BOARD OF HEALTH
REPORT SERIES No 19

REPORT OF THE COMMITTEE ON THE DIETETIC PROFESSION

WELLINGTON 1973
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(d) The co-ordination of the activities of local authorities under this Act, and of the activities of voluntary associations in respect of public health, with the activities of the Department of Health.
DIETETIC PROFESSION

BOARD OF HEALTH
(Under Health Act 1956)

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"Since nutrition so completely affects the well-being of each individual, every man has a right to be informed concerning the current knowledge of nutrition, or at least to have nutrition knowledge translated for him into practical terms of food and meals."


"The duties of the dietitian in a hospital can be divided into three groups, namely: administrative, scientific, and teaching. Her status must be well established, with clear-cut understanding in regard to her functions, duties and relations. Her services are absolutely essential, and no hospital can get along properly without her from the standpoints of economy and efficiency.

"It is recognised today that each hospital should have one qualified dietitian for every one hundred patients."


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INTRODUCTION

At the request of the Minister of Health, the Board of Health established this committee to study the dietetic profession in New Zealand.

The decision to conduct this study was welcomed by the Dietitians Board, the New Zealand Dietetic Association, the Medical Association of New Zealand, and also by the University of Otago and the hospital training schools which have been responsible for the training of dietitians. After thirty years there is a need for a reappraisal of the country's dietetic profession. Increasing attention is being given to nutritional factors in health care, new developments are taking place in medical dietetics, an increasing number of specialised medical units in hospitals are requiring meticulous dietary services, rapid development in food production methods and food service systems are taking place, and there is a growing insight into the necessity for education in nutrition and dietetics. All these factors make new demands upon the role and skills of the dietitian. In addition the expansion of the country's hospital and health services is making demands in number and quality of dietitians which call for some changes in the current system. These reasons provided ample justification for the establishment of a committee to redefine the role of the dietitian and to recommend measures to meet the changes and challenges which New Zealand society will present to the profession in the future.

The terms of reference assigned to the committee were “To examine and report on the profession of dietetics in New Zealand with particular reference to:

1. Its functions and scope in the present and future.
2. Assessment of the extent to which it is fulfilling those functions and how the demands of the future can best be met.
3. Examination of the present training and future needs for training.
4. Other related matters which may be referred to the committee.”

The committee invited submissions from a wide range of professional and voluntary organisations and from individuals or groups with an interest in the field of dietetics. A list of submissions received is given in appendix A.

Questionnaires were sent to all hospital boards in the country, all dietitians whose names are on the Register of Dietitians and for whom addresses were known, and to a sample of senior medical and nursing staff from hospitals throughout the country. Results of these questionnaires appear later in the report.

1. DIETITIANS

1.1 Title of Dietitian

Early in the study it became evident that there was some confusion about the name “dietitian”. The differences between the work of a
dietitian and others in related fields, e.g., nutritionist, food scientist, food service manager, caterer, were not always understood.

Some submissions expressed a negative reaction to the term. They applied the word “diet” to a regime adopted in sickness, but having little to do with positive health or preventive health care. The dietitian was seen by several as a “spoil sport”—the person who took away the good things to eat and left the less pleasant and less attractive. There were several advocates for the abandonment of the name “dietitian” and its replacement with one giving a better image. The committee considers that there should be no move to change the name “dietitian”. This term already has wide international professional status and recognition, and by definition appropriately describes the role to be fulfilled. It is clear, however, that wider and more effective public relations are needed to promote a better understanding of and a positive attitude towards the dietetic profession.

1.2 Definitions

For the purposes of this study the committee has adopted the following definitions.

1.2.1 Nutrition

“Nutrition is the science of food, the nutrients and other substances therein, their action, interaction, and balance in relation to health and disease and the processes by which the organism ingests, digests, absorbs, transports, utilises, and excretes food substances. In addition, nutrition must be concerned with certain social, economic, cultural and psychological implications of food and eating.”

1.2.2 Dietetics

“Dietetics is the interpretation and application of the scientific principles of nutrition to the human being in health and disease throughout the life cycle.”

1.2.3 Dietitian

The dietitian “bridges the gap between the science and the application of nutrition”. A dietitian is educated and trained to apply the science of nutrition to the needs of people in health or disease.

1.2.4 Further Definitions

Further definitions accepted by the committee to cover dietitians in specialised roles are given in appendix G.

1.3 Registration of Dietitians

In New Zealand a dietitian must be registered as a dietitian under the Dietitians Act 1950 before she may use the occupational or
professional title. This is not the case in all countries. Throughout this report, all references to a dietitian mean a person who is registered and has, therefore, met standards of qualification laid down by the Dietitians Board established under the Dietitians Act.3

2. THE NEED FOR DIETITIANS

This committee, seeking to assess the role of the dietitian in the country's health services, held no doubts as to the need for dietitians. It did, however, wish to obtain from a representative sample of other health professionals who are either using the services of, or working alongside dietitians, their assessment of the contribution and value of the dietitian's work.

The submissions invited from the medical profession and its specialist associations, hospital matrons, and nurses, and hospital boards gave much supportive evidence, although there was some divergence of opinion about the role, responsibilities and present effectiveness of dietitians.

2.1 Confirming the Need for Dietitians

To gain a broader picture of the attitudes to dietitians as seen by colleagues in the major area in which dietitians are employed, namely the country's hospital services, a questionnaire was prepared. A sample of senior medical and nursing personnel in hospitals representing 90 percent of available occupied beds in New Zealand general hospitals were asked to assess the value of the dietitian in hospitals employing dietitians.

Participants were requested to give opinions and evidence as to whether patient care was improved by the presence of a dietitian or inadequate because of the absence of one. They were also asked how the dietitian contributed or could contribute in their particular fields and in the hospital; and how the dietitian assisted or could assist in the prevention of disease.

Replies to questionnaires were received from 131 (69 percent) of medical and nursing personnel approached by the medical superintendents and matrons of the 21 hospital boards included in the sample. The committee took no part in selecting individuals within the sample and anonymity of replies was safeguarded.

2.1.1 Responses from Hospitals Employing Dietitians

The great majority of senior medical and nursing personnel strongly supported the services of a dietitian.

Ninety-five percent of senior medical and nursing staff in the sample recognised improved care of both inpatients and outpatients because of the assistance of a dietitian. The following comments were among those made by medical staff:
"I regard the dietitian as really essential for the type of work I do."

"A physician can guide and instruct a patient from a dietary point of view to a limited extent, but where long term, involved problems occur, and for initial assessment a dietitian is indispensable."

"I find that I am constantly forwarding patients to the dietitian for advice in her special field."

"In probably no field of clinical medicine are the services of a dietitian more needed than in paediatrics."

The following are representative of the few critical comments made:

"The dietitian fails to rise above the aura of a kitchen manager."

"The dietitian is too infrequently visible in patient areas."

Nursing staff, possibly because of greater opportunity to closely observe, emphasised the dietitian's contribution to maintaining a nutritionally adequate food service of a high standard.

In preventive health care 65 percent were convinced that there was a positive role for the dietitian, and there was considerable support for strengthening this aspect of her work.

2.1.2 Responses from Hospitals Not Employing Dietitians

The need for a dietitian was recognised by 75 percent of the sample, and approximately 45 percent reported inadequacies in patient care as a result of the lack of a dietitian. The potential contribution of the dietitian in a preventative role was recognised by just over half the respondents.

The attitude of those not supporting the need for dietitians in their particular hospitals may be summarised by the following comment:

"I do not think our patients miss out on anything that a dietitian could give."

2.2 General Evidence Concerning Need for Dietitians

A changing pattern of needs for dietetic services is foreseen. This includes increased involvement with community health services, with nutrition education, increased participation in specialised areas of therapy and less direct involvement in meal service tasks.

Considerable concern was expressed that dietitians were spending too much of their time on tasks not appropriate to their training, and too little in their true professional role. Some advocated the employment of catering officers for general hospital food services, to free the dietitian for patients requiring special dietetic care.

Comments critical of the dietitian were almost entirely concerned with inadequacies in her training and function, not with the need for her services. In this connection it is important to note that the recently published report of the Study Commission on the Profession of Dietetics in the United States, stated that in spite of criticisms "...not one person testifying before the Commission could visualise an effective and comprehensive system of health service without the substantial and effective participation of dietitians."
There is in the New Zealand evidence considerable appreciation by the medical profession, particularly physicians and paediatricians, of the need for dietitians as an essential part of their own total role in health care. At the same time there is an apparent lack of recognition by some doctors of the need for dietitians as professional colleagues. Although in this situation some criticism can be levelled against dietitians themselves, criticism can also be levelled against some sections of the medical profession. Nutrition at present receives minimal attention in the training of medical practitioners and this deficiency needs urgent attention.

The committee considers that as the doctors in the community pay greater attention to nutritional factors in positive health, and in disease prevention and treatment, so too will the demand for dietitians receive considerable impetus. It further believes that failure to provide for a strong dietetic profession for both preventive and therapeutic health services will be a very costly mistake in the welfare of New Zealand society.

2.3 Summary

1. Throughout this study there has been clear confirmation that the dietitian by her specialised knowledge and skills is an important member of the health care team.
2. She is recognised as having a unique contribution to make in the translation of the science of nutrition to the art of planning food for human needs in sickness or in health.
3. Patient care in sickness is identified as the present most important need for her services.
4. A much wider role in preventive health is advocated.
5. The need for dietitians' service will steadily expand as the medical profession gives greater recognition to the growing importance of nutrition in health care.

3. BACKGROUND TO DIETETICS IN NEW ZEALAND

3.1 Development of Training

The training of dietitians was established in New Zealand in 1941, and in 1950 the Dietitians Act provided for State registration and established the Dietitians Board as a controlling authority. Regulations under the Act were first gazetted in 1953. In the early 1920s a hospital commission recommended that dietitians should be trained and established in hospitals. During the 1920s and 1930s some 30 home science graduates went to the United States, Canada, Great Britain, and Australia to complete a dietetic or institutional management training. Because few openings in hospitals for
dietitians existed in New Zealand many remained overseas, or, on their return, accepted teaching or other positions. When eventually dietetic training was introduced in New Zealand, the overseas experience gained by some of these graduates was invaluable.

In June 1939, at the instigation of Miss M. I. Lambie, Director of the Division of Nursing, Department of Health, a meeting of representatives of the Department of Health, the School of Home Science of Otago University, and of several main hospitals was held to plan a definite curriculum.

The drafting of the syllabus content was largely the responsibility of Dr Elizabeth Gregory (School of Home Science), Dr Muriel Bell (Nutritionist to the Department of Health), Miss M. B. McKenzie (Senior Dietitian, Wellington Hospital), and Miss Lambie. The training was based upon the American rather than the British concept of the dietitian. In the United States the dietitian was responsible for the entire hospital food services and in Britain for the therapeutic diets only.

The organising of the course involved collaboration among three parties:

(a) The School of Home Science, University of Otago, which was responsible for the required university course;

(b) The Department of Health which provided the machinery for the introduction and the regulation of the training; and

(c) The hospital boards who provided facilities and staff for theoretical and practical aspects in the hospital section of training.

The Department of Health accepted responsibility for the examination leading to the certificate of proficiency in dietetics. The examination comprised three written papers: administrative dietetics and quantity food service, two papers (section 1); normal nutrition and diet therapy (section 2).

In January 1942 Auckland, Wellington, and North Canterbury Hospital Boards accepted the first intake of home science graduates and diploma holders for a 1-year training. A course enabling registered nurses to qualify as dietitians was offered by the Dunedin Hospital in conjunction with the School of Home Science. (This has now been discontinued). The Otago Hospital Board subsequently operated a training school from 1958–62.

During 1942 two qualifying examinations were held. The first in June was for those who had previously worked in a hospital dietary department for at least a year and who had requisite experience in food service and diet therapy. The second in December was for students of the new scheme. Thirty qualified in these two examinations. Subsequently an examination was held annually. In 1943 the training course was increased from 12 to 15 months but in 1966 was condensed to 12 months, excluding annual leave.
The organisation of training originally laid down is still followed in broad principle, although amendments to the regulations have been made by the Dietitians Board to provide for modification of the syllabus and course prescriptions.

3.2 Legislation for Dietitians

In 1948 ministerial approval was given to the formation of a Dietitians Committee as a controlling board for dietitians in New Zealand, with its authority vested in the Department of Health. This committee functioned for 3 years, and was then reconstituted as the Dietitians Board, which assumed authority for administration of the Dietitians Act 1950 and regulations 1953.

The present Dietitians Board comprises:
- Director-General of Health.
- Dean of the Faculty of Home Science, University of Otago.
- Director of the Division of Nursing, Department of Health.
- An officer of the Department of Health, having special knowledge or experience in the science of nutrition.
- The Registrar (a registered dietitian employed in the Department of Health).
- Two dietitians nominated by the New Zealand Dietetic Association (Incorporated).
- One other person.

3.3 Number Trained

Since dietetic training commenced in 1942, 404 New Zealand-trained dietitians have been admitted to the Register of Dietitians kept in accordance with the requirements of the Dietitians Act 1950. In addition, 33 dietitians who have trained overseas have been admitted to the register. The New Zealand trained dietitians who have not registered are mainly dietitians who qualified before the passing of the Dietitians Act.

Eleven New Zealand-trained dietitians have gained masters' degrees from overseas universities. Of these, three are professionally employed in New Zealand and five are in positions overseas. One overseas-trained dietitian with a master's degree is also employed in New Zealand.

In 1972, 135 practising certificates were issued.

<table>
<thead>
<tr>
<th>Dietitians 1972</th>
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<tbody>
<tr>
<td>Employed</td>
<td>Estimated Vacancies</td>
</tr>
<tr>
<td>Full Time</td>
<td>18</td>
</tr>
<tr>
<td>72</td>
<td>24</td>
</tr>
<tr>
<td>Part Time</td>
<td>12 hospital boards</td>
</tr>
<tr>
<td>14 hospital boards</td>
<td>18</td>
</tr>
</tbody>
</table>

15
As at 30 November 1972, 72 full-time and 24 part-time dietitians were employed in hospitals administered by 14 of 30 hospital boards. Four dietitians were employed in the Department of Health and four were engaged in university teaching. It is estimated that 18 vacancies for dietitians existed in hospitals under the control of 12 hospital boards at the same date. One established vacancy exists for a dietitian in the public health field.

<table>
<thead>
<tr>
<th>Qualifying Yearly</th>
<th>Percentage Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 dietitians</td>
<td>27 percent</td>
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</table>

An average of 20 students have qualified as dietitians in each of the past 5 years. A considerable number have resigned from employment as dietitians. The retention from the 1967 qualifying group was only 27 percent after 5 years. The main causes of this loss can be attributed to marriage and overseas travel as is the case in other professions predominantly followed by women. Over the same period, however, the number of married dietitians returning to work has steadily increased. One-quarter of practising dietitians are employed part time. All of these and also a number of the dietitians in charge working full time are married.

<table>
<thead>
<tr>
<th>From 1942</th>
<th>1972</th>
</tr>
</thead>
<tbody>
<tr>
<td>437</td>
<td>135</td>
</tr>
<tr>
<td>dietitians registered</td>
<td>certificates issued</td>
</tr>
</tbody>
</table>

| | |
| | 96 |
| | practising in hospitals |

3.4 **Summary**

1. In 1941 training of dietitians was established in New Zealand through collaboration among the School of Home Science of the University of Otago, the Department of Health, and hospital boards.

2. The Dietitians Board was established in 1951 to assume authority for the administration of the Dietitians Act and regulations.

3. Four hundred and thirty-seven dietitians have been admitted to the Register of Dietitians since 1942. In 1972, 135 practising certificates were issued.

4. Regrettably few New Zealand trained dietitians have obtained higher degrees in their field and of the 11 who have done so only 3 are employed in New Zealand.

5. The loss to the profession during the first five years after qualification is high.

6. A number of married dietitians are returning to work full or part time. One-quarter of hospital employed dietitians are working part time and all of these are married.
4. THE PRESENT PRACTICE OF DIETETICS: INFORMATION RELATING TO QUALIFICATIONS AND EMPLOYMENT OF DIETITIANS

4.1 Sources of Information

Information in this chapter is based on submissions received from individuals and groups, questionnaires completed by dietitians, and questionnaires completed by hospital boards (appendix B).

4.2 Qualifications of Dietitians

Of the 303 dietitians who responded to the questionnaire, 75 percent hold the diploma in home science, and 19 percent the bachelor of home science from the University of Otago as a prerequisite qualification. Of the remainder, 3 percent trained overseas and 3 percent entered dietetics under the earlier scheme for registered nurses (fig. 1). Eleven New Zealand dietitians obtained higher degrees from overseas universities, while a further 13 gained other additional qualifications, e.g., bachelor of arts degree (table 1, appendix B).

4.3 Present Employment Status of Dietitians

Thirty-four percent (102) of New Zealand registered dietitians in the sample are employed in their professional role. Fourteen percent are otherwise employed in a variety of occupations including school teaching and clerical work. Fifteen percent are overseas, of whom over one-third are employed as dietitians and 37 percent are not employed (fig. 2). Of the 102 dietitians employed professionally 41 percent have qualified within the 5 years 1967–71 inclusive (table 2, appendix B).

Eighty-nine percent of professionally employed dietitians are engaged in hospital dietetics, 4 percent in university teaching, 4 percent are in the Department of Health, and 3 percent are self-employed (fig. 3). Details are given in table 3, appendix B.

Full-time positions are held by 71 percent of dietitians (fig. 4). Average employment hours of part-time dietitians are shown in table 4, appendix B. Part-time dietitians, when graded, are usually known by their specific area of responsibility. Data for all part-time dietitian respondents irrespective of time worked, have been recorded as “part time”.

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FIG. 2: FIELDS OF EMPLOYMENT

PERCENTAGE TOTAL DIETITIANS, 1972

- DIETETICS
- OTHER FIELDS
- NOT EMPLOYED
- OVERSEAS

FIG. 1: DIETITIANS QUALIFICATIONS

PERCENTAGE TOTAL DIETITIANS, 1942-1972

- B.H.Sc.
- Dip.H.Sc.
- Registered Nurse
- Certificate of Proficiency in Dietetics (1942-50)
- Registration Exam. (1951-Present)
- Overseas
- Overseas

Overseas,
Present)
FIG. 3: FIELDS OF DIETETIC EMPLOYMENT

FIG. 4: AVERAGE HOURS PER WEEK EMPLOYED
4.4 Reasons for Leaving or Changing Employment as a Dietitian

Reasons were sought in questionnaires for resignation from employment or for changes in positions by dietitians. Responses from dietitians show that family commitments caused most resignations. Unsatisfactory conditions of work was next most-frequently mentioned and travel overseas also accounts for a significant number.

Hospital board responses show that after overseas travel and marriage, transfer to another hospital or to other occupations were most-frequently given as reasons for resignation.

4.5 Number of Dietitians Employed by Hospitals

A Department of Health memorandum (appendix C) recommends that: “A dietitian or dietitians should be employed to supervise the food service in hospitals of 100 or more average occupied beds. The number of dietitians employed will depend on the numbers to be catered for, type of hospital and the number of services provided by the dietary department.”

The hospital boards provided figures from which the ratio of dietitians employed to the total number of meals served in hospitals has been calculated. These figures show major variations, indicating very heavy meal service responsibility for dietitians in some hospitals (tables 5 and 6, appendix B).

Other factors affecting the numbers of dietitians needed in hospitals are:

(a) The number and size of food service units and the extent of the dietitian’s responsibility for ward food service from those units.

(b) The number, kind, and size of specialised departments.

(c) The division of total meals served among inpatients, staff, and other meal services.

(d) The extent of dietetic counselling services provided for outpatient departments, day care centres, extramural services, and private patients of doctors.

(e) Availability of back up services such as personnel, purchasing, clerical staff, and trained food supervisors.

(f) Whether the hospital is a university teaching hospital and the number of students of dietetics, nursing, medicine, and other disciplines.

4.6 Execution of Dietetic Functions in Hospitals

Information related to dietetic function submitted by hospitals of over 100 occupied beds included 23 hospitals where dietitians are employed and 10 where none is employed.
The distribution of dietetic functions is in general consistent with the Department of Health's recommended schedule of duties for dietitians and food supervisors (appendix C).

4.6.1 Hospitals Employing Dietitians

Where dietitians are employed they are responsible for the food service to all patients and staff in the hospital.

Within the hospital board organisation the dietitian in charge (also known as the supervising, senior, or chief dietitian) is responsible to the medical superintendent-in-chief and thence to the board for the overall policy related to dietetic services within the board's institutions. This follows the same chain of responsibility as that of heads of other special departments and matrons-in-chief. The dietitian in charge at a board's base hospital acts in an advisory capacity to other hospitals under the employing board's control.

Within each hospital, the dietitian in charge is responsible to the medical superintendent for dietetic services. She supervises all staff within the dietary department, including other dietitians. Thirty-nine percent of dietitians supervise other dietitians, and 4 percent supervise over 12 dietitians.

Dietitians within the hospital services are designated by a variety of titles, the majority in accordance with the Hospital Employment (Dietitians) Regulations others by titles descriptive of their specific area of responsibility, for example "therapeutic dietitian".

4.6.2 Hospitals Without Dietitians

Of the 10 reporting hospitals without dietitians, 3 employ diet sisters who are responsible to the matron for food services. In the remainder, food supervisors are similarly responsible.

4.7 Employment of Ancillary Staff for Dietetic Function

Food supervisors are employed in hospitals both with and without dietitians. Where they are employed in association with dietitians they are responsible to the dietitian. Duties are delegated by the dietitian within the general framework of the schedule of duties for food supervisors. It was evident from reports that the extent to which duties are delegated vary. Food supervisors are engaged mainly in the supervision of food preparation and service in kitchens and dining rooms; in control of food use, food waste, and also cleanliness in these areas. While the dietitian retains responsibility for the menu, she may delegate to food supervisors such duties as food ordering, supervision of preparation and cooking of modified diets, and staff training and control.

Food supervisors working in hospitals without dietitians carry out to the best of their abilities, dietetic functions in relation to food services, but with the exception of diet therapy and teaching.
**Summary**

1. Information on the present practice of dietetics was obtained from submissions and from questionnaires completed by dietitians and hospital boards, and material relevant to qualification and employment extracted.

2. Of the 303 dietitians in the sample, 75 percent hold the diploma in home science and 19 percent the bachelor of home science degree from the University of Otago.

3. Eighty-nine percent of the 102 professionally employed dietitians working in New Zealand are employed in hospitals. Forty-one percent of the 102 have qualified between 1967–71 and 29 percent are holding part-time positions.

4. The dietitian in charge is responsible for the overall policy related to dietetic services within the hospital boards' institutions. Thirty-nine percent of dietitians supervise other dietitians and 4 percent supervise over 12 dietitians.

5. The number of dietitians needed in hospitals is affected by the type and extent of services provided as well as by the number of meals served.

6. Food supervisors undertake delegated duties in hospitals employing dietitians. In hospitals without dietitians the food supervisor carries out most food service functions apart from diet therapy and teaching.

**5. THE PRESENT ROLE OF THE DIETITIAN**

In New Zealand, hospitals employ 89 percent of practising dietitians; 4 percent work as public health dietitians, 4 percent are employed as university teachers, and 3 percent are self-employed (fig. 3).

**5.1 The Hospital Dietitian**

The dietitian in the New Zealand hospital assumes a number of roles. By training she is the specialist responsible for the nutritional care of patients and staff. In practice this overall responsibility is translated into responsibility of administration, quantity food service, therapeutics, teaching and research.

The dietitian in sole charge or in smaller hospitals must act as a generalist who assumes responsibility for all these areas of hospital dietetics. In larger institutions where assistant dietitians are employed, senior dietitians delegate authority and responsibility to specialists for aspects of the department’s activities.

**5.1.1 Administrative Role**

The dietitian in an administrative role is responsible for the entire management of a major hospital department which is required to be in operation for a minimum of 14 hours daily, 7 days a week, to supply meals for all patients and many staff. In addition, provision must be made for the service of meals to night staff and to meals-on-wheels recipients.
She is required to make recommendations on, and implement hospital boards' policies concerning food service to patients and staff, food and equipment purchasing, staffing, cost control measures, inter-departmental co-ordination and co-operation.

The base on which the dietitian's responsibility for nutritional care rests is the skilfully planned menu which takes into account recognised nutritional standards, cost, and acceptability. During the translation of the planned menu to appetising meals the dietitian supervises the ordering of food requirements, the preparation, cooking, and service of the meal under safe hygienic conditions. To ensure the best possible nutritional care of patients, she needs to make regular visits to the wards to maintain contact with patients and with the nursing staff.

The standard of meals which the dietitian can achieve is largely dependent upon the calibre of the kitchen staff. The number of staff employed in dietary departments ranges from 30 in a small hospital to 95 in a large teaching hospital. As few hospital boards employ a personnel officer, the dietitian devotes a considerable portion of her administrative time to finding, engaging, and training new staff. Within the hospital, the dietitian is one of the few department heads primarily engaged in the control of staff governed by a union agreement: the New Zealand Hospital Domestic Workers Award.

Dietitians carry complete responsibility for a considerable portion of a hospital board's budget. An estimated annual cost for the dietetic services in New Zealand hospitals is $10 million. The most economic use of the allocation requires constant vigilance by dietitians over food use, food waste, labour utilisation and costs, and equipment use and maintenance.

Few people in any field, commercial or otherwise, have the responsibility to spend at their discretion, such large sums of money without the checks normally imposed. The acceptance of this duty by dietitians is a tribute to their integrity, ability, and training.

In view of the dietitian's accountability for financial expenditure, the committee considers the dietitian should be a member of the hospital's budget committee.

When a new dietetic department is being planned or an existing one improved, the dietitian should always be involved in drawing up the architectural brief and be consulted during the preparation and in the evaluation of plans. Her experience in operating a food service unit, and her knowledge of equipment is invaluable to the architect in ensuring functional efficiency.

5.1.2 Therapeutic Role

In this role the dietitian is the link between doctor and patient in the care of those patients who require a modified diet as part of their treatment or way of life. She is responsible for the translation of the doctor's prescription into meals which are attractive and acceptable to the patient within the limits prescribed. To assist the individual patient she
must work in co-operation with medical and nursing staff and other members of the health team. She must seek the patient's co-operation and allay his fears by visiting him and explaining the necessity for the diet prescribed.

