SB 380 Will Require Physicians to Learn about Human Nutrition

After the unanimous passage by both houses of congress on September 6, 2011, California Governor Jerry Brown signed into law Senate Bill (SB) 380. The sole purpose of this directive is to remedy the widespread lack of basic knowledge of California physicians about human nutrition. Simply put, medical doctors do not know what their patients should eat to prevent, treat, and often cure common diseases, including obesity, type-2 diabetes, and heart disease.

The fate of (1) more than 38 million men, women, and children living in California, (2) the economy of California, and (3) the reputations of California-licensed medical doctors all hang in the balance of effectively implementing SB 380. The ripple effect of doing so will be felt across the nation. The Medical Board's first SB 380 Working Group Meeting will be held on July 17, 2013 in Sacramento, California.

Although "diet and lifestyle" are often discussed as being interconnected, these are separate issues in terms of SB 380. The importance of lifestyle matters, such as the need for tobacco cessation, and curtailing alcohol and substance abuse are well recognized and accepted by physicians, and the Medical Board of California, but are irrelevant to the current senate bill. SB 380 is about food. (Diet is referenced three times and nutrition is talked about nine separate times in this bill, whereas tobacco, alcohol, and illicit drugs are not specifically mentioned.)

Before SB 380 was passed in 2011, opponents, including members of the California Medical Association and several subspecialty groups representing the business interests of California physicians, told me and our congressional leaders that there is no need to have doctors' practice behaviors regulated by the government of California. I was assured that medical doctors are responsible professionals actively involved in keeping their own houses in order. This is factually untrue.

Healthcare is a Big Business

It's easy to lose sight of the obvious, that the practice of medicine is a business and physicians work for profit. After an average of seven years of rigorous schooling on the care of their customers (people), medical doctors (and Doctors of Osteopathic Medicine) have learned almost exclusively about relieving the ailing minds and bodies of their patients by prescribing pills and performing surgeries (both valuable tools). Pharmaceutical companies and medical device manufacturers rule when it comes to the education of doctors, nurses, and other healthcare professionals. Even respected medical societies and non-profit disease awareness organizations in the United States receive much of their funding from industries.

The American Medical Association reported that 16 drug, device, and communications companies donated nearly $5 million in 2007 for continuing medical education (CME) programs and communications conferences. Various physician subspecialty organizations, such as the North American Spine Society, the Heart Rhythm Society, and the American Academy of Allergy, Asthma and Immunology have been heavily funded by industries with special interests. Efforts have recently been made to help make these relationships more transparent to the public. Even when conflicts of interest are completely open and honest, these declarations do not negate the biases inherent in a speaker's talk or the research sponsored by industry.

Because of economic pressures common to all businesses, physicians' practice behaviors can remain unchanged even after indisputable evidence of harm to patients is revealed. For example, angioplasty, with or without stents, performed for chronic coronary artery disease does not save lives. As a consequence, guidelines by the American College of Cardiology and the American Heart Association have been issued to curtail improper practices by cardiologists. Unfortunately, these robust national guidelines have been largely ignored; no change in the number of angioplasties has been seen. Money has been identified as the reason for continued malpractice. Widespread publicity of physician misconduct, with the potential for lawsuits brought by patients and their families, has been suggested as a possible remedy. However, I believe SB 380 would be a less painful solution for physicians and their patients by providing the highly effective and competitive approach of diet therapy for coronary heart disease.

Physicians Know Little about the Diet of Human Beings

On April 24, 2011 I asked members of the California Senate committee who originally heard SB 380, if any of them or their families had been treated for diseases related to diet (obesity, diabetes, elevated cholesterol, blood pressure, arthritis, etc.) with a strong recommendation from their physicians to make serious changes in the foods they eat. None responded in the affirmative. That is because medical doctors are not trained on the effect of food on people's health.

The brief nutrition education offered by medical schools has not been focused on the practical application of diet therapy for patients. "Nutrition education" means students memorize obscure facts about biochemical pathways and cellular metabolism. As a result most US medical schools and teaching hospitals are severely deficient in training students, postdoctoral residents, and practicing physicians in what a healthy diet really looks like and how to help their patients transition to one. More than half of students surveyed report that nutrition education is inadequate. The American Medical Association has recognized the need for improvement in this area.

Is Knowing about Diet Important?

Most deaths in the United States are preventable and related to nutrition. Seven out of 10 deaths among Americans each year are from chronic diseases, like heart disease, stroke, diabetes, and common forms of cancer. It is estimated that health care costs for chronic disease treatments account for over 75% of the healthcare expenditures. The latest report from the World Health Organization concluded that diet was a major factor in the cause of chronic diseases.

In 2011, national health spending was estimated to have reached $2.7 trillion annually. These figures have been magnified to mean 17.3% of the gross domestic product (GDP) is spent on medical care, which is among the highest of all industrialized countries. California spends $230.1 billion annually on healthcare.

Rates of Dietary Diseases Among Californians:

Adult Obesity Rates: More than 60% of adults are overweight and 24% are obese. The obesity rates in California are expected to increase: from 24% in 2011 to 46.6% in 2030 if current trends continue.

Childhood Obesity Rates: These have more than doubled in children and tripled in adolescents in the past 30 years. Among California's children (ages 2 to 5) an estimated 16% are overweight and more than 17% are obese.

Diabetes Rates: Approximately 8% of Californians have diabetes (mostly type-2). California has the greatest number of people in the US who are newly diagnosed with diabetes. In 2007 about 7.9 million (29%, or nearly 1 in 3) adults in California had pre-diabetes. Type-2 diabetes is due the obesogenic effects of the Western diet.

