Chapter One

Introduction

*Food changes into blood, blood into cells, cells change into energy which
changes up into life and since your lifestyle is imaginative, creative, loving,
energetic, serious, food is life.*
—Verta Mae Smart-Grosvenor, 1992, p. 296.

1.1   Introduction to the study

People eat food, not nutrients, and food itself is much more than just something to
eat. According to some authors (Murcott 1983; Lupton 1996; Santich 1996), the
definition of food, and what individuals consume as food, is as much determined by
social forces as by biological parameters. As a consequence of the multiple roles food
has in their lives, humans have a complex relationship with food. This complex
relationship with food has led Fischler (1988) to conclude that the foods individuals
choose to consume must be central to their sense of identity, since people are
constructed biologically, psychologically and socially by the foods they incorporate
in their diets. In Visser's (1986, p. 12) opinion, food is so important in the lives of
human beings that it 'shapes and expresses us even more definitively than our
furniture and houses'.

Hospitalisation disrupts most people's food praxis, either directly by different
mealtimes or the prescription of a modified diet, or indirectly by the inability or
failure of the institution to provide foods which satisfy the individual's
psychological and/or cultural needs. Issues such as compliance with dietary
modifications, and power relationships which are played out via hospital rules and

regulations can have a negative influence on the patient's sense of self. As food is central to sense of self, it should also follow that disruption of normal food praxis could consequently affect the patient's food consumption.

Affecting patients' food consumption can have a significant impact on their health. Malnutrition in hospital patients is a well-known problem, first given wide publicity by Bistrian et al. (1976) in the 1970s, and the phenomenon of worsening nutritional status as the length of the hospital stay increases has been well documented (Metz 1982; Askew et al. 1982). In Australian hospitals, the prevalence of malnutrition remains high and does not appear to be diminishing (Huq et al. 2005; Naylor et al. 1996; Zador & Truswell 1987). This phenomenon of worsening nutritional status during hospitalisation may well be related to the patients' experiences and perceptions of food in hospital which disrupt their normal food praxis compromise their food intake and, ultimately, affect their nutritional status. Although there are many studies related to the prevalence of hospital malnutrition and its effects on clinical outcomes, there are no studies which investigate the psychosocial aspects of food in hospitals in relationship to patients' food consumption.

This chapter is an introduction to the research study of 'Food in Hospitals: The Patients' Perspective'. This chapter provides the background to the study and describes the purpose, aims and significance of the study. As the researcher, I introduce myself to the reader, and my background and interest in the research topic are outlined. There are many different aspects to the study of food, and confining the research to those which are relevant to the topic was an extremely difficult task. Even deciding the relevance of some aspects of the study of food and nutrition to this particular study was difficult as I did not want to limit the study by including too little, nor confuse the outcomes by trying to include too much. The sociological

imagination, the theoretical framework chosen for this study, not only assisted me in clarifying which aspects of the study of food were relevant to the research topic but identified possible links and relationships within the research data, enabling me to provide a coherent explanation of the findings of the study. An introduction to the sociological imagination and the methodology used to guide the study are presented in this chapter. In addition, the scope of the study and key assumptions are identified. Finally, the chapter describes the organisation of the thesis itself.

1.2   Background to the study

Australia is a multicultural society. Since the conclusion of the Second World War there have been successive waves of foreign migration to Australia. For example, in one health service area in central Sydney, 40% of the total resident population was born overseas (Wen et al. 2003). Over 80% of those born overseas, or one-third of the total population of this health service area, are from non-Anglo-Celtic backgrounds (Wen et al. 2003). However, in Australian hospitals most menus are based on the traditional Anglo-Celtic food patterns of the first European settlers, and the times at which meals are served in the hospital are designed to fit in with hospital routines rather the patients' preferred eating times (Williams 1994; Mibey & Williams 2002). While most hospitals regularly survey patients for meal satisfaction, which generates a great deal of quantitative data, there is a dearth of studies exploring the personal experiences of individual patients related to food, hospitals and medical treatment, and the effects of hospital food-related practices on the individual.

According to Crotty (1988), the literature on food and institutionalised people is divided into two discrete sections. The larger body of this literature is concerned with the scientific aspects of nutrients, nutritional adequacy and malnutrition, while the literature concerned with the psychosocial aspects of meals and eating in

institutions is very sparse. Fischler (1988) believes that there are fundamental differences in the approach to food and food consumption between the empirical sciences, which include nutrition and medicine, and the social sciences. In Fischler's (1988) opinion, in the study of food and eating empirical science is inclined to regard social science mainly as an aid to explaining and rationalising food praxis which determines the individual's 'wants', rather than his or her physiological 'needs' which are defined by science. Furthermore, in the opinion of Heldke (1992), the western epistemological tradition, in which discussions of theory are also commonly structured as scientific models, has never held food and cooking in high regard. This author believes that cooking, as a traditional female activity, is viewed by western philosophers as irrelevant, mainly because cooking, child rearing and other such women's activities do not fit into any philosophical category. This is a view shared by Gregory (1995), a sociologist interested in the study of food-related behaviour. Gregory (1995) also believes that food and eating are associated with the female domestic world and are such fundamental activities that they have never been considered worthy of serious academic attention.

The western medical model is based on the concept that there is a fundamental division of mind and body. According to some authors (Davis & George 1993; Lupton 1994b), modern medical practice tends to concentrate on the functions of the body and to disregard the social, environmental and psychological aspects of illness. This concentration on the physical aspects of illness has been reinforced by advances in medical technology. Significant discoveries in biology in the nineteenth century revealed the structure of the human body and, according to Lupton (1994b), once Pasteur had demonstrated the correlation between bacteria and disease, illness was confirmed as being the result of either an anatomical or biochemical abnormality and therefore independent of consciousness. Following this discovery the focus of

medical attention became the disease rather than the patient. As a result, scientifically determined needs are emphasised to the detriment of the individual's wants (Capra 1983).

Nutrition is both an art and a science, as it has traditionally encompassed the psychosocial as well as the empirical. However, according to Duff (1990) nutrition has followed the precedent set by the medical model by becoming increasingly focused on scientific perspectives and less attuned to its psychosocial dimensions. In hospitals, attention is paid to the nutritional adequacy and microbiological safety of the meals, while the individual social and psychological needs of patients with regard to food tend to be a secondary concern. However, in the late 1980s, the New South Wales Department of Health (NSWDOH) mandated that these needs be addressed. The NSWDOH requires hospitals to provide meals which are acceptable to patients in terms of type, quality, quantity and variety of foods offered, as well as in temperature and standards of presentation (NSW Department of Health 1989). The meals served to hospital patients must therefore meet patients' psychological and sociological needs as well as their physiological needs. However, with such a multicultural population it is difficult to meet the psychosocial needs of all patients and the lack of research and knowledge in this area further compounds the problem.

The focus on the scientific aspects of nutritional care of patients causes clinicians to undervalue the psychosocial aspects of nutrition (Duff 1990). For patients, however, food is one of the few familiar aspects of the hospital environment. By understanding the relative importance of food to patients in hospital, and how the hospital admission affects normal food habits, the experience of being in hospital may be improved for patients, and their nutritional status during the admission may also be either maintained or improved as a consequence.

1.3 Purpose and aims of the study

The purpose of this study is to explore the psychosocial aspects of food in hospital from the perspective of the patients, and to determine whether the psychosocial aspects of food are an important determinant in the patients' consumption of hospital food. Although hospital malnutrition has been recognised since the 1970s (Bistrian et al. 1976), its prevalence is not diminishing (Huq et al. 2005). The motivation for this study is the desire to find out what determines the food preferences of hospital patients, and whether individual food preferences, and the experiences patients have in hospital, affect their eating. Whether patients eat while they are in hospital will ultimately affect their nutritional status. The answers to these questions should provide important information for improving patients' food intake in hospital.

The aims of this study are threefold. The first aim is to explore the effect that hospitalisation has on the normal food praxis of individuals. The second aim is to describe the experience of food and eating in hospital from the patients' perspectives, and the third, and final aim is to determine the ways in which healthcare practice and food culture interact and the effect this has on patients' food consumption in hospital. The ultimate objective of the research project is to obtain valuable information on the basis of which recommendations can be made for improving patients' food-related experiences in hospital.

In order to realise the study aims the following three research questions were formulated:

1. What determines the food preferences of hospital patients?
2. What are the food experiences of patients in hospital?
3. Are patients' food preferences important in determining what people eat in hospital?

As food is a pervasive social phenomenon it is impossible to study food holistically from the viewpoint of any single discipline, so this study was informed by the literature from many disciplines including anthropology, food service management, geography, management, nursing, nutrition, psychology, philosophy, physiology and sociology. Such a cross-disciplinary approach in food studies has been referred to by Brown and Mussell (1984, p. 7, quoted in Bell & Valentine 1997, p. 4) as a nexus study, as 'food is posited as a nexus for the convergence of traditional disciplinary methods and insights'. I was confident that fresh insights into traditional perspectives and assumptions about patients and hospital food would result from such a cross-disciplinary approach.

1.4   Researcher's perspective

Roberts and Taylor (2002) are of the opinion that disclosing the researcher's perspective assists in equalising the power differential between the researcher and the participants. This was a particular concern in this research study where the participants are also patients who are, according to the literature (Coe 1978; Capra 1983; Lupton 1994b), already disempowered. It was essential that the study findings reflect the true opinions of the participants, and that the participants would feel able to freely discuss their experiences and express their criticisms and concerns. It was also important that I was cognisant that my own perspective is that of a clinician and that the patients' opinions of food and food-related practices in hospitals may not align with my own opinions.

I am a dietitian with many years experience in clinical dietetics. My role at the time of this study was Director of Nutrition and Dietetics for an area health service in Sydney. In this role I am responsible for the staff and clinical service delivery activities in the nutrition and dietetics departments in two large teaching hospitals

and one smaller metropolitan hospital. I have line responsibility for approximately sixty staff, including dietitians and diet technicians. Although I do not have direct responsibility for the food services in these hospitals, my role is intimately involved with the provision of food to the patients in these hospitals. In order to achieve this I work in close cooperation with the Director of Food Services for the area health service to provide meals which are nutritious, safe, culturally appropriate and well accepted by the patients.

