Letters

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Lifestyle medicine is no Trojan horse: it is an inclusive, evidence-based, and patient-focused movement

We welcome positive aspects of Nunan *et al*'s article[1] and the opportunity to briefly discuss their analysis. However, likening lifestyle medicine to a Trojan horse implies deception and malice; and is both unworthy and unjustified.

There are important positive messages conveyed, for example, articulating many of lifestyle medicine's key drivers (Box 1), plus individual and public health-level interventions (Box 2).[1]

However, there are important fallacies too and we seek to correct these:

1. Misrepresenting British Society of Lifestyle Medicine (BSLM) only as accrediting GPs. Although 885 (~50%) members are GPs/GPSTs, membership includes all medicine disciplines, including internal medicine/surgery/nurses/allied health professionals/trainees. We also have patient members, encouraged to attend meetings through invitations via their clinicians (https://bslm.org.uk/events/bslm-2021-conference/) and read our open-access journal, *Lifestyle Medicine* (https://onlinelibrary.wiley.com/journal/26883740);
2. Inaccurately linking alternative medicine practices/practitioners to lifestyle medicine; including bracketing BSLM with organisations like the (recently rebranded) British Association for Nutrition and Lifestyle Medicine and (functional medicine-oriented) Prescribing Lifestyle Medicine;
3. Concern that 'lifestyle medicine practitioners' may exploit commercial opportunities. The common fallacy here is blaming General Medical Council-/Nursing and Midwifery Council-/Health and Care Professions Council-registered practitioners for unregulated/commercial activities. This criticism ('smearing by association') is especially unworthy, especially as BSLM is standard setting to mitigate these risks;
4. The 'Health Inequalities' section is probably the most contentious. In brief, we recognise that environment and public health have key roles.[2] However, we refuse to accept that: we are likely to widen inequalities; medical practice cannot evolve; and personal/public health interventions don't synergise. A more detailed exposition is available online.[3] Criticising BSLM for not addressing upstream health determinants is simply incorrect: we do exactly that.

Lifestyle medicine is inclusive, evidence based, patient focused, and is not a movement needing to attack other health delivery approaches. We hope that scientific debate can be more dignified and constructive going forwards. We absolutely agree that primary care and public health colleagues should work together and practise what we preach.

Given rapid BSLM growth, plus the success and popularity of progressive curricula like Imperial College's 'lifestyle medicine and prevention' undergraduate medicine modules, which are evidence based and rooted in population health and inequalities, lifestyle medicine is becoming mainstream. We suspect future generations will term lifestyle medicine as simply 'medicine'.

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Competing interests

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Is evidence-based medicine the real Trojan horse?

I enjoyed reading your thoughtful analysis of lifestyle medicine[1] but worry that it is evidence-based medicine (EBM) itself that is the 'Trojan horse' that has smuggled in numerous harmful, unnecessary pharmaceutical interventions. Applying the same crude methodology to 'lifestyle medicine' misses the common sense that the majority of these interventions are not only extremely likely to help, whether evidenced or not, but also likely not to cause harm. Relying on validation from EBM before applying our objective common

sense is precisely what has eroded the trust of our patients and opened us up to justifiable claims of professional arrogance in dismissing alternative approaches to health care. Nobody is arguing that these are not more effective when applied at a population health level, but this should not preclude GPs from applying our professional common sense in tailoring sensible and safe lifestyle interventions for our patients.

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The academic triad in general practice

Reilly *et al*'s article on GP scholarship[1] is important and we warmly support it. They rightly state that academic general practice should be *'integrated and accessible to grass roots GPs'*. Secondary care has long had its teaching hospitals and long trumpeted the academic triad of good service for patients, teaching, and research all in the same place. GPs should seek to replicate this triad.

We report that our practice obtained the Investors in People award and has been twice rated outstanding by the Care Quality Commission. For educational development, since 1987, seven different GP managing partners have received higher university degrees. A nurse practitioner and an attached midwife obtained master's degrees and an attached district nurse a BSc. A medical student won the Quintiles prize for women in science while at the practice. In a typical year, over 40 medical students receive teaching in the practice.

There is a designated research room for research designed and conducted within the practice, and for 10 years running the practice has employed three successive postdoctoral research fellows. There have been 22 practice-based publications in peer-reviewed medical journals, as well as four in educational and policy publications, in the last 5 years. Our systematic review[2] of continuity of doctor care and mortality, in *BMJ Open* in 2018, was designed and conducted entirely within the practice, involved two medical students as co-authors, and has an Altmetric score of 2421, with 250 citations and over 87 000 downloads.

We offer this example as evidence that the academic triad can be built in general practice. NHS GP care, the teaching of medical and postgraduate students, and active research can all occur simultaneously in a single general practice. What is needed now is what teaching hospitals have had since 1948 — public recognition and reasonable financial support. Both the Royal College of General Practitioners and the Department of Health have responsibilities to ensure a level playing-field for general practice.

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Behavioural determinants of health: individual versus societal responsibility

Nunan *et al* draw our attention to the emphasis of so-called 'lifestyle medicine' on behavioural determinants of health and the responsibility of individuals for behaviour modification.[1] While it is important to address the leading behavioural determinants of premature mortality in England, namely tobacco use/unhealthy diet/alcohol and drug use/physical inactivity,[2] the authors rightly highlight the importance of considering the wider determinants of health.

An important point being made here is that overemphasis on health behaviours and individual-focused interventions (intentional or unintentional) may actually increase health inequalities and draw attention away from the main drivers of poor health, namely the wider socioeconomic and environmental determinants of health. As the Marmot reviews have shown us, differences in socioeconomic status are associated with dramatic differences in rates of premature mortality and disability; the 2020 review reported a 12-year difference in healthy life expectancy at birth between the most and least deprived regions of England.[3] Moreover, a recent cross-sectional study of 2.5 million premature deaths in England found that one-third of these deaths were attributable to socioeconomic inequality.[4]

Clearly, a balance must be struck between individual responsibility and wider societal/governmental responsibility. It is important not to minimise individual responsibility for one's own health or create a false dichotomy between individual responsibility and societal responsibility; both are important and should be advocated for simultaneously. Nunan *et al* provide a useful framework regarding ways to integrate 'individual-level interventions' with 'public health interventions' to address key modifiable risk factors. In doing so, the authors remind us of the importance of national policy in improving the nation's health and reducing health inequalities, by placing some of the responsibility at the feet of governments and national public health organisations.

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