

PROCEEDINGS OF THE NUTRITION SOCIETY

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SYMPOSIUM ON 'NUTRITION IN HOSPITALS'

The role of dietitians in hospitals

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Dietetics can be described as the practical interpretation of the scientific principles of nutrition in health and in disease. The work done in hospitals by dietitians varies considerably from country to country, but this paper will be confined to hospitals in the United Kingdom.

Courses in dietetics

Current training courses are as follows:

Degree	4 years	} including 1 year of practical experience including 6 months of practical experience
Diploma	3 or 4 years	
Post-graduate Diploma	1½ years	

The courses are frequently under review to ensure that those qualifying have the knowledge and skills required to fulfil the changing role of the dietitian. By 1984, it is planned that all courses should lead to a degree.

Duties of the hospital dietitian

The work of dietitians in hospitals can be divided into four main categories, namely, (1) advisory, (2) educational, (3) therapeutic, and (4) research and investigation.

Advisory role

Close co-operation between the catering manager, catering officer and dietitian is essential, since they all have complementary functions. Areas of liaison are outlined in the circular HM(71)82 D.H.S.S. Function of Dietitians and Organization of Hospital Dietetic Services. These areas include (1) planning of menus to ensure that nutritionally balanced meals are available for all patients, and where there is a choice of meals, that most diets can be selected from the range of food provided, (2) methods and timing of cooking to ensure retention of nutrients

and (3) assessment of new foodstuffs e.g. the potential and limitation of textured vegetable proteins in large scale catering.

Decisions must take into account the availability and calibre of the cooks and the finance available; these are the main problems of most catering managers.

Different types of hospitals have their own problems of nutrition. In long-stay and geriatric hospitals the patients' well being can be improved and the cost of laxatives prescribed can be considerably reduced if adequate dietary fibre is provided. A very soft or liquid diet must be nutritionally adequate and, since it is not usually possible for the patient to consume enough at mealtimes, supplementary drinks must be provided between meals. The dietitian will provide advice of this sort to psychiatric hospitals, where she may also be asked to assist in the treatment of anorexia nervosa. This is a situation fraught with difficulties, as the patient will often be delighted to discuss food in great detail with someone whom he or she considers has the same intense degree of interest in the subject. The psychiatrist, nurses and dietitian must have a closely integrated team-approach to such patients; the dietitian's responsibility is to ensure that all food offered is of good nutrient value in small bulk and to help the patient develop a more normal attitude to meals.

In day-care centres for the elderly which are attached to hospitals, the occupational therapist often has obese or diabetic patients among those whose kitchen practice she is encouraging and assessing, so suitable recipes must be provided and informal talks given, or discussions led, by the dietitian. Distant small hospitals which cannot be visited by a dietitian should be provided with up-to-date diet sheets, recipes and information on new foods which will be of use to them. A two-way advisory system should exist between dietitians working in hospitals and those in the community. As the latter become more numerous, they will take over the liaison with health visitors, and so provide advice to pregnant women, and information on the feeding of babies, infants and children. This advice is often supplied by a hospital dietitian at present.

Educational role

There is no formal training for diet cooks, although the Scottish Health Service Catering School run two one-week courses for those in post. Thus, the dietitian must ensure that the designated cook and all others who will make special diets are taught what to do and know why they are asked to make some apparently strange dishes. The skilled diet cook, who is kept informed of the progress of individual patients, can achieve a high level of job satisfaction. Assistant and trainee cooks can be taught by working with the diet cook, but dietitians should give tutorials to add to the basic diet therapy which they learn at their training colleges. Trainee catering managers usually spend a few weeks in a dietetic department.

Student nurses are required to have 6 h of applied dietetics in their training, and this should be given by a dietitian. We must all accept the fact that many young nurses are not in the least interested in food and find great difficulty relating their lectures, which are given early in their training, to the care of their patients. One

way of kindling their interest is to ensure that the nursing tutors are well informed regarding the practical application of nutrition in hospitals so that they can relate it to the total care of the patient in their tutorials. These tutors are usually very receptive to the offer of guidance in reading matter, assessment of commercially available aids, and occasional 'brush-up your nutrition and/or dietetics' talks from a practising dietitian. Nursing colleges which train pupil nurses are not obliged to ask dietitians to assist in the training, but are usually glad to accept the offer of help. This is probably best done on an informal group basis, using known patients as teaching models, rather than in the classroom situation. Many hospitals now have in-service nursing education departments whose personnel are to be cultivated to ensure that they have a good grasp of nutrition and hospital dietetics. When this is done, dietitians are asked to contribute to the in-service education of all grades of trained staff, and to the basic training of auxiliaries. Clinical nursing tutors are now becoming more numerous, and it is they who ensure that student and pupil nurses can translate theory into practice. It is often only at this level that nurses begin to grasp the need for a good working knowledge of dietetics, so the clinical tutor must be kept aware of current dietary treatments.

