of Diabetes Educators and published as a consensus report[11]. Another

Internal Medicine

General Reviews

diabetes group in England published a position statement with examples of types of language that could promote positive outcomes[12].

Some communication principles could be universally applied while promoting lifestyle medicine interventions:

- To avoid stigma, leading to stress, judgement or shame
- Person centred approach, based on respect and inclusion
- Health care professionals language should emphasize what the patient knows, encouraging him or her to see many positive possibilities
- The language has to emphasize the person rather than the disability
- Trying to avoid language that impose rules and empower the patient by giving freedom of choices

In conclusion, more has to be done in noncommunicable diseases prevention, lifestyle medicine is more withevidence based fundament and emphasize the need to change the way of doing recommendations. The key in lifestyle change is negotiation and cooperation. Physicians should become more and more role models for their patients and adopting a more " coach " approach will give better results. More ways of empowering patients in planning a healthy lifestyle will lead to sustainable change.

References

1. www.thelancet.com Published online April 3, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30041-8

2. www.who.int

3. Rani Polak, Rachele M Pjednik, Edward Philips,Lifestyle medicine education, American Journal of Lifestyle Medicine vol 9 no 5, 2015

4. Gray ID, KrossAR, Renfrew ME, Wood P.PrecisionMedicine in Lifestyle Medicine: The way of the future? American Journal of Lifestyle Medicine, Feb 2019. https://doi.org/10.1177/1559827619834527

5. Elisabeth Pegg Frates, Jonathan Bonnet, Collaboration and Negotiation : The Key to therapeutic lifestyle change, American Journal of lifestyle medicine, vol XX, nr X, May 2016.

6. Milder IE, Blokstra A, de Groot J, vanDulmen S, Bemelmans WJ. Lifestylecounseling in hypertension-related visits :analysis of videotaped general practice visits. BMC Fam Pract. 2008;

7. Oshio A. Development and validation ofthe Dichotomous Thinking Inventory. SocBehav Pers. 2009;37:729-742. doi:10.2224/sbp.2009.37.6.729

8. Cognitive behaviour therapy for eatingdisorders: a "transdiagnostic" theory andtreatment. Behav Res Ther. 2003;41:509-528.

9. Sogg S, Grupski A, Dixon JB. Badwords: why language counts in ourwork with bariatric patients. Surg ObesRelat Dis. 2018;14:682-692. doi:10.1016/j.

10. Link BG, Phelan JC. Stigma and its publichealth implications.
Lancet.2006;367:528-529

11. Dickinson JK, Guzman SJ, MaryniukMD,et al. The use of language in diabetes care
and education. Diabetes Care.2017;40:1790-1799.

12.Cooper A, Kanumilli N, Hill J, et al. Languagematters. Addressing the use of language in the care of people withdiabetes: positionstatement of the English Advisory Group.