I recently had the opportunity to interview David Jones, MD, president emeritus of the board of directors for the Institute for Functional Medicine. Before meeting Dr Jones, I had expected to conduct a traditional interview with him. I had a list of questions that I thought could be presented in typical interview format. However, within 5 minutes of speaking with him, I realized that my questions paled in comparison with Dr Jones’s far more interesting story. So, I set aside my questions and listened for the next hour as he described his career in medicine.

In integrative medicine, storytelling is important. Practitioners must listen to their patients to find the best recommendations to meet their needs. Yet we must also listen to the stories of our doctors. The following is a narrative I have composed: It tells the story of Dr Jones as I recall from our conversation.

Most clinicians go into health care because they want to care for the patient. This ideal seems to get lost because, Dr Jones believes, it is difficult to care for the patient without being trained to understand that caring for the patient means getting to know the patient. Early in his career, Dr Jones realized that the practice of medicine was beyond the pharmaceutical, durable goods or surgical answers that he was taught in medical school:

I was 2 years into my family practice, sitting at my desk and looking at my patient list and thinking half the people that came today would be better off if they hadn’t come, because I was starting to see the side effects of chronically administered pharmaceuticals. Then I looked at the list for the next day and I really didn’t know who to call and say, “Don’t come, because I haven’t helped you.” I said, “I just don’t know enough.”

This revelation started Dr Jones’s journey of searching for an alternative model that would better serve the needs of his patients. He had observed the ineffectiveness of the conventional approach, which was plagued by chronic, complex problems. He believed there must be a better option.

So, Dr Jones’s search began. His first conference—either by coincidence or providence—was at the Northwest Academy of Preventive Medicine. The chief speaker was Jeff Bland, PhD, and his presentation made a lot of sense to Dr Jones. After the conference, Dr Jones invited Dr Bland to southern Oregon, where Dr Jones had formed a group of professionals. The group began studying Robert W. McGilvery’s textbook, *Biochemistry: A Functional Approach* (1983), with Dr Bland’s assistance.

Dr Bland had begun to focus on the importance of biochemistry as one of the fundamental principles of modern scientific medicine, and these meetings served many important purposes. Among other outcomes, they engendered long friendships, which included not only Dr Bland but a group of very thoughtful professionals in the healing arts. Mentors such as Leo Galland, MD, and Sidney Baker, MD, were key contributors. Many other intelligent and thoughtful clinicians, researchers, and lab scientists were involved, and their work eventually added important components to the model that we now call functional medicine.

Dr Jones’s quest for a better model continued as he integrated information on genetics, biochemistry, and molecular sciences into his clinical practice. According to Dr Jones, the practice of functional medicine inevitably comes back to the patient’s story. He believes that every patient is unique, and if the practitioner sits down with the patient, science can be used to figure out where the patient fits in the picture. To become successful, the practitioner needs to become effective at practical reasoning. This skill is not the same as a scientist’s skills. A scientist aggregates individuals and concludes with generalities. The integrative practitioner, on the other hand, individualizes those generalities to find what specifically fits the patient.

Finally, in 1999, Dr Jones joined Jeff and Susan Bland at the Institute for Functional Medicine (IFM) in the role of president. The 3 began to develop a model at IFM that could accommodate the uniqueness of not only each person but also his or her environment. This became, and still is, one of the foundational principles of functional medicine. Dr Jones was instrumental in developing the
architecture of functional medicine that is taught today. He surrounded IFM with expert faculty who have inspired physicians worldwide to learn and apply the functional medicine model. Under his leadership, IFM began stitching together a more modern, systems medicine–type of clinical architecture. The model is able to accommodate diverse principles such as traditional Chinese medicine, ayurveda, and others.

