Virtual Mentor
American Medical Association Journal of Ethics
April 2013, Volume 15, Number 4: 299-305.

ETHICS CASE
The Ethics of Hospital Cafeteria Food
Commentary by Lenard I. Lesser, MD, MSHS, and Sean C. Lucan, MD, MPH, MS

Dr. Ashby, Dr. Bennett, and Dr. Morgan all serve on their hospital board, which met to discuss a proposed new policy to revamp the cafeteria and inpatient dietary offerings. The board members expressed many opinions about this issue, and the physicians debated the issue hotly.

Standing to address the board, Dr. Ashby said, half jokingly, "Esteemed colleagues, I believe that it is simply unethical to be serving patients' families and visitors and our staff members the unhealthy food that is currently being sold in this institution. It is our responsibility as a health-promoting organization to foster all aspects of health. The hospital is a role model for our visitors and staff, and we must set high-quality standards when it comes to our nutritional offerings."

Next to the podium was Dr. Bennett. "While I agree with Dr. Ashby that we want to promote health," states Dr. Bennett, "When it comes down to it, it's every person's responsibility to make his or her own food choices. Our main responsibility as the hospital's representatives is not to change individual behavior but to serve the low-income population in our community—and to do that we must ensure the fiscal future of our institution. Our current food vendor is the only option that makes that possible. In order to uphold both our fiscal responsibility and our duty to educate the public about health issues, we could post the ingredients, calories, and nutritional content such as the amount of fat, cholesterol, and sodium in the cafeteria offerings and then leave it up to the visitors and staff to make their own choices."

Dr. Morgan piped up, "While I think that Dr. Ashby and Dr. Bennett both bring up valid points and have some solutions that we might want to consider, we should not forget that, as a large hospital, decisions we make about the food served in our cafeteria affect not only the health of the patients, their visitors, and employees, but also the broader community, society, and the environment."

Commentary
A Hospital's Mission to Promote Health and Healthy Eating
Before considering ethics related to a hospital's cafeteria offerings, it may be useful to consider a hospital's mission more broadly. Hospitals have traditionally engaged in treating acute illnesses and had financial incentives to keep beds full. Now they also manage chronic conditions and have financial incentives to keep patients well. Hospitals today have incentives to prevent readmissions and, more generally, to promote community wellness and public health. As large employers, hospitals are

invested in keeping their workers healthy, and, as teaching institutions, they are invested in passing on lessons of wellness to their students and clinicians in training.

Prevention is a principal focus of most hospitals' work. Given that many leading causes of preventable illness and premature death in the U.S.—obesity, diabetes, heart disease, cancer— are diet-related, it is logical that hospitals have a stake in providing health-promoting food. Doing so helps a hospital fulfill its mission to prevent disease and promote wellness and health, both by sending a message about proper nutrition and by nourishing patients, students, volunteers, staff, visitors, and others.

Financial Considerations and Mission

In order to fulfill its mission, a hospital has to remain fiscally solvent. As Dr. Bennett notes, a chief concern is to ensure the fiscal future of the institution. Whether a hospital is for-profit or not-for-profit, its fiscal future depends on an overall balance of revenue over costs, and ideally each of the services it provides should be "in the black." Cafeteria service is no exception.

However, if a hospital cafeteria achieves profitability by selling items that promote poor eating habits and poor health, there is a conflict between that business practice and the hospital's broader mission. Certainly, a hospital might generate valuable revenue by selling any number of products that are bad for one's health (e.g., cigarettes). But selling such products would contradict the health-driven mission, and any revenue generated would not be a defensible offset. Offsets from selling foods that clearly damage human health would, likewise, be indefensible. We agree with Dr. Ashby that serving definitively unhealthful food items to patients, visitors, and staff is simply unethical.

