Are dietitians puzzling?

In the previous issue of the Journal the leading article by Tim Gill, Director of the NSW Centre for Public Health Nutrition, was at odds with the National Heart Foundation’s position statement on dietary fat and overweight/obesity published in the same issue (1,2). The media took up the issue, with headlines of ‘Uproar at claim that fat is not fattening’ (3). ABC radio noted that the document was designed for health professionals, and yet dietitians were ‘puzzling’ amid concerns that people might believe they can eat fat and not put on weight (4). Should dietitians really be puzzling, or is this something they normally deal with in everyday practice?

The situation emphasises the need to categorise a knowledge base carefully. Practitioners in particular need to be clear about how information is formulated and the context in which it is best used. Systems of knowledge management, such as the Cochrane database and the National Health and Medical Research Council (NHMRC) guidelines for the development of clinical practice guidelines (5) are examples of institutionalised responses to this need. There are also economic imperatives. Evidence-based practice is filtering through the system to serve a number of purposes. Food legislation is moving toward the provision of substantiation for health claims on food products (6). All this points to a need for a clear understanding on the type of evidence required for that specific purpose. In practice, dietitians may refer to nutrition principles, practice guidelines, medical nutrition therapy and the nutrition care process. These are all different forms of information and they relate specifically to the type of work that dietitians undertake in specific contexts based on their unique set of attributes. Other health professionals, policy makers and consumers themselves will need information that relates to the type of tasks they have to address in the food and nutrition environment. It really all depends on what you are trying to do.

To work through the apparent maze of directives, it is helpful to begin with definitions. Evidence-based medicine is the application of research knowledge and acceptable clinical data in the process of deciding on treatment (7). Evidence-based Medical Nutrition Therapy (MNT) is the specific application of nutrition knowledge and clinical data in the management of disease (8). This practice refers to Nutrition Recommendations which are a set of comments ranked according to the level of support from the literature, and derived from Nutrition Principles which have resulted from a systematic review of the literature and graded according to the presence of strong or some or limited evidence (8).

It is important to note that the purpose of Nutrition Recommendations is to improve the quality of clinical judgements, not that each individual is given the same advice. Treatment must be set in context, relative to clinical and other data that is available on the patient’s profile. Nutrition Practice Guidelines (NPG) are protocols validated by clinical testing. They define outcome measurements, a timeframe for evaluation of outcomes and guides to decision making. The American Dietetic Association has developed NPGs for the management of diabetes mellitus, hyperlipidemia and chronic kidney disease (non dialysis). In that country, NPGs for diabetes management form important reference material for the receipt of Medicare cover for MNT in diabetes (9).

Medical Nutrition Therapy however, only really covers the clinical area of dietetic practice. A more generic system has recently been published to cover all domains of nutrition care. The Nutrition Care Process and Model (NCP) outlines a systematic problem-solving method for establishing nutrition care in a range of contexts. The process comprises four steps: Assessment, Diagnosis, Intervention and Monitoring/Evaluation for undertaking the task (10). It focusses on the process of action rather than the content and hence equates to standardised processes, not standardised treatments. Long-time community nutritionists will recognise the similarities with Green’s PRECEDE model for an educational and environmental approach to health promotion planning, with components of diagnosis, implementation and evaluation (11). (This was clearly a medical derivative for health promotion, but it played a significant role in moving the health promotion concept forward, and the same may be said of developments within dietetics.)

There are two important points to make here. First, all the above discussion refers to how a defined group of practitioners might best work with an extensive and growing information base. The focus is the practitioner and to this end, it appears these frameworks are acknowledged within their social context. The second point is that statements that do not have the practitioner as the primary target are likely to serve different purposes and be constructed differently. Healthy public policy has many target groups to consider, and refers to an environment far more broad than individual healthcare practice. For example, US agricultural policies may be having a significant impact on that nation’s obesity epidemic (12) which has implications for policy development, but that knowledge is of little help to the practitioner responding to an individual’s request for advice on food choice in their circumstances.

In social research there is an understanding that there are no pure data, only those mediated by practice (13). The way in which knowledge is constructed really has to do with the purpose, not just the outcomes of the exercise. Dietitians (indeed most people) need not ‘puzzle’ over apparently conflicting statements and positions if they understand the difference.

Linda Tapsell PhD APD
Editor, Nutrition & Dietetics
Director, National Centre of Excellence in Functional Foods
University of Wollongong, NSW
References

3. Robotham J. Uproar at claim that fat is not fattening. Sydney Morning Herald 2003 September 22. p.3.