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Welcome to the second official ALMA newsletter, aimed at keeping you up to date with the latest research, information and resources in the area of lifestyle medicine. The newsletter will also keep you abreast of the work of the association and its committee.

In our last newsletter we gave an overview of the Annual National Lifestyle Medicine Conference held in Harbord, Sydney. In this edition we interview one of the invited speakers from the conference, and President of the American College of Lifestyle Medicine, Dr Wayne Dysinger. See pages 2 & 3 to hear what he has to say about the area of lifestyle medicine.

Also included in the newsletter is a review of the book *The China Study*, tips for allied health professionals for working with GPs, a selection of recent lifestyle medicine-related articles from the journals and some upcoming events which may be of interest. If there are other topics or information you would like to see in future editions of this newsletter, then please let us know by emailing info@lifestylemedicine.com.au



About ALMA

Mission: To improve knowledge and practical skills of health care practitioners in lifestyle behaviour change within Australia

Aims:

- ✓ Raise awareness of the need and value of lifestyle behaviour change in the management and prevention of chronic disease
- ✓ Improve knowledge and skills of practitioners in lifestyle behaviour change
- ✓ Encourage and engage more health practitioners in the field of lifestyle change
- ✓ Facilitate improved transfer of information and skills development in effective lifestyle change
- ✓ Foster research and accreditation in this area
- ✓ Act as an advocate for the development of policies and program in this area, as "a political Association".

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Interview with...Wayne Dysinger, President of the American College of Lifestyle Medicine

Can you tell us a bit about the American College of Lifestyle Medicine and the work you do?

ACLM was begun in 2004 by Dr. John Kelly and several other physicians and health care providers at Loma Linda University. For the first four years it struggled significantly as infrastructure and financial foundations were developed. These began to solidify in 2008, and ACLM has experienced steady growth since then. In 2011, partly due to continued infrastructure development and partly due to the current culture in the USA, ACLM experienced tremendous growth. We now have over 300 members. About three-quarters of them are physicians. The rest are a mix of dietitians, pharmacists, nurse practitioners and other wellness health care professionals.

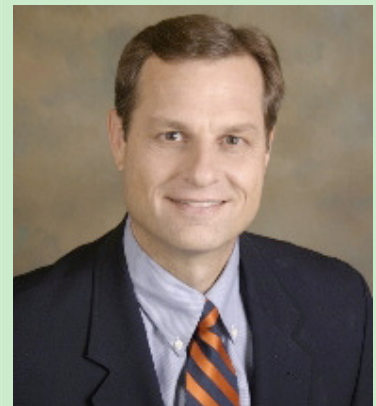
Rates of obesity and diabetes continue to escalate in countries like the US and Australia, and are providing a huge burden on our health system. Do you think that lifestyle medicine is the answer to this epidemic?

Diabetes and obesity are obviously multi-factorial diseases which can and should be addressed from many angles. Lifestyle Medicine is, without a doubt, one of the most important components of addressing these. These are predominantly lifestyle diseases, which means the treatment should be predominantly lifestyle based. No one disagrees with that, but the typical health care provider receives very little training in lifestyle approaches and lots of training in pharmacologic approaches, so unfortunately too often we use medications before lifestyle has been fully given a chance. It's also important to note that Lifestyle should be implemented both during 1:1 health care provider/patient interactions as well as in population and public health based arenas.

How does lifestyle medicine need to be promoted in this country? Does it need to be publicly focused, or do we need to focus our efforts on medical practitioners being the vehicle for change?

As referenced above, lifestyle medicine needs to be a part of what each health care practitioner does, as well as part of the public health approaches we take. My take is that public health people are probably doing a better job of addressing lifestyle issues than individual practitioners are. ACLM is primarily focused on helping individual practitioners do a better job of lifestyle medicine.

Dr. Dysinger currently serves as Director of the Lifestyle Medicine Institute, Chair of the Department of Preventive Medicine and Director of the Lifestyle Medicine Track of the Family and Preventive Medicine Residency at Loma Linda University. He actively practices, teaches and performs research around a variety of Lifestyle Medicine topics. He is a member of the AMA's Health Lifestyles Advisory Group, and is a board member of Lifestyle Center of America. He is Chair of the Graduate Medical Education Committee and member of the Lifestyle Medicine Taskforce for the American College of Preventive Medicine. Dr. Dysinger has served as co-director of the Dartmouth Hitchcock Leadership Preventive Medicine Residency, director of the Division of Preventive and Community Medicine, and Medical Director for the Capital Region Family Health Center. He is board certified in Preventive Medicine/Public Health, and in Family Practice.



Dr Wayne Dysinger, President of the American College of Lifestyle Medicine

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The American College of Lifestyle Medicine

The American College of Lifestyle Medicine (ACLM) is a new national medical specialty society. It has been formed in answer to the need for quality education and certification of the practice in clinical lifestyle medicine.