As part of my role as a dietitian manager, and because of a lifelong commitment to education, I am involved in the teaching and training of student dietitians by providing formal lectures at a university training school and internships within the nutrition departments under my aegis. I am also committed to the ongoing education of staff and I encourage staff to undertake research as part of their clinical practice.

My interest in food extends far beyond its nutritional implications, and I actively pursue my interests in good food, good wine and good cooking outside of work. Because food is such an important aspect of my life I believe that food and eating should be pleasurable whatever the situation, hence my interest in improving mealtime experiences for hospital patients, as well as optimising their nutrition.

As my experience extends over many years, I have seen first hand the gradual shift in focus away from, and the inability to cater to, the personal food preferences of patients. In the days when I was a junior dietitian it was possible to have a boiled egg or an omelette, or other small tempting dishes, cooked individually for patients who were very ill or eating poorly. In recent times, budgetary constraints, staff reductions and the introduction of less flexible food service systems have largely removed the capacity to provide food items which are not on the menu of the day.

Dietitians now turn to commercial, nutritionally complete supplements as the universal solution to patients' poor food intake, and I believe that in doing so the nurturing aspect of the nutritional care of patients, or the art of nutrition, has been diminished as a consequence.

1.5 Significance of the study

The findings from this study will serve a number of purposes. First, on a practical level, the study findings will clarify the relationship between the patients' food-related experiences in hospital, their food consumption and the potential impact of these factors on patients' ongoing nutritional status whilst in hospital. As a result, recommendations for policy and improvements to clinical practice will be made.

In both the United Kingdom (UK) and Europe hospital malnutrition has been targeted as an area requiring immediate and drastic improvement (Allison 1999; Beck et al. 2001). The approach which has been taken is to highlight the deficiencies in hospital food provision and to focus attention on the quality and nutritional adequacy of the food, and the planning and management of the patients' nutritional care (Allison 1999; Beck et al. 2001). In this approach, the psychosocial aspects of food and nutrition in hospitals are not addressed. Drawing attention to this overlooked area of patient nutritional care will provide fresh insights and a different perspective on the provision of food to patients, and will add to the body of literature concerned with the psychosocial aspects of nutrition.

Finally, in giving the patients' perspective of food in hospitals, this study will give patients a voice. The study findings will provide insights for clinicians on the importance and impact food has for patients. Lupton (1994b) has described the different perspectives of clinicians and patients with regard to hospitalisation, and cites examples of clinicians who have had the personal experience of being a patient,

after which many changed the way they practise medicine. I hope to bring an awareness of the perspectives of patients to clinicians by recounting the stories of patients' food experiences in hospital so that dietitians, nurses, doctors and others will have an understanding of what it is like to be a patient. It is hoped that these clinicians will then modify their practice to make the nutritional care of their patients more personal and individual.

1.6   Theoretical framework and methodology

According to Germov and Williams (1999 p. 3) 'a sociological explanation of food habits examines the role played by the underlying social environment in which food is produced and consumed'. As this research is aimed at determining the relationship between individuals, food praxis and society, which in this case is the hospital, a sociological theoretical framework and qualitative research design have been chosen as the most appropriate approach. The framework used in this research study is one proposed by the sociologist C. Wright Mills (1959) in his book *The Sociological Imagination*. Mills (1959) characterised the sociological imagination as the capacity to shift from the political perspective to the psychological perspective, and to see the relationship between the two. More simply, the sociological imagination is the ability to range from extremely impersonal situations to the most intimate aspects of the person, and to link them in the context of a particular phenomenon. This theoretical framework was used to facilitate an understanding of the personal realities of the participants in the context of the social realities of the hospital.

Willis (1999) developed Wright's (1959) concept of the sociological imagination into a template which can be applied to any sociological problem. This template requires the researcher to view the problem from four different perspectives: the historical, the cultural, the structural and the critical. In Willis' opinion a sociological

explanation is incomplete unless these four dimensions are taken into consideration. These perspectives will be further described in Chapter Two.

Germov and Williams (1999) suggest that Willis' (1999) sociological imagination template can be applied to the study of food by posing the following four questions, each of which relates to one perspective of the sociological imagination:

- When did you first eat that way? (historical perspective)
- With whom and why? (cultural perspective)
- In what setting? (structural perspective)
- Why has or hasn't it changed? (critical perspective)

Although different research questions were used to guide this study, these four questions were useful in locating various aspects of the study of food and food-related behaviour in relation to the appropriate perspective of the theoretical framework. In accordance with Crookes and Davies' (1998) recommendation, the theoretical framework of this study was used to guide the development of the study aims, the literature review, the interview schedule and the classification and interpretation of the study findings.

The data for this study was obtained using semi-structured in-depth interviews and was analysed using a thematic analysis technique. This technique was chosen because, according to Braun and Clarke (2006), thematic analysis can both reflect reality and unravel the surface of reality. Thematic analysis describes patterns in the data and, according to Willis (1999), if individuals have similar experiences, and a social pattern emerges, it suggests that there is a common foundation to these experiences. While only a small sample of patients from a small proportion of hospitals in NSW were included in the study, I believed that a pattern of similar experiences among the respondents would indicate both the need for improvement and the need for further research into this area.

1.7 Scope and key assumption

Thirty one respondents who had admissions in 22 hospitals in NSW were included in this study. Given the small sample size and the small number of hospitals where the respondents had their admissions relative to the number of hospitals in NSW, it will not be possible to generalise the findings of this study to all hospitals. However, generalising the results was not the purpose of this study which sought instead to obtain rich, valuable data on which recommendations for improving patients' food-related experiences in hospital can be based.

A key assumption of this study is that patients' food praxis is disrupted in hospital and that this effects their food consumption. This perceived problem was based on my experience as a clinical dietitian, anecdotal evidence from colleagues and evidence of the decline in hospital patients' nutritional status from the literature (Metz 1982; Askew et al. 1982).

1.8 Organisation of the thesis

This thesis is arranged in six chapters. A brief description of the content of each chapter follows. Chapter One has introduced the research study and provided the background for the study. The purpose, aims, and research questions of the study have been presented, and the significance of the study was discussed. The theoretical framework and methodology employed in the research, as well as the scope of the study and major key assumption were also outlined in Chapter One.

In Chapter Two the relevant literature related to the research is critically reviewed. The literature review is divided into four sections, each section corresponding with one of the four perspectives of the sociological imagination framework utilised in the study. The first section of the literature review relates to

the historical perspective of the sociological imagination. In this section the determinants of personal food praxis are reviewed, such as family influences, leaving home, marriage and cohabitation, and food and identity, and the concept of 'the proper meal' is introduced.

The second section of the literature review corresponds with the cultural perspective of the sociological imagination. In this section the cultural determinants of food praxis are reviewed. These include traditional food practices in illness, and the effects of the introduction of new cuisines as a result of migration, seen from the perspectives of the host nation and the migrants themselves.

In the third section of Chapter Two, literature related to the structural perspective of the sociological imagination is reviewed. In this section, aspects of hospital food service systems such as menus, meal times, food quality and nursing practices are explored. Power relationships in the hospital setting, and the effect these have on patients, are also reviewed.

The final section of the literature review corresponds with the critical perspective of the sociological imagination. When applied to the study of food praxis, the critical perspective is concerned with public health nutrition education and the model of healthcare delivery in Australia. In addition, the phenomenon of hospital malnutrition and its impact on patients is reviewed in this section. In summary, Chapter Two is designed to provide the reader with an understanding of the many factors which are involved in personal eating praxis, and the influences which affect what patients eat when they are in hospital.

Chapter Three presents a justification for the research paradigm used in this study, as well as evidence for the congruency of the research approach with the research topic. A qualitative approach using semi-structured, in-depth interviews

and thematic analysis was the chosen method for this study, and the merits of this research design in providing rich and meaningful data are discussed. This chapter also provides a description of the selection and recruitment of the participants, as well as a description of the method of data collection and the development of the interview schedule. In addition, a discussion of the rigour and trustworthiness of the study is presented. Finally, the ethical issues and methodological limitations which are germane to this study are identified and discussed.

The results of the study are presented in Chapters Four and Five. Throughout Chapters Four and Five the findings of this research are linked to both the literature and the theoretical framework of the research study. In both chapters the results are presented as themes and sub-themes, and the major findings are presented for each theme and sub-theme. Chapter Four contains a detailed justification of the data analysis technique, as well as the first section of the results. The study findings in Chapter Four are related to the historical, cultural and critical perspectives of the sociological imagination framework. This chapter commences with a justification for the data analysis techniques, followed by a demographic profile of the respondents and the study findings which are accompanied by quotes from the respondents. Chapter Five continues with the findings of the research which are related to the structural perspective of the theoretical framework.

The thesis concludes with Chapter Six which provides a discussion of the conclusions and implications of the study. The study findings are presented with six major conclusions which demonstrate the extent of the changes in food praxis in the respondents during their lifetimes, and the implications this has for the respondents' acceptance, and consumption, of hospital food. The study findings also demonstrate the impact that structural issues such as hospital food service practices and medical practices have on patients and their ability to eat while in hospital. The study

findings reported in Chapter Five are further discussed in the context of the hierarchical structure of acute care hospitals and the biomechanical model of medicine. Finally, the implications of the study findings for policy and practice are identified and recommendations for further research related to food in hospitals are made.

1.9 Conclusion

This chapter has laid the foundations for this thesis by introducing the research topic. The primary purpose of the study was to provide insights into the factors which influence patients' meal consumption in hospital, with the goal of improving patients' mealtime experiences, food intake and ultimately, nutritional status. The theoretical framework and the methodology were introduced and an overview of each chapter was provided. The following chapter presents a review of the literature relevant to the topic.

Literature Review

The act of swallowing divides nutrition's two 'cultures'. The post-swallowing world of biology, physiology, biochemistry and pathology and the pre-swallowing domain of behaviour, culture, society and experience.
—Patricia Crotty 1993, p. 109.