The Dietitian's Board of the Council for Professions Supplementary to Medicine approves dietetic departments in which students can be based for their practical experience. In addition, the students spend 4 weeks in a smaller department the organization of which is essentially different from the base hospital, and where the experience gained can be complementary, thereby providing an all-round range of work.

Is the nutrition of animals considerably more important than that of the human race? If not, why then does it form an important subject in the training of veterinary surgeons, but is only taught in haphazard fashion in Medical Schools. Sweden has recognized this deficiency and has created four chairs of nutrition within medical faculties, and as a result there is a much greater awareness of the relationships between nutrition and morbidity and there are more integrated approaches to produce solutions. Dietitians in teaching hospitals give a few lectures to medical students and may participate in symposia and tutorials for both students and post-graduates, but this is only a drop in the ocean compared to the real need. Many dietitians make the mistake of assuming that if their help is not requested in particular wards or departments, they have probably little to offer there. They would do well to remember the deficiency in nutritional knowledge of many physicians and surgeons, and set about remedying the situation. This is not an easy undertaking. Surgeons are particularly difficult to locate as they move between operating theatre and out-patient clinics, but meetings must be arranged. The effective dietitian must have her own public relations system to keep medical staff informed of new dietary treatments and suitable foods, but most important of all, must prove her worth by being seen to contribute to the total treatment of the patient.

Most of the teaching done by dietitians in the past has been on a 'one-to-one' basis. There is no doubt that this practise remains essential for those patients and

their relations who require detailed individual advice on the more complicated diets, such as are required in advanced renal disease, but the effectiveness of such teaching with many obese or mildly diabetic patients must be in doubt if we are to judge by results. Some dietitians provide advisory courses for groups of out-patients with similar dietary problems and they can assist health visitors to do the same for obese subjects. The most effective courses run for only a limited number of sessions as their purpose is to motivate, to inform and to provide the patient with a chance to show that he or she can cope at home. The dietitian must beware of dependent patients who wish to use her as a regular 'confessional' rather than accept responsibility for their own food intake and thus for the treatment.

Dietitians put themselves in the position of being judged by the lay public according to the standard of their printed diet sheets, booklets and other informative literature which are widely read by the patients' family and friends. Such information must be clear and unambiguous, yet sufficiently comprehensive to cover most of the dietary queries which may arise at home. The aid of clinical psychologists can be enlisted to advise on layout and wording of dietary information and thus heighten and maintain motivation. To teach efficiently, dietitians must be competent in the use of all available teaching aids and be aware of the relative merits and limitations of each.

Therapeutic role

Therapeutic diets can be considered as (1) essential, (2) prophylactic and (3) palliative.

Some of the conditions in which diet is an *essential* part of treatment are as follows: (i) inborn errors of metabolism, (ii) gluten-sensitive enteropathy, (iii) malabsorption, (iv) advanced renal failure and dialysis, (v) diabetes, (vi) tube feeding and (vii) nutrition of the debilitated surgical patient.

This paper cannot be concerned with the intricacies of diet required to treat these conditions. Dietitians work closely with medical staff in the treatment of conditions (i) to (v). Once dietary treatment has been established and seen to be effective, contact is maintained with the patient by regular out-patient appointments, by monitoring results of relevant blood analyses and by referring him for medical supervision should the need become apparent. Close ties often develop between the dietitian and the patient and their families, particularly if the patient is a child. This contact is important because the concept of an altered food intake as essential treatment is a very difficult one to grasp and a continuous close supportive relationship can do much to reassure the family. Among these groups, patients have formed themselves into associations such as the Coeliac Society, the Diabetic Association, Parents of Diabetic Children and the Renal Dialysis Association. Dietitians, whose particular interest lies with any of these groups, are usually active participants who give further support and education.

The inclusion of (v) and (vi) in the category of essential diets might be questioned. The experienced dietitian will take into account such factors as degree and type of trauma, blood chemistry, temporary renal impairment, associated drug

therapy and standard of available nursing care before providing the required nutrients and programme of administration. There are still many surgical wards where maladministration of tube feeds can significantly worsen the patient's condition by producing diarrhoea with consequent electrolyte imbalance and even malnutrition.

