



Making Time for Nutrition Counseling

Why are health care providers so reluctant to discuss nutrition with their patients? I believe one of the reasons is that we know from our own experience how integral food is to human life. The foods we eat and how they are prepared are part of both our cultural and personal identity. Sharing a meal is a profoundly human experience in which more than food is exchanged. Movie producers have made films that in part show how much shared meals mean to, and even change, individuals, families, and whole communities. I am thinking of *Babette's Feast*, *Eat Drink Man Woman*, *Soul Food*, *The Big Night*, and a personal favorite, *Tortilla Soup*. For most religions, food is a powerful symbol. The breaking of bread is essential to Christianity, and Hinduism, Islam, and Judaism require food restrictions of their followers. If we ask someone to give up eating a certain way and try new foods or food preparations, we may in a sense be asking them to reject part of their heritage.

I believe there are two other reasons for our reluctance to discuss nutrition with our patients. The first is that many health care providers still feel unprepared for such a discussion, although there are some rays of hope. Over the last 15 years, there has been a concerted effort by some medical education programs to integrate nutrition across the first 2 years of the curriculum, especially by incorporating nutrition in problem-based learning, and including nutritional counseling objectives in the clinical objectives of clinical clerkships.¹ The Nutritional Academic Award Program has developed model curriculum and Web resources so that schools do not have to “reinvent the wheel.”^{2,3} A 2006 survey of medical schools found that medical students had an average of 24 contact hours of nutrition science education, but there was a wide range (2–70 hours).⁴

I suspect that many midwives feel similarly underprepared. For students in midwifery programs who are already nurses, some basic nutrition and nutrition science formed part of their undergraduate preparation, but its extent and depth may have been limited. I could find no recent information regarding nutrition education in undergraduate nursing programs. The American Association of Colleges of Nursing (AACN) baccalaureate nursing program requirements merely mention nutrition as a potential topic that can assist nurses in meeting clinical prevention and health promotion objectives.⁵

There has been no published survey of the hours of nutrition content in midwifery education programs. I suspect that few programs, if any, require a separate nutrition course, and that the number of hours devoted to the

subject in clinical midwifery courses is quite limited. The most commonly used textbook in midwifery programs, *Varney's Midwifery*,⁶ in its chapter on primary care for women, does a good job covering basic nutrition and how to assess for eating disorders, but it does not provide advice or suggested tools on how to obtain a quick dietary assessment in a busy clinical practice, and has only limited information on the role maternal diet plays in maternal and neonatal health.

Behavior change is a neglected topic in most health care provider training. Although health behavior accounts for nearly 50% of mortality from all causes,⁷ most health care visits concentrate on immediate issues, such as infections. In part, the reality of the 15-minute visit inhibits even broaching potentially complex, time-consuming topics such as changing a person's habits. The natural reaction is to postpone the discussion of smoking cessation, drug use, obesity, exercise, or even intimate partner violence for the mythical “better time.” However, as with anything else, practice brings fluency, and fluency creates time for such conversations—that is, if clinicians make a concerted effort to start them. Articles in this issue about nutrition counseling for pregnant and obese women^{8,9} and for women with possible disordered eating¹⁰ mention practical assessment tools for providers. Hopefully, readers will familiarize themselves with these tools and begin incorporating them into their practices, and also take advantage of the *Share With Women* handouts designed to be read easily by most women.

The other reason I believe there is reluctance to get too involved in the subject of nutrition is that the state of the science is “messy.” To paraphrase what one anonymous reviewer for this issue wrote, “How do you separate truth from hype about nutrition claims?” Briefly, while there has been plenty of hype, it is also true that some real advances have been made. Recent biochemistry has improved our understanding of the importance of intracellular communication and the powerful effects of eicosanoids, which are produced locally by individual cells all over the body. These findings seem to indicate that what we eat—the actual type of food, its preparation, and its combination and quantity—exerts a more powerful biologic effect on the body than any drugs we ingest. For example, the Diabetes Prevention Trial showed that people at high risk for type 2 diabetes who lost as little as 15 pounds (5% of body weight) and walked briskly 150 minutes a week, had a 58% decreased risk of diabetes, compared to a 31% risk decrease in the metformin (drug) group.¹¹

However, nutrition research is often still quite “messy.” It is extremely difficult to conclusively document dietary intake over a sufficiently long period of time, let alone perform a randomized blind trial under similar conditions. A 2008 randomized trial of three different weight-loss diets was notable for its relative rigor. The researchers followed study participants for 2 full years—a long time for a nutritional trial—and knew with certainty that participants were eating the prescribed diet at least at lunch time (the main meal in the culture) because, by agreement, participants were provided only their prescribed meal at the company cafeteria.¹² However, even that study had to rely on participant self-report for the remainder of nutrition intake during each day. Given the money, time, trouble, and care needed for such relatively rigorous studies, it is no wonder that the bulk of nutrition research relies on less expensive, but unfortunately also less precise, methods of determining total dietary intake.

Therefore, researchers are more likely to conduct trials using a single nutrient in the form of a pill supplement. An added advantage is that placebo pills make it easy to blind researchers and participants. Even with well-done studies of this sort, the full biologic effect (if any) of a single nutrient is inherently difficult to isolate within the total diet. Nonetheless, this issue of the Journal does highlight two nutrients that have received a great deal of attention in women’s health: omega-3 fatty acids and vitamin D. There are two articles about the role of omega-3s in pregnancy and mental health by Jordan and Kendall-Tackett.^{13,14} In addition, the article on vitamin D pays particular attention to its role in infant development.¹⁵

Observational nutrition studies of large population cohorts can have their problems, but they can also be useful. For example, if we are interested in the role that nutrition in utero or during childhood may play in the development of adult chronic diseases, we must rely on such studies. If we select well-done studies and are careful with our conclusions, real progress in understanding can result. For example, and as I discuss in the article “Maternal Nutrition and Perinatal Outcomes” in this issue,¹⁶ the evidence in support of the Barker hypothesis—that is, that the in utero environment influences the development of adult chronic diseases—is now strong enough to move it some considerable distance from hypothesis to proven fact.

Some of the most reasoned evidenced-based nutrition advice comes from the results of the longstanding Nurses’ Health Study. In the first article in this issue, Skerrett and Willett¹⁷ summarize the latest knowledge about general good nutrition and healthy eating gleaned from this study. Willett’s Healthy Eating Pyramid incorporates this knowledge in an easy to understand and easy to teach tool for patients—something that cannot be said for the new US Department of Agriculture MyPyramid. The review article on maternal nutrition attempts to introduce the reader to some of the newer concepts of the effect of food on the body and then summarizes current research on how nutri-

tion and individual nutrients affect perinatal outcomes.¹⁶ Siega-Riz et al.¹⁸ give the background for the latest Institute of Medicine pregnancy weight gain guidelines.

Women need our assistance in improving and maintaining their nutritional health. This reality is especially emphasized in the article by Graves⁸ on obesity issues in general, and in the articles by Harris¹⁰ and Harris and Barger¹⁹ on caring for women after bariatric surgery and for women with disordered eating. Nutrition counseling during pregnancy can help keep pregnancy and birth “normal.” For these reasons, I hope that readers of this issue will come away feeling motivated and empowered to discuss nutrition and behavior change with their patients.

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There are now *Share With Women* patient handouts covering more than 50 topics, of which several are also available in Spanish. All of these handouts are copyright free so they can be shared with women. Visit www.midwife.org/share_with_women.cfm to view the complete series.