

Edward M. Phillips, M.D.

The founder of Harvard Medical School's new Institute of Lifestyle Medicine is determined to teach the world that 'Exercise is Medicine'

By Patricia Amend

CBI: Given the fact that you're the coauthor of a new book—*American College of Sports Medicine's Exercise is Medicine: A Clinician's Guide to the Exercise Prescription*—we have to ask: What does your own exercise regimen consist of?

EDWARD PHILLIPS: Ironically, the more writing and speaking I do about exercise, the less time I have to do it. So I work hard to integrate exercise into every corner of my life.

I'm currently an adjunct professor at the Jean Mayer-USDA Human Nutrition Research Center on Aging at Tufts University, where I'm working on studies that deal with nutrition, body composition, exercise physiology, and resistance training in the elderly. When I'm doing research and need to clear my head, I go the center's exercise lab to lift weights.

I also own three bicycles: a road bike that I use during vigorous scheduled rides with my wife, Alison, on weekends; a second that I ride with my kids—my son, Jesse, 14, and two daughters, Becca, 12, and Aliza, 9; and a third, small foldable bike that I take on the subway and ride to work.

CBI: Do you belong to a club?

EP: In bad weather, I'm off to a Gold's Gym in Needham (Massachusetts) to do some Spinning with Alison. We also do hot yoga at the H.Y.P. Studio in Needham, and train for triathlons because that's always motivating. We actively, mindfully, consciously plan our exercise for the entire week.

CBI: You're also the founder and director of the Institute of Lifestyle Medicine (ILM) at the Harvard Medical School. What, exactly, is lifestyle medicine?

EP: I don't regard it as a new specialty, but, rather, as a special approach, a particular discipline. Physicians who practice it consider their patients' current lifestyles; the physician's own knowledge about the benefits of exercise, good nutrition, smoking cessation, and stress management; and their personal experience with these matters. They then counsel their patients toward sustainable lifestyle improvements. →



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Highlights

- » Docs walking the talk
- » Institute of Lifestyle Medicine
- » *Exercise is Medicine* initiative
- » Clubs as a healthcare brand

Edward M. Phillips, M.D., received a B.A. from Yale College, and an M.D. from the State University at Buffalo's School of Medicine and Biomedical Sciences. He served his internship at the Millard Fillmore Hospitals in Buffalo, and his residency at the Columbia-Presbyterian Medical Center in New York City. He serves on the staff of McLean Hospital in Belmont, Massachusetts, and is director of outpatient medical services at Spaulding Rehabilitation Hospital in Boston, where he's currently a consultant. Phillips is an assistant professor at Harvard Medical School and an adjunct scientist at the USDA-Jean Mayer Human Nutrition Research Center on Aging at Tufts University. He also has a musculoskeletal practice at Massachusetts General Hospital. He's a member of ACSM's *Exercise is Medicine* task force, and the founder and director of the Institute of Lifestyle Medicine (ILM). —

CBI: How did you happen to become involved in this emerging discipline?

EP: I got interested in college, in the late '70s, when I took a year off from Yale University and went to work for the American College of Preventive Medicine in Washington, D.C. While I was there, we began to track a new word—*wellness*. I called companies to see what they were doing for their employees. On returning to Yale, I started a program to help students take care of their health, and, when I went to medical school in Buffalo, I got involved in a similar initiative for doctors. In Buffalo, I also met a man who was 87 and still competing in, and completing, triathlons—he was very inspiring. I found myself being drawn to physical medicine and rehabilitation.

people to become more active—are novel and exciting. How did they come about?

EP: First, I realized that getting physicians to change their own lifestyles was critically important. If they experience and enjoy the benefits themselves, they'll counsel their patients to do the same thing. I also found that it was necessary to convince practitioners that counseling their clients about exercise is easy to do, time-efficient, and can make a significant difference in their patients' lives. The exercise prescription is simple to give, and can start a person on the road to behavior change because they trust what their doctors tell them.

A survey conducted recently by the American College of Sports Medicine

EP: Yes. That's exactly the idea! However, I hope that, this time, it doesn't take 50 years to see rewarding results. Up until 1953, there were ads in medical journals, as well as in popular magazines, that featured doctors talking about the *benefits* of smoking. All of that changed, however, when reports about the hazards, including the landmark 1964 Surgeon General's study, began coming out. Through the '60s, '70s, and '80s, doctors told their patients that they, themselves, had quit smoking, and counseled their patients to do likewise. Thankfully, by 2004, there were more ex-smokers than smokers in the U.S. Still, more than 1,200 people die every day from smoking cigarettes, so our work certainly isn't finished.

CBI: What prompted you to launch the ILM, and what do you hope to accomplish through the institute?

EP: We know that one-half to three-quarters of all disease, death, and healthcare costs are directly related to behavior choices that patients make. Ironically, and regrettably, students don't receive adequate training in nutrition, exercise, stress management, and smoking cessation in medical school. And even when physicians are knowledgeable in these areas, they may not know the best way to counsel their patients.

At one point, when I was teaching in India, where they have physicians specializing in lifestyle medicine, one of the best of them offered a suggestion. He said that, if I wanted to create change, I should develop an Institute of Lifestyle Medicine at Harvard Medical School—*then* physicians would take notice.

CBI: And how did you get from that point—the concept—to an actual functioning education institute?

EP: To start with, we organized the Harvard Medical School course in Lifestyle Medicine, presented in India. I also collaborated with Margaret Moore, the founder of Wellcoaches, who works with the American College of Sports Medicine (ACSM), to develop our first

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CBI: Did you have some sort of epiphany, a shift in the way that you thought about medicine?

