King Edward's Hospital Fund for London

MEMORANDUM

on

THE SHORTAGE OF DIETITIANS

For consideration by hospitals

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FOREWORD

In 1957 the Catering and Diet Committee of King Edward's Hospital Fund for London felt that there was a pressing need for an enquiry into the present state of diet therapy in hospitals and the effect on it of the acute shortage of dietitians. Accordingly they referred these questions to a working party under their Chairman, Dr. F. Avery Jones. Enquiries were made from and discussions were held with various interested parties including doctors, dietitians, the Ministry of Health and the Royal College of Nursing. The findings of this working party are reproduced in the first part of the Memorandum.

Concurrently an investigation was undertaken jointly by the Fund and the Ministry of Health into the present work of dietitians within the hospital service. The report on this joint investigation forms Part II of the Memorandum.

SHORTAGE OF DIETITIANS IN THE HOSPITAL SERVICE

1. INTRODUCTION:

A dietitian is needed in a general hospital if patients are to benefit from present day knowledge of nutrition. She is required to provide low salt diets necessary in the treatment of cardiac and hepatic disease, to arrange diets for dyspeptics, for diabetics and for those who are over and under weight. A few diagnostic tests requiring the strict control of diet, also call for her services and it seems likely that she will be more and more concerned with diet in the treatment of atheroma and certain types of heart disease. On the preventive side of medicine she is concerned with advising pregnant women and mothers of young children on correct feeding, with teaching diabetics and other patients who need to continue dietary care at home and with helping the elderly to plan and budget for their meals. She helps to instruct the nurses in the basis of proper feeding in health and disease and can make a valuable contribution in ensuring a balanced dietary when she is allowed to review the general hospital menus with the catering officer.

Unfortunately to-day only a minority of hospitals can provide a full dietetic service. The subject is not entirely neglected as interested ward sisters, doctors and catering officers may help but there is no doubt that under the present arrangements many patients do not get the full benefit of modern nutritional knowledge.

2. HISTORICAL NOTE:

The first dietitians in this country were trained in America, where training schools were in being as long ago as 1925. About this time special diet kitchens were opened at St. Thomas's, St. Bartholomew's, University College Hospital and the Infirmaries at Edinburgh and Glasgow and all these accepted nurses and science graduates for training. Later special courses were arranged for them and for students with certain domestic science qualifications at the Glasgow and West of Scotland College of Domestic Science, at King's College of Household and Social Science and, in 1942, at the Royal College of Nursing.

Many of the diseases which these first dietitians helped to treat can be treated more easily now by drugs or the diets have since been much simplified, as in the management of bleeding peptic ulcers. On the other hand the principles of dietetic treatment of diabetes have stood the test of time and certain other dietetic regimes based on scientific fact, such as the gluten-free diet for coeliac disease, have been introduced. Furthermore, the link between a good nutritional state and speed of recovery, especially after burns and surgery, has been established.

The concept of the dietitian has changed out of all recognition since the early days when she was tied to the kitchen, weighing pieces of food or grinding raw liver for patients with pernicious anaemia. She is now regarded, not only as one who is concerned with therapeutic diets but also as an adviser and as a teacher. ([1] : [2]). As a teacher she explains to patients the management of their diets at home and she lectures or demonstrates to nurses. As an advisor she uses her special knowledge to " advise on those aspects of catering calling for special knowledge of nutritional requirements in health and disease ".

3. NUMBER OF DIETITIANS REQUIRED :

According to information supplied by the statistical branch of the Ministry of Health and the British Dietetic Association in 1956, 207 dietitians were employed in England and Wales.

There is no agreed standard for the number of dietitians required in the hospital service although two informed guesses have been made. The report on Medical Auxiliaries suggests that " ideally there should be a dietitian for each 150 beds in hospital " ([1]), which at that time (1951) meant that 1,500 dietitians were required. Two years previously, i.e., 1949, there were only 139 dietitians employed in hospitals in England and Wales.

The Planning Committee of the Nutrition Society (English Group) in their Memorandum of 1945 suggest that " every hospital of about 150 beds or more should have a qualified dietitian "—" each hospital of about 500 beds or more would require a number of junior dietitians as well as a senior one ". On the basis of one dietitian per 150 bedded hospital and over, about 300 dietitians would be required in non-teaching general hospitals. This takes no account of the needs of small hospitals or of junior dietitians for 500+ bedded hospitals and for specialist or teaching hospitals for which at least another 200 could be added making a total of 500.

An assessment of the need also can be made on the number of acute beds. In general hospitals it is usual to find that between 10 and 15 patients in every 100 require dietary treatment. The approximate number of general beds in non-teaching hospitals in England and Wales is 183,000. In Provincial teaching hospitals it is approximately 11,300 and in London teaching hospitals 13,300

([1]) Reports of the Committees on Medical Auxiliaries. Cmd. 8188.

([2]) Third Memorandum on Hospital Diet, King Edward's Hospital Fund for London.

a total of 207,600. Hence about 20,700 patients (i.e., 10%) require dietary treatment. By taking an arbitary figure of one dietitian per 30 diets and ignoring questions of relief for off duty, it seems that about 700 dietitians are required in England and Wales alone.

4. PRESENT STUDY :

The attention of the Catering and Diet Committee was first focused on this problem in 1957. Since the publication of the Fund's Second Memorandum in 1945 great progress has been made in implementing recommendations to set up separate hospital catering departments and as a consequence marked improvements in hospital catering have been made. Improvements in the therapeutic dietary service have not, however, kept pace with improvements in general catering. When the concept of a catering department divorced from nursing staff was originally put forward it was envisaged that the caterer should either be a dietitian or should have expert advice from one. As it has turned out, however, there are so few dietitians that the majority of hospitals are without dietetic advice. In England and Wales 180 of 238 H.M.Cs. with general hospitals are without dietitians and only 58 employ one or more.

In order to study the problem further, the Catering and Diet Committee of the Fund set up a sub-committee under the chairmanship of Dr. Avery Jones to consider arrangements for providing special diets and giving dietary advice in hospitals. The sub-committee has interviewed reprensentatives of the British Dietetic Association, the Royal College of Nursing and the Ministry of Health, and has sent letters asking for information to 60 physicians in one Metropolitan Region. It has also arranged to undertake a joint investigation with the Ministry of Health to discover the work which dietitians are doing in hospitals and what, if anything, hampers them in this work. (The findings of the investigation are the subject of Part II of this report.)

5. OBSERVATIONS made by the SUB-COMMITTEE :

(a) Figures provided by the Ministry of Health and the B.D.A. revealed to the sub-committee the following position :-

In fourteen regions in England and Wales in H.M.C. hospitals there were in 1956 :

15 part-time 72 full-time	therapeutic dietitians and 8 caterer/dietitians	Total 95

In Provincial and London Teaching hospitals there were:

106 full-time } therapeutic dietitians
2 part-time } and 4 caterer/dietitians Total 112

Thus on the lowest estimate of dietitians (500) the hospital service had about 40% of those required and on the highest (1,500) only 13%. Whichever estimate is taken the position is serious in that a necessary modern service is so grossly under strength.

Both doctors and administrators who vainly try to fill long-standing vacancies are acutely aware of the shortage. Many hospitals have ceased to advertise after inserting costly advertisements to which no replies are received whilst others are hesitant to set up a diet department, knowing the difficulties of appointing a dietitian to take charge.

In addition to the overall shortage there is disparity between teaching and non-teaching hospitals and between Metropolitan and other regions. Thus teaching hospitals employ 54% of the dietitians in England and Wales and the four Metropolitan Regions employ 58% of dietitians (Metropolitan teaching hospitals included).

(b) Replies to letters of enquiry sent to general hospital physicians in the North West Metropolitan Regional Hospital Board showed that dietitians were working in only a small minority of the hospitals and even some 600-bedded hospitals were without any dietetic assistance. This was regarded by the physicians as a very unsatisfactory state of affairs. The following are some representative comments:—

(1) "It is quite impossible to get a satisfactory diet arranged for medical cases."

(2) "We have a great need of a dietitian and I propose to start a diabetic clinic when we can find one."

(3) "I feel that a dietitian in this hospital is very necessary. We manage surprisingly well, all things considered, without one but a really rigid sodium restriction diet is difficult to obtain without expert advice and facilities."

(4) "We would very much welcome a part-time dietitian."

