

« HEALTH FOOD CONSUMPTION AND STRATEGIES FOR PRACTITIONERS »

Editorial

Delivering effective nutritional messages without increasing workloads!

General practitioners are on the front line in managing chronic disorders related to lifestyle, such as diabetes, obesity and cardiovascular diseases. Patients and physicians are aware that nutrition plays a key role in care management. Analyzing a patient's eating habits, offering appropriate nutritional counseling and evaluating the resulting behavioral modifications take a lot of time. Physicians sometimes feel overwhelmed by the size of the task. Nevertheless, by using appropriate strategies, it is possible for a practitioner to improve a patient's eating habits and decrease his risk factors. This is precisely what the articles in this new IFAVA issue are all about.

Lauren Ball et al. analyzed data from nine intervention studies evaluating the efficacy of nutritional interventions delivered by general practitioners during their usual consultations. First conclusion: it's effective. Patients increased their consumption of fruits, vegetables, fish and fibers while reducing their overall caloric intake, as well as meat and fat consumption. In addition, the number of consultations was not a determining factor for nutritional intervention efficacy. Effective nutritional messages can be delivered without increasing workloads!

Sara Bleich et al focused on general practitioners' personal beliefs concerning obesity and their influence on techniques for managing it. The study surveyed 500 American physicians. Five probable causes of obesity give rise to five different nutritional recommendations. You will discover them in their article. And what are their conclusions? A practitioner's convictions concerning the nutritional origin of obesity may translate into practical recommendations to patients. In addition, training physicians on the subject of eating factors that contribute to obesity could help them to deliver brief, repetitive messages to their patients.

Finally, Sonia Kim et al. presented strategies that health professionals can use to increase fruit and vegetable intake among younger patients. They can directly orient the children's food choices by getting them involved in various activities (gardening, cooking, purchasing), by encouraging the creation of social and family environments favorable to healthy food choices and by offering useful advice to the community on how to increase fruits and vegetables availability.

These articles are all sources of encouragement to general practitioners who can, without increasing workloads, deliver brief, repetitive and effective nutritional messages to patients to help them to improve their state of health.

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Do physician beliefs about causes of obesity translate into actionable items on which physicians counsel their patients?

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Despite national guidelines for primary care physicians (PCPs) to counsel their patients to lose weight, evidence suggests that most patients do not receive recommended obesity care¹⁻². Potential physician-related reasons for this sub-optimal care include: insufficient time, negative attitudes towards obese patients; and general beliefs that obese patients cannot lose weight³⁻⁸.

The Health Belief Model puts forward the idea that an individual's views and attitudes towards health influence their choices and behaviors⁹. However, limited attention has focused on whether physician beliefs about obesity impact their care of heavier patients. For other health conditions, such as diabetes and hypertension, there is evidence that physician beliefs about the causes of a disease may be as important as physician knowledge in determining practices like prescribing behavior¹⁰⁻¹². Obesity care may improve if evidence-based clinical guidelines on obesity management could align physician beliefs with recommended practice behaviors.

Relationship between physician beliefs and counseling habits for obese patients

In this study, we evaluated whether PCP beliefs about the causes of obesity are associated with actionable topics on which physicians counsel their patients. We hypothesized that physician beliefs about the causes of obesity would be associated with the type and frequency of nutritional counseling; in particular, the belief that modifiable diet-related factors cause obesity would be positively associated with nutritional counseling while the belief that immutable biological factors that cause obesity would not.

To accomplish this, we analyzed a national cross-sectional internetbased survey of 500 U.S. PCPs collected between February and March 2011. A total of 2010 invitations were sent at random to members of the Epocrates Honors panel, an opt-in panel of 145,000 US physicians. They received a \$25 incentive to participate; 58 invitations were undeliverable. We had a response rate of 25.6%.

Using a list of five possible causes of obesity, we asked respondents how important they felt each item was, using a scale of very important, somewhat important, not very important, and not at all important. We then assessed nutritional counseling habits by asking how frequently they provided five different types of nutritional counseling to their obese patients, using a scale of very frequently, somewhat frequently, not very frequently, or not at all frequently.

Physician beliefs about the causes of obesity is associated with providing specific nutritional recommendations

PCPs that identified overconsumption of food as a very important cause of obesity had significantly greater odds of counseling patients to reduce portion sizes (OR 3.40; 95%Cl: 1.73–6.68) and to avoid high calorie ingredients when cooking (OR 2.16; 95%Cl: 1.07–4.33).

