My response to second allegation

> Allegation 2 : "The patient letter indicates that I dismissed previous evidence based advice given to this patient and provided contradictory advice, resulting in a confused and disgruntled consumer."

My initial response is below, but as that has been deemed unsatisfactory, I will address the specific matters as requested.

> Initial response: As patient confidentiality precludes me from talking about the specifics of this case, I will answer this allegation as best I can in general terms of how I conduct my interviews.
>
> In line with how I conduct my interviews, I would have explained to the client pathways of carbohydrate metabolism and the rationale for regular exercise and to find a level of carbohydrate intake that is suitable to the individual. Also, that this is different for different people and can best be ascertained by trial and error of different regimens.
>
> I should stress that what I explain is the physiological response to carbohydrate intake and the rationale for engaging in regular exercise and monitoring carbohydrate intake.
>
> I then discuss different approaches for carb restriction eg CSIRO Wellbeing diet, limiting carbs to one meal per day, reducing portion sizes of potato/ rice/ pasta etc. In conjunction with a client, an eating plan is then worked out that to be trialed for a short period of usually 1 to 4 weeks. We then discuss the pros and cons of the eating plan at the next visit.

DX advised the client to keep the appointment that she had made with me because, "…it can be useful to gain knowledge from a number of practitioners". She also encouraged the client to return to her after the appointment "…for further support". (I find that a very odd thing to say)

A. Some of the statements made by the client eg that I didn't listen to her nor answer questions, would necessarily come down to her word against mine. I deny completely this misrepresentation and ask that you contact my manager for her opinion as to the likely accuracy of this, ask for copies of Patient Satisfaction Surveys and contact one or two hundred clients and ask whether they found me to be as this client suggests.

B. That I stated "my way was the way to treat diabetes" and drew diagrams that she couldn't understand. I did not say and have never said that my way is the way to treat diabetes. This is a lie. I have been through my explanation of carbohydrate metabolism many times and introduce it by saying," Before we talk about diet, I firstly want to explain what happens when we eat carbohydrate foods". I then write down the list of carb foods as you see on the page provided by DX. I say that starch is made up of glucose units joined together in long chains and the sugars in fruit, table sugar etc consist of single or double sugar units. These sugar units are broken apart and the end result is predominately glucose, which goes into the blood and our BGL rises. I then show how much glucose we get from the breakdown of a slice of bread, 1/3 cup rice etc (see diagram). This explanation is fairly straightforward and the majority of clients are interested in this information and often express surprise that they have never had that explained to them before.
The next thing I explain is that ideally we would like this glucose to go quickly into muscles, where some is put into storage (these are the round dots for glycogen in the muscles on the handout) and the rest is burnt for energy. This is what we'd like to happen but in many people, instead of being burnt for energy, glucose can't get into muscles easily and is diverted to the liver and converted into fat for storage, predominantly around the tummy.

This is the outline of the explanation I provide and I give more information in response to clients' questions, level of understanding etc. From my notes it is clear that the client asked about fruit/ juice and my diagram shows that I said most fructose from fruit bypasses the muscles and goes

directly to the liver and converted into fat (TG). I always say that fruit is a healthy food because of the nutrients it contains, but its sugar content also needs to be considered.

As can be seen at the top of the page, my recommendations are for regular exercise (to improve IS of muscles and the uptake of glucose), Mg as it's required in the cell wall for glucose entry, and less carbohydrate. I would have said, as I always do, that the aim is to find a level of carb that will suit an individual eg in terms of BGLs, Tgs and weight etc.

The next diagram I drew shows the amount of glucose in different breakfast choices. The client's usual breakfast of museli and toast is shown to breakdown to 7 tsp sugar and 2 other lower carb options are provided. At no point here am I recommending any of these options, just giving information about their glucose content and likely effect on BGL.

