Nutrition and patients: a doctor's responsibility

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Introduction

Nutritional care is often neglected in clinical practice, despite a huge increase in the prevalence of obesity as well as a growing awareness of the hazards of both over- and undernutrition during the past two decades. Recognition of these issues led to the establishment of a College working party to examine the role of doctors in nutritional care in both hospital and community, to look at the impact of malnutrition (over- and undernutrition) on disease processes and medical treatments, and at the potential for change in terms of both nutritional care and medical training. The purpose of the resulting report, *Nutrition and patients: a doctor's responsibility*[1], is to raise awareness of the fundamental importance of nutritional care in everyday clinical practice, and thereby improve patient care.

Although nutritional imbalance is a major issue in public health worldwide, the report focuses on clinical practice in western society, and it deals with principles rather than details of clinical care. It signals the urgency of addressing dietary factors in disease, particularly in a population that is not only becoming increasingly obese but also living to a greater age, with attendant ill health and nutritional vulnerability. Although it centres on the care of adult patients, the issues raised are just as relevant to infants and children.

The report is mainly addressed to doctors, but it strongly emphasises the need for a multidisciplinary approach, involving all the healthcare professionals involved in nutritional care. It also recognises the importance of preventive measures designed to affect diet in the community, thus reflecting local and central government initiatives to improve the national diet and reduce obesity.

Fundamental to any changes in current practice is the need to introduce adequate training in nutritional care. Up to now, teaching of nutrition to undergraduates in medical school has suffered from lack of co-ordination between the different disciplines involved and nutrition is therefore not recognised as a clinical entity. This has arisen because many clinical teachers themselves have had little or no training in the subject and so tend not to teach it. The result is that many doctors neglect clinical nutrition through lack of awareness of its potential benefits. The report identifies areas for change at undergraduate and postgraduate level, and in doctors' continuing professional education.

The size of the problem

Undernutrition

In comparison to the developing world, the number of people suffering from undernutrition in the UK is obviously small (around 2%). However, it is important that clinicians are aware of particularly vulnerable groups. For example, 12.4% of those aged 65 and over living in the community are at high or medium risk of undernutrition, rising to 20.4% of the same age group living in residential accommodation. Also, up to 40% of hospital admissions suffer from undernutrition[2,3].

Undernutrition can not only cause and contribute to illness, but is also likely to affect the course of medical treatment and length of recovery time. It can develop acutely or insidiously in patients as a complication of injury or a wide variety of disorders involving inflammation, disability or cancer. It can affect the function of every system of the body, producing adverse effects on physical and psychosocial well-being. Even when unaccompanied by disease, undernutrition tends to cause apathy, depression, self-neglect, hypochondriasis, loss of libido and deterioration in social interactions.

Overnutrition

Despite the clinical importance of undernutrition, overweight and obesity are now the major nutritional disorders affecting the developed world and are also emerging as significant problems in developing nations. This was recognised by the World Health Organization in 1997 when it stated: 'The epidemic projections for the next decade are so serious that public health action is urgently required'. Obesity, defined as a Body Mass Index (BMI) of more than 30, is now so prevalent that it deserves to be considered as a disease in its own right and managed, like any chronic disease, with a programme of detection and continued support and follow-up[4]. In England and Wales, the most recent health survey confirmed an increase in the prevalence of obesity in adults from 6% in men and 8% in women in 1980 to 17% of men and 21% of women in 1998[5].

Again, overweight can adversely affect the outcome of medical treatment as well as cause illness. Overweight and obesity are causally related to the development of a large number of chronic conditions that include type 2 diabetes mellitus, dyslipidaemias, hypertension, obstructive sleep apnoea, certain cancers, problems with mobility, reproductive disorders and depression.

What are the benefits to patients of good nutritional care?

A number of studies have demonstrated clinical benefits of nutritional supplementation in undernourished patients in terms of rate of complications, length of hospital stay, and mortality. Such clinical benefits from short-term nutritional support are evident within both community and hospital practice. Also, the appropriate use of enteral and parenteral nutrition can sustain life for patients who cannot take normal food for a period because of their illness, and can be life-saving when an inability to eat or absorb adequate nutrients is prolonged or permanent[6].