(5) "Because we were unable to obtain dietitians, the post was lost to the staff establishment as an economy measure."

(6) We have never been able to recruit dietitians to maintain our establishment."

6. REASONS FOR THE SHORTAGE:

There are two aspects of the problem of shortage: firstly, the

recruitment and training of the required number of dietitians and secondly the retention of the services of those who are already qualified.

(a) Recruitment and Training

Many professions and trades compete for the intelligent school-leaver. Dietetics except to the few with a sense of vocation has few immediate attractions. The training is long and the educational standard specified for entry is high, yet these are met in hospitals by comparatively poor financial rewards and conditions of employment.

The British Dietetic Association has done much to stimulate recruitment; ten thousand leaflets on training and prospects have been distributed through Youth Employment Officers; a panel of speakers gives talks to school-leavers and visits to dietetic departments are arranged. Yet the number of students in training has risen hardly at all during the past few years. Also since 1949 the overall number of dietitians in the service has increased only from 139 to 207, a very small rise indeed when the total extra number needed amounts to hundreds,

There are two ways of training as a dietitian either by taking a preliminary training of at least 3 years followed by a dietetic diploma course of 15-18 months or by taking a dietetic course of 4 years' duration. In the former case the preliminary qualification consists of one of the following: a degree in pure science, household science or nutrition: domestic science teachers' Diploma: Institutional Management Diploma: a specified catering training or State Registration in nursing. The 15-18-month dietetic Diploma course which follows includes a period of 6 months' practical work in a diet kitchen. Most would-be dietitians train in this way and from start to finish the course takes $4\frac{1}{2}$ years.

Since the war the second method of qualifying has been introduced at Dublin and Battersea Colleges of Technology (Advanced) respectively where four-year courses in dietetics have been introduced. Few students, however, have so far qualified in this way in England. In certain circumstances the course at Battersea can be reduced to 3 years.

The disadvantages of the first method of qualifying, apart from its length, are difficulties encountered in obtaining grants for the second part of the training. Further, at the completion of the first 3 years the student is qualified to take a well paid post. In many cases she can command more salary as a teacher in a domestic science or technical training college or in catering than she can as a therapeutic dietitian. The one advantage of the two-part courses is that the shorter second part offers a quick means of training for those who hold the necessary preliminary qualifications.

(b) Retention of dietitians within the service

Dietitians' salaries have an effect on their recruitment, on their remaining in the service and on their deployment among the hospitals. In examining salaries it is not enough to compare them with other medical auxiliaries. They should be compared rather with what dietitians and potential dietitians can command outside. As stated already, hospital dietitians' salaries are not as good as those of teachers nor do they compare well with rates paid in industry, the school meals service or the higher civil service grades. In this connection, it is interesting to note that according to the British Dietetic Association at least half their working members are employed outside the Health Service and more leave it annually.

Salaries are based on the number of assistants employed in the department, hence senior posts are confined to very few hospitals (mostly teaching) in which 3 or more assistants are employed. This salary grading is likely to be one of the causes of unequal distribution of dietitians between teaching and non-teaching hospitals.

Hours of work and week-end duties, which might be expected to deter dietitians from entering or remaining in the service apparently are not so important as the comparatively low level of salaries. On the other hand professional standing, working conditions and the scope of work offered by the hospital are all important determining factors and it is clear that insufficient thought has been given to these in many hospitals.

PROFESSIONAL STANDING AND CONDITIONS:

The overall shortage of dietitians is made worse because they are concentrated in comparatively few hospitals. The joint survey undertaken by the Ministry of Health and King Edward's Hospital Fund has thrown some light on the factors which hamper dietitians in their work and which may therefore be expected to discourage them from working in some hospitals or even in the hospital service at all.

These factors are:—

(1) the interest or indifference of the medical staff;

(2) the scope and variety of work offered by the hospital;

(3) the status afforded;

(4) kitchen and working conditions generally, including accommodation and equipment;

(5) assistance from kitchen, catering and nursing staffs.

The deciding factor in the success or failure of the dietitian's work is the doctor. The dietitian as a medical auxiliary looks

to the doctor, not only as the source of her work, but also for guidance and encouragement. In many hospitals the dietitian is accepted as part of the medical nursing team, she goes on ward rounds, is a member of case consultation committees and can regularly see the doctor to discuss patients' dietetic treatment. In some hospitals, however, and especially in those for which a dietetic department is a new venture, the dietitian's services are rarely requested and she finds herself relegated to providing routine diets. With so many interesting posts available, enthusiastic and highly trained people are unlikely to remain in hospitals which offer them little scope or encouragement.

It was found in the survey that teaching hospitals on the whole offered greater variety of work than non-teaching. Dietitians were called on to help more out-patients, to take a more active part in treatment, to give more lectures and demonstrations to a greater variety of people. The hospitals did not differ in their treatments nor yet in the types of patient treated but rather it was found that, in general, doctors in teaching hospitals were more aware of diet as a therapeutic agent. Hospitals soon become known for the scope and variety of their work and those which are recognised as dull find difficulty in retaining or replacing dietitians.

The status accorded dietitians follows the importance which is attributed to their work and to some extent status also depends on the length of time the department has been established. In new departments there is often a lack of understanding of the dietitian's duties which may lead to a failure to employ her to the best advantage.

Accommodation offered by hospitals was found to vary greatly. Some have spacious and well-equipped diet kitchens or bays in the main kitchen, accommodation for the dietitian to interview patients and do office work and changing room for diet kitchen staff. On the other hand some dietitians were unable to obtain, after many months, even so much as a desk or filing cabinet in a shared office.

By its very nature the dietitian's work is dependent in large measure on the good will and co-operation of the matron and the catering officer and their respective staff. In many hospitals however there is a lack of interest and understanding on the part of both the catering and the nursing staffs. Regrettable though this is, it is not surprising since the catering officers are frequently chosen for their experience of commercial catering, which seldom includes a knowledge of nutrition or even an appreciation of its importance in hospital catering. Nurses, too, tend to lose interest in the nutritional and therapeutic aspect of patients' feeding since they have ceased to be responsible for the catering.

RECOMMENDATIONS

1. Training

(a) Future shorter courses

The length of a course of training for dietitians should be shortened to 3 years and such a course should be designed especially for them. By careful pruning of unnecessary material in the existing two part courses, it should be possible to cover the ground in 3 years or less without lowering the standards of final qualification. The six months' practical training in a diet kitchen need not be part of this course but rather should form a part of a year's paid internship at a recognised hospital. The student would not qualify for inclusion on a register until the successful completion of this year, which would be spent in studying and gaining practical experience in all aspects of hospital dietary. Internes should be paid at a trainee rate for this fourth year.

(b) Existing two part courses

Although two part courses should be replaced gradually by the proposed three-year dietetic course, there will be a place for some time yet for short courses for those who have completed the preliminary qualifications.

In such courses the six months' practical work, which is spent in a hospital diet department, should demonstrate not only elaborate methods of assembling and serving diets as may be needed in teaching hospitals, but also simpler methods more suited to H.M.C. and single-handed hospital departments.

To assist students to train as dietitians, grants should be made by Local Education Authorities to cover the whole training or in some cases the second part of the training. Also the Ministry of Health could offer secondment to suitably qualified people within the hospital service.

2. Registration

There should be a nationally recognised certificate or diploma in dietetics. At present each College sets its own standard and whilst the British Dietetic Association keeps a watchful eye on training, it has no power to demand a standard. A national standard of examination is an essential for state registration and this is long overdue. Until dietitians are registered medical auxiliaries their status in the Health Service will not be equal to that of nurses or similar registered bodies.

3. Professional Standing and Conditions of Work

If a hospital requires the services of a dietitian then it must

accord her the professional standing and scope of work which her training and capabilities demand. It is suggested that the Medical Staff Committee could nominate one of its members to assist the dietitian partly in co-ordinating her work and partly in clearing initial administrative problems. This latter is especially necessary in hospitals where no dietitian has been appointed before.

Separate accommodation for the dietitian is essential and the amount will depend on the type of service envisaged. The least is a properly equipped office where patients may be interviewed, diets calculated, menus planned and medical literature studied. Dietitians with responsibility for feeding in-patients will require either a bay within the main kitchen area with space for day-to-day storage and refrigeration, or a completely separate diet kitchen with storage and refrigeration and with cloakroom accommodation for diet kitchen staff.

