



# **KAFP** JOURNAL

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**FINDING  
COMMON  
GROUND:  
GARDENING AS A  
TOOL TO FIGHT  
OBESITY &  
MALNUTRITION  
IN ECUADOR &  
KENTUCKY**

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MEANING  
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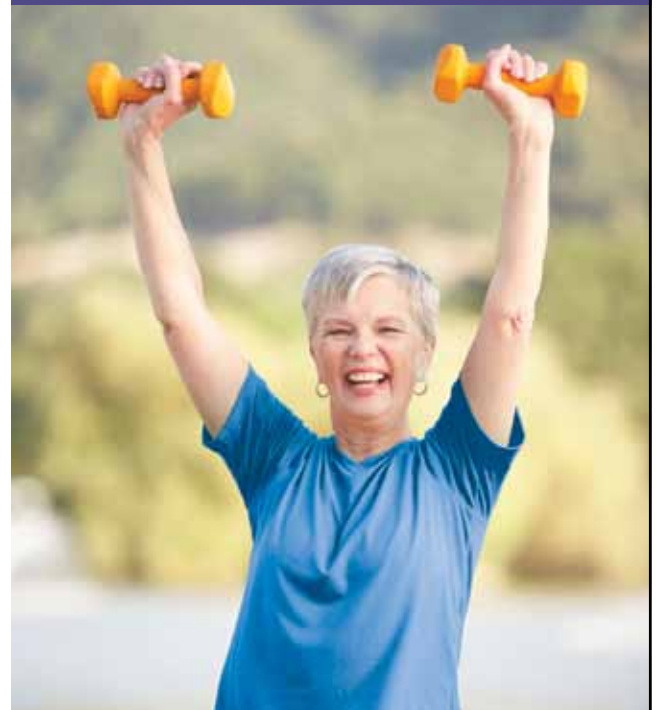
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# TABLE OF CONTENTS

4 ► KAFP Directory

6 ► Message from the President  
MARK A. BOYD, M.D., FFAFP

8 ► Letter to the Editor  
PHILLIP W. BALE, M.D.

11 ► Message from the Editor  
BILL CRUMP, M.D.

14 ► Henrietta Lacks and the  
Patient Centered Medical  
Home  
A. STEVENS WRIGHTSON, M.D.

16 ► Survey

18 ► Finding Common Ground:  
Gardening as a Tool to Fight  
Obesity & Malnutrition in  
Ecuador & Kentucky  
JILL RUSHTON-MILLER, MD

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# message from the PRESIDENT *PROMETHEUS AND ME*



YOU ARE A FAMILY PHYSICIAN: WHAT ONE THING ARE YOU GOING TO DO TODAY TO IMPROVE YOUR PATIENT CARE, YOUR PASSION FOR MEDICINE, YOUR LIFE? WHAT IS HOLDING YOU BACK? FOCUS ON THE INCH-PEBBLES, NOT THE MILE-STONES. YOU CAN CHANGE THE WORLD ONE DAY AT A TIME. CARPE DIEM!

**Prometheus**, the Titan from Greek mythology remembered for his perseverance, reminds me of many family physicians today. Prometheus was a champion of mankind, known for his wily intelligence for stealing fire from Zeus and giving it to mortals. Zeus then punished him for his crime by having him bound to a rock while a great eagle ate his liver every day, only to have it grow back to be eaten again the next day(1). Many family physicians feel like this going to ‘work’ every day. The external forces placed on physicians these days and the country’s economic woes make the outlook for the business of family medicine worrisome.

If I were a Greek god, oh the powers I would wield for family medicine in Kentucky: tort reform—done; SGR cuts—eliminated; Electronic medical records—more efficient, easier and more enjoyable to use. Everyone would have a family physician and a patient centered medical home. Insurance companies and Medicaid managed care organizations would appreciate family medicine and increase their payment to family physicians to cover all the care we provide for our patients. Deficit reduction initiatives in the state and nationally would be focused upon the cost effective care delivered by family physicians.

My wife reminds me I am no Greek god. Like many physicians, I often get flabbergasted by the slow pace of change, tired of bearing the weight of inequities from government and insurance company bureaucracy, and frustrated with the feeling

“TODAY, DESPITE ALL THE INTERNAL AND EXTERNAL NEGATIVE FORCES ACTING UPON THEM AND DESPITE THE UNCERTAINTIES OF OUR ECONOMIC TIMES, MANY FAMILY PHYSICIANS SERVE AS BEACONS OF HOPE FOR THEIR PATIENTS, THEIR COLLEAGUES, AND THEIR COMMUNITIES.”

some days of running on a treadmill at work. I believe a lot of this angst comes when we fail to recognize slow progress. We fail to recognize progress in our professional and personal lives. Johanna Rothman, a management consultant, re-focused

business progress on “inch-pebbles” instead of mile-stones(2). Inch-pebbles are the breakdown of each task or goal into very small components, no more than one or two days in duration. Inch-pebbles are either done or not done; they are not some percentage complete. Collections of inch-pebbles are the multiple-day or multiple-week tasks that we normally think of when we build project schedules.

I like the metaphor of inch-pebbles use in business, but I think it could have a greater benefit on our private lives. I may not have the knowledge today to teach a course to our staff on using our EMR, but I can learn and share one new thing that will simplify our charting and improve continuity of care. I may not have time today to develop an advocacy initiative on smoking cessation, but I can access the KAFP web site and send

a quick message to my congressman. I may not have the enthusiasm today to work on an education series for increasing medical students’ passion for family medicine, but I can offer to mentor a medical student and try to maintain my optimism and enthusiasm for medicine during our interactions. As a physician educator, I have learned that it is always easier to change my behavior, to change my attitude, than to change anyone else. I may not be able to run a mile today, but I may be able to move an inch.