Heart Disease Rates: Approximately 6% of Californians have heart disease. Heart disease and strokes account for 35% of deaths in California.

Diet-therapy Is Proven Therapy

Diet therapy has been used for thousands of years to cure people of common illnesses. The best-known example from ancient history is the controlled experiment reported in the first chapter of Daniel in the Bible from more than 2500 years ago: Daniel 1:12-15: "Please test your servants for ten days: Give us nothing but vegetables to eat and water to drink. Then compare our appearance with that of the young men who eat the royal food, and treat your servants in accordance with what you see. So he agreed to this and tested them for ten days. At the end of the ten days they looked healthier and better nourished than any of the young men who ate the royal food."

Modern day examples of highly effective diet therapy used to treat thousands of patients include the classic works of Walter Kemp-

ner MD, the founder of the Rice Diet at Duke University; Nathan Pritikin, founder of the Pritikin Longevity Center; and Roy Swank, MD, at Oregon Health & Science University and Dean Ornish, MD of Preventive Medicine Research Institute and the University of California, San Francisco.

By these treatments alone, using no medications or surgeries, diet therapy has been scientifically documented in our most respected medical journals to stop and/or reverse obesity, heart disease, type-2 diabetes, hypertension, kidney disease, arthritis, multiples sclerosis, and some common forms of cancer.

Diet also plays the key role in longevity. The longest living populations on planet Earth today live on starch-based (low-animal food) diets. These include people from Okinawa, Japan; Sardinia, Italy; Nicoya, Costa Rica; Ikaria, Greece; and the Seventh Day Adventists in Loma Linda, California; all live in what are called the "Blue Zones."

Unique to diet therapy is that it is cost-free and side effect-free. Patients treated with diet therapy, and often cured, are taken off of expensive medications with serious side effects, and they avoid costly and painful procedures.

SB 380 Needs Teeth

Possible actions that can be taken during the Medical Board's first SB 380 Working Group Meeting on July 17, 2013 include:

1) Requiring continuing medical education (CME) requirements for all newly licensed and relicensed physicians,
2) Requiring California's eleven medical schools to teach diet therapy,
3) Requiring the 393 general acute care hospitals in California to dedicate significant time to diet therapy at ongoing educational meetings held for their doctors,
4) Auditing medical practices for the appropriate use of diet therapy (as opposed to drugs and surgery),
5) Sending nutritional education materials to physicians.

All of these measures need to be enacted; however CME requirements for physicians should be the first and foremost effort made by the Medical Board of California. Industry knows this approach is effective and that is why of the total $2.4 billion spent in the United States on CME in 2006, 60% came from the industry.

Nationwide Laws Requiring CME

- California requires a one-time requirement of 12 hours pain management and end-of-life care.
- Florida requires at 1st time renewal: 1 hour on HIV/AIDS, 2 hours medical error prevention; subsequent renewals: 2 hours medical errors prevention; every 3rd renewal: 2 hours medical errors prevention, 2 hours domestic violence.
- Iowa requires 2 hours on chronic pain and 2 hours end-of-life care every 5 years.
- Kentucky requires a one-time requirement of 3 hours on domestic violence; 2 hours of approved HIV/AIDS every 10 years.
- Massachusetts requires 3 hours of pain management, 2 hours end-oflife care, and 10 hours risk management.
- Nevada requires 2 hours ethics; 20 hours in specialty; 18 hours any AMA Category 1. New applicants: 4 credits in WMD/bioterrorism.
- New Jersey requires a one-time requirement of 6 hours of cultural competence.
- New Mexico requires 5 hours of pain management every 3 years.
- New York requires courses on child abuse every 4 years, and on infection control (approximate: 2-4 hours).
- Oklahoma requires 1 hour on prescribing controlled substances every 2 years.
- Oregon requires 7 hours on pain management or end-of-life care, which must be completed within 12 months of initial license.
- Tennessee requires 1 hour on appropriate prescribing.
- Vermont requires a minimum of 1 hour on hospice/palliative care.

West Virginia requires a one-time requirement: 2 hours end-of-life care, including pain management.

Requiring CME to remedy a deficit in physician education is commonplace throughout the US. An important precedent was set in California on October 4, 2001: AB 487 was signed into law, and requires most California-licensed physicians to take, as a one-time requirement, 12 units of continuing medical education on "pain management" and "the appropriate care and treatment of the terminally ill."

The Medical Board of California has the opportunity, if not the responsibility, to require CME for physicians to improve their understanding of human nutrition, which will result in better care for their patients. As written, SB 380 begins with this statement: "Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons."

Section 2 of SB 380

"In order to ensure the continuing competence of licensed physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board may also set content standards for any educational activity concerning a chronic disease that includes appropriate information on prevention of the chronic disease, and on treatment of patients with the chronic disease, by the application of changes in nutrition and lifestyle behavior. The board shall require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years."

But change will not be easily won since profit rather than science is behind the vast majority of doctors office visits, hospitalizations, tests, pharmaceuticals, and procedures carried out in California. Because of serious threats to profits and their dominance over patients' care, big industries have opposed, and will continue to oppose "anti-business legislation" of the kind brought by SB 380. When the Medical Board's first SB 380 Working Group Meeting is held on July 17, 2013 in Sacramento, California, much will be at stake. Effective implementation of this law will mean healthier and less medicated citizens of California, a more robust economy for our state, and a chance for medical doctors to more effectively fulfill their professional calling as "healers."

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