For those who are overweight or obese, a relatively modest weight loss of 5–10% can have considerable health benefits. These include reduced symptoms of angina, increases in exercise tolerance, impressive reductions in fasting blood glucose and insulin concentrations, clinically important reductions in blood pressure, improvement in sleep breathing and increased mobility[7].

Measures needed

In view of the seriousness of the effects of malnutrition, attention to the nutritional status of every patient should become a fundamental part of all clinical care. The following priorities need to be addressed:

- Simple measures to assess a patient's nutritional state should be recorded as occasion presents in primary care, at every hospital consultation, and regularly during a hospital admission or in residential care. When patients first present at hospital or in general practice, straightforward observation should be used to identify those who may be at nutritional risk. Where nutritional problems seem likely, screening tools can be used to assess whether nutritional help is needed and the type of management required. This information should be recorded and communicated to colleagues involved in the subsequent care of the patient, and the patient's nutritional state should be monitored and recorded thereafter.
- All doctors also need to be aware of the crucial role of other disciplines in nutritional care and to work closely with

Table 1. Recommendations from *Nutrition and patients: a doctor's responsibility*[1].

1. All doctors should be aware of nutritional problems and how to manage them. Every doctor should recognise that proper nutritional care is fundamental to good clinical practice.
2. A doctor should be responsible for ensuring that adequate information concerning nutritional status is documented in a patient's clinical record, and that appropriate action has been taken to deal with any nutritional problem.
3. Nutritional screening of all patients should be an integral part of clinical practice. Screening is a rapid process that will identify patients who are overnourished or undernourished. If an abnormality is detected, further assessment and a specific management policy should follow.
4. Doctors should encourage patients and their families to avoid becoming overweight and assist those who are overweight to lose weight. Similarly, doctors should play a key role in the detection and management of undernutrition.
5. Primary care, hospitals, nursing and residential homes should develop explicit protocols and standards to cover the whole process of nutritional management.
6. Hospitals should have a multidisciplinary nutrition steering group to establish policies for nutritional care. Doctors should be actively involved in this development. In addition, doctors should play an active role in a multidisciplinary support team for the care of patients with complicated undernutrition and/or patients requiring long-term tube feeds or parenteral nutrition.
7. Those responsible for clinical governance should identify nutrition as an important aspect of clinical practice that involves caterers and many healthcare disciplines. The inadequate provision of nutritional care has both medico-legal and ethical implications.
8. The process and outcomes of nutritional care should be part of regular clinical audit.
9. Medical undergraduate and continuing professional training programmes for doctors should include relevant aspects of clinical nutrition, along with consideration of the inter-relationships between under- and overnutrition, and illness and health. Undergraduate and postgraduate examinations should include both written and practical evaluations of nutritional knowledge.
10. The Royal College of Physicians should build on its capacity to educate, contribute to public debate and influence national policy by:
    - recognising and bringing together those with a special interest in nutrition
    - encouraging the development of knowledge about nutrition within the medical profession
    - acknowledging the importance of multiprofessional involvement for effective nutritional care
    - encouraging doctors to champion nutrition and nutritional care within NHS trusts.

nurses, dietitians, speech and language therapists and other health professionals.

- Hospital doctors, and doctors caring for patients in residential care, must make themselves familiar with the relevant aspects of food service to their patients and appreciate the importance of dietary intake; the particular needs of older patients cannot be emphasised too strongly.
- It is the doctor's responsibility to prescribe, when indicated, nutritional supplements and, if appropriate, arrange enteral tube or parenteral feeding. It is also essential that doctors in primary and secondary care communicate and collaborate when a patient is discharged from hospital but needs to continue nutritional treatment in the community. This is particularly important when artificial feeding is involved. Doctors should also be aware of their responsibilities about decisions on the ethical aspects of artificial nutrition, particularly when a patient is incompetent to make decisions due to illness[8].
- Finally, doctors with a special interest in nutrition should be actively involved in a hospital nutrition support team responsible for artificial nutrition and act as a member of a nutritional steering committee responsible for nutritional policy in an NHS trust.