During the Greek War of Independence, Prometheus became a figure of hope and inspiration for Greek revolutionaries. Today, despite all the internal and external negative forces acting upon them and despite the uncertainties of our economic times, many family physicians serve as

beacons of hope for their patients, their colleagues, and their communities. Family medicine does offer the best opportunity to improve the health care of Kentuckians. You are a family physician: what one thing are you going to do today to improve your patient care, your passion for medicine, your life? What is holding you back? Focus on the inch-pebbles, not the mile-stones. You can change the world one day at a time. Carpe diem!

*References*

1. *Prometheus, Dictionary of Greek and Roman Mythology.*<http://www.theoi.com/Titan/TitanPrometheus.html> Accessed 8/10/11.
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THEN MOTIVATING  
PATIENTS TO  
INCORPORATE  
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THEIR LIVES.

# ▶ LETTER TO THE EDITOR:

Marshall's Prunty's message from the President in the Spring 2011 edition of the KAFP Journal is a provocative reminder of the evidence-based conundrum facing every family physician, every day, with almost every patient encounter.

With 32 years of experience in private practice I take a somewhat different, and more optimistic, view of evidence – based, “best practice” medicine. Guidelines in no way are meant to replace or supplant the importance of hands-on medical care and when used appropriately should augment the process of care given to each patient.

Contrary to Dr. Prunty's implication that EB medicine diminishes the need or use for the art of medicine, I have found that the EB approach demands even greater reliance on the art of medicine. Indeed, personalized medicine requires not only keeping abreast of the latest evidence, but also demands the abilities to incorporate that evidence into practice routines, patient visits, and patient lives.

Skilled family physicians experienced in the art of medicine will be even more valuable in an evidenced-based, best practice system of care. Only when the science of medicine is coupled with the art of medicine will we approximate a truly patient-centered system of health care.

Sincerely,  
Phillip W. Bale, M.D.

## **DOES THE ART OF MEDICINE STILL MATTER?**

One might understandably suppose that the science of medicine has become so advanced and technically accurate that the more elusive art of medicine has become passé. MRIs, PET scans, 64 slice CT scans, virtual colonoscopy, ultrasonography, angiography, advanced lab test, etc. have taken most of the guesswork out of even difficult clinical presentations. Compared to previous generations of physicians, today's technocrats are capable of reducing patient encounters to brief discussions pertaining to the latest test reports, medication adjustments, and high tech interventions. Norman Rockwell's idyllic depictions of health care providers seem like a distant memory for most patients experiencing modern medicine's version of the fast food industry. Recent reports reveal that even psychiatrists don't talk at length to patients anymore with most of them being agents of modern pharmacology.

With the explosion of new knowledge in all corners of science, our understanding of disease processes and our ability to prevent and/or treat disease has become much more complex and sophisticated. Long gone are the days when a sympathetic ear was a doctor's most powerful weapon in a limited arsenal contained in his hallmark black bag. Physicians today have the daunting task of keeping up with the latest evidence, incorporating that evidence into their practice routines, relating that evidence into a patient visit, and then motivating patients to incorporate change into their lives. When you consider that most physicians have to see 4-6 patients an hour to have an economically viable practice, it is not difficult to understand why better, more personalized care is not happening in America. An article in the Journal of the American Medical Association in November of 2007 reported that 50% of patients leaving an office visit have no idea what was told to them and that two-thirds of people with chronic diseases in America have poor control over their diseases (1). It's difficult to be compliant if you did not hear or understand the information intended to improve one's health.

While difficult, if not impossible, to measure, the art of medicine is the point at which knowledge is extended by wisdom, where understanding is broadened by empathy, where desperation is softened by hope, and where rigidity is replaced by possibility. Science is magnificent in action;

*continued on page 10*



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art is noble in purpose. When practiced simultaneously, the results can be magical.

In order to improve outcomes and reduce the burden of disease, America needs to find ways to personalize each patient's care. Even the treatment of chronic diseases, which account for 75% of the spending for each health care dollar in America, is not a one size fits all proposition. Clinicians need to be trained to view each patient as the unique individual that they are and must fashion a treatment plan to meet their specific needs. More than ever in our long history of medicine which dates back to Hippocrates, our current system of care begs for every individual to have their own health care provider skilled in the art of medicine. Instead of relegating this ancient attribute to nostalgic memory, our medical schools and post-graduate training programs should recognize the central importance to healing and should more strongly consider an applicant's communication skills prior to admission to any school of the healing arts. Simply put, it is not enough to be a skilled technician or brilliant student of disease. Patient's deserve, just as our system screams for, the human touch and personalized care that embodies the art of medicine. The late paleontologist and evolutionary biologist Stephen Jay Gould once described religion and science as residing in separated domains or "non-overlapping magisteria". One could not explain the other but both have primacy in their own realms. Perhaps like religion, the more ethereal art of medicine should be viewed as separate but equal in importance to the science of medicine. However, unlike science and religion which do not overlap, there are critical interdigitations between the science and the art of medicine. One might even argue that the more science we have at our disposal the more we need the art to navigate the increasingly complex array of diagnostic and therapeutic options which now exist. At the very least, the modern men and women of medicine need to recognize, and in many cases resurrect, this vital tool of healing.

*References*

1. Bodenheimer T, *A 63 year old man with multiple cardiovascular risk factors and poor adherence to treatment.* JAMA. 2007;298(17):2048-2055.

