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Review Article

Clinical Well-Being Literacy and the Eight-Domain Lifestyle Prescription: An Integrative Narrative Review for Preventive, Person-Centered and Lifestyle Medicine

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Abstract

Background: Contemporary clinical practice is increasingly confronted by a combined burden of noncommunicable diseases, mental health disorders, sedentary lifestyles, sleep disruption, occupational burnout, loneliness, financial stress and digital overexposure. These conditions are not independent phenomena. They interact through biological, psychological, social, occupational, economic and technological pathways that shape prevention, treatment adherence, recovery, quality of life and mortality risk.

Objective: This article proposes Clinical Well-Being Literacy as a translational framework for preventive, lifestyle and person-centered medicine. It also introduces an Eight-Domain Lifestyle Prescription that organizes clinically relevant determinants of well-being into body, thought, emotions, meaning, social life, professional life, financial stability and technological use.

Methods: A narrative and integrative review was conducted across literature on noncommunicable diseases, mental health, lifestyle medicine, social determinants of health, health literacy, shared decision-making, occupational health, digital health, compassionate care and positive psychology. The purpose was not to estimate pooled effect sizes, but to synthesize a clinically usable model for assessment, communication, intervention planning and future research.

Results: The synthesis supports a core proposition: well-being should be treated as a modifiable clinical ecosystem rather than a vague aspirational state. The eight domains can be translated into brief screening questions, lifestyle prescriptions, referral pathways and measurable outcomes. The model is compatible with motivational interviewing, shared decision-making, interdisciplinary care and equity-sensitive prevention.

Conclusion: Clinical Well-Being Literacy may help bridge the gap between medical evidence and daily life. By integrating movement, sleep, nutrition, cognition, emotional regulation, meaning, social connection, healthy work, financial awareness and digital hygiene, medical practice can strengthen prevention without reducing health to individual willpower. The proposed framework requires empirical validation, but offers a practical pathway toward more human, preventive and life-centered care.

Keywords: Preventive medicine; lifestyle medicine; well-being; health literacy; person-centered care; mental health; social determinants of health; digital health; occupational health; compassionate care

Highlights

- Clinical Well-Being Literacy is proposed as a practical language for integrating daily life determinants into medical care.
- The Eight-Domain Lifestyle Prescription translates well-being into body, thought, emotions, meaning, social life, professional life, financial stability and technological use.
- The framework supports prevention, adherence, patient activation and person-centered clinical communication.
- The model explicitly avoids lifestyle blame by incorporating equity, social determinants and structural constraints.
- Future research should validate scales, implementation pathways and clinical outcomes across primary care, chronic disease and occupational health.

Abbreviations

AI, artificial intelligence; CBT, cognitive behavioral therapy; CVD, cardiovascular disease; HbA1c, glycated hemoglobin; NCDs, noncommunicable diseases; WHO, World Health Organization.

Introduction

Modern medicine has achieved extraordinary progress in diagnosis, pharmacology, surgery, imaging, genetics, emergency care and digital monitoring. Yet many of the most prevalent threats to health are generated, maintained or aggravated by ordinary daily conditions: inactivity, poor sleep, chronic stress, loneliness, unhealthy diet, fragmented attention, financial strain, work overload and loss of meaning. The World Health Organization reports that noncommunicable diseases killed at least 43 million people in 2021, representing three quarters of non-pandemic-related deaths globally, while recent WHO data also indicate that more than one billion

people live with mental health disorders [1,2,76,77]. These figures show that the future of medicine cannot be limited to technical intervention after disease has appeared. It must also strengthen prevention before illness becomes irreversible.

The need for integration is reinforced by the social determinants of health. The conditions in which people are born, grow, live, work and age, as well as their access to power, money and resources, strongly influence avoidable health gaps [3]. Lifestyle recommendations therefore cannot be reduced to personal responsibility alone. A patient may know that exercise, sleep and healthy nutrition matter, but still be constrained by poverty, unsafe neighborhoods, shift work, caregiving burdens, loneliness, low health literacy or unstable employment. Preventive medicine must be scientifically rigorous and socially realistic.

