DIETITIANS IN THE COMMUNITY

REPORT OF AN EXPLORATORY STUDY

by

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Summary

The current provision of dietary services in the community and the demands falling on dietitians working in the community was studied by means of postal questionnaires to all medical officers of health of local health authorities, secretaries to hospital management committees and clerks to boards of governors of teaching hospitals in England, and by interviews with selected dietitians.

Considerable differences were found between regions in respect of the employment of hospital dietitians, as well as in the involvement of hospital dietitians with the community. It was learnt that 379 dietitians (whole time equivalents) were employed in hospitals in England, that 42% of H.M.C. groups did not employ dietitians, and that 23.5% of established posts were unfilled. Only nine local health authorities and three general practices were found who employed dietitians and most of these appointments were recent innovations.

Most hospital dietitians gave dietary advice outside the hospital, though this was in each case of limited extent and in many cases was carried out as an 'off-duty' occupation. The dietitians employed by local health authorities varied in their methods of working, some being almost exclusively involved in consultations with individual patients while others were largely committed to teaching nutrition and to the supervision of group sessions organised by others, e.g. slimming clubs.

Obesity was the most frequently occurring condition referred to the dietitians, stated by some to comprise 99% of their workload. Many of the dietitians considered that dietary advice in some dietary and nutritional disorders could be given by other professional workers but that further training in these subjects was necessary for these workers. The change in emphasis from advising on specific therapeutic diets for individual patients to that of giving advice on diet and nutrition to large sections of the community and more particularly to "high risk" groups such as the housebound elderly, obese children and families on low income was widening the field of work of the dietitian. Dietitians are employed in the health service in insufficient numbers to meet these changing needs entirely by consultations with individuals, and consideration must be given to effective methods of presenting expert opinion on nutrition and diet to large numbers of people.

It is recommended that careful thought is given by employing authorities to the needs of the community in respect of advice on diet and nutrition before employing dietitians in the community, and before a national extension of community dietetic services takes place.

Introduction

In recent years, a number of hospital dietitians have begun to extend their services into the community,[1] a few local health authorities have established posts for dietitians,[2] and a small number of general practitioners have employed dietitians.[3] The development of primary care teams has been gathering momentum over the last few years, and suggestions have been made that further additions could be made to such teams, e.g. members of the Professions Supplementary to Medicine.[4][5]

In certain disorders, specific therapeutic agents have been discovered which have replaced therapeutic diets, e.g. vitamin B_{12} in pernicious anaemia, while continuing doubts are expressed about the relevance of specific diets in the treatment of some diseases, e.g. peptic ulcer.

The identification of inborn errors of metabolism such as phenylketonuria and the increased understanding of coeliac disease and other malabsorption diseases, however, have resulted in new areas of application of specific diet therapy as have the developments in medical and surgical treatment of certain conditions, e.g. chronic renal disease.

Nutritional problems in the community, of which obesity is by far the most frequently encountered, are causes for concern. High risk groups may be identified, such as the elderly (particularly those who are housebound), the immigrant population and families with low incomes, all of whom may present problems relating to inadequate nutrition and who may require dietary advice.

The developing emphasis on community care and the changing nature of the problems presenting to dietitians suggest that a review of the work and deployment of dietitians is timely.

The objectives of this study, therefore, were to:-

1. Assess the extent of existing dietetic services in the community.
2. Examine the experience of dietitians working in the community.
3. Consider the nutritional and dietary problems presenting to dietitians.
4. Make comments and recommendations concerning future developments in the organisation of dietetic services and the training and recruitment of dietitians.

METHODS

Questionnaires were designed to identify those local health authorities, hospital management committees and boards of governors of teaching hospitals in England who had an establishment for dietitians and currently employed or had recently employed dietitians.

The questionnaires to local health authority medical officers also asked for their opinions on the adequacy or otherwise of dietetic services to their community and invited suggestions for improving any perceived inadequacies in the delivery of dietetic advice. A question was included to elicit information about the employment of dietitians by other local authority departments. (Appendix I).

The questionnaires to secretaries of hospital management committees and to clerks of boards of governors of teaching hospitals were in two sections, (i) a one-page section, to be completed by the hospital secretary or clerk, aimed at eliciting information about the establishment for dietitians in the group, the number of dietitians currently employed, and whether any existing vacancies were being advertised; and (ii) a seven-page section, to be filled in by the group dietitian (or most senior dietitian employed in the group), and composed of questions about the content of their work particularly that which involved giving dietary advice to patients residing outside hospitals and to individuals and groups working in the community. (Appendix II).

It was anticipated that only a few general practitioners would employ dietitians in their practices, and in order to contact these general practitioners, letters were placed in various medical journals requesting any general practitioner who employed a dietitian in his practice to inform the project director.

Interviews were carried out by the author with those dietitians found to be employed by local health authorities, those who were employed by general practitioners and a selected number who were believed, from answers to the postal questionnaires, to be involved in extension of their services outside hospitals.

PROCEDURE

A list of medical officers of health employed by county councils and county borough councils in England, and those employed by London boroughs were obtained from the 1972 edition of the Municipal Year Book. This list was stated to be accurate as at 30th September 1971 and was updated where possible from personal and printed knowledge of changes.

Questionnaires were posted in October 1972 to all 156 local health authority medical officers of health in England (45 employed by county councils, 78 by county borough councils and 33 by London borough councils). Each questionnaire was accompanied by an introductory letter, addressed to the medical officer of health by name, and a stamped-addressed envelope in which to return the questionnaire.

A reminder was posted in December, 1972 to the eight medical officers of health who had not replied to the initial approach, all of whom replied to this reminder.

The list of hospital management committees and of boards of governors of teaching hospitals in England was obtained from the Hospital Year Book 1972.

The questionnaires were posted in November 1972 to all 321 hospital management committee secretaries and clerks of the boards of governors of teaching hospitals listed, each questionnaire being accompanied by an introductory letter addressed to the secretary or clerk concerned, and a stamped-addressed envelope in which to return the questionnaire.

Reminders were posted in January, 1973 to the 23 secretaries who had not replied to the first mailing.

From the replies, it was learnt that 8 out of the 321 groups listed in the Hospital Year Book had subsequently amalgamated with other H.M.C. or teaching hospital groups, and these 8 were excluded from the total, leaving a total of 313 hospital groups functioning at the time of the survey.

Three general practitioners replied to the letters placed in medical journals requesting general practitioners who employed dietitians to contact the project director.

Following a preliminary analysis of the questionnaires, four hospital dietitians and seven dietitians employed by local health authorities who had reported that they were involved in giving dietary advice to the

community were interviewed during May 1973 by the author, as were the three dietitians employed by the general practitioners who had answered the requests in the medical press.

Responses to Postal Questionnaire

By January 1973, replies had been received from all 156 medical officers of health, and by February 1973, replies had been received from all but three secretaries and one clerk to the board of governors of a London postgraduate teaching hospital. (Table 1).

RESULTS

Dietetic Establishments and Employment of Dietitians

The number of local health authorities, hospital management committees and boards of governors of teaching hospitals who had establishments for and who employed dietitians is shown in Table 2.

(a) Local health authorities

The employment of dietitians by local health authorities and the dates of the commencement of such employment is shown in Table 3 where it is seen that whereas one county borough council has employed a dietitian since 1949, five of the remaining eight authorities which employed dietitians commenced employing dietitians during 1972.

One full-time dietitian employed by a county council was stated to be terminating her appointment in December 1972 on moving to another part of the country. This vacancy was being currently advertised, as were vacancies for dietitians by two county borough councils who had not previously employed dietitians.

Only one authority, a county borough council, had discontinued the establishment for a dietitian, no details being given about the reasons for this change, or for how long a dietitian had been employed.

The number of other local authority departments who employed dietitians, as stated in the replies from the local health authority medical officers of health, is shown in Table 4, in which it is seen that 16 local authorities employed dietitians in departments other than health departments, and that in two London boroughs dietitians were employed in health departments and were also employed in either education or social services departments.

Thus, a total of 23 local authorities employed dietitians, of which 7 employed the dietitians only in health departments, 1 employed dietitians in health and education departments and 1 in health and social service departments, 10 employed dietitians only in education departments, and of the remaining 4 authorities 2 employed dietitians only in social service departments and 2 in both social service and education departments.

(b) Hospital authorities

Established posts for dietitians were reported by 164 (59%) of the secretaries to hospital management committees, by all nine clerks to boards of governors of provincial teaching hospitals, and by 18 (72%) of the clerks to boards of governors of London teaching hospitals. (Table 2).

The teaching hospitals at Nottingham and Southampton who were without boards of governors, were included in the replies from hospital management committees. The London teaching hospitals which had no establishments for dietitians were all postgraduate teaching hospitals.

Table 5 shows that 91 establishments (48% of the total) were for single-handed (part-time or full-time) posts, and that whereas all provincial teaching hospitals and 13 (72%) of London teaching hospitals with establishments were for more than two dietitians (whole time equivalents), only 43 (26%) of the H.M.C. groups possessed as large an establishment.

Considerable differences in the proportion of hospital groups who had established posts for dietitians was seen to exist. In the Newcastle and East Anglia R.H.B. areas, two-thirds of the H.M.C. groups had no established posts for dietitians while at the other extreme only two of the H.M.C. groups in the Liverpool R.H.B. area had no establishment.

The number of established posts for dietitians by career grade is shown in Table 6, (expressed as whole time equivalents) where it is seen that 379 posts (81.6% of the total), were for basic grade or senior dietitians. Where a hospital group employs only one full time or part-time dietitian, the established post must be that of senior dietitian grade.[6] This probably explains why more senior grade dietitians, than basic grade dietitians, were employed by R.H.B. groups.

The career grade of a dietitian is otherwise dependent upon the size of the establishment for dietitians, thus there was a higher proportion of group, chief and deputy chief dietitians' posts in teaching hospitals which possessed, in general, larger establishments than did H.M.C. groups.

All established posts for dietitians, however, were not filled, and Table 7 indicates the extent of the employment of dietitians (expressed as whole time equivalents). The shortfall was most marked in R.H.B. groups, where 23.5% of established posts were unfilled, compared with the teaching hospitals where only 8.1% were unfilled posts. (Table 9). The vacancies appeared to exist at all career grades, though at basic grade level there were greater shortages in the H.M.C. groups than in the teaching hospitals, perhaps reflecting the ability of these latter hospitals to retain student dietitians after qualification. The table shows that 37.7% of all dietitians were employed in teaching hospitals and that nearly one-fifth of hospital dietitians in this country were employed in the N.W. Metropolitan region, a region which included eight teaching hospitals with dietitians in employment.

The distribution and recruitment of dietitians have changed over the past two decades. There has been a steady increase in the employment of dietitians in hospitals in England and Wales (see graph, Appendix 5), and the figures produced by the then Ministry of Health and the British Dietetic Association for 1956 were:- 72 full-time and 15 part-time therapeutic dietitians and 8 caterer/dietitians employed in H.M.C. hospitals in England and Wales and 106 full-time, 2 part-time therapeutic dietitians and 4 caterer/dietitians employed in teaching hospitals.[7] (It must be borne in mind that this refers to persons, not to whole time equivalents). In 1967, as result of a survey carried out for the British Dietetic Association, 132 (51%) dietitians (w.t.e.) were reported to be employed in non-teaching hospitals and 128.91 (49%) in teaching hospitals in England and Wales.[8] There has, therefore, been a change in the distribution of hospital dietitians, between H.M.C. groups and teaching hospitals though marked differences still existed between regions.

The number of hospital dietitians employed in proportion to population, to occupied hospital beds and to hospital discharges and deaths is shown in Table 8. In England, on average, one hospital dietitian served a population of 128,000 but marked differences were seen between R.H.B. areas. In Birmingham R.H.B. there was one hospital dietitian employed for every 220,000 population while in the N.W. Metropolitan region there was one dietitian per 60,000 population.

Similarly, over the country as a whole, there was a ratio of one dietitian per 893 hospital beds, but whereas in the Oxford region the proportion was 1 to 490 beds, in the Liverpool region the proportion was 1 to 1,695 beds, though it must be remembered that although nearly all H.M.C.'s in the region had establishments for dietitians the Liverpool region contains more hospital beds per population than any other region.

Again, if one relates the number of dietitians with the number of hospital discharges and deaths, marked differences were seen between regions.

In terms of the contribution by hospital dietitians to the needs of the community, the ratio of dietitians to the population must be considered, but the figures for the distribution in dietitians per hospital beds and hospital discharges indicates the potential workload variation between regions of hospital dietitians towards patients attending or residing in hospitals.

(c) Employment of Dietitians by General Practitioners

Only three general practitioners reported the direct employment of dietitians. In one practice a three-man group, the dietitian attended two sessions per week, and in the remaining two practices the dietitian was employed for only one session per week.

Two other practices had reported the experimental employment of a dietitian but both had discontinued this service. In one of these practices, it was found over a three-month period that 38 patients had made a total of 95 attendances at a cost of £1.75 per patient and "In view of the fact that the study was financed by the doctors themselves it was abandoned after three months trial".(3)

COMMUNITY INVOLVEMENT OF HOSPITAL DIETETIC DEPARTMENTS

(1) Open access - Referral of patients by general practitioners

The number of hospital groups who permitted open access by general practitioners to their dietetic departments and the number of patients said to have been referred in one calendar month are shown in Table 10. Of the 171 groups who employed dietitians, 106, permitted open access, but in only 30 of the 106 hospital groups at which open access was available did the general practitioners refer more than five patients each week, and in 14 groups no patients had been referred to the dietetic department during the month. One group dietitian made the comment that she "did not consider open access referrals by general practitioners as satisfactory without the help of supporting services, e.g. pathology reports, patients notes, etc." One dietitian who was in a part-time single-handed post commented that she had been asked by the H.M.C. to discontinue open access, presumably due to pressure on her services, and one dietitian commented, "This is a sore point .... permission was refused by the Medical Committee".

(2) Patients outside hospital - Attendance by hospital dietitians

Some hospital dietitians attended individual patients in premises outside the hospital (Table 11). Dietitians in four hospital groups visited general practitioners' surgeries at least three times per month to attend individual patients and in another three groups the dietitians visited health centres with equal frequency. In 74 groups dietitians visited individual patients in their own homes, though in 62 of these groups, less than one visit per month was made.

During subsequent interviews with hospital dietitians, it was learnt that one hospital dietitian visited patients in their homes who were unable to attend her sessions at general practice surgeries, and in another, the dietitian visited patients, referred by general practitioners, who were unable to attend the dietetic department or could be seen more conveniently in their own homes.

(3) Visits to institutions by dietitians

Dietitians from seven hospital groups visited institutions at least once per month to give general dietary and nutritional advice (Table 12).

One group dietitian commented that the premises mentioned had been visited by the hospital dietitians in the group before a county health dietitian was appointed, and in another the dietitian commented that the school meals organiser in her area was a state registered dietitian. In one hospital group, the dietitians visited a prison regularly to give general nutritional advice.

(4) Informal discussions with community workers

There was some contact between the dietitians in most hospital groups and general practitioners and health visitors. (Table 13). In the three groups in which informal discussions were held between the dietitians and district nurses at least three times per month, equally frequent discussions were held in these groups with both general practitioners and health visitors. In another three groups dietitians held informal discussions with both general practitioners and health visitors at least three times per month.

In respect of other community workers, there is less contact, both in terms of the number of hospital dietitians involved in informal discussions with these workers and in the frequency of such discussions.

