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CHRONIC DISEASE AND MEDICINE: PREVENTION DOESN'T PAY

Why your doctor only wants to see you after something has gone wrong.

BY BRITTNEY SALINE



Most physicians have received minimal nutrition education and are ill-equipped to tell their patients which foods to eat.

Dr. Stephen Schimpff calls it the paradox of American medicine. “We have really well-trained, well-educated providers. We are the world’s envy for biomedical research. We’ve got excellent pharmaceutical (and) biotechnology companies and diagnostics (tools). But the paradox is on the other hand we have a terribly dysfunctional health-care delivery system,” said the retired CEO of the University of Maryland Medical Center in Baltimore.

Despite our technology, education and wealth—in 2014, total national health-care expenditures hit **US\$3 trillion**—chronic disease remains the nation’s top **killer**, with seven of the top 10 causes of death in 2010 stemming from chronic illnesses such as heart disease, stroke, cancer, Type 2 diabetes and obesity. In 2010, **86 percent** of all health-care spending was attributed to chronic disease—conditions labeled **preventable** by the Centers for Disease Control.

So why are we still so sick?

“America does not have a healthcare system; we have a ‘disease industry,’” Schimpff wrote in a 2010 **article**. “We focus on disease and pestilence and do a good job of caring for those with acute illnesses and trauma. But we certainly do not address health well and we are not good at caring for chronic illnesses.”

It’s an industry based on one fundamental problem, Schimpff said.

“We don’t put our money where we could have a huge impact, which would be prevention and wellness.”

Nineteen Hours

Dr. Stephen Devries, preventive cardiologist and executive director of the non-profit **Gaples Institute for Integrative Cardiology**, echoed Schimpff’s sentiments.

“Prevention is not a priority, which is a serious problem,” he said.

The problem, he continued, begins in medical school, where a lack of education on nutrition and fitness—two major lifestyle factors that can help **prevent** the development of chronic disease—sets physicians up for failure from the start.

“Doctors currently receive very little education about nutrition, and therefore at the present time most doctors aren’t as well equipped as they should be to counsel a patient about nutrition, and that’s a major problem,” Devries said.

He reported that medical students receive an average of 19 hours of nutrition education across the entire curriculum of the medical degree.

“Even the paltry amount of nutrition education in medicine today is largely devoted to basic science and the biochemistry of nutrition and nutritional deficiency states that are very uncommon nowadays,” he continued.

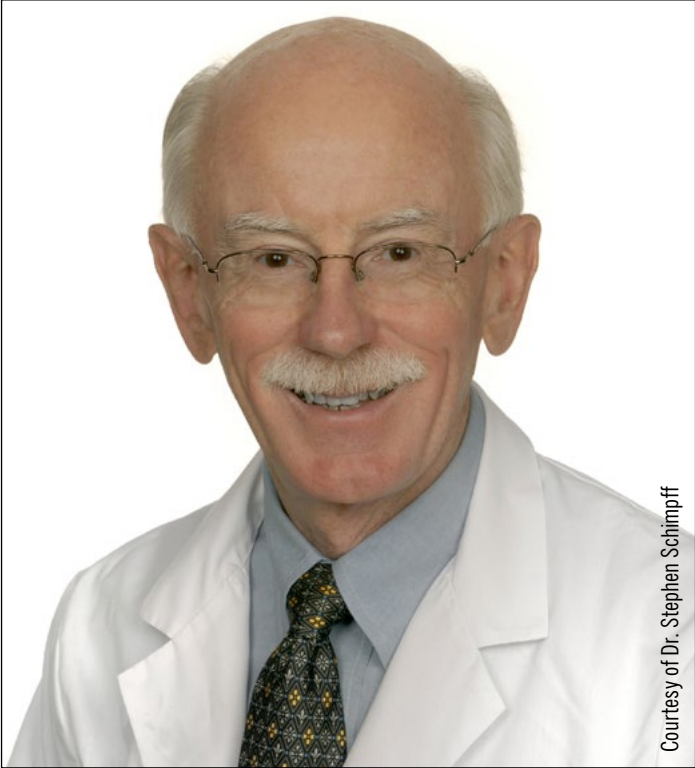
Dr. John Williams, a third-year internal-medicine resident at the

University of Colorado and a CrossFit athlete of nearly 10 years, described a similar experience despite attending medical school more than two decades after Devries.