2.1   Introduction

As indicated in Chapter One, this research study utilised the concept of the 'sociological imagination', first proposed by Charles Wright Mills in 1959 and later developed by Evan Willis (1995) into a framework that views sociological problems from four different perspectives. These four perspectives (the historical, the cultural, the structural and the critical) are all aspects of the phenomenon which impact on the individual, who remains central to the problem at all times. The sociological imagination distinguishes between personal problems, which are the domain of individuals, and public issues, which occur in a broader context and are related to the way society and its social institutions are organised (Willis, 1995).

In this research study, the first of the four perspectives of the sociological imagination, the *historical* perspective, looks at the personal history of the individual and the determinants of his or her personal food choices. It also places the individual in the context of the time in which he or she exists. The *cultural* perspective refers to those aspects which are either learned or symbolic, such as language and ways of life (Willis 1995). The cultural perspective is an important element of this study as food praxis is culturally determined. The *structural* perspective attempts to answer questions about the way society is organised that

would explain the subject of interest and how the structure of society might explain the behaviour of its individual members (Willis 1995). There is a difference between agency and structure, that is, whether the actions of human beings create social structure or whether social structure constrains and creates the actions of individuals (Willis 1995), and this difference should be recognised. The *critical* perspective is a critique of the existing social world, in this case the effect of Australian public health nutrition policy on the individual's food praxis, the biomedical model of healthcare and the phenomenon of hospital malnutrition. The critical perspective is concerned not only with *what is* but also *with how it could be different* and *what might be* (Willis 1995).

Germov and Williams (1999, p.5) suggest that when applying the sociological imagination template to the study of food praxis the following questions are posed:
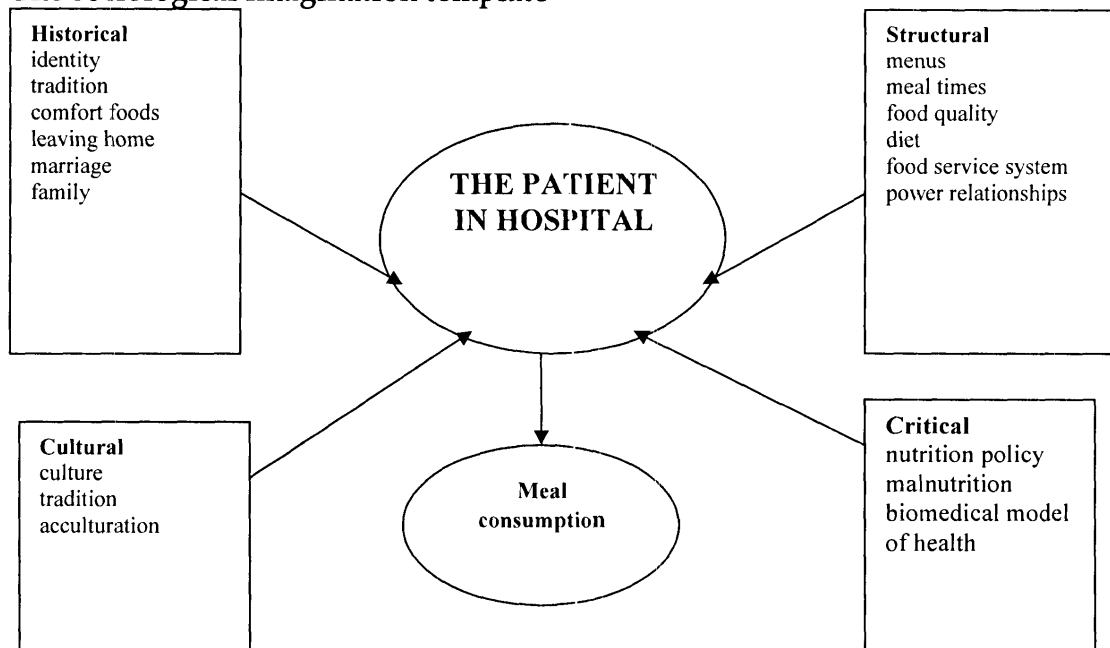
- **Historical:** when did you first eat that way?
- **Cultural:** with whom and why?
- **Structural:** in what setting?
- **Critical:** why has or hasn't it changed?

Figure 2.1 (page 18) illustrates the way the four dimensions of the sociological imagination were applied to this research study.

Germov and Williams (1999) believe that, while the sociological imagination template is useful in simplifying the process of sociological analysis, the four perspectives of the sociological imagination are interdependent and reinforce each other. This means that there can be considerable overlap between the perspectives, which may sometimes make it difficult to differentiate them from each other. The use of the sociological imagination framework, however, not only simplifies the analysis of the research data but facilitates a holistic view of the problem. In this research study the patients' personal food preferences are linked with their

individual experiences of food during the hospital admission and with the broader context of the production and serving of meals in the hospital environment.

Figure 2.1
The sociological imagination template

Historical		Structural
identity		menus
tradition		meal times
comfort foods		food quality
leaving home	**THE PATIENT**	diet
marriage	**IN HOSPITAL**	food service system
family		power relationships

Cultural
culture
tradition
acculturation

Meal consumption

Critical
nutrition policy
malnutrition
biomedical model
of health

2.1.1 The purpose of the literature review

A literature review, or overview of the literature in the general topic area of the research, is essential to research in order to determine what other researchers have found, and also to make the researcher aware of concepts relevant to the research findings. The literature review also places the relevant literature within the context of the research study. Qualitative research differs from quantitative studies with respect to the role of the literature review (Holloway 1997) and there are differing opinions as to when in the research process the literature review should occur. Grbich (1999b) is of the opinion that a review of all potentially relevant literature should be undertaken once the broad parameters of the study have been defined, although this author does not believe it necessary to make an exhaustive search of

all the literature related to the topic and then critically analyse it, as in quantitative studies. One potential disadvantage of early intensive reading of the literature is that it can 'narrow the analytic field of vision', leading the researcher to overlook important aspects of the analysis (Braun & Clarke 2006. p. 86). Holloway (1997), on the other hand, believes it is useful to the research endeavour to perform a literature review consisting of both classic studies and the most recent research, and to be informed of methodological approaches used in these studies before the research is undertaken. According to Braun and Clarke (2006) this could enhance the researcher's sensitivity to the more subtle features of the data. In accordance with Holloway's (1997) advice, the literature review for this study was undertaken prior to the research as the researcher believed that, given the many and varied factors which are related to food praxis, and particularly food praxis in the hospital setting, it was important to be aware of concepts which could be easily overlooked, as it was difficult to determine which factors needed to be addressed when planning this research study.

In the case of this research study, the literature pertaining to many different fields of study such as food services management, food technology, geography, medicine, nursing, nutrition and dietetics, philosophy, physiology, psychology and sociology were accessed, all of which employed many different research designs and conceptual frameworks. The literature review highlighted considerable gaps in the literature related to the non-scientific aspects of food in hospitals, with very little current research conducted in this area.

Food habits, and the foods which are eaten, are highly dependant on culture and context, so the literature has been drawn, where possible, from Australian sources, with the exception of seminal works and areas where the national literature is sparse. Crotty (1988) observed that the literature on food and institutionalised

people is divided into two sections: that which is concerned with nutrients, nutritional adequacy and malnutrition, and that which is concerned with meals and eating, with very little overlap between these two divisions. While there is an abundance of research literature concerned with nutrient requirements, the nutritional value of food, and with hospital malnutrition, there is a very small body of work related to mealtimes and the eating behaviour of people in institutions. Beardsworth and Keil (1992) support this, and believe that the social and cultural dimensions of food and eating have only relatively recently become a subject of interest to the social sciences. For some of the topics explored in the literature review there is a paucity of research-based publications and, although there are many articles published about food and nutrition in the popular press and in food service trade magazines, it was imperative that the literature review be confined to texts and research studies published in peer reviewed journals. For some of the topics only one or two relevant research studies were found, which were not very recent. For example, Habeeb's (1973) study has been cited here, even though it was conducted more than thirty years ago, as it is similar to this research study in that it is a qualitative study which yielded important information about the relationship between food, eating and illness in hospitalised patients.

2.1.2   Identification of the literature and modes of access

The literature review was conducted using both electronic and manual means. The primary source of relevant journal articles was via an electronic search of the literature using the Ovid search engine to perform searches of the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL) and MEDical Literature Analysis and Retrieval System onLINE (MEDLINE). Other search engines such as ProQuest, Emerald, ISI Web of Knowledge, Yahoo and Google were also employed. Many key words were used both singly and in

combination for the searches and these included: acculturation, comfort foods, culture, disease, dysgeusia, food and cohabitation, food and families, food habits, food for sick people, food safety, food service, foodborne disease, folk remedies, hospital menus, hospital, hospital mealtimes, institutions, patient, patient satisfaction, malnutrition and power in hospitals. In addition, a secondary search was conducted using the same electronic databases, but using the names of key authors identified from the primary search.

Key textbooks and journal articles were traced using library catalogues. Appropriate references cited in other related journal articles were also used as secondary sources to augment the body of literature, especially in areas where the research literature was scant. Finally, an extensive collection of nutrition journals was available in my workplace and these were searched manually for relevant articles.

2.1.3   Organisation of the literature review

In this chapter the literature is arranged in four sections corresponding to the four different perspectives of the sociological imagination framework in order to establish the context of the respondents' experiences of food in hospitals. The historical perspective in this research study presents the various factors which determine personal food preferences and food choices. It includes the influence of family food traditions and looks at the factors which may change an individual's food habits during the course of a lifetime. The cultural perspective, in this context, includes the influences of ethnic and community food patterns and what is considered to be edible and/or appropriate food for sick people. The structural perspective is concerned with organisational factors such as hospital food service systems. In this study, this includes the processes of preparing and serving food to

hospital patients and factors such as dietary restrictions, ward routines and power relationships within the hospital which may impact on the patient's enjoyment and consumption of meals in hospital. Finally, the critical perspective examines Australian public health nutrition policy and the effect it has on the food praxis of individuals, the biomedical model of healthcare in western society and the phenomenon of hospital malnutrition.

These four perspectives are important in gaining an understanding of the factors that are instrumental in determining what patients eat in hospital.

