

# PREScribe WHAT TO WHOM—AND WHY?

Russell Berger attends Exercise Is Medicine credential workshop and discovers gaping holes in methodology.

BY RUSSELL BERGER



We needed to know more, so on Feb. 20, Russ Greene and I attended the two-day EIM credential workshop in Atlanta, Georgia—which is also home to the headquarters of Coca-Cola.

## Credentials and Licensure

[illegible]

But there was one important point I wasn't hearing. The ACSM wants the EIM credential to be legally required for anyone who wants to receive clients in this way. While the organization has backed away from attempts to license and regulate all trainers, the ACSM "does support licensure" for those who "work with patients and clients with medical conditions that require minimal to advanced clinical support."

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From what I could tell, the success of the EIM scheme relies completely on the success of trainer licensure. After all, if anyone—regardless of experience or credential—was allowed to train unhealthy populations, why would someone attend the EIM workshop? Did it offer some valuable methodology or information that would give trainers an edge in the battle against chronic disease? Not from what I could tell.

But before I could raise this question, Hutber explained how EIM sees its value to trainers.

“The health-care industry doesn’t trust us,” he began. “If you were a doctor, would you send your patient to someone who was certified in a weekend?”

Hutber immediately answered his own question: “It doesn’t matter, because they won’t.”

Hutber went on to explain that the EIM program was designed to meet the requests of the health-care industry itself. Without the EIM credential, doctors, insurers and health-care providers would have no “quality assurance” of exercise professionals.

The irony of Hutber’s comment seemed lost on the audience and Hutber himself. The EIM credential workshop, after all, is a weekend course. If attendees pass the test at the end of the second day, they are qualified by EIM to work with unhealthy populations.

But there was a more serious problem with Hutber’s view. On one hand, Hutber was saying the EIM credential is necessary because the public and health-care industry distrust “unqualified trainers.” On the other hand, Dick Cotton, the ACSM’s national director of certification, was intimately involved in publishing the infamous “[CHAMP paper](#).” The “Consortium for Health and Military Performance and American College of Sports Medicine Consensus Paper on Extreme Conditioning Programs in Military Personnel” raised alarm about the potential danger of CrossFit and other fitness programs not accredited by the National Commission for Certifying Agencies (NCCA).

The effect of the CHAMP paper on CrossFit’s reputation is almost impossible to estimate. The fear-mongering the CHAMP paper promoted was echoed by dozens of academic papers and hundreds of news outlets. In other words, the public fear of unqualified trainers is owed to the efforts of CrossFit’s competitors in the fitness industry—the ACSM leadership included.

After lunch, I had an opportunity to speak with Hutber privately, and he very explicitly assured me that the ACSM does not promote or support legislation that would make the EIM credential a legal requirement for working with unhealthy populations. I pulled out my phone and opened the ACSM position statement that claimed exactly the opposite. Hutber looked deeply concerned as he read his own organization’s words, which contradicted what he was telling me.

“I’ll have to check with Dick Cotton on this,” he told me.

I walked away with the impression that Hutber legitimately did not know his own organization supports legislation that would make the EIM credential a legal requirement for working with unhealthy clients. I recalled Hutber’s words: “Health care doesn’t trust us.”

If by “us” Hutber was referring to the ACSM, maybe health care is wise not to extend its trust.

Setting the issue of trainer regulation aside, I realized there were a number of important questions the EIM workshop had yet to address. Specifically, I wanted to know what methodology EIM was teaching its trainers to employ. What movements, nutritional prescriptions and metrics did this methodology comprise? Without this information, I had no way of predicting the efficacy of EIM’s effort to combat chronic disease.

By the end of the next PowerPoint presentation, I had the answers to these questions.