Eleven respondents mentioned informal discussions with social workers in the "other" category, while another reported that the dietetic department was involved in supplying 25 diabetic meals-on-wheels each week to elderly patients living in the hospital catchment area. Five other respondents reported occasional discussions with headmasters and school teachers about the dietary problems of schoolchildren.

(5) Attendance at outpatient sessions by dietitians

Table 14 presents the responses by the dietitians to the question "How often are patients with each of the following conditions, who attend the outpatient department, seen by you or your colleagues in the group?". In 112 hospital groups the responding dietitians claimed that all patients attending outpatient departments because of obesity were seen by the dietitian every time they attended, whereas in only 49 groups did they claim to see diabetic outpatients every time the patient attended. In spite of the reservations one must make about the accuracy of these responses, particularly as to whether a dietitian would be aware or informed of every attendance by an outpatient, it would seem that many more respondents believed that they saw obese patients at every attendance than they did those patients with other conditions.

A request for comments on this question elicited a considerable response. A number of other disorders were quoted as being seen by the dietitians, e.g. inborn errors of metabolism, hepatic, gastro-intestinal, oesophageal and gall bladder disorders and anorexia nervosa.

Eight respondents mentioned that they held dietetic outpatient clinics and arranged appointments within their department for patients who required follow-up; of these eight respondents four specified that the clinics were for obese patients. One respondent commented, "My colleagues and I hold our own diabetic clinics and patients are referred to our clinics. I cannot say how many are not referred". Yet another commented, "We have a system whereby we could see each patient every time they attend, but we do not:- (1) They don't all need to come every time, and (2) If they did I would need twice my establishment of staff".

Many factors appeared, from the comments, to influence the involvement of hospital dietitians with outpatients. In some cases the dietitians attended outpatient sessions as part of the medical team, whereas in others the dietitians held their own clinics and either arranged for patients to see them or awaited referrals from a consultant. In others it would appear that the pressure of work restricted the involvement in outpatient departments.

(6) Continuation of dietetic advice to patients after their discharge from hospital

Follow-up by hospital dietitians of inpatients who had been discharged from the hospital and who had received dietary advice during their stay, was most commonly carried out by the dietitian requesting the patient to return to the dietetic department. (Table 15).

In 57 groups every patient who had been discharged from hospital and who had received dietary advice from the hospital dietitian was requested to return to the dietetic department. This may reflect the long-term nature of the work. One respondent commented, "All patients who have received dietetic advice are given my telephone number and the times they can contact me for further advice or for an appointment with me", while another stated, "Most patients who need to continue diet at home are seen on at least one occasion after discharge".

Of the 30 respondents who made a comment about their "other" method of following-up patients, 13 stated that they retained contact with patients by post or by telephone, of whom 7 specifically mentioned that this mainly applied

to patients on reducing diets. Six respondents stated that they occasionally contacted school meals organisers or school teachers, and one mentioned contact with the local health authority dietitian working in the area.

7. Formal lectures on nutrition and diet

The hospital dietitians appeared to devote a considerable time to lecturing on nutrition and diet to community workers in different fields and to groups and organisations in the community. Of the 164 fully completed questionnaires returned by the dietitians, only 46 (28.0%) of the respondents stated that the dietitians in the hospital group did not lecture outside the hospital. As well as the types of audience specified in Table 16, lectures on nutrition and diet were given to women attending ante-natal clinics in 49 of the hospital groups, and in the "other" category respondents quoted lectures given by hospital dietitians to nursing, domestic science and home economics students as part of the formal training of these students.

The most commonly occurring group receiving lectures on nutrition and diet were the voluntary organisations, almost half the respondents reported that lectures on nutrition and diet had been given to these organisations by the dietitian in the hospital group.

In 31 hospital groups the respondents reported that they had given lectures to general practitioners, and in 39 groups lectures were stated to have been given to health visitors. The respondents in 13 of these hospital groups had given lectures to both types of audience.

Table 17 indicates the range of involvement by the hospital dietitians in respect of lectures on nutrition and diet. In general, the lectures delivered by the hospital dietitians were carried out on a voluntary, spare-time basis and were usually given as a result of a request from the organisation or group concerned. It would appear, therefore, that there was a perceived commitment, by more than just a few enthusiasts, amongst the hospital dietitians to lecture on nutrition and diet, both to other professional workers and to members of the community.

Summary (Hospital Dietitians in the Community)

Some involvement of the hospital dietitians with both professional workers in the community and with patients or others living outside the hospital was seen to occur in many of the hospital groups. This commitment varied between hospital groups and with the type of involvement; very few were found to report a widespread involvement with the community.

Two or more patients were seen weekly on average at the direct request of general practitioners in only 30 hospital groups. In 6 hospital groups dietitians were attending patients in health centres or general practice premises at least three times per month on average and in 78 groups the dietitians reported visiting patients in their homes. Frequent (3 or more times per month) contact with general practitioners and health visitors was reported in 38 hospital groups, though in 127 hospital groups, less frequent discussions were reported between the dietitian and the general practitioners while equally infrequent discussions with health visitors about patients were said to take place in 117 groups.

Only two respondents claimed to contact the general practitioner concerned on every occasion that a patient who had been receiving dietary advice was discharged from hospital, and one claimed to notify the health visitor concerned. In 57 groups the general practitioner was not contacted and in 75 groups the dietitians never contacted the health visitor about such patients. The more usual method of follow-up was to request the patient to return to the dietetic department.

In 31 groups the respondents reported that they had given lectures on nutrition and diet to general practitioners and in 39 hospital groups lectures on the subject were given to health visitors. Of these, 13 reported lectures to both these professions.

All but four of the respondents attended outpatients', either with the consultant concerned or by organising special diet clinics.

About half the respondents stated that they had given lectures on nutrition and dietetics to groups and organisations in the community.

An involvement with all aspects of contact with the community by the hospital dietitians was not apparent, though cooperation with the staff of local authority Health and Social Service Departments and the delivery of dietetic advice to inpatients on discharge and to outpatients and/or their relatives is specified as part of the functions of hospital dietitians.[9]

As a crude measure of the extent of community commitment of an individual hospital group dietetic department, a simple scoring was applied to the different categories of involvement. Each section of questions 2 - 7 inclusive, and question 9 were scored (see Appendix 3). A maximum of 3 points was possible for question 2, 15 points for question 3 and 4, 26 for question 5, 24 for question 6, 16 for question 7 and 10 for question 9. The distribution of scores (out of a possible total of 109) for individual

hospital groups is represented in Table 18. Only four hospital groups achieved a score of at least 40, the highest being 47, and only in these four hospital groups was the highest score achieved in more than one category. In general, most respondents claimed to be involved in at least one aspect of the community involvement specified in the questionnaire, but there was no evidence to suggest that a few hospital dietetic departments carried out extensive work in all or even most of the different categories. Those who were giving lectures on nutrition and diet, for instance, were not those who visited patients in the community or allowed open access to the dietetic department and in fact most respondents who stated that they had given such lectures did so to only two or three of the groups and organisations listed in the questionnaire.

Thus, some extension of the work of hospital dietitians is fairly widespread, though in many instances, as for instance, in lectures to groups and organisations in the community it is carried out as an "off duty" occupation rather than an integral part of the working day.

COMMUNITY DIETETIC SERVICES

Opinions of L.H.A. Medical Officers of Health

The postal questionnaire addressed to L.H.A. medical officers of health included the question "Do you consider that groups and individuals in your community can, in general, obtain adequate dietary advice?".

Of the 139 who replied to this question, 97 (70% of those responding to the question) considered the services adequate (Table 19). The opinions did not appear to be significantly related to the type of employing authority, or to whether a local health authority dietitian was employed (Table 20). The number of local health authorities employing dietitians is too small to allow any great significance to be attached to this finding however.

In response to the question:- "If 'yes' who is mainly supplying the service?", answers were received from 95 of those 97 who stated that they considered the services adequate. Twenty-seven considered that the health visitor and local health authority nursing staff and/or the general practitioner were the main supplies of dietary advice to the community. A further 18 included the hospital dietitian amongst those giving dietary advice to the community, and 14 considered that the hospital dietitian alone was providing an adequate dietary service to the community.

The health education officer, either alone or in conjunction with others was quoted by 25 respondents as the main source of dietary advice to the community. Other sources of dietetic advice mentioned were medical officers of health, school nurses, slimming clubs and the mass media.

The replies received to the request for suggestions for improving the dietetic service to the community came from 35 respondents, of whom 16 suggested the employment of dietitians in the community. An additional 6 recommended further instruction in nutrition and diet for local health authority professional workers, and others offered a variety of suggestions including the increase in employment of local health authority nursing staff, the promotion of health education programmes and the extension of hospital dietetic services into the community.

General comments on community dietetic services were made by 36 respondents. Five of these respondents recommended the employment of dietitians in health education and one commented in some detail - "The role of the dietitian in the community can best be fulfilled as a member of a team concerned to ensure that vulnerable groups in society are provided with the most suitable foods to maintain and promote health. Looking to the future there is much to be said for developing a more closely knit nutritional service linking the activities of dietitians inside and outside the hospital with the educational efforts of others working in the field of health, education and welfare. Such a concerted approach is essential if an integrated health educational effort is to be mounted in the twin fields of prevention and treatment".

This respondent also mentioned, as did two others, that the reorganisation of the N.H.S. in 1974 offered an opportunity to "take a fresh look at the key subject of nutrition with particular reference to the contributions of the dietitian to the health of the community at large".

Four respondents felt that there was a need for the services of a dietition to advise professional workers in the community, e.g. "There is a place in the Local Health Authority Service for a dietitian, to whom health visitors, nurses and others, including general practitioners could turn for advice and help". "Health visitors do a great deal of work in this field but more expert advice is required from time to time.

Two respondents suggested that it would be an advantage if more dietitians were employed in peripheral hospitals and seven commented on their ability to obtain the assistance of hospital dietitians whenever necessary through informal links.

Groups specified by the respondents as being most in need of dietary advice were obese schoolchildren, expectant mothers, Asian immigrants, the elderly, obese workers and the residents of welfare homes. Supervision of school meals and home meals and advice on nutrition and diet to the organisers of these services was also mentioned.

The general comments are given in full in Appendix 4.

RESULTS OF INTERVIEWS WITH DIETITIANS

Hospital dietitians

From the postal survey, four hospital groups were identified as providing comparatively extensive dietary services to the community, i.e. those four groups who scored 40-47 on the scale shown in Table 18. Visits were made to these four dietetic departments and the dietitians were interviewed.

In one of these four hospital groups, the move to a new hospital since the postal survey had caused the dietetic department to curtail its activities in order to concentrate on organising the dietetic services within the hospital. The appointment of a local health authority dietitian in the area had further affected the extended role of the hospital dietetic department as it was considered that the need for community involvement by the hospital dietitians was lessened as a result of this local health authority appointment. Liaison between the hospital dietitians and the L.H.A. dietitian was good and it was hoped to strengthen this by arranging a part-time secondment of the L.H.A. dietitian to the hospital dietetic department. The group dietitian believed such a secondment would improve the continuity of care of those patients who received dietary advice within the hospital.

The dietetic department was involved in advising general practitioners about the diets of patients. This was a purely informal arrangement carried out as a result of telephone requests from the general practitioners and was almost invariably concerned with patients who had been discharged from hospital and who had received dietary advice during their stay. These telephone requests were said to occur about once a month on average. The dietitians hoped to start an outpatient obesity clinic in the near future as they believed that groups of 10-20 patients could be more effectively treated in group sessions.

The three other dietetic departments visited, although defined from the postal questionnaire as having comparatively extensive community commitment, showed considerable variation in their involvement with the community. Two of the departments involved were each staffed by a single-handed dietitian and the third department employed three dietitians.

All three provided open access to general practitioners, visited old people's residential accommodation and visited the homes of patients.

In the case of the two single-handed dietetic departments, about two patients were seen each week at the request of general practitioners and in the third department about four patients were seen each week.

One of the single-handed dietitians estimated that 90% of the referrals from general practitioners were of patients suffering from diabetes; almost all the remaining patients were referred for reducing diets. The other two dietetic departments were said to be almost exclusively involved in seeing patients with obesity. In one case the dietitians estimated that 98% of the patients referred by general practitioners were referred for advice about obesity, 1% for diabetic advice, all other conditions making up only 1% of the referrals.

In all three hospital dietetic departments where open access was provided, patients referred from general practitioners were accompanied by a letter giving brief clinical details and the reasons for the referral.

In two of these three dietetic departments, approximately one patient per month was seen at the request of a health visitor. Such patients were usually referred for advice aimed at correcting faulty eating habits or were referred for further advice concerning therapeutic diets which had been advised while the patient was in hospital.

Much less frequent were the referrals from general practitioners and health visitors of patients suffering from malabsorption conditions, chronic renal disease, hyperlipidaemias, gastric tube feeding, and digestive disorders. In response to a request to list any conditions which the dietitians considered should be referred and which were not at present being referred, one dietitian was unable to specify any such problems, while a second dietitian suggested that infants' and children's dietary-problems were "the greatest deficiency in the people referred".

Infant feeding and the diet of children were also mentioned by the dietitians in the third (larger) dietetic department as being important subjects not at present referred but which the dietitians believe would benefit from expert dietary advice. They added five other groups or conditions which they considered were in need of expert dietary advice:-

(a) Gastric disorders - patients often need advice on "liberalisation" of strict dietary regimes. The dietitians believed that many patients who had, in the past, received advice on severely restricted gastric diets were still adhering to such diets and that this was both unnecessary and potentially harmful in respect of adequate nutrition.

(b) Intestinal disorders - patients need advice on sensible eating, and, in some cases, there is a need to correct the advice given formerly about low residue diets.

(c) Mild diabetes - many patients were believed to have received insufficient dietary advice and were therefore unnecessarily restricted in their freedom of choice of diet and were also at risk of receiving an inadequately balanced diet.

(c) Low income families - it was believed that this group would benefit considerably from dietetic advice about obtaining an adequate, balanced diet from low-priced foodstuffs, and

(e) Patients who had received inadequate dietary advice - the dietitians believed that many patients received diet sheets or only the most cursory instructions about diet, and that there was a need for much deeper discussion about therapeutic diets than could be gained from such methods.

In the larger dietetic department, but not in the case of the two single-handed departments, visits were made to buildings outside the hospital in order to attend patients. A dietitian held two evening sessions per month in one group practice, one evening session per month in another practice, a morning session once a month in a health centre and one morning session per month in a local health authority clinic.

The sessions held by these dietitians in general practice surgeries usually lasted 2 hours, during which time 8 - 10 patients were seen, by appointment. New patients were given a 20 minute appointment and return patients were given 10 minute appointments. Approximately two new patients and two follow-up patients were seen at the sessions held by the dietitian in the health centre and the local authority clinic.