Individual Choice and Paternalism

Dr. Bennett might argue that it is not the hospital's responsibility to change individual behavior. We disagree. Promoting health and preventing disease in an era of chronic disease *is* part of a hospital's mission, and that mission can only be achieved through behavior change. Insalubrious behaviors are principal causes of chronic disease, and poor diet is (perhaps only after tobacco use) chief among them [1, 2]. Just as doctors (derived from the Latin *docere*, "to teach") are responsible for teaching individual patients about good eating practices, so are the hospital systems for which they work responsible for promoting dietary change in broader communities. To do otherwise would undermine their doctors' efforts.

We agree with Dr. Ashby that a hospital is a role-model for both visitors and staff that must set high-quality standards when it comes to nutritional offerings. Food service is particularly outward-facing; it is an extension and a symbol of the hospital's relationship to the broader community and the foods provided should be consistent with dietary advice of clinicians. Patients are likely to interpret what hospitals serve as "healthy." For instance, one study showed that families visiting a

hospital with a McDonald's in it were twice as likely as those visiting a hospital without a McDonald's to think McDonald's was healthy [3].

Without regard to the foods hospitals serve, Dr. Bennett argues that individuals are responsible for the choices that impact their health. We agree that individual responsibility is important. But many food choices bypass conscious deliberation; they are strongly influenced by the environment in which choices are made [4]. Thus, we believe it is a hospital's ethical responsibility to make the health-promoting choice the easy choice. Hospitals have no obligation to provide definitively unhealthful foods, and there is an ethical problem with doing so. Individuals unable to satisfy their food preferences in hospital cafeterias can choose to eat elsewhere, or bring food from home, or order in. But hospital cafeterias should work to discourage the eating of unhealthful food. Hospital cafeterias should capitalize on their inherent convenience and promote their healthful options over unhealthful options available elsewhere (for the good of the institution's bottom line and the health of patients, visitors, students, volunteers, and staff).

Local and Global Responsibility

Surrounding communities might benefit, too, as cafeteria policies may reach the broader world with messages about what does and does not promote health [4, 5]. For instance, hospitals could recognize local restaurants that offer and promote nutritious food [5]. This could transform the food offered in proximity to a major medical center. Hospital policy can also send a message to the community. With smoking, it was hospitals that started the movement to ban smoking in public spaces [5]. In the food arena, Montefiore Medical Center in New York recently banned sugar-sweetened beverages in cafeterias on all of its campuses [6], sending a very clear message to New York City and the nation as whole that such beverages are not healthy.

Beyond spreading messages of good nutrition, as duly noted by Dr. Morgan, a hospital should ensure that its offerings are beneficial not only for those it serves directly, but for our planet and its inhabitants as a whole.

Doing what is ethical in a global sense—with concern for people, animals, and the planet—may also help an organization best serve its local mission [7]. For a hospital cafeteria, for example, choosing dairy products produced without antibiotics for growth promotion is better for the animals *and* may reduce the problem of emerging infections with multidrug-resistant bacteria for local hospital patients [8]. Choosing food grown regionally may support local farmers and economies, improving the standard of living and health for local patient communities [9]. Ensuring beef comes from cows pastured on vegetation as opposed to those fed unnatural mixes of corn, antibiotics, and offal serves animal and environmental welfare and may improve the nutritional quality and safety of the food for cafeteria consumers [10]. Still, even responsibly raised beef might contribute more to greenhouse gas emissions than other sources of protein like poultry and fish (which in turn contribute more to greenhouse gases than lentils, nuts, beans or grains) [11]. Thus, menu selection can

have an impact on human, animal, and environmental health, and ideally a hospital would do what is ethical for all.

Idealism vs. Pragmatism

From a practical standpoint, an inherent sticking point with the arguments above is that the concepts of "healthy" and "unhealthy" foods are not absolute but relative, contextual, debatable, and ever-evolving. Even within the nutrition community, there is disagreement as to how to categorize various foods [12]. Are 100 percent fruit juices healthy [13, 14]? Are fruits [15]? Eggs [16]? Red meat [10]? What about food constituents like sodium [17]? Cholesterol [16]? Does "organic" make a difference, or the way foods are produced more generally [10]?