Physicians who believed that restaurant/fast food eating was a very important cause of obesity had significantly greater odds of counseling patients to avoid high calorie menu items outside the home (OR 1.93; 95%CI: 1.20–3.11).

Physicians who reported that sugar-sweetened beverages were a very important cause of obesity had significantly greater odds of counseling their obese patients to reduce consumption (OR 5.99; 95%CI: 3.53–10.17).

Physicians who believed that biological factors were the most important causes of obesity showed no association with nutritional counseling practices.

From these findings we reach two main conclusions:

1. PCP beliefs about the diet-related causes of obesity may translate into actionable nutritional counseling topics for physicians to use with their patients.

2. Targeted education about major diet-related contributors to obesity may be a feasible strategy that facilitates physicians' delivery of brief, frequent nutritional messages to patients.

Our study had limitations, including a cross-sectional design that does not allow us to make causal inferences and our reliance on physician self-reporting. However, this is the first study that has explored the relationship between physician beliefs and counseling practices for obese patients, and further research should be undertaken to explore this subject further.

BASED ON:

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Strategies for Healthcare Providers to Increase Fruit and Vegetable Consumption in Children

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Fruits and vegetables (FV) provide many important nutrients¹. Higher intake of FV is associated with a reduced risk for heart disease¹, stroke¹, diabetes², and some cancers¹. Replacing energy-dense foods with FV may assist in healthy weight management³. Eating habits developed early in life impact dietary behaviors in adolescence and adulthood^{4,5}. Because most children do not consume the recommended amounts of FV⁶, it is important to understand strategies to increase children's consumption of these foods.

Healthcare providers can be an important influence on children's consumption of FV. This article summarizes strategies that healthcare providers can use, which were detailed in a previously published paper⁷. Through counseling during clinic visits, providers may be able to directly influence children's food selections, encourage caregivers to create a home environment supportive of healthy choices, and recommend community resources that improve access to FV. Health care providers can also create a healthy food environment in the clinical setting where they work to serve as a role model for patients and the community.

Below, we summarize some specific activities health care providers can engage in at the patient level, healthcare facility level and community level to create healthier communities and empower patients and families.

Opportunities at the patient level, healthcare facility level and community level for healthcare providers to influence children's FV consumption

Patient level: assess, counsel, and provide resources

- Integrate assessment of, and counseling on, FV consumption into clinical practice. The American Academy of Pediatrics provides a guide for billing⁸.
- Give a FV prescription on a prescription pad to document and emphasize the importance of consuming recommended FV servings each day⁹.
- Develop referral guides to resources, e.g., Special Supplemental Nutrition Program for Women, Infants and Children [WIC], WIC Farmers Market Nutrition Program [FMNP], and the Supplemental Nutrition Assistance Program [SNAP], farmers markets, cooking classes, and community gardens.

Healthcare facility level: create a healthy environment

- Be a role model by providing healthy foods and beverages for patients, visitors, and employees.
- Host a farmers market or community-supported agriculture program.
- Create guidelines for increasing FV in vending, food service venues, hospital shops, and inpatient meals. Consult the Health and Sustainability Guidelines for Federal Concessions and Vending Operations for an example¹⁰.

Community level: support healthy food environments where children spend time

• Work with community stakeholders and partners, such as health departments, schools, child care and early care and education (ECE), and community organizations to improve FV access and consumption.

Patient visit: strategies healthcare providers can advise caregivers to use to encourage children's FV consumption

Individual level: get kids involved

- Garden, cook, and grocery shop with kids.
- Take kids to a local farm or community garden so they can see where their food comes from.

Social environment: have positive feeding interactions with children

- Expose children to a variety of FV.
- Avoid controlling feeding practices like overly pressuring children to eat certain foods and overly restricting food.
- Eat together regularly as a family.
- Role model healthy behaviors.

Physical environment: make FV readily available

- Make FV accessible by having them washed, cut, and ready to eat on a counter, or at eye level in the refrigerator.
- Incorporate vegetables into dishes such as breads, pasta, chili, soups, casseroles, and pizza.
- Pack FV for kids to take to school, ECE, the playground, pool, or camp.
- Provide FV when bringing snacks to school or sports events.