As stated previously obesity was the predominant condition presenting to these dietitians, and the great majority of patients seen were adult females though all age groups and both sexes were represented. Obese patients were usually seen at monthly intervals for six months, this

PROGRAMME

11.00 a.m.	Coffee
11.25 a.m.	Introduction
11.30 a.m.	Paper: Exploratory Study of Dietitians in the Community. Dr. K. Sheridan Dawes
12.40 p.m.	Sherry
1.00 p.m.	Lunch
2.15 p.m.	Discussion: Size and nature of the nutritional problems in the country. Differences between diet and nutrition
2.35 p.m.	Discussion: Contribution of dietitians to the problems. Contribution of Health Visitors. Health education on nutrition for vulnerable groups in the population and for individuals.
3.00 p.m.	Discussion: Organisation of services. Location of dietitians, relationships with hospital dietitians and community professional workers.
3.30 p.m.	Discussion: Education and training of dietitians and health visitors.
3.50 p.m.	Conclusion
3.55 p.m.	Tea

List of Participants

J.M. Bevan	Deputy Director, Health Services Research Unit, University of Kent at Canterbury.
Miss P. Brereton	Chief Dietitian, Northwich Park Hospital, Watford Road, Harrow, Middx. Vice Chairman. British Dietetic Association.
Dr. K. Sheridan Dawes	Senior Research Fellow, Health Services Research Unit, University of Kent at Canterbury.
Mrs. R. Dowie	Research Fellow, Health Services Research Unit, University of Kent at Canterbury.
Dr. T. Eimerl	Department of Health and Social Security.
Dr. A.J. Essex-Cater	County Medical Officer, Monmouthshire County Council.
Miss Jean Marr	M.R.C. Social Medicine Unit, The London School of Hygiene and Tropical Medicine.
Miss B. Maurice	Senior Health Visitor Tutor, Medway and Maidstone College of Technology
Miss C. Murland	Group Dietitian, North Middlesex Hospital. Chairman, British Dietetic Association.
Miss J. Okell	Dietitian, Health Education Department, Hertfordshire County Council.
Mrs. N. Thomson	Group Dietitian, Ipswich Hospital.
Miss P. Torrens	Department of Health and Social Security.
Dr. K.O. Vickery	Medical Officer of Health, County Borough of Eastbourne.
Professor M.D. Warren	Director, Health Services Research Unit, University of Kent at Canterbury.
Dr. R. Yorke	General Practitioner, Maghull, Lancashire.
Dr. J. Wilkie	The London School of Hygiene and Tropical Medicine.

Professor Warren welcomed the participants and gave a brief account of the background to the study. He pointed out that the original possibility of carrying out an evaluation of dietetic services in the community was found to be seriously hindered by a lack of recorded evidence of such activities, and by the difficulties of obtaining suitable indices of measurement. It was therefore decided to carry out a study to examine the current experience in the field of community dietetic services.

The objectives of the conference were to obtain the reactions to the preliminary findings of the study of those professional workers who were involved in community care or the delivery of dietetic services and to provide a basis for discussion of the present situation with experts in these fields.

Dr. Dawes then presented a paper summarizing the preliminary results of his study following which there was a discussion relating to the findings.

Dr. Yorke raised the subject of the observed frequency of attendance of obese patients in hospital dietetic departments, as he had believed that few obese patients were referred to hospital except in extreme cases, but the hospital dietitians were unanimous in confirming the findings of the survey, as their own experience suggested that many cases of simple obesity were referred to hospital dietitians.

Dr. Eimerl expressed his interest in the observations concerning the uneven distribution of hospital dietitians, and wondered about the reason underlying such differences; whether the provision of this as with other services was related to the expectations of the people in an area and the perceptions of the role of those delivering the service or whether one could discover other social and environmental factors which influence the provision of health services.

Miss Torrens mentioned the problem arising from the fact that many dietitians were married women whose geographical location depended on the location of employment of their respective husbands, and that vacancies were often filled only when the husband of a dietitian became employed in that area. Another factor was that in those hospital groups where failure after a period of time to attract applicants for dietetic appointments produced the tendency to re-allocate funds, thus making it difficult to employ a dietitian if one moved into the area.

Dr. Vickery suggested that appointments were often made as the result of

local individual initiative, that if someone was sufficiently interested and enthusiastic about a subject, steps were taken to establish a post or a department.

Mr. Bevan asked whether in those areas which were relatively short of dietitians lecturing and group sessions were carried out by the dietitian in order to maximise the distribution of her services.

Dr. Dawes replied that from the interviews, it would appear that the method of working was related entirely to the personal preference of the dietitian, that some preferred individual consultation while others preferred to spend their time in education and supervising groups.

Miss Okell stated that this raised a fundamental issue: Who should deliver the advice? In view of the shortage of dietitians it would seem better for health visitors and others to give dietary advice than for the dietitian to attempt this herself. In this way the service could be delivered to a much larger proportion of the population.

Miss Maurice commented on the results of the survey which showed that the district nurse was rarely contacted by the hospital dietitian and suggested that in many ways the district nurse was a more suitable source of dietary advice than the health visitor, particularly in respect of special diets.

Dr. Essex-Cater, however, disagreed with the view and stated that not only in the preventative aspects but in contacts with the hospital and attachments to general practice, it was the health visitor who assumed a major role. The link between diabetic clinics and health visitors had existed for many years and some authorities had appointed health visitors to deal exclusively with diabetic patients.

Professor Warren asked if this point could be left over until later in the day as the aim at this stage was to discover whether everyone agreed that the study had presented a reasonable picture of the present situation in order that we could take up the issues highlighted by the findings.

Dr. Vickery stated that he was surprised at the extent of community involvement of the dietitians that had emerged, and expressed surprise that they could find time to carry out this work.

Dr. Dawes commented that many of these activities were carried on outside working hours, as, for example, in the lectures on nutrition given by dietitians and attendance at slimming clubs which were evening activities. It was obvious during the course of the study that dietitians worked for much longer periods than the statutory 37-hour week.

Miss Marr commented on the recent trends towards the delivering of dietetic advice in the community, stating that until very recently only three dietitians were known to be employed in local authorities.

Professor Warren asked if the work in the community which was carried out by the hospital dietitians attracted fees or whether, as for instance with lectures, the arrangement was a purely personal one.

Dr. Vickery said that the extent of work in the community carried out by the hospital dietitians was made an even more remarkable finding by the fact that in general terms there was no remuneration for this extra work.

Miss Torrens also commenting on the recent nature of community dietetic services felt that the impetus usually came from the medical and administrative staff who, if community orientated, allowed the hospital dietitian to develop these links with the community, and that this community orientation had been developing rapidly in the past five or six years.

Miss Marr stated that the most interesting result of the survey was that a considerable change had occurred in staffing over the past six years. A study of the deployment of dietitians which she had undertaken in 1967 showed a much greater concentration of dietitians in the teaching hospitals.

Miss Torrens agreed with this view of the change in distribution in the past six years and suggested that the establishments in teaching hospitals had remained at the same level while any increase in employment had taken place in non-teaching hospitals.

Professor Warren in closing the morning session, stated that it would seem that the results of the study had stood up well to criticism and that we could discuss the problems highlighted by the study during the afternoon session.

Professor Warren, in opening the afternoon session, said that the conference should now focus on meeting the needs and on the implication, as for example in organisation and education, of improving the service. This must be considered with reference to the impending reorganisation of the health service in 1974. Initially we must be clear about what problems we are trying to solve before discussing the implications.

Dr. Dawes stated that the subject of obesity had already been mentioned during the morning session and that, numerically, this was the most important problem facing the dietitians. Problems existed in obtaining acceptable definitions and measurements of obesity, and claims of the prevalence of the condition varied, some authorities even suggesting that 40% of the adult population in this country was overweight. The importance of obesity lay in its association with degenerative disorders and with increased mortality, and recent work on adipose cells and on infant obesity suggested that the problem should perhaps best be tackled in patients in their first year of life. Commercial interests in the food and drug industry and the success in the sales of magazines and "special" slimming foods indicated both the interest in the subject and the pressures applied to the population. Claims of success in the treatment of adult obesity tended to be overestimated, often because these claims related to people who completed a course and did not take into account those who defaulted.

Diabetes mellitus is said to affect 500,000 people and possibly 7% of the population has a raised blood sugar level. He was sure the delivering of dietary advice to these patients could be improved by improved organisation.

Problems exist with the diets of the immigrant population. Recent work had suggested a relation between the high phytic acid content of chapates with rickets and osteonalacia, and the possibility of genetic influences on the ability to synthesise Vitamin D in a country with a reduced amount of sunshine somewhat less than their native land.

The work of Exton-Smith and Stanton had indicated problems in the nutrition of the elderly, particularly those who were housebound, and concern is expressed, though no figures are available, of the problems of families on low income.

There are still areas of doubt and discussion about mild vitamin deficiences and whether some groups, particularly the elderly, are receiving an inadequate intake of these substances.

Inborn errors of metabolism and the malabsorption diseases are being increasingly understood and require expert dietary advice. Continuity of care is a problem in this field, for the affected child eventually terminates care by paediatricians at a time when social pressures and other factors tend to produce a reaction against continuing a strict dietary regime.

New dietary problems are arising with the modern treatment of chronic renal disease and in intensive care units, when highly complicated specific dietary regimes are required.

Professor Warren then asked if the conference could offer any other problem areas which they considered important.

Miss Torrens suggested that a large area of need lay in giving dietary and nutritional education to those who were caring for the mentally handicapped patients. She stated that in many cases hospitals did not realise the need for attention to the nutritional intake of psycho-geriatric and the mentally affected, physically handicapped patients.

Dr. Essex-Cater expressed surprise at this, as in his experience he considered obesity was the major problem in these patients, unlike other countries he had visited in which the money available for feeding mentally ill patients was less than in this country.

Dr. Wilkie suggested that patients with tumours of the gastro-intestinal tract were a vulnerable group, particularly where treatment with radiation had been carried out. These patients were often restricted to a fluid or semi-solid diet for long periods and were at risk of inadequate nutritional intake.

Dr. Vickery agreed with the statements about vulnerable groups and individuals, but said that we should also focus on the preventive aspects of nutrition. The mother of a family tended to feed her family on foods which were stocked at the supermarket and was influenced by the advertisements of the mass media. People with somewhat less than adequate resources tended to concentrate on eating a diet high in refined carbohydrates and low on other nutritive items. The work of Burkitt and Painter concerning diverticulitis and many other disorders which they have claimed result from inadequate roughage in the diet, and the extent of dental caries imply that for many people the dietary intake is less than satisfactory. I would see the dietitian in the community as someone associated with the health education officer and the health visitors, concentrating her skills on the preventive aspects of nutrition.

Dr. Eimerl in agreeing with the importance of the preventive aspects of nutrition quoted the experience of countries like Japan where a change to Western-type diets had been accompanied by the appearance of new disorders though this could not, as yet, be accepted as a cause and effect situation.

Dr. Yorke asked for the opinion of the dietitians on diet in peptic ulcer patients, as dietary advice to these patients formed the second largest category seen by his practice dietitian. He felt that there was a definite place for advice on dietary habits to these patients.

Mrs. Thomson agreed that there was a place for dietary advice in these conditions, but stated that this advice must be on dietary habits, not on special semi-solid diets or on swallowing large quantities of milk as had been advised in the past.

Dr. Dawes said that most of the dietitians who were interviewed stated that they spent a considerable time taking people off diets which had been prescribed many years ago which were now thought to be too restricting or were actually unnecessary. It appears that what is now needed in many disorders is advice on nutrition and correction of faulty diets rather than on specific therapeutic diets.

Mrs. Dowie commented on the problems of food allergies, particularly in children and wondered whether this was an important problem for the dietitian.

Mrs. Thomson stated that this was a problem and was one in which there needed to be close co-operation between dietitian and health visitor.

Professor Warren then asked if the conference could now deal with diet and nutrition.

Dr. Dawes quoted the W.H.O. definition of nutrition as "the process whereby living organisms take in and transform extraneous solid and liquid substances necessary for the maintenance of life and growth and the normal function of organs and the production of them". Human nutrition is the scientific discipline of dealing with nutrition in man. Dietetics is defined as the interpretation and application of the scientific principles of nutrition to the human subject in health and disease.

The differences between nutrition and dietetics, on the one hand, are often misunderstood while on the other hand there is generally a lack of liaison and co-operation between the workers in these two separate fields.

Professor Warren stated that it would appear that in the past we tended to think of dietetics in terms of individual advice to a patient and to consider nutrition as a public health activity of promoting "healthy" diets, and wondered whether we should continue to divorce the two activities.

Dr. Yorke said that he felt that the important difference lay in that the former dealt with knowledge while the other dealt with application of that knowledge.

Miss Marr considered that one of the major problems in this situation was a result of the different training programmes for dietitians and for nutritionists, and that dietitians, who have training in nutrition as well as dietetics, are reluctant to allow nutritionists to enter the dietetic field without further training.

Miss Torrens replied that if the nutritionist was to become involved in dietetics they need to have dietetic training, and that although the two professions are separate, this did not preclude close cooperation between the two.

Professor Warren said that the trends shown in the survey were that dietitians were becoming involved in nutrition in the community and that this trend appeared to have general approval. Clearly it is necessary to understand the terms and at the same time not prevent changes which are beneficial becoming hampered by rigid definitions.

Dr. Wilkie asked what were the implications on manpower, and whether nutritionists could be employed to relieve the shortage of dietitians.

Miss Marr commented that in fact there was a dearth of employment for nutritionists and food scientists and many were taking the dietetic diploma course.

Miss Torrens agreed and said that in those areas in which nutritionists were trained, the demand for dietetic diploma courses was increasing. Formerly people attending these courses came about exclusively from institutional management and catering graduates with a few entrants from nursing, whereas at present the greatest proportion of entrants came from graduates in food science and nutrition.

Professor Warren suggested that although the situation had not been clarified, the discussion had certainly emphasised the importance of the problem.

Mrs. Thomson added that the difference was less obvious at individual level, for the dietitian when advising on a specific diet was subconsciously giving consideration to the nutrition of the family, the implications of one of its members being on a diet, the various financial problems involved and the manner in which the diet of one member affected the feeding habits of the family.

Professor Warren suggested that the conference should turn to the problem of the dietitians and the role of other professional workers, particularly with reference to the treatment of obesity.

Miss Okell stated that the prevention of obesity was easier than treating the condition and less time should be spent on the latter. In this field the co-operation between dietitian and health visitor was vitally important, for the health visitor could contribute so much to the knowledge of the social background of the patient and to examining and defining the possible reasons for the obesity.

Miss Gastrell suggested that this was an area in which attachment of health visitors was of great benefit, and provided opportunities for joint action by doctor, health visitor and dietitian.

Miss Maurice agreed with this and expressed the feeling that the most effective method of dealing with obesity was carried out in the patient's home by the health visitor who could then be involved in both the therapeutic and the preventive aspects of the problem. She wondered whether group sessions could be effective as individual problems could not be discussed in such sessions, though one supported the concept of group because it was economical in time and staff.

Miss Torrens also agreed with the importance of dealing with a family unit, as this method ensured that the various problems, including financial, of the family were taken into account and discussed. Widespread effective health education could be carried out in this way.

Professor Warren asked for clarification and elaboration of what could be done to prevent obesity.

Miss Maurice said that experience both as midwife and health visitor had caused her to believe that an excellent time for giving dietary advice was to women during their ante natal attendances. However, this advice appeared to be less often given and less often taken up by the mothers after the birth of their children. One needed to link this ante natal advice with the dietary advice to the mothers and later to the children, preferably advice given by someone who has attended the family throughout the period and who has close liaison with school teachers.

Dr. Yorke agreed that this, from the general practitioner point of view, was an extremely important function of a health visitor, though refresher courses in dietetics and the updating of knowledge was required, for the pressures from commercial interests must be counteracted and developments in the field of nutrition and dietetics must be learnt.

Miss Maurice accepted this need for updating knowledge and suggested that a very useful role of the dietitian would be that of giving lectures on nutrition and dietetics to groups of health visitors as well as to other groups. She was sure that health visitors would welcome this as a more satisfactory way of keeping up-to-date than by reading the literature produced by commercial firms.