2.2 Food and the self: The historical perspective

The first section of the literature review looks at the *historical* perspective, that is, the personal history of the individual and also the context of the era in which the individual lives. This review discusses the factors which determine the way each individual eats, such as personal tastes and family food patterns, the events which influence changes in the food praxis of individuals such as leaving home and beginning to live with a partner. The role that comfort foods play in illness is also explored.

2.2.1 Food and identity

Food is perhaps the most important driving force in human existence. It not only provides the nutrition which is essential for survival and the maintenance of good health, but it also satisfies a number of important social and psychological needs (Crotty 1995). The foods which contain the nutrients necessary for biological survival, however, must themselves survive a complex set of social forces before ingestion occurs (Khare 1980). Food has been described as a 'liminal substance' as it acts as a bridge between culture and nature, between the outside and the inside, where the mouth is the portal to the body (Atkinson 1983). Having made the

decision to swallow, the person begins the process of transforming the exterior world into the interior world of the body, literally *incorporating* the food which has been eaten. As a result, a person is not only constructed biologically by the food he or she consumes, but is also socially and psychologically constructed in the choice of food and by the manner in which the food is eaten (Fischler 1988).

Fischler (1988) contends that food is central to our sense of identity which is not only linked to organic constituents of food but, more importantly, to its symbolic meaning (Lupton 1994a). Keane and Willetts (1994, p. 16) describe food as 'a self-referent part of the repertoire from which personal identity is forged' and assert that 'changing one's diet can effectively redefine the self'. Warde (1994b) believes that people also define themselves via the messages transmitted through the goods they choose to consume. What we choose to eat not only makes a statement about who we are and what we like but also about our origins. We learn to eat the way we eat in early childhood (Fischler 1988) and the way we learn to eat in childhood determines, to a large extent, the way we eat for the rest of our lives (Wansink et al. 2003).

2.2.2 Personal food choices

Hunger and taste are not only physiological phenomena but also products of the sociocultural environment into which we are born (Lupton 1996). While hunger is a basic drive which, in normal circumstances, forces humans to seek and consume food, the taste of the food is the basis of acceptance or rejection of any particular food item. The choice of the food an individual eats, and eats at any given time, also has a sociological basis. Lupton (1996, p.6) expresses it succinctly when she writes 'the physiological dimension is strongly encoded and inextricably entwined with the symbolic'. In societies where food is plentiful and there is an abundance of choice,

the reasons people choose the particular foods they eat include hunger (both physiological and psychological), pleasure, comfort, sociability and communion (Santich 1996).

Figure 2.2 below pictorially represents the factors which Santich (1996) believes influence choice of food.

Figure 2.2
Determinants of food choice
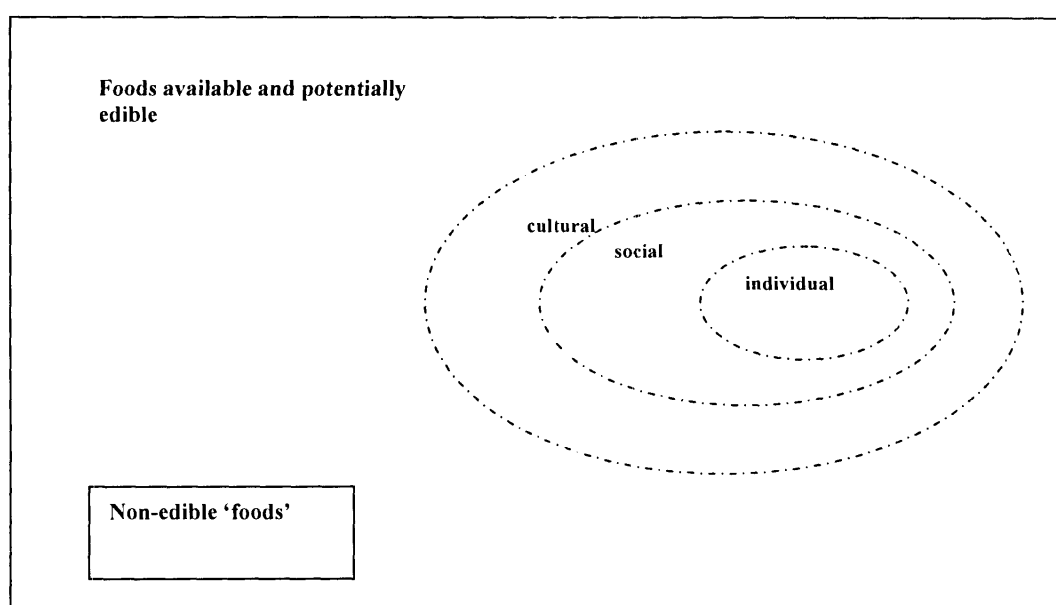
Adapted from Santich 1996, p. 39

This schema involves a series of filters which are successively applied to the total availability of all plant and animal products. What a person eats reflects individual preferences within what is socially and culturally appropriate. From the range of potential foods, things which are dangerous, inedible or not fit for consumption are rejected. Of the edible foods which remain, the first filter operates at a cultural level, proscribing foods such as pork for Jews and Muslims, beef for Hindus, ants and witchetty grubs for non-Aboriginal Australians and so forth. This filter allows only foods which are acceptable to the culture to pass through. The

second, social screen operates for sub-groups within a culture such as vegetarians and vegans, and eliminates unacceptable foods such as meat and/or animal products for these groups. A final, and individual, filter operates for each person, screening out the particular foods that person has learned to dislike from past experience. Only what is deemed edible for that individual will pass this filter. Thus it can be seen that what a person eats is a reflection of personal predilections within what is socially and culturally acceptable (Santich 1996).

Stewart (1981) explains personal predilections in food choice using the theory of Personal Constructs, which was conceived by Kelly and further developed by others such as Bannister and Fransella (Stewart 1988). Using this framework Stewart (1981) seeks to elucidate the reasons an individual will select particular foods in particular situations, and the reasons one person will respond differently from another person in the same situation. The premise of Personal Construct Theory is that foods have no intrinsic meaning aside from those which are ascribed to them by individuals, and that the choice of food by an individual is a personal event, an act of acceptance or rejection, which is based on relationships intrinsic to that person and is unrelated to the outside world. The 'meaning' of a food is very different between individuals and is the result of personal experience, the individual recognising the food and either seeking to replicate the experience associated with that particular food, or rejecting the food on the basis of past unpleasant associations. Stewart (1988) believes that this concept of the meaning of foods explains idiosyncrasies in food choices and why food choices may change in differing contexts, for example, why porridge is acceptable as a breakfast food but is not generally acceptable at other meals, or why the same food evokes different responses at different times of the day in the same person.

2.2.3 Comfort foods

Many people have comfort foods which they like to consume during periods of stress. Comfort foods are foods which evoke a psychologically comfortable and pleasurable state for a person (Wansink et al. 2003). There is some physiological basis to comfort foods as the body releases trace amounts of opiates in response to their consumption, elevating both mood and satisfaction while at the same time reinforcing a preference for foods which evoke these feelings (Wansink et al. 2003). Many preferred comfort foods have their origins in childhood experiences which can be critical in forming life long food preferences and habits (Wansink et al. 2003). When people are in highly stressful situations, such as hospitalisation, familiar foods are important as they represent comfort and security. Milk, as a food of early childhood, is a comfort food for many people (Fieldhouse 1995). Consumption of comfort foods is also gender dependent. Wansink et al. (2003) surveyed 1005 randomly selected North Americans by telephone. Using a five point hedonic scale, the subjects were asked to rate the extent to which they regarded a series of foods as comfort foods. They found that males tended to prefer warm, hearty, meal-related foods such as steak, casseroles and soup, while females preferred non-meal-related comfort foods such as chocolate and ice cream (Wansink et al. 2003).

In an Australian study of the food preferences of inpatients in a large Australian teaching hospital, Kennewell and Kokkinakos (2001) found statistically significant gender differences in food preferences. Five hundred and twenty three inpatients were asked to indicate in a questionnaire how much they either liked or disliked 223 food items using a nine-point hedonic scale. It was found that men preferred red meat and poultry while women preferred vegetables, salads and fruit. An earlier study in the United Kingdom, in which data from the British Health and Lifestyle

Surveys of 1984-85 and 1992 were analysed, also found that women had a preference for salads and fruit (Tomlinson 1998).

While many cultures have foods which are traditionally served during periods of illness, Habeeb (1973) found in her observational study of inpatients in a US hospital that individual patients' conceptions of the foods appropriate to the treatment of illness were quite personal, and varied considerably between individuals. The provision of what the patient considered to be correct foods, whether correct by dietary prescription or by the patient's personal definition, was seen as symbolic of care. Habeeb (1973) found that the equation of food and care was so strong that even relative strangers who were instrumental in procuring a desired food item for her respondents were perceived as being caring. The physical links between nurturing and nutrition are well established, but there are also links between food and psychological well-being. In a study of 1,597 consumers' opinions of hospital food services in five US Army medical facilities, Maller et al. (1980) found that there were significant correlations between ratings of the food and the food service and patient satisfaction with medical care. These authors believe these findings indicate the extent to which food is entwined with more general feelings and attitudes, in this case, caring. Lupton (1996) is of the opinion that, in the context of the family, food is a potent sign of love and duty, and that food as a gift retains those connotations. Lupton (1996, p. 47) believes that a gift of food 'relates more to evidence of care, a demonstration of affection, than does an actual commodity, wrapped and presented to an individual by the giver'.

Therefore, the availability of familiar foods and comfort foods in hospital can be an important aspect of patient care. When people are admitted to hospital they are in a strange environment which is disruptive of their usual routines. The provision of familiar foods in an unfamiliar setting can be instrumental in 'fighting off panic

and disorientation' which results from the unfamiliar and stressful experience (Bell & Valentine 1997, p. 19).

