Show them what we can do: are case studies the key to unlocking Primary Care?

Last month, BANT's Science and Education Manager Clare Grundel argued compellingly that Nutritional Therapists should be in NHS Primary Care. But how could this ever come about? **ELEANOR STRANG** has some powerful suggestions about engaging with GPs.

I qualified as a Registered Nutritional Therapist in 2012 and over the years have often heard the words, "We could do with one of you in our GP practice!" as happy clients departed my clinic room. An optimist by nature, I always believed the time would eventually come - it's not rocket science to see that when poor diet and lifestyle choices have induced chronic, non-communicable disease, changes and improvements to that diet and lifestyle can be an effective tool to back-pedal that individual to better health.

It certainly felt like a positive step in the right direction when in April 2015 the General Medical Council (GMC) released guidance to its members confirming that "Doctors can refer patients to practitioners on Accredited Registers".

For those in the nutritional therapy world who had been knocking on the door of primary care, this was a very welcome announcement. Just two years earlier in 2013, BANT had initiated a "GP Engagement" project with 200 NTs dotted around the country writing to their local GPs with a BANT-designed leaflet explaining nutritional therapy, its benefits, and how they as GPs could work together with Nutritional Therapists. With an accruing evidence base showing we could improve patient outcomes in the arena of lifestyle-related chronic disease, we dared to hope that GPs might finally make use of our clinically trained, knowledgeable, evidence-based cohort of practitioners.

In 2017, two years after the GMC announcement, I was contacted by Toby Green of the Royal Society of Public Health, to take part in a group discussion and survey of randomly chosen representatives of accredited CNHC (Complementary and Natural Healthcare Council) practitioners, ostensibly to provide feedback from the Nutritional Therapists' perspective. The title of the resulting booklet was telling: *Untapped Resources: Accredited Registers in the Wider Workforce.* Not inclined to hold back in a discussion of my favourite topic, I soon discovered exactly the same frustrations were being echoed by most of the other contributing disciplines and one of my quotes was illustrated on page 18 (right).

Change in some quarters unfortunately occurs at glacial speed, and the actual number of Registered Nutritional Therapists who currently receive referrals from GPs remains stubbornly low. There are exceptions - and while GP referrals make up a relatively small percentage of my own clients, I have had some return from both writing letters to GPs (keeping them informed of their patients) and sending those in my local area a few case study summaries by way of introduction and *education.* Because don't underestimate this: many GPs have no concept of what we do; they exist in a tightly controlled, rigidly formulaic profession, with clinical guidelines dictated from above.

It's not the direct fault of any GP that they received scant nutrition instruction during their medical training. A recent UK study of 853 medical students and doctors found that more than 70% had received less than two hours nutrition training while at medical school. In the strictly compartmentalised world of mainstream medicine, why would the doctors need to overlap the dietitians? Subsequently, it's hard to engage the services of a Nutritional Therapist, or feel confident referring your patients to one, if you have little understanding of what the therapy involves or what it can achieve.

If you decide to approach Primary Care in your area, first do some research on the staff listed on any practice website. At the risk of being ageist, those who qualified in the last ten years are likely to have a little more knowledge about nutrition than those who qualified back in the '80s and '90s. Also, never pass up an opportunity when any client refers to their GP, to enquire if they think their doctor is "old school" or open and receptive to the use of dietary intervention.

Some GPs might have independently embarked on nutrition or functional medicine training. In his interview in this issue, for example, Michael Ash reports that more than 1200 GPs and about 800 primary care assistants have been through the RCGP-approved basic course on lifestyle medicine he developed with Dr Rangan Chatterjee and other colleagues: it certainly helps to aim an approach through the door of someone who is already interested.

Lessons from the low-carb GP

I'm sure many of you have now read Dr David Unwin's wonderful interview with Simon Martin in *IHCAN*'s August issue, showing how he is transforming the treatment of pre-diabetic and type 2 diabetic patients at his practice in Southport, Merseyside, simply by moving patients towards a low-carb diet, enabling them to come off medication. This is currently saving their drugs budget around £68,000 per year. Easily enough to pay for the services of a Nutritional Therapist within the practice.

It's no coincidence of course that Dr Unwin was aged 55 with retirement looming, when a period of somewhat disappointed - even dissatisfied - reflection on his 40-year medical career prompted him to risk stepping outside convention, when a diabetic patient astonished him by revealing they had achieved remission simply by switching to a low-carb diet. He didn't even know this was possible, but after checking the practice data, he realised he had witnessed an eight-fold increase in diabetes during the 40 years - and that lightbulb moment spurred him to make a right-hand turn and devise an approach that aimed to put type 2 diabetes into remission, rather than "manage it" conventionally with drugs. There was initial opposition from his partners who argued "We do not get paid to do this!" (now that's telling – there are literally no incentives for doctors to do this), but Dr Unwin was now a man on a mission.