A second generation family physician, Dr. Phillip W. Bale has been in private practice in Glasgow, Ky since 1979. He was the founding director

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FROM THE ONE  
WRITING THE  
PRESCRIPTIONS  
PROVIDES A HEALING  
FORCE THAT CANNOT  
BE MATCHED.

## WHAT IS THE MEANING OF GOOD DOCTORING? THERE IS HOPE

PROLOGUE: This editorial is written from a distinctly Christian perspective, borrowing widely from Catholic theologians. The tent housing family physicians is large and inclusive, and our Journal welcomes written pieces from all faith traditions and secular perspectives.

I tried several times over the last 4 weeks to sit down and write this editorial. The plan was for me to add another perspective on the family doctor's role in the Patient Centered Medical Home, as so nicely described in other pieces in this issue. I just had to wait until my brain was ready to write, and something entirely unexpected came out.

As I sat with my father during his final illness and death and I continue to stand vigil during my daughter's illness, I encountered many health care workers and physicians in the hospital, doctor's offices, and emergency department. Some knew of my role "behind the curtain" and some did not. Some of them were amazing examples of compassion and caring, and some were not. I wish I could say that compassion tracked with specialty training in our favor, but truthfully some of the best were subspecialists.

As I reflected on this, the concept of "the other," as used in the study of war in history occurred to me (1). Oversimplified, this concept holds that many of man's worst transgressions such as violent racism and brutality in war are explained by the perpetrator truly believing that the victim is so unlike him as to be like a different species. Our interactions with patients are

seldom so savage, but the concept is valid, I think.

If I was smart enough to keep quiet, despite pain and nearly complete loss of control, my father and daughter (in hospitalizations separated by space and time) repeatedly connected with their doctors and nurses. I could watch the distance between the patient and the care-giver melt away. Suddenly, instead of "the small bowel obstruction in 368 (the other)," in the eyes of these nurses and doctors, my family became more like their care-givers than different.

I also encountered a few health professionals that never let their guard down. Despite my family's best efforts, the distance never decreased, as they went through the motions of a perfunctory physical exam or charting vital signs and pain scores.

This experience left me entirely unsettled. And when that happens to me, I first turn to Christian Scripture, and then to a favorite book written by a Franciscan friar who is also a general internist (2). And in both sources, there it was, big as life. Some care-givers understand the immense power of hope, and some simply don't.

First, from Hebrews 11:1 with a comment from Sulmasy (2):

*"Faith is the assurance of things hoped for."*

*"Without faith, there can be no hope."*

Sebastian Moore wrote that the fundamental question for all humans is whether their life and their person have meaning (3). This passage reads like poetry, and I had to read it twice, slowly, to understand it completely:



**STRIVE TO  
EXPERIENCE  
GOD'S PRESENCE  
AT THE MOMENT  
OF HEALING,  
AND ENGAGE  
EACH PATIENT  
WITH REVERENT  
ATTENTIVENESS.**

*“Religion is the believed-in answer of the unknown other, to the question: “Am I valuable in your eyes?” Unless we can come to understand the question as our question and the most human thing about us, we shall never understand the religious answer as the fulfillment of our whole desire for meaning.”*

So hope is the key, and meaning is the vehicle, as Sulmasy tells us:

*“Health care professionals also need to remember that hope is sustained and nurtured in relationship and community. The ultimate end of human hope is a loving relationship with God. But patients can catch glimpses of that ultimate relationship if health care professionals provide them with evidence that they are still very much a part of the human community. People often build walls around the sick. They project onto the sick their own lack of faith, lack of hope, and lack of love. People deny their own death by portraying dying persons as essentially different from them.”*

Death is not the ultimate enemy—loneliness is. But the physician who provides hope by connecting with the suffering patient and reassuring him that he

is valued and really not so much different from the one writing the prescriptions provides a healing force that cannot be matched.

I'll close with a short summary of a talk I gave to the student chapter of the Christian Medical Dental Association at U of L a couple of years ago. Based on Sulmasy's prescription for what he calls the “Prodigal Profession (2),” I suggested

a 4-step approach to being the kind of doctor that dispenses hope all day, every day:

1. Every encounter with every patient is an encounter with the mystery of God. He comes to us in the sick, the scarred and the downcast every day. Strive to experience God's presence at the moment of healing, and engage each patient with reverent attentiveness.

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What happens will probably surprise you. Someone from the outside can tell there's something different about your practice.

2. The healer/patient relationship is built on trust. The patient comes to you vulnerable and desperate. Take time to understand these feelings and act all day, every day like you are worthy of this trust.
3. Keep in mind that the power to heal belongs to God, not you. If you try your best, He'll let you borrow that power from time to time. Every herbal, every pharmaceutical, every machine made of silicon and glass comes to us from Him, so use them wisely.
4. Make a renewed commitment to health care as service. Follow the example of Christ washing the feet of His disciples. And this is not just to recruit more paying patients from your town's best churches to your practice. We serve each patient

simply for the sake of serving them, as each is created in the image and likeness of God.

Maybe I did end up writing about the patient centered medical home. We as physicians can't change all the social and financial forces swirling around us. But with the grace of God and a little self-reflection, we can change ourselves. Comments appreciated.