2.2.4 Family food habits

As seen in Figure 2.2 above, culture also has a role in determining food preferences of individuals, and this largely occurs by regulating exposure to foods and also in the flavourings and the methods of preparation (Rozin & Vollmecke 1986). There are, however, many differences in the food preferences of members within the same culture. Food is important in creating a common identity for the family unit (Keane & Willetts 1994), which is reinforced by the family sitting down together and sharing a meal. It is therefore reasonable to assume that family food habits, and the foods which are served and consumed together, have a role in determining the food likes and dislikes of individuals.

However, in her study of 128 pre-school children aged between 3 and 5 years and their parents, Birch (1980) found no significant correlations between the food preferences of parents and their children, although she did find somewhat more evidence to support similarities in the food preferences of siblings. This author found that parent/child food preferences were no more similar than between those of the children and the parents of other children in the study. Birch (1980) concluded that the low positive correlations between parents' and children's food preferences were due to commonality within a sub-cultural group rather than to transmission of food preferences from parent to child.

In contrast, two other studies of parents and children found the food preferences of family members to be more similar than would be expected by chance. Pliner (1983) asked 105 college students and their parents to rate their degree of liking of 47 foods on a seven-point scale. This author found that food preference

correlations were significantly more similar in children and their own parents than between children and the parents of other children in their study, indicating that there is some variance which is unique to the family. She also found closer similarity in food preferences of children and their same sex parents, suggesting two possible explanations for this phenomenon: exposure and imitation.

In the other study Logue et al. (1988) surveyed the food preferences of 77 high school students and their parents and siblings, a total of 241 subjects, using a nine-point hedonic scale. They found that food preferences were significantly positively correlated between pairs of relatives. The strongest correlations were between spouses and between female family members, leading the authors to conclude food preferences are environmentally rather than genetically determined. These authors believed that the findings of their study may indicate the mechanism by which food preferences are transmitted, that is via the females in the family.

Both Pliner (1983) and Logue et al. (1988) proposed the family environment, namely parental influence, in explaining the similarities of food preferences of individuals within families. It is possible that Birch's (1980) subjects, who were much younger than the subjects in the other two studies, had not had sufficient time to have either developed a definitive set of personal food preferences or to absorb the family food culture.

In the more recent literature, Coveney (2002) reviewed the published research related to food and families and concluded that, while there could be some genetic predisposition to food preferences, it is the dynamics of family relationships that affects the food choices of individuals. This author asserts that, although adults influence the food choices of their children, family food preferences are also subject to influence from the children. This view is supported by a recent study of 143

parents of Dundee primary school children by Turner et al. (2006). Using a questionnaire to investigate the influence parents perceive their children have on family food purchasing decisions, the authors found that 60% of the respondents believed that their children influenced their food purchasing decisions when the children accompanied them on shopping trips. This study was a preliminary study to further research and the respondents were all from Dundee. The authors acknowledged that, until similar studies are carried out in other regions, the results cannot be generalised (Turner et al. 2006).

2.2.5 Changes in food habits

Food choice is affected by individual food preference, and by changes and fluctuations in food preferences. Although food praxis appears to be initially influenced by the family, an individual's food habits continue to evolve over a lifetime, particularly in relation to life events such as leaving home, marriage and migration (Craig & Truswell 1988). Periods of social change may also affect the food praxis of individuals. Examples include the introduction of cuisines from other cultures to the community, and the influence of food-related health messages which, over time, alter food praxis. Other factors such as ease of preparation and the availability of foods also play a part in the evolution of the food habits of individuals (Warde 1994a; Warde 1999; Satia et al. 2000). These will be discussed in the following sections.

2.2.6 Marriage and cohabitation

Caplan (1997, p. 6) remarked that 'young people who spent their teenage years living on snacks and fast foods appear to change their food habits when they begin to live with a partner and have children'. When people marry or begin to cohabit and cook and eat together, the food habits of each party generally undergo some

compromises and trade-offs (Craig & Truswell 1985; Worsley 1988). Craig and Truswell (1985) found from their pre- and post-marriage surveys of the food preferences of 78 young Sydney couples that their food habits became more similar after two years of marriage. Craig and Truswell (1988), in a further report on the same research, noted that the wives made significantly more cooperative changes to their food habits than the husbands in the early part of the marriage. However, in relation to Charles and Kerr's (1988, p. 64, quoted in Lupton 1994, p. 667) famous observation that 'men, although they do not stir the cooking pot, control to a significant extent what goes into it', Craig and Truswell (1988) found on the contrary that, as the marriage lengthened and the influence of the women increased, the reverse became true and the men made more changes to their food habits than the women.

In the 1990s this trend was also noted by Kemmer et al. (1998) in their study of the changes in eating habits of Scottish couples beginning to cohabit. They found the wives to be more influential in making food choices and significantly less likely to defer to their husbands' food preferences than had been reported in previous studies. A further study by Kemmer (1999) in which 22 Scottish couples were interviewed before and after cohabiting found that, while there was some sharing of food preparation chores between the couples, the women were prepared to trade off the disadvantages of taking on the role of cook for the perceived advantage of more control over making the food choices for the couple. Although Kemmer's (1999) study did not explore changes in their food consumption patterns, those women who were the main preparers of the meals believed that the family would not eat very well if their partners were in charge of the kitchen. These women were of the opinion that making decisions about the foods to be consumed by their partners was 'for his own good' (Kemmer 1999, p. 578).

In the Craig and Truswell (1985) study, it was found that foods which were eaten together at shared meals such as meat and bread were most likely to have a higher degree of cooperative change, while beverages such as coffee and beer were the least likely to undergo cooperative change. This finding is consistent with the findings of the Kemmer et al. (1998) study, which found that daytime eating in general was not affected by change in marital status while there were significant changes in the structure and content of the evening meal.

In the late 1980s the Victorian Nutrition Survey was conducted. This was a large scale population survey in which 5,000 adults randomly selected from the electoral rolls were mailed a questionnaire about health habits, nutrition policy and the frequency of consumption of 170 foods and beverages (Worsley 1988). Three thousand people (67%) responded to this survey. The respondents' age and sex distribution was similar to that of the general population of Victoria and, although ethnic minorities were reported by the author as being under-represented, the numbers of respondents from ethnic minorities were in the same proportions as in the population of Victoria. The results of this survey showed statistically significant differences in the consumption of many foods between single males, single females and cohabiting males and females (Worsley 1988). This study showed that cohabitation is accompanied by increased consumption of foods requiring preparation, such as roast meats and casseroles.

In a much smaller qualitative study on food choices and food preferences of cohabiting couples, Lupton (2000) interviewed 34 Australian rural couples and found that cohabitation precipitated major changes in both partners' food habits. Many participants interviewed in this study remarked that they thought their diets had become healthier because they were now eating more 'proper meals' (Lupton, 2000). This conclusion is partially supported by the results of the Victorian Nutrition

Survey from which Worsley (1988, p. 107) concluded that 'cohabitation appears to improve the healthiness of men's diets but worsens women's diets' because it was shown that cohabiting women consumed more foods high in fat, salt and sugar, while the cohabiting men increased their consumption of fruits, vegetables and fat and salt-reduced foods.

An interest in cooking on the part of the food preparer seems to play a part in positive dietary change occurring households. In a study conducted by Santich (1995a) to determine women's attitudes towards cooking and dietary experimentation, 49 Australian-born women between the ages of 19 and 74 living in a low income area of Adelaide were interviewed. The author found that the preferences of other members of the household, and the conservatism of the partner, inhibited the respondents' willingness to experiment with new dishes and the introduction of dietary changes. It was also found that the older women in the study derived greater pleasure from cooking than the younger women, and were therefore more likely to experiment with new dishes, 'thus offering the household the perceived benefits of a varied diet' (Santich 1995a, p. 12).

Leaving home also appears to be a catalyst for dietary change. Lupton (1996) used semi-structured interviews with a purposive sample of 33 adults of various cultural backgrounds aged between 20 and 60 years to determine their food preferences. All the participants reported major changes in their food habits since leaving home, particularly if they had grown up eating standard Anglo-Celtic food. These respondents said that trying new foods was something they enjoyed, and believed it was indicative of their willingness and adaptability to change (Lupton 1996).

From these studies it can be seen that the food praxis of individuals continues to evolve, and is subject to many influences. Understanding whether the willingness to change food habits over time imparts flexibility in food and eating in any situation, or whether individuals regress to childhood food preferences in stressful situations may be an important factor in determining whether patients eat well in hospital.

2.2.7 The 'proper meal'

As seen in the previous section, Lupton's (2000) respondents believed that their diets had improved because of the inclusion of more 'proper meals'. The Anglo-Celtic construct of the 'proper meal', which is the presentation of a main meal in the context of a family, is a theme which recurs in all of the reviewed studies of family food habits, including the Australian studies. Typically, the Anglo-Celtic 'proper meal' consists of roast or grilled meat and two or three vegetables, the roast or baked dinner being the archetypal example of the proper meal (Douglas 1975; Murcott 1982). Murcott (1982) describes the 'cooked dinner', another term for the proper meal, as being defined not only by its components of meat, potato and vegetables, but its presentation. The meal must be served on a flat dinner plate and eaten with knives and forks. The food must be arranged on the plate as discrete components, not piled or mixed together, and is to be cut into smaller pieces by the diner, the whole meal being accompanied by gravy.

The significance of the structure and content of the proper meal is that it not only exemplifies nutritional balance in the minds of the consumers but it is symbolic of family values and caring because of the effort taken in its preparation, and the fact that it is always a shared meal (Kemmer et al. 1998; Lupton 2000). The individual components of the meal can be adjusted to reflect the preferences of individual members of the family, and in doing this the proper meal can be an expression of the

special relationship between the cook and that particular diner. Because the proper meal is always individually served, it is personalised (Murcott 1982). Even where a meal does not occur at a table it retains its symbolic significance as a powerful metaphor for the family (Murcott 1982; Caplan 1997), the proper meal standing for values such as health, security, predictability, caring and love (Lupton 2000). In an Australian study, Santich (1994) used semi-structured interviews to determine the food beliefs and attitudes of 49 South Australian women. The author found that more than three quarters of the respondents reported 'meat and vegies' as the standard weekday evening meal, which represented good, wholesome, natural food to them.