“The nutrition education I had basically came down to a three-hour lecture and an intake journal,” Williams said. “And in terms of exercise, there’s really not a lot that they give us. The party line is ‘exercise 30 minutes three times a week,’ and it’s (only) cardio.”

That isn’t to say the U.S. medical system doesn’t value disease prevention—a whole **task force** of experts reports to Congress annually and is devoted to “clinical preventive services such as screenings, counseling services, and preventive medications.”

The problem, Devries said, is that “most of the prevention work rests on early detection of disease rather than preventing the formation of disease, which is where I believe it needs to go.”



Courtesy of Dr. Stephen Schimpff

Dr. Stephen Schimpff

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If doctors focused on prevention, they would discuss diet and exercise during annual meetings with healthy patients looking to maintain or improve their health.

Lip Service

If physicians aren't focused on preventing disease before it starts, what's happening in the exam room?

Think back to your most recent doctor's appointment. Most likely, you were there either seeking treatment for a specific ailment or for a routine health-maintenance physical. In either case, the physician's main goal was to address the situation and send you on your way as quickly as possible.

"Usually the presenting problem is identified by the patient," said Melissa Scanlan-Duncan, clinic manager for HealthPartners North Suburban Family Physicians in central Minnesota. "You make an appointment for the doctor because you have ear pain. (The physician) is not gonna talk about the fact that you're clearly obese. Or the patient is coming in because they need a refill on their insulin. (The physician) is going to see that patient, talk about the refill on their insulin—is it controlling their blood sugar?—and they're out the door."

Even the regular annual physical does little in the way of prevention, Williams said. During a routine physical, Williams will first ask the patient if he or she would like to discuss any active issues. Then they go over social history.

"Are they smoking, are they drinking, are they using any recreational drugs?" he said. "Usually I don't get (patients) who come in and ask about recommendations for preventative (measures) like diet and exercise. That's few and far between. And so that usually doesn't get addressed unless it gets to the point where it's manifesting in something like disease."

And at that point, the discussion becomes more about disease management than prevention. For instance, people with diabetes are at greater **risk** for heart disease. Instead of talking about diet and exercise, Williams said, at that point the main focus is medication.

"A lot of the stuff we look at (in that case) is focused on preventing a heart attack, so we start a statin, a medication to help keep the cholesterol low and that's been shown to reduce the amount of heart attacks," he said. "But I wouldn't really call it restoring health; I would more refer to it as slowing decline."

But neglecting to discuss the basic foundations of prevention—lifestyle choices—gives patients the wrong impression, Devries said.

"When a patient goes to their doctor and the doctor asks about the pills and doesn't spend much time talking about lifestyle and weight, then the patient feels, rightly so, that perhaps the weight isn't that important or that their diet's not important because the doctor never mentioned it," he said. "And that's what the patient walks away with. Although it's a team effort and it comes down to the patient doing the work, I think the physician needs to be a source of information and motivation, and that

just isn't happening today."

Physicians have even less to say to healthy patients about how to maintain that health or what steps they can take now to prevent future disease.



Dr. John Williams

Courtesy of Dr. John Williams

"When someone healthy comes in, not much is done," Williams said. "I know many of my friends who have been asked 'why are you here?' by a physician when going for a regular check-up. Typically, if there isn't a problem to fix there's not much done. We aren't really trained on how to reach peak health. We're trained on stabilizing and managing disease."

**"We aren't really trained on how to reach peak health. We're trained on stabilizing and managing disease."
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Even if the patient displays warning signs of potential future chronic illness—such as being overweight—but he or she is oth-

erwise healthy, the extra pounds aren't likely to get much airtime.

