Dietary advice in family medicine 1–3

Chris van Weel

ABSTRACT This article discusses the conceptual basis of dietary advice in family medicine. Given the large number of illnesses and diseases encountered in family practice for which diet and nutrition are relevant interventions, food-related advice is an important part of daily practice. To enhance the effectiveness of diet-related advice and counseling in family practice, it should be linked to the strengths of the family physician: (1) the patient-centered approach, which allows for tailor-made advice; and (2) the continuity of care, which provides the family physician with several contacts over time to present and reinforce advice. From this position, family physicians should approach their patients with advice and counseling in "ready bits" that fit into the time constraints of regular consultations and make sure these bits are consistent over time and address specific individual patients' values and barriers with regard to modification of food habits. Orientation of patients' expressed readiness to change can present a template of patient-centeredness. Primary care nutritional guidelines should in particular acknowledge the strengths of family medicine.

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KEY WORDS Family physician, advice and counseling, patient-centeredness, continuity of care, primary care

Most episodes of illness that receive professional medical treatment are provided by family physicians (FPs; in Europe referred to as general practitioners) (1). Given the findings of the Nijmegen academic research network (Table 1) (2, 3), several of the most common chronic diseases in family practice require advice on diet for prevention and treatment. A conservative estimate is that 1 in 6 consultations in routine practice focuses on diet as a main intervention (2), whereas many more address food-related questions in one way or another. In addition, patients perceive their family doctor as one of the most obvious and reliable resources for information about food (4). This implies that advice on nutrition features prominently on the FP's professional agenda: it can be estimated that each year about 1000 patient-contacts in an average family practice focus on patients' diets and nutritional behavior.

Theoretically, nutritional interventions promise substantial effects in the prevention and treatment of many diseases. However, the extent to which the efficacy can be realized in daily practice (effectiveness) depends on several factors (5). For nutritional advice, the most important factors in the gap between what is possible and what is feasible in daily practice are (1) the appropriateness of the advice, which depends on the practitioner's knowledge and advice-giving skills; (2) the patient's willingness to accept the advice; and (3) the availability of essential support at the place of treatment. In general, FPs have a positive attitude about diet but are discouraged about putting it into effect because of lack of practical support. Dutch and other Northwest European FPs are mainly reimbursed on the basis of a capitation fee that does not take into account specific interventions. Insofar as financial incentives address reimbursement of items of service, dietary advice fares less prominently than, for example, prescriptions, referrals, or surgical procedures.

In the pursuit of effective, efficient dietary advice in primary care, it is particularly important to see how FPs can cope with these challenges and to what extent the strengths of primary care make it a particularly appropriate venue for the provision of nutritional care.

THE PATIENT AND THE ILLNESS

With nutritional advice part and parcel of primary medical care, FPs' approach should be embedded in what they are best at: caring for individual patients, based on an approach that places the health problem in the context of that patient's somatic and psychosocial characteristics. Nutritional advice given this way becomes tuned to the patient's understanding of the importance of changing food habits and the perceived problems and barriers to putting such advice into effect. This way, professional nutritional values can be weighted against the values patients, their families, and their peers attach to nutritional habits.

ENCOUNTERS AS OPPORTUNITIES TO BUILD ON

In sheer numbers of contacts, the amount of nutritional advice may look daunting, in particular with routine consultations restricted to 7–10 min. Therefore, it is important to consider continuity of care in family medicine (6) as a way of coping with the time factor. FPs often encounter in their practice patients they have treated before, and they probably know patients' families (7, 8). Upon these earlier contacts, knowledge about the patients' medical and psychosocial histories is continuously built and updated. To this must be added that continuity of care involves ongoing care for the same health problem. Nutritional advice is particularly relevant for patients with chronic conditions such as obesity, diabetes mellitus, or cardiovascular disease. At least 3–4 encounters annually for the follow-up of these chronic conditions provide 20–30 min a year to present, boost, and modify dietary advice (9). In other words, nutritional counseling should

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be seen not as a single session in which everything has to be taken care of but as a dynamic process that extends over time, in which knowledge of the patient and the disease is constantly updated and more nutritional information can be added.