As the first national specialty society for clinicians emphasizing the use of lifestyle interventions in the treatment and management of disease, the ACLM is currently working to develop formal recognition for this important field of medical practice and research. In the future, it is the goal of the ACLM to establish an official Board of Lifestyle Medicine that will grant board certification in Lifestyle Medicine.

Formed in 2004 in California, the ACLM has members across the United States and international membership is growing rapidly. The value of Lifestyle Medicine is becoming recognized by all aspects of medical practice, and ACLM members represent the broad diversity of the medical profession. Members include primary care physicians, specialists, researchers, professors, students, public spokespersons, hospital administrators, nutritionists, public health professionals, and many others.

For more information visit <http://www.lifestylemedicine.org/>



Interview continued....

Should there be any legislative moves made by governments to encourage healthy lifestyle and behaviour change? If so, what would be some viable starting points for such legislation?

The involvement of the government in legislating lifestyle change is a philosophical question that each society and community needs to decide for themselves. Certainly when we look at other successful health behaviour change endeavours in the past - such as fighting nicotine dependence, on motor vehicle deaths, legislative initiatives have been very important in achieving decreased illness and death. Legislating food is trickier, but I personally believe we do need to be providing our communities environments that promote health, and industry (especially the food industry) doesn't seem to be able to independently contribute to that the way I'd like to see them do so. We're working with two things here in California right now. One is promoting health to unhealthy restaurant ratios and getting local communities to ensure they have at least as many healthy food choices as unhealthy (fast food/convenience food) food choices. The second is legislating insurance companies to reimburse for intensive therapeutic lifestyle change. They pay for CABG and stents - they should also pay for ITLC which is just as effective.

With lifestyle factors, particularly nutrition and exercise, becoming key factors in preventing and managing chronic diseases, who are the key professionals to provide nutrition and exercise advice?

There is need for team approaches to lifestyle change. Physicians need to be actively involved, but patients will benefit most if there are nutritionists, physical therapists, occupational therapists, behavioural therapists, and multiple other health care professionals that they can work with. Ideally this will all be coordinated.

What are the main pieces of advice you would give to a patient who sought your advice about improving their health with lifestyle medicine

It depends on the patient. Most patients do well with concrete small steps of improvement, every few weeks or months adding another step forward towards healthier diet and increased physical activity. Some patients, however, need more intense therapy. This can be done in an outpatient setting with weekly or multiple times/week interventions (ie. Sanitarium's CHIP program). It can also be done in residential settings such as done by Dr McDougall, Weimar Institute, and Canyon Ranch here in the USA. To be successful most patients need a strong and ongoing accountability/support system.

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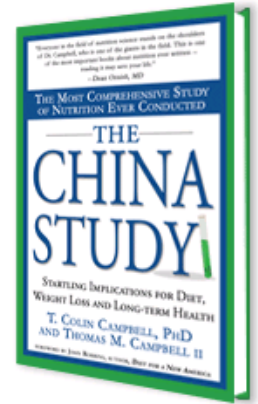
Book review

The China Study

Campbell & Campbell. Benbella Books, 2004

Subtitled *The most comprehensive study of nutrition ever conducted with startling implications for diet, weight loss and long-term health*, The China Study details the connection between nutrition and heart disease, diabetes, and cancer, and also its ability to reduce or reverse the risk or effects of these illnesses. It is based on a 20-year research project studying diseases and lifestyle factors in rural China and Taiwan. One of the major findings was that people who ate the most animal-based foods got the most chronic disease while those who ate the most plant-based foods were the healthiest and tended to avoid chronic disease.

The China Study outlines the main lessons learnt from the study and discusses the diseases of affluence for which nutrition plays a major role including cardiovascular disease, obesity, diabetes, cancers and autoimmune diseases. The book also includes a 'good nutrition guide' explaining how to eat to reduce the risk of these diseases. The authors also discuss sources of nutrition confusion and misinformation.



For more details visit <http://thechinastudy.com/>

Resources: Tips for allied health professionals for working with GPs

Thanks to Dr Andrew Binns, past president of ALMA for these tips for working with GPs:

- ▼ Remember that GPs are pushed for time so try to put yourself in their shoes - if you are helping them with their day to day tasks then this will be appreciated.
- ▼ Most GPs will already be involved in chronic care management using the Medicare item numbers for care plans and working in with allied health professionals, so understand the importance of dietitians and exercise physiologists (if they don't then move on to the ones who do!).
- ▼ Target the practice manager or practice nurse initially, but if you are able to contact the GP directly then do so.
- ▼ Have a calling card and a short introductory letter or you may be able to use email in some instances.
- ▼ Try to get a meeting and if a group practice, organise a group meeting to pitch what you have to offer – but remember time is limited.
- ▼ Drug reps bring lunch sometime but your budget will probably not allow that - some GPs disapprove of that anyway so don't despair.
- ▼ Explain your services in particular relating to people with chronic disease and how you tailor your program to the patient's needs.
- ▼ Provide feedback to the GP - a brief report describing how their patient is going and what exercise modalities you are engaging their patient with.
- ▼ Patient feedback is vitally important - if the patient likes the intervention and feeds that back to the GP then the GP will be impressed and refer more.
- ▼ What really matters most of all is the ability of the exercise physiologist/nutritionists to engage and motivate the patient.