"Although there might be some lip service (given) to nutrition, something like 'you need to be active' or 'you need to lose weight,' ... there would typically be, unfortunately, too little done and likely not a significant intervention until a problem developed," Devries said.

No Time to Prevent

The generic lip service to the tune of "eat better and move more" can be attributed partly to physicians' lack of training in those areas, Williams said, but equally to their lack of time.

"We just don't have the time to sit down and explain to the level of detail that's necessary to (teach) how to break down your food (and) how to exercise," he said. "Most of the time, to be perfectly honest, it's not addressed."

The average doctor sees 20-30 patients each day, according to Schimpff. Assuming 24 patients per day and an eight-hour workday, that's three patients per hour. But in reality it's fewer than that because the doctor needs time to answer email, write in patient charts and do other administrative work, reducing the average visit to 15 minutes or shorter, which Schimpff says is not enough to tackle prevention of chronic disease.

"What's the cause of a chronic illness?" he asked. "Yes, genetics are important. Yes, your environment is important. But more than anything else, it's lifestyle—eating a non-nutritious diet and too much of it, not getting enough exercise, both aerobic and resistance ... being chronically stressed, and tobacco. These are the things that we gotta deal with, front and center.

"Can the primary-care physician deal with them? And the answer is 'not in our current system.' The doctor needs more time per patient, but insurance isn't paying for that."

Sick People, Healthy Budgets

Imagine a 35-year-old woman goes to see her doctor for her annual physical. The doctor measures her height and weight, takes her blood pressure and administers her immunizations. He notes she's about 30 lb. overweight.

"That's the end of the conversation," Scanlan-Duncan said. "We do not talk about, in that visit, if you are sick and you need something else. Because what will happen if you move into discussing (weight management), you have now entered a higher level of acuity than your routine health physical."

Acuity is a measure of how complex a patient's visit is, and it directly corresponds with how the physician codes that visit. Current procedural terminology (CPT) codes determine the bill for the visit. The sicker the patient, the higher the bill.

While most insurance plans offer free annual routine health maintenance, the moment treatment or counseling extends beyond the limited scope of that visit, "You've entered that next level of acuity, your bill goes up, and now it's no longer a free visit. It's a paid visit," Scanlan-Duncan said.

The result is that patients often purposely avoid seeking the counsel or treatment that could be the very thing that keeps them from getting sicker down the road.

"As consumers get savvier about their insurance plans, particularly those with a high deductible, they are going to refrain from answering the question, 'Is there anything else I can do for you today?'" Scanlan-Duncan continued. "Because they know it's going to cost them money, and a lot of it."

If chronic disease is the leading cause of death in the U.S. and if it can be largely prevented with lifestyle choices, why don't those discussions rank highest on the acuity scale? The answer is all about money.

Most hospitals and clinics make their money through fee-for-service billing of government and private insurance companies. And insurers, Schimpff **wrote**, "pay for doing 'something.'" That "something" looks like prescriptions and procedures, not heart-to-hearts.

"(CPT codes) are not designed around prevention; they're designed around disease," he said. "If a doctor spends 15 minutes (on prevention) with a patient, that's 15 minutes I'm not gonna get paid for."

It's not that doctors are looking to pad their pockets. Though businesses that saves lives, most hospitals are still just that: businesses, with expenses that need to be met by generating revenue. And the best way to cover costs is with volume—hence doctors' jam-packed schedules—and coding of visits with the highest plausible level of acuity. Discussing veggies and squats doesn't pay the bills.

It's an issue Scanlan-Duncan is well familiar with.

"My job as the clinic manager is to ensure that I'm meeting budget," she said. "The only way my clinic meets budget is if we're producing revenue. The only way I produce revenue is that my doctors see enough patients."

Pressure to meet budget requirements gets passed on to physicians, who are often required to meet specified production goals. At North Suburban, that looks like around 5,300 relative value units (RVUs) per year, wherein the higher the patient's acuity, the more RVUs the physician gets. The pressure inevitably results in office visits that aren't geared toward prevention by means of lifestyle choices.