This article proposes Clinical Well-Being Literacy as a framework to organize this complexity. The concept refers to the ability of patients, professionals and health systems to understand, communicate, assess and improve the daily determinants of well-being that influence health outcomes. It is a bridge between medical evidence and lived experience. It is not a substitute for clinical diagnosis, pharmacological treatment or specialist care. It is a complementary method for translating evidence into habits, habits into behaviors and behaviors into sustainable health pathways.

The article also introduces the Eight-Domain Lifestyle Prescription. The model organizes well-being into eight clinically relevant domains: body, thought, emotions, meaning, social life, professional life, financial stability and technological use. These domains are not independent silos. They operate as an interacting ecosystem. Poor sleep may worsen emotional regulation; financial stress may reduce adherence; digital overexposure may disrupt sleep and attention; loneliness may increase depression and cardiovascular risk; work strain may produce chronic stress; loss of meaning may reduce motivation for self-care [4-16].

The central thesis is that medicine becomes more effective when it treats disease while also understanding the life that surrounds disease. A prescription is more likely to be followed when the patient understands it, believes it is meaningful, can realistically perform it, receives support and sees it as part of a dignified life rather than as a punishment for being ill.

Methodological Approach

This manuscript is an integrative narrative review and translational conceptual framework. It does not claim to be a systematic review, meta-analysis or clinical trial. Its purpose is to synthesize evidence from adjacent fields and translate it into a clinically usable model for prevention, patient communication and lifestyle prescription.

The conceptual synthesis was structured around five questions: (1) which daily determinants of well-being are most relevant for prevention and clinical outcomes; (2) how can these determinants be organized without fragmenting the person; (3) how can clinicians discuss lifestyle and meaning without abandoning scientific rigor; (4) how can recommendations be personalized without blaming patients; and (5) what future research designs could validate an eight-domain model?

The reviewed bodies of literature included WHO reports and guidelines on noncommunicable diseases, mental health, physical activity, social determinants of health, digital health and artificial intelligence in health; seminal work in the biopsychosocial and salutogenic traditions; research on health literacy, shared decision-making, motivational interviewing and behavior change; evidence on physical activity, nutrition and sleep; literature on stress, emotion regulation and compassion in healthcare; studies on social connection, loneliness and social prescribing; occupational health research on burnout and job strain; and literature on digital health literacy and screen-related well-being [1-6,9-13,17-31].

The narrative method is appropriate for the objective of this article because the proposed framework integrates heterogeneous domains that cannot be meaningfully reduced to a single pooled effect estimate. The outcome is not a definitive clinical guideline, but a model that can generate hypotheses, assessment tools, pilot programs and controlled trials.

Why Clinical Practice Needs Well-Being Literacy

Three clinical gaps justify the need for Clinical Well-Being Literacy. The first is the translation gap. Patients often receive correct but vague recommendations: exercise more, eat better, sleep more, reduce stress or use screens less. These instructions may be scientifically valid, but they do not automatically become behavior. Behavior change requires motivation, self-efficacy, emotional relevance, environmental design, feedback, support and repetition [26-29].

The second gap is fragmentation. Medical systems commonly separate physical disease, mental health, occupational stress, social isolation, financial insecurity and digital behavior into different professional territories. Patients, however, experience them as one life. A person with type 2 diabetes may also experience depression, insomnia, debt, shift work, loneliness and compulsive night-time screen use. The clinical plan must recognize this interaction rather than pretending that each variable can be treated in isolation.

The third gap is humanization. Person-centered care requires respect for values, preferences, needs and context. Shared decision-making and patient-centered communication are associated with better understanding, trust and alignment between treatment and patient priorities [34-37]. Clinical Well-Being Literacy strengthens this approach by offering a structured vocabulary for discussing life determinants in a medically responsible way.

The model is also aligned with the biopsychosocial approach, which challenged the reduction of illness to biological mechanisms alone [32], and with salutogenesis, which asks how health is generated and maintained under conditions of stress [33]. In this sense, well-being literacy is not decorative. It is a clinical capacity to identify sources of risk and sources of recovery.

