The Food and School Issue

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Most of the articles in this issue of the *WMJ* have a direct or indirect connection with food—where we buy it and how it affects our lives. One of the ironies of food in our society, of course, is that we are struggling with the tension between too little of it for many people and the wrong kind of food for many others.

Food insecurity is a term that might be familiar, but Guerrero and colleagues,[1] in their statewide study of food insecurity, operationalize it by asking how many people feel they have had difficulty having enough food for their family. Their findings make the issue quite real. Looking at a population or community without asking that question might mislead us into thinking that visible sources for food means there will be little food insecurity. All of us, whether in cities or rural practices, will find food insecurity at what most of us would consider a surprisingly high rate if we ask our patients.

In addition to poverty, Guerrero and colleagues' analysis shows a cluster of variables that affect financial access to food: younger, less educated women who are uninsured and already have a much higher burden of illness and poorer self-reported health status, are a cohort who need more help in many ways, including food. One of the more surprising findings in this study was that there are no significant urban/rural differences regarding the prevalence of food insecurity. Hunger and inadequate nutrition are a reality in all communities. Just because one lives in an agricultural area or is surrounded by big box grocery stores doesn't mean there is better access to food.

A second study by Tolzman and colleagues[2] takes the level of analysis deeper on the city level by looking at people who live in one of the designated "food desert" areas of La Crosse, Wisconsin. They look at one component of food insecurity—ready access to sources of food—and surveyed residents of areas that suffer from lack of access. Not surprisingly, they found that over a third of respondents have limited access to food and, more disturbingly, almost 15% of respondents admitted to hunger being an issue on a regular basis.

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One lesson for clinicians from this study is that even in a city with a 4.7% unemployment rate like La Crosse, there are neighborhoods where food insecurity is a serious and immediate problem. Combining the data from the Survey of the Health of Wisconsin (SHOW) and the La Crosse community study should make all of us aware that, although most of the national attention has been on obesity as an "epidemic," another underlying and more perverse social issue that affects health is simply not having enough food to make it through the day, week, or month. Most data connect the two by demonstrating that even if access is addressed, unless people have enough financial resources, including federal supplements, they will go hungry. That food pantries and community meal services continue to be stressed, even in light of an improving economy, is evidence of disparity in our communities that affect health. Once again, the people in the SHOW study who had the highest levels of food insecurity were disproportionately burdened with poor health. Food and health go together, and the solutions are at the community level, not in our health systems. Physicians have a role, but it means moving outside of our hospitals and clinics and advocating for solutions that have a chance at improving the lives of our patients who struggle with basic human needs.

Another paper in this issue deals with the more familiar food-related clinical problem of obesity in children. Chelvakumar and colleagues[3] describe a survey and followup chart review of a network of pediatric practice sites to determine to what extent those practices take basic measurements to determine obesity (they do it well), to what extent they document those data (they fall short), and to what extent pediatric clinicians say they give advice to

patients and families about improving nutrition and exercise compared to what is documented in their patients' charts (they do a poor job). The authors wanted to establish a baseline so that, in an era of electronic medical records and large practices with multiple clinicians caring for populations of children, improved documentation will become less of an issue of billing and more a way of looking at the success of interventions in the clinical environment. Without the ability to identify at-risk children and families in practices, there is no way to approach them with ideas and programs or measure whether those programs are effective.

Then we move to the study by Eldredge and colleagues,[4] who partnered with the school system of the Archdiocese of Milwaukee to assess the readiness of schools to respond to possible food-related emergencies and whether schools had policies that might decrease the likelihood of such emergencies. What they found was humbling. A quarter of schools responding to their survey lacked policies for food allergies. When they added action plans (accommodations for food allergic children) to the mix, they found that a quarter of schools did not record a student with a food allergy or have an action plan in place, and a third of schools responding to the survey had no training for anaphylaxis treatment. So there was a long way to go. But the best outcome of the study was the creation of an online training program for school personnel on policies, plans and treatment for food allergies, which is the best thing investigators can hope for: that their findings stimulate change and improvement. When they repeat their study there undoubtedly will be real progress.

Staying on school emergency readiness, the survey of high school athletic directors by Harer and Yaeger[5] about CPR training of first responders to collapse showed that only a third of schools require CPR training for coaches. Athletic directors strongly favor CPR training for coaches but identify time as a factor in not getting trained. It would seem that they might be able to find the time while they implement that training. In the study, participants reported that 29% of schools had had a student collapse and 25% had had an adult collapse. If community physicians are looking for somewhere to help their communities in an important way, work with the schools to bring CPR training to coaches and staff.

Finally, one of the best titles for a paper in recent memory is a case report about a patient with carbonated drink-related syncope, by Witcik and Meskin.[6] "Pop and Drop" is real, and we need to start asking patients with syncope whether they noticed patterns of drinking or eating when it happened.

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