**PRIMARY CARE IN ACTION: BREAKING NUTRITIONAL ADVICE INTO EASY-TO-MANAGE BITS**

Many practitioners find advising patients about food habits is difficult. The relationship between disease and nutrients, and between nutrients and foods, is complicated and sometimes hard to explain to patients. Moreover, it is not always known what effect advice and counseling will have on patients’ behavior. However, the challenge for FPs with regard to diet can be related to the basic concepts of family medicine (6, 10) when grouped under the following 4 headings:

- **Promoting health by promotion of healthy food.** For most common health problems (Table 1: obesity, diabetes mellitus, or cardiovascular disease), dietary advice should focus on “healthy foods”—both what they are and how much of them to eat. Information about healthy foods and nutrition instructions for patients are easily available in a user-friendly form that can be used in the practice.

- **Cooperation with dietitians.** The FP is a member of a larger health care team. For diseases that require more specific nutritional instructions, practice guidelines can summarize concrete actions (11) and instruction by dietitians is possible. In this way, sufficient expertise is made available for patients who need it and doctors worry less about diet and nutrition advice.

- **Continuity of care: long-term perspective and focus on greatest needs.** Continuity of care enables the FP to break down advice and counseling over successive consultations. This allows the doctor to coach the patient over time to find his or her own way of putting the advice into effect, rather than present the patient with a ready solution. This allows for tailoring of advice to patients’ personal circumstances and for spending due time on the assessment of the likelihood that patients will actually change their nutritional behavior. Simple interventions linked to the “stages of change” model (12) produce promising results in nutritional advice (13).

- **Family medicine: involvement of the family.** A specific aspect of food—and consequently of nutritional advice—is that eating is a social and cultural activity as well as a necessary act. Effective changes in diet are often feasible only when the entire family makes the changes. In this way, the family orientation of family medicine allows for a systems approach rather than individual intervention.

**CONCLUSION**

Nutritional advice is an important aspect of primary care, but unfortunately there is insufficient use of available resources, with practitioners relying mainly on enthusiasm, optimism, and goodwill. The specific characteristics of family medicine offer the promise to enhance effective counseling. But there is reason for concern about the place of nutrition in the guidance of patient care. Disease-specific guidelines have the tendency to focus more on pharmacologic interventions than on diet, because of the perceived quality of the underlying clinical research (14).

What is important is the increasing awareness of multidisciplinary expertise that is available in the field and can strengthen the effectiveness of dietary interventions. Closer interdisciplinary cooperation is not the solution, but it is a good initial goal. It enables the launch of a development agenda of primary care nutrition advice. Three major points feature on this agenda:

- **Transfer of skills and knowledge.** The need for more and better empirical data should not hide the fact that important expertise is already available but could be put to a better use. Education of the professionals who deal with patients’ diets falls into this category. A systematic review of the scientific evidence is also needed.

- **Field studies and clinical trials.** Nutrition is an orphan in the domain of clinical interventions. A systematic evaluation of the effect and limitations of diet-based treatment on major conditions in the community (obesity, diabetes mellitus, cardiovascular disease, chronic obstructive pulmonary disease) would enable a much more targeted application.

- **Paradigm of patient-centeredness.** The most important part of the agenda is the true implementation of patient-centered care, and the multidisciplinary involvement should touch in particular on this. No nutritional intervention is even imaginable without the active involvement of the patient. This is in fact the core truth within primary care today. So even if there are many nutrition ideas in primary care, without patient involvement none of them will work.

This agenda will make it possible to include effective advice and guidance in the broad field of regular family medicine for patients irrespective of their health status or sociocultural/socioeconomic background.

There are no conflicts of interest.

**REFERENCES**

5. Tugwell P, Bennett KJ, Sacket DL, Haynes RB. The measurement-iterative

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**TABLE 1**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Incidence</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td>Hypertension†</td>
<td>3</td>
<td>54</td>
</tr>
<tr>
<td>Obesity‡</td>
<td>2</td>
<td>42</td>
</tr>
<tr>
<td>Chronic ischemic heart disease‡</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>Arthritis of hip or knee‡</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Chronic respiratory disease (asthma, chronic obstructive pulmonary disease)‡</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>Eczema</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>Diabetes mellitus‡</td>
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<td>21</td>
</tr>
<tr>
<td>Hay fever</td>
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<td>18</td>
</tr>
<tr>
<td>Hyperlipidemia‡</td>
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</tr>
<tr>
<td>Psoriasis</td>
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<td>13</td>
</tr>
</tbody>
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†From van Weel (2).
‡Number of new diagnoses per year per 1000.
§Total number of cases (new and already diagnosed) per year per 1000.
*Nutrition-sensitive diseases.*