Definition and Core Principles

Clinical Well-Being Literacy is defined as the ability to understand, communicate, assess and improve the daily determinants of well-being that influence prevention, disease progression, adherence, recovery, quality of life and human flourishing.

This definition contains four operative dimensions. Understanding refers to recognizing that health is shaped by biological, psychological, social, behavioral, occupational, financial and technological factors. Communication refers to using clear, respectful and motivating language. Assessment refers to identifying risk and protective factors across daily life. Improvement refers to converting information into feasible, measurable and meaningful actions.

The framework rests on six principles:

- Clinical rigor: well-being recommendations should be compatible with evidence-based medicine and professional scope of practice.
- Person-centeredness: the patient is not a disease carrier but a person with values, fears, resources, history and context.
- Behavioral realism: the best prescription is not the ideal one, but the one the patient can actually begin, repeat and sustain.
- Interdependence: body, mind, relationships, work, money and technology interact continuously.

- Equity sensitivity: lifestyle medicine must never become a language of blame against people living under structural constraints.
- Measurability: well-being can be translated into clinical indicators, patient-reported outcomes and follow-up goals.

The Eight-Domain Lifestyle Prescription

The Eight-Domain Lifestyle Prescription is a structured way to translate well-being into clinical practice. It does not require that every domain be addressed at every consultation. Rather, it provides a map that helps clinicians identify which domain is most relevant, most urgent and most actionable for a given patient.

Table 1. Eight-domain lifestyle prescription: clinical meaning, screening questions, interventions and potential indicators.

Domain	Clinical relevance	Brief screening question	Possible prescription	Potential indicator
Body	Movement, nutrition, sleep, rest, metabolic and cardiovascular prevention.	How are you moving, eating and sleeping in an ordinary week?	Progressive activity plan, sleep routine, nutrition referral, rest recovery.	Steps, sleep quality, BMI, blood pressure, HbA1c.
Thought	Beliefs, health literacy, self-efficacy, cognitive flexibility and adherence.	What do you believe is helping or blocking your recovery?	Teach-back, cognitive reframing, written plan, decision aid.	Health literacy, self-efficacy, adherence.
Emotions	Stress, anxiety, depression, emotional regulation and shame.	Which emotion is most present in this illness experience?	Breathing practice, stress plan, psychological referral, compassion-based communication.	Perceived stress, GAD-7, PHQ-9, emotional regulation.
Meaning	Purpose, values, dignity, spirituality and motivation for change.	What makes this health change worth doing for you?	Values-based goal, meaning-centered conversation, spiritual care when desired.	Purpose in life, quality of life, goal adherence.
Social life	Loneliness, belonging, family support, community and care networks.	Who supports you when your health is difficult?	Social prescribing, peer group, caregiver involvement, community referral.	Loneliness scale, support network, attendance.
Professional life	Work strain, burnout, identity, occupational risk and recovery time.	Is your work helping or harming your health right now?	Boundary plan, occupational health referral, workload recovery, ergonomic change.	Burnout, absenteeism, sleep, work functioning.
Financial stability	Cost-related non-adherence, stress, access and food or housing insecurity.	Are costs or money worries making this plan difficult?	Medication-cost review, social work referral, simplified plan, access support.	Cost-related adherence, financial distress.
Technology	Digital health literacy, screen exposure, sleep disruption, attention and misinformation.	How does your use of technology affect your sleep, mood or care?	Digital hygiene, reliable sources, app support, screen-free sleep window.	Screen time, sleep latency, app engagement, misinformation risk.

Body: Movement, Nutrition, Sleep and Somatic Awareness

The body domain is the most visible entry point for preventive medicine. Physical activity reduces risk for cardiovascular disease, diabetes, some cancers, depression, cognitive decline and premature mortality [4,9-11]. WHO guidelines recommend 150 to 300 minutes of moderate-intensity aerobic physical activity per week, or equivalent vigorous activity, alongside muscle-strengthening activity adapted to age and condition [4,9]. Yet a clinical prescription must go beyond the abstract instruction to move more. The patient needs an achievable first step, such as walking ten minutes after meals, standing every hour, joining a supervised rehabilitation program or performing strength exercises twice weekly.