The development of specialised care units within hospitals is intensifying the therapeutic role of the dietitian through her inclusion as a member of the treatment team. This is making new demands on her skill and knowledge in devising special diets within very precise limits.

In her therapeutic role the dietitian plans the menu to meet a variety of dietary modifications. Although in most cases “special” foods are not required, a dietitian needs to be fully acquainted with proprietary foods, their characteristics, and uses in specific diseases. To ensure the correct conversion of the planned menu to meals which meet patients' therapeutic requirements, she supervises the preparation, cooking, and service of the modified diets.

As it is often necessary for patients to continue with modified diets at home the dietitian will assist by discussing with them and their families all aspects of dietary treatment. To be effective she must be able to produce practical and economic diets for home use and to give clear, concise instructions. Such patients may be followed up in outpatient clinics or in their own homes. Dietitians are also available in hospital outpatients clinics for giving dietetic advice in a wide range of medical conditions. For these patients she has similar responsibilities as for inpatients.

The advent of the extramural hospital has given an added dimension to the dietitian's role, and is taking her out into the community but her work in this field, although expanding is, as yet, limited.

5.1.3 Teaching Role

The dietitian's role as a teacher brings her into association with patients, staff, and others with diverse backgrounds. One of her major responsibilities is in the counselling of patients, and her skill in this role can be an important part of treatment and recovery where diet is a medical necessity.

In hospitals which serve as training schools for dietitians the senior dietitian, as principal, is responsible for organising the teaching programme for the students. In two of the three training schools she is assisted by a tutor dietitian. Close liaison with medical, administrative, and dietetic staffs is essential for the successful operation of the training school. The principal and tutor dietitians participate in the teaching programme, and guide and counsel the students throughout their training. All dietitians working in a training school contribute to the students' learning and must be thoroughly conversant with current developments and practice in their specific fields.

In hospitals with nursing training programmes the dietitian, in cooperation with the nursing education department, is responsible for
organising and supervising the teaching of patient meal service and nutrition and diet therapy to student nurses.

The dietitian is also substantially responsible for the training of all food service staff in the dietary department. Very little formal training is available in New Zealand for any category of food service personnel which means that almost all teaching has to be done on the job. Food supervisors, cooks, and kitchen assistants require teaching and may have a great diversity of background, technical skill, education, age, nationality, and language ability. The skill with which the dietitian is able to develop an efficient work force substantially affects the standard of meals from her department, and the control of expenditure on food and labour. Hence her ability to train and develop staff is a critical factor in determining her success.

5.1.4 Research Role

The dietitian may be involved in research in the therapeutic, administrative, or extramural aspects of her work.

In therapeutic research the dietitian plays an important part in the calculation and preparation of the diet for diagnosis and treatment according to the doctor’s requirements, and in enlisting the co-operation of patients and staff to ensure accurate results. She may also undertake research or act as part of a team investigating both short and long-term effects of alteration in the diet or dietary patterns on biochemical disorders or disease processes.

Administrative research projects such as the evaluation of new products, new equipment, new management techniques, or of new food service systems place the dietitian in the role of a principal investigator, with responsibilities for planning, execution, and evaluation of results.

5.1.5 Division of Time as Reported by Dietitians

From data supplied by dietitians, the percentage of time devoted to the broad aspects of dietetic responsibility was estimated (figs. 5-10). The majority of dietitians spend a substantial part of their time on administrative and supervisory duties. In larger hospitals therapeutic duties are usually undertaken by dietitians at second assistant level or by part-time dietitians, who spend the major portion of their time upon these duties. In smaller hospitals dietitians in charge and assistants have to undertake all aspects of dietetic function.

The committee believes that in larger hospitals both therapeutics and administration should become separate specialist functions. In the past, promotion within the profession has been gained through a career in administration rather than in therapeutics.

Responses from dietitians indicate that research activities at present occupy a relatively small amount of most dietitians’ time. Two reported spending 40–50 percent of their time on research.
5.2 Problems Identified in the Present Role of the Hospital Dietitian

Concern was consistently expressed throughout submissions that the dietitian has such diverse responsibility and frequently onerous duties that it is virtually impossible for her to do real justice to every aspect of her work.

5.2.1 Responsibility for Total Food Services

As has been stated, New Zealand dietitians have responsibility for the total food services in hospitals. Considerable thought was given by the committee as to whether this policy should be continued and evidence for and against the policy was carefully discussed.

Various methods of food service employed in hospitals in the United Kingdom, United States, Australia, and Canada were examined, including the use of commercial caterers and of catering officers. After full consideration of alternatives the committee recommends that in New Zealand the dietitian should remain in overall control of hospital food services. This decision was influenced by—

(a) The importance of maintaining the high standards achieved under this system.

(b) The importance of the dietitian in the economic management of food services.

(c) The lack in this country of other trained personnel in the food service occupations.

(d) The advantages of a single line of responsibility for food services against the problems of a divided food service.

The New Zealand Dietetic Association and the Medical Association of New Zealand strongly supports the retention of this policy which was adopted when dietetic training was first established in New Zealand.

The committee believes, however, that the system can be continued only if the dietitian is able to delegate routine tasks to adequately trained supportive staff.

She will require competent food supervisors able to accept delegated responsibility and authority and to exercise control. Other trained food service staff, clerical staff, and the collaboration of executive and personnel staff within the hospital administrative system are also seen as essential.

When trained food supervisors become available it will be most important that dietitians be willing to delegate responsibility to them without relaxing high standards of dietetic practice. The dietitian can then be released to give more attention to her specialist role. To use a major portion of her time in routine tasks is serious misuse of her professional skills, and of the money invested in her training. Such misuse has contributed to the "kitchen image" which has affected the attitude of other professional staff to her role, and of the dietitian to her own role.
5.2.2 Food Supervisors

Trained food supervisors are needed urgently for positions in larger hospitals with dietitians, in smaller hospitals without dietitians, in university or school food services, welfare homes, and all areas where groups of people are fed. There is no established training programme in New Zealand for food supervisors. In the past dietitians have given on-the-job training in hospitals, and the Department of University Extension at the University of Otago has for several years organised a series of 4-day concentrated courses.

It is not surprising that, with no official training or qualifications and an uncertain employment structure, insufficient numbers of suitable people are attracted to institutional food service.

A training programme which gives a nationally recognised qualification is urgently required. This must be accompanied by an employment structure to give appropriate status and remuneration to either male or female supervisors. Such a scheme is likely to attract a larger number of suitable people to this work, and will offer greater job satisfaction than has so far been the case. Attention is drawn to the Department of Health memorandum (appendix C) which outlines appropriate duties for food supervisors.

A recommendation of major importance in this report is that immediate attention be given to the training of food supervisors and of other food service staff for hospitals and institutions throughout New Zealand.

A study undertaken by the University of Otago Department of University Extension in 1971 showed that of 478 institutions included in the survey, only 36 employed food supervisors with a specific qualification, about half of whom were employed in hospitals. Evidence from this study shows that the establishment of both pre-entry and post-entry training courses for food supervisors and other food service staff are urgently required.

The committee was pleased to learn that since this study, steps are now being taken by the Vocational Training Council towards establishing training courses for food supervisors, and subsequently for other food service staff. It urges that these plans be given high priority. Technical institutes would seem to be the most appropriate educational bodies to organise such courses; dietitians must be involved in planning and teaching these courses.

5.2.3 Other Ancillary Staff

Adequate clerical help is essential in any food service department to carry out such tasks as daily recording of ward food orders, telephone coverage, and the typing of menus, reports, and correspondence. It is the responsibility of hospital boards to provide sufficient clerical assistance and at present only 11 of 33 hospitals provide any clerical assistance to dietetic departments.
In the case of the large boards, particularly those with training schools in addition to clerical staff, the senior dietitian needs the help of an executive officer to whom she can delegate administrative and coordinating duties.

The committee expressed surprise that with one exception, large hospital boards do not employ personnel officers. In larger hospitals where labour turnover is high, as in some urban areas, it is considered unreasonable for the dietitian to perform the task of hiring labour. She should have the help of a personnel officer who would be responsible for securing and screening staff, leaving the dietitian to make the final selection.

5.2.4 Food Service in the Hospital Ward

The committee gave considerable thought to a recommendation in submissions from both the New Zealand Hospital Matrons’ Association and the New Zealand Nurses’ Association, and from others, that the dietitian should in future assume responsibility for meal service in the ward. Current discussions on nursing education and duties arising from the Carpenter report\(^9\) take the view that the serving of patients’ meals reduces the time that nurses can spend in assisting and/or encouraging ill and disabled patients with their meals and in observing the appetite and food intake of patients.

It was agreed that where sufficient trained personnel are available it is desirable for dietary staff to be responsible for food all the way from kitchen to patient. Lack of dietary personnel makes this impracticable in most hospitals at present, and the fragmented layout of many hospitals makes supervision by the dietitian extremely difficult.

Investigation of typical hospital meal service systems produced the following information which was noted by the committee:

(a) The system operating in almost all New Zealand hospitals of bulk decentralised service with nursing staff responsible for ward meal service, is considered by some of its practitioners to operate well and to have advantages, namely:

(i) Meals are seen by nursing staff to be an important part of patient treatment and recovery.

(ii) Nurses remain interested in patient appetite and intake as an indicator of patient condition and senior nursing staff can advise medical staff accordingly.

(iii) It is an economic system in terms of the hospital’s total salary and wage bill, although this is being achieved through the use of time of nursing staff.

(b) The use of menus which offer patients an advance choice of foods is seen by dietitians who have used the system to be beneficial. It leads to greater patient satisfaction, better control over food quantities with consequent financial savings, and a more streamlined serving routine for nursing staff. These advantages apply to both a centralised and decentralised system.
(c) In the two hospitals where the dietitian has assumed responsibility for meal service in some wards, the dietitians report the following advantages:

(i) Greater job satisfaction for dietitians and dietary supportive staff through closer patient contact.
(ii) Direct control over food quantities.
(iii) Better control over modified diets, i.e., greater accuracy in measurement of food intake.

Attention is drawn to the recommendations on food services made in the Department of Health Working Party report: "Where the physical layout permits, a centralised tray service which may use both conventional and convenience foods is preferred. For proposed new food services, taking into account the geography of the site and the planning of buildings, it is recommended that either centralised tray service or ward level reconstitution areas for patient food service be adopted". The committee supports the use of a centralised system of food service which offers presentation of meals to patients in a most attractive and economical manner.

5.3 The Public Health Dietitian

The role of the dietitian in the public health field is one of scientific adviser, consultant, educator, and research worker in the broad field of nutrition and dietetics. Such activities bring her into contact with the general public, Government departments, food processors, a wide variety of organisations serving the community's health needs, and educational bodies. Her advice on many aspects of food, nutrition, and dietetics is sought by other divisions of the Department of Health, other dietitians, hospital boards, welfare institutions, schools, and hostels.

The public health dietitian as educator is responsible for nutrition education programmes within the Department of Health, for assisting with courses for food service supervisors and other dietary department staff. In research she is responsible for initiating and executing dietary research projects, research into future staffing needs, and the effects of new developments in food service. The dietitian filling the position of Registrar of the Dietitians Board is responsible for making recommendations concerning the training of dietitians.

5.4 The Dietitian in University Education

The dietitian employed in the university in a teaching capacity has, along with other academic staff, the responsibility for laying sound foundations and principles and for developing the students' capacity to work independently and assess new knowledge with critical judgment. She is responsible for the development of the curriculum for courses related to dietetics and food service management.
and for the standards established in these courses. The curriculum includes methods of teaching applicable to dietitians in the teaching of other hospital personnel, staff, and patients.

She maintains a close liaison with other subject fields particularly nutrition, and whenever applicable integrates the work of other courses with that of her own. As a counsellor to students who have an interest in dietetics, she is in a position to have a positive influence on their choice of career.

The dietitians at the School of Home Science, together with those of the Department of Health, have for several years played a major role in the teaching of annual schools for food service supervisors, organised by the Department of University Extension, University of Otago.

As a research worker the university dietitian may be expected to collaborate with and complement the studies of nutritionists under controlled laboratory conditions.

5.5 The Dietitian in Private Practice

Only one dietitian is known to be engaged in private practice on a full-time basis. In replies to questionnaires two others indicated that they are consulting on a part-time basis, one for a private hospital. It is also known that several have specific commitments for advisory work in medical practice, and in food service management for private institutions.

The dietitian in private practice assumes a similar role to that of her counterpart in hospital service. She interprets the doctor's prescription, translates it into practical and acceptable meals within prescribed limits and within the patient's economic and physical abilities. As a food service consultant, she advises on menu planning, food purchasing, preparation and service, staffing, selection of kitchen equipment, and design of food service systems.

It is recommended that the New Zealand Dietetic Association should lay down guidelines for fees to be charged by dietitians in private consulting practice as is the case in other professions.

It is further recommended that the implications of a subsidy from social security funds should be studied. This will be important as dietitians become involved in group practices and health centres.

5.6 Assessment of Fulfilment of Dietetic Functions

Dietetics as a profession has become established and acknowledged as making a valuable contribution to health care, largely in hospitals, and to some extent in public health. Where dietitians are employed in hospitals they are substantially fulfilling the functions for which they have been trained. These are to provide high quality, nutritionally sound, normal, and modified meals for patients and staff, at reasonable cost. The achievements in the short period of 30 years are seen as praiseworthy.
and the standards of hospital meal service in New Zealand compare very favourably with those of other western countries. The committee commends dietitians, often still in their early twenties, who have carried extensive responsibilities for meal service to large numbers of patients and staff, for management and for financial expenditure. These have been borne despite the wide range of duties, poor support services, and lack of recognition.

5.6.1 Shortcomings in Hospital Dietetic Services

As seen by her colleagues in hospitals the dietitian fails, in some areas, to offer the specialist service expected of her. The chief criticisms have come from medical staff who claim that with some exceptions the dietitian in the therapeutic field lacks confidence and initiative. Her contribution to the doctor in the patient care team is sometimes less effective than he would wish. He feels she may fail to provide him with the nutritional information and guidance he seeks, particularly in special areas. As a result she is frequently excluded from ward rounds and can be overlooked by medical staff. The committee endorses opinions expressed that in some cases doctors have themselves contributed to this situation by failing to give recognition and encouragement to the less experienced dietitian and to include her in their teams.

The dietitian is not sufficiently involved with research and development activities regarded as complementary to hospital dietary services. Although the committee realises that at present she has little time to undertake research, it notes that lack of ability to identify areas requiring research, and lack of knowledge and confidence in setting up and carrying through projects are given as reasons contributing to this deficiency. Opportunities for interesting work and co-operative projects can thus be missed by the dietitian.

She is seen by nursing staff as not playing a strong role in medical assessment, implementation of treatment, and observation of response.

In the field of general meal service the dietitian makes good use of her unique knowledge of nutrition in the planning of menus and in the production of meals. She could, however, play a more active role in patient care. It is frequently reported that she is seldom seen in the wards as a counsellor to general patients on dietary problems. She should also give more time to investigation of patient food intake as an assessment of menu adequacy, popularity, and cost. More patient contact in the wards would help to make the dietitian better known and to widen her sphere of influence. Visiting patients is as much a responsibility of the administrative dietitian as it is of the therapeutic dietitian. Work such as this which makes use of the dietitian’s specialist knowledge is seen as more appropriate than some of the housekeeping and clerical duties which some dietitians fail to delegate. She should also be making a greater contribution to, and be more available in ante natal clinics and in infant feeding in maternity and paediatric wards.

It was stated on several occasions that much of this lack of visibility
on the part of dietitians is due to too few dietitians for too many demands to become more widely involved with patients and professional colleagues. They are often reluctant to emerge from food service duties in which they feel most confident.

5.6.2 Shortage of Dietitians

Serious deficiencies in dietetic services are caused by the shortage of dietitians to fill positions. At the time of collecting data for this report, it was estimated that there were 18 vacancies for dietitians in established positions in hospitals. Marlborough, Thames, Waitaki, Wanganui, and West Coast Hospital Boards have not been able to fill established positions for dietitians in hospitals of over 100 occupied beds for periods of up to 20 years. The complete absence of dietitians in some hospitals has resulted in inadequate overall supervision of hospital food service, and a total lack of professional dietetic consultative services for the patients of doctors in the hospitals or general practice. In other hospital boards such as Northland, Taranaki, South Canterbury, and Southland, where the ratio of dietitians to meals served is very low, the subsidiary hospitals cannot receive the attention which they need.

The low ratio of dietitians to meals served also affects the time that the dietitian can devote to specialist therapeutics, patient consultation, and teaching, particularly when there is a lack of trained supportive staff.

It is evident that overall there are insufficient dietitians available for established positions. The deficiencies in the existing services point clearly to the fact that established positions are insufficient to carry out the duties required. To meet further expansion in the role of the dietitian substantially increased numbers will be needed.

It should be noted that since the committee began drafting its report, the employment situation has changed. In Auckland, Wellington, and Christchurch there are a few newly qualified dietitians who are unable to obtain positions unless they move out of the main centres. This is largely due to less movement on the part of the younger dietitian, married or single, from main centre appointments.

Such a situation can create a false impression of a surplus of dietitians at the time hospitals in the provincial centres still have inadequate numbers or no dietitians at all.

An investigation must be made of this situation and a system devised whereby a number of staff dietitian positions are made regularly available to the newly qualified dietitian to gain experience in a well-staffed dietetic department. Without this experience they cannot be adequately prepared for a sole charge position and unless the experience is available the problems of the smaller hospitals throughout the country will remain unsolved.

The committee also suggests consideration by the Department of Health of a form of incentive scheme to attract dietitians to smaller centres. The precedent for this is already established in the medical profession.
5.6.3. Public Health Dietitians

A valued advisory and consultant service has been provided for 25 years by public health dietitians employed by the Department of Health. The training of student dietitians and the maintenance of high standards at the training schools have been the concern of a public health dietitian as Registrar of the Dietitians Board. Regular advisory visits have been made to dietary departments of all public hospitals and more recently to psychiatric hospitals. This continuity of advice and support to the dietitian “on the job” has been a key factor in establishing dietetic services in New Zealand hospitals.

Four dietitians, one of whom is part time, employed by the Department of Health are to be commended on their considerable achievement over a wide range of duties. One further established position is vacant.

Submissions repeatedly emphasise the need for more dietitians to be involved with public health in education, advisory, and counselling capacities and attention has been drawn to the lack of dietary counselling in social welfare agencies of all types.

5.6.4 Morale of Dietitians

Submissions, questionnaires to dietitians, and evidence clearly indicate that the morale of many members of the profession, and particularly of its younger members, is low. A number of reasons contribute to this unfortunate state.

Dietitians state that failure by some doctors to recognise the potential of the dietitian results in frustration and the feeling that their specialised knowledge is being wasted.

Doctors state that some dietitians feel ill-prepared to deal competently with nutritional and biochemical complexities and, therefore, tend to avoid stimulating and interesting problems. Some also develop the feeling of being an overlooked and unwanted group. No doubt in a situation such as this there are faults on both sides.

The dietitian’s self-image is frequently stated to be poor. She finds much of her work mundane and far removed from the ideals which influenced her to choose dietetics as a career. Those advancing this view cite as solutions the need for delegation of routine tasks, more emphasis on therapeutics, and more active participation as a member of the health care team.

Recently qualified staff dietitians consider there is an “attitude” gap between themselves and senior dietitians as an impediment to communication. They feel that some senior dietitians are not prepared to listen to their ideas and are unwilling to delegate sufficient responsibility and independence of action. As a result they achieve little sense of purpose and a lack of challenge to their abilities. These factors are having a negative affect on professional commitment at an important stage in the career of a young dietitian.

Salaries and conditions of work are also given as reasons for low morale and these are dealt with later in this report.
5.7 Summary

1. The present role of the dietitian in hospitals includes duties in the areas of administration, therapeutics, teaching, and research.

2. The largest portion of the dietitian's time is spent in administrative functions including policy formulation and implementation in relation to patient care, food services, staffing, equipment, planning of food service systems, and overall cost control.

3. Therapeutic functions involve dietitians in patient care as part of the health care team. She translates prescribed diets into acceptable food for patients. She works in hospital departments, both inpatient and outpatient, and to a limited extent in the community. The committee notes that opportunities for promotion for therapeutic dietitians are restricted at present.

4. Teaching is an integral part of the dietitian's function. Present teaching responsibilities include patient counselling, teaching of student dietitians and nurses, and training of food supervisors and staff.

5. Research at present occupies a very limited amount of the dietitian's time. The opportunity for research is recognised in therapeutic dietetics, particularly as part of medical research projects in metabolic or biochemical disorders and in administrative aspects of dietetics.

6. The few dietitians employed in public health and university education are active in maintaining liaison with allied fields, and in providing the community with information on food and nutrition. They are closely concerned with the education and work of dietitians. Considerable emphasis is placed upon the need for expansion of activity in the public health field.

7. The committee recommends that dietitians should remain in overall control of hospital food services but that this can occur only if routine tasks are able to be delegated to adequately trained supportive staff.

8. The committee recommends that immediate attention be given to the establishment of a nationally recognised training for food supervisors and for other food service workers to meet the needs in hospitals and other institutions throughout New Zealand.

9. The committee recommends the provision of clerical assistance in all dietetic departments, and executive assistance in larger hospitals.

10. Present difficulties associated with the conflict as to whether actual meal service in wards is a dietetic or nursing function were considered. The committee supports the adoption in future hospital planning of a centralised system of food service which obviates many of these difficulties and offers presentation of meals to patients in a most attractive and economical manner.

11. Assessment of the present fulfilment of dietetic function shows the substantial achievement by a small and relatively young profession. At the same time there are shortcomings particularly in the lack of initiative and confidence in the therapeutic field, a lack of involvement in patient areas, and too little participation in investigation and research.
12. Examination of the supply of dietitians shows that positions cannot be filled except in the major cities where less difficulty is encountered in recruiting recently qualified dietitians. No dietitians are available in some areas of the country.

13. There is evidence of low morale among some members of the profession and particularly the younger members. Dietitians frequently feel overburdened by the demands of food service tasks and frustrated by lack of involvement in the health care team. Some doctors fail to recognise the potential contribution of the dietitian. Some newly qualified dietitians expressed the view that because they are not given sufficient responsibility or the opportunity to show initiative and independence their commitment to the profession is adversely affected. Poor financial reward for long hours of responsibility is also given as a reason for low morale.

6. THE FUTURE ROLE OF THE DIETETIC PROFESSION

The committee is fully convinced that there is an expanding role for the dietetic profession in future health services in New Zealand. The actual objectives of the dietitian will continue to be essentially the same, but the increasing scope and importance of her contribution in health care are being recognised. This development will come through a number of factors.

6.1 Greater Recognition of Nutritional Factors in Maintaining Good Health

Over the last 30 years the pattern of disease in the western communities has changed; the important lethal and crippling infectious diseases such as diptheria, pneumonia, poliomyelitis, streptococcal, and staphylococcal infections have either been eliminated or now assume minor importance in national health. Serious problems now include arteriovascular disease with its sequelae of coronary heart disease, cerebrovascular and peripheral vascular disease, cancer, hypertension, obesity, and diabetes.

There is considerable evidence that many of these serious and important diseases which are causing so much concern in western societies are due to faulty habits of living. In this connection changes in diet during this century are thought to play a very important role. There is little doubt that faulty dietary habits play a large part in the causation of the so-called degenerative diseases, including obesity and diabetes. The National Heart Foundation of New Zealand and many similar organisations throughout the world have advised modifications of dietary patterns for people at risk from coronary heart disease. Its submission emphasises the
urgent need for dietitians to be available for working in close collaboration with medical practitioners and in an educational role in the community in the prevention and treatment of hyperlipidaemias and other conditions predisposing to coronary heart disease. In some countries (e.g., Scandinavia) changes in national dietary habits have been recommended for the whole population.

There is certainly need for much more research in the relationship of nutrition to these and other diseases. There is surprisingly little accurate information on the dietary habits of New Zealanders.

Evidence was frequently given to the committee of the necessity for dietitians to form part of teams involved in research into nutritional problems in medicine and it was also stated many times that the services of dietitians are essential to translate general dietary advice to practical instruction which the patient and his family can understand and act upon.

6.2 Disease Prevention

As major advances and knowledge in the control of disease continue to be made it is obvious that there must be a drastic shift in primary emphasis from the treatment to the prevention of disease states.

It is now recognised that prior to the development of pathological or structural changes in the body as a result of diseases the earliest discernible changes may be biochemical ones. Such biochemical changes in the cells or in the blood may be detected by presymptomatic screening techniques. Lord Rosenheim, who until his death in December 1972 was chairman of the Advisory Committee of Medical Research for the World Health Organisation, believed that wide-spread screening of populations for evidence of certain biochemical disorders or their precursors, would undoubtedly increase in the future. Dietary intake, trace mineral content of food, soil and water, alterations in vitamin content, pollutants, and other reactions to environmental factors are all suspect as contributors to these biochemical abnormalities. Other theories point to effects of increasing industrialisation, developments in food production and distribution, and technologies which affect work habits and leisure patterns of our society. All these changes and their consequences will undoubtedly influence the role of the nutritionist and dietitian and the spheres in which they will work.

6.3 Organisation of Health Services

New Zealand adopts a commendable policy of forward planning in the provision of health services. There is little doubt that as the treatment of gross pathology in hospitals becomes increasingly expensive we must adopt a policy of preventive health education, the early detection of abnormalities, and their subsequent early correction by various forms of treatment. Failure to adopt such a policy will result in a health service
beyond the economic resources of the country and beyond the reach of
the average citizen.

A preventive service will require changes in the training of para-
medical personnel. It will also call for an adequate number of people to
educate the public in the means of maintaining good health, and for
screening for disease and early detection of abnormalities. It will require
adequate numbers of doctors, dietitians, nurses, social workers, and
psychologists to undertake preventive treatment before overt illness
develops.

Sample screenings have already been carried out including the small
studies made on the populations of Rangiora and Carterton. These
indicate that over 20 percent of total adults in the community may have
already detectable disorders of their biochemistry and thus symptomless
disease. The significance of this figure in terms of education and treatment
is apparent in a policy of preventive health care. This new concept will
also need to be supported by continuous research activities but will
become an investment in long-term economy of human resources.