At the next step I always say that if a lower carb approach is indicated eg because of high PP BGLS, there are different diet approaches that can be considered, including Atkins, having carbs in one-meal per day, CSIRO Wellbeing diet, Dukan etc. I then work with the client to decide which approach would suit them best and that they would like to trial. I do not force a diet on anyone and if they say that they are happy with what they are doing and do not want to change, then that is fine. As is clear from my notes, the CSIRO diet plan was chosen **for a 2 week trial** and then to be evaluated with the client.

At no point did I suggest or recommend having carbs in one meal per day for this client and this is supported by lack of information that I would have provided had this diet approach been the client's choice. I provided info on the CSIRO plan, explaining that it was a lower carb approach in that it restricted starchy carbs and fruit, while ensuring adequate protein for satiety. (refer to my notes)

> Going back to the diagrams that I provided. I have given this explanation hundreds of times. I can present it very simply or with more detail, depending on the client. Invariably they are interested in this information and this is documented in Client Satisfaction Surveys that have been undertaken at [redacted] and could be provided by my manager if requested. I always check on a client's understanding throughout the interview and respond to any questions. I have a very clear memory of the client's reaction in this case because it was very different from the usual. After I had explained the pathways of carb metabolism and the carb content of different breakfasts and likely effect on BGL, the client looked disgruntled rather than interested. I asked if there was a problem and had I explained the processes ok and her response was that she understood what I'd said, but that it was different to what she had been told before. This is in direct contrast to her comment when reporting back to DX that she "could not really understand".

C. The third point that I said she should have carbohydrate once per day is incorrect. I recommended that she trial CSIRO for 2 weeks, went through the handout with her and suggested she get the book from the library if she liked the plan. (Refer to my notes on this). If I had suggested carbs in one meal per day, I would have provided food lists, suggested meals and recipes. I DID NOT.

D. The patient was confused that I told her to have carbs in one meal per day but gave her the CSIRO guideline.

As I never suggested that she have carbs in one meal per day and rather that she trial CSIRO for 2 weeks, the information provided was entirely appropriate and I would not think confusing.

E. That I reiterated that my diet was right for diabetes. There is no "my diet". I explained the effect of carbs on BGLs and the rationale for finding a level of carbohydrate intake to suit an individual. I suggested a 2-week trial of CSIRO, which I wouldn't refer to as "my diet"

F. Question about GI.

That I said to "throw low GI out the window."
This is language that I never use.
My response to questions about GI is that it may play some part in the management of BGLs but that the amount of carbohydrate eaten at meal has the most significant impact on postprandial BGLs.

I believe this to be in line with ADA guidelines, which state under the heading Glycemic Index and Glycemic Load:
Substituting low–glycemic load foods for higher–glycemic load foods may modestly improve glycemic control. c*

The ADA recognizes that education about glycemic index and glycemic load occurs during the development of individualized eating plans for people with diabetes. Some organizations specifically recommend use of low glycemic index diets (124,125). However the literature regarding glycemic index and glycemic load in individuals with diabetes is complex, and it is often difficult to discern the independent effect of fiber compared with that of glycemic index on glycemic control or other outcomes. Further, studies used varying definitions of low and high glycemic index (11,88,126), and glycemic response to a particular food varies among individuals and can also be affected by the overall mixture of foods consumed (11,126).
Some studies did not show improvement with a lower-glycemic index eating pattern; however, several other studies using low-glycemic index eating patterns have demonstrated A1C decreases of -0.2 to -0.5%. However, fiber intake was not consistently controlled, thereby making interpretation of the findings difficult (88,118,119,127). Results on CVD risk measures are mixed with some showing the lowering of total or LDL cholesterol and others showing no significant changes (120).

If a client is challenged by my view that GI can have some effect on BGL, but the major impact is from the amount of carb eaten, then it makes for an interesting discussion. I don't remember a discussion around this with the client.

G. I booked a review appointment for 2 weeks and the client cancelled. That was her prerogative.

H. She wanted to warn the GP of her experience.

The referring GP, as well as many others in [redacted], continue to refer to me because of the approach that I use and the results that their patients have achieved over the last 10 years. If I was rude, obnoxious, dismissive, patronizing and everything else suggested by DX on the basis of one disgruntled client, I would not be booked out in my clinics until Feb 2015 and I assume I would have had numerous complaints made against me. I receive a lot of positive feedback from clients about my professionalism, ability to communicate etc and many have said they would be happy to talk to you if you would like to hear from them.

