September 12, 2012, Vol 308, No. 10 >

< Previous Article Next Article >

Viewpoint | September 12, 2012

Changing Eating Habits for the Medical Profession

Lenard I. Lesser, MD, MSHS; Deborah A. Cohen, MD, MPH; Robert H. Brook, MD, ScD

[+] Author Affiliations

JAMA. 2012;308(10):983-984. doi:10.1001/2012.jama.10427

Health professionals spend a great deal of time at meetings. Grand rounds, noon seminars, research meetings, and medical conferences are part of the life of a health professional. At many of these activities, food is available. Although some members of the health professional community have called for changes to the food environment in the community in which they live, they have paid less attention to the quality of food served at hospitals, physician offices, and at conferences.

LARGE NUMBERS

In 2010, there were more than 40 000 accredited continuing medical education events in the United States.[1] In addition, there are currently more than 9000 residency programs; many have at least one “free lunch” conference per week and provide their residents with free meal cards when they are on call. Add to this the weekly medical student “free pizza” club meetings at many of the 125 medical schools and the lunches provided to more than 46 000 applicants to residencies and fellowships each year. Then, there are the meals at research meetings, funded at least in part by 21 000 grants from the National Institutes of Health and health foundations.

Most people in the United States eat too much food. Health professionals are not immune to the obesity epidemic; the Physicians' Health Study found that in 2004, 44% of physicians were overweight or obese.[2] In a study of military physicians, 3 years of residency training resulted in a weight gain of 4 lb.[3] Overweight physicians may have an effect on patient care, because overweight physicians are less likely to counsel patients about obesity.[4]

The Institute of Medicine recently recommended that health care professionals should act “as role models for their patients and provid[e] leadership for obesity prevention efforts in their communities by advocating for institutional, community, and state-level strategies that can improve physical activity and nutrition resources for their patients and their communities.”[5] Yet there has been little change in the food provided to health professionals, which is paid for by health care dollars.

Research has shown that there are too many calories in the food served at children's hospitals and academic medical centers.[6] Food served at medical meetings does not seem to adhere to any nutritional guidelines.[7] Just as patients are advised to increase their consumption of fruits, vegetables, and whole grains, it is time to incorporate this advice into meals served in health care settings, so health care professionals can practice what they preach.

CORRELATES TO THE TOBACCO MOVEMENT

Many years ago, it was accepted behavior for physicians to smoke in the hospital. Once the dangers of smoking became clear, physicians realized that this practice should stop. As part of a Joint Commission on Accreditation of Healthcare Organizations standard, smoking was no longer allowed inside hospitals. The policy led to an increased smoking cessation rate among hospital employees. Then, hospitals started to only allow smoking in designated areas. Soon many hospital campuses banned smoking entirely. The movement then gained traction outside of medicine, with public institutions forbidding smoking. Now, many states and cities ban smoking in all public places. Similarly, the medical profession could ignite a movement to improve the food environment in local communities.

IMPROVING EATING HABITS

The movement to remove smoking from health institutions started with incremental changes (ie, no smoking in patient rooms) and then progressed to more overarching changes (ie, no smoking on the entire campus). The same policy progression could be used for healthy food. Medical organizations could take several initial steps. At a minimum, meeting organizers could require calorie labeling, with an indication as to whether the food item has more or less than the recommended calories. Sugar-sweetened beverages could be replaced with noncaloric drinks. Desserts and snacks could be made available in 100-calorie or smaller "tasting" portions.

A group of medical organizations could then certify healthy meeting meals. A simple start would be to ensure that each meal was less than 700 calories, including a drink and dessert. More detailed specifications could ensure that each meal served resembled those like the one on *ChooseMyPlate.gov*, with half the plate made up of fruits and vegetables.[8]

Subsequently, each medical school, hospital, funding agency, and foundation could require that their money could only purchase meals and snacks that meet this certification. Precedent exists for this type of policy, although not necessarily for the purpose of health. For instance, the University of California prohibits the use of any funds for the purchase of alcohol. However, purchasing of sugar-sweetened beverages is allowed, indicating that current food procurement policies are not necessarily based on health guidelines.

A healthy food policy might improve the health of the medical profession. It might also improve medical education and productivity, because a high glycemic index, unhealthy meal results in sleepiness during the educational event, or after the meeting, during patient care. The healthy food policy could even be expanded to require 10 minutes of activity during every hour of meetings, creating a greater health benefit.