## Concise Questions, Vague Answers

Lobelo began the next presentation with a claim: Traditional corporate wellness programs don’t work because they fail to change participant behavior. The solution was to train EIM credential holders in “behavioral-modification strategies.” For the next four hours (not counting lunch and coffee breaks), we learned about “communication styles” and were exhorted to employ “motivational interviewing” that uses “thoughtful interview and support” to create “positive behavior changes” in clients.



Is exercise really medicine?

As a CrossFit trainer, I have personally experienced the difficulty of trying to get an unhealthy friend or family member to come try a workout. Yet once this initial hurdle is overcome, the person is generally hooked for life. It was unusual to hear so much discussion about the difficulty in getting people to consistently show up for training. Was this a critique of EIM’s own methodology? After all, who would want to stick with a fitness program that offered little to no quantifiable results?

As Lobelo continued on in a seemingly endless string of behavior-change jargon, the question kept nagging me: What behavior changes? Finally, I heard something that sounded like an answer. Lobelo’s “behavior change” was to get at-risk populations to follow the national Physical Activity Guidelines—specifically, 150 minutes of moderate-intensity physical activity per week.

That was it. The EIM exercise prescription for combating our nation’s chronic-disease epidemic was 150 minutes of “moderate-intensity physical activity” per week. I was at a loss for words. Sure, this type of generic advice isn’t wrong,

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but it’s also a phenomenal underestimation of what a professional trainer is capable of doing for his or her clients. Does the ACSM not recognize the enormous range between an effective fitness program and an ineffective fitness program? What would possess it to completely ignore the type of activity trainers were using and focus only on the quantity?

I raised my hand. “How should we quantify success? What metrics should we use to determine that our program is working?”

The answer was complicated and confusing, and the question was battled between all three EIM presenters before they were finished. Their response boiled down to something like this: The goal of the EIM trainer is to get people to show up to the gym and be “active,” so how you do that really doesn’t matter. EIM trainers should not concern themselves with measuring fitness or health improvements because it’s impossible to guarantee someone will get fitter or improve his health metrics by following your program, as these things are determined by genetics.

In other words, the EIM presenters all assumed that measurable improvements to performance or health metrics were an elusive and mysterious phenomena, and when a fitness program failed to deliver these results, it was the client’s fault, not the trainer’s.

This problem was compounded by the fact that the presenters had no quantifiable definition of “fitness” and no consistent measure for “intensity.” When I asked the presenters how they quantified fitness, the answer was summarized as “VO<sub>2</sub> max, sometimes.” When Greene asked the presenters how they measure intensity, the answer was “heart rate or perceived exertion.”



The latter presents a significant problem. Without a standardized definition of moderate intensity and a way to measure it, tracking “moderate-intensity activity” is meaningless. Imagine a doctor prescribing a “moderate” dose of acetaminophen to a patient but having no way to quantify that dose. EIM trainers, clients and doctors have no accurate or precise way to decide what counts as moderate-intensity activity and what doesn’t.

I had been suspending my judgment of the EIM program’s methodology only to find out the methodology doesn’t exist. EIM reduces trainers to their lowest common denominator: activity babysitters. What EIM trainers would offer doctors is nothing more than the assurance that patients were spending time off the couch—something that guarantees a small statistical reduction in the risk of developing chronic disease. This is, of course, better than nothing, but as I’ve already noted, the ambiguity of focusing only on “activity” vastly underestimates the positive benefit a trainer can have if she is armed with the right technology.

As it turns out, this underestimation may be by design.

Next, I asked Lobelo if the EIM workshop was going to address diet and nutrition. I referenced Dr. Robert Lustig, whose work shows sugar is the only type of food that predicts Type 2 diabetes prevalence independent of obesity and other confounders (such as sedentary behavior and alcohol use).

“So should we tell our clients to stop drinking soda?”

At my question, Lobelo became flustered. He explained that determining which nutritional prescriptions a trainer should utilize is impossible because “we still don’t know what a healthy diet is.”