A cornerstone for these new models is the notion that everything is connected. Dr Jones was beginning to see the harm in clinical practice, caused by the failure to consider this web-like network of effects. For example, some practitioners may not consider that drugs with potentially positive effects on one system can be harmful to other systems. Some of the early cardiovascular drugs had a positive effect on the contractile components of the heart muscle, yet those same drugs could destroy the patient’s liver or cause cognitive dysfunction and neurological side effects. Dr Jones came to the conclusion that the personalization of care achievable through the functional medicine approach is the only viable solution to the crisis of chronic disease facing us today.

Functional medicine continues to evolve. It is a model that takes the whole patient into consideration—what his or her preferences are, what the individual’s risk landscape is, what the totality of that particular patient’s life is about, which genetics are in play, and so forth. Functional medicine is becoming a medical model that is understandable and practical but has different and better outcomes for the whole person that the conventional acute-care model lacks. Conventional care includes a chronic care team, but the team is not like the one at Dr Jones’s family practice. Conventional, chronic care teams essentially ensure that patients take their drugs. A functional medicine chronic care team is one in which everybody—nutritionists, bodywork people, and others in the community—is on the same page. Such coordination provides patients with tools and instructions for achieving their aspirations. Dr Jones remarked,

“We often think that doctors should be physician scientists. This is probably the worst thing you could do because a scientist by nature is looking for the generality that comes from aggregating individuals. We turn that upside down and we’re looking for the individual among the aggregate.”

Although IFM was established to conduct research, its mission has shifted under the guidance of Dr Jones to focus on training physicians and clinicians on what they need to practice comprehensive care for complex medical problems. Clinicians still need the science, so research is and will always be important; however, Dr Jones believes that knowing how to apply the research is equally important. Such a philosophy shifted Dr Jones’s direction to provide the kind of training that is needed to actually grow—a shift in which patients could be evaluated from a more comprehensive platform. These programs need the same rigor and discipline that students received in medical school.

Another important topic that Dr Jones stressed was the need for functional medicine practitioners to understand their patients. When visiting with a patient, the practitioner must consider 2 primary questions: (1) “Is this person experiencing the early and unsuspected antecedents or triggers for a downstream, more serious illness?” and (2) “Is something happening in this patient’s life that, if I fail to understand it, will result in finding the patient at the bottom of the waterfall, already in a seriously broken state?” Dr Jones continued: “I don’t want to wonder later on whether we could have changed the outcome if we had focused our attention more upstream.” The development of functional medicine—and the brilliance of the people who have been involved in its development—contributes to Dr Jones’s daily understanding about how practitioners stratify that risk, what antecedents are at play in that risk, and what mediators are continuing to take that patient in the wrong direction. Fortunately, with these tools, there is always the potential to understand which steps can be taken to change the direction, or the angle, of those vectors so that the patient enjoys a healthier life.

Our conversation then turned to nutrition. We discussed several types of diets, including vegetarian, Mediterranean, Paleo, and others. To my surprise, diet type was not a major concern for Dr Jones. He believes that “the most important factor is finding a diet that fits the patient.” In preparing for the 2014 IFM conference, he talked with many experts concerning diet. What was his conclusion?

“What I heard from everybody—the international people—is that the big studies show that whether you’re on a Paleo diet or whether you’re on a vegetarian diet or whether you’re on a Mediterranean diet, there’s about 20% of people that really do well and can continue that diet, and about 80% for which the diet doesn’t really fit.”

He questions if the genetics of each person determines what type of diet works for them and acknowledges that we do not yet have the answers. Despite these uncertainties, Dr Jones emphasizes the importance of eliminating sugar and highly processed foods from the diet.

“We need the same rigor and discipline that students received in medical school.”

