EDITORIAL

Nutrition in primary health care

In the course of a year, most Australians consult a general medical practitioner. Such interactions provide a unique opportunity and responsibility for doctors to engage in the improvement of the nutritionally related health of many individuals.

The general practitioner is regarded by the general public, in various surveys, as the most dependable source of nutrition advice. It is often argued by the critics of contemporary medical practitioners that this is not a well placed view, because of their lack of formal medical training in nutrition. However, the broad base of biomedical and psychosocial training in medicine equips the medical graduate to take on many fields of medical work, including clinical nutrition. What is needed over and above the present curriculum is more knowledge of food; an improved ability to elicit information about food habits and intakes; and the development of the skills necessary to perform a nutritional evaluation at large. These skills can be acquired, as can the skills needed for a neurological or a cardiovascular assessment. A knowledge of food-health relationships and the ability to counsel about nutrition and to arrange nutritional support are also essential.[1]

What is especially valuable in conducting a nutrition assessment and management programme is that non-nutritional contributory factors can be identified and differential diagnoses can have a nutritional perspective without undue distortion. For example, an unfavourable glycaemic profile in a patient with diabetes may be attributable to an unsatisfactory food intake, but may equally, or to a greater extent, be attributable to psychological stress or physical inactivity. Priorities can be assigned accordingly in management. (*Further reading:* Gracey M, et al)

Most medical graduates learn from and enjoy a problem-orientated approach. Once discussion with patients about their food and health is a part of practice and, as long as a spirit of enquiry is maintained, learning proceeds and patients benefit. (*Further reading:* Wahlqvist M L, Vobecky J S.)

Preventive nutrition and nutritional management of ill health are complementary activities in clinical practice. Indeed, people can reasonably expect that doctors will learn prospects for prevention from their experience and enquiry about disease - an opportunity few others ever have.

There need to be better learning opportunities for medical practitioners to fulfil their desire to cover the 'nutrition gap' in their own practice. Short courses are becoming available through the RACGP and University Faculties of Medicine.[2] (Further reading: Truswell; Wahlqvist M L, Strauss B.)

We live in a pluralistic health care system. Public health measures and community development in health (CDIH) (*Further reading:* Community Development in Health) should and will proceed side by side with clinical work in order to improve health. But there may be no more rapid and effective way to favourably influence the way the nation eats than for general practitioners to be the agents of change.

There are some riders. We need an action plan that includes dissemination of information such as the publication of this issue of *Australian Family Physician*. We will need to take account of the age, ethnic, educational, attitudinal and socio-economic diversity in the Australian population. And we will need to provide advice at a time of rapid change in information from food and nutrition science, to say nothing of the major changes taking place in the food supply. Not least, we will need to be increasingly mindful of how the very production, transport, processing and packaging of food affects our environment and, in turn, our health.

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