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From the journals:

Goode AD, Reeves MM, Eakin EG. Telephone-delivered interventions for physical activity and dietary behavior change an updated systematic review. Am J Prev Med. 2012 Jan;42(1):81-8.

Lahiri M, Morgan C, Symmons DP, Bruce IN. Modifiable risk factors for RA: prevention, better than cure? Rheumatology (Oxford). 2011 Nov 24. [Epub ahead of print]

Gillison F, Greaves C, Stathi A, Ramsay R, Bennett P, Taylor G, Francis M, Chandler R. 'Waste the waist': The development of an intervention to promote changes in diet and physical activity for people with high cardiovascular risk. Br J Health Psychol. 2011 Jul 6. doi: 10.1111/j.2044-8287.2011.02040.x. [Epub ahead of print]

Quinlivan JA, Julania S, Lam L. Antenatal dietary interventions in obese pregnant women to restrict gestational weight gain to institute of medicine recommendations: a meta-analysis. Obstet Gynecol. 2011 Dec;118(6):1395-401.

Delahanty LM, Pan Q, Jablonski KA, Watson KE, McCaffery JM, Shuldiner A, Kahn SE, Knowler WC, Florez JC, Franks PW; for the Diabetes Prevention Program Research Group. Genetic Predictors of Weight Loss and Weight Regain After Intensive Lifestyle Modification, Metformin Treatment, or Standard Care in the Diabetes Prevention Program. Diabetes Care. 2011 Dec 16. [Epub ahead of print]

Joos S, Musselmann B, Szecsenyi J, Goetz K. Characteristics and job satisfaction of general practitioners using Complementary and Alternative Medicine in Germany - is there a pattern? BMC Complement Altern Med. 2011 Dec 19;11(1):131.

Houle J, Doyon O, Vadeboncoeur N, Turbide G, Diaz A, Poirier P. Effectiveness of a Pedometer-Based Program Using a Socio-cognitive Intervention on Physical Activity and Quality of Life in a Setting of Cardiac Rehabilitation. Can J Cardiol. 2011 Dec 14. [Epub ahead of print]

Palmer AJ, Tucker DM. Cost and clinical implications of diabetes prevention in an Australian setting: A long-term modeling analysis. Prim Care Diabetes. 2011 Dec 6. [Epub ahead of print]

Jiwa M, Meng X, Sriram D, Hughes J, Colagiuri S, Twigg SM, Skinner T, Shaw T. The management of Type 2 diabetes: A survey of Australian general practitioners. Diabetes Res Clin Pract. 2011 Dec 5. [Epub ahead of print]

Wilmut EG, Davies MJ, Edwardson CL, Gorely T, Khunti K, Nimmo M, Yates T, Biddle SJ. Rationale and Study Design for a Randomised Controlled Trial to Reduce Sedentary Time in Adults at Risk of Type 2 Diabetes Mellitus: Project STAND (Sedentary Time AND Diabetes). BMC Public Health. 2011 Dec 8;11(1):908.

Metcalfe RS, Babraj JA, Fawkner SG, Vollaard NB. Towards the minimal amount of exercise for improving metabolic health: beneficial effects of reduced-exertion high-intensity interval training. Eur J Appl Physiol. 2011 Nov 29. [Epub ahead of print]

Bälter O, Fondell E, Bälter K. Feedback in web-based questionnaires as incentive to increase compliance in studies on lifestyle factors. Public Health Nutr. 2011 Nov 29:1-7. [Epub ahead of print]

Bälter O, Fondell E, Bälter K. Feedback in web-based questionnaires as incentive to increase compliance in studies on lifestyle factors. Public Health Nutr. 2011 Nov 29:1-7. [Epub ahead of print]

Nilsen V, Bakke PS, Gallefoss F. Effects of lifestyle intervention in persons at risk for type 2 diabetes mellitus - results from a randomised, controlled trial. BMC Public Health. 2011 Nov 25;11:893.

Tsai AC, Chang TL, Chi SH. Frequent consumption of vegetables predicts lower risk of depression in older Taiwanese - results of a prospective population-based study. Public Health Nutr. 2011 Dec 16:1-6.

Upcoming Events

24th February, 2012: The Science of Wellbeing: more than the absence of illness. Adelaide, Australia.
<http://thinkers.sa.gov.au/Thinkers/MartinSeligman/Events.aspx>

19th to 21st April 2012: 5th Exercise and Sports Science Australia Conference – Research to Practice. Gold Coast, Australia. <http://www.essa.org.au/conference2012/>

29th to 31st April, 2012: Filex – the Fitness Industry Convention – Leading the Way. Sydney, Australia.
<http://www.fitnessnetwork.com.au/filex2012/business>

Quote of the month

"Eat Food. Mostly Plants. Not too Much."
Micheal Pollen

