



Discussion

When food isn't medicine - A challenge for physicians and health systems

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ABSTRACT

Food can be powerful medicine. Good nutrition helps promote health and prevent and treat disease. Yet nutrition is not often part of a physician's training or clinical practice. Food might not be medicine when its importance is under-recognized and healthful eating is under-prescribed. Moreover, food cannot be medicine when it is not available to patients (or when available only in the form of unhealthful fare). This paper considers evolving thinking about when food isn't medicine by chronicling the experience of one physician—from college coursework to providing patient care and conducting research. The paper is framed around the experience of a representative patient struggling with diet-related chronic conditions, and describes some community-focused initiatives to help address issues related to food access in challenged communities. A principal focus is the overabundance of foods from 'plants' (the industrial processing kind) and the low availability of food from 'plants' (the living botanical kind). Physicians and health systems can support access to healthier food and healthier eating, and the idea of food as medicine, through a variety of approaches that extend beyond hospital and clinic walls. Examples of such physician and health-system approaches are provided.

“Where am I gonna find whole-wheat bread around here?”

1. Introduction

T.C. is a patient of mine. Like most of my patients, T.C. suffers from obesity. She has diabetes and hypertension and her lipid profile can only be described as high-risk. She wants to eat better, but can't. That is, she might choose to eat better if the choice was hers to make. But it isn't, or hasn't been—not really; not in any practical sense.

When I first meet T.C., during a 'well' visit at the Federally Qualified Health Center where I see patients in the Bronx, NY, I ask her about her diet. After hearing the unhealthful particulars, I inquire as to where she gets her food. She describes a circumstance where most options available to her are a far cry from health-promoting. Her neighborhood—the neighborhood where many of my other patients live and face the same constraints—is a virtual buffet of predominantly unhealthful fare.

So I treat with medication what might be better addressed with better food ... again (as I have done too many times in the past). And I reflect

I think about the steps along my journey to becoming T.C.'s doctor and my evolving perspective on food as medicine. And I think about how doctors like me, and the health systems for which we work, can better help T.C. and all the other patients like her.

2. Nutrition (and its absence) in medicine

I first came to appreciate the role of nutrition in health through an elective course in college. During the course, I learned that we really are what we eat in the most literal sense. Our food becomes our flesh and bone, our bodies and brains, our fluids, neurotransmitters, and all the rest.

Food is a significant human exposure. Those of us fortunate enough to have food tend to eat every day, on multiple occasions, and through myriad mechanisms and biological pathways, the foods we consume (or fail to consume) impact general health and wellness, the prevention (or promotion) of chronic illness, and the management of virtually all diseases (Katz et al., 2015).

Food can definitely be medicine. Too frequently though, the power of healthful eating is under-recognized or under-applied. Guidance related to food is not often part of a physician's armamentarium.

The problem begins with lack of training. When I was in medical school, nutrition was not part of the standard curriculum. Today, more than 15 years later, it mostly still isn't (Adams et al., 2015). Certainly there are some schools that offer more than a few hours of nutrition education (Adams et al., 2015), sometimes even through innovative hands-on *electives* as at the institution where I now teach (Albert Einstein College of Medicine, 2016). But the sparse-to-nonexistent nature of nutrition education for many, if not most, physicians in training is frankly astounding. After all, dietary intake ranks near the

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top of factors that affect human health, and patients—often confused by seeming controversies in both traditional and social media—want guidance.

“Brown bread is healthy, right?”

Doctors can provide basic guiding counsel, and need not operate as dietitians to do so.

3. A junior doctor makes do

When I started seeing my own patients, patients like T.C., I knew that counseling on healthful eating would be part of my own clinical practice. My undergraduate readings, and (by the time of residency) my subsequent MPH courses, an *optional* lecture series during med school, and some additional research I had done in prevention, all led me to a guiding principle for dietary advice:

Choose foods from plants (the living botanical kind) *not plants* (the industrial processing kind).

The idea was not that everyone should be vegan, or that only strictly whole foods would do. But the idea was that consuming minimally processed, predominantly plant-based diets—composed chiefly of foods as close to what occurs in nature as possible—benefits the health of patients, communities, and the planet. Conversely, choosing foods from factories (i.e., ultra-processed, highly refined, mostly artificial concoctions) or from factory farms (inhumanely and unsustainably produced animal products) can be a detriment to all.

The concept of ‘plants not plants’ has been a staple of my clinical counseling since residency. Patients seem to get it. T.C. certainly does. But despite her understanding, and her motivation to eat better, T.C. has had structural barriers to more-healthful eating. A big barrier, perhaps the biggest, relates to food access and the types of foods available in her community.