Bill Crump, M.D  
Madisonville, Kentucky

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1. Clark JA. *Unleashing hell: The culture of revenge and the law of retaliation in revolutionary Georgia. Master's Thesis, Eastern Kentucky University. May, 2009.*
2. Sulmasy DP. *A balm for Gilead. Georgetown University Press. 2006. Washington, DC.*
3. Moore S. *The fire and the rose are one. Seabury Press. 1980. New York.*

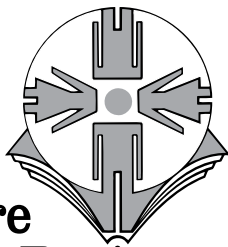
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## ▶ HENRIETTA LACKS AND THE PATIENT CENTERED MEDICAL HOME

For my birthday, my daughter gave me a copy of Rebecca Skloot's book, *The Immortal Life of Henrietta Lacks*. I had heard about the book, but since my opportunities to read for pleasure are limited, I was not likely to purchase it on my own. But my daughter said, "It's about ethics and research, so I thought you would like it." Well, a trip to California with a 12 hour delay allowed me to start the book, and I was finished 3 days later, spending several late nights in the hotel room rushing to get to the end of it.

The book was certainly about ethics and research. For those that have not heard the story, Henrietta Lacks (1) was a poor, black tobacco farmer with five children, who discovered, herself, she had a cervical mass. Fortunately for the rest of the world, she lived near Johns Hopkins Hospital. She was diagnosed with cancer. Cells removed from her cancer in 1951, called HeLa cells, became the first and most prolific cell lines used in research, aiding in the development of the polio vaccine and countless other medical and scientific advances. The ethics: those cells were removed and used for study without her knowledge or the knowledge of her family. In fact, it wasn't until 20 years later that her family knew the cells existed and only then because HeLa cells were famous in the popular press for the achievements they allowed.

So let me say first, I enjoyed the book. I actually worked with HeLa cells in medical school during a biochemistry elective that I took. Ms. Skloot tells a story that all health care professionals should know. Patient's lives are deeply rooted in their cultural and socioeconomic backgrounds and that has a major impact on their health. We know that, almost like we know the ABCs. But sometimes, I feel, we get too complacent on how it affects individuals today, in 2011. I remember as a medical student reading "consent

Patient's lives are deeply rooted in their cultural and socioeconomic backgrounds and that has a major impact on their health.

to treat" forms for patients. I would say, "This line says your tissues might be used in research, but I am not aware of any studies going on right now so you don't need to worry about that." Or another situation, when a patient died and I, the intern, was asked to get consent for an autopsy. "Tell them we might find out about some disease or cancer that could help the family," my upper level resident would say. This book provides some insight into those seemingly innocent interactions.

But what I really wanted to do was to emphasize how Henrietta's legacy, more than ever, demonstrates the need for a patient-centered medical home for everyone. Where I work with patients, the Bluegrass Community Health Center



in Lexington, we are working towards the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition. I feel this recognition will allow us to provide better care, less expensive care and care that is more satisfying to our patients, staff, and not unimportantly, to me and my fellow providers.

Henrietta's care was not particularly patient-centered. Would you expect that in 1951? Not really. Why not? Well, I will get to that later. Henrietta had to struggle to access health care. Her choice for primary care, if you could call it that, was the walk in clinic and emergency room at Johns Hopkins. Johns Hopkins was committed to providing care for the poor. But this was 1950 in Baltimore. Care for a poor, black woman meant the "colored" entrance and a separate "colored" wing. Were the physicians the same for all? Possibly. Was the care the same? That's a bigger question. I get the feeling she was aware she had cancer. I think she was not prepared for what that might mean. And certainly her family wasn't prepared. I am not talking about any HIPAA breaches here. I am talking about preparing a patient and her husband for the issues that will likely arise if he is left to care for his five children alone. Much of the book deals with the struggles of the surviving Lacks family and speaks volumes to the role that Family Physicians and other Primary Care Providers play in the lives of the families they serve.

Health care in the 1940s and 1950s was all about acute disease management. There wasn't much done about prevention. PAP smears weren't really introduced until the mid 1940s, and we still struggle with providing them universally to our patients such that they remain a Universal Data Set (UDS) measurement required by the federal government for Community Health Centers such as ours. We have come a long way with cervical cancer screening, HPV vaccines and education to patients. Patients should be informed about those important life choice decisions. I was struck by how often

Henrietta's children felt "out of the loop" when it came to their mother's notoriety. Much of the unknown centered on how their mother's health would affect her children. Would the girls in the family also die in their 30s? We now address these questions our patients have, provide some answers, teach families how to talk about life style choices, all in a culturally appropriate setting.

But this book is about ethics in medicine, especially in research. Should Henrietta have been asked if her cells could be used in research? Not in 1950. It was standard practice to harvest tissue and see what could be learned. And no one could imagine that Henrietta's cells would provide the breakthrough in science that they did. At some point, however, it may have been appropriate to inform her family of the successful cell line that HeLa had become. Maybe when Henrietta died and there was a request for an autopsy so more cells could be harvested? Am I saying the autopsy wasn't requested solely to provide needed health information to the family? I don't think so. Or maybe the family should have been informed when Henrietta's name was going to be released to the press. Or when the researchers called to collect blood samples from the family for DNA testing. Anytime might have allowed for a decrease in the suspicion and skepticism that pervaded the family's relationship with Johns Hopkins and medicine in general.

So how does research figure in with the PCMH? The idea of tracking patients, looking at trends, measuring patient outcomes and provider performance is research. Do we let patients know that? We should, and we should ask them to partner with us, because, after all, we want to be patient-centered. What if we discover a trend that is unexpected and reportable? Now we know that we would ask the patients' permission before releasing any information, or at least ask an Internal Review Board (IRB) if we can discuss the information in an anonymous way. We can track data because of our

computers, first used for billing data, now used for our medical records. I know we aren't all there yet, but if ever there was a need to move electronic, it is to facilitate achieving the components of the PCMH initiatives.