The decision to build a diet kitchen or diet bay is one for the hospital authorities to make, bearing in mind the accommodation available, the size of the main kitchen and the fact that it is more economical for the catering and diet departments to share food trolleys, central storage and refrigeration space and central preparation. This sharing is easier to attain when the two departments are adjacent. In many Regional hospitals a diet bay in the main kitchen is a more practical proposition than a separate diet kitchen.

It is recommended that the dietitian should work in the out-patient department, and that the patients should be referred to her by the consultant for dietary instruction when necessary.

4. Salaries

Salaries need further reviewing. Dietitians are scarce and there is evidence of a drift from the hospital service; therefore to recruit more people and to encourage those in the service to remain, higher salaries need to be offered.

More dietitians are required in the provinces as the figures quoted previously show, and more are needed to work single-handed or in group posts. Hence the policy of giving London weighting and of paying the highest salaries to those with the most assistants defeats any attempt at redeployment.

An alternative basis for salaries is difficult to suggest but salaries could be based on the number of acute beds. The demand for special diets comes from these patients and it is usual to find a flourishing out-patient department in a general hospital. By this means a group post or one in a large hospital would command a higher salary than a small or single handed department.

5. Group posts and part time workers

Posts in which the dietitian's services are shared between two or more hospitals in the group are to be encouraged both as a means of helping the present shortage and as a further development. Group posts afford the experienced dietitian with new and challenging opportunities.

Part-time posts are useful either for small hospitals where there is insufficient work for a full-time person, or for two or three part-time dietitians together to cover a full-time appointment.

6. Training of other hospital staff in Nutrition

Both to assist in the wider appreciation of the dietitian's work and to help with further improvements of hospital catering, the study of nutrition should form part of the training of all nursing and senior catering staff. At many hospitals the mechanics of catering have reached a high order, but further necessary improvements especially in patient's feeding can be achieved only by the real understanding and practice of nutritional principles. The study of invalid diets, cookery and dietetics is at present a part of the nurse's training but much of it is often out of date. It would seem unnecessary as well as out-moded for nurses to learn about making beef tea, barley-water, etc., and it is urged that their nutrition and dietetic instruction be geared to modern requirements and modern knowledge.

Ideally, nurses in training should have a period of practical work in the hospital diet kitchen. Only a small proportion of nurses are able to do so however, and to off set this refresher courses in therapeutic diets for medical ward sisters should be encouraged. Indeed King Edward's Hospital Fund has already offered one such course after consultation with the Royal College of Nursing.

Catering Officer's training should also contain the elements of nutritional principles. There is some evidence that where patients' dietaries are well planned there is less need and less call for " special " diets.

CONCLUSION

The dietitian makes an important contribution to the medical service of a modern hospital.

The present acute shortage of dietitians calls for a review of their training, conditions of work and salary. It will be solved only when it is recognised that the problem exists and a co-ordinated effort is made to solve it by the Ministry of Health, the British Dietetic Association and the Medical Profession.

PART II.

INVESTIGATION INTO THE WORK OF THERAPEUTIC DIETITIANS

Joint survey undertaken by the Ministry of Health and King Edward's Hospital Fund

INTRODUCTION:

It has long been realised that there is a shortage of dietitians in the hospital service. This shortage is reflected in complaints by doctors and hospital authorities unable to fill long standing vacancies; by repeated enquiries from hospitals to the British Dietetic Association and by the fact that well established departments are now finding difficulty—some for the first time—in attracting and retaining trained staff. That the position is unlikely to improve is shown by the fact that entrance to the profession has kept at a fairly steady pace since the war, yet the number in the hospital service actually fell in 1957-1958. This is partly accounted for by wastage through marriage but it is noteworthy that, according to the British Dietetic Association, more and more dietitians each year are taking non-hospital posts mainly in teaching, the school meals service and in industry.

In addition to the overall shortage there is an uneven distribution of dietitians both between hospitals and Regions. Of the estimated 195 therapeutic dietitians employed in England and Wales, 56% are employed in the Metropolitan regions and 44% in other regions in England and Wales. Moreover 58% of dietitians in London and the Provinces are working in teaching hospitals, compared with 42% in non-teaching hospitals. Other questions, unanswered until the present time, include the use which is being made of part-time dietitians, the value of shared posts and the extent to which the duties outlined in the Reports of the Committee on Supply and Demand, Training and Qualifications of Dietitians in the National Health Service[1] (commonly known as the "Cope Committee Report") are in fact carried out. (See later for the Committee's conclusions.)

To throw light on these problems, two investigators, with the sanction of appropriate committees and departments of the Ministry of Health and King Edward's Hospital Fund, undertook a joint survey into the work of therapeutic dietitians. (Although caterer/dietitians were employed at some of the hospitals visited the study was concerned with therapeutic dietitians only).

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[1] Reports of the Committees on Medical Auxiliaries. Cmd. 8188.

AIMS OF THE STUDY:

To discover:

(i) Precisely what work is carried out by therapeutic dietitians in hospitals and how far it conforms with the conclusions of the Cope Committee Report*.

(ii) How effectively dietitians are employed.

(iii) What, if anything, hampers them in their work.

***Cope Committee Report — Conclusions:**

" . . . Trained dietitians are needed in hospitals to undertake inter alia, the following duties:—

(1) The preparation of special diets in hospitals according to doctors' prescriptions.

(2) The giving of advice concerning the nutritive value of hospital diets to those caterers who have no special training in nutrition.

(3) The giving of advice to out-patients and of lectures and demonstration to nurses, student dietitians and medical students, on the subject of therapeutic and normal diets."

Whilst making these investigations possible reasons for the shortage of dietitians emerged and are commented upon.

SAMPLE AND METHODS:

Dietitians are employed in 72 hospital groups and to obtain a representative sample it was decided to visit one-third of these. As just over half the departments† are in the Metropolitan Regions and half in the remaining Regions of England and Wales, 13 departments in the Metropolitan hospital regions were chosen and 11 in other Regions. It was hoped to match hospitals in these two areas but owing to the individual diversity of departments it was impracticable to do so.

The sample finally chosen was as follows:—

6 teaching hospitals (3 Metropolitan, 3 in other Regions referred to in tables and in the text as T.H.A., T.H.B., T.H.C., T.H.D., T.H.E., T.H.F.)

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† Diet department means here the unit in which the dietitian and her staff, if any, work.

6 non-teaching, single hospital departments with 2 or more dietitians (2 Metropolitan, 4 other Regions, G. H.; O. P. R. S.).

5 non-teaching, single hospital departments with one dietitian (4 Metropolitan, 1 in another Region, I. J. K. L.; Q.).

5 non-teaching departments covering more than one hospital (2 Metropolitan, 3 in other Regions, T. U.; V. W. X.).

2 non-teaching departments staffed by part-time staff (2 Metropolitan, M. and N.).

The sample includes 2 hospitals, teaching hospital T.H.F. and general hospital L in which the catering was in the hands of a caterer/dietitian and the therapeutic dietitian was on her staff.

At each hospital visited the work undertaken by the dietitians and other staff employed in the dietary department was seen in progress and the facilities of the department were observed. By reference to records and by discussion with senior medical, dietetic, nursing and administrative staff, an assessment of the scale and scope of the work was noted.

TABLE I

DISTRIBUTION, WITHIN THE SAMPLE, OF GRADES OF DIETITIANS IN TEACHING AND NON-TEACHING HOSPITALS, METROPOLITAN AND OTHER REGIONS OF ENGLAND & WALES

HOSPITALS	Dietitian Caterer	Asst. Dt. Caterer	Chief Dietitian Grade I	Chief Dietitian Grade II	Deputy Chief	Senior Dietitian	Therapeutic Dietitian	TOTAL
TEACHING Metropolitan Regions 3	–	–	1	2	2	–	12	17
Other Regions 3	1	2	–	1	1	1	10	16
NON-TEACHING Metropolitan Regions 10	1	–	–	–	–	8+3 P.T.	1 (Vacancies 2+1 P.T.)	13
Other Regions 8	–	–	–	–	–	6+2 P.T.	4+1 P.T.	13
	2	2	1	3	3	15+5 P.T.	27+1 P.T. (Vacancies 2+1 P.T.)	59

Note.—P.T.=Part Time.