6.3.1 Hospital Services

Hospitals will of course continue to provide care for the acutely ill,
and for patients requiring specialised tests and diagnosis with all the
attendant services.

Changes in morbidity patterns have resulted in fewer hospital beds
being used for such cases as pneumonia, tuberculosis, and gastric and
duodenal ulcers. At the same time increasing numbers of beds are being
used for the investigation and treatment of obesity, vascular disorders
(e.g., coronary disease, strokes, peripheral vascular disease), metabolic
diseases such as diabetes, and for geriatric patients. All require the
services of dietitians. Dietary treatment is also important in cases of liver
disease, renal medicine, complications of pregnancy, the control of
genetic metabolic disorders and other paediatric illnesses, some psychia-
tric conditions, and deficiency states, particularly in the young and the
elderly.

Outpatient and extramural services have expanded rapidly in recent
years and will continue to do so as every effort is made to conserve
available hospital beds for acute cases. Day care facilities are already in
operation in some hospitals. Many patients with lipid and other meta-
bolic disorders are treated in big outpatient clinics where the services of
dietitians are essential for translating the therapeutic views of doctors
into practical meal patterns as a part of treatment.

Dr Jean Mayer, Professor of Nutrition at Harvard University, states
that: "Ideally, a professional dietitian would function as a physician's
assistant in ruling out nutrition in the patient's initial examination
(something that is not being done at all at present). The dietitian would
clicit the patient's food habits: what he ate that day, what food he likes,
and whether his diet is balanced, particularly with respect to fats and salt
intake."
“In hospitals,” says Dr Mayer, “we need more therapeutic dietitians to go on rounds, more outpatient dietitians to start teaching the patient—especially the heart patient—proper nutrition while he is still in the hospital, and more supervisors of food services.”

6.3.2 Psychiatric Hospitals

The dietitian’s sphere of influence has widened as the result of the integration of psychiatric services into the general hospital. Control of food services in the psychiatric hospitals has been the responsibility of food service supervisors (appendix C). They are frequently without adequate training, qualification, and experience to fulfil the job requirement. In addition they are not able to administer prescribed therapeutic diets or give dietary advice and have little or no contact with medical and nursing staff. Some advice and assistance has been available to food service supervisors through public health dietitians. Dietitians will now include advisory services to psychiatric hospitals under the administration of their employing hospital board. They will advise the food service supervisors on total food service policy and menu planning for normal and modified diets. They will give dietetic advice when prescribed for inpatients and outpatients and establish liaison with medical and nursing staff on dietary matters. Dietitians will also assume the responsibility for the nutrition and diet therapy instruction of nurses. They will advise on staff training programmes in food handling, preparation, cooking, and service. As soon as sufficient dietitians are available they should be employed in psychiatric hospitals in the same manner as in general hospitals.

6.3.3 Medical Practice

Medical specialists, general practitioners, and their patients have indicated in submissions a definite need for better access to dietetic advisory services. It is becoming increasingly apparent that practitioners have neither sufficient time nor an adequate understanding of many aspects of dietary therapeutics to be able to do what dietitians are trained to do. Again to quote Dr Jean Mayer “not only does the average physician not know much about nutrition, he doesn’t know much about foods either. He can’t translate nutritional knowledge into foods, and the dietitian can.” It is expected that with more promotion of the use of dietary modifications in prevention and treatment of the many disorders already mentioned, there will be increasing needs for the services of the dietitian. Physicians who have been closely involved with dietary control programmes have been convinced that for effective results much more is needed than handing out a diet sheet or a calorie counter with a few words of encouragement. The principles of the diet, the diet itself with details concerning the use of various foodstuffs need careful explanation and time must be given to answering practical questions. The diet must fit the resources of the family budget and must be clearly understood by the member of the household (frequently not the patient) who does the
food buying and cooking. Most important, too, is a continuing domiciliary follow-up association with the patient and his family to check on difficulties, give confidence and encouragement. All these important aspects of efficient and effective dietary treatment are tasks not for the doctor but for the dietitian.

A great effort in education is frequently required to change people’s eating habits and to be successful, the dietitian must be convinced of the wisdom of such changes. It must also be remembered that a long time often elapses before the results of their efforts are manifest.

6.3.4 Group Practices and Health Centres

To make the most economic and effective use of scarce and expensive medical, specialist, and paramedical manpower and facilities, the concept of group practices and health centres has growing support. New Zealand’s first health centre is now under construction in Mosgiel, and others are shortly to follow. The doctors in the health centres will be supported by a variety of allied health services which should include those of the dietitian.

This system is likely to bring increased co-operation between health services, as hospital extramural services and those provided by public health authorities work with the health centres for comprehensive community health care programmes.

6.3.5 Regional Health Services

It is possible that we will move towards a single health service for larger regional areas. Hospital specialists will go out to groups of practitioners working in health centres and traditional boundaries between hospital and the community will diminish as services become interrelated components of total health care. As part of this development the dietitian will widen her sphere of influence beyond the hospital environment. This will be important as successive decades of younger members of the community are educated to the need for a preventive rather than a sickness service. People must accept the need to manipulate both the environment and the diet to provide continuing good health and prevent the insidious onset of degenerative diseases with their final devastating consequences. As finance becomes available, computers will be used as an important tool of management and patient-based investigations, and they will be increasingly used to facilitate health screening of large sections of the population. Patients requiring special advice and services such as dietetic advisory services will be identified by specially written computer output data.

6.4 The Dietitian in the Future

The committee has recommended that the dietitian remain in overall control of food services in New Zealand hospitals. This means that the planning and provision of a nutritionally sound and high standard meal
service to patients will continue to be a major responsibility of dietitians. At the same time the committee believes that changes in some aspects of the present function of the dietitian are essential if she is to contribute to her full potential in the promotion of positive health in the community.

6.4.1 Specialisation

The rapidly increasing body of knowledge is making specialisation in the practice of dietetics essential.

The committee recommends the planned development of three major categories of dietitians: the general dietetic practitioner; the administrator of dietetic services; the clinical (or community) dietitian.

6.4.2 The General Dietetic Practitioner

The general dietetic practitioner will be engaged in the general application of dietetics and is likely to be employed in a sole charge position or advisory post in a smaller community hospital. Like the general practitioner in medical practice her role is important and the demands upon her are wide.

In addition to the direction of the meal service to patients she will be responsible for keeping in contact with patients in wards, for consultation with medical staff and patients concerning prescribed diets, for holding outpatient clinics, and for acting as a dietary counsellor in community health services. To function in this capacity she needs a soundly based general training. Demands on her knowledge and skills will expand, change, and diversify. To maintain her competence she will need opportunity for frequent contact with professional colleagues in the larger hospitals and in all specialties. She will also need well-organised and regular opportunities to update her knowledge, particularly in therapeutics.

6.4.3 The Administrator of Dietetic Services

The administrator of dietetic services is likely to be employed by a hospital or other large organisation responsible for the overall management of a complex of food service units. The duties will include formulation of policy related to food services and planning new food service units using new techniques as they become available. Spiralling food and labour costs and the increased autonomy vested in hospital boards will add to the dietitian's importance in budgetary planning and control. In addition to hospital food service there is considerable scope for an administrator of dietetic services to direct university food service systems catering daily for many thousands of students.

The use of the computer will assist the dietitian and the food supervisor with such tasks as menu planning, food ordering, cost control, stores inventory, job analysis, and staff rostering. While the dietitian will not need to be skilled in computer programming she will need to understand the overall principle of the use of computers, supply accurate
input data, and interpret the results produced. The administrative dietitian will also be responsible for initiating schemes for training staff and retraining those affected by technological changes in food services and food handling procedures.

6.4.4 The Clinical Dietitian

The clinical (or community) dietitian will be employed in hospitals or community health services as the specialist responsible for the nutritional care and treatment of individuals and their families. Such dietitians could be in roles as varied as therapeutic adviser, counsellor, educator, or research worker. In the future she is likely to be more closely involved with the identification and evaluation of nutritional problems.

In the therapeutic role she will be responsible as a member of the health team for the translation of the dietary prescriptions into appetising, acceptable, economic, and practical meals for the patients. She can expect to be in frequent contact with patient, doctor, and nursing staff. Where appropriate she should follow the patient from hospital bed to outpatients' clinic or into the home after discharge.

The clinical dietitian will be increasingly seconded to specialist departments or units such as paediatric, gastroenterology, endocrinology, surgery, renal, cardiovascular, metabolic, obstetric, geriatric, and to the outpatients' services operating from these units. In these units she will be responsible for the calculation and preparation of diets within very narrow limits for diagnostic and balance studies and for treatment purposes. The dietitian will need specialised training particularly if she is to be involved in diagnostic and research activities.

Traditional job titles will probably disappear and those descriptive of dietetic specialities will emerge. Lines of responsibility are also likely to be modified. A specialist dietitian responsible for a particular activity may relate directly to the administrator of dietetic services and provide consultant advisory services for the region. In other cases dietitians seconded to special units may owe joint loyalty to the directors of the units and the teams of which they are an integral part, and to the central dietetic service from which they are seconded.

The clinical (or community) dietitian will have increasing responsibilities and demands through extramural hospital services. This will take the form of counselling of patients, particularly vulnerable groups such as expectant mothers, parents of infants, and geriatric patients. Such work will be in collaboration with medical and nursing staff and social workers.

The continued development of health centres and group practices seems certain. The clinical dietitian must be a member of the paramedical specialities associated with these centres. She may be employed by a group of doctors, be working in consulting practice, or be available in a health centre by arrangement with a hospital board.

In the health centre the dietitian should perform duties similar to those associated with outpatient and extramural hospital services. These
centres will give an added opportunity to exert influence in a preventive role and will considerably broaden the dietitian’s community contact.

6.4.5 Educational Role of Dietitians

It is logical that increasing involvement of the dietitian in health care will necessitate her participation in education. Every dietitian is essentially involved in some form of teaching. In a hospital she should participate in the training of other dietitians, nurses, medical students, other health care groups, and in the training of staff in the dietetic department. The teaching of patients and their families to understand and manage their specific dietary problems will always be tasks of major importance.

Outside the hospitals a limited number of dietitians should be employed in university and other tertiary educational institutions, and have responsibilities in the teaching of nutrition, dietetics, and allied subjects to students in medical and paramedical training programmes. They should also be involved in training courses for food service personnel which need to be provided on a growing scale in technical institutes at national and regional level.

In public health, dietitians will have the difficult and challenging responsibility for public education and counselling in order to influence dietary habits as increasing knowledge and evidence makes this desirable. She will need to work with and influence all groups and ages from prenatal to the over sixty-fives. Schools and teachers’ colleges are obvious places in which nutrition education is desirable. She should work through all channels available to her—radio, television, and press, as well as by direct contact. Considerable information given in popular magazines, is frequently unsound, unscientific and full of fads and fallacies. The dietitian must compete with this material and be able and ready to refute misleading information and advice.

There are three stages in health education—knowledge, attitude, and behaviour. To pass on knowledge alone is insufficient. Effective ways must be found to first change attitude and then behaviour. No one else in the array of medical and educational personnel is in a better position to meet the challenge than the dietitian, but to so so, she must reflect belief in her aims and her influence.

These varied and difficult teaching responsibilities require an adequate training in teaching techniques. Introduction to teaching method is an important part of the prequalification training, and for those whose duties involve a full-time or major teaching commitment the opportunity for post-graduate teacher training is considered essential.

6.4.6 The Public Health Dietitian

The future role and tasks of the public health dietitian in health education have been outlined above. Such activities will be the major means of extending her influence into the community. Unless these services are extended, the dietitians role in preventive health will remain very limited. Particular groups with which public health dietitians
should be collaborating are social workers, public health nurses, and dental nurses. The present small number of positions in the public health field makes effective work with these agencies virtually impossible.

The committee recognises the present difficulty in obtaining suitably qualified and experienced dietitians for public health positions but considers that an increasing number of positions must be established to serve all regions in the country. There is at present no public health dietitian available in the entire Auckland province where work for several must already exist, and future scope be almost limitless.

The committee recommends that a policy be adopted to steadily increase the establishment of positions for public health dietitians, and that every effort be made to recruit, train, or retrain suitable dietitians for these posts. Assistance and encouragement should be given to dietitians to gain post-graduate qualifications overseas in public health nutrition.

6.4.7 Advisory Role in Institutions Not Employing Dietitians

In some institutions standards of food service leave much to be desired. Staff training in the organisation and management of food services is unknown in many institutions and this is frequently reflected in low standards of quality, efficiency, and economic management. The nutritional standard of food service is of particular importance in an organisation where a full meal service is provided for groups of people in residence on a regular basis. Boarding schools catering predominantly for the 12–18-year age group are seen as having a special need for sound nutritional standards.

The committee recommends that the services of dietitians in a part-time or consultant capacity should be widely used in an effort to improve standards in food service management in institutions such as small hospitals, welfare homes, universities, and school and industrial food services.

This development should now commence. There are a considerable number of dietitians in the community who are not in full-time professional employment because of family commitments. Many of these would be both capable of and interested in consultative work of this nature on an appropriate fee-for-service basis. The services of a dietitian, on either full- or part-time basis, could be shared by a group of institutions in one centre.

6.4.8 Dietetic Research

There is need for research in all aspects of dietetics. In clinical dietetics research opportunities are recognised as part of the medical research projects in metabolic or biochemical disorders. It is envisaged that clinical research will increase as post-registration and post-graduate courses are established. Another area in which research is important is in the relationship between dietary habits and the maintenance of good health. Dietary surveys are urgently needed and should be undertaken by dietitians and nutritionists. We have only fragmentary knowledge of
the actual dietary patterns of our population, even of the particularly
vulnerable groups within the population—infants, the elderly, or those
suffering from specific disease states. Limited surveys to date suggest that
deficiencies in the diets of the elderly in our community may contribute
to their suboptimal health. More knowledge of dietary habits is an essen-
tial part of the development of preventive health measures.

There is also scope for research in administrative aspects of dietetics
such as new food service systems and new management techniques. Research activities will require substantially increased allocation of funds.

6.4.9 Liaison with Related Fields of Work

In the future there should be much greater liaison between dietitians
and nutritionists, food technologists, and the food manufacturing and
processing industries. The effects of processing on the nutritive value of
food must be assessed, and information about the actual nutritive value
of foods made widely available.

6.4.10 Food Tables

Accurate food tables giving the content of all New Zealand foods
are needed by all groups involved and particularly by the dietitian. The committee welcomed information that the Food and Nutrition
Advisory Committee of the Board of Health has established a sub-
committee to pursue the preparation of food tables.

6.5 Achievement of Future Role

The achievement by the dietitian of her future role is dependent on
changes in function and attitude by the dietitian herself, on changes in
attitude to her function by medical colleagues and by employing author-
ities, and on changes in attitude by the general public.

The dietitian herself must adapt to new forms of professional work
and be prepared to evaluate and implement changes in practices. Her
training must provide adequate preparation for her expanded responsi-
bilities and enable her to practise with competence and confidence. Retraining is also essential for those already in the profession.

6.5.1 Availability of Trained Food Service Staff

As already indicated the dietitian should be relieved of her present
heavy involvement with the routine supervision of food services in
hospitals. It is impossible for any dietitian to meet the full demands of
her professional role if a major portion of her time and energy is spent
on tasks which could be carried out successfully by less-qualified persons.

The appropriate way to meet this problem is to take urgent action in
instituting training courses for food supervisors and for other food service
workers. At the same time it is essential to establish an employment
structure to give recognition and remuneration to persons, men or women, undertaking the training. This development is seen as crucial to the future of the profession.

6.5.2 Recognition of the Dietitian

A wider recognition of role and potential must be accorded to the dietitian. It has already been stated that greater cognisance of nutrition by doctors in the daily practice of medicine is of major importance in gaining this recognition by the medical profession and public. Nutrition should become part of the basic training of every doctor regardless of his subsequent specialty.

A better appreciation by employing authorities of the place of the dietitian in the health team is necessary to enable full use of her specialised skills and knowledge.

A change in attitude on the part of the general public is necessary. A large number of people have only vague ideas about the role of the dietitian. Most associate the dietitian mainly with restriction of food in cases of obesity, illness, or disease. Regrettably, few see her as important in preventive medicine and positive health care. A major public relations programme is necessary to clarify the contribution of the dietitian in the community. Only then can the dietitian hope to succeed in the extremely difficult role of exerting influence on the eating habits of the general public.

A change is needed in the widely held attitude that dietetics is solely a female occupation for which there is no support beyond custom and prejudice. The profession could, with considerable benefit, offer a career for men as well as women. There are a number of male dietitians in other countries, including the United States. Male recruits would be welcomed at all levels of training and practice. (The use of the pronoun “her” throughout this report is adopted only because all New Zealand dietitians are at present women.)

6.6 Summary

1. The role of the dietitian will expand as medical evidence increasingly points to the relationship between dietary habits, health, and degenerative and other disease states. This knowledge will bring a change in emphasis from treatment to prevention of disease. Screening techniques are making possible the detection of biochemical disorders prior to the development of many diseases, and nutrition along with other environmental factors is suspect as a contributor to these disorders. These developments and their consequences will affect the role of the nutritionist and the dietitian.

2. An increase in the use of hospital beds for investigation and treatment of disorders requiring specialised dietetic services, and the expansion of outpatient and extramural hospital services, emphasise the need for more clinical (therapeutic) dietitians to participate in initial assessment, nutritional care, and teaching of patients.
3. The integration of psychiatric services into the general hospital system widens the sphere of the dietitian. Increasingly advice will be needed on food service policy and management; responsibility will need to be assumed for therapeutic dietetics in psychiatric hospitals.

4. Dietary advice is seen as a growing need in medical practice within the community which can be best met by access to the services of a dietitian. Consultant dietitians should be among the paramedical personnel available in health centres and group practices and in future regional health services. These avenues will widen the dietitian’s influence beyond the hospital into the community.

5. Specialisation in the practice of dietetics is essential to future professional standards.

6. Future dietetic practice is likely to be divided into three main divisions: the general dietetic practitioner, the administrator of dietetic services, and the clinical (or community) dietitian. The latter group will specialise further for work in specialist medical units. In each division demands on knowledge and skills will expand, change, and diversify as the dietitian works more in interdisciplinary teams. Teaching and research will be part of the role in each area. Opportunities for specialised training, and regular updating of knowledge will be essential for effective practice.

7. An expansion of responsibility in an educational role will accompany increased involvement in health care. This will include teaching of patients in hospitals and in the community; participation in training of other dietitians, nurses, medical students, and other health care groups; and training of staff in the dietary department. The dietitian’s teaching services will also be required in universities, other tertiary educational institutions, and in public health nutrition education programmes through all possible avenues. Training in teaching methods will be necessary to meet these demands.

8. The services of a dietitian should be used in an advisory capacity to improve standards of food service management in institutions not employing dietitians and without trained staff.

9. Continuous research is needed in all aspects of dietetics and will require increasing financial support. Research areas include the relationship between nutrition and disease which will involve dietary surveys; clinical research particularly as part of medical projects on metabolic and biochemical disorders; and the study of new developments in food service systems and their management.

10. Liaison between dietitians, nutritionists, food technologists, and food manufacturing and processing industries is important to maintain accurate information on the nutritional content of New Zealand foods.

11. The achievement by the dietitian of her future role is dependent on changes in attitude and function by the dietitian, changes in attitude by professional colleagues, employing authorities, and the general public. It is also dependent upon the availability of trained ancillary staff.
7. PRESENT TRAINING OF DIETITIANS

7.1 Training Programme

The present training for dietitians prescribed in Dietitians Regulations 1953, requires a degree or diploma in home science conferred by a university in New Zealand, or any other such degree or diploma which is in the opinion of the Dietitians Board, substantially equivalent thereto; and a period of training of 12 months in a principal training school and one or more subsidiary training schools as the board decides.

The prerequisite courses in home science are offered by the University of Otago. The two courses, bachelor of home science (4 years) and diploma in home science (3 years) include a similar range of subjects, the principal difference being in the level to which science subjects are taken. Outlines of both courses and a synopsis of the two subjects, nutrition and food service administration are given in appendix D.

Dietetic training is given in three principal training schools administered respectively by the Auckland, Wellington, and North Canterbury Hospital Boards. In each case the hospital boards' dietitian in charge (as defined in Hospital Employment (Dietitians) Regulations) is the principal of the training school. The basic form of the training is akin to an apprenticeship with the student acquiring clinical experience, practical skills on the job, and theory in the classroom—1 day per week.

The statutory authority for the training of dietitians is vested in the Dietitians Board, as set down in the Dietitians Act 1950. The minimum requirements for the instructional course and the syllabus of subjects for the examination under the Dietitians Act are laid down in the Dietitians Regulations 1953.

The Dietitians Regulations state that all lectures and other instruction shall be given by registered medical practitioners and registered dietitians or by other competent instructors as approved by the board.

7.1.1 Observations by the Committee on Prerequisite University Training

The prerequisite courses of the degree or diploma in home science have provided appropriate instruction in the basic sciences, in the pre-clinical sciences of physiology, biochemistry, and human nutrition, and in foods, food science, and food service administration. The science departments and the medical school preclinical departments of the University of Otago contribute to the teaching.

The structure of the courses is broadly based and prepares students for entry to a variety of occupations related to home science, including teaching, dietetics, research, product development, and promotion work in the food industry, and to a lesser extent positions in textiles, clothing, and design. Only limited specialisation is available in each area of the course.

Intending dietitians are taking subjects within these courses which have no direct relevance to dietetics, but which are relevant to a general
qualification in home science. Food service administration is a subject of the final year of the home science courses and is taken by all students planning to proceed to a dietetic training. It is also taken by other students not intending to become dietitians.

In the past, the broad prerequisite qualification seemed desirable as it did not involve an early commitment to a specific occupation, and enabled graduates and diploma holders to move fairly freely between occupations.

The greater depth of knowledge now required for professional competence in specialised fields points to the need for re-examination of the training requirements for dietetics. It is doubtful that time should still be devoted to subjects not relevant to immediate needs, when a course planned more specifically to professional needs would offer more advantages to intending dietitians.

7.1.2 Observations by the Committee on Aspects of Present Hospital Training

Applicability of the Present Dietetic Training—The principal aim of the present training has been to equip dietitians to work in New Zealand hospitals. The dietitian has been trained as a generalist fitted to assume overall responsibility for the food service to all patients and staff, and to advise those requiring modified dietary treatment. She has the added responsibility of teaching individuals and groups about food and nutrition. Depending on the dietitian’s personal interest and aptitude, in larger hospitals she has been able to specialise to some degree.

Nevertheless, the lack of post-qualification courses has meant that dietitians wishing to work in the community health field, in nutrition education, or in other specialised fields such as metabolic work, or in research, have felt their training to be inadequate and stress that further specialised training is essential.

The same applies to dietitians responsible for teaching duties in training schools. Dietitians at present undertaking these duties are working under considerable difficulties of too little extra training, too little opportunity for study and investigation, and too many other commitments.

During 1972 each of the training schools schedule lectures, seminars, and discussions in excess of the minimum requirements for each of the three subjects in the syllabus. All schools gave their students practical experience in accordance with the regulations, with the exception of practice in teaching nutrition and diet therapy when approximately half the minimum requirement was reached.

7.1.3 Library Resources

The quality and extent of library resources available to students is variable. Students have access to the medical libraries in each of the
training schools. Each school attempts to maintain a library of textbooks and journals within the dietetic departments, but the policies and practices governing the purchase of these differ between hospital boards. One school receives a percentage of the hospital board's library allocation; another receives books and journals when these have been replaced by later editions in the medical library, a procedure deplored by the committee. It is clear that the present situation needs re-examination by all hospital boards. Up-to-date journals must be held in all dietetic departments if university-trained staff are to maintain standards of practice. Training schools need both journals and full access to a good reference collection in all aspects of dietetic practice. The committee questioned whether dietitians had been sufficiently active in pressing for improved library facilities.

7.2 Opinions Expressed to the Committee on Present Training

Comment on present training was expressed in submissions, evidence received by the committee, and in questionnaires completed by dietitians. Those dietitians who completed training in the 5 years 1967–71 were asked to comment on course content and on effectiveness of presentation of subject matter.

7.2.1 General Comments

Dietitians generally consider that their training has given them a satisfactory foundation upon which to build a career, and those who subsequently worked overseas felt well prepared. They see the home science courses as a generally sound qualification preparatory to dietetics. From the comments and criticisms of medical and nursing professions and hospital boards, it is evident that there is satisfaction with quality of meal services provided and the efficiency and economy with which this is achieved. It is also clear that the dietitian is making a significant contribution to patient care. However, some members of the medical profession, particularly specialist physicians and paediatricians are of the opinion that the present overall training does not equip the dietitian with sufficient knowledge, skills, confidence, and initiative to provide them and their patients with the dietetic information they require for investigative or treatment purposes.

7.2.2 Comments on the School of Home Science Courses

Many dietitians are critical of course structure as applied to their needs. They consider some subjects irrelevant and name clothing, design, education I (paper a) and home management in this category. (The content of education I (paper a) has recently been changed and degree students entering dietetics no longer take home management.)
There are also comments about the omission of subjects considered necessary, with clinical nutrition (diet therapy), sociology, psychology, counselling, and statistics specifically mentioned. More work relating to teaching methods and practice is also advocated.

The division of normal nutrition taught as part of the home science courses, and clinical nutrition deferred until the dietetic training are seen as difficult and frustrating to both teacher and student particularly at the School of Home Science. Some dietitians feel that due to this division they were introduced only to the administrative side of dietetics while at the School of Home Science.

Members of the medical profession questioned the depth of knowledge of physiology and biochemistry as a basis for exacting therapeutic nutrition.

Criticisms were made of the ability of home science students to apply their knowledge, particularly nutrition, to the practical feeding of people. Dietitians reviewing their home science training commented that they were not called upon to show sufficient independence and initiative.

7.2.3 Comments on Dietetic Training

The hospital dietetic training was also subject to criticism. Many dietitians considered that the present training does not give sufficient opportunity for the students to work with patients and gain confidence, and a number feel that their time is too rigidly scheduled with little chance to follow their own dietetic interests. Criticism was made of the time spent in food service duties, and of the overlap between food service administration as a home science subject, and some aspects of administrative dietetics in the hospital training.