I am going to conclude with a controversial remark. (Sorry). Henrietta Lacks' care, and that of her family, could not be considered "patient-centered." I could say the reasons include that it was 1950, that medical knowledge was lacking, that there were no computers, let alone any EMR to track data, that preventive care was a future area to explore and discover. All those would be correct, for 1950, 1960, maybe 1970. Why have we begun to embrace the idea of patient-centered care now, and I mean in the last 10 years? We all know the drill. "If we keep doing the same old thing, we will keep getting the same results." And actually, with the rise in obesity, diabetes, and other chronic health problems, it looks like we are getting worse than the same. We are embracing these changes because we will save in the long run. We will save money, save patients from suffering (in some cases), and save our profession by convincing students to enter the very satisfying field of primary care. I suppose that is not so controversial after all, to the choir that is reading this editorial. It takes a team of interested, enthusiastic participants to create a patient-centered practice. Working together for and with our patients and their families, we can achieve improvements that could only have been imagined in Henrietta's time. Chalk up another item for the legacy of Henrietta Lacks. It is truly amazing what a contribution Henrietta, an individual, can make, but working together, with informed patients and families, compassionate care givers, expertly trained clinical staff and a sprinkle of information technology, we can achieve so much more.

#### References

1. Skloot, Rebecca, *The Immortal Life of Henrietta Lacks*. Crown Publishing Group, New York, NY, February 2, 2010.

# ▶ TO MY FELLOW KAFP MEMBERS:

Change is happening. Change in government, the economy, healthcare and even at KAFP. Every three years KAFP develops a strategic plan to assist our organization to establish priorities that better serve the needs of the membership. We are ready to start our strategic change now and are asking for your feedback.

We want to know what you, the KAFP member, would like to see your Academy do for you!

Please take 10 minutes and fill out this survey so that the KAFP board and staff may develop our 2011-14 strategic plan. Your feedback is greatly appreciated and the results of the survey will be shared with you!

Please complete the survey by Sunday, October 30th. If you do not use the online survey at <https://www.surveymonkey.com/s/kafpOct302011> then you can fax your response 1-888-287-0662. If you have any questions, please e-mail Gerry Stover, our EVP, at [gerry.stover@kafp.org](mailto:gerry.stover@kafp.org) with any questions. Thank you for your time!

KAFP President Mark Boyd, M.D.

## 1. Please choose one of the following that best describes you:

- Family Physician actively see patients
- Family Physician, not retired, not seeing patients
- Retired Family Physician
- Family Medicine Resident
- Medical Student

*Sub question: How likely are you to match in family medicine?*

- Very likely
- Somewhat likely
- Not likely
- Unsure

## 2. Please chose one the following that best describes your primary practice setting:

- Private, solo practice
- Private, primary care group practice
- Private, multi-specialty group practice
- Private, hospitalist
- University-affiliated, solo practice
- University-affiliated, primary care group practice
- University-affiliated, multi-specialty group practice
- University-affiliated, hospitalist
- Hospital-affiliated, solo practice
- Hospital-affiliated, primary care group practice
- Hospital-affiliated, multi-specialty group practice
- Hospital-affiliated, hospitalist
- FQHC/Primary Care Clinic
- County Public Health Department
- Medical School Department of Family Medicine
- Urgent Care
- Emergency Room
- Hospice Care
- Hospital Administration
- Long-term and nursing home care
- Student Health clinic
- Retired/volunteer
- Family Medicine Resident
- Medical student
- Other:

## 3. Please chose one to three of the following that best describes your secondary practice settings:

- Private, solo practice
- Private, primary care group practice
- Private, multi-specialty group practice
- University-affiliated, solo practice
- University-affiliated, primary care group practice
- University-affiliated, multi-specialty group practice
- Hospital-affiliated, solo practice
- Hospital-affiliated, primary care group practice

- Hospital-affiliated, multi-specialty group practice
- Medical School Department of Family Medicine
- Urgent Care
- Emergency Room
- Hospice Care
- Hospital Administration
- Medical director – long-term and nursing home care
- FQHC/Primary Care Clinic
- County Public Health Department
- Student Health Clinic
- Retired/volunteer
- Other:
- N/A

## 4. How many of the following full-time employees work in your practice?

- Physicians:
- Nurse practitioners:
- Physician assistants:
- Other health providers: (LCSWs, Dieticians, Dentists, etc)
- Other clinical staff: (RNs, CMAs, Radiology technicians, etc)
- Administrative staff:

## 5. How many of the following part-time employees work in your practice?

- Physicians:
- Nurse practitioners:
- Physician assistants:
- Other health providers: (LCSWs, Dieticians, Dentists, etc)
- Other clinical staff: (RNs, CMAs, Rad Techs, etc.)
- Administrative staff:

## 6. Do you find The KAFP Journal to be of value to you?

- Yes
  - No
- Comments:

**7. Do you find the KAFP Advocacy Fax/ Email Blast on issues to be of value to you?**

- a. Yes
- b. No

Comments:

---

**8. If KAFP were to start using Web-based social networking/media tools (e.g. Facebook and/or Twitter) to communicate important information to members, how likely are you to reference and use those tools?**

- a. Very likely
  - b. Likely
  - c. I will never use those tools
- 

**9. What are the issues that 'stress' you?**

---

**10. Did you participate in Medicare PQRI?**

(Yes / No) If No, why not?

---

**11. Who makes practice management decisions such as contracting with health plans?**

- a. I do
  - b. My employer
  - c. Other:
- 

**12. In my primary practice site, I use an Electronic Medical Record.**

- a. Yes
  - b. No
  - c. No, but I will be implementing an EMR in the next 12 months.
- 

**13. Will you be participating in either:**

- a. Medicaid Meaningful Use
  - b. Medicare Meaningful Use
  - c. Do not have an EMR
  - d. No, because?
- 

**14. Should KAFP assist its members in transforming their practices to patient-centered medical homes?**

- a. Yes
- b. No
- c. I need to learn more about Patient Centered Medical Home
- d. I have not heard about Patient Centered Medical Home.