FINDINGS:

1: NUMBER OF DIETITIANS EMPLOYED

In the 24 hospitals visited a total of 59 dietitians was employed (including 4 dietitian/caterers or assistants) and there were 3 vacancies. (For the distribution between the types of hospitals see Table 1 opposite.) From this table it can be seen that 33 dietitians (average 5.5/hospital) were employed in 6 teaching hospital groups and 26 in 18 non-teaching hospital groups (average 1.4/hospital). The uneven distribution commented on in the introduction is thus reflected in the sample. The table also shows that higher grades of therapeutic dietitians, which attract the higher salaries are found only in the teaching hospitals.

2: SCOPE AND SCALE OF THE WORK

As assessment of the scope and the scale of a department's work must take into account not only the number of in-patients for whom diets are prepared, but also the type of diet supplied, e.g., metabolic diets demand a high degree of accuracy and require much more attention from the dietitians themselves than any other type of diet. Account must also be taken of whether diets are prepared completely or only partially in the diet department; the number of out-patients seen and the extent of teaching and advisory work undertaken.

Table II on page 18 shows the number of in-patients and metabolic diets served daily, the number of out-patients seen per month and the total staff in each department. It shows wide differences in the amount of work undertaken by the different departments: thus the number of in-patients regarded as requiring dietary treatment varied from 2.8 to 40 per hundred beds; only the teaching hospitals regularly prepared metabolic diets; the number of out-patients seen per month varied from 4 to 800. Further, these differences cannot be related to the number or grades of staff employed. For example, H and O are comparable in number of beds and staff employed, yet at H 120 in-patients are served daily and 50 out-patients seen per month, whereas at O, 150-160 in-patients are served daily and 212 out-patients seen per month. T.H.A. and T.H.B. are similar in bed complement and work performed, yet the former employs approximately twice as many staff as the latter.

TABLE II

SCOPE AND SCALE OF WORK: NUMBER AND GRADES OF STAFF EMPLOYED IN THE 24 DEPARTMENTS INVESTIGATED

Hospital	No. Beds	Total Diets Figures in Parentheses "Diets" per 100 Beds	Metabolic Diets	No. Out-Patients/ Month	Dietitians	Cooks and Assistants	Other Staff	Nurses, etc.
T.H.A.	722	108-140 (17)	5–9	223	8	8	7	
T.H.B.	789	117 (15)	2–3	132	4	5	2	
T.H.C.	686	70 (10)	6	800	5	3 & 1 P.T.	2	2 nurses
T.H.D.	675	160–195 (26)	2–3	225	4	6	1 P.T. Porter 6	3 nurses 4 nursing cadets
T.H.E.	600	83 (14)	2	280	4 and some services of asst. d/c.	5	5 1 P.T.	I.M.A. Students
T.H.F.	638	50–55 (8)	1–2	80–100	3 and some services of d/c.	2	2 4 P.T.	6 nurses
G ...	460	70 (15)	Few	140–280	2	3	3	
H ...	509	120 (24)	Few	50	2	3	2	
I ...	1060	30 (2.8)	Few	40–50	1	2	1	
J ...	200	40–50 (25)	Nil	125–130	1	3	2	
K ...	974	200 (20)	Nil	50	1	4	1	
L ...	660	120 (18)	Nil	36 (clinics at 3 hpls.)	1	No special staff allocated to diets only. Under Caterer/ Dietitian		
M ...	502	80–100 (20)	Nil	10–15	2 P.T. = 1 F.T.	4	4 P.T.	
N ...	378	70 (18)	Nil	80	1 P.T. 4 Sessions	2 1 P.T. and some assist. from main kitchen	1 P.T.	
O ...	500	150–160 (31)	Nil	212	2	2	2	

Ast. D.C. = Assistant dietitian/caterer.

D.C. = Dietitian/caterer.

TABLE II—continued

P ...	320	80–100 (28)	Nil	4	2	2	1	2 nursing cadets intermittent
Q ...	441	66 (15)	Nil	107	1	1 2 P.T. relief		
R ...	636	73 (11)	Few	100	3	2	2	4 nursing cadets
S ...	408	35–40 (8)	Few	36	1 1 P.T.	2	1	2 nursing cadets
GROUP T 1	243	90–100 (40)	Nil	26)		1		Plus help from main kitchen
2	170	50 (29)	Nil	40)	1 shared by 3 hospitals in Group	1	1	
3	150	60 (40)	Nil	13				
GROUP U 4	700	180 (25)	Few	Nil	1 shared by 3 hospitals in Group	Relief plus 2	2	
5	513	170 (33)	Nil	Few			2 P.T.	
6	254	36 (15)	Few	105				
GROUP V 7	180	35	Few	Total for Group 82	1 shared by 8 hospitals in Group	No separate staff		
8	—	60	Nil					
GROUP W 9	189	50–60 (29)	Nil	Total in 2 Hospitals 100	1 shared between 2 hospitals	1 1 relief	2 P.T.	1 P.T. nursing cadet
10	194	30–40 (18)	Nil			1 1 relief	2 P.T.	
GROUP X 11	No separate responsibility for in-patient work		Nil	130	1 P.T. shared by 4 hospitals	No separate staff		

The marked difference between hospitals in the number of patients requiring special diets, on further investigation proved to be false. It was not so much the number of patients needing diet which varied as the hospitals' concept of a "special diet". In some hospitals the term included non-therapeutic diets such as vegetarian and those imposed by religious tabus, all gastric and light diets (i.e., convalescent as well as strict first stages), whereas in others it was only metabolic and therapeutic diets which were considered to be within the province of the diet kitchen.

If non-therapeutic diets are excluded from total "diets" it will be seen from diagram Ib that the majority of hospitals come within the range of 8-12 diets per hundred beds. In contrast, if the hospitals' definition of diet is accepted, diagram 1a shows the wide divergence in the number of patients who are regarded as needing spcial treatment from the diet kitchen.

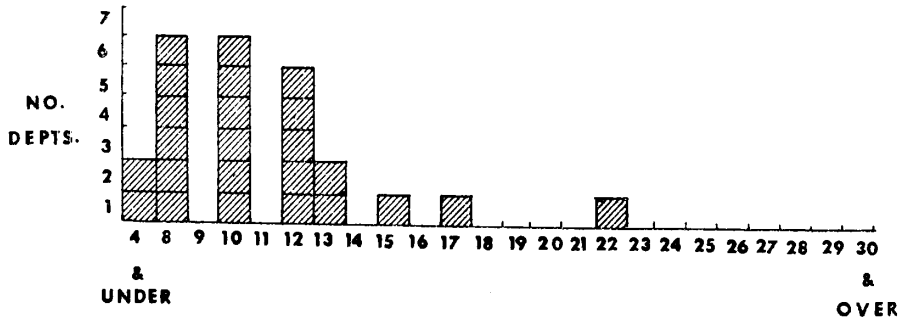
DIAGRAM 1A

Diets catered for by diet departments per 100 beds.

Diets/100 beds.

DIAGRAM 1B

Diets excluding convalescent gastric, light and non therapeutic per 100 beds.



Diets/100 beds.

In some instances the numbers fed from the diet kitchen were inflated because patients needing only light food were ordered "gastric diets". This was done by both doctors and sisters, because meals from the main kitchen for light diets were unsuitable in some way.

The total number of diets served was also influenced by the methods of ordering both initially and subsequent daily requisitioning. Satisfactory control of initial orders was exercised in most hospitals as orders were only accepted if signed by a doctor. Notification of discontinuance was usually the responsibility of the nursing staff and was not so well controlled. As a result food continued to be supplied unnecessarily and patients were discharged without instructions as to how to manage their diets at home.

3. COPE COMMITTEE REPORT

Conclusion (1)

"Preparation of special diets in hospitals according to doctors' prescriptions."

In one hospital group visited the dietitian was appointed to advise out-patients only but in all others she was engaged in some degree in preparing diets according to doctors' prescriptions.

(a) Methods of Preparation:

In order to provide diets prescribed by doctors, the correct food must reach the individual patient for whom it is intended and it must do so in an appetising condition. In the hospitals investigated four main ways were used to achieve this object and from observations elsewhere these are known to be typical:—

(i) the most usual, found in 18 of the 24 hospitals visited, was for the diet department to provide part of the diet and for the nursing staff to serve the meals and to provide the remainder of the diet, i.e., beverages, bread, butter, cake, jam, etc. The food from the diet kitchen was weighed and/or served in individual portions for some diets or several portions together for others;

(ii) in one hospital visited (hospital I) all food was supplied in individual portions and much of it in weighed and wrapped portions (i.e., bread and butter) from the diet kitchen. It is interesting to note that in this hospital only 30 diets out of a total of over 1,000 beds were supplied; 40-50 out-patients seen per month and the dietitian had no teaching or advisory duties;

(iii) in four hospitals (T.H.D., T.H.E., N and R) the therapeutic diets were set up on trays for each patient and delivered by the diet kitchen staff to the wards. N was a special case as the diet kitchen was in the medical block adjacent to the wards;

(iv) in one other hospital (T.H.A.) the tray service was taken a stage further and all meals were delivered to the patients' bedside by the dietitians, thus relieving nursing staff of all responsibility for the patients' food.