It's commonly argued that GPs lack the time and the tools to coach patients in the long-term behavioural and dietary changes necessary to steer them back to drug-free health. But as I stated at the beginning, some of what we do - like advising on a low-carb diet - is not rocket science. And Dr Unwin began by using group coaching, explaining to patients that the "sugariness" of their blood caused circulation problems, and the main food culprits outside of the obvious cakes, biscuits and soft drinks were bread, pasta and white rice. He also achieves this pared-down education within his usual one-to-one, ten-minute consultations, and his practice recently saw the 130th patient who had achieved drug-free remission. His excitement at recently discovering the pleiotropic effects of a low-carb diet on other comorbidities is palpable.

Send GPs concise case study summaries

Clearly there are other chronic health conditions and more complicated patients that require far more consideration, investigation and unpicking using the functional medicine model, that would not be best served by either group coaching or the ten-minute consultation, but it's worth noting what initially roused Dr Unwin's attention: a patient giving a brief account of how a low-carb diet had achieved a desirable clinical outcome - remission from diabetes. And this is why I like to use concise, case study summaries when approaching GPs.

The summary needs to be brief, concise and to the point, stating an anonymous patient's age, sex, health condition and medication (using medical terminology where possible), summarising the protocol and outcome in layman's language without claiming to treat or cure, seeking only to "support" the patient's symptoms, and providing a link to research that shows the evidence base for the protocol.

Each summary need fill no more than half - or two-thirds -of an A4 page. Providing a GP with three or four case studies at most - showing what Nutritional Therapy can achieve - plus your contact details so they can always get in touch if they want more detail, may just whet the appetite.

Your covering letter as per BANT's Toolkit guidelines will provide the necessary security of qualifications, PSA accreditation, and the (government approved) CNHC register etc. Just make sure you bring attention to the enclosed/attached case studies early in the letter. You want to hook their interest by showing them the results we get with chronic lifestyle-related disease - the one area with which mainstream medics struggle to achieve positive outcomes because the drugs they have at their disposal tend to do no more than manage a state of disease rather than achieve wellness or remission.

The one caveat on diabetes cases worth noting, however, is that GP practice nurses have taken on more responsibilities and become significantly more skilled in providing auxiliary services - including dietary advice - to their diabetic patients. They may not be delivering the same message as Dr Unwin, nor achieving his results, but they may not welcome competition. They will also be monitoring long-term conditions like asthma and hypertension, so beware of sounding critical or superior by implication.

Waking them up

Clare Grundel's article last month was a wonderful call to arms, demanding that Primary Care and Clinical Commissioning Groups wake up to the under-used resource of clinically trained Nutritional Therapists. Our evidence-based, functional medicine training is tailor-made to deliver this lifestyle medicine. And ahead of the curve are the patients themselves! Many know they need post-antibiotic gut support to preserve essential intestinal microflora. Many of them know they need specific dietary support on receipt of a diabetes diagnosis or when risk of stroke has been flagged. Few might suspect that nutrient insufficiencies or gut dysbiosis are worth investigating when depression or anxiety comes knocking at the door. So it's worth pointing out that an organic acid urine test can show that what we eat does not always reflect what we have absorbed. That simple fatty acid panel showing omega-3 deficiency and the research supporting its use in depression makes a good linear case study with a positive measurable outcome.

As Clare observed, Nutritional Therapy can be effective at managing "syndrome" conditions which, lacking a clear aetiology, can be challenging for a GP to treat with conventional medicine. Morale in Primary Care is low; they are struggling to meet the rising demand for appointments, while experiencing significant challenges in staff retention. And maybe there is frustration at the realisation that the health concerns they are mostly dealing with require a different sort of intervention. They see chronic lifestyle-related diseases not getting better, the patients aren't "cured", the status quo gets "managed" with polypharmacy, heading down a one-way street. So by focusing your Nutritional Therapy case studies in this area, you just might grab their attention.

So, let's support Clare's rallying call to arms by taking the time to communicate more frequently with our clients' GPs. Let's face it, they could certainly do with some heartening news and support, and the time might be just right to let them know the cavalry is over that brow of the hill, waiting for the call!

• References online at www.-ihcan-mag.com/references.

About the author

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After 12 years of clinical practice, she supports a range of clients who are either referred by medical practitioners or come to her direct. She has a special interest in gut health, optimising digestion, supporting autoimmune conditions, gluten sensitivities and pre-conceptual health/fertility.

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