One of the fundamental issues facing practitioners, according to Dr Jones, is how they treat their patients—something that should be a part of doctor training. Dr Jones believes that there are 2 models for training a doctor. One model approaches the role of doctor as a “tradition of healing, with the added bonus of understanding how to appropriately apply science.” The second model views the doctor as a physician scientist who cures patients with drugs. In his opinion, it might be nice to sit and chat with patients, but if the practitioner does not go about the conversation correctly, he or she will have no idea what to discuss.
do with the information. Dr Jones believes that a training program is needed that allows practitioners to work with a patient from the point of view that their participation is needed for healing. You need to address the issues that keep patients from achieving the aspirations that they want, not what practitioners want for them. “If you train that way, it doesn’t take me any longer to do it than when I did it the old way. The thing is there’s no burn out.”

Medical school trains doctors to become scientists. The physician scientists deal only with disease elements of an illness. Dr Jones has worked to transform doctors into clinician healers. The job of the 21st-century clinician is discovery of the person: finding the sources of illness and suffering within the person and, with that knowledge, developing methods for their relief while revealing the power within the person.

We also discussed patients who choose not to be involved in their health care. Dr Jones refers to them as “do-me patients.” These patients come to the office, sit down in the exam-room chair, and say, “Just do me.” Practitioners who give in to these patient demands simply encourage patients to continue having this attitude. A practitioner who takes time to discuss the complexity of the underlying issues, on the other hand, provides the patient with far more effective care. Dr Jones uses this approach for his own patients. Some of his patients despair and believe their issues are too complex to understand, relying only on him. But Dr Jones does all he can to make things understandable for patients while engaging them as necessary to play out their essential role in a healing partnership. These things are not taught in formal medical education. Practitioners need to be taught the paradigm of being with a patient in such a way that each is perceived as a person, not as a disease.

At this point in the conversation, Dr Jones told me about how IFM has affected the field of medicine. He believes that IFM has created a pedagogy, or a methodology, for practitioners that says, “If we get in the trenches together here, we’re going to find answers that have long term efficacy way beyond any drug I can give you.” He explained that the heart of a doctor is to nurture and care and, if the doctor is placed in the right context, that is what they will do. But in the wrong context, one that prioritizes the quantity of patients seen over the quality of care provided, doctors will develop the negative mindset of simply putting in time. IFM, on the other hand, has the philosophy of nurturing and caring for patients. Dr Jones explained that many doctors have lost touch with this critical mission. Patients must be encouraged to achieve their aspirations, and IFM is all about inspiring people, “re-enchanting” medicine, and providing patients with tools so they can achieve what they aspire to be.

Another important component of the nutrition initiative established by IFM is patient education. The institute has developed several tools to meet its objective of providing quality education. Dr Jones and colleagues reviewed a tool developed for physicians to explain how to use the physical exam for nutrition. The tool includes handouts about vital nutrients in a patient’s diet, which explain how to use nutrition to improve physical health. A practitioner can imagine the power of such a tool, which helps analyze which diet is the most appropriate for a patient based on their medical workup. The patient then leaves the office with something that they can believe will improve their health. IFM will provide tools that help practitioners reach individual needs using a chronic care team. Dr Jones and colleagues use the tools with a baby-steps approach to teach patients to regain control of their life when patients do not believe this for themselves.

According to Dr Jones, “We think we’re physicians’ scientists—and we must know and understand appropriate applications of clinical science, but we must also be talking about healing the loss of hope.”

We wrapped up our conversation with a brief discussion of what was next for Dr Jones after IFM. I quickly learned it was not retirement. He will be working on demonstration projects in which the elements we discussed in our conversation will be implemented in a real-life clinical programs. These programs will include a core assessment based on functional medicine and a team approach based on habit change, inspiring lifelong commitment and the regeneration of patients’ hope. This business model is designed to work in any environment with many different insurance policies.

Dr Jones concluded by saying,

Patients really need to be reinspired to take control of their lives. They are searching for something their body is telling them that they need and they are getting a drug instead. Then they need another drug and then another drug to ameliorate the side effects of the first 2. There is human desire to be in charge of your life, but when you are so confused by your illness that you feel lost, it is like being in the labyrinth of the Minotaur. There is hope for exiting their labyrinth. If there weren’t, I would retire instead.

References