Mitchell (1999) believes that the structure and content of the proper meal is subject to influence by both conservative and developmental forces. On one hand, conservative forces such as tradition and socialisation reinforce continuity of traditional eating patterns while on the other, developmental forces which include technology and the wider availability and choice of foods, encourage change. To determine whether change has occurred in the British diet Mitchell (1999) identified trends from national dietary consumption surveys conducted in Great Britain in 1995 and 1997. From this data the author concluded that, while British meals remain identifiable in their structure, the elements of the meal are changing. The roast beef, roast potatoes and cabbage of the traditional British proper meal are metamorphosing into microwaved chicken, frozen chips and courgettes.

The significance of the findings in this section is that, regardless of the actual foods on the plate, the structure, and therefore the code of the proper meal, remains intact and recognisable. In a study of patient menus in New South Wales (NSW) hospitals Williams & Brand (1989) examined the printed menus for patients on unrestricted diets from 128 hospitals, or 35% of the hospitals in NSW. All of these

hospitals had menus based on the traditional meal pattern of three main meals per day, with two or three courses at each meal. Since hospitals in NSW use proper meals as the template for their menus, most patients, even those born overseas, should be able to recognise the code of the proper meal, and therefore should find the structure of hospital meals familiar.

2.3 Food and culture: The cultural perspective

This section explores the *cultural* perspective of the sociological imagination, and its impact on individuals and their food habits. Culture refers to things which are either learned or symbolic, for example language and customs (Willis 1995), and cultural cuisine is the corpus of food-related practices of a culture which are transmitted to the members of the cultural group. Cultural cuisine includes a range of specific basic foods and food combinations, rules dealing with acceptable and unacceptable foods, food flavourings and preparation styles, menus, ritual foods and the social context of eating (MacLennan & Zhang 2004). Furthermore, Santich (1996) asserts that culture is an influential determinant of the food preferences and praxis of individuals.

This section of the literature review looks at how culture influences the food praxis of individuals, with the view to determining the possible effect culture has on patients' food consumption. This section examines changes in food praxis as a result of acculturation, or the transition of the food habits of one cultural group to another, and the place of folk remedies and traditional illness-related food practices.

Since culture is one of the determinants of individual food praxis, the cultural perspective is an important element of this study. The 2001 Census showed that 25% of the population of NSW was born overseas (Wen et al. 2003). In some metropolitan areas the proportion of residents born overseas is much greater. For example, 40% of

the residents in the central Sydney area were born overseas, and over 80% of these overseas born residents are from non-English speaking countries (Wen et al. 2003). It is therefore important that hospital menus are designed to accommodate the changing tastes of hospital patients, and the food preferences of ethnic groups.

2.3.1 Cultural determinants of food choices

Food and cuisine are the basic elements of every culture (Lupton 1994a) and they provide the central component of a collective sense of belonging in a group (Fischler 1988). Food acts as a marker of ethnicity by delineating differences between cultures, and strengthens the identity of both national groups and others who identify as groups, such as teenagers and some religious groups (Lupton 1994a).

People eat in a cultural context and, according to Fischler (1988) this supplies a kind of generalised implicit taxonomy tied to identity. 'If we do not know what we eat how can we know what we are?' (Fischler 1988, p. 281). Some countries have dishes which are so unique that they are regarded as being as symbolic of the nation as their flag (Keane & Willetts 1994), and are therefore strongly tied to the personal identity of the populations.

Booth (1994) believes that cultural determinants of eating behaviour can operate in two ways. The individual may either be participating in a culturally determined social activity which involves eating and drinking, or the person may construe food and drink as more or less appropriate to the situation as a result of prior acculturation. These two factors can also operate simultaneously. Booth (1994) is also of the opinion that food and drink are used by people as cultural symbols as much as they are to satisfy hunger, provide nutrition, satisfy cravings and soothe emotional distress. In this context, the ability of hospitals to accommodate culturally determined practices related to illness foods and comfort foods has potential

significance for patients from different cultures. Cultural food practices may also be important for maintaining the patient's sense of personal identity.

In Australia, the British culinary heritage brought by the first European settlers has been modified by waves of migrants from other countries at different periods of history. Australian bush foods, the traditional foods of the Aborigines, by contrast, have had very little impact on the development of a cuisine which is unique to Australia (Ripe 1993). Ripe (1993) believes that the reason for this is that bush foods are difficult to harvest and are therefore generally not produced in commercial quantities. In addition, many bush foods, witchetty grubs for example, fall outside of what is considered edible by many people.

While the structure of the British and Australian main meal is readily identifiable as a meat dish accompanied by potatoes and vegetables, Mitchell (1999) is of the opinion that meals from some other cultures follow a similar format, albeit that the components of the meal are very different. This author describes meals generically as having a core component which is central to the meal, with secondary dishes accompanying the dominant dish. As examples, Mitchell (1999) cites Chinese meals consisting of soup, with rice or noodles as the core component, plus additional meat and vegetable dishes as secondary foods, and Indian meals which may include a vegetable or meat dish with rice, naan and a pulse dish. The significance of Mitchell's (1999) view is that, while the overall structure of the meal remains, some of the components of the meal may change and the meal will still be recognisable and culturally acceptable.

Wright et al. (2001) contend that, historically, countries which have been geographically situated on trade routes have been open to the influences of many cuisines and new foods such as tea, sugar and spices. In the modern context, global

brands, marketing and improved transportation and distribution mean that products and produce from all parts of the world are available to consumers. Not only do consumers have access to dishes from other cultures but their recipes have been reinvented. Indian Balti, which has its origins in Manchester in the UK, is cited by Wright et al. (2001) as an example of an ethnic dish which was developed in another country, an example of acculturation as new foods and ingredients are adopted and adapted.

Warde (1994a) studied changes in food practices in the United Kingdom by systematically comparing all articles published in a sample of popular British magazines in 1967–68 and 1991–92. He found that, although the proportion of recipes of ethnic origin did not change significantly between the two periods, there was increased concern with their authenticity. Whereas in the 1960s there was a greater tendency to substitute ingredients in foreign recipes to suit British tastes, in the 1990s there was emphasis on the accuracy of the recipes and authenticity of the ingredients. Such a focus on authenticity suggests an increased level of familiarity with the cuisine, rather than the novelty of experimenting with new dishes.

In their study of 12 London householders' knowledge of the origins of food, Cook et al. (1998, p. 162) proposed the idea that foods themselves have a history and a biography, and that foods should be regarded as 'small cultural artefacts' which have a life of their own before they reach the supermarket shelf. These authors believe that such an approach 'gives concrete expression to the way in which food choice is at the same time both intensely personal, bound up with individual tastes and household experiences, and thoroughly public, an important aspect of citizenship' (Cook et al. 1998, p. 162). In other words, the foods people choose are an expression of their personal identity, not only who they are, but also where they belong.

The foods that people buy, cook and eat are increasingly from global food supply networks and global sources of foods. This study showed that, while consumers do not know everything about the origins of the food they purchase they do have some knowledge, and this can be a significant factor in their food choices. Fischler (1988) believes that not knowing the origins of the food supply contributes to disorientation of identity, even in France which has a strongly ingrained food culture.

The concept that the cuisines of various cultures are master menus which provide rules for preparing, combining and presenting foods has been proposed by Beardsworth and Keil (1992). These authors believe that there is a gradual breakdown of food customs in modern society due to exposure to different, competing menus from other cultures, which they term menu pluralism, or fusion cuisines, where flavour elements from one cuisine are incorporated into the dishes of another. Examples of menu pluralism are found in Asian/French and Tex/Mex cuisines.

In their survey of the food preferences of patients, Kennewell and Kokkinakos (2001) used a slightly modified version of the survey instrument used by Williams (1988) in the same large central Sydney hospital. The food preferences of 524 inpatients were obtained and compared with the food preferences of 500 inpatients surveyed by Williams (1988) twelve years earlier. A significant shift in food preferences towards foods from various cultures was found in the group surveyed by Kennewell and Kokkinakos (2001). Whether this shift is due to increasing numbers of patients from other cultures in the hospital, or the acculturation of Australian born patients, or both, is not known. However, knowledge of the impact of the food cultures and its impact of the food preferences of hospital patients is clearly essential in the provision of foods which are acceptable to patients.

2.3.2 Acculturation

Menu pluralism is an example of the process of acculturation. Acculturation, or the transition of one cultural group to another, is usually bi-directional, bringing about changes to both groups. Dietary acculturation for the host group is most likely to be due to the appearance of new foods and diversification of the food supply and cuisines in the community, while for the migrant group it appears to be a passive, non-cognitive process driven primarily by daily life issues such as convenience and cost (Satia et al. 2000). In Australia several waves of Asian immigration have resulted in the introduction of new ingredients to the host nation such as rice, soy, Asian green vegetables and exotic fruits, and an increase in fat and sugar to the diets of the Asian migrants (Wahlqvist 2002). Changes in the diets of Greek migrants residing in Australia also reflect a movement towards the majority food culture, with increased consumption of breakfast cereals, pork and milk products (Kosmides et al. 1980). A similar trend towards the adoption of Australian dietary patterns with increased consumption of meat, eggs, fruit and vegetables, dairy products and sugar and decreased consumption of bread, legumes and seeds has been found in Lebanese migrants who have been living in Australia for 15 years or more (Hadj 1988).

A recent study of the post-migration food habits of 139 sub-Saharan African migrant households in Victoria showed that dietary acculturation was characterised by the addition of new foods, retention of available traditional foods and substitution for unprocurable traditional foods, as well as adoption of mainstream Australian foods (Renzaho & Burns 2006). The Australian foods most frequently adopted by this group were pizza and breakfast cereals, but new fruits and vegetables were also included in the migrants' diets (Renzaho & Burns 2006).

For other groups such as Aboriginal and Torres Strait Islanders, acculturation has been largely a one-way process with an adverse impact on indigenous populations as access to traditional foods has been limited by the transfer of populations to reserves. This has resulted in a change from a diet of nutrient-dense native foods to energy-dense, high fat and high refined sugar foods and loss of traditional knowledge and culture (Shannon 2002). As noted earlier, bush foods have generally not been incorporated into the mainstream Australian diet because of the difficulties of large scale cultivation for many of these foods (Ripe 1993), and also because some bush foods are unacceptable to many people (Santich 1996).