But I had not asked Lobelo about the existence of an ideal “healthy diet.” I asked him if we should tell clients with chronic disease to stop drinking soda. Behind me, a female ACSM trainer gave me her own answer: “That’s outside of your scope of practice.” I turned to Lobelo: “Is that EIM’s position as well, that nutritional recommendations are outside of a trainer’s scope of practice?” His answer, which was far from direct, indicated that it was.

I raised my hand again.

“Is your view on nutrition at all influenced by the fact that your department at Emory University has received over 2 million dollars from Coca-Cola?”



**Becoming more active is a start, but it’s not enough. Precise, measurable fitness programs implemented by competent trainers can dramatically improve health.**

The room was suddenly full of mumbling and shuffling sounds. Lobelo was ready with an answer: “I didn’t personally take any money from Coca-Cola.”

Again, Lobelo seemed to be answering questions he wished I was asking, not the questions I was actually asking. I continued, “But your department has received over 2 million from Coke, correct?” Lobelo avoided a direct answer to this question and simply denied that Coca-Cola’s money had influenced his views. He quickly transitioned back into his PowerPoint slides and seemed to avoid looking toward my side of the room for the rest of his presentation.

But this was not Lobelo’s only bizarre claim regarding nutrition. In his closing remarks, he said something even more discouraging. He insisted that nutritional recommendations for clients

simply don’t work: “Diet-specific behavior change typically doesn’t work. It goes against nature.” In other words, Lobelo’s advice is to focus only on exercise because it’s too hard to get clients to stop consuming refined sugar.

Something was deeply wrong. Here was a man who had just lectured for four hours on the power of behavior change yet was telling trainers not to bother trying to change the nutritional habits of clients.

## Don’t Talk Diet

During the next break, I noticed Hutber standing in the back of the room near the hotel-provided coffee station. By this point I had recovered from the initial culture shock of being

told we shouldn’t advise clients to abstain from consuming refined sugars, but I needed to know how the ACSM justified this position. I approached Hutber and asked. He admitted the importance of nutrition in combating chronic disease and suggested trainers could make “general food-pyramid recommendations” based on United States Department of Agriculture (USDA) guidelines. Anything more specific, he said, was breaking the law.

I asked him what trainers should do when registered nutrition experts are giving bad advice—advice that in many cases is slowly killing their clients.

“Should we do what presents the least potential liability or should we do what is ethically right?”

A small group of participants began forming around us. Hutber considered my question and seemed to concede that this was a problem.

“What if the ACSM joined CrossFit in combating the licensure and regulation of nutrition and dietary advice?” I asked Hutber.

In the group around us, a few heads nodded in agreement.

“If you did we could easily fix this problem of nutritionists’ and dietitians’ trying to prevent us from giving life-saving advice to our clients.”

Hutber nodded quietly, almost somberly. He likely did not miss the irony of my proposing that the pro-licensure ACSM work to remove legal barriers for trainers.

# DAY 2

## Agree to Disagree

During our second day at the workshop, the majority of presentations were on the topic of “Chronic Diseases and Prescriptions.” These were lead by Jim Skinner, chair of the EIM International Advisory Committee. Skinner taught that one of the EIM program’s key recommendations is to segment group training by type of chronic disease. For example, trainers should not have patients with heart disease in the same group class as those who have Type 2 diabetes. The rationale for this is that different populations need distinctly different types of training, an archaic assumption Skinner supported by systematically walking through a number of chronic conditions and discussing the relevant precautions, methods of assessment and exercise recommendations for each.

Many of these precautions and considerations were very sensible. For example, a trainer working with an obese client may need to reconsider what postural changes are included in training (supination and pronation), as they might be too difficult for the client without assistance. Yet Skinner’s lecture failed to deliver anything that looked like effective or meaningful exercise recommendations. I attributed this to the aforementioned ACSM failure to define fitness or intensity in any consistent or scientifically quantifiable way.

But Skinner said something else in his presentation that caught my attention. He noted the existence of a number of health recommendations “we can all agree on.” These three recommendations were, “Do not smoke, eat less fat and fewer calories, and exercise.”