One submission from paediatricians felt that 12 months in service training overall was inadequate to gain the clinical knowledge and experience required.

The New Zealand Dietetic Association expressed the opinion that much of the dissatisfaction during the dietetic training year arises from the varied academic background of students, both degree and diploma being taught together in small classes. The lecturing of small classes of five or six students in therapeutic dietetics was regarded as inefficient by some of the medical profession.

Some dietitians consider that the present dietetic syllabus is inadequate for dealing with community health problems, dietetic research, management skills, and computer technology, but the committee considers these criticisms should more appropriately be levelled against the lack of continuing education opportunities.

Recently qualified dietitians were asked to suggest changes needed in training. The main needs stated were for increased content in therapeutic nutrition, more opportunity for patient contact, and more emphasis and experience in teaching and counselling skills. Newly qualified dietitians stated that they completed the course without feeling adequately trained.
to work with medical staff and patients. There were also proposals of more emphasis being concentrated on interviewing techniques, neonatal nutrition, and financial planning in the syllabus.

Comments from hospital boards emphasise demands imposed by the dual role of the senior dietitian in a training school. On one hand she is responsible to her board for the organisation, management, and standards of dietetic practice and meal services. On the other she must also accept responsibility for the organisation and supervision of the training school programme, and of teaching students. A further problem is the shortage of suitably qualified and experienced staff for training schools.

The Department of Health consider hospital board controlled schools giving apprenticeship type training to be outmoded.

One point stressed by dietitians, physicians, and the Dietitians Board, was the need for a tutor dietitian experienced in dietetics and trained in teaching methods to supervise the training programme at each training school. The committee considered that for effective clinical teaching a ratio of tutors to student dietitians of 1:6 will be necessary.

7.3 Summary

1. The present New Zealand training for dietitians requires the candidate to be the holder of a degree or diploma in home science from a university in New Zealand followed by 12 months’ training in a dietetic training school approved by the Dietitians Board. The Dietitians Board has statutory authority for the training and subsequent registration of dietitians, as defined in the Dietitians Act and regulations.

2. The prerequisite home science courses provide appropriate work in basic sciences, nutrition, and supporting preclinical sciences, and in foods, food science, and food service administration.

3. The home science courses are broadly based. Intending dietitians at present include basic courses in the full range of home science subjects, but limited specialisation is available in the final year of the courses.

4. Dietetic training was established with the principal aim of preparing dietitians to work in New Zealand hospitals as generalists able to assume responsibility for therapeutic duties and for directing the operation of hospital food services. Lack of post-qualification training in specialised aspects of dietetics has restricted opportunity for specialisation.

5. There is a general satisfaction with the quality of meal services and a recognition of the dietitian’s contribution to patient care. There are reservations about her knowledge, initiative, and confidence in therapeutics.

6. Although the prerequisite home science courses are considered to give a sound background, some required subjects are considered irrelevant and other subjects considered necessary are omitted.

7. The dietetic training in the hospital training school is regarded as generally applicable and helpful. Criticisms include inadequate opportunity for clinical work with patients, too much time spent in food service
duties, and a too-rigidly scheduled programme. Suggestions were also made for some changes in emphasis in the syllabus.

8. Other needs include opportunities for additional training for specialist functions in management, therapeutics, community health, teaching, and research.

9. The appointment to each dietetic training school of tutor dietitians experienced in dietetics and trained in teaching methods is a clearly defined need.

10. Library resources in dietetic departments are variable and in some cases very unsatisfactory. Library policy in relation to dietetic departments needs revision by hospital boards.

8. FUTURE TRAINING OF DIETITIANS

This committee has been charged with the responsibility of making recommendations for training which will produce dietitians of the number and quality required to meet the country's future needs. The present system has served well in the past, and has produced dietitians who have raised hospital food services to a high standard in New Zealand. It has produced dietitians highly regarded in both New Zealand and overseas. There is, however, a growing realisation on the part of many dietitians themselves and of those closely associated with their work that there are problems in the profession. A number of these problems relate to training.

8.1 Problems Affecting the Future of the Dietetic Profession

The committee is convinced that future prospects of the profession and consequently the contribution it will make to health care in New Zealand are being affected because:

(a) The training and special knowledge of the dietitian are not being fully utilised.

(b) An insufficient number of dietitians is available to meet present needs throughout the country.

(c) An insufficient number of recruits of the high calibre required is being attracted to dietetics to meet the even more demanding future needs.

(d) Dietitians frequently are not given the status and recognition which their level of training and their responsibilities should command.

(e) The medical profession states that it is not always getting the service it needs and expects, especially in clinical dietetics and research activities. Such deficiencies will become even more apparent as these areas of medical treatment and investigation expand.

(f) Recently qualified dietitians, in particular, are expressing dissatisfaction with the nature of some aspects of their work and with their status, salaries and career prospects.
(g) Dietitians and students are expressing dissatisfaction with some aspects of their training. All these problems are inter-related. They are reflected in the image which the dietitian has of herself, her image with medical and other hospital colleagues, and her public image. Recruitment is inevitably affected by these attitudes. The committee believes that while there is no single solution to these problems, change in the approach to training is of major importance in helping the profession to gain recognition which would substantially improve this present disturbing situation.

In making recommendations for future training, the committee has sought to preserve the strengths of the established New Zealand training scheme and overcome the major problems and deficiencies which have been clearly identified. Account has also been taken of existing resources and the recommendations make full use of these resources.

The following recommendations are, therefore, realistic in terms of the additional finance and facilities required for their implementation. At a future date, as recruitment increases, further extension of facilities may be required.

8.2 **Outline of Recommendations for Training**

8.2.1 *Training for Registration*

For registration and entry to the profession it is recommended that there should be two principal means of gaining qualifications and registration as a dietitian:

(a) By gaining a degree in dietetics to be established as a 4-year degree programme which co-ordinates clinical studies with the pre-clinical component of the undergraduate course.

(b) By gaining a prerequisite qualification in home science followed by a 1-year professional training based on a single training school. This school should be attached to a major hospital and be associated with the clinical departments of a medical school.

8.2.2 *Post-registration and Post-graduate training*

It is recommended that immediate steps be taken to provide for:

(a) Courses leading to post-graduate and post-registration qualifications for those seeking specialised training.

(b) A scheme giving financial assistance to enable selected dietitians to travel within New Zealand or overseas for specific and approved professional assignments.

(c) Regular updating of knowledge of practising dietitians.

(d) Retraining of dietitians who re-enter the profession after a break in service.
8.2.3 **Educational Basis of Training**

The committee strongly affirms that basic training for dietitians belongs in a university. Only in the educational environment of a university can they acquire the sound foundations in the basic sciences and the capacity for critical and analytical thinking gained from study in a university discipline. No submission suggested any other than a university-based training. It is further affirmed that the training should be in a university which has the resources of a medical school with both pre-clinical and clinical departments.

8.2.4 **Aims of Training**

In order to clarify the essential content of a dietetic training the committee recorded a list of general aims. It was agreed that the initial training of a dietitian should enable her to:

(a) Translate the principles of nutrition into practical and acceptable meals for individuals and groups.
(b) Apply sound management principles to the organisation and administration of a hospital dietetic department or other food service unit.
(c) Effectively communicate nutritional information to individuals and groups in her care.
(d) Contribute to the influence of public opinion regarding the importance of nutritional factors in the well-being of individuals and groups.
(e) Apply the scientific method of inquiry to any aspect of her work.

8.2.5 **Assessment of General Aims in Relation to Future Needs**

From evidence submitted the pattern for the future of dietetic practice indicates the need for increased involvement by the dietitian in patient areas, greater specialisation in specific areas of practice, increased involvement with community health services, and decreased direct involvement with meal service tasks.

To meet these needs the education programme should enable the dietitian to:

(a) Play a more active part with medical staff in the nutritional management of patients.
(b) Establish and maintain standards of food service while delegating many management tasks to trained ancillary staff.
(c) Extend her educational role to have wider influence as a member of the health team in both the hospital and the community.
(d) Participate in research studies and initiate investigation.

8.2.6 **Educational Requirements in Relation to Goals**

To successfully achieve these goals the dietitian will require:

(a) Detailed knowledge of food and its composition.
(b) Knowledge of the processes of digestion and absorption, with understanding of intermediary metabolism.

(c) Knowledge of the community in which she is working, with an understanding of the food habits of various social, economic, and ethnic groups.

(d) The ability to assess nutritional needs of patients and of other individuals or groups.

(e) The ability to transmit her knowledge to others in the health services, to individuals in need of care or counselling, and to staff under her direction.

(f) An introduction to research methodology and to statistics.

8.2.7 Consideration of Specialisation at Undergraduate Level

Some submissions advocated provision for specialisation in dietetic training at undergraduate level but it was agreed that a general training leading to professional qualifications is the most suitable for New Zealand's needs and conditions in the foreseeable future. This training should introduce the student to all aspects of the work of a dietitian and enable her to function competently as a general dietetic practitioner. It should also have sufficient background upon which to subsequently build a specialist training according to individual talents and interests.

8.3 Introduction of a Degree in Dietetics

The committee recommends the establishment of a 4-year degree in dietetics which introduces clinical studies co-ordinated with preclinical subjects of the undergraduate course. It is proposed to include experience in the clinical situation concurrently or alternately with academic study of professional subjects.

It is expected that some students will welcome an early involvement with applied aspects of a chosen career. More immediate relationship between theory and its practical application will be advantageous in terms of appreciation of the relevance of subjects studied, leading to increased motivation, interest, and earlier commitment. It is also anticipated that early exposure to the clinical situation will lessen the problems of transition from the educational to the practising professional role.

8.3.1 Location of Course

Although there are a number of reasons why it would be desirable to site this course in a centre of concentrated population, where a large number of clinical cases are available during the training period, the University of Otago is now providing preclinical training in subjects appropriate to the needs of intending dietitians and has the staff and facilities to continue to do so. The University of Otago Medical School is already involved in the teaching of preclinical subjects, and the only university department of human nutrition at present in the country is sited at the School of Home Science.
It is, therefore, logical that the degree in dietetics should be offered within the University of Otago until numbers make necessary a duplication of courses and facilities. To provide adequate clinical experience it is proposed that students be distributed for practical clinical experience at teaching hospitals throughout the country.

8.3.2 Outline of Proposed Dietetic Degree

The first 2 years would be comprised of the basic and preclinical sciences of chemistry, biology, human anatomy and histology, physiology, biochemistry, food chemistry, elementary microbiology, human, and social development together with a basic course in food selection, preparation, and service.

Year one should be taken in common with home science degree students, and application made on the successful completion of this year for entry to the remaining 3 years of the dietetic degree. The only subject requiring new provision would be human and social development. All other courses are already offered at appropriate levels either by the home science faculty, the science faculty, or the medical faculty.

The third and fourth years of the proposed course combine preclinical studies and clinical application and experience. They should include normal nutrition, clinical nutrition (diet therapy), introduction to clinical medicine, introduction to social medicine, food service administration, communication and teaching methods, introduction to research methodology and statistics including completion of a minor research study. The home science faculty, clinical departments of the medical faculty, the department of education of the university, and the management staff in the commerce faculty will be able to contribute to the teaching.

In addition students should spend a prescribed period in each of the third and fourth years gaining clinical experience in hospitals including inpatient, outpatient, and extramural departments and in other community health services. This hospital experience should be undertaken at hospitals with clinical schools in different parts of the country, with each student gaining experience preferably at more than one major hospital. An outline of the structure proposed for the dietetic degree appears in appendix D.

In this report the committee is not attempting to lay down precise details for the proposed course as it considers this would be best achieved by a curriculum planning team set up for the purpose. This team should include representatives from the university preclinical and clinical departments, the dietetic departments of training hospitals, the New Zealand Dietetic Association, and the Department of Health, as all these bodies would need to co-operate towards the success of the proposed training programme. They should plan the co-ordination of the academic and clinical aspects of the course.

A member of the committee has undertaken a detailed feasibility study for implementation of such a course to ensure that it is a realistic proposal. This study will be made available to a curriculum committee.
8.3.3 Implementation of the Proposed Degree

The implementation of this co-ordinated type of degree programme would in the committee's opinion involve the following action:

(a) The University of Otago be asked to accept responsibility for the degree course and to proceed with the immediate appointment of a director of the dietetic course as a university appointment. The appointee should visit training centres overseas before planning the course.

(b) The director should be assigned the task of organising and co-ordinating all aspects of the course, in consultation with nominated representatives of all groups who would contribute to the teaching of the programme. This would involve university staff including those in clinical schools and the dietetic, medical, and other staff who participate in the clinical and practical aspects of student training.

(c) Tutor dietitians should be appointed as joint university-hospital appointments to each teaching hospital which will participate in clinical training.

(d) Travelling expenses should be provided to enable the director to make regular visits to participating hospitals and to enable the tutor dietitians to make regular visits to the parent training centre.

8.4 Continuation of the Present System of Training

The committee recommends for the shorter term the continuation of the present system of training for dietitians based on the prerequisite qualification in home science followed by a 1-year professional course in dietetics. The two types of training provide alternative methods to gain qualification and registration as a dietitian. The continued “end-on” dietetic training will maintain a steady number of recruits while the new training is being developed. It will provide for the student who prefers the broader based and more flexible background of a home science qualification rather than the more specialised curriculum proposed for the dietetic degree, and also for students who do not wish to commit themselves to a definite career choice at the end of 1 year in university. On the longer term the desirability of two forms of training will need review.

In supporting the continuation of this system of training the committee believes it essential that modifications in the university training and reorganisation of the hospital training should be made.

8.4.1 Modifications in University Training

1. Immediate steps should be taken to introduce into the home science course requirements for intending dietitians:

(a) Human growth and social development.

(b) Introduction to research methodology.
These additions are seen as compatible with the requirements of a general home science qualification.

2. To meet the need for increased depth in preclinical sciences as a basis for increased involvement with therapeutic practice and research the committee recommends that the diploma course should be gradually phased out as a prerequisite qualification for entry to dietetics. This should become practicable as the numbers graduating from the new dietetic degree are built up to a satisfactory level. Students now taking the diploma course with the intention of becoming a dietitian will be encouraged to take the new degree in dietetics. The year 1980 is proposed as a target date for discontinuing acceptance of diploma holders into dietetic training but the final cut off date should be reviewed in the light of the current availability of degree qualified dietitians. After this step has been taken, the 1-year professional training could remain available to the holder of a degree in home science. In subsequent paragraphs it will also be recommended that a similar or modified training should be available to graduate nutritionists (p. 61).

The recommendation to phase out the diploma course supports the view of the New Zealand Dietetic Association which in its submission states that, in order to maintain standards of future practice it is essential for a degree to be encouraged as the basis for qualification.

8.4.2 Reorganisation of Dietetic Training

1. It is recommended that as soon as possible the present 1-year professional dietetic training be based on a single hospital in a major population centre. The hospital dietetic department in association with the medical clinical school at that hospital should provide the lecture programme in clinical dietetics and administrative dietetics, and practical experience should be gained at subsidiary hospitals or at associated teaching hospitals in other centres as necessitated by numbers of students. The committee considers Auckland Hospital to be the logical place to locate the “principal” training school for this scheme. Existing training schools at Wellington and Christchurch should continue to be used as “associated” training schools. Other hospitals, such as Waikato could be included for training purposes as student numbers increase.

It is proposed under recommendations for post-graduate education, that the principal training school should also become the base school for post-registration courses and that it should be responsible for organising some post-graduate courses. It should be noted that all such courses would not necessarily be undertaken in the principal training school.

2. To meet the need for student dietitians to have better knowledge and confidence in the clinical areas of practice and to be better accepted by medical colleagues, the clinical experience during the dietetic training year should be increased. This will require the co-operation of medical staff with a commitment to the importance of nutrition in medical and general health care.

3. Less emphasis than is the case in the present training should be placed on the routine tasks of food services.
8.4.3 Implementation of Reorganised Training

The implementation of this training would in the committee's opinion involve the following action:

(a) Negotiate modifications in home science course content.
(b) Request the Auckland Hospital Board to accept responsibility for the single training school for dietetics (principal training school).
(c) Proceed with the appointment of:
   (i) A director or principal tutor for the training programme as a senior level position.
   (ii) Additional tutors full or part-time on the basis of one full-time tutor for each six students.
(d) Provide for the appointment of tutor dietitians on a part-time basis at all teaching hospitals to be used in addition to the base training hospital for the clinical experience of student dietitians.
(e) Make immediate provision for the organisation of a seminar workshop type course for tutor dietitians to assist them in overcoming their earlier lack of preparation for their teaching role. Also provide for regular meetings of all tutor dietitians for collaboration with the university and others involved in training programmes.
(f) Make provision for the interim period during the introduction of alternative training as set out in broad principle in the following paragraphs.
(g) Make financial provision for the proposals.

8.5 The Transition Period during Introduction of Alternative Training

It is recognised that there will be some problems until the new training is fully established. From the third year of the first dietetic degree intake there will be students from two training schemes requiring clinical experience in the teaching hospitals at the same time. After 2 or 3 years it is expected that the numbers will adjust and it will be possible to manage the 1-year dietetic course at the one base hospital in co-operation with its subsidiary hospitals. In the interim period with a projected intake of 20–25 students to the single school, it will be necessary for students to travel to other main centre teaching hospitals for clinical experience.

This situation will require:

(a) Tutor dietitians at each of the present training hospitals in a part-time capacity to direct the practical experience of student dietitians from the single-base training school. These tutors will need to become full-time appointments as joint university-hospital appointments when the students from the dietetic degree are assigned to these same hospitals for clinical teaching.
(b) Financial provision to assist students with travel and to subsidise living costs during the training period away from the base hospital. This will most readily be achieved by providing subsidised places in a nurses' home.
The committee envisages that the student taking the post-graduate dietetic course will continue to receive a salary as is the present case. Some adjustment in hospital board finances will be necessary. The student in the co-ordinated training will receive the usual student allowances under the university bursaries system, but require a higher subsidy than the salaried student during periods of clinical experience away from the university centre and some compensation for the extended academic year of the third and fourth years of the course.

8.6 Relationship of Graduate Nutritionists to Dietitians

The University of Otago now offers a bachelor of science (hons) degree in human nutrition. This is a 4-year course following the structure of other honours degrees in the science faculty. The student applies to enter the honours school after completion of a first year in basic sciences. For the next 3 years, an in-depth study of the science of nutrition is pursued, together with supporting subjects. An outline of the structure of this course is given in appendix D.

It is highly desirable that nutritionists and dietitians work in complementary roles as they share many of the same objectives. A nutritionist can make a valuable contribution to the work of the dietetic profession. Holders of a degree in human nutrition who wish to work with patients in clinical aspects of nutrition should undertake further training and meet registration requirements as is the case with other medical and paramedical professions.

8.6.1 Recommendations for the Registration Requirements of Nutritionists

The committee recommends that graduate nutritionists who wish to undertake clinical responsibilities be required to obtain registration as dietitians by following training based either on that required of home science graduates for registration, or on the final year of the co-ordinated degree course, with modifications in each case.

In part 3 (final year) of the honours course four papers are required. One of these may be an elective covering metabolic disorders and principles of therapeutic dietetics. Honours graduates with this elective could be required to follow a modified course including an introduction to food service administration and a period in a teaching hospital gaining varied practical experience in both therapeutic dietetics and in the overall management of a dietetic department. The time envisaged for such a training would be 6–8 months. The honours graduates who have not followed the elective on metabolic disorders and principles of diet therapy could be required to follow the full year course with some adjustment to compensate for the differences in background between the home science and the nutrition degree.
8.7 **Post-graduate and Post-registration Training**

Post-graduate training is essential to the leadership and standing of any profession. Its introduction into the dietetic profession is long overdue in this country.

The training of a dietitian only prepares her for an initial position in the profession. Dietitians themselves recognise the need for updating their knowledge and view further training as an incentive to remain in the profession and develop beyond the basic qualification. They seek opportunities which will provide stimulation, allow career progression toward more challenging duties, and lead to increased status and remuneration.

The dietitian with further training available to meet her specialist needs will contribute in her professional work with greater confidence and satisfaction. The New Zealand Dietetic Association submission emphasises the need for post-graduate* training.

8.7.1 **Present Opportunity for Post-graduate and Post-registration Training in Dietetics**

Present opportunities for post-graduate study in nutrition in New Zealand are confined to the master's degree and doctoral degree in human nutrition offered by the School of Home Science, University of Otago. The dietitian with a bachelor's degree in home science would, however, not normally have the prerequisite of chemistry, advanced 2, which is at present required for the master's degree in human nutrition. New Zealand dietitians holding masters' degrees in the field of dietetics or food service management have had to undertake this study in the United States. This has been done either at their own expense or with some grant in aid from the university attended, or a scholarship of United States origin.

8.7.2 **Recommendations for Post-graduate and Post-registration Training**

1. Immediate steps should be taken to develop training for post-registration work in specialised areas of dietetics, thus enabling dietitians already in the profession to increase their qualifications.

2. An appropriate central body should control the numbers and the conditions of acceptance of applicants for post-registration courses with consideration of the needs of hospitals and health services. Such a body might be a “dietetic education committee” with representatives from the New Zealand Dietetic Association, university and teaching hospitals, and the Department of Health.

*Throughout this section, the term “post-graduate” is used to apply to qualifications taken in a university and leading to recognised university degrees or post-graduate diplomas. The term “post-registration” applies to courses in specialist areas which may cover a wide range of subjects relevant to dietetics, and for which recognition by certificate should be made.*

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3. Post-registration courses in clinical aspects of training should be organised by the single training school proposed for preregistration training. Clinical departments of the medical clinical school attached to this hospital group should be approached to assist in the provision of these courses for dietitians. However, where a strong special unit exists in another centre this should also be approved for training purposes.

4. In clinical aspects of specialist training the student should spend a specified period, to be decided in consultation with the clinical department concerned, in a part-service situation in that department. Her work would be arranged by the principal tutor dietitian in the training school and be under joint guidance with medical staff in charge of the department or unit. A special study or investigation should be undertaken as part of this course. On the satisfactory completion of the training period a certificate should be issued. When subsequently employed in an appropriate special unit or hospital position, the holder of this certificate should receive a salary supplement.

5. Dietitians seeking further qualifications in other aspects of dietetic practice should be released to take a post-graduate course in management or education in a university, or courses in other institutions offering them at an appropriate level.

6. Funds should be allocated annually to assist with specialist and post-graduate training. The committee recommends that in the first instance the equivalent of two salaries at staff dietitian level should be made available each year to pay dietitians while taking courses. Those in a service situation in clinical departments should receive part salary which could be supplemented from the money available under the proposed scheme.

7. To meet longer term needs, post-graduate facilities should also be developed with provision for university post-graduate diplomas, masters' degrees, and for those with adequate background, doctoral degrees. Such courses might be taken either from the University of Otago, from university medical clinical schools, or from other universities offering relevant graduate courses.

8.7.3 Teacher Training for Dietitians

The need for training in teaching methods as part of undergraduate, specialist, and continuing education is apparent and is pointed out in the chapters on the role of the dietitian. The proposed training programmes place a major responsibility upon those who become the tutor dietitians. As a short-term measure the committee has proposed that a short seminar-type course be provided for all tutor dietitians. In the longer term, a suitable post-graduate or specialist teaching qualification should become an expected prerequisite for appointment to positions as tutor dietitians. It will also be most important for tutor dietitians to have continuing education in the major aspects of dietetic practice.
8.8 **Overseas Study Leave**

A scheme of assisted overseas study for graduate courses or special study assignments is necessary. The principle of overseas post-graduate study assisted by the Department of Health has already been established for doctors and nurses. The committee proposes two annual study awards including salary and travel assistance, tenable overseas long term for purposes of gaining approved qualifications or experience. One award should be longer term enabling the recipient to gain a post-graduate qualification, and the other shorter term for specific experience or study in any aspect of dietetics. The awards would be based on merit and potential contribution to the profession. A bonding agreement would be a condition of the award, as is the case with nurses' awards.

8.9 **Continuing Education**

The New Zealand Dietetic Association is to be commended for the efforts which it makes to help its members keep up to date. Annual conferences are held at which papers on varied aspects of dietetics are presented in a very full 2-day educational programme. Two refresher courses, in 1958 and 1972, were organised by the Department of Health.

The committee believes that in addition to the conferences which serve an important purpose, provision is needed for training courses to be organised on a regular basis. They, therefore, recommend the introduction of concentrated courses in specific areas to be held over several days. These courses should be planned to meet defined needs and repeated when necessary. The courses could be based on the single dietetic school and be organised by the principal tutor. They may on occasion be held in association with a university or a teaching hospital in another centre. Encouragement should also be given to arranging courses jointly with other groups such as the Nutrition Society, or with post-graduate seminars or courses arranged by medical clinical departments on topics relevant to dietitians, e.g., the recent post-graduate course on diabetes and adipose tissue metabolism organised by the Faculty of Medicine of the University of Otago.

An appropriate sum of money will need to be made available for these activities. Dietitians should be given opportunities to attend such courses as are applicable to their sphere of work and have study leave on full pay with fees and travelling expenses met by the employing authorities.

8.10 **Retraining for Dietitians Returning to the Profession**

Provision for retraining is needed if dietitians returning after a break in service are to effectively re-enter employment. At present there is no provision for retraining, but hospital boards have co-operated with the Department of Health in accepting dietitians for short in-service retraining courses.
The committee recommends that provisions for retraining be made based on training programmes within existing facilities, either in universities or hospitals depending on the skills required.

Retraining may take several forms:
(a) A specified period spent in a training hospital under the direction of a tutor dietitian. In this case the candidate should be paid by her employing authority.
(b) Release from employment to attend approved courses in a university clinical school or other educational institution.
(c) Full-time participation in selected parts of the university course, the student to be assisted at the level of a dietetic bursary, now available to regular university students.

Each application will need to be considered on its merits. The Dietitians Board would appear to be a suitable body to make recommendations on retraining programmes.

8.11 Regular Assessment of Training

The committee recommends that a regular 5-yearly assessment be made by the Dietitians Board in consultation with the university and the Department of Health of the effectiveness of all training schemes, and of their organisation and administration.