Nutrition is another major determinant. Dietary patterns such as the Mediterranean diet have been associated with cardiovascular and metabolic benefits [12,13]. However, nutrition advice must be culturally, financially and practically feasible. A patient with limited income, limited cooking time or food insecurity needs a different prescription than a patient with abundant resources. The goal is not nutritional perfection, but a sustainable pattern that improves metabolic health, energy and dignity.

Sleep is a third bodily pillar. Sleep health influences cognition, mood, metabolism, immunity, pain sensitivity and cardiovascular risk [14-16]. Many patients present fatigue, irritability or poor adherence without recognizing that sleep disruption is central to their condition. A body-centered prescription may include consistent sleep timing, light exposure, reduced evening alcohol, reduced late caffeine, treatment of sleep apnea or a screen-free period before bed.

Somatic awareness should also be included. Patients need to learn how the body communicates through pain, fatigue, breath, hunger, satiety and tension. The body is not merely a machine to optimize. It is a source of clinical information and a pathway toward self-regulation.

Thought: Cognitive Patterns, Beliefs and Health Literacy

Thought patterns influence health behavior. Beliefs about illness, aging, medication, risk, identity and change may facilitate or obstruct recovery. The common-sense model of illness representations, self-efficacy theory and cognitive-behavioral approaches all show that what patients believe about their condition affects coping, adherence and help-seeking [23-29].

Clinical Well-Being Literacy therefore includes cognitive clarity. A patient may not follow treatment because the plan is not understood, because the disease feels abstract, because medication is associated with weakness or because the future seems hopeless. Health literacy research has shown that the ability to access, understand and use health information is a public health goal and a clinical safety requirement [30,31].

The clinician can intervene through clear language, teach-back, written plans, visual aids, shared decision-making and respectful correction of misinformation [34-37]. Cognitive prescriptions may include reframing catastrophic thoughts, identifying one controllable action, clarifying the purpose of medication or inviting the patient to track symptoms and triggers. The objective is not to force optimism. It is to build mental flexibility and practical understanding.

Emotions: Regulation, Compassion and Psychological Safety

Emotions are clinical information. Chronic stress is associated with neuroendocrine, immune, cardiovascular and metabolic consequences [17-20]. Anxiety and depressive symptoms can reduce adherence, increase symptom burden and impair recovery. Shame can silence patients, especially in conditions related to weight, substance use, sexuality, mental illness or financial difficulty.

Emotion regulation refers to recognizing, naming and modulating emotional responses rather than suppressing them [21,22]. In clinical practice, this may involve brief stress assessment, breathing exercises, referral to psychotherapy, mindfulness-based strategies, crisis planning, treatment of depression or simply giving the patient permission to describe fear without being interrupted.

Compassion is central to this domain. Compassionate care has been associated with patient trust, satisfaction, adherence and professional meaning [55,56]. Compassion is not sentimental excess. It is an evidence-informed clinical behavior that reduces isolation and increases safety. In the language of well-being literacy, the patient should not only know what to do; the patient should feel accompanied enough to try.

Meaning: Purpose, Values and Existential Health

Meaning is a neglected but powerful determinant of health behavior. Purpose in life has been associated with psychological well-being, healthier behaviors and lower risk of mortality and cardiovascular events [57-60]. Serious illness often disrupts identity and meaning. A diagnosis may raise existential questions: Why me? What now? What remains possible? Who am I after this illness?

Medicine cannot impose meaning, and clinicians must never use spirituality or values in a coercive way. Nevertheless, person-centered care can respectfully ask what matters most to the patient. Meaning-centered approaches have shown value in oncology and palliative care, and spiritual care literature has emphasized the importance of whole-person care when patients desire it [60-62].

A lifestyle prescription becomes more powerful when attached to meaning. Walking is not only exercise if it allows a grandfather to play with his grandchildren. Sleep is not only recovery if it restores patience with family. Taking medication is not only adherence if it protects the possibility of continuing a beloved vocation. Meaning transforms instruction into commitment.