In support of this supposed consensus, Skinner cited the American Heart Association, the American Cancer Society and the American Diabetes Association. I was fairly surprised to see the promotion of the nearly extinct low-fat diet. I also mentally noted that each of the organizations Skinner cited has suckled at the teat of Big Soda, receiving over \$2 million collectively from The Coca-Cola Co.

After the workshop, I was able to check Skinner’s citations and found they were completely false. Since 2013, the Amer-

ican Diabetes Association has placed no limitation on total fat intake, while it has recommended the limitation of elimination of sugar-sweetened beverages. Similarly, the American Cancer Society does not recommend an overall limitation of dietary fat but does suggest limitation of “sugar-sweetened beverages such as soft drinks.” What about the American Heart Association? It recommends limitation of “saturated fat, trans fat, sodium, red meat, sweets and sugar-sweetened beverages.”

To make matters worse, Skinner’s recommendation to limit fat consumption doesn’t conform to current USDA guidelines—the same guidelines to which the ACSM expects trainers to limit their nutritional recommendations. In January, the USDA shifted its stance on sugar dramatically, putting limits on daily



The energy-balance myth would have clients believe both choices are OK as long as you work off the calories. In reality, refined sugar is far worse for the body.

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—Russell Berger

intake that would require the average American to cut his or her sugar intake by half.

At this point, Greene raised his hand and asked Skinner a very specific question: “If we have a client with Type 2 diabetes and he comes into the gym with a Powerade, should we address that?”

For anyone who understands the relationship between sugar consumption and diabetes (or anyone simply following the nutritional guidelines of the organizations Skinner had already cited), the answer would be a resounding “yes.” Our aim was to see if Skinner would fall into this camp, and if so, how he would justify EIM’s hostility toward trainers giving sugar-related nutritional advice.



But Skinner had a different answer: “The body needs carbohydrate,” he said. “If they are exercising, they are using it. So it’s not a problem.”

Skinner’s answer indicated that he holds to a theory known as “energy balance”—the view that all calories, regardless of type or source, have an equivalent effect on health. Thus, metabolic derangement and chronic disease could not be caused by consumption of refined sugar but by simply consuming more calories than you expend. Until last year, this theory was championed by an organization called the Global Energy Balance Network (GEBN), another partnership between the ACSM and Coca-Cola. The GEBN collapsed and died in the midst of public embarrassment when The New York Times published internal emails exposing the organization as a scientific front designed to protect Coca-Cola sales.

The pattern here was obvious. I raised my hand again and for a second time asked a question: “It seems to me that you’re so obviously avoiding discussion of sugar consumption that it’s becoming awkward. Is that because EIM was co-founded by Coca-Cola?”

Skinner was ready with his answer: “No.”

I pointed out that the ACSM’s current president, Larry Armstrong, says funding does affect objectivity in research.

“Do you disagree with your organization’s president?” I asked him.

The participants around me erupted, some in moans of frustration, others in laughter. There was enough noise to drown out a portion of Skinner’s answer, but I caught the gist of it. He said he disagreed with a lot of people in his organization but insisted that Big Soda’s founding and funding of the EIM program had nothing to do with his systematic avoidance of the topic of sugar.

# SWEET DECEIT?

On the drive home from the workshop, I was left to ruminate on Skinner’s false citations, outdated nutritional advice and complete avoidance of the topic of refined sugar; Lobelo’s doubting that we can identify that sugar is harmful, as well as his absurd advice to avoid trying to change client nutritional behaviors; and Hutber’s repeated pleas to avoid giving “illegal” dietary advice to clients. There was only one rational explanation for this behavior: The Coca-Cola money paying these men’s salaries.

Attending the credential workshop confirmed our view of the EIM scheme. In many ways, it is the perfect investment for Coca-Cola, a brand that has suffered greatly from declining soda sales and a growing body of scientific evidence that sugar is directly linked to some, if not all, chronic disease.