In an ideal world, a hospital would focus on providing health-promoting foods. From a practical standpoint it is not clear that "health-promoting" is possible to define precisely, let alone possible for hospitals to provide exclusively. Perhaps focusing on whole, minimally processed foods, produced using ecologically friendly means is a start; foods that nourish individuals, communities, and ecosystems. Admittedly, agreement about what foods those are might vary.

It may be easier to define what foods are unhealthful and have hospital cafeterias focus on not offering those [5]. For instance, there is probably broad agreement that highly processed foods are not health-promoting. Candies and sodas, chips and fries, refined grains, and cured and preserved meats provide some examples. Yet even these foods may not pose as great a risk to one's health as a product like a cigarette does. If they did (and the evidence is emerging in this regard), it would clearly be unethical for hospital cafeterias to sell these foods or to contract with fast-food chains that have such foods as their core offerings.

Current Reality and Where to Go From Here

Unfortunately, foods widely believed to be unhealthful are currently abundant in hospitals, and a substantial number of hospitals have fast-food chains operating their cafeterias [18]. A recent study in California's children's hospitals rated hospital cafeterias on a "healthiness" scale from 0 to 37, where 0 was least healthy and 37 was the healthiest possible; the average score was 19 [19]. The California study did not consider societal or environmental impacts of food. As discussed above, these impacts may be appropriate to include in an overall "healthiness" rating scale.

Such a scale, applied to individual foods, might be one way for hospitals to move forward. That is, until there is broad consensus about what foods are definitively health-promoting or not, hospitals will inevitably have to provide a mix of both "healthier" and somewhat "less-healthy" foods and attempt to distinguish between them. A rating scale could help serve this purpose and allow hospitals to promote the consumption of "healthier" over "less healthy" foods. Such a rating scale is a variation of Dr. Bennett's suggestion for labeling (i.e., to "post the ingredients, calories, and nutritional content"), which would be another option. Other options include selective signage (e.g., promoting "healthier" items only) [20], price

adjustments (charging more for "less-healthy" items, less for "healthier" items) [21], portion modifications (making "less-healthy" items available only in small amounts) [5], and changes in product placement (e.g., positioning "less-healthy" items further from the point of purchase [22]). For instance, at the UCLA hospital cafeteria, simply putting fruit next to the cash register and cookies further away led to an increase in fruit purchases and a decrease in cookie purchases (unpublished data).

Whether cookies make the list of "less-healthy" foods a hospital is willing to provide based on consideration of its mission will be a matter of debate. Regardless, all of the above strategies make use of what economists have termed *asymmetric paternalism* [23], nudging individuals towards healthier behavior without limiting freedom of choice. Such strategies can allow hospitals to maintain ethical integrity as they attempt to navigate the gray areas between choice and responsibility.

References

1. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Correction: actual causes of death in the United States, 2000. *JAMA*. 2005;293(3):293-294.
2. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA*. 2004;291(10):1238-1245.
3. Sahud HB, Binns HJ, Meadow WL, Tanz RR. Marketing fast food: impact of fast food restaurants in children's hospitals. *Pediatrics*. 2006;118(6):2290-2297. http://pediatrics.aappublications.org/content/118/6/2290.long. Accessed March 18, 2013.
4. Cohen DA. Obesity and the built environment: changes in environmental cues cause energy imbalances. *Int J Obes (Lond)*. 2008;32 Suppl 7:S137-142.
5. Lesser LI, Cohen DA, Brook RH. Changing eating habits for the medical profession. *JAMA*. 2012;308(10):983-984.
6. Montefiore president joins Mayor Bloomberg to highlight devastating health impacts of obesity [news release]. New York, NY: Montefiore Medical Center; June 5, 2012. http://www.montefiore.org/body.cfm?id=1738&action=detail&ref=454. Accessed March 18, 2013.
7. Barrett MA, Steven A. Osofsky. One Health: The interdependence of people, other species, and the planet. In: Katz DL, Wild DMG, Elmore JG, Lucan SC, eds. *Jekel's Epidemiology, Biostatistics, Preventive Medicine, and Public Health*. 4th ed. Philadelphia, PA: Elsevier; 2013.
8. Wallinga D. The invisible epidemic: giving voice to the faceless victims of antibiotic overuse, *Think Forward*/Institute for Agriculture and Trade Policy. September 14, 2012. http://www.iatp.org/blog/201209/the-invisible-epidemic-giving-voice-to-the-faceless-victims-of-antibiotic-overuse. Accessed March 18, 2013.
9. Berkenkamp J, Wenzel B. Everyone at the table: local foods and the Farm Bill. *Think Forward*/Institute for Agriculture and Trade Policy. March 28, 2012. http://www.iatp.org/documents/everyone-at-the-table-local-foods-and-the-farm-bill. Accessed March 18, 2013.