8.12 Summary

1. Although the New Zealand-trained dietitian has established high standards of practice in this country's hospitals, and is highly regarded overseas, it is recognised that there are problems in the profession, some of which relate to training.
   2. Some problems are related to inappropriate use of knowledge and training, and others to inadequacies in knowledge and experience. In some cases there is lack of recognition and status. There are not enough dietitians for the country's present and future needs, and there is dissatisfaction with some aspects of training and career prospects.
   3. Recommendations for future training have sought to preserve existing strengths, face recognised deficiencies, utilise and strengthen existing resources, and provide a flexible system able to adapt to future needs.
   4. The initial qualification should prepare the dietitian for general dietetic practice.
   5. The committee recommends the operation of two forms of training, one a newly established degree in dietetics, the other a reorganised form of the present system.

   The proposed degree is a 4-year course including some subjects of the home science degree and others more particularly relevant to the needs of dietitians. The third and fourth years of the course aim to co-ordinate academic study and clinical and practical experiences. The student will
be required to spend a prescribed period in each of the third and fourth years in an approved training hospital (associated training school).

The reorganisation of the present system provides for the dietetic training year to be based on a single training school (principal training school). Auckland is proposed as the most suitable location for this school. Hospitals in other centres (associated training schools) would be used for clinical and practical experience. This scheme also includes modifications in course content in both the university and dietetic training and includes phasing out of the diploma as a prerequisite qualification.

6. The committee suggests that a curriculum planning team be established to consider the proposed degree course with particular reference to the co-ordination of the academic and clinical aspects of the course.

7. The appointment of tutor dietitians to principal and associated training schools to provide a tutor-student ratio appropriate to clinical teaching is regarded as essential.

8. It is expected that after a transition period the student numbers in the two courses will adjust to permit the 1-year dietetic course to be contained in the principal school using the base and subsidiary hospitals in that centre. All training schools would become involved in providing experience for students from the dietetic degree as numbers make this necessary.

9. It is recommended that holders of a degree in human nutrition who wish to work in clinical aspects of nutrition be required to gain registration as a dietitian by undertaking an approved post-graduate training.

10. Establishment of a system to provide specialist post-graduate and continuing education is recommended. It is proposed that these post-registration courses be organised by the principal training school in co-operation with the universities and medical clinical schools. A scheme to assist in financing post-graduate study is proposed including study leave within New Zealand and overseas.

11. The importance of teacher training for dietitians, and particularly for those who become tutor dietitians is emphasised.

12. A review of training schemes every 5 years is recommended.

9. TRAINING OF DIETITIANS IN OTHER COUNTRIES

During the study, the committee made contact with national dietetic associations in a number of other countries, in order to gain background information on the training, status, and practice of dietitians in these countries. An outline of training and registration requirements in selected countries follows.
9.1 The United States

In the United States the American Dietetic Association lays down standards for membership and for registration. It should be noted that registration is not a legal requirement of the right to practice, and the title of "dietitian" is not protected.

There are three main ways of gaining qualification as a dietitian:
(a) A bachelor's degree (usually in home economics or its equivalent) followed by an internship approved by the Executive Board of the American Dietetic Association.
   The degree, a 4-year programme, must include prescribed minimum content in specific academic areas. The internship time is usually 9–12 months but this varies between 6 and 18 months. Most intake quotas are between 6 and 12 students, but these vary between 4 and 27 at 1 very large hospital.

(b) A degree gained from a university offering an "integrated" programme leading to a bachelor of dietetics. The degree must meet academic requirements laid down by the American Dietetic Association.
   The term "integrated" implies the combination of academic study with practical experience in the 4-year undergraduate course including one or more summer sessions.

(c) A master's degree gained by a combination of graduate study and internship or experience in a university hospital or medical centre. The length of time required is approximately 18 months following admission to graduate school.

Registration in the United States is, since 1969, for an initial 5-year period. In order to maintain registration status every registered dietitian must submit evidence of a prescribed amount of approved continuing education in every 5-year period.

9.2 Canada

The Canadian Dietetic Association lays down requirements for membership and professional status. Registration is on a provincial basis, and conditions vary a little between provinces. Registration is not a legal requirement in all provinces for the right to practice or to use the title "dietitian".

There are two main ways of gaining qualification:
(a) A bachelor's degree (usually in home economics) followed by an internship approved by the Canadian Dietetic Association.
   The degree must include prescribed minimum content in specific academic areas. Most degrees are 4-year programmes, but a few require a 3-year minimum time.
   The internship time is 50 weeks.
   Usual intake quotas are five to eight but these vary from four upward according to the staff, facilities, and opportunities for clinical experience.
(b) A bachelor’s degree as above but including commencement of an integrated internship at undergraduate level, which continues after graduation.

The integrated internship is divided into three phases, two of 15 weeks are taken, one in each of the last 2 years of undergraduate work, and a third of 20 weeks is taken after graduation. This means that qualification is completed in 4 years plus 20 weeks\(^1\).

9.3 United Kingdom

In the United Kingdom a dietitian must have qualifications approved by the Dietitians Board of the Council for Professions Supplementary to Medicine in order to gain registration. Registration is a statutory requirement for both United Kingdom and overseas trained dietitians wishing to practice.

The British Dietetic Association lays down requirements for membership. There are four main ways of gaining the necessary qualifications:

(a) An 18-month course leading to a dietetic diploma following one of:
   (i) A degree in science with chemistry and physiology (3 years).
   (ii) A degree in home economics, food science or nutrition (3–4 years).
   (iii) A higher national diploma in institutional management (3 years).
   (iv) A teachers certificate in home economics (3 years).

(b) A 4-year diploma integrating hospital and catering experience into the third and fourth years of the course for a period of approximately 40 weeks.

(c) A degree in nutrition integrating clinical and practical experience. The University of Surrey offers a 4-year degree in nutrition. The third year of the course is spent away from the university gaining experience in various fields relating to applied nutrition. Intending dietitians are required to spend 6 months of this year in the dietetic department of a recognised hospital. The remainder of the year may be spent in a food industry, catering, public health nutrition, welfare, or research laboratory experience. The fourth year in the university offers electives and requires a small research project.

(d) A post-graduate diploma in dietetics. This diploma is offered by Queen Elizabeth College, University of London, following a degree in nutrition or food science from that university, or a degree from another university provided there are adequate prerequisites in chemistry, physiology, and foods courses. The diploma consists of two academic terms followed by 24 weeks’ practical training in a recognised teaching hospital\(^2\).
9.4 Australia

In Australia there are two main ways of gaining a recognised qualification as a dietitian:

(a) A 3-year tertiary level course majoring in appropriate sciences, and including other relevant subjects, followed by a post-graduate course in dietetics of 12–14 months (dependent on contents of preceding course).

A number of universities and tertiary institutions offer suitable courses, and the post-graduate courses may be taken as a post-graduate certificate or a diploma gained in either a hospital training programme or a university.

(b) A 4-year integrated tertiary level course such as that leading to the degree of bachelor of applied science (dietetics) offered in New South Wales.

In Australia there are separate professional organisations in each of the five states and in the Australian Capital Territory. All are affiliated with a federal body, the Australian Dietetic Council. Registration is required only in the State of Victoria under the Dietitians Registration Board of Victoria. Dietitians seeking employment by the Commonwealth Government, or by the State Governments of Queensland, South Australia, Tasmania, or Western Australia are required to hold qualifications of the same standard as those recognised for registration in Victoria.

In New South Wales, dietitians seeking employment in state-controlled hospitals must have their qualifications approved by the New South Wales Institute of Dietitians. The institute recognises only an appropriate university degree followed by a post-graduate qualification in dietetics, or alternatively a 4-year integrated university degree course in dietetics \(^{19}\).

9.5 The Netherlands

In the Netherlands, dietitians qualify for membership of the Dutch Society of Dietitians. The education of dietitians in the Netherlands is given in colleges for Higher Professional Education and not as yet in the university.

Before 1972 dietitians were required to obtain a 3-year prerequisite diploma generally comparable to a diploma in home science followed by a one-year course leading to a diploma in dietetics.

As a result of criticism of the division between the two sections of the course and the lack of introduction to clinical observation and experience, the training has been reorganised. As from September 1972 the training requirement is a 4-year integrated diploma. Some introduction to practical situations is given during the first 2 years of training by organised visits to families, institutions, hospitals, and food and catering industries.

During the third and fourth years a total of 30 weeks is spent in blocks in no less than two institutions, gaining clinical and practical experience in dietetic practice. A special study is undertaken in year four. It was interesting to note that the size of groups for any form of practical experience was limited to a maximum of eight students \(^{20}\).
9.6 Reciprocity of Dietetic Qualifications between New Zealand and Other Countries

Dietitians from other countries applying for registration in New Zealand are considered on an individual basis by the Dietitians Board. The Dietitians Act requires that overseas training must be assessed as "substantially equivalent" to New Zealand training in order to grant registration.

In practice dietitians who are members of the American Dietetic Association and the Canadian Dietetic Association are granted New Zealand registration as their minimum training requirements are strictly laid down and are based on university courses comparable to that required in New Zealand.

Dietitians trained in the United Kingdom and Australia have a more variable background training. These trainings are generally comparable to New Zealand training but on occasions some additional training, experience, or examination may be required. Applications from other countries are varied and are carefully assessed after details have been obtained from official sources.

New Zealand dietitians seeking to work in other countries find that differences are made between those who hold the degree and those who hold the diploma as a prerequisite qualification. Degree holders only are recognised by the dietetic associations in the United States, Canada, and New South Wales in Australia. All efforts to negotiate recognition for diploma holders with these associations have been unsuccessful. Degree and diploma holders, provided they are eligible for New Zealand registration, are generally given reciprocity in the United Kingdom, and in all Australian states other than New South Wales.

The committee trusts that when New Zealand registration is based on either a degree in home science, or in human nutrition followed by post-graduate dietetic training or on a 4-year degree in dietetics, the New Zealand-trained dietitian will gain full reciprocity with major western countries.

The committee recognises that reciprocity of professional qualifications between countries is a difficult procedure in which it cannot become effectively involved. It does, however, advocate as liberal as possible international exchange between dietitians, provided the high standards of the profession are fully safeguarded.

10. REMUNERATION AND CONDITIONS OF EMPLOYMENT

The salary scale (at 26 October 1972) for hospital employed dietitians is as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merit grade</td>
<td>7,261/7,654</td>
</tr>
<tr>
<td>Grade 1</td>
<td>5,677/5,862/6,143/6,474/6,874</td>
</tr>
<tr>
<td>Grade 2</td>
<td>5,012/5,263/5,462/5,677</td>
</tr>
</tbody>
</table>
Salaries for dietitians employed in graded positions are determined by the Dietitians Grading Committee established in accordance with the Hospital Employment (Dietitians) Regulations. Such determinations are based on the degree of responsibility contained in the job, qualifications, and experience of the dietitian. The range of salaries commanded by various categories of dietitians is as follows:

<table>
<thead>
<tr>
<th>Hospital Size (Average Occ. Beds)</th>
<th>Dietitian in Charge $</th>
<th>First Assistant Dietitian $</th>
<th>Second Assistant Dietitian $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal dietetic training school</td>
<td>6,874–7,654</td>
<td>5,012–5,462</td>
<td>4,688–5,677†</td>
</tr>
<tr>
<td>500–800</td>
<td>5,462–7,654</td>
<td>4,525–5,462</td>
<td>4,141–5,677</td>
</tr>
<tr>
<td>300–500</td>
<td>4,864–6,874</td>
<td>4,250–5,021</td>
<td>4,141–5,012</td>
</tr>
<tr>
<td>100–300</td>
<td>4,250–5,862</td>
<td>4,250–4,525</td>
<td>4,525</td>
</tr>
</tbody>
</table>

*Salary as at 26 October 1972.
†Senior second assistant dietitians.

There are four grades and a merit grade in the dietitians scale; progression through the grades involves 21 steps. There is no increment between grades and it is possible to move to a higher grade with little or no salary increase.

The grade of each particular job is determined by a grading committee which aims to achieve a balance between job content and personal experience. Within each grade there is automatic progression though it is necessary to be regraded to move from one grade to a higher grade. The grading committee has a right to put a bar on an individual's salary to prevent a dietitian rising through a grade without any increase in responsibility. This system operates to protect the profession from such anomalies. Approximately 10 dietitians are on barred salaries. Promotion depends on regrading or vacancies in higher grades.

The salary scale (at 26 October 1972) for dietitians employed in the Public Service is as follows:
<table>
<thead>
<tr>
<th>Grade</th>
<th>Current Salary/Rated Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>7,339/7,770</td>
</tr>
<tr>
<td>6</td>
<td>6,907/7,339</td>
</tr>
<tr>
<td>5</td>
<td>6,907</td>
</tr>
<tr>
<td>4</td>
<td>6,474/6,907</td>
</tr>
<tr>
<td>3</td>
<td>6,474</td>
</tr>
<tr>
<td>2</td>
<td>5,660/6,061</td>
</tr>
<tr>
<td>1</td>
<td>5,660</td>
</tr>
</tbody>
</table>

Conditions of employment for hospital employed and public health dietitians are given in appendix E.

Opinion expressed in most submissions received from non-dietetic groups was that the salary scale for dietitians needs improvement. It should be much more commensurate with qualification and responsibility. The dietitians themselves consider their salaries compare unfavourably with those paid to other occupations requiring similar qualifications.

Two groups of dietitians expressed gross dissatisfaction with salaries and conditions of employment. A substantial number of recently qualified staff dietitians are not satisfied with their present salaries and with the fact that dietitians do not receive penal rates for weekend and statutory holiday work. Relative to some other grades of hospital employees, the dietitian feels she has inferior status and, though money may not be the main motivating factor in her life, it is significant. The young dietitian does not regard the salary scale as a sufficient impetus to move from one level of job to another or to seek additional qualifications; a master’s degree carries only approximately a $200 premium; she looks at the salary scale from top to bottom and sees only a differential of $3,000 for a lifetime’s service. Some of the present staff dietitians consider that salaries for higher positions are insufficient incentive to remain in the profession.

A considerable number of dietitians working part time are critical of salary and conditions of work, which do not compare favourably with teaching, especially for married women who have school-age families. The practice of some hospital boards to limit part-time dietitians to staff dietitians’ salary rates is considered unfair. Other hospital boards do employ part-time dietitians in graded positions.

10.1 Relative Position of Salaries

Much of this discontent stems from the fact that the dietitians’ salary scale has not been revised since 1964. There has been a gradual but marked deterioration in the salaries of dietitians relative to other professions and groups in hospital employment (fig. 11).

In 1964 dietitians were marginally above radiographers and physiotherapists, on a par with matrons, tutors, supervising sisters, and on an average 10.8 percent less than grade laboratory staff.

By 1972 the differential between dietitians and physiotherapists had been maintained but the position between dietitians and radiographers had been reversed, though the margin was small. The two groups which
5.1 May 1972 since which time there have been prolonged and protracted negotiations, the last of which took place in June. Negotiations have been held from time to time with the unions on a number of issues, including seniority, pay, and conditions of employment. These discussions have resulted in the establishment of a number of agreements, which have been implemented, and which have provided some degree of stability for the workforce.

5.2 The main reason for the deterioration of conditions salaries is the increase in the cost of living, which has led to a reduction in real income. This has been exacerbated by the fact that the cost of living has increased more rapidly than wages, resulting in a decrease in the purchasing power of wages. The chart below illustrates this trend, showing the decrease in the purchasing power of wages over the past few years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean Salary</th>
<th>Scale 1</th>
<th>Scale 2</th>
<th>Scale 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1964</td>
<td>$10,000</td>
<td>$12,000</td>
<td>$14,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>1965</td>
<td>$10,500</td>
<td>$12,500</td>
<td>$14,500</td>
<td>$16,500</td>
</tr>
<tr>
<td>1966</td>
<td>$11,000</td>
<td>$13,000</td>
<td>$15,000</td>
<td>$17,000</td>
</tr>
<tr>
<td>1967</td>
<td>$11,500</td>
<td>$13,500</td>
<td>$15,500</td>
<td>$17,500</td>
</tr>
<tr>
<td>1968</td>
<td>$12,000</td>
<td>$14,000</td>
<td>$16,000</td>
<td>$18,000</td>
</tr>
</tbody>
</table>

1969 the New Zealand Dental Association was called the main reason for the deteriorations in the wages of nurses, engineers, and teachers. The chart below illustrates the decrease in the purchasing power of wages over the past few years.
10.2.2 It is not unfair to say that the New Zealand Dietetic Association did not learn the lessons of 1968 very well or take a lead from the nursing profession and obtain the services of a skilled negotiator. In this they were unwise. If one adds to the amateurism of the association in matters of reward systems and negotiating technique and the fact that dietetics does not have the emotive power of the nursing profession or the numerical strength (103 dietitians to 12,000 nurses), a decline in the relative position of dietitians' salaries was probably inevitable.

10.2.3 The Department of Health and hospital board administration may both carry some of the blame. Their concern for staff welfare has not been obvious and they have appeared to hold the view that job satisfaction and community service justify lower salaries than those groups outside. There is a tendency, therefore, to respond to pressure groups rather than be concerned with equity and interests of minority groups. It is to the dietitian's credit that in the past she has made light of the differential issue.*

10.3 Effect of the Loss of Differential

In this climate an inadequate salary can become a major cause of problems of recruiting, retention, and re-entry into the profession. It may, in part, account for the expressed reluctance of married dietitians (as revealed in questionnaire replies) to re-enter the profession after a lessening of family responsibilities.

Recruitment into the profession is a matter for concern. Dietetics is failing to attract a sufficient number of young people with a sound science background. Home science graduates know they can obtain higher salaries in teaching and that a broken career presents fewer problems to the trained teacher than to the dietitian.

The committee considers that the present salary range does not give adequate scope for rewarding merit and responsibility. Recognition and reward for performance, particularly exceptional performance, are critical factors in morale and motivation. The traditional environment of the hospital, its dominance by the medical profession, and the lack of training in human resources management, combine to prevent innovation in salary systems. Lack of adequate rewards for specialist and postgraduate qualifications has discouraged the most able from seeking rapid promotion.

10.4 Recommendations

10.4.1 It is essential to pay salaries which are sufficient to attract talented people into the dietetic profession, and keep them there by

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*Salary negotiations have since been completed; the new scale and conditions of employment are given in appendix E. In view of the serious problems outlined, the new scale is extremely disappointing and fails to take these problems into account. The committee's views are reinforced by this new salary determination which is still grossly inadequate at the upper levels.
rewarding them sufficiently for the challenging work and responsibilities they undertake. The committee emphasises the necessity of achieving relativity between dietitians' salaries and those of other graduate hospital employees with similar educational backgrounds, training and responsibilities. Unless this is achieved the Hospital Services Committee will not do justice to the dietetic profession.

10.4.2 The committee considers it to be of vital importance to reward people for qualification and exceptional performance. Increments and promotion should be based to a greater extent upon performance appraisal. It is unjust that the poor performer should receive the same annual increment as an outstanding worker. In making this recommendation the committee is aware of the difficulties inherent in introducing such a policy into the Public Service but firmly believes it is in the public interest as well as being equitable to the employee to give rewards for merit.

10.4.3 The committee wishes to emphasise that salary policy and structure are only viable if determined by co-operation between the employing authority and profession. We recommend that a thorough study of job classification and job evaluation be undertaken to determine the correct salary levels for the profession in relation to other comparable professions and, within the dietetic profession, for each grade of job. Such evaluation will deal with the lack of margin between grades, and determine the total salary range. It could be undertaken by a committee nominated by the profession jointly, with an equal number of representatives of the Department of Health.

11. CAREER PROSPECTS

The reputation and attractiveness of a profession upon which depends the ability to recruit and retain members of high calibre is influenced by several considerations. These include the quality of initial training, status and salary levels, the opportunities for the development and promotion of individuals within the profession, and the prospects for retraining.

11.1 Current Career Path of Dietitians

The current career path of the dietitian is determined by a number of factors which include:

(a) The size of the hospital in which she works.
(b) The pyramid organisation structure of hospital dietetic departments.
(c) The lack of orientation and development of junior staff.
(d) The conflict between the need for specialisation and for administration within the hospital organisation.
(e) The weighting of salaries in favour of administration and hence against the therapeutic or teaching dietitian.
(f) Impeded progress through the organisation and the inadequate opportunities for training for promotion and for retraining.
(g) Subjective methods for determining promotion.
(h) Few opportunities for employment as a dietitian outside the hospital service.
(i) The absence of a manpower plan for the profession.

11.1.1 Size of the Hospital

The large hospital provides opportunities for progression through the dietetic department from a first-level appointment as a staff dietitian, to second assistant, to first assistant, and thence to dietitian in charge (see definitions of function appendix G). The typical organisation structure (chart 1, appendix C) includes four levels of responsibility and seven dietetic appointments.

In smaller hospitals employing two or three dietitians, opportunities for progress are limited to transfer to a larger institution. Provincial centres may have senior dietitians, married and permanently resident in the locality, who remain in one hospital for several years. Thus junior dietitians would have to transfer to larger institutions to further their careers. Conversely, the smaller hospital seeking dietitians in charge may be unable to attract them because younger dietitians with suitable experience may be unwilling to isolate themselves even though promotion is offered.

11.1.2 The Pyramidal Structure of Hospital Dietetic Departments

The present structure of hospital dietetic departments is hierarchical and compartmentalised engendering an authoritarian style of management. This is more evident in a hospital in which a large staff of dietitians is employed, than in the smaller hospital where two or three dietitians tend to share duties while still being responsible for specific sections of the department. The hierarchical structure and authoritarian management limit the scope for individual professional development and specialisation. Opportunities for team work in all aspects of patient care and for working with colleagues in other functional areas are restricted.

11.1.3 The Orientation and Development of Junior Staff

The commencement of the young dietitian's career is considerably affected by this type of organisation. Her induction is usually into one section of the department and is seldom planned. Instances of staff dietitians spending as long as 6 to 8 months in one section without rotation have been reported; consequently they do not have the opportunity to experience the scope and potential of the various aspects of the profession. The committee has considered repeated evidence which indicates that at a critical stage in their careers many young dietitians are denied
opportunities to be involved in patient care and are not introduced sufficiently early to clinical work or association with medical teams. This result is expressed as frustration and as a barrier to gaining competence and confidence in clinical work.

Objective performance appraisal techniques for staff and subsequent career counselling and development have not traditionally been taught or required in the hospital service. Few dietitians appear to have been told how well they have performed and the value of their contribution, by either their administrative heads or doctors. This lack of recognition has a serious effect on morale and motivation. One dietitian informed the committee that no one had ever asked if she had an opinion about improving the dietetic service, that when she tried to put forward ideas they were ignored, and that her approach to the medical superintendent had been of no avail.

11.1.4 Conflict Between Need for Specialisation and for Administrative Duties

As indicated the large hospital provides considerable scope for specialisation. Clinical dietetics and food service management require increasing knowledge and experience if the hospital is to be well served by the dietetic profession. From each of these aspects must also come teachers and research dietitians. The problems arising from the lack of planned induction and of in-service training upon which future specialisation depends are complicated by assignment to a solely administrative position early in the career of most dietitians. After a scientific training, many young dietitians have expressed dissatisfaction with the time they are expected to spend in mundane jobs requiring relatively little skill or knowledge, such as the direct supervision of a cafeteria meal service.

The conflicts between the need for specialisation and for good administration are not confined to dietetic departments; they exist within other hospital departments and other public institutions where ill-defined jobs, multiplicity of roles, duplication of effort, overworking of key staff, and underutilisation of junior staff are common features. The fact that the full role of the dietetic department is frequently not sufficiently understood operates against some hospital administrators taking remedial action. A recent conversation with a medical superintendent concerning the role of the dietitian in the health centre brought forth the comment that there would be no food served in a health centre, implying that there was, therefore, no need for a dietitian. A further example of lack of understanding is a case where no dietitian was included in the team investigating ward kitchens and planning equipment purchase. Thus the key person with most practical knowledge and relevant experience was ignored.

11.1.5 Weighting of Salaries in Favour of Administration and Thus Against the Therapeutic or Teaching Dietitian

Administrative responsibilities of dietitians increase as movement up the hierarchy of the department takes place. With no developed pro-
gramme of specialist and post-graduate training and no recognised path of promotion through specialisation, there has been a reluctance to attempt to specialise. This is reinforced by the fact that dietitians who have specialised within available limits, such as in the demanding duties of a metabolic unit, rarely advance to the salary or status of first assistant who has administrative responsibilities.

11.1.6 Progression Through the Organisation and Opportunities for Training for Promotion and for Retraining

Promotion through the existing dietetic department is frequently by an uncharted route, more dependent on circumstance or coercion than on proved performance, career planning, and further qualification. Those few who have gained additional qualifications have done so on their own initiative and at their own expense. Prepromotion training has not been mandatory for dietitians. This parallels the situation that no specialist or post-graduate courses are developed, and few relevant short courses are available even in the main centres.

Retraining facilities for dietitians wishing to return to the profession after a break in service do not exist. Hospital boards, however, have cooperated with the Department of Health in accepting dietitians for short in-service retraining courses, particularly for those re-entering employment in the smaller provincial hospitals.

11.1.7 Opportunities for Employment as a Dietitian Outside the Hospital Service

The increasing public awareness of the importance of nutritional factors in health care has, as yet, had little effect on the development of dietetic services outside the hospital. Community health programmes are in their infancy, but the committee believes they will have an impact on the future demand for dietitians. The committee is, however, surprised that more demand is not already made on dietitians by medical practitioners and public health authorities.

11.1.8 Manpower Planning

There has been no manpower plan for the dietetic profession and intake has not been related to demand. Rotational training and training for promotion have not taken place, and promotion opportunities have been poor.

11.2 Future Career Path and Promotion Training

The future career path of the dietitian should be based upon a sound induction programme designed to give an appreciation of all the branches of the profession and a good understanding of the role she can play as either a generalist, a specialist in administration, a specialist in clinical dietetics, and subsequently a teaching or research dietitian.

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The committee considers that a minimum of 1 year will be necessary to enable this survey of prospects, after which by appraisal and career counselling she can elect to enter a specialist field or become a generalist in a small institution. Promotion of either the specialist dietitian to the assistant director level, or the generalist to a larger administrative post, must then be consequent upon specialist training and qualification in clinical dietetics, management, and teaching or research.