Social Life: Connection, Loneliness and Care Networks

Social connection is a determinant of health. Meta-analytic research has associated stronger social relationships with reduced mortality risk, while loneliness and social isolation are increasingly recognized as public health concerns [38,39,74,79]. Social support also influences coping, adherence and emotional recovery [40].

Clinical practice can screen briefly for isolation: Who lives with you? Who would help if your condition worsened? Do you feel lonely? Do you have someone who understands your diagnosis? These questions are not peripheral. They may determine whether the patient can follow the plan.

Social prescribing seeks to connect patients with community resources, peer groups, cultural activities, exercise groups or voluntary organizations [41,42]. The evidence base remains heterogeneous, but the underlying clinical logic is strong: some health problems require not only medication, but belonging.

Professional Life: Work, Burnout and Occupational Health

Work can be a source of identity, income, purpose and social connection. It can also become a source of chronic stress, sleep disruption, musculoskeletal pain, depression, anxiety and cardiovascular risk. Burnout, job strain, effort-reward imbalance and provider well-being have been widely studied in occupational health and clinical systems [43-46,72-73].

Professional life belongs inside preventive medicine because many symptoms are work-mediated. Headaches, hypertension, fatigue, insomnia, gastrointestinal symptoms and anxiety may worsen under toxic workloads or low control. For clinicians themselves, burnout is also a threat to quality of care, empathy and patient safety [43,78].

A professional-life prescription may include recovery time, microbreaks, ergonomic review, occupational health referral, workload negotiation, boundary setting, protected sleep after night shifts or leadership-level intervention. The clinician cannot redesign every workplace, but can recognize when work is part of the diagnosis environment.

Financial Stability: Economic Stress and Access to Care

Financial stability is a health determinant because money influences access, nutrition, housing, transport, medication, stress and dignity. The social determinants literature makes clear that income and wealth are not external to health; they shape exposure, vulnerability and access to resources [3,47,80].

Financial toxicity has been extensively discussed in oncology, but cost-related distress and non-adherence appear across many areas of care [48]. Patients may skip medication, avoid appointments, delay tests, buy cheaper food or live in constant stress because of costs. A lifestyle plan that ignores financial reality may become clinically unrealistic.

Clinicians can ask respectful questions: Are costs making it difficult to follow this treatment? Have you skipped medication because of price? Are transport, food or housing problems affecting your health? Such questions do not require clinicians to become financial advisers. They require awareness that affordability is part of adherence.

Technology: Digital Health, Screen Exposure and Human Presence

Technology is now inseparable from health. Digital tools can support telemedicine, remote monitoring, patient education, adherence, triage and self-management [5,49,50]. At the same time, excessive screen exposure, misinformation, sleep disruption, sedentary behavior, social comparison and fragmented attention may harm well-being [51-54].

Digital health literacy is therefore a clinical competence. Patients must be able to identify reliable sources, understand digital health information, protect privacy and use tools without becoming overwhelmed. Clinicians also need digital wisdom: technology should support care, not replace listening, judgment or presence [5,6,54].

A technology prescription may include a validated app, remote blood pressure monitoring, a reliable information source, a digital medication reminder or, conversely, a deliberate reduction in evening screen exposure. The key clinical question is not whether technology is good or bad. The question is whether it helps this person live, heal and adhere.

Clinical Implementation: From Conversation to Prescription

The eight domains become clinically useful only when translated into a simple workflow. The proposed sequence is screen, prioritize, personalize, prescribe, connect, support and review. It is designed for use in primary care, chronic disease management, preventive consultations, occupational health and interdisciplinary programs.

Screening does not require a long questionnaire in every visit. A clinician may select two or three domains based on the patient's presentation. A patient with fatigue may require sleep, emotion, work and financial screening. A patient with poor glycemic control may require body, thought, financial and social screening. A patient with anxiety and insomnia may require emotion, technology, professional life and meaning screening.

Prioritization is essential. Trying to change eight domains at once is unrealistic. The clinician and patient should identify the domain with the highest clinical relevance and the greatest readiness for action. Personalization then adapts the prescription to age, diagnosis, culture, resources, risk level and patient values.