10. Lucan SC. That it's red? Or what it was fed/how it was bred? The risk of meat. *Am J Clin Nutr*. 2012;96(2):446.
11. Environmental Working Group. Meat eater's guide to climate change + health. http://www.ewg.org/meateatersguide/at-a-glance-brochure/. Accessed January 3, 2012.
12. Lucan SC. Patients eat food, not food categories or constituents. *Am Fam Physician*. 2011;83(2):107-108.
13. Nicklas T, Kleinman RE, O'Neil CE. Taking into account scientific evidence showing the benefits of 100% fruit juice. *Am J Public Health*. 2012;102(12):e4.
14. Wojcicki JM, Heyman MB. Reducing childhood obesity by eliminating 100% fruit juice. *Am J Public Health*. 2012;102(9):1630-1633.
15. Lucan SC. Fruit-and-vegetable consumption may not be inadequate. *Am J Public Health*. 2012;102(10):e3.
16. Lucan SC. Egg on their faces (probably not in their necks); the yolk of the tenuous cholesterol-to-plaque conclusion. *Atherosclerosis*. 2013;227(1):182-183.
17. Lucan SC. Attempting to reduce sodium intake might do harm and distract from a greater enemy. *Am J Public Health*. 2012;103(2):e3.
18. Lesser LI. Prevalence and type of brand name fast food at academic-affiliated hospitals. *J Am Board Fam Med*. 2006;19(5):526-527.
19. Lesser LI, Hunnes DE, Reyes P, et al. Assessment of food offerings and marketing strategies in the food-service venues at California children's hospitals. *Acad Pediatr*. 2012;12(1):62-67.
20. Thorndike AN, Sonnenberg L, Riis J, Barraclough S, Levy DE. A 2-phase labeling and choice architecture intervention to improve healthy food and beverage choices. *Am J Public Health*. 2012;102(3):527-533.
21. Andreyeva T, Long MW, Brownell KD. The impact of food prices on consumption: a systematic review of research on the price elasticity of demand for food. *Am J Public Health*. 2010;100(2):216-222.
22. Cohen DA, Babey SH. Candy at the cash register--a risk factor for obesity and chronic disease. *N Engl J Med*. 2012;367(15):1381-1383.
23. Loewenstein G, Brennan T, Volpp KG. Asymmetric paternalism to improve health behaviors. *JAMA*. 2007;298(20):2415-2417.

Lenard I. Lesser, MD, MSHS, is a research physician at the Palo Alto Medical Foundation Research Institute in California. He is a practicing family physician and a former Robert Wood Johnson Foundation Clinical Scholar. Dr. Lesser's research focuses on how food marketing affects what people eat.

Sean C. Lucan, MD, MPH, MS, is a public health researcher at Albert Einstein College of Medicine/Montefiore Medical Center, a practicing family physician in the Bronx, and a former Robert Wood Johnson Foundation Clinical Scholar. Dr. Lucan's research focuses on how different aspects of urban food environments may influence what people eat and what the implications are for obesity and chronic diseases, particularly in low-income and minority communities.

Related in VM
The Physician's Role in Nutrition-Related Disorders: From Bystander to Leader, April 2013

Unintended Consequences of Obesity-Targeted Health Policy, April 2013

Health Span Extension through Green Chemoprevention, April 2013

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.