The second part of this aspect of the complaint is from DX.
I'll address the issues she raises in order.

A. As I have described in detail how I conduct my interviews, I do not believe that I need to address her allegation that my conduct is dogmatic or inflexible etc. If you require more information about my conduct, I suggest you speak to my manager rather than take DX's opinion from one disgruntled client.

B. The CSIRO Wellbeing plan is in line with the newer CSIRO plan for diabetes, as CSIRO states. The plan is suitable for people with diabetes, as it advocates a reduced carbohydrate intake in order to improve glycaemia. That DX has used CSIRO's disclaimer as evidence of the diet's unsuitability, rather than understanding the concept and rationale of the eating plan, shows a disturbing lack of understanding and logic.

C. Another of DX's gripes was that the CSIRO diet is for weight loss and the client didn't need to lose weight because her BMI was 25.2. If in the 2 week trial on the eating plan the client had lost 0.5 to 1 kg, she would still have been in the normal BMI range. The eating plan could then have been adjusted to prevent further weight loss if needed.

D. CSIRO diet and calcium intake. Bone health in older people is reliant on many factors, including intakes of protein, magnesium, calcium, as well as exercise. The CSIRO Wellbeing plan provides for all these.

E. DX says, "The dietary advice is not that of the wider scientific community" and "A low carbohydrate diet is not best practice for diabetes care".
DX obviously is unaware of ADA guidelines, which DAA recommends dietitians follow.

F. "The diet described by the client with carbohydrate once per day……."

DX should have checked her facts, as she is mistaken in what she believes I recommended to the client. If I had recommended carbs in one meal per day, which I clearly did not, it would none-the-less be supported by ADA's guidelines.

G.DX's concern over problems with glycogen stores, potential mobilization of glucose from protein stores resulting in loss of muscle tissue and negative effects on bone health from low carb diets, displays a lack of knowledge of basic physiology and nutritional ketosis. I'm assuming that anyone reading this is not so ignorant and therefore does not expect me to explain the difference between nutritional and starvation ketosis or how the body adapts to a very low carb diet. I would suggest that DX be referred to the work of Prof Steve Phinney or Prof Tim Noakes, both of who are knowledgeable in nutritional ketosis induced by very low carb diets. The ADA have also looked at very low carb diets in the management of type 2 diabetes and support their use.

DX's remaining concerns have already been addressed in the body of my response. It is obvious that the client was disgruntled and clearly did not like the information I provided. It is also obvious that she has misrepresented what I said.

The letter from the client to the complainant I believe indicates a gross misrepresentation of our interview.

I would also like to address specific allegations made in the letter of complaint from the patient to DX.

1. That I do not support what the Diabetic Dietitians say.
   My response to clients who question why my approach may be different to what they have heard or been taught, is that there is not a 'One size fits all ' approach when it comes to managing diabetes. This is in line with ADA guidelines that state, " A variety of eating patterns (combinations of different foods or food groups) are acceptable for the management of diabetes. Personal preferences (e.g., tradition, culture, religion, health beliefs and goals, economics) and metabolic goals should be considered when recommending one eating pattern over another."

   I provide people with information about the possible underlying causes of the disorder, so that they have the knowledge and tools to evaluate different diet approaches and find what works for them.

If a client said to me that they had seen another dietitian and the advice given suited them, I would encourage them to follow that advice. If a client said to me that they had received advice from another dietitian but that they wanted to seek my advice as well, then I would do as I explained above.
I agree with and follow the principle of not a one-size-fits-all approach; therefore I do not denigrate the practices of others. I provide information and encouragement to the client to help them decide which approach best suits them. I suggest that they trial different approaches to inform this decision.

I look forward to hearing your verdict.

Regards, Jennifer