Professor Warren said that it appeared there was general agreement that the health visitor should play a major part in delivering dietary advice but that she must have support from a dietitian, both as an expert to whom referrals can be made and as someone who provided continuing education.

He also asked for the views of the conference on the activities in clinics in respect of infant weight gain. Do the staff of clinics use the percentile charts and give advice on the correction of obesity?

Dr. Essex-Cater said that in his own area weighing of infants was only rarely carried out, and was only performed if the mother expressed a strong desire to know the weight of her baby.

Dr. Vickery confirmed this attitude in respect of his area, and said that the health visitors were well enlightened and did not over-use the scales or emphasise the value of the infant's weight, and that the health visitors in his area stress that they are weighing the baby to ensure that he or she has not gained too much weight.

Professor Warren questioned whether the information was widespread and whether mothers were acting upon the advice when it was given.

Dr. Essex-Cater said that the problem of pressures from commercial organisations was again a feature in this situation.

Dr. Vickery agreed and said that he noted the point about the reaction of mothers and that it was something which should be examined.

Dr. Dawes added that concern was being expressed about the increasing number of obese infants, and that this suggested that the message was either not being given or was not being acted upon.

Dr. Essex-Cater stated that he agreed that efforts to prevent obesity must be concentrated on mothers of infants; the damage was done by the time the child started school. School meals he felt contributed little to the calorie or carbohydrate daily intake of schoolchildren because of the money available for supplying these meals.

Dr. Dawes agreed with this, adding that tuck shops and sweet shops in the vicinity of a school contributed much more to the intake of carbohydrates. The dietitians employed by Bristol Health Authority had organised a campaign to try to encourage children to eat fruit and cheese rather than chocolate and sweets.

Miss Okell also agreed that school meals were not a problem but that the "bits and pieces" consumed during the day were a major contribution to obesity.

Professor Warren suggested that the discussion was touching on the point raised by Dr. Vickery about the nutrition of the population generally, for if the population were consuming proper diets the problem of obesity would largely disappear. Other vulnerable groups existed, however, such as the house-bound elderly, the immigrants and low income groups. What was the best approach in these cases? Are we to look to the health visitor for primary advice backed up by the dietitian?

Dr. Essex-Cater answered that in view of the shortage of dietitians the health visitor must be taught by the dietitian to carry out the work.

Miss Marr mentioned the earlier comment about the district nurse being contacted less often than the health visitor, by the dietitian and felt that district nurses could play an important part in delivering dietary advice as they were in close contact with many of the house-bound elderly.

Dr. Essex-Cater disagreed with this and stated that the district nurse only came into contact with people who were ill. Many of the vulnerable groups were not ill and these people should be visited by the health visitor. There were many other demands on the health visitor, however, and not all could be given the time that one would like.

Dr. Vickery in agreeing with Dr. Essex-Cater, added that we should ensure that others in contact with these vulnerable groups such as the increasing number of social workers should be trained to spot nutritional problems and to elicit information about the diets of the elderly living alone.

Dr. Essex-Cater mentioned that home helps were another group of workers who could greatly assist in eliciting vulnerable groups, and commented on the difficulties of liaison now that they were no longer employed by the health department and were not trained by the health authority.

Miss Torrens said that the community dietitian should be concerned in the teaching of nutrition to all local authority department staff.

Dr. Yorke added that he considered it essential that the health visitor should be attached to general practice and that they had a far greater role to play in the field of delivering dietary advice, but was still uncertain of their role and their relationship with the dietitian.

Miss Maurice stated that health visitors were taught basic nutrition and the essentials of diets, usually by dietitians.

Miss Marr commented that not all people visited by the health visitor were in need of dietary advice. The problem was to identify those people who were nutritionally vulnerable, and, most importantly, to be able to offer advice which would be acted upon.

Dr. Essex-Cater suggested that a visit to the home at meal times enabled the health visitor to assess the situation, and Dr. Vickery added that a health visitor could observe the nutritional behaviour of the person visited by examining the larder. It was agreed, however, that these were crude

measures and that further research was needed to define indices of nutritional vulnerability and of methods of screening for high risk individuals.

Miss Brereton commented on the habits and religious principles of many immigrants who required specialised dietary advice which took account of these factors.

Miss Maurice added that those families with social problems generally required financial management advice rather than dietary advice. The greatest difficulty here was in "reaching the person", and in having advice accepted.

Professor Warren said that a project in the computing laboratory at the University was devised to correlate nutritive values of foodstuffs with current costs. Prices of foodstuffs were updated weekly by visits to local shops and costs of diets could be obtained very rapidly. If this was developed and extended a print-out of "best buys" could be made and circulated to the local press each week.

Dr. Essex-Cater stated that his department had tried to produce a weekly list of "best buys" for the elderly. A health visitor compiled the list from her experience of available foodstuffs, making a list of specimen meals to be distributed via the local authority publicity department. The cost of this exercise, however, was found to be prohibitive.

Professor Warren suggested that the cost of the exercise must be largely that of distribution of the information, and that this could be drastically curtailed if the press, both local and national, were willing to print the information without charge. The newspapers would, at least, provide information to the health visitors, if not the vulnerable groups.

Miss Maurice said that we were still faced with the problem of getting the message across to these groups.

Mrs. Dowie asked who these people, especially the families with social problems, listened to. It would appear they do not listen to advice from the health visitor. Do they accept advice from the general practitioner? Is he the person who should be given the training in nutrition and dietetics?

Dr. Dawes said that we should realise that these groups are influenced by certain pressures - Bingo halls are full, people are affected by commercial television and other advertising. We need to emulate these methods and techniques if we are to reach the public. Too much health education is devoted to telling people not to do things, a more positive approach is needed.

Professor Warren suggested that the conference should now turn to the disease groups, of which diabetes appeared to be a major problem in the dietetic field. There were half a million diabetics in this country, mortality rates were increasing particularly in the older age groups. Could it be that there was now less attention paid to diet since the advent of hypoglycaemic drugs?

Miss Murland felt that present hospital diabetic clinics were too crowded to be a satisfactory method of dealing with diabetic patient diets. In her own clinic, a consultant, registrar and dietitian may deal with 80 patients during an afternoon session. Advice on diet to a diabetic patient attending for the first time was ineffective due to the emotional state of the newly diagnosed patient. The dietitian needs to give the dietary advice at a follow up visit, but did not otherwise see the need for subsequent follow up by a dietitian unless problems presented.

Dr. Essex-Cater agreed and said that in many areas it was the health visitor, usually attached to a diabetic clinic, who followed up the patient, and tended to give the advice in the patient's home which allowed the health visitor to take home, financial and other factors into account.

Miss Murland added that it would seem unnecessary for the dietitian to visit the patient's home as the patient was already being visited by the health visitor and possibly the general practitioner.

Mrs. Thomson said that on rare occasions when she had visited patients in their homes she realised how much easier it was to give dietary advice in the patient's kitchen. She suggested that what was really wanted was closer liaison between the professional worker in the community and the hospital diabetic clinic.

Professor Warren commented that this suggested a concept of employing the consultant and dietitian in the hospital providing support and backing for the general practitioner and health visitor who would supply the service to the patient in the community.

Dr. Eimerl stated that we were suggesting a new concept which was still based on existing methods of delivering advice, and wondered whether we should be thinking now of new methods and techniques of delivering the advice rather than merely on which person should be employed to give this advice.

Mrs. Thomson remarked that one of the most important aspects in long term illness was that there must be continuity of care, the patient required to receive the advice from one expert, not from a number of sometimes conflicting experts.

Dr. Eimerl said that we had already touched on the influences and pressures in modern society - television commercials, advertising techniques and impulse buying. Perhaps we are wrong in continuing to exert our influence on a one-to-one basis.

Professor Warren replied that he believed 'modern' approaches should be tried, but one was most worried about the individual in a group session, whether everyone present absorbed the information.

Dr. Vickery claimed that because of the incidence of diabetics and taking account of such problems as the incredible increase in the disease of those Indians who emigrated to South Africa and presumably changed to a new diet, there was an urgent need to develop mass public health programmes.

Dr. Yorke quoted the work of Dr. Midgely who was examining the use of programmed learning techniques in general practice.

Miss Okell, however, pointed out that with diets, it was essential to develop motivation. The knowledge by the patient that someone cared was a prime factor in developing sufficient motivation to continue a diet. It was true that there was a need to disseminate information about nutrition and diet, but feeding was an extremely personal habit and a personal approach was still required in delivering the advice.

Professor Warren commented that what appeared to be developing from the comments was that technological methods can be used as well as personal consultation. Programmed learning could be used to replace some of the follow up consultations or replace part of a consultation.

Dr. Dawes added that with diabetes we had so far identified certain groups as for instance the juvenile diabetic or the mature onset diabetic, but there is still a tendency to manage all diabetics in the same way, irrespective of their ability to absorb advice or cope with diets. There were those within these groups whose intelligence, learning ability, financial status, etc. made them especially vulnerable, yet they were often "swamped" by the numbers attending a clinic, many of whom need not attend for advice.

Professor Warren added that this presented a new area of research work, to identify those groups within vulnerable groups, who by their personalities or other problems required concentrated attention.

We still had two items to discuss: the organisation of dietetic services and the question of training.

In 1974 the three branches of the services were to be unified, and we shall consider the implications of this, particularly in respect of the deployment of dietitians.

Miss Torrens suggested that we needed to develop a service for the whole community, and we should utilise our existing and future resources to this end.

Miss Marr added that a suitable career structure for dietitians must be made an integral part of our thinking on the subject.

Miss Torrens pointed out that the career grading had been under consideration for some time and, in view of the imminent reorganisation of the health service, the need for decisions was becoming increasingly urgent.

Dr. Essex-Cater saw two functions of a dietitian. One was that of delivering advice to individual patients, the other was part of a professional group occupied with preventive medicine. The emphasis on prevention should and must be increased in the future, and therefore the dietitian should be seen as a member of the community care team first and a therapeutic hospital dietitian second.

Miss Torrens asked whether the dietitian needed to be so rigidly divided into two; could she not play both roles? At present dietitians were hospital orientated; is it possible to alter this?

Dr. Essex-Cater said that this depended on numbers of dietitians available and whether they wanted to work in the community.

Miss Torrens added that the hospital medical staff would not welcome withdrawal of dietetic services.

Mrs. Thomson believed that hospital dietitians were in a position to state their views now on dietetic services in the future. Where long-standing arrangements for community dietetic services were in existence, it was probably unwise to make a major upheaval, but any new arrangements and organisation must be carried out with the concept of delivering a service to the whole community.

Dr. Vickery asked for the views of the dietitians present on how they saw their optimum deployment. Where a dietitian was employed by a local health authority medical officer there was a hierarchical relationship. Does she have any such relationship in hospital work? Does she feel professionally isolated? Do dietitians see themselves as members of a team of dietitians separate from and having no wish to belong to medical or nursing teams?

Miss Okell felt that in local health authority employment the dietitian was closely associated with a medically organised team, but in hospital work she merely worked in co-operation with the medical and nursing staff.

Miss Torrens added that, at present, the hospital dietitian is directly responsible to the senior administrator, but works for a number of individual consultants, and that this system appeared to work satisfactorily.

Dr. Yorke suggested that this system would still apply after re-organisation, the dietitian being responsible to the District Administrator, but would carry out the "prescriptions" of the clinicians.

Professor Warren stated that it could be said that the dietitian was responsible, managerially, to the district management team in general matters and to the administrator for detail. The community physician would be another consultant "prescribing" for community dietary and nutritional problems. If more than one dietitian was employed in a district, one of these would be the usual recipient of "prescriptions" from the community physician.

Dr. Essex-Cater commented on the differences in personalities and attitudes and was doubtful of the ability or willingness of some hospital dietitians to accept a community role. He did not accept that the local health authority medical officer was in an hierarchical relationship with the community dietitian. There was a close professional relationship and co-operation, the dietitian working as a professional in her own sphere and occasionally seeking support or guidance from the MOH.

Miss Brereton outlined the system at Northwick Park Hospital whereby a dietetic advisory group, which included medical members and which could discuss such problems as the workload of the dietetic department and uneven referral patterns from consultants.

Miss Torrens asked if the conference was quite certain that the district was the focal point for dietetic services. Was there a need for an area dietitian in a multi-district area?

Miss Marr expressed the hope that an area dietitian would be an acceptable appointment in the not too distant future. The area dietitian would be needed to co-ordinate the dietetic services.

Dr. Yorke asked if the dietitians felt it was a viable concept to employ dietitians in health centres which housed, say, ten to twelve general practitioners, and dealt with a population of around 30,000?

Professor Warren suggested it was essential for the dietitian to at least visit such centres, to talk to doctors and health visitors and to learn of the problems, If there were several districts in an area, which will occur in a few areas, he saw a need for a co-ordinating area dietitian, and this re-introduced the subject of career structure. He did not see a need for a regional dietitian (a view which was agreed by all participants).

Miss Marr reiterated her views on the importance of the career structure and mentioned the possibility of recruiting males into the dietetic profession, with a resultant pressure for a more realistic career grading. The recruitment and retaining of dietitians was a vitally important factor in meeting the needs and demands of a dietetic service.

Professor Warren added that some of the problems we had discussed were those which needed to be tackled at area level. Once or twice the subject of research needs had been mentioned, and it would be most useful to have

a dietitian working with a research intelligence unit in order to look at specific problems and to observe changes and developments in the service.

We should now turn to the important subject of education and training though many aspects had already been discussed. There would appear to be a need for re-orientation courses for hospital dietitians for further training in nutrition and dietetics for health visitors and doctors, and for education of the public.

Miss Murland said that the profession was very aware of the need for training of dietitians in community and preventive care, in communication and educational methods. At present the number of student dietitians was increasing but the problem of providing suitable places in hospital dietetic departments was causing concern.

Dr. Yorke commented on the new "workshop" in community dietetics set up by Professor Truswell at Queen Elizabeth College which had resulted from discussions with the British Dietetic Association.

Dr. Eimerl asked if he could proffer one or two thoughts before the conference ended: "We have heard that we are in a rapidly changing situation. There was still a need for dietitians to give advice to individual patients but there is a larger need for dietetic and nutritional advice to the population. One must seriously question the ability of some 1,100 dietitians being able to cope with such a problem. We have the situation of a small cadre of highly skilled professionals who need to disseminate their knowledge through others. Firstly, we need to know what are the specific skills of a dietitian. Secondly, what function can she alone carry out. Thirdly, what training is required. We may also add, how to implement changes in training most effectively. It may be helpful not to restrict our thinking to the professional approach but to look at the methods and techniques used in industry and commerce when faced with problems of change and of limited resources. Similarly workers in operational research are those who par excellence can examine a skill and suggest methods of meeting defined objectives. Industry, faced with the need to disseminate large quantities of information to a wide audience, employ new techniques such as audio-visual programmed learning. Perhaps we should think of package programmes of dietetic instructions for patients and for other professional workers involved in the care of patients. I may add, with particular relevance to our presence here at a research unit, that we also need monitoring of innovations, of evaluation of changes, and recurrent or even continuous assessment of needs."

Professor Warren, in closing the conference, thanked the participants for their contributions and hoped that the benefit we had gained from the conference had not been one-way, but that those attending had found benefit in attending.