This can be seen clearly in the ACSM’s and EIM’s positions on nutrition. The EIM scheme is not simply agnostic on sugar; it is downright hostile to the suggestion that trainers should talk to clients about food. Within five days of my attending the EIM workshop, the ACSM issued the revised position statement “[Nutrition and Athletic Performance](#).” The revisions emphasized the ACSM’s view that “athletes should be referred to a registered dietitian/nutritionist for a personalized nutrition plan.” The revisions do not mention the word “sugar” once.

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Even if trainers were left without guidance on how to approach nutrition, many could accidentally stumble onto a diet that reduced sugar intake and improved client health. This won’t happen if EIM representatives frighten trainers into thinking they will be sued for telling a client to stop drinking soda.

By my estimation, the legal risk for trainers giving general dietary advice is virtually non-existent, especially with recommendations as simple as “don’t drink soda.” Of the tens of thousands of CrossFit trainers operating in the U.S., not a single one has ever been sued for making nutritional recommendations to his or her clients. In 2012, North Carolina blogger [Steve Cooksey](#) sued the state’s Board of Dietetics/Nutrition after the board accused him of “providing nutrition care services without a license.” Cooksey had published an



article describing how with the Paleo Diet and to do the same. The dropped when the North new guidelines allowing dietary advice without a license.

he beat his diabetes encouraged others lawsuit was eventually Carolina board adopted people to give ordinary

The EIM’s position on liability also seemed to be highly selective. While they were willing to repeatedly warn about nutrition recommendations, the EIM workshop ended with a presentation by DOJ Global Vice President Michael McBrayer, who demonstrated a number of joint-stabilizing braces produced by his company. The EIM presenters (Hutber in particular) then encouraged trainers to tell their clients to use therapeutic aids to address pain or injury. If telling clients not to consume refined sugar is a job best left to licensed nutritionists, why is the recommendation of orthopedic braces not best left to licensed physical therapists? The EIM staff’s inconsistency showed just how frivolous their concerns really were.

Recalling Coca-Cola’s founding influence on EIM helped make sense of its position on fitness. In CrossFit, the effectiveness

of a diet is measured directly by its impact on fitness. The diet that doesn’t lend to increased work capacity across broad time and modal domains isn’t worth following. EIM encourages trainers not to improve fitness but to “increase client activity.” By instructing trainer’s to avoid measuring quantifiable fitness or health metrics, any chance of a trainer’s broaching the subject of nutrition through the back door of performance is eliminated.

It’s worth noting that many of those in the EIM audience shared my concern and skepticism about Coca-Cola’s founding of the program. After all, the audience comprised fitness trainers, doctors and health-care workers—people who are generally drawn to their career out of a desire to improve the lives of others. After speaking at length with a number of them, it became clear to me that the ACSM’s lack of transparency was the real problem.

Few of them knew of the collapse of the GEBN or Coca-Cola’s founding relationship to the EIM program. Yet it is these trainers themselves who could be most harmed by the EIM scheme, which neuters the professional trainer of any influence he or she might have in altering the nutrition of unhealthy clients. If it is successful, the ACSM, acting as Big Soda’s puppet, would become the gatekeeper for those desiring to train the chronically ill. Meanwhile, Coca-Cola improves its image, obfuscates the relationship between sugar and chronic disease, and protects soda sales. As a fitness trainer myself, I can imagine nothing more concerning.

During one exchange with EIM presenters on the role of nutrition in preventing chronic disease, a participant interjected: “Our job is to focus on just the exercise.”

Remember, that’s exactly what Coca-Cola wants you to think. ■

**About the Author:** Raised in Atlanta, Georgia, Russell Berger spent four years in 1st Ranger Battalion. After leaving the military in 2008, he opened CrossFit Huntsville, where he spent three years as head trainer. He now works full time for CrossFit Inc.