Each of these methods imposed progressively greater demands upon the diet kitchen staff and especially on the dietitians, which meant that either more staff were employed or less work per number of staff employed was accomplished. Yet the simple systems seemed to give satisfactory results. An advantage of the more simple systems was that the diets did not take so long to assemble, hence food was not kept hot so long and did not dry or lose its palatability before reaching the patient. With some systems there was a delay of 1½–2 hours between the commencement of service and the patients' reception of the diet.

It was found that complicated methods of assembling and delivering food were used more in departments where student dietitians were trained and in discussion with dietitians in other departments it seemed that they had, in many cases, adopted systems in use in their training departments without attempting to evolve a less elaborate method, more suited to the needs of their hospital.

The following were noted as being important in achieving good results with a saving of time and hence to some extent staff :

(a) equipment, particularly that used in serving and distributing meals;
(b) methods of labelling containers and compiling kitchen work-sheets;
(c) the degree of co-operation between the diet and main kitchens.

(a) Some equipment involved the use of four or five containers for each patient, into which food was served in the kitchen and from which it was transferred in the ward. Other departments had evolved systems which reduced the number of containers to a minimum, e.g., plates or Pyrex dishes which could be served direct to the patient. The saving of time during service in the kitchen and on the ward and the reduction in washing-up was thus very material.

(b) Even more time was saved by developing a system of labelling, which not only ensured correct delivery but also involved the least amount of clerical work.

The labelling procedure varied considerably in the different departments, e.g., in some cases one tray per patient was marked with the ward and patient's name only, while in others each item was labelled separately with ward, patient's name, and diagnosis

and contents of the dish. In many cases the system necessitated this work being done by the dietitians themselves, while other departments so organised their work that food could be simply marked by the cooks whilst service was in progress. The time spent in writing labels and work sheets in the different departments was difficult to assess accurately but it apparently varied from a few minutes to 2½ hours or more daily.

(c) The majority of diet kitchens worked entirely independently of the main kitchen, separate menus were followed and all food was prepared and cooked independently. A few departments co-operated to the extent that the main kitchens peeled vegetables for the diet kitchens and in one or two main kitchens items of cooked food such as milk pudding for gastric diets, were prepared along with that for general diets. Co-operation was achieved more easily when the diet kitchen adjoined the main kitchen and when the dietitian based her menus on those of the catering officer.

(b) Place of Preparation: the diet kitchen

Each of the six teaching hospitals visited had a diet kitchen which in five were stated to be adequate in area and equipment, kitchen floor areas ranged from 320 - 1,134 sq. ft. Storage and office accommodation were satisfactory although the siting of these was not always convenient in relation to the kitchen. All three London teaching hospitals had separate metabolic kitchens but the provincial ones had not. The one provincial teaching hospital at which the diet kitchen was reported as too small would have been adequate if metabolic work could have been done in a separate kitchen. In each of the provincial teaching hospitals the need for a metabolic kitchen was stressed both by the medical staff and the dietitians.

Very few metabolic investigations were carried out in non-teaching hospitals but whether this was owing to lack of facilities or because they were deemed unnecessary did not emerge from this study. Of the 18 non-teaching hospitals visited none had metabolic units and 14 had separate diet kitchens. Only two of these were judged adequate in size and equipment for the work undertaken. One other would have been adequate for therapeutic diets only but was overloaded with convalescent gastric, light and non-therapeutic diets (H). Some, however, were grossly inadequate in size; an area below 200 sq. ft. was a common finding and there was one of 99 and another of 40 sq. ft. In the last-named 60 diets had to be prepared and as there was no window there was neither direct ventilation nor natural lighting.

Some kitchens gave the impression of having been equipped with cast-off and disused equipment which was unsuitable in capacity, either being too large to cook for the comparatively

small quantities, or of domestic capacity and hence too small. Some kitchens lacked liquidisers or hot cupboards, sinks or equally essential equipment.

Storage, too, was commonly reported to be inadequate and food stores including perishables, tended to be kept in cupboards and on shelves within the perimeter of the kitchen.

The general standard of the diet kitchens both regarding area and suitability of equipment was found to be markedly lower in non-teaching hospitals than in teaching hospitals and may be a factor in deterring dietitians from entering or remaining in the former.

In four groups there was no separate diet kitchen. Two groups did not require one, as the work was satisfactorily organised in the main kitchen (at one of these a dieitian/caterer was in charge of general catering). In two other groups a separate kitchen was desired, in one because the diet work was done in the private patients' ward kitchen and in the other because the diet department shared the nurses' home kitchen. Both were far from the main kitchen, stores, trolley park and main hospital block.

It is interesting to note that the majority of dietitians stated that they preferred a separate diet kitchen. The catering officers seen were of the same opinion and also stressed that the two kitchens should be near together so that common use could be made of main stores and trolley park.

3. COPE COMMITTEE REPORT

Conclusion (2)

" Giving of advice concerning the nutritive value of hospital diets to those caterers who have no special training in nutrition."

In half the hospital groups visited dietitians advised the catering officers on nutritional matters; at two of the remaining 12, dietitians were in charge of the catering, and in 10 no advice was given. Advice ranged from informal verbal comment to systematic scrutiny of all menus or to assistance with their planning. Where the dietitian's advice was sought, she normally attended catering committees but did not do so in the other hospitals.

Where the dietitian was not expected to advise, opinions were divided as to the practicability and desirability of such an innovation. Medical and administrative staff felt that difficulties would arise if one officer were to attempt to advise another. On the other hand, many matrons and some doctors stated that they would welcome advice to the catering department on patients' feeding and a common complaint was the inadequacy and unsuitability of

patients' menus, especially for those who are very ill. In two groups visited doctors stated that they would like regular dietary surveys carried out which might well help to initiate advice to the catering department where none had existed before.

3. COPE COMMITTEE REPORT

Conclusion (3)

"The giving of advice to out-patients and of lectures and demonstrations to nurses, student dietitians and medical students, on the subject of therapeutic and normal diets."

(a) Out-patients

Dietitians in all the hospitals visited advised out-patients but Table II (pages 18 and 19) which shows the number of out-patients seen per month, does not give an entirely accurate picture of the work done in the various departments. The figures relate to total attendances and an attendance may involve anything from a few minutes spent in re-weighing a patient up to half-an-hour or more spent in taking a dietary history or in giving a detailed instruction in diet to a new patient. But this does not wholly explain differences between hospitals of similar type, size and dietetic staff. The chief reason for these differences appeared to be the interest taken by consultant medical staff and their senior registrars. Many consultants, especially in provincial hospitals, were unused to working with well established diet departments and were unaware of the help dietitians can give in explaining and adapting therapeutic diets to the needs of individual patients. Consultants did not seek such help of their own accord and the deadlock could be broken only by the enterprise and initiative of the dietitian, convinced of the value of her work, or by the appointment of a registrar, fresh from a teaching hospital and used to the services of a dietitian. Once the dietitian had "proved her worth" doctors began to refer appropriate patients as a routine matter.

Other hospitals made extensive and interesting use of their dietitians, for example, in one Northern provincial hospital, the consultant in the diabetic clinic was assisted by a dietitian and a health visitor, working as a team; the health visitor was employed solely for work with diabetics and continued the physician's and dietitian's teaching in the patients' own home. Frequent visits were necessary, but as a result it was almost unknown for a diabetic to be admitted to hospital except for complications. Many other diabetic specialists were of the opinion that expensive hospital beds might be saved and patients progress more favourably if they were stabilised as out-patients. Again in the department of one consultant on dental disease the dietitian gave advice on correct feeding to mothers of pre-school children with dental caries, the advice

being based in each case on diet histories. This had resulted in a marked reduction in the spread of the condition and the consultant was convinced that advice for one child affected the dietary pattern of other children in the family and was therefore of considerable preventive value. He stated that he could use the services of a dietitian full-time, although at present he had to restrict his requirements to the most urgent cases.