TABLE 9

Distribution of hospital dietitians (w.t.e.) employed in England

R.H.B.* Area	Dietitians per 100,000 popn.	Dietitians per 10,000 hosp. beds	Dietitians per 10,000 discharges **
I Newcastle	0.58	7.7	0.5
II Leeds	0.89	10.6	0.8
III Sheffield	0.57	9.1	0.6
IV East Anglia	0.79	11.8	0.9
V N.W. Met.	1.68	20.3	1.3
VI N.E. Met.	1.03	13.5	0.9
VII S.E. Met.	0.81	10.5	0.7
VIII S.W. Met.	1.23	10.9	1.0
IX Wessex	0.67	9.4	0.7
X Oxford	1.25	20.4	1.1
XI S.Western	0.55	6.4	0.5
XII Birmingham	0.45	6.4	0.5
XIII Manchester	0.62	8.3	0.6
XIV Liverpool	0.52	5.9	0.4
Total	0.78	11.2	0.8

* Teaching hospitals are included in relevant R.H.B. area.

Source of popn. and bed and hospital discharge statistics: Health and Personal Social Services Statistics 1972 H.M.S.O.

** Based on "Discharges and deaths during 1970"

TABLE 9

Number of current advertisements (w.t.e.) for hospital dietitians in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	-	-	-	-	-	-	4	-	0.36	-	4.36	-
II Leeds	-	-	-	-	-	-	-	-	1	2	1	2
III Sheffield	2	-	-	-	-	-	2	-	2	-	6	-
IV East Anglia	-	-	-	-	-	-	-	-	-	1	-	1
V N.W. Met.	-	-	-	-	-	-	1	-	1	0.27	2	0.27
VI N.E. Met.	1	-	-	-	-	-	2	-	2	-	5	-
VII S.E. Met.	-	-	1	-	-	1	-	-	2	-	3	1
III S.W. Met.	-	-	-	-	-	-	-	-	-	-	-	-
IX Wessex	-	/	-	/	-	/	1	/	-	/	1	/
X Oxford	-	-	-	-	-	-	-	-	-	-	-	-
XI S. Western	-	-	-	-	-	-	-	-	-	-	-	-
XII Birmingham	-	1	1	-	-	-	2	-	1	-	4	1
III Manchester	-	-	-	-	-	-	4	1	1.73	-	6.73	1
XIV Liverpool	-	-	-	-	-	-	2	-	2	1	4	1
Totals	4	1	2	-	-	1	18	1	13.09	4.27	37.09	7.27
	5		2		1		19		17.36		44.36	

TABLE 10

Open Access to Hospital Dietetic Departments by General Practitioners

Number of hospital groups by number of patients referred in one calendar month (October 1972)

Referrals in calendar month	Number of hospital groups
5 patients or more referred	30
1 - 4 patients referred	62
No patients referred	14
No open access	58
Not stated	7
Total number of hospital groups employing dietitians	171

TABLE 11

Patient contact outside hospital

Number of hospital groups in which dietitians attend individual patients outside hospital

By place and frequency of attendance

Frequency of attendance by dietitian	Patients located in			
	G.P. Surgeries	Health centres	Welfare accommodation	Own homes
3 or more times per month	4	3	1	2
1-2 times per month	-	2	2	10
Less than once per month	2	6	14	62
Not at all	158	153	147	90
Total	164	164	164	164

N.B. 1. No hospital group appears more than once in the "3 or more times per month" category

2. Only two groups appearing in the first row across also appear in the second row

TABLE 12

Visits to institutions

Number of hospital groups in which dietitians visit institutions to give general dietary advice

By place and frequency of visit

Frequency of visit by dietitian	School meals centres	Schools	Special schools	Welfare accommodation
3 or more times per month	-	-	2	2
1-2 times per month	-	1	1	2
Less than once per month	4	20	20	13
Not at all	160	143	141	147
Total	164	164	164	164

N.B. 1. Only one hospital group appears twice in the first two rows across

TABLE 13

Informal Discussions with Community Workers

Number of hospital groups in which dietitians hold informal discussions with community workers

By type of community worker and frequency of discussions

	General practitioners	Health visitors	District nurses	District midwives	School meals organisers	Home meals organisers	Welfare accommodation staff	Other
3 or more times per month	16	22	3	-	-	1	-	9
1-2 times per month	40	27	11	2	7	1	4	8
Less than once per month	71	68	47	18	41	25	46	25
Total	127	117	61	20	48	27	50	42

N.B. Based on 164 fully completed questionnaires

TABLE 14

Attendance at Outpatients by hospital dietitians

Number of hospital groups in which dietitians attend patients in outpatient depart ent

By disease category and by frequency of consultation

Disease category	Every time patient attends	Occasionally	Never
Obesity	112	47	4
Diabetes	49	108	6
Coronary artery disease	17	125	21
Chronic renal disease	68	85	10
Malabsorption	42	105	16
Vitamin deficiencies	22	99	42
Obstetric	12	101	50
Other	32	53	73

N.B. Based on 163 replies to this question

TABLE 15

Provision of dietary advice after patient is discharged from hospital

Number of hospital groups by method used and by frequency

	Dietitian visits patient's home	Dietitian requests patients to return to diet.dept.	Dietitian contacts G.P.	Dietitian contacts H.V.	Other
For every patient	-	57	2	1	1
Occasionally	59	102	105	88	37
Never	105	5	57	75	125

TABLE 16

Lectures on nutrition and dietetics

Number of hospital groups in which hospital dietitians lecture
By type of audience

Type of audience	Number of hospital groups
General practitioners	31
Health visitors	39
District nurses	33
District midwives	19
Social workers	10
Home helps	8
Home meals organisers	4
School meals organisers	3
Schoolchildren	29
School teachers	7
Voluntary organisations	81

Based on 164 fully completed questionnaires

TABLE 17

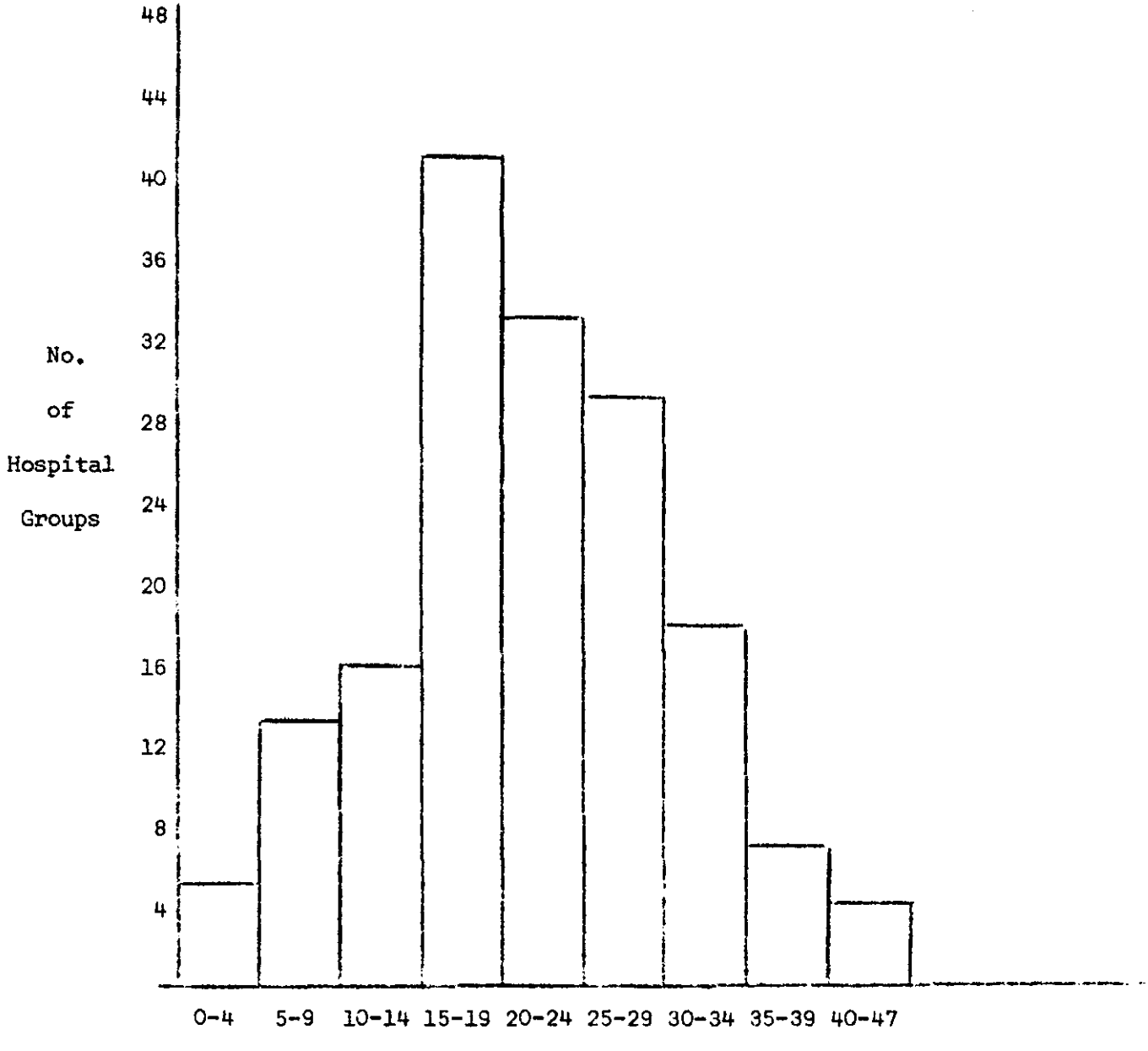
Lectures on Nutrition and Diet

Number of hospital groups in which hospital dietitians lecture, by numbers of different types of audience receiving lectures by the dietitians in each group

Number of different types of audience	Number of hospital groups
7 or more	2
6	10
5	6
4	16
3	20
2	27
1	37
0	46
Total	164

TABLE 18

EXTENT OF COMMUNITY COMMITMENT OF HOSPITAL DIETITIANS



(Possible Total = 109)

Based on 164 fully completed questionnaires

TABLE 19

Adequacy of Dietetic Services to the Community

Opinions of Local Health Authority M.O's.H.
by employing authority

Employing authority	Services adequate	Services inadequate	No answer
County councils	29	10	7
County boroughs	47	23	8
London boroughs	21	9	3
Total	97	42	18

TABLE 20

Adequacy of Dietetic Services to the Community

Opinions of Local Health Authority M.O's.H.
by employment of LHA Dietitians

	Services adequate	Services inadequate	Total
Dietitian employed	7	3	10
Dietitian not employed	90	39	129
Total replies	97	42	139

APPENDIX 3

EXTENT OF COMMUNITY INVOLVEMENT OF HOSPITAL DIETITIANS

Scoring Method

		Score
(1)	Open access to general practitioners	
	No answer or no direct access	0
	Yes, but number of patients referred not specified	1
	No patients referred in previous month	1
	One to four patients seen in previous month	2
	Five or more patients seen in previous month	3
(2)	Visits to institutions, formal lectures, informal discussions	
	No answer or never	0
	Less than once a month	1
	Once or twice a month	2
	Three times or more a month	3
(3)	Outpatients seen, advice to patients after discharge	
	No answer or never	0
	Occasionally	1
	Every patient	2

APPENDIX 4

GENERAL COMMENTS OF L.H.A. MEDICAL OFFICERS OF HEALTH

1. L.H.A. Dietitian employed

047 It is only a few weeks since a dietitian took up her appointment with us. My own thinking on the subject is that initially she would be used as as a nutritionist teaching people about nutrition and it would only be secondarily that I would use her to advise patients on diets.

052 The Social Services Directorate and the Borough's Catering Department may also ask for advice from the community dietitian who is on the staff of the Medical Officer of Health.

058 It is worth explaining the position of the dietitians especially in their relationship to the Catering Officer. The two dietitians, whom you will notice are both part-time, share the week Monday - Friday by each working half a day, totalling five half-days. Their primary task is to supervise the preparation of the dietary meals (120 - 140 per day) and they also take part with the Catering Officer in the compilation of the Luncheon Club, Meals-on-Wheels menus. The dietitians are Health Service employees, but the Catering Officer comes under the Director of Administration.

092 In spite of my answer to question (6), I think there is much scope for a greatly improved dietetic advisory service at the eight health centres we have provided (and there are seven more in the pipeline). General practitioners would refer patients who at present receive fragmentary and often only intermittent advice from hospital outpatient dietitians, e.g. coeliacs, diabetics, hypertensive and obesity patients. This would mean employing further dietitians.

2. No L.H.A. Dietitian employed

004 On question 5, although we do not actually employ a dietitian in this department, we have from time to time made use of the services of the dietetic staff based at Addenbrookes Hospital, e.g. to help draw up diet sheets for parents of school children, to advise on diet at school dinners in the case of a child with coeliac disease.

On question 6, the medical staff feel that the answer should be "NO". Groups and individuals in the community may get advice from health visitors, district nurses, health education officers, and also from local authority medical officers at child health clinics and schools. However, in the case of the nurses and health visitors, very little nutrition is taught in this training and even less in the health education training. The Hospital Service is an in-patient one, and the extent to which it is used by the consultants varies with the particular consultant.

As to improvement, it is felt that there is a place in the Local Authority Health Service for a dietitian, to give guidance in matters of nutrition, and to whom health visitors, nurses and others, including general practitioners, could turn for advice and help. At present, the feeding of immigrants is being spotlighted in certain areas, where the dietitian is most useful.

Subject to financial considerations, it is felt that there is a place for dietitians in the Public Health field.

006 More dietitians could with advantage be employed by the peripheral hospitals.

008 Probably the health visitor service should be a sufficient source of advice but for this they will need further training and more reorientation to and among the elderly.

013 Without mounting a special survey I could not estimate either the total unmet need for dietary advice in the county, nor the extent of the work carried out. Health visitors give a great deal of general dietary advice, some are attached to diabetic clinics, nearly all help in interpretation and fulfilling of advice given by dietitians.

018 The present H.M.C. have authority to appoint a hospital dietitian shortly. This should be the nucleus under the Areas Medical Officer of a community Dietary Service, with responsibilities in Health Centres and General Practitioners' Group Premises, and in training of nursing and health visiting staff.

Education staff are already covered by the School Meals Organiser.

The inclusion of the dietitian in the Preventive Services would emphasise the positive aspects of sensible diet in the prevention of certain diseases, as well as the narrower field of merely planning menus for sick people.

019 So far as my knowledge goes from observation of schoolchildren and the extensive nutritional survey undertaken in conjunction with St. Thomas' Hospital and the Department of Health and Social Security, the evidence available to me indicates that adequate nutritional standards exist.

041 This is included in the Health Visitor's training but the Health Visitor's contact with the general public is limited.

The information is available if it is asked for or if it is required by an exisiting patient.

057 Because of the large number of Jewish faith in our community there would be special difficulty in this area.

062 I agree that the appointment of a dietitian would be helpful. I would make such an appointment as part of the staff of our specialised Health Education Unit, which consists of two professional staff supported by a technician. Specific dietary advice could then be given to expectant mothers, to schoolchildren where obesity is a real problem and in industry from whom requests are currently received for slimming advice. Some education of the elderly would also be appropriate.

078 The role of dietitian in the community can best be fulfilled as a member of a team concerned to ensure that the vulnerable groups in society are provided with the most suitable foods to maintain and promote good health. Apart from the dietitian others involved include the general practitioner, the local authority doctor (embracing maternal and child welfare and school health), the health visitor, the midwife, the home nurse, the school nurse, the biology or domestic science teacher, and those giving dietary advice in relation to the school meals service, luncheon clubs for the elderly and the meals on wheels service.