Health care providers can engage in many strategies in and outside the clinic setting at the individual, social, and physical environment levels to positively influence children's fruit and vegetable consumption.

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General practitioners can offer effective nutrition care to patients with lifestyle-related chronic disease

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Lifestyle-related chronic diseases, such as overweight and obesity, Type 2 diabetes and cardiovascular disease, account for over 60% of deaths worldwide. Nearly two-thirds of the risk factors for overweight and obesity, Type 2 diabetes and cardiovascular disease relate to poor nutrition behavior.

Importance of nutrition care provided by general practitioners

Nutrition care is a core principle of best practice guidelines for the management of chronic disease, and includes practices such as the assessment of a patient's nutrition intake, the provision of nutrition-related advice, and the evaluation of nutrition behaviour on patients' health outcomes. Patients perceive nutrition care to be an important part of the care provided by general practitioners (GPs) for lifestyle-related chronic disease management. Moreover, the demand on GPs to provide nutrition care is increasing.

Improvement in the nutrition behaviour and risk factors

We conducted a systematic review of published literature that investigated the effectiveness of nutrition care provided by General Practitioners (GPs) in improving the nutrition behaviour and subsequent risk factors in individuals with lifestyle-related chronic disease. Nutrition behaviour outcomes included overall dietary intake, energy consumption, and macronutrient intake. Risk factors included body weight, Body Mass Index (BMI), waist circumference, blood pressure, and serum lipid levels.

Of the 131 articles originally screened, nine relevant interventions studies (five American¹⁻⁵, three European⁶⁻⁸, one Australian⁹) were chosen according specific criteria:

- Adult populations (>18 years of age).
- The effectiveness of the intervention must have been investigated using a control group.
- The nutrition care must have :
 - been provided by a GP or international equivalent (not included: practice nurses, nutritionists, dietitians); and
 - occurred in standard GP consultation.

• The intervention must have included identical baseline and follow-up measurements of either nutrition-related behavior or biological indicators of health.

These nine interventions were published between 1989 and 2008 and consisted of 9,564 participants (number of participants included in each study ranged from 77 to 3,179). The interventions incorporated between one and six consultations with a GP, where the GP provided basic nutrition

care to the participant (nutrition-related training for the GPs prior to the intervention/national dietary guidelines as supporting material for the nutrition care).

We observed improvements in the nutrition behaviour of participants, such as:

• An increase in :

- fruit and vegetable intake by two serves per week⁶;
- fish intake to at least one serve per week⁶; and
- fibre intake of 0.55 g/1000 kcals⁴.

• A reduction of :

- energy consumption of 0.7 MJ/ day⁷;
- meat consumption to three serves or less per week⁶; and
- fat intake of 5-10%^{3,4,7}.

Concerning risk factors, we observed significant reductions in participants' body weight of 0.4-2.3 kg, or $0.2-0.81 \text{ kg/m}^{2}$ $^{1-3,6-7}$. Reductions in serum choles-terol levels of 0.46-0.83 mmol/L, and reductions in diastolic blood pressure of 4.0 mm Hq were also observed⁹.

Interestingly, the studies that observed improvements in participants' nutrition behaviour were not necessarily the same studies that observed improvements in participants' risk factors. It would appear that the number of consultations is not a determining factor for the effectiveness of nutrition care provided by GPs. This suggests that effective nutrition care can be provided in relatively few consultations, and may not have a significant influence on GPs' workload. The interventions suggest that GPs may be effective at providing nutrition care to individuals with lifestyle-related chronic disease.

WHAT GAP THIS FILLS

What we already know: The demand on general practitioners (GPs) to provide nutrition care to patients with lifestyle-related chronic disease is increasing. However, it is unclear whether GPs are effective at improving the nutrition behaviour and associated risk factors in these patients.

What this study adds: This systematic review demonstrates that GPs have the potential to provide nutrition care that improves the nutrition behaviour and risk factors in individuals with lifestyle-related chronic dis¬ease. However, the consistency and clinical significance of the intervention outcomes are unclear. Further support is needed for GPs to provide nutrition care to patients.

BASED ON:

Ball L, Johnson C, Desbrow B, Leveritt M. "General practitioners can offer effective nutrition care to patients with lifestyle-related chronic disease." J Prim Health Care. 2013 Mar 1;5(1):59-69.

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