Comment:

---

**15. Please indicate one thing that your Academy could be doing for you in the near future:**

Thank you very much for your feedback and time! Please fax to toll free 1-888-287-0662 or go to <https://www.surveymonkey.com/s/kafpOct302011> to complete your survey online.

Optional:  
Name

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# FINDING COMMON GROUND: GARDENING AS A TOOL TO FIGHT OBESITY & MALNUTRITION IN ECUADOR & KENTUCKY

*Jill Rushton-Miller, MD is currently in her 3rd year of residency with the University of Kentucky Department of Family and Community Medicine. During her residency she has participated in the Global Health Track during which she travelled to Santo Domingo, Ecuador to study health practices and outcomes in the developing world. She grew up in rural Northern California, graduated from Marshall University Joan C. Edwards School of Medicine in Huntington, West Virginia and plans to return home to California to practice.*

At first glance, one wouldn't think that Kentucky and the South American country of Ecuador had much in common. Kentucky is in the United States and embodies the prosperity, and perhaps the excesses, of a developed nation - from public water and sanitation systems to major commercial headquarters such as AllTech, Humana, Yum and Papa John's. Ecuador on the other hand is a fragile emerging democracy whose stability is threatened by the narcoeconomics of Peru and Colombia as much as by commercial deforestation and contamination of its intensely biodiverse slice of the Amazon Basin. Despite their differences, one might be surprised to learn that poor nutrition affects the health of millions of people within the borders of both locations. What then, causes two separate populations with entirely different socioeconomic backgrounds to have similar nutritional health problems?

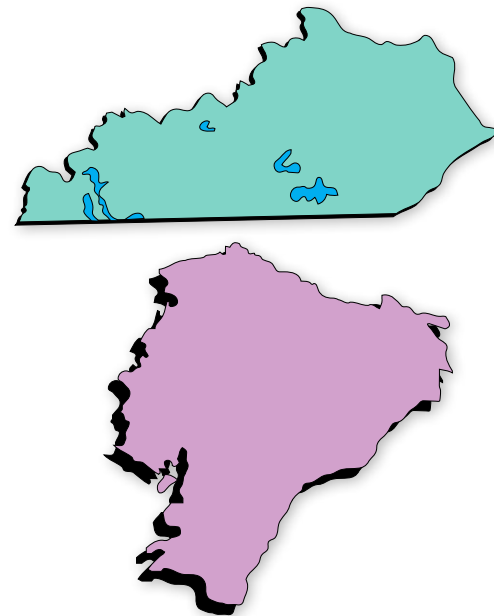
First, let us examine what components go into an assessment of nutrition. The first component of good nutrition is adequate protein, carbohydrate and fat intake. Poor intake of the above leads to wasting and stunting. The term "wasting" is defined by the WHO (World Health Organization) as having a weight for height Z-score of less than -2.0. The term "stunting" is defined by the WHO as having a height for age Z-score of less than -2.0. Wasting is considered a marker of acute malnutrition and is due to loss

of fat and muscle mass. If wasting is prolonged in children, it leads to stunting. Stunting is considered a marker of chronic malnutrition and is due to poor caloric

**"CULTURE IS GENERALLY NOT CONSIDERED TO BE A SOCIAL DETERMINANT OF HEALTH, HOWEVER IT TOO, GREATLY AFFECTS NUTRITION IN KENTUCKY AS WELL AS IN ECUADOR. A LOT OF WHAT ANY INDIVIDUAL EATS HAS TO DO WITH WHAT THEY WERE RAISED EATING. FAMILY RECIPES MEAN A LOT TO MANY PEOPLE, PARTICULARLY IN KENTUCKY."**

intake leading to a lack of attaining a normal height as a child grows. Wasting is reversible, while stunting is considered more irreversible (1).

The second component of good nutrition



is adequate intake of micronutrients. In most studies, the most important micronutrients are considered to be iron and vitamin A. Iron deficiency leads to iron deficiency anemia, which causes symptoms of fatigue, pallor, depression and pica among others. Vitamin A deficiency leads to night blindness, dry skin, dry hair and poor immunity in addition to other health problems.

The third component of good nutrition is avoiding the problems caused by over nutrition - overweight and obesity. A normal body mass index (BMI) is defined as 18.5 to 25. According to the WHO, an individual is overweight when their BMI is between 25-30 and obese when their BMI is >30 (1). The Center for Disease Control

(CDC) uses a different scale to define overweight and obesity in children (BMI percentile), but for ease of comparison the following discussion is based on the WHO's criteria.

Classically in developing countries, combating malnutrition involved fighting against stunting, wasting and micronutrient deficiency. In the past, obesity was primarily a nutritional disease of the developed world. As time has progressed and the entire world has become more industrialized, developing countries have also seen a rise in obesity. This is known as the double burden of malnutrition. The term describes the co-existent problems of both undernourishment, particularly of children, leading to a high prevalence of stunting and wasting and micronutrient deficiency in addition to a newer problem of having a high incidence of overweight and obesity. The double burden of malnutrition is becoming more and more prevalent in both developed and developing countries (2).