The full recommendations of the working part report on the responsibilities of doctors in patients' nutritional care are shown in Table 1.

Nutritional care and clinical governance

Clinical governance is about assuring quality of care – making sure that patients are treated well, in every respect. It means seeing each healthcare experience through the eyes of the patient, and making changes to improve the way things are done. Nutritional care in every setting – whether primary or secondary care, residential care or nursing home – should be fully integrated into clinical programmes and developed within a framework of clinical governance[9].

There are several aspects of nutritional care that make it well suited to a clinical governance approach:

- The quality of food in hospital and nutrition are high on the list of patient and carer concerns.
- Nutrition is clearly linked to health, well-being and clinical recovery.
- There are simple measuring tools for assessing nutritional status and monitoring consumption.
- Making improvements can save resources in the longer term.
- A wide range of staff are involved in preparing and providing food.
- Many of the lessons learned can be generalised into other areas of care.

Management arrangements for coordinating nutritional care at trust level will inevitably vary from trust to trust, but every trust should establish a multidisciplinary coordinating committee (ie a nutrition steering group involving senior management, doctors, nurses, dietitians and pharmacists), led by a clinician specialising in nutritional care. The group should oversee hospital catering and all aspects of nutritional care for patients in hospital. The delivery and quality of food for patients in the community should be subject to similar scrutiny.

Education and training

Nutrition forms part of every medical discipline. Medical curricula contain a wealth of information relevant to diet and nutrition, but generally represent a classical approach through biochemistry and physiology. It remains uncommon for nutrition to be taught as metabolism at the whole body level which would enable doctors to understand how function is maintained in health and disturbed by disease. The need for improved medical undergraduate training in nutrition was the subject of a report in 1983 by a task force of the British Nutrition Foundation[10]. Although there have been moves towards providing an integrated course in clinical nutrition for undergraduates[11], many recently trained doctors still have an inadequate knowledge of the nutritional aspects of health promotion and disease treatment.

The clinical importance of a patient's nutritional care is also patchily addressed in general professional medical training. Its importance is identified within a number of specialist training curricula but a systematic and coherent approach across specialties is lacking and, importantly, the topic is not regularly assessed within professional examinations. Furthermore, nutrition and nutritional topics are seldom included in programmes of clinical development for doctors.

Nutritional care and the role of the Royal College of Physicians

The publication of this working party report[1] underlines the importance the College attaches to nutritional care within clinical practice. The College can play a significant part in ensuring that the report's recommendations are achieved, partly

Table 2. Measures taken by the College to improve nutritional care and training.

Strengthening of specialist skills in medical training:

- new nutrition support section in JCHMT revised gastroenterology curriculum.

Setting of standards in nutritional care

- eg guidance on management of overweight and obese patients with particular reference to drugs[12].

Support for improved nutritional care and training by

- College Committee on Nutrition, leading to publication of *Nutrition and patients: a doctor's responsibility*[1]
- Intercollegiate Group on Nutrition (with representatives from 11 of the medical Royal Colleges) leading to development of two courses for doctors:
  - (a) on general principles of human nutrition
  - (b) orientated towards specialist training in nutrition related to clinical practice.

by building on its capacity to teach, contribute to public debate and influence national policy. It can also recognise and bring together those with an interest in nutrition and encourage the development of knowledge about nutrition in medical training.

The College should additionally encourage close collaboration between medical and allied health professions in the delivery of nutritional care. This should be supported by advice from the College on standards of nutritional care in relation to clinical governance and public health, as well as support for the establishment of clinical nutrition as a subspecialty of an associated major specialty such as gastroenterology and diabetes. Measures already taken by the College to improve nutritional care and training are shown in Table 2.

The College takes seriously its responsibility to ensure the recommendations of the report are addressed – to do otherwise is not in the best interest of patients or society as a whole.

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