Prescription converts advice into a specific action. Instead of telling a patient to reduce stress, the plan might be: practice five minutes of breathing before sleep for fourteen days and record sleep quality. Instead of telling a patient to be more active, the plan might be: walk ten minutes after lunch five days this week. Instead of telling a patient to improve digital habits, the plan might be: keep the mobile phone outside the bedroom for two weeks.

Connection links the action to meaning. Support identifies resources: family, nurse coaching, social worker, psychologist, physiotherapist, dietitian, community group, occupational health professional or digital tool. Review closes the loop by examining progress, barriers, symptoms and next steps.

Table 2. Seven-step clinical sequence for an eight-domain lifestyle prescription.

Step	Clinical question	Output	Example
1. Screen	Which domains are clinically relevant?	Brief domain map.	Sleep, stress and work identified in fatigue visit.
2. Prioritize	What matters most now?	One main target.	Sleep selected as first intervention.
3. Personalize	What is realistic for this patient?	Adapted plan.	No costly gym; use walking and home routine.
4. Prescribe	What exact behavior will be tried?	Specific action.	Screen-free last 30 minutes before bed.
5. Connect	Why does this action matter?	Value link.	More morning energy for family and work.
6. Support	What help is needed?	Referral or resource.	Nurse follow-up and sleep diary.
7. Review	What happened and what changed?	Iterative adjustment.	Assess sleep, fatigue and adherence in 3 weeks.

Integration with Existing Clinical Models

Clinical Well-Being Literacy does not compete with existing models. It integrates them. Motivational interviewing helps clinicians explore ambivalence and strengthen intrinsic motivation [27]. The behavior change wheel offers a systematic method for understanding capability, opportunity and motivation [28]. The transtheoretical model emphasizes stages of change [29]. Shared decision-making supports alignment between evidence and patient preferences [34,35].

The proposed framework also aligns with contemporary definitions of positive health, lifestyle medicine competencies, cardiovascular health promotion, health promotion theory and self-determination theory, which emphasize daily habits, motivation, prevention and patient agency [63-72]. Its distinctive contribution is the explicit inclusion of meaning, professional life, financial stability and technological use as structured clinical domains rather than optional contextual notes.

The model may also complement public health interventions. At population level, policies should address safe environments, food systems, housing, education, work conditions, access to care and digital governance. At clinical level, professionals need a language for helping individual patients navigate these realities without pretending that all determinants are individually controllable.

Equity and the Risk of Lifestyle Blame

A major ethical danger in lifestyle medicine is blame. Patients may be told to move more, eat better, sleep longer or reduce stress while living under circumstances that make these behaviors difficult. Clinical Well-Being Literacy must therefore distinguish between personal agency and structural constraint. This is consistent with health equity frameworks, provider well-being approaches and the recognition that social isolation, community conditions and institutional environments affect health [72-75]. The patient may have responsibility, but never in isolation from context.

An equity-sensitive prescription asks: What is modifiable now? What barriers are outside the patient's control? What support can the health system provide? What social or occupational determinants must be addressed? Such questions prevent prevention from becoming moral judgment.

This point is especially important for obesity, diabetes, depression, chronic pain, addiction and poverty-related illness. Shame worsens silence, avoidance and disengagement. Dignity improves trust. Therefore, the clinical tone of well-being literacy must be compassionate, respectful and realistic.

Potential Clinical Applications

In primary care, the framework can support annual preventive visits, chronic disease reviews and early identification of lifestyle barriers. A short eight-domain checklist could be completed before consultation and used to guide a focused discussion.

In cardiovascular prevention, the model can connect blood pressure, lipids, activity, diet, sleep, stress and social support. In diabetes care, it can identify how work schedules, food access, mood, money and technology influence glycemic control. In mental health care, it can complement psychotherapy and pharmacotherapy by addressing body, social connection, work strain and digital overload.

In oncology and chronic illness, meaning, financial toxicity, social support and fatigue management may be especially relevant. In occupational med-

icine, professional life, burnout, sleep and emotional safety may become central domains. In geriatrics, loneliness, mobility, digital exclusion, medication understanding and purpose may be prioritized.