Advice on diet following an illness which has necessitated specialised investigation and treatment is best provided by a dietitian closely linked with the hospital concerned.

Looking to the future there is much to be said for developing a more closely knit nutritional service linking the activities of dietitians inside and outside hospital with the educational efforts of others working in the field of health, education and welfare. Such a concerted approach is essential if an integrated health educational effort is to be mounted in the twin fields of prevention and treatment. 1974 offers an excellent opportunity to take a fresh look at the key subject of nutrition with particular reference to the contribution of the dietitian to the health of the community at large, of which the hospital forms part.

083 This is an industrial area with big families living in corporation estates - the cutting of the School Milk Grant has been felt. Not only for the health of the children but for the mothers as it would seem that many of the mothers are on an inadequate diet.

100 In an authority of this size there would not be sufficient work for a full-time dietitian. As the local authority has very close ties with the clinicians at the hospital, the present arrangement appears to be working quite satisfactorily.

107 Health visitors do a great deal of work in this field but more expert advice required from time to time.

108 When requiring advice from hostels, O.P. homes, sheltered workshops, day centres, etc., I have always been able to call on personnel of the hospital service for such advice, owing to the fact that I am part in the employ of the R.H.B. as well as being M.O.H.

I would agree that there is immense scope for advice to the community over and above what normally passes for Health Education.

109 When the new Area Health Authorities are established in 1974, the hospital dietitians will probably become available for giving advice.

110 I have been M.O.H. for nearly 20 years and none of the women's organisations have ever asked for dieting advice although I include it in a favourite talk - "healthy living". The obese schoolchild is the main problem, and we do encourage them to diet and a printed guide is handed out.

117 In a Utopian society one could do with more dietitians but as the situation exists these services are best used in the hospital field.

123 The Senior Hospital Dietitian, acts as honorary dietitian to health visitors in the department, who are in turn involved in advising patients of the doctors to whom they are attached. I understand the Department of Social Services has a similar arrangement for advising Meals on Wheels service and also catering in the old persons' homes.

There is in my view a considerable opportunity for deployment of dietetic skills within the community.

125 It is thought that more dietary advice could be given through health education programmes.

129 Although we have no post on our establishment for a dietitian we have nevertheless, been investigating the possibility of establishing a project between ours and one of the local hospitals as part of our Health Education Programme. This will involve the organisation of a Weight Reduction Clinic at which advice on diet and food values generally would be promulgated. At the moment, however, these discussions are in a very preliminary stage and we have no copy of a firm scheme which we could show you.

131 (1) Nutrition should be accepted as a subject of public health importance in our society, (2) Education of doctors and nurses, (3) Better teaching of nutrition at undergrad stages (4) Employment by l.h.a's of dietitians, (5) M.O.H. department to provide skilled nutrition advice to other departments - using dietitians in medical/nursing/science team.

I am delighted this subject is being looked at.

136 Information about nutrition is provided through the general health education programme, as follows:-

Ante and post-natal clinics	-	by health visitors
School groups	-	through the general health education programme at the Health Education Centre and in 'Health in Adolescence' courses.
		materials are also provided for teachers including leaflets, films, and background information
General public	-	in response to specific requests for information on 'Diet' in general. Dissemination through leaflets, films, etc. and inclusion of the subject in specifically titled lectures or in connection with 'modern hazards to health ' topics.

Whilst most of the professional staff are in a position to give general information, there is no-one to whom we can turn who has a State Registered qualification or an advanced training in this field. We have, on occasions, made use of graduate dietitians from such organisations as the National Dairy Council, the Gerber Baby Council or the Milk Marketing Board. These visiting specialists have talked to groups of the staff and, on a very limited number of occasions, to clinic groups.

138 The only dietitians employed in the area are in the Hospital Service. They provide a good service to patients referred to them from consultant clinics only, but are willing on a personal basis to give advice to organisations or professional individuals who seek it.

My own department is asked for advice by internal organisations such as the Schools Meals Service and the Social Services, Residential Section, and we cheerfully give general advice based on medical rather than dietetic expertise.

We have occasionally suggested that the D.H.S.S. advisory service should be consulted.

140 While I can see the desirability of having a qualified dietitian available, it is extremely doubtful if there would be enough work to justify this appointment. When this was a combined health and welfare authority we did have visits from a dietitian from the Department of Health to talk to the matrons of day nurseries, residential homes, etc.

With the attachment of nursing staff to general practices I forsee that they are liable to be asked to give advice to diabetics etc. from time to time. At the present time I am exploring the possibility of some inservice training from a hospital dietitian.

141 The hospital is willing to supply special diet sheets to general practitioners.

151 Clearly there is inadequate dietetic advice to certain groups, e.g. Asian immigrant babies and the old. A dietitian could not prevent this. She could reinforce and help Health Visitors but in general to these groups very general advice is appropriate which is within the reasonable capacity of Health Visitors, etc.

Where a dietitian can help is in regard to advice to staff of residential establishment, e.g. home for the elderly, with regard to dietary advice to the overweight child in clinics for this purpose, to the diabetic outpatient and patient under care requiring any specific dietary limitation.

To my mind therefore a dietitian is of value if based actually with two functions:

1. General (i) on diets in residential establishment

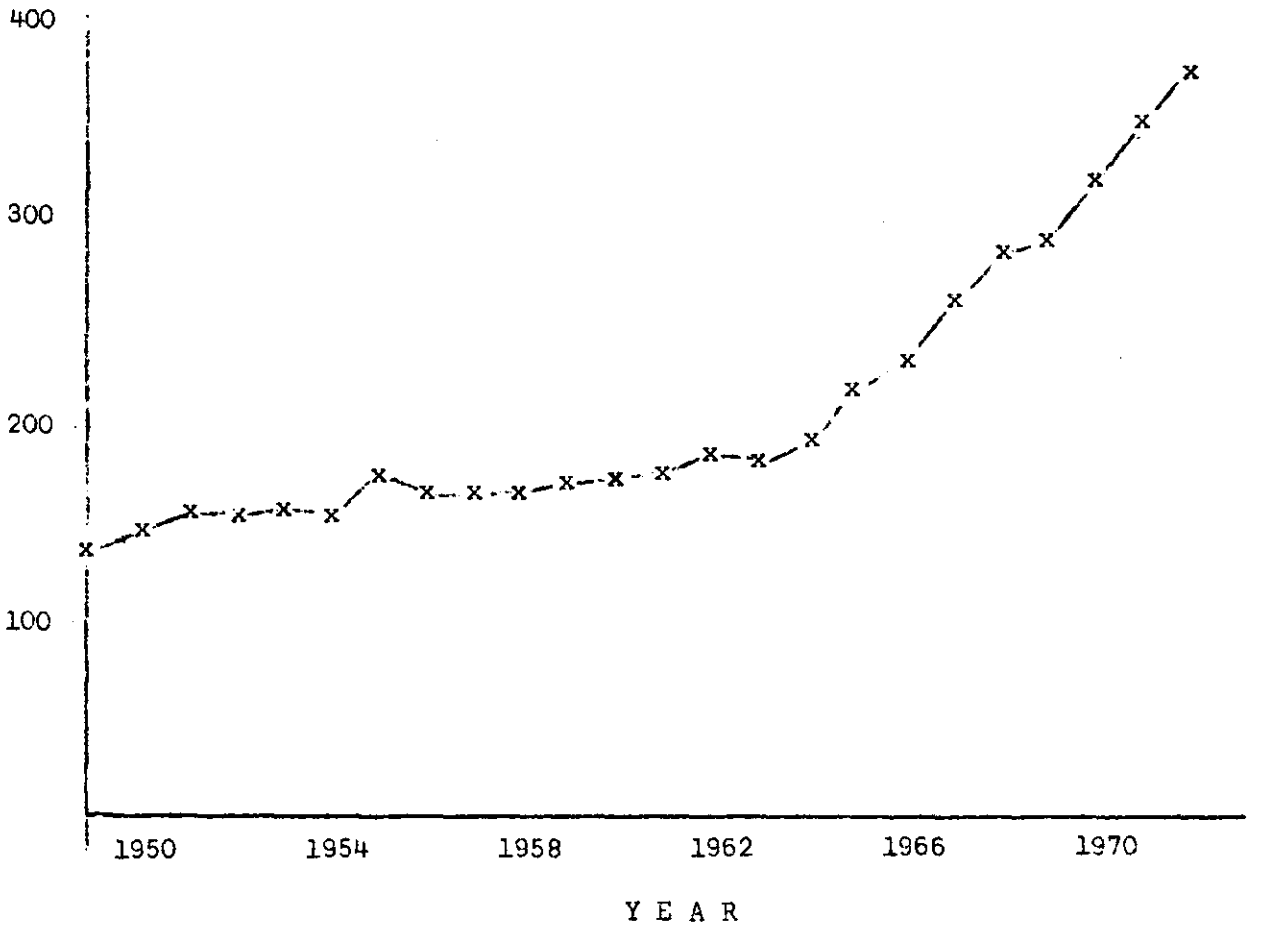
   (ii) to staff dealing with general advice on particular problems. e.g. Asian diet group

2. Specific In association with clinics for the overweight, the diabetic or any other group with marked dietary problems. For this purpose she must work at the clinic (hospital or otherwise) dealing with the medical care of such persons

155 In a compact County Borough advice is easily obtained from hospital consultants for the more difficult cases. Health department staff have a good knowledge of dietary needs and the G.Ps. often have printed diet sheets for a variety of conditions. (These are based either on hospital advice or culled from the multiplicity of medical journals).

APPENDIX 5

NUMBER OF DIETITIANS EMPLOYED IN N.H.S. HOSPITALS IN ENGLAND AND WALES 1949 - 1972



Source: D.H.S.S. Annual Reports

N.B. 1. Figures for 1955 - 1972 represent whole-time equivalents

2. Figures for 1949 - 1954 (inclusive) represent full-time dietitians

3. The numbers of part-time dietitians employed in 1949 - 1954 were 5; 4; 6; 12; 15; 18 respectively

APPENDIX 6

THE BRITISH DIETETIC ASSOCIATION

251 Brompton Road, London SW3 2ES

NOTES FOR GUIDANCE FOR DIETITIANS WORKING IN THE COMMUNITY

This guide has been formulated from the ideas of dietitians already working in this field. It is not intended as a job description but it is hoped that it will provide a basis from which others may work and also inform those interested in the scope of dietetics in the field of community health.

1. The main aims of community work are:

   (a) To promote health

   and

   (b) To prevent disease
   by promoting improved nutrition in the population at large

2. The principal fields of work could include:-

   (A) Community health The role of the community health dietitian is to work in conjunction with:

   (i) Community physicians: by -

   (a) advising on nutritional problems

   (b) providing up-to-date specialised nutritional data

   (c) attending meetings when appropriate

   (d) providing nutrition education material when required for:

   Chief dental officers
   School doctors and school nurses
   Public health inspectors

   (e) liaising with GP services and GP attached health visitors

   (ii) Nursing services: by -

   (a) participating in training schemes for health visitors, district nurses and midwives

   (b) having group discussions with trained staff

   (c) advising on individual dietetic problems working, as far as possible, through a health visitor or nurse and using domiciliary visiting for demonstration purposes if necessary

   (d) giving talks in clinics, e.g. in maternity and child health clinics

(iii) Health education services: by -

(a) evolving nutrition education material such as leaflets promoting good nutrition, and diet sheets

(b) assessing nutrition literature, films, loops and film strips available from other sources

(c) advising on displays promoting nutritional topics in clinics, schools and GP surgeries

(d) participating in health education campaigns

(e) giving talks on nutrition in health education courses

(iv) Working with groups e.g. obesity therapy and anti-smoking

(B) The social services department: The role of the community health dietitian is to:

(i) have formal and informal talks with social workers

(ii) advise on catering, dietary modification and nutritional requirements in residential homes and to participate in in-service education of cooks

(iii) have group discussions with home helps

(iv) participate in training courses for matrons of residential homes

(v) talk to groups of physically handicapped and elderly people

(vi) advise on menus and nutritional requirements for "meals-on-wheels", luncheon clubs and day centres

(vii) work with mentally handicapped, their parents and their supervisors in adult training centres

(viii) have discussions with day nursery matrons

(C) The education services: The role of the community health dietitian is to:

(i) liaise with school meals organisers, advise on dietary modification and participate in courses for cook-supervisors

(ii) work through schools at:

(a) primary level - by direct contact with children and through teaching staff

(b) secondary level - by liaison with home economists and science teachers; by diet counselling to children

(c) by giving talks to parent-teacher associations

(d) further education - by participating in pre-nursing and nursery nurse courses

(iii) arrange relevant practical experience for student dietitians and give talks to dietetic, medical and other groups of students

(iv) contribute to pre-retirement and "cookery for one" courses

(v) organise seminars on nutrition for professional colleagues

(vi) participate in other projects as requested

(D) Specialist services: The role of the community health dietitian is to:

(i) advise and give talks as requested to voluntary organisations, voluntary work organisers and women's organisations

(ii) work with organisations such as the British Diabetic Association and the Coeliac Society at national and local level

(iii) liaise with gas, coal and electricity boards

(iv) maintain contact with and provide mutual support for other dietitians in the area

(E) Research: The role of the community health dietitian is to initiate and participate in appropriate projects.

November, 1973

APPENDIX 7

Report of a Conference on Dietitians in the Community at the University of Kent at Canterbury

28 June, 1973

procedure being adjusted by the response, attitude, etc. of the individual patient.

No group sessions were held by any of the three selected hospital dietetic departments, though one of the single-handed dietitians stated that she held twice-weekly sessions of 20 - 30 minutes duration in the outpatient department for 4 - 5 obese patients, and in the larger dietetic department, a dietitian attended one session of a ten-session course organised by health visitors for obese patients.

Lectures on nutrition and diet had been given by the dietitians of all four hospital dietetic departments visited. These lectures ranged from individual lectures to such organisations as Townswomen's Guilds and Rotary Clubs to series of lectures to health visitors as part of the health visitor training course. In one dietetic department a two-day conference for health visitors, nurses and general practitioners had been organised and guest speakers had been invited to talk on nutrition and diet. In another department, the dietitian had been involved in seminars held as part of the vocational training scheme for general practitioners.

None of the hospital dietitians who were interviewed were involved in catering outside the hospital, but all expressed a willingness to advise those involved in catering in the community health and social services if requested.

The opinions of the dietitians about nutritional and dietary advice in the community were found to show marked differences. Only one dietitian considered that the work of a dietitian in the community did not differ from that of the hospital dietitian, and carried this point of view further by stating that she believed that all dietitians should be employed in hospitals, though they should extend their present role by continuing to give advice to patients following their discharge from hospital, and allow open access to the dietetic departments by general practitioners and health visitors.

In the three other hospital dietetic departments which were visited, the dietitians expressed the view that the role and function of a dietitian in the community differed greatly from that of the hospital dietitian, but in one case the dietitians believed this was due largely to the deficiencies of the hospital dietetic services which placed too great an emphasis on therapeutic diets and paid insufficient attention to the preventive and nutritional aspects of patient feeding. There was agreement by the dietitians of these three departments that the dietitian in the community was

required to undertake a stronger educational role than did the hospital dietitian, and conversely should spend less time on individual patient consultations.

