Guidelines Recommending That Clinicians Advise Patients on Lifestyle Changes

TO THE EDITOR: Despite robust evidence implicating lifestyle as the most influential and controllable factor affecting global health and chronic disease (1), Johansson and colleagues (2) opine that lifestyle changes recommended in guidelines are "a popular but questionable approach to improve public health." Guideline panels must evaluate the directness of evidence for recommendations, address implementation challenges, and consider any associated harms or opportunity costs. However, these actions are fundamental to all trustworthy guideline recommendations, not unique to lifestyle interventions (2).

Unfortunately, National Institute for Health and Care Excellence guidelines with lifestyle recommendations often violate these requirements, with many supported by missing or low-certainty evidence and with inadequate attention to harms, costs, and treatment burden (3). However, extrapolating from the National Institute for Health and Care Excellence to other guideline developers or to lifestyle changes in general is unjustified and violates the directness of evidence emphasized by the authors. Also unsupported by direct evidence is the claim (2) that "even high-quality guidelines recommending lifestyle interventions . . . overestimate benefit, miss key limitations of the evidence, neglect possible harms, and do not adequately consider feasibility and opportunity costs." Many guidelines have deficiencies in development that compromise trustworthiness, but singling out lifestyle interventions as a unique example is again unwarranted. Moreover, there is no evidence cited to support a later assertion (2) that lifestyle interventions, compared with drugs or other therapy, lead guideline panels to "often assume they are effective, safe, and feasible approaches to health promotion."

Adherence to guideline recommendations is a universal concern and not specific to lifestyle behavior change as suggested by the authors. Therefore, the American College of Lifestyle Medicine highlights the importance of interdisciplinary teams in achieving sustainable lifestyle behavior change (4). This applies to all 6 pillars of lifestyle medicine, namely, plant-predominant nutrition, adequate physical activity, restorative sleep, stress reduction, positive social connections, and avoiding risky substances (5).

There is robust evidence for a beneficial effect of lifestyle interventions in preventing and managing chronic health conditions, including obesity, type 2 diabetes, cardiovascular disease, and colorectal cancer (2, 5). Trustworthy guidance is critical for moving from evidence to action, but denigrating the importance of lifestyle change with a catchy article title and overgeneralized opinions in a high-impact medical journal is unhelpful and unjustified.

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TO THE EDITOR: Johansson and colleagues' (1) critique of guidelines recommending clinician advice on lifestyle change rests on flawed assumptions and overgeneralizations that substantially weaken their argument. Their main position is to challenge National Institute for Health and Care Excellence methods (with examples drawn from U.S. guidelines); yet, their writing seems to have omitted gathering any patient representative data. Patients have been integrated into National Institute for Health and Care Excellence processes, including scoping and guideline development groups, since inception (2), and the National Institute for Health and Care Excellence always considers potential harm and costs. The authors contend that recommending clinician advice on lifestyle change lacks sufficient evidence of effectiveness, feasibility, and safety.

Contrary to their assertions, robust evidence from randomized controlled trials shows that brief interventions—including but not limited to those related to smoking cessation, physical activity, nutrition, and weight loss—are effective and feasible (3). For example, a brief, conventional intervention supplemented by group consultations for a low-carbohydrate diet achieved sustainable remission of type 2 diabetes in more than 50% of participants, with savings in prescription costs exceeding intervention costs (3). These results indicate that lifestyle interventions driven by clinician advice can be scaled effectively without excessive burden on the health care systems.

Randomized controlled trials also have limitations when evaluating lifestyle interventions, which the Hierarchies of Evidence Applied to Lifestyle Medicine framework is designed to address (4). Johansson and colleagues' insistence on studies for ultimate health outcomes overlooks well-established evidence of intermediate outcomes—such as dietary changes and smoking cessation—leading to reduced major adverse cardiovascular events and improved health.

The authors' reliance on a single survey data set by the same research team undermines the analytic breadth (references 1, 2, and 10 in their commentary), and cost estimates seem to be overestimates based on disease rather than person. Their view that lifestyle interventions are resource-intensive ignores the high cost of pharmaceutical therapies, offering a narrow, drug-focused perspective. A stronger case would have emerged if they had considered the alternative costs of high-priced drugs and long-term synergistic benefits of preventive approaches, including cost-effectiveness.

Finally, Johansson and colleagues raise concerns about the potential harms of directive advice but overlook how such person-centered approaches as lifestyle medicine effectively mitigate these risks. These approaches emphasize empathy, individualized care, and sustained behavior change while reducing stigma. We contend that the case for the effectiveness of clinician advice on lifestyle change is well-established. What lies ahead is refining existing and novel models to optimize their safety and feasibility, scaling through such approaches as group consultations (5), and refining best practices through implementation science.

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IN RESPONSE: We thank Dr. Rosenfeld and colleagues and Dr. Birrell and associates for their interest in our commentary. We agree that healthy habits are important for

public health. We question whether the best approach to improve lifestyle habits in the population is for clinicians to target one person with unhealthy habits at a time.

The major point of our commentary is that guideline panels should make clear whether the available evidence supports beneficial effects of a lifestyle intervention (that is, that the advice will help people change behavior and that the behavior change will result in improved health outcomes) or whether the available evidence supports the beneficial effects of the lifestyle habit only. Experts often do not make this distinction clear, as is the case in Lippman and coworkers' article (1) that Dr. Rosenfeld and colleagues cite.

In the absence of direct evidence, guideline panels could combine studies (ideally high-quality randomized trials) that investigate whether the clinician intervention helps people change behavior and other studies (usually observational) on whether the lifestyle change is associated with outcomes that matter to patients. Dr. Birrell and associates state that "robust evidence from randomized controlled trials shows that brief interventions—including but not limited to those related to smoking cessation, physical activity, nutrition, and weight loss—are effective and feasible." Their statement is followed by a citation of an observational study that showed an association between patients opting to follow advice about diet change and reduced need for pharmacologic diabetes treatment (2). This shows the feasibility of our proposal.

Our commentary contends against moving the goalposts for what counts as reliable evidence for the efficacy of individual lifestyle advice. To confidently recommend individual lifestyle advice for large populations despite the lack of reliable evidence suggests that panelists can afford to be wrong about effectiveness because they assume these interventions have low costs and harms. Our commentary warns against making this assumption.

We are not arguing against individual lifestyle advice. Instead, we wish to highlight that freeing clinicians from the overwhelming lists of must-do tasks with questionable value (for example, identifying every sedentary adult and providing advice to increase physical activity) will make room for clinicians and patients to work out when it is appropriate to discuss such lifestyle habits as smoking cessation and when it is not.

We also hypothesize that community-oriented, structural interventions may be the inexpensive and safe alternative to individual lifestyle advice by busy clinicians, not pharmaceutical interventions.

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