If entities started adopting these policies, the benefits would not be restricted to medical settings. The medical profession started setting the standard for smoke-free campuses; the same could be true for healthy food. Many caterers and restaurants would realize that to provide food to the large numbers of medical professionals, they must be able to provide these "certified healthy" meals. Soon, other businesses (law, accounting, and consulting firms) interested in health and that cater foods for their events and meetings could start requesting these types of meals. Since restaurants will already have recipes for these meals, they could start offering them inexpensively to the general public.

For example, a typical lunch served at a noon medical conference consists of a turkey sandwich, a bag of chips, a cookie, and a 12-oz sugary beverage. This meal of 1280 calories is double what most adults require and contains virtually no vegetables. Suppose the hospital or the funder of a conference required that only "certified healthy" meals could be served at lunch meetings. The caterer would be required to offer these or risk losing their business from the institution. The caterer could determine which of their meals meet this designation and gain certification. A new meal may consist of a vegetable and hummus sandwich on whole wheat bread, a small piece of dark chocolate, and unsweetened iced tea, equaling approximately 700 calories and containing a few servings of vegetables. The caterers/restaurants that offered these items would have an increase in business. Since the restaurant was already serving these meals to the medical institution, other businesses nearby the hospital could start requesting them. The restaurant could list these on its menu and serve them to the public as "certified healthy" meals, and could even indicate that "These are the lunches your doctor eats."

The medical profession was influential in reducing smoking in the United States; it has the capacity to encourage food-system change within its own institutions. This would likely reduce caloric consumption of health professionals, promote the health of physicians, and could also cause a ripple effect in local food economies.

AUTHOR INFORMATION

Corresponding Author: Lenard I. Lesser, MD, MSHS, Health Policy, Palo Alto Medical Foundation Research Institute, 795 El Camion Real Ames Bldg, Palo Alto, CA 94306 (LesserL@pamfri.org).

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Lesser reported providing free consultation on improving the food offerings at several California hospitals and receiving travel expenses for serving on an expert advisory committee from the Centers for Disease Control and Prevention. Dr Brook reported receiving a grant from the Robert Wood Johnson Foundation to fund the Clinical Scholars program in which Dr Lesser was enrolled when this work was performed. The foundation had no role in the preparation of the manuscript. Dr Cohen reported no disclosures.

REFERENCES

1 Accreditation Council for Continuing Medical Education. *ACCME Annual Report Data 2010*. Chicago, IL: Accreditation Council for Continuing Medical Education; 2011

2 Ajani UA, Lotufo PA, Gaziano JM, et al. Body mass index and mortality among US male physicians. *Ann Epidemiol*. 2004;14 (10):731-739
PubMed

3 Arora R, Lettieri C, Claybaugh JR. The effects of residency on physical fitness among military physicians. *Mil Med*. 2004;169 (7):522-525
PubMed

4 Wells KB, Lewis CE, Leake B, Ware JE Jr. Do physicians preach what they practice? a study of physicians' health habits and counseling practices. *JAMA*. 1984;252(20):2846-2848
PubMed

5 Institute of Medicine. *Accelerating Progress in Obesity Prevention*. Washington, DC: National Academies Press; 2012:478

6 Lesser LI, Hunnes DE, Reyes P, et al. Assessment of food offerings and marketing strategies in the food-service venues at California children's hospitals. *Acad Pediatr*. 2012;12(1):62-67
PubMed

7 La Puma J, Schiedermayer D, Becker J. Meals at medical specialty society annual meetings: a preliminary assessment. *Dis Manag*. 2003;6(4):191-197
PubMed

8 US Department of Agriculture. ChooseMyPlate.gov. *http://www.choosemyplate.gov*. Accessed August 1, 2012

VIEWPOINT

Changing Eating Habits for the Medical Profession

Lenard I. Lesser, MD, MSHS
Deborah A. Cohen, MD, MPH
Robert H. Brook, MD, ScD

HEALTH PROFESSIONALS SPEND A GREAT DEAL OF TIME at meetings. Grand rounds, noon seminars, research meetings, and medical conferences are part of the life of a health professional. At many of these activities, food is available. Although some members of the health professional community have called for changes to the food environment in the community in which they live, they have paid less attention to the quality of food served at hospitals, physician offices, and at conferences.