Both the United States and Ecuador are affected by the double burden of malnutrition. The United States has a much lower prevalence of undernourishment. Statistics collected in both nations from 2005-2009 demonstrate an undernourishment prevalence of 15% in Ecuador versus <5% in the United States (3). In children under age 5, 1.3% were found to be underweight in the United States versus 6.2% in Ecuador. Stunting was also found to be higher in Ecuador at a rate of 29.0% versus 3.9% in the United States. At the same time, United States has more of a growing epidemic of obesity with 8.0% of children under the age of 5 found to be overweight compared to 5.1% of children in Ecuador (3). When comparing Kentucky to the remainder of the United States, Kentucky has a slightly lower rate of stunting (5.9% vs. 6.0%), slightly higher rates of underweight (7.3% vs. 4.3%) and slightly lower rates of obesity overall in children less than 5 years (12.6% vs. 14%). At the same time, though, when looking at

only children between 2 and 5 years and obesity with Body Mass Indices (BMI) greater or equal to the 95th percentile Kentucky has a prevalence of 15.6% compared to national average in the US of 14.7% (4). Please see table 1 for a graphical comparison of the above data.

An important concept to understand when trying to discover what is causing a particular health problem, such as the double burden of malnutrition, is the concept of the social determinants of health. The WHO defines the social determinants of health as being the conditions in which people are born, grow, live, work, and age, including the health system (5). Social determinants of health are the social problems that an individual encounters that lead up to all of their health problems. Examples of social determinants of health include poverty, food insecurity, lack of education, housing, sanitation, working conditions and health care services among others. The following addresses the issue of poverty and education and discusses how it pertains to the malnutrition problem affecting Kentucky and Ecuador.

Poverty in Kentucky as well as Ecuador is a major issue affecting health and specifically nutrition. Kentucky as a state is less affluent than many in the United States. Please see table 2 for a comparison of the gross domestic products (GDP), health care expenditure and populations of Kentucky, the United States and Ecuador (6-9). Ecuador, as a country, has over three times as many people living within its borders than Kentucky, but produces one third of Kentucky's GDP. Kentucky itself, when comparing per capita GDP has a lower GDP than when compared to the United States as a whole. One specific way in which poverty in Kentucky directly contributes to the double burden of malnutrition can be observed when comparing the accessibility of grocery stores in wealthy versus impoverished neighborhoods in Lexington.

Many low-income Kentuckians living in Louisville and Lexington rely on public transportation for their shopping. The

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CITY.**

main supermarkets tend to be in the more affluent areas on the outside of town and are accessible easily by car but are more of a challenge for people who rely on bus or taxi to buy their groceries. In a quick evaluation of Lexington's zip codes, the four wealthiest zip codes, determined via average home price (10), have a total of seven supermarkets located within their borders. The four poorest zip codes have only three. Please see table 3 for more details. This makes economic sense for the grocery stores, which are not going to move willingly into low-income areas due to both a lack of affluent people spending money at their store as well as an increased need for money spent on security. This discrepancy between the access of the wealthy versus the impoverished to inner city grocery stores has been repeatedly observed in the past in other cities across the United States and is believed to be a contributor to malnutrition in the United States (11, 12).

In the past, Kentucky's economy was more agrarian than it is today. Many rural people lived on family farms where

*continued on page 20*

TABLE 1

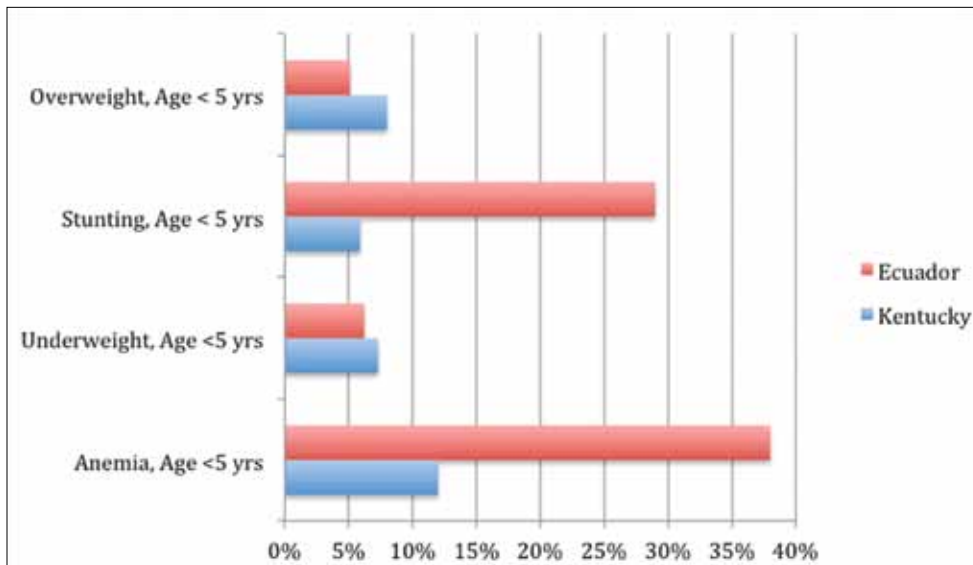


TABLE 2 Economics and Health Care Expenditure of Kentucky, the United States and Ecuador

	Kentucky	Ecuador *	United States
GDP	158 billion (2008)	47 billion (2009)	14 trillion (est 2011) **
Per capita GDP	\$39,500	\$3,300	\$44,700
Population	4 million	14 million	313 million
Health Care Expenditure, per capita ***	In 2004: \$5473	In 2008: \$466	In 2008: \$7538 In 2004: \$5283

\* Data on Ecuador pop/GDP reported by UNICEF/World Bank (3).