The majority of hospitals visited had adopted some system whereby patients were referred to the dietitian by appointment so that she did not waste time sitting in the out-patient office waiting for patients to arrive.

(b) Teaching

Dietitians in five of the six teaching hospitals regularly gave lectures to nurses in training. This was confined in some cases to lectures in diet in disease but in others, lecture/demonstrations in normal nutrition and invalid cookery were given to students in the Preliminary Training School. The time spent in this work ranged from 40 hours to 233 hours per year.

It was rare to find instruction given to groups other than nurses but in one hospital (where 233 hours per year were spent in formal teaching) lectures were given to medical and dental students and practical teaching for patients was arranged in the diet kitchens, and in another teaching hospital cookery demonstrations were given to mothers attending ante-natal clinics.

In the 18 non-teaching hospitals visited, dietitians in five departments had no teaching duties and of the remaining 13, formal teaching was mainly to nurses in training. One dietitian gave occasional talks to apprentice cooks and two were responsible for nutrition and cookery teaching in the Preliminary Training School. In one department 174–180 hours per year were devoted to teaching and in two others 77 and 65 hours per year respectively were so occupied but in the remainder, the time averaged 16 hours annually (average of 10 hospitals).

4. GROUP OR SHARED POSTS

In five groups visited, the dietitian shared her services between some or all the hospitals in the group. There were essentially three approaches to this problem :

(i) Advice to out-patients; advice to catering and nursing staff regarding in-patient diets but no direct responsibility for patients' food.

(ii) Advice to out-patients; direct responsibility for in-patients' food through staff working in diet kitchen(s) in one or more hospitals.

(iii) Advice mainly to out-patients.

(i) Advice to in-patients and out-patients: Group T

The dietitian visited three general hospitals regularly each week and was occasionally called on by two smaller units (one general and one geriatric hospital). At each of the three hospitals (240, 170 and 150 beds, respectively), she attended two out-patient sessions weekly, gave informal nutritional advice to catering officers and at two of the three she lectured to final year nurses. This work was successfully undertaken and, especially that in out-patient clinics. The latter was appreciated by medical staff who would have liked more of the dietitian's time.

In-patient work was not so successful and was regarded by the dietitian as highly unsatisfactory. On paper the organisation was simple and workable. The dietitian planned menus for therapeutic diets at each of the three hospitals, using the caterer's menus as a basis for her own and thus avoiding unnecessary expense in ordering special foods. Standard diet sheets for use in her absence in wards and kitchens had been agreed with the doctors and she was " on call " for any diet which might need special attention. She regularly visited wards to see both patients and nursing staff. In practise, however, the dietitian judged that the therapeutic dietary service failed on two counts: one of these, being that the menus she planned and the dishes ordered for individuals were often not supplied. The meals actually served were lacking in variety and as a consequence patients were not taught by example how to vary and manage their diets when discharged. Secondly, in one hospital food was badly cooked, was served too early and was spoilt by re-heating. (Suppers were regularly served in the morning or early afternoon to be re-heated later.) The dietitian had no authority in the kitchen and therefore felt that she was unable to insist that her orders were carried out.

(ii) Advisory with responsibility for diet kitchen(s) in one or more hospitals also advice to out-patients: Group U, V and W.

Three groups of this type were visited :

(a) In Group U the dietitian was responsible for the work of a diet kitchen in one hospital and paid regular advisory visits to two other general hospitals. She was also called on rarely by three or four small units in the Group. She was doing valuable work in the Group out-patient centre but out-patients at other hospitals were not seen. She lectured to nurses weekly during their second year and arranged visits to the diet kitchen for nurses in their third year.

The diet kitchen, for which the dietitian was responsible, was well organised, and the standard of food prepared was satisfactory. Cooks, trained by the dietitian, were in charge during her absence

and were reported to be reliable. Two other large general hospitals (700 and 513 beds, respectively) were visited regularly at least once a week. At one, menus for special diets were checked (they were planned by the caterer along with full and light menus) and wards were visited to advise sisters and teach patients as necessary. At the other hospital no therapeutic diet menus were planned and food supplied for diets from the main kitchen was unsatisfactory and unsuitable. In these two hospitals, it was found, as in the case of Group T, that advisory work was limited by lack of authority; where the catering and other staffs were efficient the standard was good but a visiting dietitian was unable to influence greatly an existing poor catering standard.

(b) In Group V the dietitian was responsible for running two diet kitchens in hospitals some distance apart; for out-patient work at both and for teaching different grades of nursing staff at both these and yet one other. In addition, she was available to give dietetic advice to the other eight hospitals in the Group but was rarely requested to do so.

The dietitian divided her time almost equally between the two main hospitals. She attended on days when clinic sessions were held, arriving early in the morning so that any difficulties for the staff in either diet kitchen could be clarified, and she could still see out-patients later. If she was absent, out-patients were given a future appointment.

Both diet kitchens were staffed and run entirely separately from the main kitchens, although in each case a few items of food were obtained ready prepared. One full-time cook was employed at each hospital and there was a part-time relief cook who would work full-time at either hospital in an emergency. The organisation was simple and enabled the cooks to undertake all preparation and service with minimum supervision. During her regular visits the dietitian supervised cooking and service and explained or straightened out difficulties.

(c) The third post of this type (Group W) was in a group of 16 hospitals, 13 in the immediate vicinity of the city and the others many miles away. The Group dietitian had direct control of in-patients' therapeutic diets in one general hospital of 180 beds and a geriatric hospital of 259 beds, which were on the same site. There were no diet kitchens at either and the diets were prepared by the dietitian's staff in the nurses' home kitchen and main kitchen respectively. In a general hospital of 222 beds and a general and a maternity hospital of 150 beds, she planned the menus for therapeutic diets and visited once a week to see the catering officer, to check the diets and to see sisters and patients in the wards, particularly those likely to be discharged before her next visit.

At a mental hospital regular visits were made to discuss the patients' general menus with the catering officer and to advise on the food to be provided for the few therapeutic diets.

She was also responsible for seeing that the patients' therapeutic dietary treatment was properly continued in two pre-convalescent units.

Other hospitals consulted her by telephone as and when required. She regularly advised the catering officers at the various hospitals on the menus for light and soft diets and if necessary on the preparation of food for these diets.

A diabetic clinic was attended at one hospital each week and she was on call for two weekly medical clinics at another hospital. All other out-patients were referred to her office at the central hospital by appointment.

She was responsible for nutrition and cookery lectures at the Preliminary Training School; for lectures in diet in disease to second year nurses and for cookery classes to S.E.A.Ns. In addition, she gave talks on feeding invalids to pre-nursing classes run by the local Education Department.

(iii) Advisory mainly to Out-patients: Group X

In this group a dietitian worked six sessions a week at one hospital, three at another and one at a third. She also visited a fourth by request to see patients on discharge.

The hospital at which six sessions were worked had large clinics but only had 30 emergency beds and her work was entirely concerned with out-patients. At the hospitals where three and one sessions were worked the dietitian saw patients referred from clinics and also visited the wards for consultations with doctors and sisters about the dietary treatment of in-patients. She also instructed patients in the management of their diets at home.

Her terms of appointment excluded responsibility for the provision of therapeutic diets for in-patients and she was unable to influence the type of food supplied for them from the main kitchen.

5. PART-TIME POSTS

Two of the hospitals visited (M and N) employed part-time dietitians. Two part-time staff were employed at M and between them they covered the week from Monday morning to Friday afternoon (the dietitians were never on duty at week-ends but as both were married women with families this was hardly surprising). At the other hospital (N) a dietitian was employed for four sessions weekly, three of which coincided with medical clinics and one, on

Friday afternoons, was arranged so that food could be ordered for diets and menus planned for the week-end. The dietitian lived close to the hospital and therefore could be easily consulted if difficulties arose.

At both hospitals the dietitians planned menus for therapeutic diets, arranged the work of the diet kitchen cooks and advised out-patients whom they either saw in weekly clinics or who were referred and seen by appointment. At neither hospital did the dietitians advise the catering officers or undertake any teaching duties. Some success was achieved at both hospitals but N was much more successful than M. At the former, the dietitian had given much thought to the best way in which she could be of assistance. She had trained diet cooks to be responsible in her absence and had devised and compiled comprehensive diets for the use of both nurses and diet cooks. At M, the two part-time dietitians had attempted to take over unaltered, a routine evolved by a previous person. They spent much time writing labels, serving and checking diets in the kitchen and it will be seen from Table II (pages 18 and 19) that few out-patients were seen nor had they had any advisory or teaching duties.

