

Starting a Patient on a Low-Fat, Plant-Based Diet

A ten-minute in-office protocol — what to say, what to check, and which medicines will need attention in the first two weeks.

1 · Who this suits

The strongest candidates are patients with type 2 diabetes, pre-diabetes, metabolic syndrome, hypertension or dyslipidemia who are already motivated but have been given only the instruction to “eat better.” It is also reasonable in type 1 diabetes, with closer insulin supervision. Take more care, or defer, with frailty or unintentional weight loss, active eating disorder, pregnancy and breastfeeding, advanced chronic kidney disease, and in anyone whose social circumstances make a change of this size unrealistic this month.

2 · The ten-minute conversation

1 Give the mechanism in one sentence.

“Every time you eat, your body releases insulin — if you eat all day, it never gets to switch off.” Patients act on a mechanism they can repeat back; they rarely act on a food list.

2 Ask how many times a day they eat — not what.

Count eating occasions, including drinks with milk or sugar. Most patients are surprised by their own answer, and the number is the intervention.

3 Change one variable, not five.

Either the *plate* (half vegetables, quarter whole grains, quarter legumes) or the *timing* (two meals, earlier, nothing between). Starting with both is the most common reason this fails in week one.

4 Hand over the patient sheet and book the follow-up before they leave.

A date in the diary does more for adherence than any additional explanation. Two weeks is the right first interval if medication is involved.

3 · Baseline, before they start

- Weight, waist circumference, blood pressure
- HbA_{1c}; fasting glucose (± fasting insulin)
- Full lipid profile
- Vitamin B₁₂ and 25-OH vitamin D
- Full blood count and ferritin
- TSH
- Renal function and electrolytes if on a diuretic, ACE inhibitor or ARB
- A written list of every current medicine and dose

THE POINT MOST OFTEN MISSED

This diet works quickly enough that it changes drug requirements **before it changes the next set of blood results**. Insulin requirement can fall within days. If medication is not reviewed at the start, the first sign that the diet is working may be a hypoglycemic episode or a postural fall. Treat the medication review on the next page as part of prescribing the diet, not as follow-up.

4 · Medication watch-list for the first two weeks

MEDICINE	WHAT CHANGES	PRACTICAL STEP
Insulin (type 1 and type 2)	Requirement commonly falls, sometimes within days.	Agree a reduction plan up front, increase monitoring for two weeks, confirm they can recognize and treat a hypo.
Sulfonylureas, glinides	Highest hypoglycemia risk of the oral agents here.	Consider reducing or stopping at the outset rather than reacting to an episode.
Metformin	Little hypoglycemia risk on its own.	Usually continued unchanged. Warn that a large rise in fiber can unsettle the gut early on.
SGLT2 inhibitors	Euglycemic ketoacidosis risk rises if carbohydrate intake drops sharply or a fasting window lengthens fast.	This is a high-carbohydrate diet, so the risk sits with over-restriction — keep intake adequate and be cautious about adding extended fasting.
Antihypertensives, diuretics	Blood pressure often falls, especially alongside lower sodium.	Warn about postural symptoms; review dose at two to four weeks.
Warfarin	Vitamin K intake rises with green vegetables.	Ask for <i>consistency</i> , not avoidance, and bring the INR check forward.
Levothyroxine	Absorption is affected by soy and a simultaneous high-fiber load.	Keep the usual dosing interval away from food; recheck TSH if soy intake changes a lot.
Statins, lipid-lowering	LDL-C typically falls.	No immediate change; repeat lipids at twelve weeks before reconsidering.

5 · Supplementation

Vitamin B₁₂ is not optional on a fully plant-based diet — daily oral cyanocobalamin or a larger weekly dose, per local practice. Vitamin D by level and season; iodine if iodised salt is not used; iron and long-chain omega-3 only on a measured reason. Say plainly that B₁₂ is permanent — it is the commonest omission.

6 · Follow-up

- **Week 2 — phone or message, no appointment.** Hypoglycemia, postural symptoms, medication doses, and whether they actually started.
- **Week 6 — short appointment.** Weight, blood pressure, and what is getting in the way in practice.
- **Week 12 — appointment with repeat labs.** HbA_{1c}, lipids, B₁₂; formal decision on deprescribing.

7 · What to give the patient

The one-page *2-Meal Reset* handout is made to be photocopied and given out at the end of this conversation. Its QR code opens a free seven-day email plan — daily structure between appointments, at no further work to you.



All three clinician resources

hanakahleova.com/doctors

Patient handout, evidence summary and this protocol — free to download, print and share. No registration.