

about Stage-matched nutrition guidance for patients at elevated risk for cardiovascular disease:
A randomized intervention study in family practice *on page 751*

The challenge of helping patients change

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The leading causes of death in developed countries are heart disease and cancer, often resulting from smoking, poor diet, and lack of exercise, and excessive alcohol use.¹ Importantly, changing unhealthy behaviors—at least smoking^{2,3} and excessive drinking⁴—improves health outcomes that patients care about.

Changing behavior is not easy. Moreover, smoking, drinking, and poor diet are not biomedical conditions under the clinician's control. Brief interventions in primary care help some patients change their use of tobacco⁵ and alcohol,^{6,7} but only a small minority change. Studies of diet and exercise have shown only modest impact on disease-oriented measures.⁸⁻¹⁰ The Activity Counseling Trial, for example, showed an increase of 5% in maximal oxygen uptake, but in women only. In that clinical trial, men and women in all treatment groups reported significantly increased physical activity, but they comprised only about 3%.¹⁰ Clinician-prompted change of eating or exercise patterns is not common, easy, substantial, or lasting.

The interventions used in those studies were intensive. The study by van der Veen and colleagues in this issue of JFP examined an approach that is more feasible in family practice. They referred patients to a dietitian only when the patient was ready to change; 60 of 71 patients in the intervention group met that criterion. After 1 to 3 10-min visits with the family physician and 3 visits to the dietitian totaling about 1 hour, change in self-reported fat consumption was modest and changes in body measurements small. The intervention group on average gained 0.2 kg over 12 months, and the control group lost 0.6 kg.

What should practicing clinicians do? Our ability to help patients with eating and activity issues is limited, but we can still respond in helpful ways. First, change takes time. Obesity and sedentary lifestyles, like tobacco and alcohol problems, are chronic issues. We should not be surprised if an hour with a dietitian effects only small changes.

Second, even those small changes can be meaningful. Some people given an intervention will change more than others. For them the outcomes may be considerably improved. Furthermore, small changes distributed over many people may benefit a population significantly.¹¹

Third, if we are to find answers to family medicine's important questions, then we need to be involved in generating those answers (and in identifying the specific research questions). Addressing questions identified in practice by studying interventions in practice is the core idea of practice-based research. The study by van der Veen et al is an example; more such work is needed.

Finally, poor dietary choices, inactivity, and obesity are environmental issues. Addressing them with individual patients is necessary, but not likely to be sufficient. As a national consensus panel concluded, "Exertion has been systematically engineered out of most occupations and lifestyles."¹²

Re-engineering our lives to increase activity and decrease calories and fat will require societal change. Cultures change, just as persons do: over time, often with great effort, and sometimes in surprising ways. Family physicians with insight and creativity are needed to help find those ways.

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