Periodic continuing education courses in a specific field and re-training will be required. When the careers of dietitians are interrupted by marriage and child bearing, care must be taken to ensure re-training can begin before re-commencing practice.

The scheme in general outline is set out in the diagram below.

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11.2.1 *The Dietetic Department in the Teaching Hospital*

The committee considers that a number of the problems of training and individual development in the large institution could be solved by the design and implementation of a broader organisation structure than is at present the case.

Research has shown the importance of flattened organisation structures to increase motivation and morale by maximising the potential of members. Interdisciplinary projects, involvement in the specialties and problems of others, and in particular a development of the
awareness of career prospects should increase the desire to specialise and contribute more fully.

The revised structure should be based upon the division of the total work of the department into separate functions of food management and production, clinical and patient services, education and research. Each of these services would be controlled by an assistant director of dietetic services (chart 2, appendix C).

The director's overall responsibility would be for the provision of the total dietetic service. Policy formulation and its implementation in co-operation with the hospital board administration and senior medical and nursing colleagues would be her main task.

Assistant directors of dietetic services would be responsible for the implementation, by delegation, of one of each of the following functional areas.

(a) Food service administration and food production: responsible for the organisation, planning, and direction of the production and service of meals for patients and staff, and for related aspects of dietetic services.

(b) Clinical dietetics and patient meal service: responsible for the nutritional care of patients within the institution and those served by extramural services; for the planning, calculation, and preparation of modified diets for treatment and diagnosis when prescribed by medical staff; for nutritional advice to patients.

(c) Education: responsible for organising and co-ordinating educational programmes for dietetic, medical, nursing, and other professional staff and for semi- and non-professional food service employees.

(d) Research: responsible for organising and co-ordinating research programmes in clinical or non-clinical aspects of dietetics.

Assistant dietitians working in each of the functional areas would help the assistant directors in carrying out their tasks. Initially, and before electing a specialist role, assistant dietitians would have received planned rotational training across all the functional areas.

Food supervisors, clerical assistants, and cooks would relieve the dietitian of many routine tasks which at present reduce the time available to contribute to specialist fields. Details of responsibilities for each level within the organisation are given in appendix C.

11.2.2 The Dietetic Department in the General or Small Hospital

1. Within the general hospital there will be fewer functional departments (chart 3, appendix C). The committee emphasises that the basic principles of sound administration should nevertheless be applied:

(a) The analysis of the total amount of work to be done.

(b) The division of this work into manageable parts.

(c) The appointment of staff to carry out the assigned work.

(d) The provision of adequate supporting staff.
2. Within the small hospital where only one or two dietitians would be employed, the role would be that of a general practitioner concerned with administrative, clinical, and some teaching duties (chart 4, appendix C). It is important that these general posts be filled by dietitians who enjoy the broad spectrum of duties.

11.3 **The Relationship Between Promotion and Training**

The committee recommends the introduction of a system to develop the individual to contribute to full potential. This would include:

(a) The assessment of current performance.
(b) Careful selection of those with aptitudes for administration, clinical duties, teaching, and research.
(c) Career planning and counselling.

There is little evidence of appraisal of performance of junior staff by senior dietitians; this could be partly responsible for the misuse of skills and abilities. The need for assisting senior dietitians in the management of human resources, and of devising training and development schemes for their staff is emphasised. This is a concept in which few dietitians have had the opportunity to be trained.

In order to give dietitians the opportunity to realise their aspirations and develop their aptitudes, greater care will need to be taken in selection for career development. Career planning and associated training programmes will essentially involve rotational training and in some cases transfer to another institution will be the only way in which a young dietitian can obtain the required experience. Each type of experience should be accompanied by counselling and appraisal by senior staff. After a choice of career direction has been made, promotion within the specialisation should then become dependent on prescribed qualifications, in-service training, and experience.

The committee considers that assistant dietitians working in medium-sized hospitals should undertake specialist training in either management, clinical dietetics, teaching, or research methods before proceeding to appointments at the same level in larger institutions. Similar qualifications are considered appropriate for those seeking appointment as assistant directors and directors in smaller hospitals.

Post-graduate study in the specialist area of management, or clinical dietetics or education is considered necessary for appointment to the position of director of dietetic services in medium-sized hospitals and for assistant directors in larger institutions.

Full- and part-time post-graduate programmes must be created. The committee has made recommendations for specialist and post-graduate courses. As these are developed they should become part of the specified promotion structure. Recommendations for continuing education have also been made, and these should be regarded as a requirement for all levels of dietetic staff.
11.4 Manpower Plan and Numbers Required

11.4.1 Hospital Employed Dietitians

Increases in staff requirements are related in part to the building of new or expanded hospital facilities. An estimate of the number of dietitians required in 5 and 10 years has been made based on already programmed hospital building. These calculations show that in 1977, 155 dietitians will be required; in 1982, 185 will be required to fill existing and new positions, compared with the 91 dietitians at present employed.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>1973</td>
<td>..</td>
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<tr>
<td>1977</td>
<td>..</td>
</tr>
<tr>
<td>1982</td>
<td>..</td>
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</table>

To meet this demand it is estimated that it will be necessary to train 35 dietitians per year from 1975 onwards. Alternatively it may be possible to fill a proportion of positions with dietitians returning to the profession. Because the rate of expansion of hospital extramural and community health services is uncertain, the stated manpower projections do not take these services into account.

11.4.2 Dietitians in Public Health

The establishment of health centres throughout the community will provide worthwhile opportunities for the dietitian to extend her influence within the health services. Manpower planning in this area has not been undertaken, as the rate of progress in establishment of health centres is uncertain, and the dietitians' contribution will be dependent on the attitudes of hospital boards to health centres, and the attitude of medical practitioners to dietetic services. Nevertheless, the advent of health centres is certain to increase the demand.

The work of the community dietitian should be supported by the public health dietitian. It is estimated that within 5 years a further 6 dietitians could be employed in the public health field, bringing the total to 10. In 10 years at least 15 could be required.

11.5 Summary

1. The establishment of a manpower plan for the profession, embracing hospital, community, and public health needs is necessary. Estimations of manpower needs indicate that 155 dietitians will be required within 5 years, and 185 within 10 years.

2. To meet anticipated demands of hospitals alone it will be necessary to train 35 dietitians per year from 1975 onwards.

3. A flattened organisation structure for hospital dietetic departments should be designed and implemented.
4. An induction programme including planned rotational training of 1 year following entry to the profession is recommended.

5. Career planning and development based upon an assessment of performance is essential.

6. Entry into specialist and generalist fields of dietetics must be accompanied by appropriate in-service training.

7. Promotion within the specialist field should be preceded by planned training.

8. Continuing education and retraining of all dietitians is necessary to keep them abreast of developments, and upon re-entry after an interrupted career.

9. Management training prior to the assumption of the responsibility for the work of other dietitians is considered essential.

12. RECRUITMENT

12.1 Factors Affecting Recruitment

Recruitment of school leavers to dietetics has taken place through the activities of the Vocational Guidance Centre of Department of Education, careers advisers at secondary schools, and careers evenings at secondary schools in which dietitians participate. Personal contact with dietitians or home science graduates is also known to have influenced a number of recruits in their career choice. Department of Health bursaries in hospital dietetics have offered a financial incentive for students to qualify as dietitians.

Dietitians who qualified between 1967 and 1971 were asked in questionnaires to indicate when they had made the decision to become a dietitian. Of the 67 who replied to this question 43 made their decision before commencing the home science course, 21 during the course and 3, 1 or more years after completion of the course.

12.2 Numbers Recruited from Home Science Courses

Although student enrolment in the home science courses has increased, the proportion of students entering the dietetic training has not been maintained. This applies particularly to the degree course from which dietetics recruits regrettably few graduates. A comparison of home science graduates and diploma holders entering teaching and dietetic professions is shown in fig. 12, appendix F. In part this proportionate reduction of entry to dietetics can be attributed to an increased variety of employment opportunities for women graduates; the food industry is absorbing a number with home science training. There is, however, little doubt that a principal factor is the adverse salary differential between dietetics and teaching or other professions combined with the irregular hours and rostered weekend duties of the dietitian.
12.3 **Length of Professional Service**

An analysis was made from questionnaires of the period of service given by dietitians during professional employment (table 7, appendix F). This indicates an average length of service of 4.6 years. Excluding the last 5 years, which operate to give a false average figure because of the low possible working span, the average service is 5.9 years.

A further study of the years of professional work since registration is illustrated in fig. 13, appendix F. This indicates that the rapid reduction of numbers during the first 4 years may be accounted for by marriage and family commitments. Also evident is the return to employment of the groups whose family commitment with young children has passed. Although the group who qualified during 1967–71 do not appear on the graph, it is known that they are, on an average, giving a larger initial service than have earlier groups.

12.4 **Future Recruitment**

The committee believes that recruitment will be favourably affected by the implementation of changes in training, changes in role, improvements in salary, and more attractive career prospects with opportunities for specialisation and post-graduate training.

As these changes are introduced, those concerned in the university and the Department of Health should make up-to-date information available to all authorities concerned with careers advising. It is important that the interest of school children be captured early in their secondary school years when the choice of subjects can be influenced. Too frequently the decision comes at the sixth or seventh form level when basic sciences such as chemistry and mathematics have been omitted or discontinued; this places the potential dietitian at an academic disadvantage.

It is believed that the prospect of more direct relevance of training and earlier involvement in the chosen field offered by the co-ordinated degree will appeal to students interested in combining a career in applied sciences with a service profession dealing directly with people. It is hoped that male students can also be attracted to dietetics through this degree.

The New Zealand Dietetic Association also has a role to play in recruitment. Dietitians are already involved in careers programmes in schools and could become more active in this area. A dietitian, enthusiastic about her own work and her profession, has by far the most positive influence in recruitment.

The committee recommends that the New Zealand Dietetic Association should undertake the preparation of material to assist its members in an active recruitment programme. A series of carefully selected colour transparencies with a taped script giving up-to-date information to form the basis of a careers programme is one example of assistance. Realising the expense involved in this type of project it proposes that the expense should be shared by the Department of Health.
13. PUBLIC RELATIONS

It was clear from submissions that the role of the dietitian is not fully understood, and that the title dietitian is confused with others in related fields—e.g., nutritionist, food technologist, food supervisor. It was also clear that the dietitian is mainly associated with restriction of food for the sick, and not with the planning of food for the maintenance of health.

The present very small number of dietitians employed in the public health field, approximately one per million of the population, keeps direct public contact outside the hospital setting to a minimum level. The growth of public health dietetic services will at least bring dietitians into an improved though still slight contact with the public. The committee believes that the New Zealand Dietetic Association should make a determined endeavour to create a better informed public opinion concerning the role and potential of its members. The profession, although small, is in the situation where the performance of its members justifies improved knowledge and recognition of its activities. This is an essential factor in gaining public support.

The committee recognises that public relations as understood today can be an expensive specialist activity. The New Zealand Dietetic Association has very modest resources. Therefore, its present public relations will need to be based primarily on activities of the national association with a follow up at regional level. Professional advice might be sought on the most effective programmes. The committee envisages a greater use of radio, television, newspaper, and journals. Every situation in which a dietitian is able to participate in the activities of other national organisations and local bodies will also assist by providing a direct line of contact with dietitians and their work.

The committee recommends that the executive of the New Zealand Dietetic Association elect a public relations convenor, with the objective of setting up a public relations working party to bring in proposals for both an initial and an on-going programme for the association.

It is recognised that the ultimate success of the relationships of dietitians with employers, fellow professional staff, staff under their direction, patients, and with the public depends on the cumulative performance and personal qualities of each member of the profession.
14. CONCLUSIONS AND RECOMMENDATIONS

It is evident that in the 30 years since dietetic training commenced in New Zealand this small and young member of the health professions has a firmly established role in the country’s health system. The success of the profession can be attributed to the standards set by those who established the training, the support given by a small but enlightened and sympathetic section of the medical profession, and particularly to the dedication of many dietitians who have earned respect for themselves and the profession they represent. At no time during the study was the need for dietitians disputed, and indeed they received considerable commendation for their achievements in the face of many difficulties.

This study of the profession after 30 years of practice has revealed much progress and consolidation. It has also revealed the need for some changes in thinking, planning, and action if dietitians are to fulfil their professed role and meet the demands and challenges which lie ahead.

From submissions and evidence given, the committee identified the following problems which it considers are adversely affecting the future of the profession and for which solutions must be found and implemented.

14.1 Problems Identified in the Profession

1. The training and special knowledge of the dietitian is not being fully utilised in the most effective way.
2. An insufficient number of dietitians is available to meet present needs throughout the country.
3. An insufficient number of recruits of the high calibre required is being attracted to meet the even more demanding future needs.
4. Dietitians frequently are not given the status and recognition which their level of training and their responsibilities should command.
5. The medical profession states that it is not always getting the service it needs and expects, especially in clinical dietetics and in research activities. Such deficiencies could become more apparent as these areas of medical treatment and investigation expand.
6. Recently qualified dietitians in particular are expressing dissatisfaction with the nature of some aspects of their work, and with their status, salaries, and career prospects.
7. Qualified dietitians and students are expressing dissatisfaction with some aspects of their training.

The committee has reached conclusions and made recommendations which it considers would provide a framework for substantially assisting with these problems and for the future development of the profession in New Zealand.
14.2 The Role of the Dietitian

The statement has been made many times in submissions and evidence that the dietitian is not fulfilling her true professional role. She is commended for the standards of food service she maintains but at the same time is criticised because she is frequently seen to spend too much of her time in food service tasks which should be delegated to others. She is also criticised because she is too infrequently seen to be using her special skills and knowledge in more direct involvement with patients and medical staff as part of the health care team.

The solution to this problem is not simple. There is at present no formal training for food supervisors or other food service staff thus making the delegation of routine tasks difficult in many hospitals if standards are to be maintained. It is apparent that training for food service staff must be introduced as a matter of urgency, thus allowing dietitians to free themselves from routine duties and devote themselves to more important and more strictly professional tasks.

Medical staff have sometimes stated that, with some exceptions, they find dietitians lacking in sufficient knowledge, confidence, and initiative in the more complex clinical problems, and that they are inadequately prepared to assist with investigation and research.

It is agreed that some strengthening of the background training in preclinical sciences is necessary but this must be followed by more opportunity for clinical training and experience. This means that there will need to be more willingness than is sometimes the case, for medical staff to assist, guide, and encourage the dietitian in clinical aspects of her work and to include her in their teams. Unless this is done she will not succeed in overcoming the deficiencies for which she is criticised by the same doctors.

14.2.1 Food Service Functions

The committee gave careful thought to the submissions and evidence concerning the management of hospital food services and considered various alternatives. The decision made against a major policy change was influenced by these factors:

(a) The importance of maintaining the high standards achieved under the present system.
(b) The importance of the dietitian in the economic management of food services.
(c) The lack in New Zealand of other trained personnel in the food service occupations.
(d) The advantages of a single line of responsibility for food services against the problems of an administratively divided food service.

The committee makes the following recommendations concerning hospital food services:

- That the dietitian should remain in overall control of food services in New Zealand hospitals.
• That immediate attention be given to the training of food supervisors and other food service staff for hospitals and institutions throughout New Zealand.

• That the training programme of food service staff should lead to a nationally recognised qualification. Technical institutes are seen as the appropriate place for this training, and dietitians should be involved in the planning and teaching of courses. An employment structure to give appropriate status and remuneration to those gaining qualifications is essential.

• That the dietitian must be prepared to delegate responsibility and authority for some food service management tasks to ancillary staff while remaining in overall control and safeguarding standards.

• That in addition to trained food service staff it is essential that the dietitian be supported by clerical assistance and by personnel or executive officers particularly for staff recruitment and departmental co-ordination.

• That where sufficient trained personnel are available it is desirable for dietary staff to be responsible for food all the way from kitchen to patient. However, lack of personnel, together with the fragmented layout of many hospitals makes this impracticable as a general policy at present.

• That the use of a centralised system of food service be adopted in future hospital planning. This has already been recommended in a Department of Health Working Party report.¹⁰

14.2.2 Clinical Functions

The committee believes that there is an important present need and steadily expanding scope for the dietitian to become more involved with clinical aspects of dietetics than is often now the case. Reasons for this conclusion are:

(a) Medical evidence increasingly points to the relationship between dietary habits and degenerative and other disorders and to the use of controlled dietary intake as part of their treatment.

(b) An increased number of hospital beds are being used for investigation and treatment of disorders requiring specialised dietetic services.

(c) Outpatient and extramural hospital services are playing an increasingly important part in general medical care. This will make an increased demand on dietitians. The present dietary treatment of people with high blood lipids in the prevention of coronary heart disease is an example of this increased demand.

(d) The development of health centres and group practices where dietetic consultant services will be required along with other paramedical consultant services.

(e) An increasing need for dietary counselling to be available to patients of general practitioners.
(f) The development of special units in different branches of medicine which will require the assistance of highly skilled dietitians able to translate dietetic prescriptions within very precise limits.

(g) Research activities associated with these medical specialties which will require dietitians as part of the research teams working on the detection and treatment of complex disorders, e.g., in the metabolic field.

The dietitian can only meet these demands if she has the opportunity for specialisation within the total field of the dietetic profession.

14.2.3 Specialisation

The committee considered the possibility of introducing some form of specialisation into the undergraduate training but concluded that New Zealand's needs were best met by producing a general dietetic practitioner. After general experience, however, she should be able to decide whether to remain a generalist or to choose to specialise in one aspect of dietetic practice.

The committee recommends:

- That three major areas of dietetics be developed:
  
  (a) The general dietetic practitioner.
  (b) The administrator of dietetic services.
  (c) The clinical (or community) dietitian.

- That the initial dietetic qualification prepare a generalist who, with experience, will be able to function effectively as a general dietetic practitioner in a sole charge or smaller hospital.

- That post-graduate training be introduced to permit specialisation in either the administrative or the clinical aspects of dietetics.

- That comparable recognition for promotion and salary be established within the career progression for both administrative and clinical specialisation.

- That clinical dietitians be able to gain qualification in a special aspect of clinical dietetics by further training and experience; they would thus be well prepared for work in special units such as those associated with paediatric, renal and metabolic medicine.

- That able dietitians in all three specialisations be encouraged to take post-graduate qualifications in teaching and to assume the role of tutor dietitians in teaching hospitals.

14.2.4 Public Health Dietitians

Submissions and evidence have confirmed the committee's views that the dietitian must become more involved in health services outside the hospital if she is to have an influence in a preventive role. The presence of the dietitian in health centres will substantially assist but the public health dietitian has the opportunity for making the greatest impact. The need for more public health dietitians to be active in educational,
advisory, and counselling capacities has been repeatedly emphasised. The regrettable lack of dietary counselling in social welfare agencies of all types is also pointed out.

It is recommended:

- That the number of established positions for public health dietitians be steadily increased to make available dietetic educational, advisory, and counselling services in all regions of the country.
- That every effort be made to recruit, train, or retrain dietitians with suitable qualifications and experience to fill these posts.

14.2.5 Private Practice

It is recommended that the New Zealand Dietetic Association should lay down guidelines for fees to be charged by dietitians in private consulting practice as is the case in other professions.

It is further recommended that the implications of a subsidy from social security funds should be studied. This will be important as dietitians become involved in group practices and health centres.

14.2.6 Advisory Services

There are many institutions, including hospitals, homes, hostels, residential halls, and schools which could benefit from advice on nutritional standards, menu planning, general organisation, and economic management of food services.

The committee recommends:

- That the services of dietitians in a part-time or consultant capacity should be widely used in an effort to improve standards of food services in institutions.

14.3 Training

14.3.1 Initial Training

The committee believes that some change in the approach to training is essential if the profession is to gain dietitians of the number and quality required to meet the country's future needs.

In making recommendations for future training the committee has sought to preserve the many existing strengths of the present training, to meet recognised deficiencies, to utilise and strengthen existing resources and facilities, and to provide a system able to meet and adapt to changing needs.

The committee strongly affirms that the basic training of dietitians belongs in a university which has the resources for the teaching of foods, food science, and nutrition, and a medical school with preclinical and clinical departments.
The following recommendations are made for future training:

• That for initial qualification and entry to the profession there should be two alternative forms of training:
  (a) By gaining a degree in dietetics to be established as a 4-year course which co-ordinates clinical studies with the academic preclinical component of the undergraduate course.
  (b) By gaining a prerequisite qualification in home science followed by a 1-year professional training based on a single training school.

• The committee recommends that a curriculum planning team be established to consider the details of the proposed degree course with particular reference to the co-ordination of the academic and clinical aspects of the course.

• That the degree in dietetics be conducted by the University of Otago, and include appropriate subjects of the home science degree together with other subjects particularly relevant to dietetic practice. Clinical experience would be gained by spending a prescribed period in each of the third and fourth years of the course in approved training hospitals.

• That request be made for some modifications in the present prerequisite home science courses to meet some deficiencies in the preparation of dietitians.

• That the Auckland Hospital Board be requested to provide the staffing and facilities to establish a single training school for dietitians to become the "principal training school".

• That the present training schools in other centres be requested to serve as "associated training schools" to the "principal school" and that they subsequently serve as associated training schools for the degree course.

• That as part of the reorganisation of the 1-year dietetic training, negotiations be made with medical clinical schools to increase the clinical experience in the training period; that the routine tasks of food service receive less emphasis.

• That negotiations begin immediately for the appointment of staff to organise and initiate both training schemes and provide an appropriate staff to student ratio for the clinical aspects of the teaching—1 to 6 is the ratio recommended.

• That seminar workshop type courses be planned immediately to assist the tutor dietitians to overcome their earlier lack of preparation for their teaching role.

• That to meet the need for increased depth in the basic and preclinical sciences the home science diploma course be gradually phased out as a prerequisite qualification for dietetics. The year 1980 is proposed as the target cut off date but this should be reviewed in the light of numbers available from the degree courses.
• That other proposals for implementation of the two forms of training be adopted. These are set out more fully for the proposed degree course on page 57 and for the reorganised 1-year professional training on page 59.

14.3.2 Post-graduate and Post-registration Training

The committee considers that the development of post-graduate and post-registration training in the field of dietetics is long overdue in this country. It is needed to provide more highly skilled specialist services, more stimulation and incentive in the dietitians’ career and hence better career prospects and greater satisfactions.

The committee recommends:

• That immediate steps be taken to develop training for post-registration study in specialised areas of dietetics, thus enabling dietitians already in the profession to increase their qualifications. Proposals are set out in page 62 of the report.
• That an appropriate central body control the numbers and the conditions for acceptance of applicants for post-registration courses with consideration of the needs of hospitals and health services. A “dietetic education committee” is proposed with representation from the Department of Health, university and teaching hospitals, and the New Zealand Dietetic Association.
• That the post-registration training be organised by the principal dietetic training school with the requested co-operation of the clinical departments of the Auckland School of Medicine.
• That to meet longer term needs, post-graduate facilities should be developed alongside the basic training with provision for university post-graduate diplomas and advanced degrees.
• That to assist in financing specialist and post-graduate training, the equivalent of two salaries at staff dietitian level be made available each year from which to pay dietitians while taking courses.
• That as soon as possible suitable post-graduate or specialist qualifications in preparation for teaching become an expected prerequisite for appointment to positions as tutor dietitians.
• That two annual study awards be made available, including salary and travel assistance, to be tenable in New Zealand or overseas for purposes of gaining approved qualifications or experience.

14.3.3 Continuing Education

The committee commends the New Zealand Dietetic Association on its organisation of an annual 2-day conference to assist its members in keeping up to date. It considers these conferences valuable but believes that there is need for concentrated courses in specific areas of dietetic practice over several days duration.
It recommends:

- That concentrated courses in specific areas of dietetic practice be organised by the principal training school in collaboration with universities and clinical school. This will require appropriate financial provision.

- That dietitians be given encouragement and opportunity to attend such courses as are applicable to their sphere of work with salary and travel assistance provided by their employing authority.

14.3.4 Retraining of Dietitians

Provision for retraining is needed if dietitians returning after a break in service are to effectively re-enter employment.

The committee recommends:

- That provision be made for retraining based on training programmes within existing facilities, either in the university or in the teaching hospitals depending on the skills required. Proposals for retraining are set out on page 64 of the report.

14.3.5 Library Resources

From information given to it, the committee was made aware of the very unsatisfactory library resources available to dietitians in some training schools. These varied considerably from one school to another.

The committee considers that an up-to-date collection of journals and references are essential tools of professional practice and indispensable to a training school.

It recommends:

- That hospital boards be requested to review their library policy for dietetic departments with a view to ensuring that an up-to-date collection of journals and references is available to their dietetic staff.

14.3.6 The Relationship Between Nutritionists and Dietitians

The University of Otago is now offering an honours degree in human nutrition. It is highly desirable for nutritionists and dietitians to work in complementary roles, and some aspects of their work may be shared. The committee considers that nutrition graduates who wish to work with patients in clinical aspects of nutrition should be required to meet registration requirements as is the case with other medical and paramedical professions. This will require some post-graduate training.
The committee recommends:

- That the graduate nutritionist who wishes to undertake clinical responsibilities be required to obtain registration as a dietitian by following a training based either on that required by home science graduates for registration or on that of the final year of the degree course; modifications in each case to allow for the differing backgrounds of each course.

14.3.7 Regular Assessment of Training

The committee recommends:

- That a regular 5-yearly assessment of all training schemes be made by the Dietitians Board in consultation with the university and Department of Health.

14.4 Remuneration and Conditions of Employment

The opinion expressed in most submissions received from non-dietetic groups was that the salary scale needs improvement to be more commensurate with qualification and responsibility. Dietitians themselves consider their salaries compare unfavourably with those paid to other occupations requiring similar qualifications.

The analysis made in the report of the relative position of the salaries of dietitians of those with other professions and groups in hospital employment shows that dietitians have suffered a gradual but marked deterioration in salary relativity since the last revision of their salary scale was made in 1964. Groups near equal to them in 1964 are now over 30 percent ahead in remuneration.

Students in the home science courses with a choice of career find graduates in the teaching profession and industry receiving better salaries with better prospects and without the disadvantages of irregular hours and weekend duties.

The committee believes that inadequate salary can become a major cause of problems in recruitment and retention of able people. It also believes that morale and motivation are adversely affected by lack of adequate rewards for specialist and post-graduate qualifications, and for merit and responsibility.