The term 'hospital starvation' which is jokingly used by the obese patient, is more true of the state of those with progressive carcinoma, multiple trauma, or who have had part of their digestive tract removed. It is well known that patients with severe burns have massively increased nutrient requirements and need skilled balance of fluid and electrolytes. Most burns-units have the services of a dietitian, but few dietitians play an active part in the surgical ward team where they could do much to prevent post-operative malnutrition and its consequences of increased morbidity and susceptibility to infection. The skilled dietitian can weigh the problems posed by reduced or selective absorptive capacity, the presence of fistulae, extreme physical weakness and many other relevant factors, and institute suitable oral intake. In some units she must exercise her judgement as to when her aid is required, or run the risk of being asked for help too late to be of much use to the patient, and thus apparently be seen to fail. Combined intravenous and oral intake, or oral and nasogastric intake mean that each form of feeding must be carefully monitored to complement the other.

Prophylactic diets are required in the treatment of obesity, hyperlipaemia and atherosclerosis. Before instruction, the patient must be well motivated by the dietitian, as the success rate of adherence to the diet can be disappointingly low when no rapid improvements in symptoms are to be seen. The dietitian must continuously up-date her advice to incorporate the increasing variety of suitable foods for each condition; this involves forays into local supermarkets and contact with food manufacturing companies. Supportive out-patient care can coincide with the patient's attendance at the medical or hyperlipaemia clinic, or, in the case of simple obesity, at health centres or community clinics.

Palliative diets are required by patients with such conditions as peptic ulcer, liver failure, diverticular disease, allergic states, cholecystitis, irritable bowel syndrome, and when there are physical problems such as a broken jaw.

The aim is to restore the distressing symptoms of the condition and, when this is successful in hospital, the patients can more easily associate dietary treatment with their own improvement. Dietitians must provide very positive advice for home care as hospital out-patient care will be infrequent if it occurs at all, and some patients who can associate certain foods with their symptoms, can develop bizarre eating habits which can lead to malnutrition. The exceptions are radiotherapy where problems of nausea or impaired absorption occur only during and shortly after treatment, and physical feeding problems such as a broken mandible, when adequate advice on fluid feeding will maintain nutrition.

Research and investigation

Some dietitians are employed solely or mainly in metabolic units where they

plan and provide carefully calculated and weighed food intakes, and in many instances do some of the laboratory analysis required in the investigations.

Their work in maternity, psychiatric or teaching hospitals or in research units requires a high degree of patience and attention to meticulous detail. Dietary histories are taken routinely by most dietitians in order to establish a baseline for dietary advice to individual patients. More detailed investigations can act as an aid to diagnosis, as in cases of anaemia, liver damage and allergy. Assessment of efficiency of some drugs can be aided by the careful monitoring or regulation of food intake of in-patients or out-patients; such trials are becoming more frequent as more becomes known about drug-nutrient interactions.

There is a rapid expansion in the range of foods produced for specific dietary treatment. Many of these have been formulated in consultation with practising dietitians, who later test the product and advise on the production of descriptive literature. There are, however, many other proprietary foods the formulation of which is not ideal or which taste simply awful, and advertising leaflets can be geared more to sales expediency than to delineating clear limits of use. Thus most dietetic departments do test the usefulness of new products in relation to nutrient content, cost, convenience, taste and potential usage. Research and investigation must form part of the work of any profession, so those aspects mentioned here can only give a glimpse of the range of work currently undertaken by dietitians.

So many different roles have been shown to be the responsibility of dietitians in hospitals, that it must be apparent that no one person could possibly fulfil all, or even half of them. Specialization has become essential in the teaching hospitals, and the British Dietetic Association has recognized this by aiding the formation of four groups, for dietitians whose work is mainly in the field of paediatrics, renal dialysis, metabolic work or community nutrition. These groups act as sources of information, available to all dietitians, and for the exchange of knowledge between specialist members. These are times of change in Scotland. The first few appointments of District Dietitians have been made, whose responsibility lies in providing a dietary service to both hospital and community. One outcome of this should be an increase in dietary advisory services in health centres, leaving the hospital out-patient clinics to deal only with the more complicated dietary problems. In the long term, perhaps a more widespread knowledge of good preventive nutrition might even reduce the incidence of obesity-related conditions which require hospital care, but that, as they say, is another story!

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