6. DOCTORS' VIEWS

Doctors with a special interest in diet were seen in all hospitals except one and an attempt was made to obtain divergent opinions by seeing those working in different specialties. To some extent their interest may be expected to introduce a bias in favour of dietitians. They were asked whether the functions dietitians fulfilled were those required by the medical staff, whether other functions and duties still remained to be undertaken; their opinions on the length and adequacy of present training; their views on the reasons for the shortage of dietitians and who should take responsibility for therapeutic diets in the absence of dietitians.

In general they were satisfied that the dietitians provided the service required by the medical staff of their particular hospitals. Of the functions listed in the Cope Committee report, however, only two—control of in-patients' dietaries and advice to out-patients—were normally mentioned and the emphasis placed on the relative importance of these tended to reflect the consultants' specialised interests. Only three doctors required dietitians to advise patients on general nutrition even in the case of pregnant women. The other two functions recommended in the report, namely, the giving of nutritional advice to catering officers and teaching nutrition to staff in training, were not usually mentioned until late in the discussion or until questions were put directly. It then emerged that approximately half the doctors expect dietitians to advise the caterer on nutritional matters and one even went so far as to put this as her prime function and of much more importance than merely providing therapeutic diets for a few patients.

In regard to teaching, doctors were emphatic that instruction in nutrition and diet in disease should be included in the nurses' training. The majority intimated that in the absence of dietitians, the nurse should take responsibility for therapeutic diets and expressed concern that nursing staff were becoming less interested in their patients' dietary. One doctor voiced the majority opinion saying that " nurses' defection from feeding patients is a serious matter and something should be done to focus their attention again on this aspect of patients' care ". The doctors stated that they would welcome the dietitian in the rôle of teacher especially for nurses. It was stressed that all teaching should be practical in its approach and ideally should be linked with a period of practical work in a diet kitchen.

The general reaction regarding training was that the dietitians were adequately trained for the tasks they had to do. The doctors all required that the dietitian in their hospital should be able to talk and understand medical language in order to convert medical prescriptions into terms of food and to explain dietary orders to out-patients. Some felt that in other smaller or less specialised hospitals, " dietitians " with lesser qualifications might be satisfactory. It was stressed that such " dietitians " could work only under supervision and would not be eligible for the more senior or advisory posts. One suggestion put forward was to the effect that the dietitians' training could be streamlined to exclude much in the present two-part courses which it was contended must be unnecessary.

Although in general, medical staff were satisfied with the standard of professional knowledge and efficiency attained by dietitians, three points of criticism were mentioned :

(a) that dietitians spend too much time in work which should be left to less highly qualified staff, e.g., writing labels and serving food in the kitchens. They would be better employed in teaching patients in the wards and out-patients;

(b) that some dietitians are too " scientific " and that their diets are accurate but not necessarily palatable or practicable;

(c) that diet kitchens are expensive both as regards food and staff, when related to the work performed.

Factors suggested as contributing to the continuing shortage of dietitians were the length of training, late age of entry, expense of training coupled with the few grants available, lowness of salaries in relation to length of course and inconvenient hours worked, i.e., week-ends, and evening duties.

7. DIETITIANS' VIEWS

The majority of dietitians enjoyed their work and found it worthwhile and interesting. There were some grumbles but only a few were dissatisfied with their present posts. Repeatedly dietitians stated that the deciding factor in the success or failure of their work was the attitude of the medical staff. As medical auxiliaries, the dietitians are dependent on doctors, not only as the source from which their work originates but also for support and encouragement. In little more than half the hospitals visited, dietitians said that they were accepted as a part of the medical/nursing team (this includes all teaching hospitals). In such hospitals out-patients were regularly referred to them; they were frequently invited to attend case consultations and ward rounds and the doctors were willing to spend time in discussing patients' treatment. In hospitals where the dietitian was not fully used, she rarely saw the doctors and felt that her services were relegated to the kitchen. The view was expressed that indifference on the part of the medical staff, especially in the early stages of an appointment, could cause the dietitian to lose heart and seek other employment.

Many dietitians referred to difficulties, when first appointed, with nursing and catering staffs. This appears to have arisen where the dietitians' position and duties vis-a-vis catering and nursing staff were not made clear at the outset. However, in the opinion of some of the more senior dietitians, a part of the misunderstanding had arisen from the attitude of the dietitians themselves who appeared to have been tactless and uncompromising in their initial approach to other staffs and departments.

Hours of work and week-end duties were noted as tiresome, but were recognised as necessary. Lack of money resulting in unsatisfactory equipment, accommodation and food supplies was mentioned, but was not a prime cause for dissatisfaction.

More stress was laid on the difficulty of obtaining and keeping responsible cooks. Approximately one-quarter of the dietitians regarded shortage of trained cooks as seriously hampering their work and two would like to see special courses inaugurated for training " diet cooks ".

The comments of dietitians in group posts were of especial interest. Many of these were first appointments and their experience may help to set a pattern for the future. In general the dietitians were in favour of spreading their services over a group of hospitals rather than concentrating all their time and efforts on one. They were of the opinion that it is impossible to organise work shared between hospitals on the same lines as a well established one-hospital department. Hence the dietitian had to

be adaptable and ready to recast methods and organisation learnt in her training school. It was their experience that it was impossible to organise the work satisfactorily in a main kitchen or to rely on catering and nursing staffs to carry out an advisory dietitian's instructions. It was preferable to have a separate kitchen with the requisite staff, or at the very least cooking staff working in the main kitchen, responsible to the dietitian.

The importance of trained cooks to take responsibility in the dietitian's absence was repeatedly stressed.

Because these posts call for experience in organisation and ability to co-operate with other staffs, it was felt that Group posts call for mature and experienced dietitians.

Dietitians engaged in part-time work were of the opinion that a dietetic service could be successfully operated by two or more part-time people covering a full working week, although in the instance observed, where the dietitians rarely met, differences in method caused misunderstanding between diet kitchen and nursing staff. Also doctors were hesitant to discuss patients with one dietitian when she might not be the one to interview the patient and finally arrange and calculate his diet. Further, as both dietitians were part-time, neither was prepared to take the lead in re-organising the work to allow time for more ward visiting and work in out-patients; nor was either willing to exert her authority to improve kitchen standards of hygiene and cooking nor to insist that cooks carried out dietary orders accurately.

The dietitian employed for four weekly sessions also felt that a useful if limited service could be operated. She agreed with other dietitians that the service functions more successfully from a separate diet kitchen and that it is essential to have cooking staff responsible to the dietitian. They agreed that married women, unless they were the mothers of young children, were ideal for part-time work, provided that they lived close enough to the hospital to be readily available for consultations as the need arose. By living nearby a disproportionate part of their salary would not go in travelling expenses.

Dietitians working part-time put forward the opinion that hospitals outside London were less likely to attract recently qualified dietitians whose main interest is in work entailing scientific investigation. This work is found more in teaching hospitals. On the other hand, dietitians who have been out of the profession for family reasons for some years are interested in people and find satisfaction in talking to and helping patients, caterers and nurses rather than in the rigid calculation and control of diets. Part-time posts also give ample opportunity to married dietitians to lead full domestic lives.

DISCUSSION

The study was undertaken to find out the present duties of dietitians; how far these duties conformed to those put forward in the Cope Committee Report; how effectively dietitians are employed and what, if anything, hampers them in their work.

The survey has shown that in the majority of departments the emphasis is on the provision of diets for in-patients and that the interpretation given to the term " special diet " affects the volume of this work and to some extent the number of staff required.

In several departments it appeared that the special knowledge and qualifications of dietitians were not being used as effectively as they might be either because the range of work was restricted or because the demands made on the department and its organisation were such that the dietitians' time was taken up with work which could be done by other staff.

The uneven distribution of dietitians between teaching and non-teaching hospitals is marked and can be attributed partly to the need in teaching hospitals for staff to assist with metabolic and similar studies, partly to the greater volume of out-patient work and partly to the more elaborate organisation of the dietary departments. Furthermore, dietitians are attracted to work in these departments because their position in the medical team is well recognised, the work is varied and interesting and the number of staff employed enables newly-qualified dietitians to gain experience without too much responsibility. Also, since the grading structure is based on the numbers of assistants, posts in the higher salaried grades are available almost exclusively in teaching hospitals.