14.4.1 Salary Recommendations

The following recommendations are made:

- That it is essential to pay salaries sufficient to attract talented people into the dietetic profession and to keep them there by rewarding them for the challenging work and responsibility they undertake.
• That it is essential to achieve relativity between dietitians’ salaries and those of other graduate hospital employees with similar educational background, training, and responsibilities. Unless this is achieved the Hospital Services Committee will not do justice to the dietetic profession.

• That it is of vital importance to reward people for qualification and exceptional performance. Increments should be based to a greater extent on performance appraisal.

• That a thorough study of job classification and job evaluation be undertaken to determine the correct salary levels for the profession in relation to other comparable professions and, within the profession, for each grade of job. Such evaluation should deal with the lack of margin between grades and determine the total salary range. It could be undertaken jointly by the profession and the Department of Health.

The committee wishes to emphasise that salary policy and structure are only viable if determined by co-operation between the employing authority and the profession.

14.5 Career Prospects

The reputation and attractiveness of a profession upon which depends the ability to recruit and attract able people is influenced by the quality of initial training, status and salary levels, the opportunities for development and promotion, and the prospects for retraining.

14.5.1 The Current Career Path of Dietitians

The current career path of dietitians is determined by a number of factors which include:

(a) The size of the hospital in which she works. In a small hospital promotion may be blocked.

(b) The pyramidal structure of hospital dietetic departments which limits individual professional development and incentive for specialisation.

(c) The present lack of a system of induction, career counselling, and planned development of aptitudes and abilities.

(d) The conflict between the need for specialisation and the need for administration. This is complicated by the present weighting of salaries in favour of administration thus providing little incentive for specialisation in clinical dietetics, teaching, or research.

(e) Inadequate opportunities for specialist training and lack of a system requiring specific prepromotion training and qualification.

(f) The present lack of a system which permits promotion on the basis of individual effort in furthering qualifications and on merit of performance.
14.5.2 *Future Career Path and Promotion Training*

The committee proposes a reorganisation of hospital dietetic departments to give a flattened staffing structure beneath the director of dietetic services. This system will provide for comparable status and promotion in each of the major areas of dietetics—general dietetic practice, food service management, clinical dietetics, teaching, and research. Assistant directors will be responsible for the work of each functional area, with additional staff as assistant dietitians. The proposed scheme is set out in charts 2 and 3, appendix C, as it would apply in a large teaching hospital and in a general or smaller hospital. In the smaller hospital the generalist is important with a broadly based knowledge and experience in each area of practice.

An integral part of such a scheme is a system which prepares staff for increasing responsibility and promotion within each area. This should start with induction, training and job rotation giving experience in each functional area and an appreciation of the role of the generalist and specialist. This training should be accompanied by performance appraisal and followed by career counselling before a choice of career direction is made. From this point onwards, specialist training, continuing education, and retraining are essential. The committee believes that a plan of training for promotion is necessary with a series of alternative achievements specified for each promotion step. Such a system will provide both incentive and recognition for effort and ability in a chosen career path. Some suggestions for implementation of these proposals are made in the present chapter and in chapter 8 on future training.

14.5.3 *Manpower Plan*

The committee advocates the preparation of a manpower plan to meet the needs of hospitals and as far as possible those for community health services and public health dietitians. A clearer picture of the developments and prospects within the profession will provide incentive, and influence the direction of specialist and post-graduate training.

14.5.4 *Recommendations for Improvement of Career Structure*

The committee makes the following recommendations:

- That a flattened organisation structure be designed and implemented to replace the present pyramidal structure within dietetic departments.
- That an induction programme including planned rotational training and experience for one year be required after entry to the profession.
- That career planning and development be based on an assessment of performance and aptitudes.
That entry into both generalist and specialist fields of dietetics be accompanied by appropriate in-service training.

That a system of training for promotion be planned and implemented.

That continuing education and retraining become a regular and expected part of the professional service of dietitians at all levels.

That a manpower plan should be established incorporating the needs of hospitals, community and public health services.

14.6 Recruitment

14.6.1 Present Recruitment and Service

Present recruitment is influenced by activities of vocational guidance centres, careers advising in schools, and by personal contact with dietitians and home science graduates. Replies to questionnaires from dietitians qualifying between 1967 and 1971 showed that 64 percent made the decision to become a dietitian before commencing the home science course and 36 percent during or after the course.

The number of students entering the home science course has increased in recent years, particularly to the degree course, but the number continuing to dietetics has not been proportionately increased. Regrettably few degree holders are becoming dietitians.

Although it is accepted that the period of initial service in predominantly female occupations is short, the average length of service of dietitians calculated over a 25-year period is 5.9 years. There is also evidence of return to employment by dietitians whose family commitments have become less demanding.

14.6.2 Future Recruitment

The committee believes that future recruitment will be favourably affected by the recommended changes in training, changes in role, improvements in salary, and more attractive career prospects.

It considers that dietitians often already involved with careers programmes in schools could become more active in this area giving up-to-date information and first-hand encouragement to school pupils interested in combining a career in applied sciences with a service profession dealing directly with people. Male students should be encouraged to train as dietitians or nutritionists.

14.6.3 Recommendations for Recruitment

- That the New Zealand Dietetic Association undertake the preparation of material to assist their members in an active recruitment programme. Realising the expense involved, it is proposed that the cost should be shared by the Department of Health.
- That a start be made to combat the assumption that dietetics is solely a woman’s occupation. A more direct dietetic training and an improved salary scale should make the profession of more interest to men.
14.7 Public Relations

It is evident from submissions and evidence that there is a lack of understanding of the role of the dietitian by the general public and even by people in other branches of health services. The present small number of dietitians employed outside hospitals restricts their direct influence on the public.

The committee believes that public relations should be the concern of the profession itself through the New Zealand Dietetic Association. At the same time it realises that highly organised public relations campaigns are costly and beyond the present resources of a small profession.

The committee proposes a modest but determined approach to gain a better informed public opinion concerning the role and potential of dietitians.

14.7.1 Recommendations for Public Relations

- That the executive of the New Zealand Dietetic Association elect a public relations convenor with the objective of setting up a public relations working party to bring in proposals for both an initial and an on-going programme for the association.

In conclusion the committee wishes to express its confidence in the future of the dietetic profession. It believes that active support by the medical profession is of major importance in promoting a full contribution by dietitians to health care, and in influencing public opinion on the importance of nutrition in health.

It urges the Departments of Health and Education, the universities, and the hospital boards to support the recommendations which it believes will substantially assist in building a dietetic profession which by training and practice will be better fitted to play its proper role in the New Zealand health services.

Finally, the committee wishes to share with dietitians its belief that no matter how thorough the training, or how wide the scope of the profession, the successful dietitian must still possess the personal qualities of intelligence, integrity, enthusiasm, and belief in her purpose and profession.
15. ACKNOWLEDGMENTS

The committee wishes to record appreciation to hospital boards, medical superintendents, doctors, matrons and nursing staff, and the dietitians who assisted by supplying information and answering questionnaires. The contribution of representatives of national associations and of the dietitians and other groups and individuals who prepared submissions or gave evidence was also appreciated.

Gratitude is expressed to those who assisted in the analysis of data and the preparation of the report. These include the Health Services Research Unit, the secretarial and typing assistance in the Department of Health, Miss Margaret Hogg, senior home science student, and Mrs Sharon Duke, secretary in the School of Home Science, who has assisted the chairman throughout the study.

REFERENCES

3. 1950, No. 44. The Dietitians Act 1950.
5. 1953/27. The Dietitians Regulations 1953.
7. The Hospital Employment (Dietitians) Regulations 1969.
15. Ibid.
APPENDIX A

LIST OF SUBMISSIONS TO COMMITTEE ON THE DIETETIC PROFESSION

Auckland Hospital Board.
Department of Education.
Department of Health.
Dietitians Board.
The Medical Association of New Zealand.
Medical Superintendents’ Association of New Zealand.
National Council of Women in New Zealand (Inc.).
New Zealand Dental Association.
New Zealand Dietetic Association (Inc.).
New Zealand Federation of University Women.
New Zealand Hospital Matrons’ Association.
New Zealand Institute of Food Science and Technology (Inc.).
New Zealand Nurses’ Association.
North Canterbury Hospital Board.
Nutrition Department—School of Home Science.
Nutrition Society of New Zealand.
Otago Hospital Board.
The Paediatric Society of New Zealand.
The Royal Australasian College of Physicians.
The Royal Australasian College of Surgeons.
Scientific Committee of the National Heart Foundation.
Society for Research on Women in New Zealand (Inc.).
University of Otago (Department of Paediatrics and Child Health and the M.R.C. Human Genetics Research Unit).
Wellington Hospital Board.
Miss F. Berry.
Sir Charles Burns.
Mrs K. L. Dobbie.
Professor J. D. K. North.
Dr C. Tasman-Jones.

APPENDIX B

COLLECTION OF DATA

To obtain information about the practice of dietetics, questionnaires were completed by dietitians and hospital boards.

Questionnaires to Dietitians

Questionnaires were sent in June 1972 to all dietitians whose names are on the Register of Dietitians and for whom addresses were known. These sought information under the following headings:
1. Qualifications.
2. Dietetic experience.
3. Employment status.
4. Role and responsibilities.
5. Applicability of home science and dietetic training to practice.
6. Reasons for ceasing work as a dietitian.

Four hundred were sent from which 324 (81 percent) replies were received: 303 (75.7 percent) were complete and able to be used for analysis. Dietitians who qualified during the 1967-71 period were asked to complete additional questions related to home science and hospital training courses. Ninety-seven were included in this group. Seventy-one (73.2 percent) replied and 68 (70.1 percent) were used for analysis.

**Questionnaires to Hospital Boards**

During February 1972 the 30 hospital boards in New Zealand were sent questionnaires, seeking the following information:

1. Number of dietitians employed.
2. Responsibilities: meals supplied.
3. Reasons given by dietitians for ceasing employment.
4. Hospitals over 100 beds were asked to reply to a question relating to the execution of dietetic function.

Twenty-eight (83.6 percent) replies were received, 21 from boards administering hospitals of over 100 occupied beds and 7 with all their hospitals under 100 occupied beds. For the question related to the execution of dietetic function, of 34 hospitals who were asked to reply, 33 replies were received.

### Table 1—Qualifications of Dietitians

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<td>232</td>
<td>5</td>
<td>(f)</td>
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*Total dietitians (percent) 19.2 74.6 3.0 18.5 76.6 1.7 4.3 3.6

\* = (a+b+c+g) 
\* = (d+e+f+g) 

4* Inset
### Table 2—Employment Status

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<th>Year Qualified</th>
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### Table 3—Fields of Dietetic Employment

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### Table 4—Average Hours per Week Employed

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### Table 5—Total Meals Served Per Day in Hospital Boards: January-December 1971

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<td>Wellington*</td>
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<tr>
<td>Vincent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Hospital boards controlling dietetic training schools.
†Subsidiary hospital meals not included in totals.
### TABLE 6—Total Meals Served Per Day in Hospitals Over 100 Occupied Beds: January-December 1971

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Totals Meals Per Day</th>
<th>Number Dietitians</th>
<th>Ratio Dietitians: Meals</th>
<th>Average Occupied Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellington*</td>
<td>4,145</td>
<td>10.5</td>
<td>1:395</td>
<td>783.0</td>
</tr>
<tr>
<td>Dunedin</td>
<td>3,149</td>
<td>5.5</td>
<td>1:573</td>
<td>342.3</td>
</tr>
<tr>
<td>Waikato</td>
<td>2,993</td>
<td>5.5</td>
<td>1:544</td>
<td>710.2</td>
</tr>
<tr>
<td>Auckland*</td>
<td>2,911</td>
<td>15.5</td>
<td>1:188</td>
<td>505.5</td>
</tr>
<tr>
<td>Middlemore</td>
<td>2,621</td>
<td>3</td>
<td>1:874</td>
<td>556.0</td>
</tr>
<tr>
<td>Greenlane</td>
<td>2,482</td>
<td>4</td>
<td>1:621</td>
<td>394.0</td>
</tr>
<tr>
<td>Palmerston North</td>
<td>2,075</td>
<td>4</td>
<td>1:519</td>
<td>412.3</td>
</tr>
<tr>
<td>Hutt</td>
<td>1,948</td>
<td>2</td>
<td>1:974</td>
<td>385.8</td>
</tr>
<tr>
<td>Nelson</td>
<td>1,922</td>
<td>4</td>
<td>1:481</td>
<td>232.1</td>
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<tr>
<td>Christchurch*</td>
<td>1,799</td>
<td>7</td>
<td>1:257</td>
<td>365.8</td>
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<tr>
<td>Cornwall</td>
<td>1,524</td>
<td>3</td>
<td>1:508</td>
<td>381.0</td>
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<tr>
<td>Whangarei</td>
<td>1,307</td>
<td>1</td>
<td>1:1,307</td>
<td>261.1</td>
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<tr>
<td>New Plymouth</td>
<td>1,277</td>
<td>0.5</td>
<td>1:2,254</td>
<td>297.7</td>
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<tr>
<td>Princess Margaret</td>
<td>1,159</td>
<td>3</td>
<td>1:386</td>
<td>221.8</td>
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<tr>
<td>Southland</td>
<td>1,128</td>
<td>1</td>
<td>1:1,128</td>
<td>231.9</td>
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<tr>
<td>Napier</td>
<td>1,105</td>
<td>..</td>
<td>..</td>
<td>224.6</td>
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<tr>
<td>Hastings</td>
<td>1,091</td>
<td>..</td>
<td>..</td>
<td>235.0</td>
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<tr>
<td>Rotorua</td>
<td>1,060</td>
<td>1</td>
<td>1:1,060</td>
<td>267.3</td>
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<tr>
<td>Cook</td>
<td>1,059</td>
<td>2.25</td>
<td>1:471</td>
<td>224.8</td>
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<td>Burwood</td>
<td>997</td>
<td>3</td>
<td>1:332</td>
<td>211.2</td>
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<td>Wanganui</td>
<td>989</td>
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<td>..</td>
<td>219.1</td>
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<td>Wakari</td>
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<td>1:483</td>
<td>181.7</td>
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<tr>
<td>Timaru</td>
<td>938</td>
<td>0.5</td>
<td>1:1,876</td>
<td>218.5</td>
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<tr>
<td>National Womens</td>
<td>889</td>
<td>2</td>
<td>1:445</td>
<td>286.0</td>
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<tr>
<td>Thames</td>
<td>781</td>
<td>..</td>
<td>..</td>
<td>156.2</td>
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<tr>
<td>Masterton</td>
<td>650</td>
<td>1</td>
<td>1:650</td>
<td>185.4</td>
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<tr>
<td>Silverstream</td>
<td>630</td>
<td>0.6</td>
<td>1:378</td>
<td>193.8</td>
</tr>
<tr>
<td>Wairau</td>
<td>597</td>
<td>..</td>
<td>..</td>
<td>185.4</td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>562</td>
<td>†</td>
<td>†</td>
<td>98.4</td>
</tr>
<tr>
<td>Christchurch Womens</td>
<td>535</td>
<td>..</td>
<td>..</td>
<td>130.8</td>
</tr>
<tr>
<td>Oamaru</td>
<td>529</td>
<td>..</td>
<td>..</td>
<td>104.0</td>
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<tr>
<td>Whakatane</td>
<td>527</td>
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<td>..</td>
<td>131.6</td>
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<tr>
<td>Coronation</td>
<td>430</td>
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<td>..</td>
<td>126.4</td>
</tr>
</tbody>
</table>

*Principal Dietetic Training School.
†Shared with Rotorua.
APPENDIX C

DESCRIPTION OF DIETETIC FUNCTIONS

A. Administration

1. General Administration
   (a) Making recommendations for policy decisions concerning food services.
   (b) Assisting in planning of food service units.
   (c) Making recommendations for selecting, and purchasing plant and equipment.
   (d) Making recommendations for purchasing hospital food supplies.
   (e) Implementing food and wage cost controls.
   (f) Preparing monthly returns and writing reports.

2. Menu Planning
   (a) Menu planning.
   (b) Ordering food supplies.

3. Staffing
   (a) Selection.
   (b) Training.
   (c) Preparation of duty lists.
   (d) Rosters.
   (e) Control.

4. Catering for official hospital functions.

B. Therapeutics

1. Menu planning.
2. Diet calculations.

C. Supervision

1. Kitchens
   (a) Preparation and cooking.
   (b) Service to food trolleys.
   (c) Preparation, cooking, and service of modified diets.

2. Wards—meal service to patients.

3. Staff Dining Rooms
   (a) Preparation and cooking.
   (b) Meal service.

4. Control of food use and waste.
D. **Teaching**

1. Patients.
2. Student nurses.
3. Dietitians.

E. **Other Functions**

1. *Housekeeping and Safety*
   (a) Staff hygiene.
   (b) Cleanliness of kitchens, dining rooms, and equipment.

2. *Maintenance*
   (a) Plant and equipment.
   (b) Staff working conditions.

---

**DEPARTMENT OF HEALTH MEMORANDUM**

**SCHEDULE A**

**SUPERVISION OF HOSPITAL FOOD SERVICES**

In the Hospital Dietary Department which provides facilities for the service of meals to patients and/or staff, it is recommended that:

1. A *dietitian or dietitians* should be employed to supervise the food service in hospitals of 100 or more average occupied beds. The number of dietitians employed will depend on the numbers to be catered for, type of hospital, and the number of services provided by the dietary department. Food supervisors may also be employed in these hospitals and they should be responsible to the dietitian. The dietitian should be responsible to the medical superintendent.

2. A *food supervisor* may be employed to supervise the service in hospitals of less than 100 average occupied beds and catering for approximately 200 persons. The food supervisor should be responsible to the dietitian, or to the matron when a dietitian is not employed.

3. A *housekeeper* may be employed, as part of her duties, to supervise the food service in hospitals of less than 100 occupied beds and catering for approximately 100 persons. The housekeeper should be responsible to the matron.

4. Where a dietitian is not employed, menu outlines for therapeutic diets should be supplied by a practising registered dietitian.
SCHEDULE B

DUTIES OF SENIOR (OR SOLE) DIETITIAN AS APPROVED BY THE DIETITIANS BOARD

The dietitian should be responsible to the medical superintendent for:

1. General policy and administration of the food service department, budgetary control measures, returns, and reports.
2. Administration of food service to patients and staff.
3. Food production and service to patients and staff, including, in some instances, nurses' homes:
   (a) Menu planning;
   (b) Ordering of food supplies and stores;
   (c) Supervision of preparation, cooking, and service of meals to patients including those served by extramural services; those requiring modified diets; to staff in cafeterias and dining rooms.
4. Control of food usage and wastage in production areas, wards, cafeterias, and dining rooms:
   (a) Through regular visits to these areas to observe meal service, portion control, and plate waste;
   (b) Investigation of excessive waste.
5. Catering for hospital functions according to the board's policy in this connection.
6. Selection, training, and control of staff for all sections of the food service department.
7. Supervision of sanitation and hygiene in all areas of the food service department.
8. Maintenance of plant, equipment, and safety throughout the food service department.
10. Education:
   (a) Inpatients and outpatients who require a modified diet through visits and interviews in the hospital or as an extramural service;
   (b) Student nurses, nutrition, and diet therapy.
   (It is agreed that the teaching of nutrition and diet therapy to student nurses in larger hospitals equipped for the purpose should remain the responsibility of the dietitian. In smaller hospitals where one dietitian only is employed, she should be responsible for teaching diet therapy to student nurses, nutrition being covered by the nursing education staff.)
   (c) Preparation of educational material for professional and community obligations.
11. Execution of special projects and writing of appropriate reports.
12. Development of interdepartmental liaison, co-ordination, and co-operation.
13. Advisory dietitian to the board’s staff residences, subsidiary hospitals:
   (a) Through regular visits;
   (b) Food production and service to patients and staff, including therapeutic dietetics;
   (c) Equipment selection;
   (d) Staff training;
   (e) Teaching student nurses.

SCHEDULE C

DUTIES OF FOOD SUPERVISORS

The food supervisor should be responsible to the dietitian or, if a dietitian is not employed, to the matron for:

1. Food production and service to patients and staff:
   (a) Menu planning;
   (b) Ordering, checking, and receiving food supplies and stores;
   (c) Supervision of preparation, cooking, and service of meals to patients and staff;
   (d) Supervision of preparation, cooking, and service of modified diets, but not for policy making in regard to such diets.
   (Where no dietitian is employed, menu outlines should be supplied by a practicing registered dietitian.)

2. Control of food usage and wastage in production areas, wards, cafeterias, and dining rooms:
   (a) Through regular visits to these areas to observe meal service, portion control, and plate waste;
   (b) Investigation of excessive waste.

3. Catering for hospital functions according to the board’s policy in this connection.

4. Supervision and training of staff in all sections of the food service department.
   (Where no dietitian is employed it is desirable that the food supervisor play some part in interviewing and selection of staff applicants before final selection and engagement is made.)

5. Preparation and keeping of:
   (a) Staff rosters, time sheets;
   (b) Staff records related to employment, salary, wages, hours of duty, leave, sickness, work injuries, accommodation;
   (c) Staff duty lists.

6. Maintenance of satisfactory standards of sanitation, hygiene, and safety in all areas of the food service department.

7. Maintenance of plant and equipment throughout the food service department.

8. Recommendations to dietitian or matron regarding the need for new equipment.
Responsibilities of Food Service Supervisor:
Psychiatric Hospital

The food service supervisor is directly responsible to the hospital secretary for:

A. *Daily*
   1. Control, supervision, and training of cooks and catering assistants.
   2. Control and supervision of the preparation and service of meals.
   3. Rounds of most kitchens; inspection of stores.
   4. Supervision of general hygiene.
   5. Arranging leave and checking time book.

B. *Periodic*
   1. Compiling cycle menus.
   2. Ordering and checking food supplies.
   3. Preparation of weekly ration and requisition sheets.
   4. Consultation regarding purchasing contracts.
   5. Supervision of special diets.
   6. Catering for special functions.
   7. Maintenance and replacement of kitchen equipment.
   9. Preparation of time sheets.
  10. Arranging taxi requirements.
  11. Interviewing applicants.
PRESENT DIETETIC DEPARTMENT ORGANISATION: GENERAL HOSPITAL (Typical structure 1973)

CHART 1

Dietitian in-Charge

Clerical

First Assistant Dietitian Administration

Second Assistant Dietitian Administration

Food Production — F. Supervisor

Cafeteria L/out Staff — F. Supervisor

N. Home L/in Staff — F. Supervisor

Second Assistant Dietitian Therapeutic

Diet Kitchen — Dietitian

Outpatient Clinic — Dietitian

Teaching Nurses — Dietitian
CHART 3

PROPOSED DIETETIC DEPARTMENT ORGANISATION — GENERAL HOSPITAL.

Director of Dietetic Services — Dietitian

Clerical Section Office Supervisor

Food Production Service
Asst. Director — Dietitian

Food Production Manager — F. Supervisor

Cafeteria Services
F. Supervisor

Production Unit Supervisors — F. Supervisor

Education & Research
Asst. Director — Dietitian

Professional Staff — Dietitian

Training Section
Production & service — F. Supervisor

Clinical Research — Dietitian

Community Groups

Therapeutic & Patient Services
Asst. Director — Dietitian

Patient services — wards — Dietitian

Outpatient Clinics — Dietitian

Extra-mural Services — Dietitian

Employee scheduling & training — F. Supervisor
PROPOSED DUTIES FOR DIETITIANS

Director of Dietetic Services (Hospital Board's Institutions)

Responsible for:

1. Nutritional care of patients and staff within board's institutions, including extramural services.
2. Co-ordination of nutritional care with treatment and advice given by community health and social service agencies.
3. Food service policy for patients and staff within board's institutions.
4. Financial planning and control policy for food service units within board's institutions.
5. Staffing policy for food service units within board's institutions.
6. Educational and research policy and programmes for dietetic departments within board's institutions.
7. Planning new food service facilities within board's institutions.

Director of Dietetic Services (Individual Hospitals)

Responsible for:

1. Nutritional care of patients and staff within hospital and its extramural services.
2. Co-ordination of nutritional care with treatment and advice given by community health and social service agencies.
3. Recommendations on, and implementation of, the board's policy for food service for patients and staff.
4. Recommendations on, and implementation of, the board's policy for financial planning and control for food service.
5. Recommendations on, and implementation of, the board's policy on staffing for food service units.
6. Recommendations on, and implementation of, educational and research policies and programmes within the dietetic department.
7. Recommendations for planning new food service facilities and alterations to existing units.

Assistant Director: Food Production and Service

Responsible for:

1. Organisation, planning, and directing the production and service of meals for patients and staff.
2. Implementation of financial planning and control policies related to food production and service.
3. Training, retraining, and guidance of staff to meet production needs and technological change: co-ordination with staff training unit.
4. Co-ordination of food production and service through assistant director, patient services.
5. Co-ordinate educational and research programmes with education and research directors.
Assistant Director: Patient and Therapeutic Services

Responsible for:
1. Nutritional care, both normal and modified, for patients within the institution and those served by extramural services.
2. Translation of the dietary prescription into appetising, acceptable, economic, and practical meals for the patient in hospital and at home.
3. Calculation and preparation of diets for treatment and diagnostic purposes.
4. Co-ordinating the nutritional care of the patient with the treatment and advice given by other community health and social service agencies.
5. Preparation and presentation of nutrition education literature appropriate to the needs and ability of the individual concerned.
6. Organisation of the food service and delivery system for patients' meals in co-operation with assistant director, food production.
7. Co-ordination with food production and staff training units.
8. Organisation of nutrition services offered through outpatient clinics and extramural services.
9. Co-ordination with education and research directors when and where appropriate.

Assistant Director: Education

Responsible for:
1. Organising and co-ordinating educational programmes for dietetic and medical students and other professional groups; for non- and semi-professional food service employees.
2. Organising and co-ordinating continuing education for dietetic staff.
3. Co-ordinating hospitals dietetic educational activities for and with community groups.
4. Co-ordinating educational activities within the dietetic department and in liaison with other assistant directors.