During the interviews with these hospital dietitians it was obvious that they perceived large areas of unmet needs in the field of nutrition and diet, and that they considered that the medical, nursing and para-medical professions were inadequately trained in these subjects. The dietitians were conscious of the pressure of hospital work which prevented them from extending their role outside the hospital, an extension which was not a primary function of a dietitian employed in and by a hospital group.

Dietitians in General Practice

The three general practice dietitians who were interviewed were found to be carrying out the work in general practice as an extra to their work as hospital dietitians. Two were currently employed full time as group dietitians, one of these, who had been employed in a group practice of three doctors for over five years, carried out two three-hour sessions per week in the practice, the other who had been employed in a three-man group practice for eighteen months, held one two-hour session in the practice per week. The third dietitian worked sixteen hours per week in hospital as a senior dietitian andheld three or four sessions per month in a practice of five doctors. She had been employed in the practice for two years.

All three saw patients by appointment and all had full use of a consulting room and other practice facilities including access to patients medical records. The dietitian who worked in a three-man group practice recorded that, on average, sixteen patients per month were referred by the general practitioners, the same number of patients as those referred to the dietitian in the five-partner group practice. The third dietitian estimated that twelve outpatients were referred per month by the three doctors in the practice.

In the three-man group practice however, records were available which showed that only two-thirds of the patients referred to the dietitian were suffering from obesity, while one-fifth were referred for peptic ulcer diets, eight per cent for diets related to metabolic disorders and five per cent for diabetic diets. The work of the dietitian in this practice was being analysed by one of the general practitioners and the dietitian at the time of the interview and the findings have now been published[10]. The dietitian in this practice also carried out a group session twice monthly for 15 - 20

obese patients, the only general practice dietitian to do so, though one of the others attended the practice ante-natal clinic and gave talks on "sensible eating" and prevention of obesity.

In all three practices patients were followed up at monthly or twice-monthly intervals depending on personal and other factors of individual patients, and the patients continued to attend until "the patient decides to stop coming or the workload becomes excessive" or "as long as the patient is willing to attend".

One of the dietitians had given seven lectures on nutrition and diet in the previous six months - to nurses, general practitioners, and as part of a district nurse refresher course. No lectures had been given by the other two dietitians.

None of the three general practice dietitians had been involved in health education displays, in school meals centres, luncheon clubs or other community catering, nor had they carried out any surveys or been involved in health education.

In answer to the question:- "How does the work of a community dietitian differ from that of a hospital dietitian?", the three dietitians gave the following answers:- "They differ only in the manner in which they impart the knowledge and to whom, e.g. community work involves group sessions, lectures. Hospital work involves personal contact with patients". "There is a greater emphasis on nutritional advice in the community and less emphasis on therapeutic diets". "I am not sure what a dietitian in the community is supposed to do".*

All three commented on the informal or "homely" environment in general practice premises, one of the dietitians believing that this produced a more receptive attitude and helped the patient to retain information and advice more readily.

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*This latter response perhaps indicating most clearly the lack of a job description of community dietitians and the fact that such appointments are recent innovations.

Local Health Authority Dietitians

Dietitians who were employed by seven local health authorities were interviewed during May 1973. The two remaining authorities who had been identified from the postal survey as employing dietitians were not visited as in one case the dietitian had been appointed to the post for only a few weeks and was attempting to organise her work and define her role, while in the other case the dietitian was on extended sick leave.

Two sharply defined methods of working were observed. In the case of three authorities little of the dietitian's time was spent in face-to-face consultations with patients, whereas the dietitians employed by the other four authorities were almost exclusively involved in individual consultations.

One local health authority employed two dietitians on a part-time basis whose main responsibility was to the meals-on-wheels service. The first appointment had been made as a result of the initiative of a local councillor in 1965. The dietitians were employed for 3-hour sessions each day to provide nutritional guide lines for the 1,500 meals supplied each week and to supervise the 10% of these meals which were for special diets. The service aimed at delivering five mid-day meals per week to each recipient, the meals being designed to provide one-third of the daily nutrients and one-half of the daily iron requirements.

To allow the dietitians freedom from too great an involvement with food preparation and direct supervision, in-service education was given to the catering staff. Monitoring of the meals by the dietitians was carried out by occasional sampling of prepared meals, and the attachment of student dietitians for six-month periods enabled small surveys to be carried out in the borough.

Special diets were provided on request from the medical officer of health or general practitioner. However the dietitians occasionally held discussions with the referring doctor and/or the patient concerned in order to clarify the diagnosis or the more detailed nature of the diet, and on occasions the patient was visited by the dietitian if it was thought that dietary advice should be given or further explanation about the diet was required. It was estimated that 30% of requests were for reducing diets, 27% were for diabetic diets and most of the remainder were for light diets.

The delivery of 1,500 meals each week, of which 500 were supplied to luncheon clubs and 150 were delivered at weekends, demanded considerable resources in transport and produced problems of rapid despatch and delivery of the meals after preparation, as well as a constant anxiety that the nutritional content may be diminished by delays.

The dietitians also gave lectures to those attending luncheon clubs usually on the subject of balanced diets and involving the demonstration of easily prepared supper dishes of high nutritional content. Talks on nutrition to the staff of welfare accommodation had been carried out and it was hoped to commence lectures on nutrition to home helps.

The dietitians had endeavoured to provide leaflets and other information about nutrition and diet to health visitors, nurses and social workers, and had given talks in various schools and other educational establishments. All of this work was with the objective of providing as many outlets for nutritional advice to the population as possible, the load of the dietitians being too great to allow a personal involvement with individuals.

The dietitians in two other local health authorities spent little time with individual patients, believing that they should act as consultants and advisers to other professional workers in the health and social services who in turn would give dietary advice to individuals.

In one case, a dietitian had been employed by the local health authority since 1949, originally as a consulting service to patients in health centres and local authority clinics, but this had changed into an educational service to the community and had so expanded that a second full-time dietitian was appointed in 1971. The dietitians in this county borough spent only two sessions per week in face-to-face consultation with individual patients, usually a referral from general practitioners though they did receive a few referrals from health visitors and an occasional referral from school teachers. Again most of these referrals were of patients suffering from obesity and follow-up was arranged with the health visitor concerned, not with the dietitian. A few diabetic patients had been referred and on one or two occasions during the past year patients with coeliac disease, malnutrition or cystic fibrosis had been referred. Discussions with the dietitians at the local hospital were occurring with a view to transfer of patients from hospital attendance and supervision to the local health authority dietetic department. The dietitian carried out two slimming clinics per week, these were held during the evening with an average attendance of forty people. They were organised by the dietitian with the assistance of a lay assistant and a 'keep fit' instructress, and were scheduled by the local educational

authority as adult education classes. Both sessions were over-subscribed.

A course entitled "Keep Fit in Retirement" had also been organised by the dietitian. This course took place on Wednesday afternoons and was held on six consecutive weeks. At the previous course, 153 people aged 65 years or over had attend and it was felt that such a course could be repeated regularly. Each session involved a talk or film, a meal cooked and served by schoolchildren who also acted as hostesses, and a cookery demonstration indicating methods of providing nutritious meals at low cost and with little effort. The meals provided by the schoolchildren were also intended to demonstrate both to the attenders and to the schoolchildren the basic essentials of balanced diets. Considerable assistance had been sought and obtained from commercial firms who provided demonstrations as well as "free gifts" of their products for those attending the course. Plans were being made at the time of the interview for another such course to be organised and to consider the extension of such courses to other parts of the city.

The dietitian had initiated a health educational project aimed at discouraging the selling of sweets, chocolate and biscuits at school tuckshops and encouraging schoolchildren to eat more fruit and cheese. Talks had been given to a meeting of primary school teachers, displays set up to demonstrate an "ideal tuckshop" and a nutrition section was provided for a health education display at the annual flower show.

The dietitian had developed a close relationship with the local radio, press and television, and had given a series of talks on the local radio and had written a series of articles on slimming.

A display on nutrition was also the prime concern at the time of the interview with a dietitian employed by a county council. This display was part of a health education project devoted to coronary artery disease which was to be set up in a marquee in the centre of the county town. Posters, film strips and cartoons were being prepared to demonstrate aspects of atherosclerosis and the possible relationship of diet to coronary thrombosis.

The dietitian devoted a considerable amount of her time to the setting up and supervising of slimming clinics. At the time of the interview six such clinics were held each week, and one more was being organised. The slimming clinics were run by health visitors and others including one schoolchildren's slimming clinic run by a domestic science teacher, and in each case about 12 people attended a session.

She saw only about three individual patients per week, and of these, most were patients suffering from obesity who had been referred by a general practitioner. The medical officer of health was carrying out a campaign to identify children with diabetes with the intention of referring these children, and their parents, to the dietitian for advice on diet, and the dietitian believed that a useful extension of her work would be to organise group sessions for diabetic patients.

Personal consultations with individuals formed almost the total work of the remaining four of the dietitians who were interviewed. One of these four dietitians, employed by a county health authority, had been in a post for six months and worked a twelve hour week, visiting three health centres and one group practice surgery as well as paying visits to patients in their own homes. In one health centre, twelve new patients and fifteen return patients were seen by appointment at each session, three sessions being held each month. Sessions were held once per month at the other two health centres, approximately twelve patients per session being seen at one centre and six at the other. One session per week was spent by the dietitian at the group practice surgery at which, on average, three new cases and six return cases were seen. In visiting the group practice, the dietitian was involved in a round trip of 52 miles, and when visiting two health centres on the same day as her visit to the group practice, she was involved in driving a total of 69 miles.

Another dietitian employed for 19 hours per week since October 1972 by a county borough spent virtually all her time visiting four practices in the town. Two practices were visited each week,in order to hold appointment sessions for, on average, five patients per session. At the other two practices visited, one-hour sessions were held every other week at which five patients were seen by the dietitian.

Yet another dietitian employed by a county borough worked full time, and was almost exclusively involved in holding clinics at which she consulted individual patients. She worked from a central L.H.A. clinic, a peripheral clinic and from the medical room of a secondary school, holding six such sessions per week. At the central clinic, about 40 patients were seen each week.

The fourth dietitian involved held a joint hospital/local health authority appointment. In respect of her half-time appointment to the local health authority, she held one session per week at which 10 - 12 school-children were seen by the dietitian after referral from the school medical officer.

In all these four cases, the dietitians who were almost entirely involved in face-to-face consultation with patients were also almost exclusively involved with the problems of obesity. The patients presenting were predominantly adult females aged from 20 - 50, with the exception of the dietitian involved with obesity in schoolchildren, and were seen at intervals ranging from once per week in the case of schoolchildren to once per month. One dietitian in fact stated that she did not make routine follow-up appointments but merely offered patients the opportunity of returning at any time if they wished. All commented on the high rate of defaulting and although one dietitian wrote to defaulters, the usual method was to offer the service to those patients who had been advised to attend and to continue follow-up for as long as the patient continued to attend. All four dietitians quoted other conditions for which they gave dietary advice, e.g. "one infant for milk-free diet, one or two gastric diets and one or two underweight adults", "two patients with coeliac disease, one or two gastric diets", or "rarely a diabetic patient referred by a G.P."

Only one of these four dietitians held regular group sessions. These sessions, for people wishing to lose weight, were each held fortnightly, the dietitian organising two such group sessions during the day and two during the evening. On average 25 people attended each session. A group session usually consisted of a weigh-in, low calories refreshment, a discussion period of three or four minutes, exercises and a film or demonstration. People attending were either self-referred or had attended with a relative or friend who had been referred by a general practitioner or health visitor.

None of these four dietitians were involved in the supervision of catering though all had, at some time, given advice on request.

Six of the seven local health authority dietitians who were interviewed had given lectures on diet and nutrition. In one case, the dietitian had given 30 lectures and talks in the previous six months - to health visitors, home nurses, clinic assistants, school teachers, old-age pensioners and parent/teacher associations. Another had given lectures to home helps, welfare home officers, voluntary organisations and church clubs as well as to nurses and health visitors.

The opinions of the seven dietitians concerning their perception of how their services could be expanded if more time or staff were available,

were, with one exception, related to education. The one exception stated that she would wish to spend more time in consultation with obese schoolchildren, the housebound handicapped, problem families and children on diets in special schools.

All seven dietitians were conscious of the importance in community work of gaining the cooperation of the person receiving the dietary advice. This they perceived as being of much greater relevance than in hospital practice where the patient was "less independent" and "under greater control".

Apart from the generally expressed problems of shortage of time and the size of the problem facing the community dietitian, all expressed anxiety about the lack of a job description. The initiative for introducing a community dietetic service had come from different sources, and the perceived requirement for a dietitian varied from authority to authority. In some cases the dietitian had continued the work, in others the dietitian had expanded her role beyond that originally intended, whilst in others the work had altered considerably from that originally suggested.

CONCLUSIONS

The traditional role of the dietitian as a professional worker employed to give advice to individual patients who require or are thought to require a special diet as part or all of their treatment is undergoing considerable change.

The effectiveness of many specific diets is being questioned and a number of such diets are being discarded, while the tendency to provide diet therapy by modification of "normal" diets is increasing. Dietitians in hospital practice are much less involved in preparing as well as formulating special diets, and the special diet kitchen has ceased to exist in many hospitals. Such special diets as are required are now prepared by modification of diets prepared in the central catering establishment of the hospital.

Against this trend towards less rigid diet therapy based on the 'debunking' of many special diets for some of the commoner diseases, has been the increasing awareness in recent years of the nature of a few uncommon disorders, e.g. inborn errors of metabolism, which require specific and often complicated dietary regimes in their management. Similarly, recent advances in surgery, particularly in the renal and oesophageal field, have demanded the employment of carefully constructed dietary regimes to allow adequate nutrition of the pre-operative and post-operative patient. Intensive care units are another innovation which imply a need for very specific nutritional care of the patient, especially for the intra-venous or intra-gastric feeding of an unconscious patient.

At the same time that these changes have been occurring in the hospital service, there has been an increase in the attention paid to dietary and nutritional problems in the community.

Throughout the study the problem of obesity has been seen to be by far the most frequently met condition requiring dietary advice. The dietitians working in the community as well as those in the hospitals spend much of their time dealing with patients referred to them for advice on reduction of weight. Difficulties exist in defining obesity and in the lack of accurate evidence of the extent of the problem, but it has been suggested that, "it is likely that up to one-half of the women over 30 years old in Great Britain are at least 10% over-weight, and that no less than 10% of adult males are over-weight".[11] Obesity is generally agreed to be a major health hazard in this country and much consideration is given to its effective treatment.

Diabetes mellitus was the commonest disorder, apart from obesity, dealt with by the dietitians. Estimates suggest that there are 500,000 diabetics

in the country,[12] all of whom require life-long dietary control, and that 80% of patients with diabetes belong to the category of mature onset diabetes, many of whom are treated exclusively by dietary restriction. How comprehensively and how frequently do such patients require and receive dietary advice? The trend to greater variety in the diabetic diet and other changes in the dietary regimes required in the condition would infer that a regular review of the patient's diet was necessary.

In certain groups and individuals in the community, there is a need for dietary and nutritional advice both to prevent ill-health and as a means of improving the health of the person concerned. Such people as the housebound elderly, immigrants, and the physically handicapped may require advice concerning their diet. People with comparatively low incomes might benefit from advice on the formulation of nutritious diets at low cost. Advice on adequate nutrition during pregnancy and on infant feeding was suggested by the dietitians as an important field of work.

The following list is not intended to be a comprehensive list of diet-related disorders, but is an attempt to indicate, in approximate numbers, the prevalence of those disorders which have been quoted in this report.