\*\* United States GDP Estimate from CIA World Factbook (8)

\*\*\* Health care expenditure data from Kaiser Family Foundation (9)

they raised their own food items. Today, many people in rural Kentucky still work on farms, but instead of being small family-run operations, farms in today’s Kentucky are more and more frequently owned by large corporations that pay their employees in wages rather than in a portion of the harvest. These large corporations tend to supply fresh food items instead to large supermarket suppliers. The result of this is that people even in the rural areas of Kentucky more and more have to rely upon supermarkets located in distant suburban centers for their fresh fruits and vegetables.

In urban Ecuador, access to fresh fruits and vegetables is also an issue. In 2010, this author in Santo Domingo, Ecuador conducted a brief survey. The survey asked participants how much time it takes them to travel from their home to where they buy fresh fruits and vegetables.

We found that on average, women in the neighborhood surveyed spent 19.3 minutes travelling from their homes to the open-air market at the center of town for their groceries. Half of all women surveyed spent >30 minutes travelling. When asked, usually women would travel via bus or carpool with others travelling by car to go buy their groceries (13).

Education is another well-documented determinant of health. Kentucky ranks poorly in education compared to other states, yet compared to Ecuador the public school systems, the state education budget of \$4.875 billion, per student expenditure of \$9,144 and a graduation rate of 89.3% is remarkable (14). With increasing education we also see an increase in knowledge about nutrition and it’s affect on health as it is taught in schools.

Culture is generally not considered

to be a social determinant of health, however it too, greatly affects nutrition in Kentucky as well as in Ecuador. A lot of what any individual eats has to do with what they were raised eating. Family recipes mean a lot to many people, particularly in Kentucky. The problem is, knowledge about nutrition in the past was not necessarily as good as it is today. Foods of the past, particularly traditional hearty Kentucky foods were designed to keep Kentuckians well fed through times of food scarcity. Back then, when manual labor was commonplace and people walked as their main means of transportation, a diet of fried and breaded foods would have sustained an increased caloric requirement. In the world of today’s supermarkets, these foods are made from similar but less nutritious ingredients – made no longer by scratch but purchased frozen, boxed or canned. These high fat foods are also eaten by a people who work in offices, drive vehicles and burn much fewer calories than their predecessors. Our lifestyles have changed today, however our traditional diets still lag behind.

A similar phenomenon is seen, as well, in Ecuador. Culturally in Ecuador the traditional diet is high in carbohydrates and protein but low in essential micronutrients that people need such as vitamin A and iron. Since the beginning of its industrialization, Ecuador has been starting to see similar health problems as the United States with the increasing popularity of fast food and a decline in the consumption of the more traditional diet (2). Therefore, at the same time that obesity and metabolic syndrome are beginning to affect the health of the people, the problems with micronutrient deficiency still exist.

Ecuador, as well as other nearby countries has had a long-standing understanding of the severity of the problem of malnutrition. Several programs in other South and Central American countries have been developed to try and combat the problem of micronutrient deficiency. The



**Table 3. Number of major grocery stores per zip code, listed by highest to lowest average home value.**

Average Home Value (\$)	Zip Code	Number of Major Grocery Stores (Meijer, Kroger, Walmart)
222,100	40510	0
205,100	40513	2
178,900	40502	4
134,400	40514	1
129,500	40515	2
123,900	40509	3
121,900	40516	0
114,800	40507	0
113,700	40503	4
92,800	40504	1
91,900	40517	0
86,300	40511	2
79,500	40505	1
56,300	40508	0

government of Guatemala has tried to supplement vitamin A into white sugar in a program that is similar to how, in the United States, bread items are fortified with folic acid. Another method they have also tried is to distribute free vitamin A vitamins to all children. Both programs were found to be fraught with problems and neither truly addresses the heart of the issue, which is that people aren't eating enough vegetables (15).

One solution to the issue of improved access to fresh vegetables that has been proposed in Ecuador is the building of community gardens to increase the supply of fresh vegetables for families (2, 15, 16). One such example of a community gardening project was started in 2010 by the Yachay Initiative and involved starting 23 family gardens (17). Builders of community gardens have noticed an increase in vegetable consumption as well as an increase in education about what is required to eat to provide adequate nutrition. Community gardens work through supplying the women in a particular family with the education as well as the vegetables themselves that she needs in order to make better choices for her family members (18, 19). In Ecuador, much the same as it is in the United States, women are the main caregivers and food-makers for the family unit. Therefore,

it is the women in the family that do the shopping and the women in the family who decide what to spend money on and how to cook the food items when they arrive home. Whatever education on nutrition is provided, therefore, is best if focused on women and children in both countries.

The cultivation of vegetable gardens by schools has been shown to work in the US to educate children about how to garden and what makes up a nutritional diet (20). Examples of such educational gardens can be found at Dunbar High School in Lexington and at Berea College in Berea, Kentucky. These programs have the benefit of educating children and young adults while at the same time garnering within them an increased interest in healthy eating habits. The effectiveness of such programs has been demonstrated in the past as increasing interest and knowledge among participants and their families (20).

So how, as providers can we make a difference and improve the nutrition of our patients and improve the health of our communities? One thing we can do is to encourage our patients to garden as a way to increase their knowledge and interest in the vegetable content of their diets, not to mention the benefits obtained by the increased physical activity

that is demanded of gardening. We can also become advocates for improving nutrition education in schools and encourage our patients to teach their children that vegetables are an important part of their daily diets. We can focus on discussing vegetable consumption at every routine physical for every patient as part of a general assessment of nutrition. In addition, community gardens provide an interactive educational tool for our patients and our communities. In being an advocate for local healthy food production we can encourage our local governments to invest funds in developing more community gardens, particularly in resource-poor areas of the state. All of these actions will help our patients in improving their nutritional status and the nutrition of their families.

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continued on page 22

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