



The Santa Barbara Institute for Medical Nutrition & Healthy Weight

Let Food Be Your Medicine Too

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Prepared Statement of John La Puma, M.D. to the Legislative Informational Hearing on Diabetes and Obesity at the California State Capitol in Sacramento, CA, on August 25, 2010: Final.

Thank you for inviting me to this important legislative hearing on diabetes and obesity. My name is John La Puma. I am board certified internist, and a medical staff member of Santa Barbara Cottage Hospital. I see diabetic and overweight patients for personalized weight loss programs with Chef Clinic there.

I am also a professionally trained chef. I graduated from the Cooking and Hospitality Institute of Chicago in Professional Cooking, and taught the first cooking and nutrition course for medical students in the U.S., at the State University of New York with Dr. Michael Roizen, now Chief Wellness Officer at the Cleveland Clinic. And I spent the first 10 years of my career studying medical ethics, and the past nearly 20 years preventing and treating diabetes and obesity, primarily with nutritional and lifestyle measures.

Those 20 years can be boiled down to this: diabetes and obesity control are about “how”, not about “what”.

How to reduce obesity and prevent diabetes is now part of public health, which should make it super easy for people to make better health choices and not have to think about them. Good examples are water chlorination and milk pasteurization.

So why are we fat? For many reasons, some of them simple. A recent study from the California Center for Public Health Advocacy and a policy research group at UCLA showed that 41 percent of pre-teen kids, 62 percent of teens and 24 percent of adults drink at least one soda or other sugar-sweetened beverage every day. Regardless of sociodemographics, adults who drink one or more sugar-sweetened beverages every day are 27 percent more likely to be overweight or obese. Those companies could help this epidemic a lot.

There are other, more complex reasons. Most processed foods are cheap and calorie intense. Food and food advertising are everywhere. Stress levels are high, and activity levels are not. Even obesogens- endocrine-disrupting chemicals which may change

human metabolism, such as BPA or bisphenol A--have been recently implicated as causes.

You already know a lot about what obesity does. It worsens or accelerates diabetes, heart disease, stroke, back pain, osteoarthritis, and liver cirrhosis. Obesity promotes inflammation throughout the body through several hormonal pathways, increasing risk for 17 common cancers, including postmenopausal breast cancer and advanced prostate cancer.

But what you may not know is what my patients need. They need explicit, clear messages to eat less, to save special foods for special occasions, and to move more. They need to learn to cook more at home. These messages have yet to be cleverly crafted, but with the right technology and connectedness, could easily outperform encouragement and voluntary corporate wellness programs, some of which are very good.

Most physicians feel at a loss when faced with a type II diabetic or an obese patient. For example, I had 4 hours of nutrition training in medical school, and just 2 hours in cooking school. Physicians are not paid to speak with patients about food and nutrition. Even if they were, most do not have practical, simple tools to offer, because physicians do not know of them.

Websites such as our own ChefClinic.com and ChefMD.com offer healthy recipes and information directly to the public to begin to fill this gap. But doctors are no different than other workers: they do more of what they are paid well to do. If incentives or insurance plans covered services needed to help prevent, assess, and care for adult and child obesity and lifestyle treatment of diabetes, physicians would take a more active role.

However, I suggest several additional roles for physicians do not require those same incentives.

First, doctors should be able to write “fruit, nut and vegetable prescriptions” to be filled at farmers’ markets, with coupons given by the state for their purchase. A public-private partnership is making a pilot program like this work in Massachusetts, where participants in a “vegetable prescription” program are being monitored to assess eating patterns, weight and body mass index.

We have year round farmers markets in California, and year round fruits, vegetables and nuts. Writing “recipes on prescription slips” is something we have practiced at Chef Clinic and ChefMD for many years, and clients love it. And let’s face it--price matters. What if a bag of apples was a nickel?

Second, we should agree to stop quibbling about which nutrient is responsible for the most obesity, whether fat, carbs, protein or alcohol. More academic debate won't help solve the problem.

Third, the medical profession should establish and enforce basic standards in lifestyle counseling and behavior modification, so patients have something standard to expect from their clinician.

And fourth, from the patient and home cook side, people have too few cooking skills. Offering updated home economics classes in schools would teach basic cooking skills to kids whose parents might not have them, who have no other access to a kitchen, and might reinforce the idea that food is fundamentally cultural.

I also suggest a different dietary focus for food purchases: away from isolated nutrients and towards whole foods. The strength of our diverse population, and our cultural heritages in California can help us fight these epidemics. Almost all native ethnic diets--Mediterranean, Asian, Mexican and Latin American, for example--are more healthful than the Standard American Diet. They have in common little or no focus on nutrients (fat, protein, carbs, iron), and a big focus on eating minimally processed whole foods.

Why should you focus your efforts on food instead of nutrients in preventing obesity? Because few people can keep track of how much fat, cholesterol, fiber, calories or salt they eat in a day. And because very few nutrients by themselves--the exceptions are omega-3s, trans fat, salt and vitamin D--have a large effect on chronic disease.

But actual whole foods do change obesity risk. Eating more fruits, vegetables and nuts is consistently associated with a lower risk of obesity. Eating fish reduces the risk of death by heart disease, the leading cause of death in diabetics and in the obese. On the other hand, processed meats, packaged and fast foods, and sugar-sweetened beverages increase disease risk, including diabetes and obesity.

Certainly there are elements of addiction in obesity. Whether sugar is addictive or just preference-changing is important. But we ingest, on average, 32# each of high fructose corn syrup annually, when 40 years ago we ate none. The fast food industry refers to its best customers--those eating 14 meals per week--as "heavy users", which borrows a term from the medical addiction literature, including tobacco addiction.

Californians don't have to be addicted. There may be better prescription medication for the treatment of obesity coming, and I hope it does. But in most obese patients, there is no fundamental physiologic error to correct, no disorder of metabolism. Gastric surgery,

however, is effective and useful for the severely obese, with the proper post-operative nutritional and lifestyle support and programs. It should be a special case.

For diabetes, we have very effective medication. Yet the best studies of diabetes prevention show that diet and exercise are more effective in preventing diabetes than the standard initial drug therapy given to most type II diabetics. Significant weight loss often puts diabetes in remission--so that medication is no longer required.

Change will not occur all at once: in 1960 the national smoking rate was 45% among adults. Today, 50 years later, it is about 22%. If we work at it, we can achieve the same success with diabetes and obesity. Thank you for your time.