Creating supportive environments for nutrition guidance: towards a synergy between Primary Care and Public Health

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This supplement of \textit{Family Practice} presents the papers from the Fifth Heelsum International Workshop on Nutritional Attitudes and Practices in General Practice, named after the place in the Netherlands that hosts this tri-annual meeting since 1995. [Throughout we use the terms General Practice/General Practitioner (GP), in accordance with the European terminology. This is approximately equivalent to the terms ‘Family Practice/Family Physician’ and ‘Primary Care’.] The papers are directed to the objectives of the 2007 workshop that have been presented above [van Weel C, Hiddink GJ, van Binsbergen JJ, Brotons C, Drenthen T, Green LW, Halsted CH, Koelen M, Kok FJ, Mathus-Vliegen EMH, Ockhuizen T, Truswell AS. The Fifth International Heelsum Workshop 'more synergy between primary care and public health': Mission Statement].

History of ‘Heelsum’

Heelsum is close to the universities of Wageningen with large Departments of Human Nutrition and of Communication Sciences, and Nijmegen with its Department of General Practice/Family Medicine. The workshops have been built on research collaboration between the two universities. The workshops were initiated because of the importance of diet and eating for the health problems in the community, the fact that general practitioners (GP) were often asked for dietary advice by their patients, but that there was very little evidence to base the practice on ‘Nutrition’ fulfilled the primary care enigma, of what is most common in medical practice has been least studied in biomedical research.\textsuperscript{1} This triggered an exploration of the existing practice and experience, as came forward in the objectives of the first Heelsum Workshop in 1995:\textsuperscript{2}

1. What kinds of nutrition guidance are provided by GPs?
2. What are the nutritional attitudes and beliefs of GPs?
3. What factors determine an active participation of GPs in the nutrition guidance of their patients?

GPs, nutritionists and sociologists with special interest in this topic in research were invited from different countries, as well as the home team from the Netherlands.

By the time of the second Heelsum workshop in 1998,\textsuperscript{3} several facts had been agreed upon:

- GPs are highly trusted by their patients for nutritional advice.
- GPs do not bring nutrition into their interaction with patients as often as they could.
- Barriers were identified: shortage of time, doctors’ lack of detailed knowledge of nutrition and realization that patients find it difficult to change food habits.
- Secondary and tertiary prevention is the main place for nutrition advice in general practice.
- GPs have to distil simplified principles, essentials of dietetics.
- Obesity is difficult to treat.

Patients present a large variety of health problems to general practice, and nutritional advice is often

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relevant for its management. And patients may suffer from more than one disease at the same time (co-morbidity). They also have widely varied interest in and knowledge of nutrition. This implies that there is a need of broad nutritional knowledge and of individual tailoring of advice. The development of evidence-based medicine has been strong, in general practice, and guidelines would be a helpful, but currently underused mechanism to promote nutrition advice. The ‘time-factor’ should be placed in the perspective of continuity of care: patients consult their GP often over longer periods of time, and this allows for building and reinforcement of (nutrition) advice over a number of consultations, rather than a one-off shot. This relates to the structure of health care in different countries. In particular when GPs have a stable, official list of patients and where they are the gatekeepers for specialist medical services, they can get to know their patients and their families better and have more occasions for nutrition advice. A practice nurse or practice assistant can add dietary detail to the GP’s dietary prescription.

As Heelsum workshops met in 2001 and 2004, more research and ideas were presented and discussed. It is only quite recently that personal computers have appeared on the GP’s desk. Though there are genuine concerns that computers distract the GP from concentrating on their patient, computers bring specific information into the consultation at a scale, detail and speed that no other resource technique can. This offers the possibility to present evidence on diet and disease and dietary advice into the consultation, if the software has been prepared and updated by a country’s GP organization. The Internet also has revolutionized access to technical information, and patients can and do use it and become well informed—or confused. In the medical world, evidence-based information has changed practice too. The Heelsum workshops looked at nutrition material in the Cochrane Collaboration in 2001 and in 2004 devoted a half day to bringing general practice’s needs into the Cochrane Collaboration. Following this workshop, a new field of the Cochrane Collaboration on general practice research was initiated by Professor van Binsbergen, one of the core members of the Heelsum group. Since 2007, this has been integrated into the Cochrane Primary Health Care Field, the collaborative of the universities of Auckland, Dublin and Nijmegen.

Overweight and obesity have been increasing everywhere. GPs have not had much success in treating it, and 12 years ago, many doctors tended to look the other way. In the 1998 Heelsum meeting one of the conclusions was ‘overweight is not the fault of the GP’ . ‘The modern epidemic of obesity is not going to go away until the wider society, politics and economics and education give this priority’. This priority has by now appeared in most countries and family doctors can feel part of the wider team when they weigh patients routinely and point out if they have passed the healthy BMI range.