4. Window into a world

During residency, I had many patients like T.C. To understand their situation better, I explored the neighborhood around my residency clinic where many of my patients lived. I was struck by the ubiquity of fast foods and highly refined, pre-packaged, convenience items (foods from plants, the industrial processing kind). Equally striking was a near absence of items like whole grains and fresh produce (foods from plants, the living botanical kind).

A photograph I snapped during one store visit—a sad wooden bin containing blemished potatoes and discolored onions—is one I still use in presentations to this day: “This is a produce aisle, of a ‘supermarket,’ in an urban, low-income, minority neighborhood.” Other photos show shelf after shelf of candy, chips, cookies, cakes, rainbow-colored cereals, and sugary drinks.

The photos look not very different from stores in the neighborhood where I practice now—the community T.C. calls home. The choices patients like T.C. can make are, of course, constrained by the choices they have.

To better appreciate such choices, during fellowship I began conducting research examining food sources in neighborhoods. I continue that work to this day and what I have found can be boiled down to this: there is a lot of junk out there, disproportionately foisted on those who need it the least and often overwhelming healthful options (when there are any).

“I only see white bread in the stores near me.”

5. Unhealthful provision and promotion

Lower-income minority neighborhoods, like T.C.’s, have more fast food and more take-away outlets than wealthy white communities, and

their ‘supermarkets’ often look more like junk-food distributors than grocery stores (Lucan et al., 2016). Disadvantaged neighborhoods also present a range of less-intuitive storefront food sources with which residents need to contend (e.g., dollar stores, laundromats, auto shops, beauty salons, etc.) (Farley et al., 2010, author and colleagues, under review). There is simply more food available in more places, and more of it is just plain unhealthful (think candy at the register, vending machines offering sodas, chips in the checkout aisle, etc.) (Lucan et al., 2016; Wright et al., 2015; Basch et al., 2016).

Street vendors may only add to the problem in many neighborhoods. Less-healthful street vending (e.g., offering processed meats, sugary treats, and salty snacks) locates disproportionately in areas home to those with lower educational attainment, lower incomes, and non-white skin (Lucan et al., 2014).

And farmers’ markets may not help the situation. For instance, urban farmers’ markets often ‘tailor’ items to neighborhoods and offer and promote many items that are less-than-ideal for good nutrition and health (e.g., pies, pastries, donuts, juice drinks, and jams), particularly in communities of color (Lucan et al., 2015).

Promotion of unhealthful items is also a problem within and outside other food sources (Ohri-Vachaspati et al., 2014) and more broadly in patient communities (Lesser et al., 2013). Advertisements for high calorie, low-nutrient foods appear more often in African American and Latino neighborhoods (Yancey et al., 2009), with subway-station ads in particular targeted to neighborhoods with higher poverty, lower high-school graduation rates, higher percentages of Hispanics (Lucan et al., 2017).

Food can’t be medicine when it is unhealthful. And healthful food can’t be medicine when it’s unavailable.

6. How you like them apples?

They say “an apple a day keeps the doctor away.” There may be truth in this adage. Certainly getting more healthful foods like fresh produce into under-served communities like T.C.’s would be of benefit.

At the clinic where I now see patients we have tried a fruit-and-vegetable-Rx program, an approach that has been used elsewhere across the country and that is gaining traction (Buyuktuncer et al., 2014; Wholesome Wave, 2017). The idea is that doctors write prescriptions for produce like they would for pills. These prescriptions serve not only as written advice for patients to consume more fruits and vegetables, but also as coupons to help subsidize produce purchases. We developed our program in collaboration with local stores, with the intention of increasing both produce supply and demand in the neighborhood.

Other approaches that have been tried across the country to improve healthful-food access include siting produce-focused farmers’ markets at medical centers (George et al., 2013; Freedman et al., 2013; George et al., 2011) and offering vouchers or coupons for patients (Young et al., 2013; Baronberg et al., 2013; An, 2013). We have done both at the clinic for which I now work, with some patients becoming routine customers.

As an additional way to help food become medicine, my department is experimenting with ‘group visits’. Through separate patient groups, organized around health conditions like obesity, hypertension, and diabetes, patients explore a variety of topics tailored to group needs—e.g., how to better navigate local food environments, how to eat better given existing food choices, and how to collectively or individually advocate for improved retail options. In addition to getting healthier through these groups, patients report feeling empowered to make changes—in their lives and in their communities.

“I went to [local store], asked to speak to the manager, and asked him to carry whole-wheat bread.” T.C. says.

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