	Disorder		Prevalence per 100,000 population
1.	Obesity (i.e. more than 20% overweight)		15,000 - 20,000
2.	Diabetes mellitus		1,000 - 1,400
3.	Post gastrectomy deficiences		1,500 - 2,000
4.	Diverticulitis		250 - 1,000
5.	Renal failure		135 - 140
6.	Coeliac disease	children under 16 years of age	5 - 12
7.	Inborn errors of metabolism	children under 16 years of age	1.25 - 2.5
8.	Malnutrition in the elderly		400 - 500

These figures, obtained from various sources,[11-20] do not represent the number of people who would benefit from, or in fact require, expert dietary advice.

The many varied potential demands as a result of these and other disorders and of those groups or individuals who require dietary advice, must be related to the deployment of resources and methods of delivery of dietary advice.

Recruitment of dietitians

At the time of the survey there were 537 students in training in the United Kingdom compared with 481 in 1971 and 431 in 1970. In 1972 the number of students qualifying in the United Kingdom was 102, compared with 98 in 1971 and 106 in 1970.(21)

As the number of members of the British Dietetic Association practising in the United Kingdom in 1973 was 747, it would appear that the number of dietetic students recruited and trained is far in excess of the numbers required to replace retirements and resignations.

Whether this is a deliberate policy to counteract an expected wastage of large numbers of students after qualification or with an expectation that many more posts for dietitians would become available in the near future is a question outside the remit of the present survey. The number of dietitians employed as dietitians outside the health service is not known. There is no indication at the present time that a large increase in the number of posts for dietitians is contemplated either within or outside the health service. It would appear reasonable, however, to suggest that there is a need for manpower studies to be carried out, to establish the relationship between the number being trained and the manpower needs of the service.

Training of dietitians

Training is carried out in England at the University of Surrey, at Leeds Polytechnic, at the Queen Elizabeth College in London and at the North London Polytechnic. Until 1973 training was also carried out at Ealing Technical College in London.

Three different courses are available, (a) a comprehensive four-year course leading to a degree, (b) a comprehensive three-year course, and, (c) an intensive eighteen-month course for students who already possess a specified degree or nursing or diploma qualifications. The emphasis in the training is not unnaturally, on science, including food science and nutrition (61% of recommended hours) and food preparation (23%), the remaining time being spent in learning administration, management, teaching methods, and behavioural sciences. There is a minimum requirement of twenty-four weeks practical training in a hospital dietetic department.

Deployment of dietitians

It has been recommended that, "so far as is practicable, a senior or chief grade dietitian should be employed as Group Dietitian to cover the whole of a Hospital Management Committee or Board of Governors group of hospitals, and that dietitians working under her supervision should be located in individual hospitals where the volume of work justified such appointments."(9) From the survey, it appeared that only 163 (58.4 %) of hospital management committee groups employed dietitians and that almost half the establishments were for single-handed posts.

With the trend towards involvement with the nutrition and diet of all hospital patients, and of groups or individuals in the population together with reorganisation of the National Health Service, thought should be given to the possibility of providing dietary services at Area Health Authority rather than district level. The provision of "area dietetic departments" could produce a potential for providing training posts on hospital dietetic departments which cannot be recognised individually because of the shortage of supervising staff. Such training posts could increase the variety of experience gained by the students and may encourage a more even distribution of dietetic services over the country.

Functions

Information obtained from the survey suggested that there was an increasing tendency for dietitians to play a supporting and advisory role to other workers who in turn delivered dietary advice to individual patients.

Dietetic advice is given to a patient in many cases by a doctor, nurse or para-medical worker, and the content of the advice is such that the skills of a trained dietitian are unnecessary. With the exception of certain rare diseases and of specialised units, e.g. metabolic, renal, or intensive care, much advice on diet relates to that of adequate nutrition rather than specific diet, and this applies to patients in hospitals no less than groups and individuals in the community.

The survey has found that there was an extensive involvement by dietitians in the weight reduction of obese patients, yet there is little evidence to show that the delivery of dietetic advice to such patients, either when given by a

dietitian or by any other agency, produces long-term benefits. Without such evidence, or of evidence to support the view that the skilled dietitian achieves greater success than other workers in this field of advice on weight reduction, there is no justification for referring so many cases of obesity to the dietitian, or of the dietitian becoming so extensively involved in treating such patients.

The functions of dietitians in hospitals were defined in an official memorandum in 1971[9] and several recommendations were made. It would appear from the present survey that the uneven distribution of dietitians between different regions, mentioned in the memorandum, is still present and that the recommendation that "dietitians should be encouraged to co-operate with the staff of local authority Health and Welfare departments", has been implemented to a varying degree in different hospital groups. The changes which have occurred in recent years suggest that a review at National and local level is needed to examine the nature of the implementation of the recommendations contained in the memorandum.

Some extension of the work of the hospital dietitians into the community, the comparatively recent innovation of the employment of dietitians in a small number of local health authorities and an even smaller number in general practice was observed in the study. These efforts at introducing skilled dietary advice in the community and to patients residing in the community were perceived by the dietitians concerned as being unlikely to make much impact on the needs of the community for dietary and nutritional advice.

The needs for a job description of a dietitian in the community was expressed by those interviewed and by the other respondents. The dietitians employed in local health authorities and in general practice as well as those hospital dietitians who had extended their work outside the hospital were each working in different ways.

There would appear to be three separate, though by no means mutually exclusive, aspects to the functions of a dietitian in the community that might be developed, provided they could be shown to be efficient and effective:-

(i) Therapeutic diets

A number of patients, though probably many fewer than was thought formerly, still require therapeutic diets. Some of these patients will benefit

from direct individual consultations with a skilled dietitian while many will continue to receive dietary advice from doctors, health visitors and nurses. The dietitian should be available to work in close association with the primary care team by providing advice and help for such patients in compiling suitable diets.

(ii) Vulnerable groups

Dietary advice alone cannot correct the nutritional deficiences which may exist in vulnerable groups. Nutritional problems may be due to one or more varied reasons, e.g. the housebound elderly who are unable to shop for food, or the low income families or individuals who are unable to purchase adequate quantities of food. The prime concerns are the identification of such groups and individuals and an awareness, by all community care workers of the importance of eliciting information about the nutritional intake of such people.

The delivery of much dietary and nutritional advice will continue to be carried out by the many varied workers, both professional and non-professional who provide health care in the community. The function of the dietitian could be to provide advice to these workers on specific dietary problems when required, and by supplying suitable material on nutrition and diet for display purposes or for issue to patients and others.

The skills and expertise of the dietitian could also be used in advising on the nutritional aspects of meals supplied by the home meals and school meals services, at luncheon clubs, day centres and welfare homes.

(iii) General Nutritional Advice

Information and advice on nutrition and diet is presented extensively by the mass media. In many cases this is related to the advertising of products and in some cases is heavily biased. There is a need for objective information to be given in nutrition and diet, particularly in relation to the frequency of obesity and the problems of over-eating. The dietitian in the community might be involved in health education as it relates to nutrition. The study has shown that many dietitians both in hospital and community employment were delivering lectures on diet and nutrition. This however, was in most cases a spare-time activity, not an integral part of the working day.

If the dietitian is to become involved in the health education field a close association with teachers, health education officers, where these exist, and with health visitors is necessary. Much greater emphasis must be placed in the training schedules of dietitians on the understanding of habit formation, methods of persuasion, and on effective teaching techniques.

The aims of the community dietitian have been specified recently (October 1973) by the British Dietetic Association as:-

(a) to promote health
(b) to prevent disease

by promoting improved nutrition in the population at large and notes for guidance have now been produced (see appendix 6).

The emphasis in these notes is quite clearly towards that of providing an advisory service to other workers in the community and of assuming an educational role. As stated in the preamble to the notes, they are not intended to provide a job description. The extent and volume of the work listed would appear to be too great for any one dietitian, but serves to highlight those areas of potential activity and to indicate the relationship between the dietitian working in the community and other professional or non-professional workers. The notes also demonstrate the acceptance by the executive of the British Dietetic Association that the role of a dietitian in the community is not that of giving advice on therapeutic diets to patients, but is one of stressing the importance of adequate balanced nutrition to all members of the community.

However, further developments in the field of community dietitians require that:-

1. The objectives, in terms of outcome, must be defined in respect of those recommendations expressed by the British Dietetic Association.

2. The specific skills and role of the dietitian must be clearly identified and related to the objectives, and

3. A limited number of experiments is set up to evaluate the effectiveness and to measure the efficiency of the dietary services which would result from implementation of the recommendations.

It is recommended that these actions should be taken before a national extension of community dietetic services occurs.

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TABLE 1

Responses to Postal Questionnaire - by authority and type of response

	Local Health Authority	Hospital Management Committees	Teaching Hospitals
From first mailing	148 (95%)	260 (93%)	30 (88%)
From reminder	8 (5%)	16 (6%)	3 (9%)
Non response	0	3 (1%)	1 (3%)
Total	156 (100%)	279 (100%)	34 (100%)

TABLE 2

Number of authorities who have establishments for dietitians

By authority, establishment and employment of dietitians

	Authorities					
	County council	County borough council	London borough council	Hospital management committee	Provincial teaching hospitals	London teaching hospitals
Dietitian employed	2 (4%)	4 (5%)	3 (9%)	147 (52%)	9 (100%)	16 (64%)
Unfilled establishment	0	2 (3%)	0	17 (6%)	0	2 (8%)
No establishment	43 (96%)	72 (92%)	30 (91%)	111 (40%)	0	6 (24%)
Not stated or no reply	0	0	0	5 (2%)	0	1 (4%)
Total	45 (100%)	78 (100%)	33 (100%)	279 (100%)	9 (100%) *	25 (100%)

Percentages are in parentheses and are down each column

* Does not include Nottingham and Southampton teaching hospitals.

TABLE 3

EMPLOYMENT OF DIETITIANS BY LOCAL HEALTH AUTHORITIES IN ENGLAND

Employing authorities	Total number	No.with established posts	No.with 2 full-time dietitians	No.with 1 full-time dietitian	No.with 2 part-time dietitians	No. with 1 part-time dietitian	No.with established posts but no dietitians	Total no.of dietitians employed
County councils	45	2	0	1 (1970)	0	1 (1972)	0	2
County borough councils	78	6	1 (1949) (1971)	1 (1969)	0	2 (1972,1972)	2	5
London borough councils	33	3	0	1 (1972)	1 (1965)	1 (1972)	0	4
Total	156	11	1	3	1	4	2	11

N.B. The dates of appointment are quoted in parentheses

TABLE 4

EMPLOYMENT OF DIETITIANS BY OTHER LOCAL AUTHORITY DEPARTMENTS

Department	County councils	County boroughs	London boroughs	Total
Social services	0	2	1*	3
Education	3	5	3**	11
Education & social services	0	1	1	2
None	26	47	20	93
No reply	16	23	8	47
Total	45	78	33	156

* Also employs LHA dietitian

** One authority also employs two LHA dietitians

TABLE 5

Number of hospital groups in England
who have established posts for dietitians

(R.H.B. areas and teaching hospitals shown separately)

Area	Number of groups	Number with no established posts	Number with only one part-time post	Number with only one full-time post	Number with two full-time posts	Number with more than two full-time posts	Non response or no reply
I Newcastle	30	20	1	8	-	1	-
II Leeds	18	5	2	4	2	4	1
III Sheffield	28	10	3	7	3	5	-
IV East Anglia	12	8	-	1	1	2	-
V N.W. Met.	23	8	1	5	3	6	-
VI N.E. Met.	19	5	-	4	4	5	1
VII S.E. Met.	22	7	1	7	3	3	1
VIII S.W. Met.	23	10	-	8	1	3	1
IX Wessex	11	4	-	3	1	3	-
X Oxford	11	3	1	3	3	1	-
XI S. Western	24	13	1	6	2	1	1
XII Birmingham	18	6	-	7	1	4	-
XIII Manchester	29	10	3	7	5	4	-
XIV Liverpool	11	2	-	4	4	1	-
Provincial teaching hospitals	9	0	-	-	-	9	-
London teaching hospitals	25	6	1	3	1	13	1
Total	313	117	14	77	34	65	6

TABLE 6

Number of established posts for hospital dietitians in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	1	-	1	2	-	1	8	-	3.4	7.5	13.4	10.5
II Leeds	3.3	1	2	-	1	1	6.5	-	14.5	7	27.3	9
III Sheffield	6	1	2	-	-	-	11.3	3	12.6	2	31.9	6
IV East Anglia	1	-	1	-	-	-	2	2	6	3	10	5
V N.W. Met.	1	4	2	2	1	4	13.5	11.2	15.6	16.8	33.1	38.0
VI N.E. Met.	4	1	1	1	-	2	14	1	11	9	30	14
VII S.E. Met.	1	1	1	1	-	1	11.7	2	9	7	22.7	12
VIII S.W. Met.	1	3	2	-	-	1	10.1	4	7.0	13.2	20.1	21.2
IX Wessex	3	/	-	-	-	/	7.5	-	4.2	-	14.7	-
X Oxford	2	1	-	1	-	-	5.9	2	5.5	8	13.4	12
XI S. Western	3	1	-	-	-	-	6.8	1	5	3.3	14.8	5.3
XII Birmingham	1	1	1	1	-	-	13.4	2	11.6	4.8	28	8.8
XIII Manchester	4	-	2	-	-	1	14.5	2.4	14	3	34.5	7.4
XIV Liverpool	1	1	-	-	-	-	10	2	4	3.5	15	6.5
Total	32.3	16	15	8	3	11	135.2	32.6	123.4	88.1	308.9	155.7
	48.3		23		14		167.8		211.5		464.6	

TABLE 7

Dietitians (w.t.e.) employed in hospitals in England

(By career grade and showing R.H.B. and Teaching Hospitals separately)

Area	Group dietitian		Chief dietitian		Deputy chief dietitian		Senior dietitian		Basic grade dietitian		Total	
	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH	RHB	TH
I Newcastle	1	-	1	2	-	1	3	-	2.3	7.5	7.3	10.5
II Leeds	3.3	1	2	-	1	1	6.5	-	9.1	5	21.9	7
III Sheffield	2	-	2	-	-	-	10.2	2	9.1	1	23.3	3
IV East Anglia	1	-	1	-	-	-	2	2	6	2	10	4
V N.W. Met.	1	4	2	2	1	4	13.5	11.2	14.3	16.5	31.8	37.7
VI N.E. Met.	2	1	1	1	-	2	10.5	1	7.3	9	20.8	14
VII S.E. Met.	1	1	-	1	-	-	11.7	1	6	7	18.7	10
VIII S.W. Met.	1	3	2	-	-	1	9.7	4	6	13.2	18.7	21.2
IX Wessex	3	/	-	/	-	/	6.5	-	4.2	-	13.7	-
X Oxford	2	1	-	-	-	-	6.5	2	5.5	8.1	14.0	11.1
XI S.Western	2.5	1	-	-	-	-	5.8	1	4	3.3	12.3	5.3
XII Birmingham	1	-	-	1	-	-	9.8	2	4.5	4.8	15.3	7.8
XIII Manchester	3	1	2	-	-	1	10.5	1.4	6.4	3	21.9	6.4
XIV Liverpool	-	1	-	-	-	-	5.5	2	1	2	6.5	5
Total	23.8	14	13	7	2	10	111.7	29.6	85.7	82.4	236.2	142
	37.77		20		12		141.3		168.1		379.2	