The 2007 Workshop

In this Fifth Heelsum workshop, we had speakers from the Netherlands, Spain, UK, USA, Norway, Italy, Australia, Canada and Iran. There were two main themes in this Fifth workshop reported in the following pages: The interface between public health and individual health care and what should be done and can be done in general practice to deal with overweight and obesity.

Green (page i20) uses a model that is very relevant in this context, of a pipeline to illustrate how small a proportion of the vast amount of biological research reaches the working front of medicine, and Rosser (page i38) has worked in Canada to convert this into a practical form for GPs. Anderson (page i10) reviews the small number of Cochrane reviews on dietary change and/or exercise in treatment of obesity. Nasser et al. (page i60) report on the Cochrane reviews on individual foods and nutritional supplements. They only cover a small range and were often inconclusive. Visentin (page i71) explains why the best evidence for family practice should be based on GPs’ experience; he gives examples of important nutritional research done by a large general practice network in Italy. Brug (page i50) reviews evidence in the socio-psychological literature on factors associated with the behaviours of increased physical activity and/or change of food habits.

At the national level, obesogenic foods are coming under attack. Halsted reports (page i44) criticisms of high fructose corn syrup and Anderson (page i10) reports on the campaign to lower salt in processed foods. National support in a government paper ‘Obesity for health professionals in the Netherlands’ is foreshadowed by Drenthen (page i56) and Anderson (page i10) describes how changes in funding general practice can help increase GPs involvement in obesity. In the work of GPs, Langens et al. (page i75) have found that even in the general practice population, obese children show high levels of abnormalities of blood pressure, glucose tolerance and plasma lipids, compared with normal weight children. As well as the well-known increased prevalence of diabetes and hypertension, van Wayenburg et al. (page i93) used the Continuous Morbidity Register in four Nijmegen general practices and found that several common conditions, like colds and sore shoulders, are presented to the GP more often in obese adults. Hence, for GPs who have lists of registered patients, if there are more obese patients on the list, the doctor is going to have a busier workload. Some cancers are also more common in overweight people (Anderson, page i10).
and Hiddink (page i105) present the first report of a large longitudinal study of Dutch GPs interviewed by questionnaire in 1992 and again in 2007. Fewer GPs now think treating overweight is a waste of time, but GPs concerns of lack of time and doubt over patients’ motivation have increased somewhat.

To help with work in the practice on overweight and obesity, we can only hope for success if we fit any treatment to the individual patients needs, beliefs and problems (Van Weel-Baumgarten, page i67). Software has been developed for use in the practice with overweight patients by the Dutch college of GPs (Drenthen and van Binsbergen (page i56) and in Canada (Rosser, page i38). A Dutch group is developing a minimal intervention strategy (Fransen et al., page i112). In Melbourne, Pomeroy (page i123) found that GPs see themselves, in advising on nutrition, as influencers (mostly) or co-ordinators (with nurses and dieticians) or (less commonly) as diet educators. Worsley—now in Melbourne—reviewed earlier how to improve the impact of nutrition guidance by general physicians: public health versus individual patient? One of the stages in life when people are more receptive to nutrition advice is pregnancy (Szwajcer et al., page i99). We heard again about a successful UK model for obesity management in general practice, called Counterweight (see Frost, page i79). Eighty practices have enrolled in this programme. The whole practice must agree before they join. One of the partners and one of the practice nurses takes a special interest in those obese patients who agree to try treatment. An evidence-based protocol is used and supported by external advisers. It appears from the present paper (page 79) that more practices would join Counterweight if the National Health Service would allocate some specific funding.

Two papers deal with collaboration between public health/health promotion and individual medical care. Koelen et al. (page i25) review the literature on what is needed for successful collaboration. This is followed by the analysis of Jansen et al. of why the ‘Heartbeat’ programme in Maastricht failed (page 32). These two papers deserve careful reading as these are the two first experiences of a concerted public health/primary care approach. Their success and failures will provide most valuable experience for building further coordinated programmes.

Lastly, hardly any other aspect of nutrition has been considered in this Heelsum meeting, with one exception, the other side of the coin. Drenthen and van Binsbergen (page i56) after describing new developments to help manage overweight, in the second half of their paper address the other big nutritional concern for general practitioners—underweight and malnutrition in elderly people.

In summary, this supplement presents an update of nutrition promotion approaches to the prevention and management of disease in the primary care population.

Acknowledgements

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References

4 Van Weel C. Morbidity in family medicine: the potential for individual nutritional counseling, an analysis from the Nijmegen Continuous Morbidity Registration. *Am J Clin Nutr* 1997; 65: 1923S–1932S.