From the Editor

'Thousands starving in UK hospitals'

By all accounts a stay in a modern hospital is a hazardous venture. If one escapes acquired infection, starvation will almost certainly follow – or so we are repeatedly told. Sir Richard Bayliss noted that when he was a young doctor the average duration of a patient's stay in hospital was 55 days – time enough to restore adequate nutrition.[1] The average duration of stay has fallen dramatically over time and is now a little over five days for acute hospital admissions. This is only just sufficient time for rehydration and certainly too short for improving nutrition.

The claims of malnutrition in hospital must be examined with this perspective in mind. For most patients there is no possibility of improving their nutrition in such a short time frame. From the perspective of the nutrition team only a minority of patients are hospitalised for prolonged periods where support may be apt. Nutritional assessment, measurement of body mass index and appropriate treatment is certainly sensible for this group.

The safest and most palatable option to treat malnutrition is the use of attractively served nutritious food but the rates of correction are slow and measured in weeks or months. Supplementation of oral intake, using either nasogastric or enteral feeding, may be needed but response rates are still slow.

Intravenous parenteral feeding is expensive and its use carries a number of well-recognised risks. Response rates can be demonstrated within one week to 10 days but care has to be taken to distinguish between the benefits of the associated rehydration and the value of the intravenously administered calories themselves. This approach may be useful in the preoperative phase of the malnourished patient but must be balanced with the patient's extended hospital stay and the potential hazards of the treatment.

Which hospital patients suffer from malnutrition? For many it is the result of end-stage disease, particularly malignancy and advanced dementia, where active nutritional support would be inappropriate. Malnutrition is also a common problem among the elderly where social isolation and living alone may understandably diminish the energy and enthusiasm for shopping and cooking. This may be compounded by organic problems such as arthritis or the early stages of dementia. In these circumstances short-term intervention in a hospital setting is unlikely to achieve long-term benefits. A dispassionate look suggests that the problem of malnutrition in hospital patients needs to be addressed in only a minority of patients.

What is the origin of the clamour for wholesale action on malnutrition? Special interest groups might be keen to raise their own profile by calling to the public's attention the occasional patient whose malnutrition has been overlooked. Perhaps the clamour is a surrogate marker for the poor quality of hospital food in general. The allocated funding per day per patient is minimal and economic pressures to save even more money are ever present.

The provision of a light lunch instead of a full three course meal may sound attractive and sensible in theory but in practice the 'bowl of soup' served in a plastic beaker with a cling film-wrapped sandwich would deter all but the most desperate. Meals are often prepared in a distant kitchen and transported across the site. There is little time available for the ward-based staff to provide help and encouragement with meals. Many will be familiar with the wry smile when reading the results of a patient survey where a number report that they actually liked the hospital food!

Could a gradual mix of the NHS with the private sector, where hotel services are of a high order, exert a leavening effect? High standards of clinical care for patients have always been our priority. Perhaps this should be extended to include hotel services which for far too long have been the Cinderella of the NHS.

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Reference

1 Bayliss R. *In sickness and in health – a physician remembers.* Brighton: Book Guild Publishing, 2007.

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