"If your goal is to produce at a certain level and you're not seeing that many patients, you're in trouble," Scanlan-Duncan said. "As



Courtesy of Melissa Scanlan-Duncan

Melissa Scanlan-Duncan

a clinician, you will get talked to about that. And if you have to see this many patients in this short amount of time, you're not going to provide good holistic care because you can't. The system does not support you."

"Unless hospitals and clinics will be paid for their preventative services, they will not be provided as it would be pro bono work for everyone and take away from profitability."

—Dr. John Williams

Williams expressed a similar view.

"Unless hospitals and clinics will be paid for their preventative services, they will not be provided as it would be pro bono work



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Doctors are lifeguards: They show up when something goes wrong. Consider a healthy diet and exercise life preservers that ensure you don't need a lifeguard.

for everyone and take away from profitability," he said.

And as health care has transitioned over the decades from mostly physician-owned practices to large corporations and conglomerates, profitability—not patient health—has become the primary concern of the people at the top.

"Physicians have largely been squeezed out of the leadership and decision-making roles," Williams said. "These spots are now filled by people looking for solid financial investments. Thus the people running the hospital know little about the actual practice of medicine. Their goal is to make a profit for the shareholder and board members, who also know little about medicine.

"Right now business is good, and as long as the hospital is full of sick people, business will remain good, so why invest in preventative medicine?"

Whose Job Is It Anyway?

With all that in mind, is the doctor's office currently the best place to learn how to prevent chronic disease with lifestyle choices?

The American College of Sports Medicine (ACSM) and The Coca-Cola Co., founders of the **Exercise Is Medicine** (EIM) initiative, would have you believe it is. The application of EIM "is achieved by assessing physical activity levels of each patient at every clinic visit," "providing patients with an exercise 'prescription,'" and "referring patients to a trusted network ... led by qualified professionals."

But a closer look suggests EIM and its founders are more concerned about self-preservation than your health, fearing market competition and consequently pushing for licensure regulations that would make certain credentials a legal requisite for any

trainer working with clients in a medical context, Russell Berger **reported** in a March CrossFit Journal article.

Even if physicians began writing prescriptions for exercise, it wouldn't change the fundamental problems at the heart of prevention in U.S. health care. Hospitals will still have mounting costs (to be answered with increasing patient volume and acuity), and doctors will still face a gap in training.

"(Physicians) focus on reactive medicine, and we're good at that," Williams said. "We're not getting to the people who are healthy and young. We're seeing people who have made bad decisions over the course of their life—be it smoking, be it diet, be it inactivity—and we're catching them at the point where they're at, (with) prediabetes or diabetes and high blood pressure. The disease is already set in, and so we're stuck dealing with that. I think that's where (physicians') skill sets lie, and I think it'd be tough to try to incorporate anything else into that."

That's not to say you should cancel your next physical. But don't be foolish enough to presume that it will be enough to shield you from chronic illness.

"People think heart attacks occur in your 60s," Schimpff said. "So some guy is 67 years old and gets a heart attack. Did it just occur? Well, the heart attack did, but the plaque that was building up in his coronary arteries has been building up since he was probably 18, slowly but surely. Even the 40-year-old person who is in relatively good health and isn't terribly overweight—it still would behoove the patient if the doctor said, 'You know, if you could knock off 20 lb., that would be really good for you ... and you're gonna do it with a combination of diet and exercise.'"

"We can't focus on the population that's showing up in the hospitals now, because for most of those people it's too late," Williams added. "Someone can't un-have a heart attack. Someone can't un-smoke a pack a day for 50 years. It's possible but it's hard to reverse diabetes.

"So ideally prevention would be starting young, having education in elementary school, high school and college to include (nutrition), and then I think gym class is huge: gymnastics, mobility, flexibility, agility—all of the basics of CrossFit." ■

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