Lunchroom Revolution

Pediatric wards stock chocolate milk and graham crackers. Peanut butter packets give a hundred calories in one bite. Caffeine pills cause less diuresis than coffee.

These “tips,” passed between resident physicians practicing the healing art of medicine, expose a pitiful relationship with food. Health care professionals do not eat at work, they forage. The act of eating is typically quick, efficient, and solitary. Emails and patient charts dominate lunchtime, if such an hour even exists. This dysfunctional dash to prioritize work over biological necessity sacrifices more than just good digestion and an appreciation for the embodied self. It sacrifices community, commensality, and shared integrity.

Whether or not Hippocrates really said, “[Let] food be thy medicine,” it is easy to imagine what the father of modern medicine might have meant if he did.1 In the most basic interpretation, food sustains life. It is strange, then, that a profession devoted to preserving life holds the act of eating in such low regard.

Beyond nourishment, mealtime turns the exclusive and even intimate act of eating into a communal experience. In many cultures, mealtimes are sacrosanct. Preparing and consuming food together enhances reciprocity, cooperation, and social exchange. These cultures eat their food slowly and deliberately; the act of eating is a ritual as nourishing as the food itself. Medicine is not one of these cultures. Yet, now more than ever, it should be.

In a cross-sectional study of firefighters, communal eating—including meal preparation and cleanup in the firehouse kitchen—correlated with improved professional performance.2 A stratified national survey of adults in the United Kingdom found that participants who shared mealtimes reported increased happiness, life satisfaction, and community engagement.3 Strangers who eat the same food score higher on measures of trust, conflict resolution, and cooperative behavior.4 Add these benefits to increased efficiency and job satisfaction associated with lunch breaks at work,5 and it almost seems like medicine is flunking on purpose.

The COVID-19 pandemic deepened existing isolation and depleted financial resources to support communal meals. When restrictions lifted on group gatherings, medical professionals had no gatherings to which they could return. If any food culture existed in medicine before the pandemic, it evaporated exactly when it might have served the greatest need. How much better would everyone feel if they just sat down and ate? Or better yet, ate together? The low-hanging fruit in the fight against pervasive burnout might be actual fruit.

Earlier this year, we made a simple offer to our colleagues: come eat lunch with us. We booked the main conference room, adjacent to the pediatric intensive care unit (PICU) where we work, every Tuesday at noon. The room is private but spacious with a large central table and plentiful chairs. We sent an Outlook invitation to the division: BYOB (bring your own brown bag) to share one meal a week.

There is no agenda for these Tuesday lunches, no lectures, or even formal objectives. The purpose is strictly social, not in a frivolous sense but as a medium for human connection. If we are to trust each other or volunteer to cover shifts when one of us falls ill, or communicate effectively over shared clinical experiences, we must spend meaningful time together separate from the pressures of clinical practice. As a group, our colleagues resuscitate critically ill children together. We should, it seemed, also break bread together.

These shared mealtimes became known as the PICU Lunchroom, a throwback to our days as schoolchildren when lunch was paired with recess and never skipped. Starting from the first scheduled meeting, people gathered. They brought their food from closet-like offices to the comparatively lively conference room, a space separate enough for private discussion but close enough to the PICU to tend to clinical emergencies as needed. The mood was festive despite this proximity to the ICU, imbued with a palpable mix of gratitude and relief.

We talked about the food we ate. One attending and fellow discovered a shared indulgence in matcha green tea KitKats. We passed sections of someone’s sumo orange, comparing its flavor, appearance, and cost with standard navel oranges. At subsequent lunches, colleagues discussed new projects, confessed lingering ambivalence over difficult cases, recommended binge-worthy television shows, and laughed a great deal more than typical during a workday devoted to sick kids. To any casual observer, it might have looked like a normal lunchtime. To us, it looked like a miracle.

We do not know if the PICU Lunchroom has measurably affected performance, trust, or bonding like communal meals among firefighters because these things were not formally studied. We simply figured basic nutrition with a side of commensality must yield only positive effects, and that it’s better to eat together.
than to eat alone, or not to eat at all. And because the PICU Lunchroom does not require financial resources, no one asks us to track the benefits of our wellness intervention to justify ongoing funding. We just keep meeting on Tuesdays for lunch because it seems like the right thing to do.

Over time, we hope the PICU Lunchroom becomes part of a broader culture shift among physicians around how we treat our bodies and each other. We hope students and trainees take note: eating is not a shameful act of self-indulgence. It is a biological, social, and spiritual necessity. For a profession that lectures patients and families about nutrition—eat this much salt, that much fat, this variety of fruits and vegetables—medicine is shockingly bad at nourishing itself. If basic human needs are not met, all other efforts to mitigate burnout, compassion fatigue, and attrition will fail. Like building a house with no foundation, expensive structural investment in workforce integrity will collapse if everyone is hungry. Conversely, successful interventions will prove more durable applied to a workforce already bonded through the simple act of sharing a meal.

Establishing a food culture in medicine need not require large investment in time or even cost money. What it requires instead is a collective respect for the benefits of shared meals and an acceptance that food is necessary for life and community is necessary for living. It also requires a disquieting proportion of moxie. It requires an examination of current practice and the guts to overturn it. If your clinical practice is truly incompatible with a midday meal, you must revolt. Revolt by eating lunch and expecting those around you to do the same. Treat lunchtime as an act of resistance. For mind, body, spirit, and community—for the sake of medicine itself—just eat lunch.

**Conflict of Interest Disclosures:** None reported.