The implications of acculturation for this research study are twofold. First, the degree of acculturation of an individual or group may affect their acceptance of hospital food. Second, hospital menu planners need to be aware of the demographics and cultural cuisines of the hospital population, and base the hospital menu on the needs of its population.

2.3.3 The meaning of food

Telfer (1996, p. 37) observed that 'food and eating, at any rate, are what they are and often many other things as well, and we often value them because they are these other things, not because the food tastes good'. For example, according to Renzaho and Burns (2006, p. 100), 'maintaining or relinquishing traditional foodways is one way of renegotiating the power between the host and the migrant/refugee. That is, food is used to establish a boundary – a way of saying "I am different from you"'.

Food choices, however, can be influenced by factors other than culture. People attach labels to food that are either real or symbolic. Telfer (1996) calls these labels 'connotative meanings' and she believes that they reflect a person's values and beliefs. According to Stewart (1988) the meanings individuals attach to foods are

unique to that person, are very different between individuals and are the result of personal experience. Stewart (1988) believes that the meanings individuals attach to foods are the basis of food choices for that person. Foods can also have meanings which are shared by populations.

Reaburn, Krondl and Lau (1979) surveyed 112 low-income housewives using questionnaires and follow-up interviews in order to elucidate the social determinants of food selection. One of their findings was that foods have meanings which are shared by populations, for example luxury foods. Foods may be classified according to their meanings, each food having its own unique social profile as perceived by a homogeneous population which can be measured and quantified using attitudinal scales. Such considerations can be important in menu planning. For example, rabbit and offal are unpopular menu items in Australian hospitals (Kennewell & Kokkinakos 2001; Arney & Tiddy 1992; Williams 1988), possibly because these meats were very cheap, and therefore had a low social profile. These dishes are generally not considered for inclusion on hospital menus (Williams & Brand 1989) because of their low popularity, even though they are as nutritious as other meats.

There are many medical conditions that are linked to food habits and dietary practices either by cause or by treatment. Lupton (1996) believes that the biomedical model requires explanations so that the body can be understood. As a consequence, 'food practices and habits are now experienced through the framing of medical concerns about diet' (Lupton 1996, p. 68). The meanings of food and the emotions experienced with food and eating have therefore inevitably become connected with understandings about health and the prevention or treatment of disease.

2.3.4 Foods for sick people

According to Florence Nightingale, 'invalid diets' have been a traditional aspect of nursing care. Nightingale (1859 (1980)) was of the opinion that appropriate foods for invalids would do half the work of their digestive systems, although this view is no longer upheld. According to Booth (1994), the appetite for food has a tendency to decline during illness. Attractive foods and drinks, which are often described as 'light foods', have traditionally been regarded as important for tempting the appetites of sick people, even though there has been no research into whether such 'invalid diets' are appropriate to the cognitive structure of 'poor appetite' (Booth 1994).

In Habeeb's (1973) study of the relationship between illness and eating in hospitalised patients, the author found that the respondents had their own unique, but very definite, ideas of what constituted appropriate food for their illnesses, which they expected the hospital to provide. The author stated that, from the patients' perspective, food was synonymous with care and that her respondents utilised food in their assessment of the care the hospital provided. In the previously mentioned study by Maller et al. (1980), patient satisfaction with medical and nursing care and patient satisfaction with the food were shown to be strongly positively correlated. Lupton (1996) is of the opinion that food is inextricably linked with caring because of the nurturing relationship between mother and child.

In order to gain an understanding of patients' concerns with their care in hospital, Yen et al. (2002) used semi-structured interviews with 12 patients in a medical centre in southern Taiwan. They found that half of the subjects were dissatisfied with the quality and cost of the food, and that they felt the food offered in hospital was not consistent with Chinese traditional medicinal principles. It was

clear, however, that all of the subjects considered that having proper food was the key to their recovery and they believed that the hospital should accommodate the patients' needs and tastes in food while at the same time providing nutritious food.

In another study Williams (1988) surveyed 500 inpatients in a large tertiary referral hospital in Sydney, using questionnaires with a nine-point hedonic scale in order to determine the food preferences of hospitalised patients. The previously mentioned survey by Kennewell and Kokkinakos (2001) repeated Williams' (1988) survey at the same hospital. Both surveys showed that fresh fruit was the most popular food with inpatients, especially peaches and fresh fruit salad. Baked potato and roast chicken also scored very highly. Food items such as brains and tripe, junket and blancmange and creamed spinach, all of which have traditionally been considered suitable for the 'light' or invalid diet, were found to be among the least popular of the 223 listed foods.

2.3.5 Folk remedies and traditional food practices

There are also many traditional nostrums which involve the use of diet and specific foods for illness. Of those that fall into the 'folk remedy' class, chicken soup has long been a popular food for illness, especially for colds and influenza. Interestingly, there is some scientific evidence that the synergistic properties of chicken soup may decrease the inflammatory response associated with viral illnesses (Hopkins 2003).

Many illness-related food practices are culture specific and many cultures have foods prescribed for the treatment of specific medical conditions such as fever, colds and childbirth. While it is recognised that there are many cultures with illness-related food practices, it is not possible to review them all. Therefore the traditional food practices of the Chinese will be discussed in this review as the Chinese are the largest group of overseas-born residents of the central Sydney area where the

majority of the respondents in this research study reside (Wen et al. 2003). One of the purposes of this literature review is to provide sensitising concepts for the research study, and the researcher recognises that the respondents in the study may be influenced by the illness-related food practices of other cultures.

The Chinese have food-related beliefs dating back 3000 years which have become integrated into religion, philosophy and martial arts as well as other forms of healing such as acupuncture (Ludman & Newman 1984). Among these beliefs are that the human body is integrated as a whole and that food and nutrition is applied in four ways: food as diet, food as medicine, food as tonic and abstention or avoidance of foods (Dahl 2004). There are traditional food practices related to specific conditions, prescribing and proscribing certain foods for consumption or abstention during illness episodes. Diseases, stages in the life cycle and foods are classified as being either *yin* (cold, dark, restful, femaleness) or *yang* (heat, light, heaven, maleness), which are sometimes translated as being 'cold' and 'hot' (Ludman & Newman 1984). The Chinese believe that health is maintained by balancing a number of factors including the hot and cold properties of the food, which are independent of the food's actual temperature. For 'cold' conditions, it is necessary to consume 'hot' foods, and vice versa, to restore the balance of the body. Some foods are considered to be in direct conflict to the disease. If food clashes with the ailment, it can affect the process of the disease (Whang 1981). The extent to which these food beliefs still influence practice is not well documented.

A study by Ludman and Newman (1984) surveyed 450 Chinese subjects in the Peoples Republic of China, Hong Kong and the US using a questionnaire about health-related food practices. They found that traditional herb and food therapy continues to influence dietary practices, although there was considerable variation in the choice of specific food remedy and in the classification of hot and cold foods.

The study also found that the respondents living in the US were less likely to follow traditional food practices than those in the Peoples Republic of China and Hong Kong (Ludman & Newman 1984).

Similar disagreement in the classification of hot and cold foods was found in a study of Chinese women living in Seattle. Satia et al. (2000) conducted interviews with 30 less-acculturated Chinese-American women. The interviews included 24-hour dietary recalls and questions regarding factors that influenced food choices. In addition, they also conducted two focus groups with six Chinese-American women in each group to validate the interview findings. The respondents believed there is a strong connection between diet and disease and, like Ludman & Newman's (1984) American respondents, were found to have been influenced by both Eastern and Western beliefs regarding diet and health.

In a more recent phenomenological study, a purposive sample of 20 Hong Kong Chinese women diagnosed with breast cancer found that these women also used both Eastern and Western medicine to manage the illness (Simpson 2003). Traditional Chinese medicine was not only integral to their self-care strategies, but most importantly, Simpson (2003) found when medical advice does not fit with their traditional belief system Chinese families are reluctant to seek clarification and tend not to implement Western treatment advice rather than risk conflict with the healthcare provider.

Overall, there is potential for disagreement between dietary practices of Chinese traditionalists and Western medicine when advice and practices are incompatible. There is also the potential that patients will not eat the hospital food if the food items considered by the patient to be appropriate for the medical condition are not available. Alternatively, patients may consider some foods served to them in

hospital inappropriate for the medical condition, as was seen in the study by Yen et al. (2002) where the subjects believed the food offered in that Taiwanese hospital was not consistent with Chinese traditional medicinal principles.

2.4 Food and institutions: The structural perspective

The *structural* perspective of the sociological imagination attempts to answer questions about the way society, or in the case of this research study, the hospital system, is organised to deliver food to the patients. According to Willis (1995) society can determine the actions and behaviours of individuals. Therefore, the structure of the organisation might explain the behaviours of its individual members.

Food in hospitals is provided in the context of rules and time constraints. Batstone (1983) described catering in institutions as 'functional meal provision', that is, the most efficient way of providing nutrition for the inmates of the institution. Functional meal provision, unlike meal provision in the domestic situation, does not consider the broader functions of meals which includes the social or personal needs of the recipients (Crotty 1988; Pearson et al. 2003). For example, Mennell et al. (1992) are of the opinion that the timing of hospital activities, including patients' mealtimes, is based on conventions which suit the hospital rather than the patients. Furthermore, in keeping with the requirements of functional meal provision, hospital kitchens are usually what Turner (1995a) describes as a 'backstage area' where dirty work is performed by low status staff. In Paterson's (1981) view hospital kitchens are physically invisible to the rest of the hospital and are therefore expected to organise their work to fit in with other hospital routines.

As hospital patients are more or less totally dependent on the hospital to meet their nutritional, sociological and psychological requirements in terms of food, a

number of aspects related to food service and food-related nursing practices are examined. These include the nature and limitations of hospital food services, menus and the quality of hospital food and patient expectations, the times meals are served in hospitals and power relationships surrounding meals and eating which are common in hospitals. All of these factors may have a significant impact on patient satisfaction and the eventual consumption of the meal.