EP: I became more and more interested in the science of behavior change. I found myself asking the question, “If exercise is so good for you, why don't more people do it?” And I discovered that when you do three things—increase the person's self-efficacy; convince them that change is important; and reduce the “cost” of making the change, i.e., make it easier—then things start to happen.

CBI: Two of these ideas—the concept of exercise as medicine, and the notion of utilizing exercise “prescriptions” to encourage

(ACSM) determined that nearly two-thirds of patients (65%) would be more interested in exercising for their health if their physician advised them to do so and pointed them in the direction of additional resources. Yet only four out of 10 physicians (41%) talk to their patients about the importance of exercise, and they don't always offer suggestions about the best way to proceed.

CBI: Physicians have obviously played a major role in dramatically reducing the number of both smokers and smoking-related deaths. Can they have a similar impact on the obesity epidemic?



“A ‘prescription’ would help change people’s attitudes about exercise; it would prompt them to think of exercise as a medicine that everyone should take.”

online interactive program, Lifestyle Medicine for Weight Management, which we launched in 2005 through Harvard Medical School. Since then, physicians from 40 countries have taken the course. We’ve recently introduced a second online course, Lifestyle Medicine for Stress Management. We’re now creating more such courses; beyond that, we plan to develop educational models for use in medical schools.

CBI: How is the ILM being funded?

EP: To date—through grants from the Department of Physical Medicine and Rehabilitation at Harvard Medical

School, with further support from the Spaulding Rehabilitation Hospital Network in Boston. We’re also meeting with potential charter supporters—including insurance, consumer-products, food-and-beverage, and fitness-equipment companies; self-insured corporations; and groups within the health club industry—to obtain additional funding to implement the full vision of the ILM. In June, I addressed IHRSA’s board of directors, and we’re continuing to have discussions. We’d be pleased to work with IHRSA.

CBI: Last fall, ACSM and the American Medical Association

(AMA) announced a new Exercise is Medicine initiative that the ILM is also involved in. What’s the goal of this program?

EP: The ILM is collaborating with those groups, as well as the President’s Council on Physical Fitness and Sports (PCPFS) and dozens of other national medical, health, fitness, and wellness organizations, on this initiative. The goal is to have every physician assess every patient’s physical activity program during every visit. We’re encouraging physicians to record physical activity as a ‘vital sign’ during patient visits. Able individuals will be advised to participate in at least 30 minutes of

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moderate physical activity at least five days per week and muscle resistance training at least twice per week.

The ILM's role is unique and essential: we're going to create a definitive set of tools to, hopefully, trigger an evolution in clinical practice. Among them is the text you mentioned, ACSM's *Exercise is Medicine* guide, which I coauthored with Steven Jonas, M.D., a member of the ILM's advisory board.

CBI: How do you hope physicians will use this book?

EP: We'll encourage them to use it as a guide to help them transition from intending to promote physical activity for all of their patients—to actually *doing* it. The book addresses pragmatic operational issues, critical topics, such as: organizing the medical practice; assessing and engaging patients; applying motivational techniques;

developing individualized exercise prescriptions; and helping patients sustain their involvement in exercise, sports, and active recreation.

CBI: What's next? How does the ILM intend to follow up on the publication of *Exercise is Medicine*?

EP: The book's publication, in March, will mark the beginning of a yearlong rollout of related clinical tools and associated program materials. These will include patient assessment and counseling protocols; computer-generated, customized exercise prescriptions; consumer marketing materials; and resources to support collaborative efforts involving health-care providers, insurers, employers, and exercise/wellness providers. These resources—branded as the *Exercise Prescription Toolkit*—will be made available through the Institute of Lifestyle Medicine Website, www.instituteoflifestylemedicine.org. Additional information is available at the *Exercise is Medicine* Website, www.exerciseismedicine.org. The site also offers information for patients, the media, and policymakers.

CBI: Many IHRSA members concur with you. They'd love to have physicians prescribe exercise and, when appropriate, refer patients to their clubs. What would you suggest they do to position their business as part of the medical-care continuum?

EP: The notion of an exercise *prescription* is interesting because it's convenient, common, familiar, tangible, credible, and well accepted by both the physician and the patient. A prescription would help change people's attitudes about exercise; it would prompt them to think of exercise as a medicine that everyone should take. As with a drug, you're going to need a patient package insert—a document that explains the benefits, the risks, how to take the medicine, etc. In this case, it would also cover such things as how to fit exercise into your day, where to work out, etc.

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I'd like to see IHRSA and the ILM enter into a partnership to do a number of things, including creating this sort of material. We could develop a book for consumers, available at Amazon.com or the local pharmacy, and a brief 48-page pamphlet that would be distributed to patients by IHRSA and the ILM—this would be our version of the patient package insert.

CBI: Industry-wide efforts are obviously important and hold a great deal of promise, but what would you say to individual club operators? What advice do you have for them?

EP: Drug companies promote brand names. If, in fact, you're going to position exercise as medicine, you need to promote the club experience as a brand—rather than as some amorphous generic offering. Curves franchisees and Pilates providers, for instance,



Phillips practices what he prescribes on family outing

already understand that. You say "Curves" or "Pilates," and people immediately know what to expect, what they're going to be getting. Up until now, in the case of exercise, physicians and millions of Americans haven't been convinced that the club brand is better than the generic options.

Get someone off the couch, and walking around the block, and it will

work like a gateway drug—it will improve their life. But, inevitably, they'll get bored, and ask what's next. It's our nature to reach one goal, and then begin striving for the next one. As a club, you can be the brand that's constantly providing people with new choices. —

—Patricia Amend, pamend@aol.com

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