Assistant Director: Research

Responsible for:
1. Organising and co-ordinating research programmes in clinical areas and in non-clinical aspects of dietetics.
2. Liaison with medical, dietetic, nursing, and other staff in development of projects.
3. Publication of reports.
4. Training of technical staff.
Assistant Dietitian: Food Production

Responsible for:
1. Planning and directing the production and service of meals for patients and staff.
2. Supervision of production and service standards.
3. Training and retraining of staff in co-operation with staff training unit.
4. Implementation of financial planning and control policies related to food production and service.

Assistant Dietitian: Patient and Therapeutic Services

Responsible for:
1. Nutritional care, both normal and modified, for patients; selection of meals using selective menu; visiting patients in own homes when required.
2. Translation of the dietary prescription into appetising, acceptable, economic, and practical meals for the patient in hospital and at home.
3. Calculation and preparation of diets for treatment and diagnostic purposes.
4. Co-ordinate nutritional care of patient with treatment and advice given by other community health and social service agencies.
5. Preparation and presentation of nutrition education literature appropriate to the needs and ability of the individual concerned.
6. Supervision of food service and delivery system for patients' meals.
7. Interviewing and counselling patients in outpatient clinics and in own homes.

Assistant Dietitian: Education

Responsible for:
1. Training schemes for non-professional and semi-professional food service employees.
2. Orientation and induction for new employees.
3. Retraining to meet demands of technological change.
4. Arranging for continuing education of semi-professional employees.

Assistant Dietitian: Research

Responsible for:
1. Implementing research projects in co-operation with medical, nursing, and other staff; collection of data.
2. Data processing.
3. Writing reports.
APPENDIX D
OUTLINE OF HOME SCIENCE COURSES

Bachelor of Home Science

<table>
<thead>
<tr>
<th>Year 1 —</th>
<th>Diploma in Home Science</th>
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<tbody>
<tr>
<td>Chemistry intermediate (as for B.Sc.)</td>
<td>Chemistry (diploma course provided by chemistry department)</td>
</tr>
<tr>
<td>Biology intermediate (as for B.Sc.)</td>
<td>Anatomy and histology (service course of 15 weeks)</td>
</tr>
<tr>
<td>Anatomy and histology (service course of 15 weeks)</td>
<td>Foods 1 and 2 and meal management</td>
</tr>
<tr>
<td>Foods</td>
<td>Clothing 1</td>
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<td>Design 1</td>
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<table>
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<tr>
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<tbody>
<tr>
<td>Physics intermediate — half unit (as for B.Sc.) plus additional physics for home science (short course)</td>
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<td>Textile chemistry</td>
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</tr>
<tr>
<td>Education 1 (paper b child development required)</td>
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</tr>
<tr>
<td>Clothing (2 terms)</td>
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<tr>
<td>or option A</td>
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<tr>
<td>Physics intermediate — full unit (as for B.Sc.)</td>
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<td>Textile chemistry</td>
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<tr>
<td>Chemistry advanced 1 (or other science unit intermediate or advanced 1)</td>
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<tr>
<td>Clothing (short course Feb/March)</td>
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<table>
<thead>
<tr>
<th>Year 3 —</th>
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</thead>
<tbody>
<tr>
<td>Food chemistry</td>
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<tr>
<td>Physiology and biochemistry</td>
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</tr>
<tr>
<td>Bacteriology and public health</td>
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</tr>
<tr>
<td>Design 1 (introductory course in visual awareness)</td>
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<tr>
<td>or option A</td>
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</tr>
<tr>
<td>Food chemistry</td>
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<tr>
<td>Chemistry advanced 2 (or other science unit advanced 1 or 2)</td>
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<tr>
<td>Design 1 as above</td>
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<table>
<thead>
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<tbody>
<tr>
<td>Chemistry (diploma course provided by chemistry department)</td>
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</tr>
<tr>
<td>Anatomy and histology (service course of 15 weeks)</td>
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</tr>
<tr>
<td>Foods 1 and 2 and meal management</td>
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</tr>
<tr>
<td>Clothing 1</td>
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<td>Design 1</td>
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<table>
<thead>
<tr>
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<td>At this stage diploma students are required to choose one of two streams</td>
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<tr>
<td>All students —</td>
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<td>Food chemistry</td>
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<tr>
<td>Physiology and biochemistry</td>
<td></td>
</tr>
<tr>
<td>Textile chemistry</td>
<td></td>
</tr>
<tr>
<td>Education 1 (paper b child development) or full unit</td>
<td></td>
</tr>
<tr>
<td>Design 2a (house planning, furnishing, history of domestic architecture and furniture)</td>
<td></td>
</tr>
<tr>
<td>Home management</td>
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<tr>
<td>General and teaching —</td>
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<td>Clothing 2</td>
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<td>Food service administration —</td>
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<td>Foods 3</td>
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<table>
<thead>
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</thead>
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<td>All students —</td>
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<tr>
<td>Nutrition</td>
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<tr>
<td>Bacteriology and public health</td>
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</tr>
<tr>
<td>Design 2b (history and appreciation of painting, sculpture, and architecture)</td>
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</tr>
<tr>
<td>Community welfare services (7 lectures only)</td>
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<tr>
<td>General and Teaching —</td>
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<td>Foods 3</td>
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<td>or clothing 3 (one required)</td>
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</tr>
<tr>
<td>or design 3</td>
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<td>Plus options according to interest</td>
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<td>Dip.Ed. papers encouraged</td>
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<td>Food service administration —</td>
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<td>Food service administration</td>
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<tr>
<td>Plus options</td>
<td></td>
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<td>Experimental foods</td>
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<tr>
<td>or half unit concepts in management</td>
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<tr>
<td>or Dip.Ed. papers encouraged</td>
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## OUTLINE OF HOME SCIENCE COURSES—continued

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<td><strong>Year 4</strong></td>
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<td>All students—</td>
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<td>Nutrition</td>
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<tr>
<td>Design</td>
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</tr>
<tr>
<td>Plus one approved chosen from A–E  as listed (option A would have been commenced in year 2 of the course)</td>
<td></td>
</tr>
<tr>
<td>A. Physiology and biochemistry</td>
<td></td>
</tr>
<tr>
<td>Bacteriology and public health</td>
<td></td>
</tr>
<tr>
<td>Home management</td>
<td></td>
</tr>
<tr>
<td>B. Food service administration</td>
<td></td>
</tr>
<tr>
<td>Foods advanced</td>
<td></td>
</tr>
<tr>
<td>Students following this option are advised to include a half unit in concepts in management or other approved half unit</td>
<td></td>
</tr>
<tr>
<td>N.B. Intending dietitians follow this option</td>
<td></td>
</tr>
<tr>
<td>C. Home management</td>
<td></td>
</tr>
<tr>
<td>Education 2 or one approved unit or its equivalent in arts or science, or not less than two subjects as prescribed for the Diploma in Education</td>
<td></td>
</tr>
<tr>
<td>D. Home management</td>
<td></td>
</tr>
<tr>
<td>Experimental foods (or foods advanced)</td>
<td></td>
</tr>
<tr>
<td>Half unit in either mathematical and statistical methods or concepts in management or other approved course</td>
<td></td>
</tr>
<tr>
<td>E. Home management</td>
<td></td>
</tr>
<tr>
<td>Clothing advanced</td>
<td></td>
</tr>
</tbody>
</table>

## SYNOPSIS OF NUTRITION COURSE

The course in nutrition is taught in two sections:

(a) Basic nutrition.
(b) Applied nutrition.

The basic course commences with a review of the history of nutrition, the composition of the human body, and a background to metabolic balance studies and nutritional status.

The intake and output of energy introduce the quantitative aspects of food consumption and the control of appetite and energy balance.
Each nutrient is dealt with separately with consideration of dietary supply, metabolism, function, likelihood of deficiency and excess, recommended intakes for different ages:

Proteins, carbohydrates, lipids, water, calcium, phosphorus, magnesium, sodium, potassium, trace minerals, fat-soluble and water-soluble vitamins.

The many inter-relationships between nutrients are discussed.

The applied nutrition course is closely linked with the basic course and gives opportunity for discussion of topical and controversial aspects of the subject. The course includes the use of food tables for calculating the nutritive value of individual meals and of diets, related to nutrient allowances and cost; the correct use of recommended dietary allowances and food guides; obesity; atherosclerosis; inborn errors of metabolism; fasting and "malnutrition" in western countries. Also included is a background to nutrition in the Pacific Islands and to the world food situation with discussion of medical, educational, agricultural, and demographic influences. The course concludes with discussion of nutrition of different ages (e.g., newborn infants, adolescents, elderly) and of typical dietary surveys. Students are required to prepare a short talk for a lay audience (in collaboration with the methods of teaching section of food service administration) and to prepare reviews on selected topics in applied nutrition.

Both sections of the nutrition course are built on previous experience in foods, food chemistry, biochemistry, and physiology and linked with courses in microbiology and social medicine.

**SYNOPSIS OF FOOD SERVICE ADMINISTRATION COURSE**

The course in food service administration is divided into two sections:

(a) Food service administration; and
(b) Principles and methods of teaching applied particularly to the dietetic situation.

The food service administration section includes:

Application of standard methods of food preparation to quantity food production. (This is based on work received in foods, chemistry of foods and experimental foods (where taken).)

Application of principles of menu planning for various types of food service units; principles and methods of purchasing foods.

Organisation and management; personnel management.

Methods of recording and determining food costs.

Hygiene regulations and practices and their importance in food service units.

Planning of food service units; evaluation of varied plans and systems (this section is supported by material received in design).

Selection of equipment for quantity food service (introduction only), safety.
Developments in food service management, their evaluation and comparison with existing and past practices.

The methods of teaching section includes:
- Teaching responsibilities of the nutritionist, dietitian, and food service administrator.
- Training programmes; planning courses of study; preparation of objectives, planning course content.
- Methods of teaching.
- Evaluation.

This section includes some practical experience in preparing and delivering talks and demonstrations to groups.

Practical experience includes:
- Meal preparation at Studholme Hall and other food service units in order to gain an insight into quantity food preparation; the use of large-scale equipment; layout of units and overall management.
- A number of visits to other institutions to give students varied experiences on which to base their standards.
- House management at Studholme Hall (2 weeks) enables the student to gain experience and confidence in the overall management requirements of a food service unit.

OUTLINE OF BACHELOR OF SCIENCE (HONOURS) DEGREE IN HUMAN NUTRITION

**Year 1**
- Intermediate chemistry.
- Intermediate physics.
- Intermediate biology or zoology.

**Honours School**

**Year 2**
- Human nutrition, part 1.
- Chemistry advanced 1—
  - Paper (a): Physical chemistry; and
  - Paper (b): Organic chemistry.
- Biochemistry advanced 1.

**Year 3**
- Human nutrition, part 2.
- Physiology advanced 1 or other approved course in physiology.

**Year 4**
- Human nutrition, part 3.
- Another approved course to be taken at a time appropriate for the subject selected.
PRESENT DIETETIC TRAINING

INSTRUCTIONAL COURSE FOR DIETITIANS AND SYLLABUS OF SUBJECTS FOR EXAMINATION UNDER THE DIETITIANS ACT 1950

1. Administrative Dietetics:
   (To be covered in a minimum of 18 hours.)
   The administration and function of the diet department and the relation of the diet department to other hospital departments.
   Policy; ethics; personnel management; teaching methods and training of staff; wages and awards; records.
   Planning of all units of the diet department. System of food service to wards and to dining rooms.
   Equipment (including its selection and care).
   Sanitation.

2. Quantity Food Service:
   (To be covered in a minimum of 14 hours.)
   Purchase of foods. Market systems, tenders, and contracts.
   Storage of Food. Issuing, costing, and inventory systems.
   Menu planning and ordering of food.
   Methods of food preparation and service applied to quantity work; portion control; avoidance of waste.

3. Normal Nutrition and Diet Therapy:
   (To be covered in a minimum of 16 hours.)
   (a) Normal Nutrition—Normal nutrition for all ages; principles of infant feeding; principles of feeding of children and adolescents; principles of feeding in old age; nutrition in obstetrics; in normal pregnancy (ante-natal and in the puerperium), and in lactation.
   (b) Diet Therapy—Introductory: Review of essentials of an adequate diet as the basis of all therapeutic diets; modifications of the normal diet in diet therapy.
   Nutrition in surgery, fevers, skin conditions, allergic conditions, in diseases of the blood, blood and blood formation, complications of pregnancy, children's diseases, and deficiency diseases.
   Nutrition in diseases of the respiratory system, gastro-intestinal system, endocrine system, circulatory system, genito-urinary system, nervous system, musculo-skeletal system, and of the metabolism and in metabolic balance studies.

   Practical work as shown below shall be included in the above syllabus. The following are to be the minimum periods of time in various sections of the principal training school and in the subsidiary training school:
1. Main kitchen in training school 12
2. Diet kitchen (to include ward clinics and visiting patients in wards) 12
3. Nurses' home food service unit, in training school 2
4. Babies' and children's medical ward 1
5. Adult wards (observation and assistance with feeding the helpless, etc.) 2
6. Administrative section (office) 2
7. Subsidiary training school 4
8. In addition each student shall:
   (i) Attend outpatients clinics for a minimum of 12 hours.
   (ii) Spend a minimum of 30 hours teaching nutrition and diet therapy, to include practical teaching in the Diet Department and also observation of teaching methods of formal lectures in nutrition.
   (iii) Make at least six field visits, including visits to other hospitals.
   (iv) Complete two case histories.
9. In addition each student may be given opportunities to observe the following:
   (i) Tube feeding (nasal, oesophageal, gastrostomy).
   (ii) Measurement and administration of insulin.
   (iii) Preparation of patient for barium meal.
   (iv) Preparation of patient for X-ray of gall-bladder.
   (v) Some of the routine analyses undertaken by the various sections of the laboratory.
   (vi) Administration in X-ray department of barium meal.

OUTLINE OF PROPOSED COURSE FOR THE DEGREE OF BACHELOR OF DIETETICS

Year 1 (Common to the home science and dietetic degree.)

Chemistry intermediate (as for B.Sc.).
Biology intermediate (as for B.Sc.).
Foods (as for B.H.Sc.).
Anatomy and histology (service course or half unit as for B.H.Sc.).

Note—Students apply at the end of year 1 to continue with the degree in dietetics. During the spring term, interested students would attend seminars on dietetics as a career, and visits to a hospital dietary department would be arranged.
Year 2

Physiology and biochemistry (as for B.H.Sc.).
Food chemistry (as for B.H.Sc.).
Human development—including an introduction to human behaviour (new course to be negotiated).
Statistical methods (service course or half unit).

Note—The present physiology for B.H.Sc. is taken with either medical or science advanced I students, and biochemistry with medical students. A service course in statistical methods for medical students is already available.

Year 3

It is proposed that the first two terms, commencing February (23 weeks) be spent in the university. The period September to November (15 weeks) would then be spent in the dietetic department of a training hospital gaining clinical and practical experience (associated training school).

University Section (February to August)
- Nutrition (section 1).
- Microbiology.
- Social medicine (man and his environment). (To include observation of health and welfare services in the community with a case study.)
- Dietetics (section 1).
  A. Food service management—introduction.
  B. Teaching methods, introduction to counselling.

Clinical Section I (September to November)

Organisation of course to be developed.
To include—orientation to hospital and dietary department and introduction to patient care; nutritional care of patients with introduction to requirements of patients on prescribed diets; administration of dietetic department.

Year 4

It is proposed that two periods—February to May (13 weeks) and September to November (7 weeks) be spent within the university. Late May to the end of August (15 weeks) would be spent in the dietetic department of a hospital training school (a different school from year 3).

University Section (February to May)
- Nutrition—to include therapeutic dietetics (section 2).
- Medicine—to include the study of diseases or conditions in which diet has either a causative or therapeutic role.
- Dietetics (section 2)—to continue.
  A. Food service management.
  B. Teaching methods, counselling, teaching practice.
- Research methodology—selection of topic for individual study.
University Section (September to November)
Continuation of above, including completion of individual investigation and report, seminars on topics related to administration, therapeutics, teaching and research.

Note—During this year it is proposed to co-ordinate the teaching in all subjects as closely as possible.

Clinical Section 2 (late May to late August)
To include nutritional care of patients with emphasis on clinical dietetics; administration of dietetic department; teaching of diet therapy and teaching of food service practices; individual investigation.
Final examinations—late November.

APPENDIX E

CONDITIONS OF EMPLOYMENT

A. Hospital Employed Dietitians

The Hospital Employment (Dietitians) Regulations allow for:

1. An 8-hour working day, working between 7 a.m. and 7 p.m. inclusive of 10-minute morning and afternoon tea breaks.
2. A meal break of 1 hour, but not counted as hours of work.
3. A normal working week of 40 hours.
4. Thirty-one days annual leave (reckoned ... in consecutive days including Saturdays and Sundays) which may be taken in one or more periods, but at least 2 weeks to be taken consecutively.
5. Additional 7 days annual leave with the approval of the Director-General of Health where a grade dietitian is regularly required to work more than 40 hours a week or where special circumstances exist.
6. Sick leave on full pay in accordance with length of service.
7. Issue and laundering of uniforms.
8. Payment of shoe and stocking allowance.
9. One month long-service leave after 20 years service.

The regulations do not permit the supply of free meals while on duty to a dietitian or student who lives out.

B. Public Health Dietitians

Conditions of employment as laid down in the Public Service Regulations.

1. A 7-hour 35-minute working day inclusive of 10-minute morning and afternoon tea breaks.
2. A meal break of 1 hour, but not counted as hours of work.
3. A normal working week of 38 hours.
4. Fifteen days annual leave, reckoned as working days.
6. Other holidays as determined by the State Services Commission.
7. One day recreation leave per year.
8. Sick leave on full pay in accordance with length of service.
9. Long-service leave of one month after 20 years service.

Dietitians in the Public Service are appointed to positions with a specified salary and promotional limits.

**Hospital Employed Dietitians Salary Scale and Conditions of Employment: Hospital Service Determination No. D.G. 47, Dietitians, 23 May 1973**

**Salary Scale (from 1 November, 1972)**

<table>
<thead>
<tr>
<th>Grade dietitians</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 9</td>
<td>$7,556/7,967</td>
</tr>
<tr>
<td>8</td>
<td>$7,145/7,556</td>
</tr>
<tr>
<td>7</td>
<td>$6,733/7,145</td>
</tr>
<tr>
<td>6</td>
<td>$6,374/6,733</td>
</tr>
<tr>
<td>5</td>
<td>$6,117/6,374</td>
</tr>
<tr>
<td>4</td>
<td>$5,834/6,117</td>
</tr>
<tr>
<td>3</td>
<td>$5,140/5,371/5,603/5,834</td>
</tr>
<tr>
<td>2</td>
<td>$4,626/4,790/4,965/5,140</td>
</tr>
<tr>
<td>1</td>
<td>$4,266/4,359/4,492/4,626</td>
</tr>
</tbody>
</table>

Progression within each grade shall be by automatic increment on the anniversary of appointment to the grade. Movement between the grades will be subject to grading committee determination.

<table>
<thead>
<tr>
<th>Staff dietitian:</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.H.Sc.</td>
<td>$4,214</td>
</tr>
<tr>
<td>Dip. H.Sc.</td>
<td>$4,009</td>
</tr>
<tr>
<td>On approval of Director-General of Health</td>
<td>$4,163</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietetic student:</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.H.Sc.</td>
<td>$3,362</td>
</tr>
<tr>
<td>Dip. H.Sc.</td>
<td>$3,154</td>
</tr>
<tr>
<td>Any other</td>
<td>$2,985</td>
</tr>
</tbody>
</table>

**Conditions of Employment—Revised conditions allow for:**

1. A normal working week of 40 hours.
2. An 8-hour working day, inclusive of 10-minute morning and afternoon tea breaks, worked where practicable between 7 a.m. and 7 p.m. on Monday to Friday inclusive.
3. Substitution of other regular hours of duty of not more than 8 per day, or 40 per week.
4. A meal break of 1 hour, not counted as hours of work.
5. Payment of overtime rates for time worked in excess of 8 hours in a day, Monday to Friday inclusive, and for all time other than penal time, worked on Saturday, Sunday, or whole holiday when such work has been properly authorised.
6. Payment of penal rates for time worked within a week on a Saturday or Sunday or a whole holiday.
7. Fifteen days annual leave, reckoned as working days, exclusive of whole holidays or substituted succeeding days.
8. Annual leave to be taken in one or more periods, but at least 10 days to be taken consecutively.
9. Sick leave on full pay in accordance with length of service.
10. Issue and laundering of uniforms.
11. Payment of shoe and stocking allowance.
12. One month long-service leave after 20 years service.

APPENDIX F

![Comparison between Home Science Students selecting Dietetic and Teaching Careers](image)

**FIG. 12:** COMPARISON BETWEEN HOME SCIENCE STUDENTS SELECTING DIETETIC AND TEACHING CAREERS
Figure 13: Dietitians' Years of Professional Employment

Percentage of group working

Registration Groups

- 1942 - 46
- 1947 - 51
- 1952 - 56
- 1957 - 61
- 1962 - 66

Years since Registration during which Dietitians Worked

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
TABLE 7—Number Years Professionally Employed in New Zealand

<table>
<thead>
<tr>
<th>Year Qualified</th>
<th>Number Replies</th>
<th>Average Years Service</th>
<th>Range Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1942-46</td>
<td>..</td>
<td>37</td>
<td>11.68</td>
</tr>
<tr>
<td>1947-51</td>
<td>..</td>
<td>40</td>
<td>7.60</td>
</tr>
<tr>
<td>1952-56</td>
<td>..</td>
<td>47</td>
<td>3.50</td>
</tr>
<tr>
<td>1957-61</td>
<td>..</td>
<td>46</td>
<td>3.60</td>
</tr>
<tr>
<td>1962-66</td>
<td>..</td>
<td>65</td>
<td>2.98</td>
</tr>
<tr>
<td>1967-71</td>
<td>..</td>
<td>68</td>
<td>1.46</td>
</tr>
<tr>
<td>Total</td>
<td>..</td>
<td>303</td>
<td>4.60</td>
</tr>
</tbody>
</table>

APPENDIX G

DEFINITIONS

A. Descriptive of Specialised Functions

1. Dietitian: Administrative—One who applies the principles of nutritional management to the organisation and control of food service for individuals and groups through menu planning, food preparation and service. May also teach student dietitians.

2. Dietitian: Therapeutic—One who applies the principles of nutrition to the planning, preparation and service of modified diets as prescribed by a medical practitioner for the treatment or maintenance of patients’ altered physiological conditions. May also teach nutrition and diet therapy to student nurses, student dietitians, professional colleagues and lay staff.

3. Dietitian: Teaching—One who plans, arranges, and participates in nutrition education programmes for student dietitians, student nurses and other staff.

4. Dietitian: Research—One who originates, plans, organises, and conducts research projects in applied nutrition and food service management, or who undertakes research in a team project.

5. Dietitian: Sole Charge—One who carries out the responsibilities listed for the above categories of dietitian, in a hospital in which she is the sole dietitian employed.

6. Dietitian: Public Health—One who acts as an advisor and consultant to diversified groups and individuals on a variety of aspects of food, nutrition, dietetics, and food service facilities, to the general public, Government departments, food processors, hospitals and other institutions.
7. Nutritionist—One who by training and profession is involved in the study and advancement of the science of nutrition.

B. Descriptive of Employment Designation

1. Dietitian in Charge—The principal or only dietitian employed in an institution.\(^7\)

2. First Assistant Dietitian—The dietitian who assists the dietitian in charge in the administration of the dietary department in an institution, and in the absence of the dietitian in charge, discharges her duties.\(^7\)

3. Second Assistant Dietitian—A dietitian who assists the dietitian in charge by being responsible to her for the administration of a section of the dietary department of an institution.\(^7\)

4. Staff Dietitian—A dietitian who does not hold one of the designations listed above, and whose salary is not subject to grading committee determination.

5. Student Dietitian—A person undergoing the course of training prescribed by regulations under the Dietitians Act 1950.\(^7\)

6. Principal Dietitian—The person in charge of the training of student dietitians at a principal training school.\(^3\)

7. Food Service Supervisor (Food Supervisor)—One who by qualification and/or successful work experience is engaged in the supervision and training of food service personnel in hospitals and other institutions; in food production and dining areas; may prepare food orders, staff rosters and maintain records under the supervision of a dietitian. In small institutions may be responsible for daily routine food service.

8. Dietary Assistant—One who by successful work experience is engaged in supervising and training food service employees in serving areas in hospitals and other institutions.

C. Other Definitions

1. Grading Committee—The Dietitians’ Salaries Grading Committee constituted under regulation 5 of the Hospital Employment (Dietitians) Regulations.\(^7\)

2. Principal Training School—A hospital for the time being approved by the Dietitians Board as a training school for dietitians in which the principal part of the course of training and instruction is given.\(^5\)

3. Subsidiary Training School—A hospital for the time being approved by the Dietitians Board as a training school for dietitians in which such limited period of training and instructions as may be determined by the board may be given.\(^5\)
Board of Health Report Series includes:

No. 1—Psychiatric Services in Public Hospitals in New Zealand (March 1960).
No. 2—Outpatient Services in Public Hospitals in New Zealand (March 1960).
No. 3—Services for the Deaf in New Zealand (Interim Report) (March 1961) (out of print).
No. 4—Medical Examination of Young Workers in New Zealand (March 1961).
No. 5—Provisional Grading of Public Water Supplies in New Zealand (April 1962).
No. 7—Employment of Dental Technicians in New Zealand (November 1962).
No. 8—Introduction in New Zealand of the Metric System in Pharmaceutical and Medical Practice (February 1963) (out of print).
No. 9—The Training and Employment of Health Inspectors in New Zealand (October 1963).
No. 10—An Evaluation of the Administration and Servicing of New Zealand Water-supply Undertakings (October 1964).
No. 11—Health Responsibilities of Local Government (Revised 1967).
No. 12—Hospital Dental Services (1965).
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No. 1—Report on Sterilisation Procedures.
No. 2—Resolutions and Decisions of the New Zealand Board of Health 1/1/57–31/12/67 (1968).
No. 4—Review of Maori Health (1971).
No. 5—Committee Reports for 1971.
No. 6—Solid Waste Disposal in New Zealand (1973).
No. 7—Committee Reports for 1972.
No. 8—Manual of Solid Waste Disposal in New Zealand.