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## Commentary: Just Why Do We Eat What We Eat?

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**Commentary: Just Why Do We Eat What We Eat?**

Mr. Smith presents with a complaint about his knee, and while solving his knee problem, you decide to tell him that his nutrition intake is wrong and he needs to change his eating habits. Mrs. Jones presents with upper respiratory congestion, and during the course of managing her problem, you decide that her blood workup shows some flaws that could be dealt with by changing her eating pattern. John J. comes into the office wanting you to help him overcome his weight problem, so you start the measurements: number of calories taken in, percent of protein taken in, types and amounts of fat taken in, etc., and wind up with a complex diet revolving around a bunch of numbers of different nutrients...

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## Commentary: “Just Why Do We Eat What We Eat?”

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Mr. Smith presents with a complaint about his knee, and while solving his knee problem, you decide to tell him that his nutrition intake is wrong and he needs to change his eating habits. Mrs. Jones presents with upper respiratory congestion, and during the course of managing her problem, you decide that her blood workup shows some flaws that could be dealt with by changing her eating pattern. John J. comes into the office wanting you to help him overcome his weight problem, so you start the measurements: number of calories taken in, percent of protein taken in, types and amounts of fat taken in, etc., and wind up with a complex diet revolving around a bunch of numbers of different nutrients.

The science and medicine of nutrition changes almost as rapidly as that of genetics. With the influence of the progress we make with the respective technologies of these two areas of science and medicine altering what we know, how we know we know, and the results of what we get to know, change is frequent, and at times, radical.

I recall a very stark example of such change from my early years in organized sports during the 1940s and early 1950s. A typical meal a few hours before a game (college or professional) could have consisted of steak, cheese, and ice cream. The point is that we have learned and changed quite a bit. Tangentially, with regard to training and fitness, lifting weight was taboo because the thinking was it would make one what was referred to as “muscle bound.” Again, owing to much research, experimentation, and technological advances, today we see resistance exercising as a boon to the athlete and becoming an integral part of maintaining good health for the average individual.

In trying to help a patient manage a healthy diet, look at what we are up against. RDAs (Recommended / Required Daily Allowances) go through periodic changes; concerns about fat intake (amounts and types) seesaw; total calorie intakes vary (depending upon which formula one subscribes to); vitamin significances change; individual food values fluctuate (“now you should---now you shouldn’t”); percent’s of daily nutrient intakes change; the value of or the need to take in specific nutrients change (“now it is good for the heart--before it wasn’t!”). In our lab testing we even go through change as to what is more important and for which disorder. We ask patients to read labels and expect them to understand them, even though the labels can be confusing with regard to amounts and serving sizes and / or proper regulatory overseeing.

Add to all of this information, “the Pyramids.” Originally, the government offered a “food pyramid,” which is a graphic of food proportions of daily nutrients intake to help people establish a healthy, daily eating plan. Then research project after research project came up with their own pyramids, and they too were subject to change as more information about eating came out of more laboratories.

Understandably, these changes result from justifiable, significant, valid research as a result of our ever-improving technology. How can we expect the average, non-trained citizen to understand or accept these changes? We want them to accept our suggestions. We want them to be part of the decision-making process. Yet at the same time, they should understand while we, the clinicians, have a difficult time keeping up.

In essence, what we might tell a patient (taking into consideration age, gender, state of health, etc.) is as follows: “Take 2,000 calories in; make sure that you take in between 45-65% or between 250-350 grams of your intake in carbohydrates; 10-35% or

between 46 to 56 grams of your intake should be in protein; 20-35% or 35 to 55 grams should be in fats; 2300 mg of sodium (if under 50 years old); exercise this amount per week; and remember these are the good carbs and these are the bad carbs....etc.” “Make sure you read the labels.” Then 3-6 months later we might come back to this patient tell him/her the changes as a result of the new guidelines. The patient attempts to eat healthy via “numbers, which of course, can be easily confusing. Not everyone has the mind of a financial analyst and is that comfortable with numbers.

Perhaps in order to have a more informed and compliant patient we should embark on a different path in helping a patient manage the diet and eat healthy (or healthier). Why don't we look to put more emphasis on educating the patient as to “why something is good and healthy, as opposed to just telling them how much to eat? Tell them exactly why and how carbohydrate is important such as its role in energy production and supply. Tell them how and why protein is so important. Tell them how sodium can be “bad” and how it can be “good”.

We are willing to trust our drug functions' explanations (via advertising) to them. Go the one step further and introduce them to their nutrients through some “soft” science. The science education of a teen these last few years, is much more intricate than 30+ years ago. They don't have to know what the Cori Cycle is, but they could be shown what the relationship of carbohydrate to glucose is, and why even though a piece of bread may not taste sweet, it could raise one's sugar glucose level in the blood. Why just tell a patient to “include Omega-3 fats in your diet because they are good for you?” Why not tell them that they are “necessary for substances or secretions that the body produces that help regulate blood clotting or the prevention of excessive bleeding”? We probably can use the term hormone instead of substance, nowadays.

Both the pharmaceutical industry and the medical community appear to be comfortable with the medication ads that give some pretty professional, detailed information, and the consumer is trusted that they can understand. Why not educate the same people by explaining to them not just “how much,” but also why we eat what we eat?