In medical education, Clinical Well-Being Literacy can train future clinicians to ask better questions. The objective is not to make every physician a specialist in every domain, but to make every clinician capable of recognizing when a domain matters and when referral is needed.

Measurement and Research Agenda

The proposed framework requires empirical validation. Future research should begin with the development of a Clinical Well-Being Literacy Scale and an Eight-Domain Lifestyle Prescription Checklist. Psychometric work should examine reliability, construct validity, predictive validity, responsiveness to change and cultural adaptation.

Feasibility studies could test whether the model can be implemented in primary care within limited consultation time. Pilot trials could compare usual care with eight-domain assessment plus personalized lifestyle prescription. Outcomes may include patient activation, adherence, perceived stress, depression and anxiety symptoms, sleep quality, physical activity, quality of life, blood pressure, HbA1c, lipid profile, healthcare utilization and work functioning.

Implementation research should examine who delivers the intervention. Physicians may initiate the conversation, but nurses, psychologists, dietitians, physiotherapists, social workers, occupational health professionals and digital health coaches may be essential for follow-up. Team-based care is likely more realistic than physician-only delivery.

Digital tools could support the model by allowing patients to complete domain screening before appointments, track habits, receive reminders and share data with care teams. However, digital implementation must follow ethical principles related to privacy, accessibility, bias, explainability and human oversight [5,6].

Table 3. Suggested outcomes for future validation studies.

Outcome level	Examples	Possible instruments or indicators
Biomedical	Blood pressure, HbA1c, lipid profile, BMI, sleep duration.	Clinical records, laboratory values, wearables.
Behavioral	Activity, nutrition adherence, medication adherence, screen habits.	Self-report, app logs, pharmacy refill data.
Psychological	Stress, depression, anxiety, purpose, self-efficacy.	PSS, PHQ-9, GAD-7, purpose scales, self-efficacy scales.
Social	Loneliness, support, community participation.	Loneliness scales, social network measures.
Occupational	Burnout, absenteeism, work functioning.	MBI, work ability index, absenteeism records.
Economic	Cost-related non-adherence, financial distress.	Financial toxicity or economic strain measures.
Experience	Patient activation, satisfaction, shared decision-making.	PAM, patient experience surveys, decision quality tools.

Limitations

This article has several limitations. First, it is a narrative review and conceptual synthesis, not a systematic review. The literature was selected to build a translational framework rather than to answer a narrowly defined effect-size question. Second, the eight-domain model has not yet been validated as a measurement instrument or intervention protocol. Third, the domains overlap. Financial stress can affect sleep, emotions, nutrition and adherence; technology can affect thought, sleep, work and relationships. This overlap reflects real life, but complicates measurement.

Fourth, implementation may be difficult in time-limited consultations. The model should therefore be used flexibly, supported by questionnaires, team-based care and referral pathways. Fifth, cultural adaptation is essential. Meaning, family, work, money, emotional expression and technology are not experienced identically across societies. Finally, the model should be tested in diverse populations to avoid creating a framework that works only for privileged patients with abundant resources.

Declarations

Ethical approval

Not applicable. This article does not involve human participants, patient data or animal research.

Informed consent

Not applicable.

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Data availability

Data sharing is not applicable because no datasets were generated or analyzed.

Author contribution

The author conceptualized, drafted, revised and approved the final manuscript.

Conclusion

The future of medicine must be technically advanced and deeply human. Pharmacology, surgery, genetics, artificial intelligence and digital monitoring will continue to transform clinical practice. Yet many decisive determinants of health remain embedded in daily life: movement, sleep, nutrition, thought, emotion, meaning, relationships, work, money and technology.

Clinical Well-Being Literacy offers a structured language for bringing these determinants into preventive and person-centered medicine. The Eight-Domain Lifestyle Prescription translates well-being into domains that can be screened, discussed, prescribed, supported and measured. It does not replace diagnosis or evidence-based treatment. It strengthens them by connecting clinical science with the patient's real conditions of living.

The model's promise lies in integration. It invites medicine to move be

yond a narrow view of disease management and toward a life-centered vision of prevention. In that vision, the clinical act is not only to reduce symptoms, but to help people recover capacity, dignity, connection, meaning and sustainable health.

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