Large Numbers

In 2010, there were more than 40 000 accredited continuing medical education events in the United States.[1] In addition, there are currently more than 9000 residency programs; many have at least one "free lunch" conference per week and provide their residents with free meal cards when they are on call. Add to this the weekly medical student "free pizza" club meetings at many of the 125 medical schools and the lunches provided to more than 46 000 applicants to residencies and fellowships each year. Then, there are the meals at research meetings, funded at least in part by 21 000 grants from the National Institutes of Health and health foundations.

Most people in the United States eat too much food. Health professionals are not immune to the obesity epidemic; the Physicians' Health Study found that in 2004, 44% of physicians were overweight or obese.[2] In a study of military physicians, 3 years of residency training resulted in a weight gain of 4 lb.[3] Overweight physicians may have an effect on patient care, because overweight physicians are less likely to counsel patients about obesity.[4]

The Institute of Medicine recently recommended that health care professionals should act "as role models for their patients and provid[e] leadership for obesity prevention efforts in their communities by advocating for institutional, community, and state-level strategies that can improve physical activity and nutrition resources for their patients and their communities."[5] Yet there has been little change in the food provided to health professionals, which is paid for by health care dollars.

Research has shown that there are too many calories in the food served at children's hospitals and academic medical centers.[6] Food served at medical meetings does not seem to adhere to any nutritional guidelines.[7] Just as patients are advised to increase their consumption of fruits, vegetables, and whole grains, it is time to incorporate this advice into meals served in health care settings, so health care professionals can practice what they preach.

Correlates to the Tobacco Movement

Many years ago, it was accepted behavior for physicians to smoke in the hospital. Once the dangers of smoking became clear, physicians realized that this practice should stop. As part of a Joint Commission on Accreditation of Healthcare Organizations standard, smoking was no longer allowed inside hospitals. The policy led to an increased smoking cessation rate among hospital employees. Then, hospitals started to only allow smoking in designated areas. Soon many hospital campuses banned smoking entirely. The movement then gained traction outside of medicine, with public institutions forbidding smoking. Now, many states and cities ban smoking in all public places. Similarly, the medical profession could ignite a movement to improve the food environment in local communities.

Improving Eating Habits

The movement to remove smoking from health institutions started with incremental changes (ie, no smoking in patient rooms) and then progressed to more overarching changes (ie, no smoking on the entire campus). The same policy progression could be used for healthy food. Medical organizations could take several initial steps. At a minimum, meeting organizers could require calorie labeling, with an indication as to whether the food item has more or less than the recommended calories. Sugar-sweetened beverages could be replaced with noncaloric drinks. Desserts and snacks could be made available in 100-calorie or smaller "tasting" portions.

Author Affiliations: Palo Alto Medical Foundation Research Institute, Palo Alto, California (Dr Lesser); RAND Corporation, Santa Monica, California (Drs Cohen and Brook); and David Geffen School of Medicine, University of California, Los Angeles (Dr Brook).
Corresponding Author: Lenard I. Lesser, MD, MSHS, Health Policy, Palo Alto Medical Foundation Research Institute, 795 El Camion Real Ames Bldg, Palo Alto, CA 94306 (LesserL@pamfri.org).

JAMA

CONTENT

Home
Current Issue
All Issues
Online First
Specialties & Topics
CME
Multimedia
Quizzes
RSS
Podcasts

SERVICES

For Authors
For Reviewers
For Readers
About
Editors & Publishers
Subscribe
Contact Us

The JAMA Network

SITES

JAMA
Archives of Dermatology
Archives of Facial Plastic Surgery
Archives of General Psychiatry
Archives of Internal Medicine
Archives of Neurology
Archives of Ophthalmology
Archives of Otolaryngology—Head & Neck Surgery
Archives of Pediatrics & Adolescent Medicine
Archives of Surgery
Archives of Neurology & Psychiatry (1919-1959)
JAMAevidence.com

AMA PUBLISHING GROUP JOURNALS

Virtual Mentor

INFORMATION FOR

Institutions/Librarians
Media
Advertisers
Subscription Agents
Employers & Job Seekers

SERVICES

Subscriptions & Renewals
Activate Subscription
Register for Free Features
Email Alerts
RSS
Reprints & Permissions
For Authors
Help

Content Resources

AMA Manual of Style
Peer Review Congress
ICMJE
WAME

Other Resources

Physician Jobs
Medical Meetings
Conditions of Use
Privacy Policy
Copyright
Advertising Policies