The factors which hamper dietitians in their work are discussed below and measures to alleviate or overcome these would do much to make the work of therapeutic dietitians more attractive.

(a) Scope of duties

The concept of a therapeutic dietitian which was found in many hospitals was that she should be mainly concerned with the calculation and preparation of diets for patients who require different food from that supplied for a full diet. The Cope Committee envisaged a wider sphere of usefulness and emphasised her rôle as a teacher, of patients in the wards and in out-patients; of catering staff and of nurses and possibly of medical students.

In out-patients the variety of the work as well as the number of patients seen varied considerably and was found to depend in great measure on the interest of the doctors. For the most part the advice required concerned the management of a few types of special diet used in treatment and the dietitians' services were only exceptionally used in the correction of dietary errors which often

accompany or precede ill-health, e.g., in paediatrics, obstetrics and dental conditions. The attempt in one Group to confine the dietitian's services to advising out-patients only, did not prove entirely satisfactory in practice.

With a few notable exceptions, the dietitian had little teaching or lecturing duties in the hospitals visited. In view of the doctors' plea that nurses should know more about nutrition and diet therapy, it would seem that dietitians could contribute more in this field if given the opportunity.

In addition to making greater use of the dietitians' knowledge, this wider range of duties gives variety and interest but where they are not undertaken the work often lacks satisfaction. It would seem that the active interest and support of the medical staff is a most important factor in determining whether a dietitian can play her full rôle in the work of the hospital.

(b) Volume of routine work

A close study of the "diets" catered for by the different departments revealed that the proportion of total patients on *therapeutic* diets did not differ greatly. The differences in the number served were mainly dependent on whether the dietitian was responsible for convalescent gastric, light and other non-therapeutic diets. In many hospitals these were ordered from the diet department because the food from the main kitchen was unsuitable and in such cases the dietetic department was being used as a cover for the catering department. The dietitian's special knowledge of the requirements of sick people could be used most profitably if, instead of undertaking the preparation herself, she were authorised to advise the catering department on the menus and recipes to be used in the main kitchen for these patients. Dietitians do not always attend catering committee meetings and it would be an advantage, for this and other reasons, if they could do so.

(c) Organisation of diet kitchens

It was found that the more complex the method used to ensure that food reached the patient for whom it was ordered, the more staff per unit of diets was needed for its operation. Yet the simpler systems gave good results, doctors' prescriptions being accurately carried out and the food being varied and well cooked. Under the more complex systems the dietitians spent a good deal of time serving food, writing labels and in clerical work. In other departments this work was done quite effectively by cooks and clerks. All departments could, with advantage, review and revise their systems of work to keep them as simple as is compatible with accuracy and a good standard of service. Particularly is this true of student training departments where it

is important that the students should be trained in methods suitable for smaller or single-handed departments.

At the same time the advantages of greater co-operation with the main kitchen might be investigated as a means of reducing the work of the dietetic department. This might include the initial preparation of vegetables and the supply of cooked foods, when suitable, from the main kitchen. Such co-operation is easier to attain if menus for therapeutic diets are based on the caterer's menus for full and light diets. This arrangement also simplifies the purchase of foods and helps to reduce costs.

(d) Facilities and Staff

The survey has shown that several departments were handicapped by lack of space and suitable equipment in the diet kitchen. In some of these the facilities would be adequate if the department were not overloaded with non-therapeutic work, but others appeared to be working with make-shift arrangements. The lack of accommodation for office work and for interviewing patients and their relatives in private caused much inconvenience.

Some dietitians were tied to the diet kitchen by lack of sufficient cooking and domestic staff, while most of those seen had difficulty in recruiting cooks of the right calibre. If dietitians are to be relieved of cooking duties and the need to give close supervision to the kitchen work the assistance of intelligent trained cooks is of great importance. This is particularly true for those dietitians who are working single-handed or are sharing their services among a group of hospitals.

(e) Group posts

In view of the present shortage, the employment of one dietitian for a group of hospitals merits careful consideration. The organisation of five groups, all of which are still experimenting in this way, is reported in detail. The most successful organisation was found in those groups where the dietitian had responsibility for at least one diet kitchen and had staff working directly under her control. In those instances she had a centre in which she could establish standards, instruct kitchen staff and from this nucleus she could gradually extend her influence to other hospitals.

In comparison with the practice of appointing dietitians to single hospitals, group posts offer a means whereby a greater number of patients can benefit from dietetic advice. This is particularly important for non-teaching hospital groups outside the Metropolitan area which have difficulty in attracting and retaining dietitians at present.

It would seem, however, that such posts should not be regarded solely as temporary expedients to meet present difficulties but more as the logical development of the profession's work in the future. Under these circumstances the dietitian can make the fullest use of her professional knowledge and be relieved of routine work which is within the capacity of other types of workers.

This development is at present only in the pioneering stage and as such demands flexibility of mind on the part of the dietitian and complete co-operation on the part of all concerned. The type of work offers a wider interest for the dietitian than many single hospital appointments but it is essentially for those with experience and would rarely be suitable for the newly-qualified or for the dietitian with limited experience in only one hospital.

Suggested duties for a group dietitian are given in the Appendix.

(f) Part-time posts

Part-time employment of dietitians seemed to be fairly effective although obviously there are difficulties inherent in this type of work. It offers another means of overcoming the shortage and is particularly suitable for married women. The part-time dietitian can take charge of a department where there is insufficient work for a full-time person or where a full service can be operated by two or more dietitians each working part-time. It is then desirable to make one of these senior to the other so that there is no doubt where responsibility for the department lies.

Shortage of Dietitians

The survey was not primarily designed to seek the reasons for the present shortage of dietitians in the Hospital Service except in so far as it might reveal factors connected with their employment in hospitals tending to make the work less attractive than that open to them outside the Service. Several such factors, within the control of the hospital authorities are discussed and the views of doctors and dietitians on other issues, such as salaries, conditions of service and training are mentioned on pages 30-33. Perhaps a major part of this problem is that of competing for the intelligent and scientifically-minded school-leaver in face of many opposing claims from other professions.

Although no quick solution of the shortage may be possible, the survey indicates measures which would help to encourage dietitians to stay in the Service and ways in which their knowledge and experience could be spread more widely.

APPENDIX

Recommended Duties for Group Dietitians

The nature and extent of the duties to be performed will differ according to the constituent hospitals of the group, how widely they are scattered and the transport available. A dietitian with responsibility for a group of hospitals cannot exercise the same degree of control at an individual hospital as would be possible if she were occupied there exclusively.

On appointment the dietitian should visit each hospital, to become acquainted with the catering organisation, the average number and kinds of therapeutic diets served, the types of out-patients' clinics held and the numbers attending. She should also meet the matrons of the hospitals and ascertain what opportunities there may be for teaching. After the initial appraisal of the Group and the work required, the dietitian must decide, in consultation with the medical, administrative and nursing staff, how her time is to be divided between the hospitals, and the nature of the duties to be undertaken at each. It is recommended that the dietitian's sessions at each hospital should be arranged to coincide with medical out-patient clinics. Her duties at each of the main general hospitals in the group may be summarised as :

(a) Drawing up of standard diet sheets, in consultation with the medical staff, for all the more usual therapeutic diets, e.g., diabetics, low salt, gastric, etc.

(b) Calculation of any individual diets required for in-patients.

(c) Compilation of the week's menus in consultation with the catering officer, for therapeutic diets based on the full and light diet menus.

(d) Providing recipes for special dishes to be used in these menus.

(e) Training and instructing diet cooks.

(f) Visiting wards to interview and teach patients and to discuss patients' dietaries with the ward sisters.

(g) Advising catering officers on the nutritive value and suitability of patients' menus, especially for light and soft diets. (If asked to do so by the catering or other appropriate committee or by the catering officer.)

(h) Advising out-patients.

(j) Assisting with lectures and/or lessons in nutrition and dietetics given to nursing and other staff.

(k) Carrying out such dietary surveys as may be requested by the medical staff.

The dietitian should also be available to advise small or specialist hospitals in the Group. It is usually unnecessary to visit these regularly unless, as with some maternity units, therapeutic dietary problems frequently arise.

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