

The Diet-Heart Dyad and Preventive Cardiology: Why Don't We Preach What We Practice?

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Elsewhere in this issue of the *Journal*, Otradovec, Blake, and Parker¹ have sounded an alarm that should stir us all. They report that patient records of primary care physicians—including family physicians—revealed little counseling of either adults or children about cardiovascular risk factors. Even the well-known correlations between high intake of dietary salt and hypertension and between high intake of cholesterol and cardiovascular disease are not being discussed. Why not? Physicians are widely aware that coronary heart disease kills more than half a million Americans every year, more than all cancers combined, and that as in most Western countries, hypertension is a leading cause of death in the United States. In fact, the popularity of nouvelle cuisine at medical meetings and the disappearance of the once familiar blue clouds of cigarette smoke from those meetings indicate that physicians themselves have donned jogging suits and fled in droves from cardiovascular risk factors. Why, then, do these physicians not share their concerns with patients and give medical advice that would save lives?

With respect to nondietary risk factors such as smoking, stress, and lack of exercise, part of the answer may lie in insufficient awareness of the newest methods of behavior modification. A recent family physician-oriented monograph on patient education² discusses some of these methods in a very practical and useful way. With respect to the dietary component of cardiovascular disease prevention, the picture is somewhat more complex and warrants special attention. Even though a

panel of experts met at the National Institutes of Health (NIH) in December 1984 to forge recommendations on diet and heart disease—recommendations that were subsequently published in *JAMA*³—and even though additional recommendations were published on the other side of the Atlantic,⁴ the work reported by Otradovec et al indicates that few physicians are translating such precepts into dietary counseling of patients. The reasons for this are multiple and varied.

First of all, it seems likely that many physicians are unfamiliar with the specific dietary modifications needed to produce meaningful physiologic changes. For example, the NIH conference (referred to above) recommended that the American Heart Association "prudent diet" be followed by all adults. In this diet, total fat intake is to constitute no more than 30 percent of total calories, and no more than 10 percent of total calories are to come from saturated fats. Dietary cholesterol intake is to be limited to 250 to 300 mg/d/person.³ But how many physicians can convert these figures into dietary specifics for their patients? If physicians respond that such is the province of registered dietitians rather than of physicians, should they not have more dietitians in their clinics and offices? And if then the objection is raised that dietitians are not cost effective in such settings, one must go on to question whether medical schools and continuing medical education classes are teaching enough about nutrition.

Further, physicians need to be sure they have their dietary facts straight. For example, it is clear that there is a correlation between high blood cholesterol and dietary cholesterol and that high blood cholesterol increases the risk of heart disease in an individual patient or family. But does this mean moderate levels of dietary cholesterol are harmful to normal individuals with normal serum chole-

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terol levels? Some say "no."⁴ Nevertheless, even if physicians duck the controversial question of "prudent diets" for infants and children and hold in abeyance the still dubious wisdom of dietary counseling for nonobese individuals with low blood pressure and low cholesterol levels, it would seem that concerned physicians would want to endorse at least some of the NIH recommendations. (The precept that individuals with blood cholesterol readings in the top 25 percent of the population should be treated vigorously by dietary means, and those with readings in the top ten percent even with drugs, if necessary, comes to mind.) The point is that physicians need dietary information, and their research colleagues should help to provide it.

Meanwhile, judging from the report in this issue of the *Journal*, physicians in at least one university medical center are withholding potentially lifesaving information from mothers and children under their care. Yet giving such information would seem no less important than advising an individual with rheumatic valvular heart disease to use prophylactic antibiotics before dental surgery. At issue are two forms of cardiovascular preventive medicine, but the one is preached by virtually all physicians and the other by only a few. In seeking to identify all possible reasons for this discrepancy, one must examine physicians' incentives to give advice to their patients. Such incentives include their own medical education, peer pressure, medicolegal concerns, the fee-for-service reimbursement system, and the insurance plans that drive that system.

Here, to be sure, is a major reason for the withholding of dietary advice. Reading an electrocardiogram is reimbursable for a physician, but counseling a mother about fat intake may not be. Physicians are paid for treating disease, not preventing it. The situation is not hopeless, however. In the past, insurance companies have provided monetary incentives for certain behavioral changes that made sense to them. For example, they have granted lower automobile insurance premiums to young drivers who have had courses in driver education and to drivers with good records. Similarly, the Matthew Thornton Health Plan in Nashua, New Hampshire, is experimenting with cash rebates for enrollees who give up smoking, and New York State has made seat belt use mandatory. So, just as incentives for behavior change by patients and others have been implemented, similar incen-

tives are possible for physicians. This area is where professional organizations and journals can help (for example, by lobbying the insurance companies and by emphasizing physicians' obligations to their patients).

But what of the ultimate outcome of patient education efforts? Are such efforts rewarded by improved health status? As every physician knows, the answer is "sometimes."⁵ Dietary instruction of obese diabetic adults results in weight loss and lower blood sugar only about 30 percent of the time, largely because of compliance problems. Admonitions to decrease one's consumption of fats, stop smoking, exercise more, etc, often fall on deaf, if not actively hostile, ears; and physicians working within a fee-for-service system can ill afford to incur hostility. Still, instructing mothers about their children's diet might well have a more gratifying outcome. Research in this area would be very useful to clinicians. For example, careful studies might encourage physicians to consider preventive cardiology teaching in childhood. Only through such research and the dissemination of its results will the goal of optimal patient care be achieved.

It is frustrating that advising patients how to prevent cardiovascular disease is so widely recognized as important and yet so rarely practiced. Even though there are certain gray areas, the facts have sufficient luster to compel action. As Otradovec et al put it, "an educational program in risk factor recognition and modification is needed for primary care physicians." Surely in 1985 there can be no excuse for doing nothing. Most would agree that physicians can and should preach more preventive medicine, at least as much as they themselves practice. Expecting this of one another will help make it a reality, a reality not only long overdue, but indispensable if we are to fulfill the highest ideals of our profession.

References

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