2.4.1 Food service systems in Australia

There are many different ways food can be prepared and served in institutions. The two main food service systems used in Australian hospitals are cook-fresh-hold, where the food is prepared just prior to the meal and held hot until served and delivered to the patient, and cook-chill, where food is cooked, chilled, served cold and then reheated just prior to delivery to the patient.

Mibey and Williams (2002) surveyed the food service departments of 93 hospitals in NSW with a 25-item questionnaire seeking information about the hospital food service. They reported that since 1993 there has been a significant reduction in the use of conventional cook-fresh-hold food service systems in favour of cook-chill systems which are now used in two fifths of NSW hospitals. They also reported that the majority of hospitals in NSW serve individual meals for patients in a central kitchen, as opposed to serving the meals at the ward level, regardless of the type of food service system. Patient satisfaction and perception of quality of service have been found to be significantly higher when food service staff deliver the meal trays (Gregoire 1994; Lambert et al. 1999), even though it has been reported that nurses tend to give better care to patients at mealtimes when meals are plated at the ward level (Carr & Mitchell 1991).

Of the 270 hospitals in NSW surveyed by McClelland and Williams (2003), all had selective patient menus although the number of food choices, the types of foods offered and the portion sizes were more restricted in cook-chill systems as a result of limitations of the technology of the system. Most significantly, popular menu items such as baked potatoes, chips and pastry dishes cannot be offered in cook-chill systems as high fat items such as these do not retain their texture well (McClelland & Williams 2003).

Traditional hot breakfasts are offered in approximately 60% of NSW hospitals. In the remainder of the hospitals continental breakfasts with no hot option, and sometimes no substantial protein source, were the only available breakfast (McClelland & Williams 2003). The lack of a traditional hot breakfast can have adverse effects on patients, especially since there are long gaps between the evening meal and the breakfast service in the majority of hospitals (Williams 1994; Mibey & Williams 2002). Hirsch et al. (1979) found that breakfast is the meal which is most completely consumed by most patients, possibly because the patients are hungry as a result of the extended period of time, up to 17 hours in some hospitals, between breakfast and the previous meal (Williams 1994). Whilst the Hirsch et al. (1979) study was conducted almost 30 years ago, a more recent study has confirmed their findings. Edwards et al. (2000) surveyed the food wastage in nine wards in four British hospitals over a period of 48 hours. They found that plate waste, or the food left uneaten by the patients, was lowest at the breakfast meal. Only 14% of the breakfast was not consumed by the patients whereas 37% and 33% of the midday and evening meals respectively were left uneaten.

The trend to serving continental breakfasts instead of hot breakfasts in hospitals (McClelland & Williams 2003) could have deleterious effects on the nutritional intakes of the patients. Coote and Williams (1993) conducted a study in which three-

day weighed food intake records were kept for 22 oncology patients and 32 obstetric patients in a large Sydney acute care hospital. Over a period of three weeks, the nutrient intakes of the patients served a traditional hot breakfast were compared with the nutrient intakes of the patients receiving a continental breakfast. The authors found that overall nutrient intakes of the oncology patients were significantly lower when only continental breakfasts were available, and that both groups of patients generally preferred traditional hot breakfasts, despite the fact that only 10% of Australians normally eat cooked breakfasts at home (Williams 2002).

Kowanko et al. (2001) audited the protein and energy intakes of patients in a large Australian acute care hospital. These authors found that in this hospital, where only continental breakfasts were available, two thirds of the patients consumed less than 50% of the energy value of their breakfast meal. Although the patients in this hospital consumed more food at the midday and evening meals, the authors found that a quarter of the patients still consumed less than 50% of the energy value of these meals, and 3% of them ate none of the meal at all (Kowanko et al. 2001). Although these findings are different from those of Hirsch et al. (1979) and Edwards et al. (2000), who found that breakfast was the meal most completely consumed by patients, Kowanko et al. (2001) stated that, in this hospital, breakfast was often rushed and the patients were interrupted by ward rounds and nursing activities.

2.4.2 Hospital menus

The menu is the primary focus of any food service system and is the point around which all other aspects of the hospital food service system revolve (Arney & Tiddy 1992). According to Williams (1994), the menu expresses the character of the hospital food service operation and is largely responsible for its good, or poor, reputation. Although it is essential that hospital menus are designed so that the Recommended

Dietary Intakes for each individual patient can be met, menus and meals should provide sufficient choice and be designed to meet the psychosocial needs of particular patient groups, including ethnic minorities (Schenker 2003).

Tailoring the menu to suit specific patient groups can significantly improve their nutrient intakes. Roberts (1982) measured energy and protein intakes of oncology patients in a Melbourne hospital before and after the change from a cycle menu to an à la carte style menu. The menu change resulted in an average increase in energy and protein intakes of 17% and 6.5% respectively. Adding wine to the meal service marginally increased these intakes by a further 1% for energy and 1.7% for protein.

Brownridge (2000), a clinician writing of her experiences as a patient, is of the opinion that, for some patients, a food service system which offers a choice at the point of service would be more effective than the patients ordering their meals in advance. Brownridge (2000) had a six-day admission and received her first self-selected meal on the day of her discharge. Kokkinakos and Ravens (1999) found this type of meal service worked well with short stay obstetric patients in a large Sydney teaching hospital. A customised menu was developed from the existing patient menu, using the most popular dishes and enhancing the menu to meet the nutritional requirements of nursing mothers. These authors found improved patient satisfaction concerning food quality and quantity, temperature and staff courtesy (Kokkinakos & Ravens 1999).

While it could be argued that the hospital food service can only be responsible for the provision of a balanced menu with hygienic food, de Raeve (1994) believes that institutions have an obligation to serve *meals* rather than *food* to patients. Whether or not the patient feels nourished by the meal is dependant on the relationship of the provider and the consumer in the context of the meal. In other

words, the patient needs to be emotionally satisfied by the meal as well as physically nourished (de Raeve 1994). The food served to patients in hospital should, ideally, be familiar and reflect the foods served in their own homes to assist in providing security and comfort in the unfamiliar setting of the hospital. The hospital routines are frequently monotonous and the regular appearances of meals and familiar foods can give some relief from the strangeness and tensions of a hospital admission (Bell & Valentine 1997) and provide some structure in the day (Habeeb 1973; Pearson et al. 2003).

2.4.3 Patient satisfaction

According to de Raeve (1994), patients may express their dislike of the whole hospital situation by complaining about the food. In the study by Maller et al. (1980) referred to earlier in this chapter, 1,579 patients and staff in five military hospitals in the US were surveyed in order to determine the acceptability of the food. Questions about non-food related variables such as satisfaction with medical and nursing care were also included in the survey questionnaire. It was found that patient satisfaction with medical care was significantly correlated with ratings of the food and food service. In another survey of 309 patients in two Swiss hospitals, Stanga et al. (2003) showed that patients' satisfaction with food and the menu declined after a length of stay of eight days, after which the patients had poorer appetite and consumed less, with 22% of patients eating little or no food at all. Maller et al. (1980) also found that satisfaction with meals declined with long-stay patients. Patients with language or comprehension difficulties tended to express lower satisfaction than the other patients (Stanga et al. 2003).

Randall and Senior (1994) identified a number of elements which are inherent in hospital food service processes, such as the customer, the menu, the food delivery

system, food service contact persons and the food itself. The authors then used these elements to map the relationships between patients and the hospital food services staff. This model was used by Hwang et al. (1999) in their survey of hospital meal service processes in all acute care National Health Service (NHS) hospitals in England. While this study did not show a consensus of opinion regarding the best meal service system for hospitals, it did highlight conflicting interests between the catering managers, who are responsible for the menu design and food production, the nurses, who are responsible for feeding patients and may be responsible for the meal delivery in some hospitals, and the perceptions and expectations of the patients themselves.

Conflicting interests between other groups responsible for the feeding of patients have been shown. In a study of the working relationships between hospital dietitians and caterers in the UK, Donelan (2000) interviewed a small purposive sample of caterers and dietitians and analysed the data using grounded theory methodology. From this research Donelan (2000) found that dietitians have values, ideals and beliefs regarding clinical practice which are intellectually conditioned and are situated in their interest in food, science and people, whereas hospital caterers are constrained by the practicalities of operating a food service year-round and 24 hours a day. This study highlighted the different value systems which underpin the practice of the two groups. The author believes this difference is the basis of the tension which is sometimes apparent between the two groups, and which the author believes can have an adverse affect on both patient care and the quality of hospital meals.

Lau and Gregoire (1998) surveyed 252 inpatient and 437 post discharge patients from a Chicago teaching hospital to determine their satisfaction with the quality of the hospital's food. These authors found that as the patients' expectations of the

quality of the food were increasingly met or exceeded, the more satisfied they appeared to be. Hwang et al. (2003) did further research on the relationship between patient perceptions and expectations, and their importance in determining overall patient satisfaction with hospital meals. In this study 609 patients in four British hospitals were surveyed using a questionnaire which measured patients' perceptions and expectations towards hospital meal services. They found that patients' expectations generally exceeded their perceptions. The greater the gap between perception and expectation, the lower was their overall satisfaction with the meal service. The greatest gap between perception and expectation was found for food quality, which included the parameters of flavour, aroma, freshness, presentation and variety. Previous studies have also shown that food quality is the best predictor of patient satisfaction (DeLuco & Cremer 1990; Dubé et al. 1994; O'Hara et al. 1997; Lau & Gregoire 1998). Hwang et al. (2003) also found that mealtime surroundings and social contact had a direct causal relationship with patient satisfaction, although this was not as strong a predictor of satisfaction as food quality. In addition, the size of the patient's appetite was found to have a direct relationship with the amount of food consumed at the meal. Figure 2.3 (page 56) depicts the factors, in descending order of significance, which Hwang et al. (2003) found to have a relationship with patient satisfaction. The 'food dimension' includes the taste, smell, temperature, freshness, variety and menu description of the food as well as receiving the correct meal order, while the 'environment dimension' includes mealtime surroundings, social contact during mealtimes, the quantity of food and information about food and nutrition.

Figure 2. 3
Causal Model of Patient Satisfaction with Hospital Meal Services
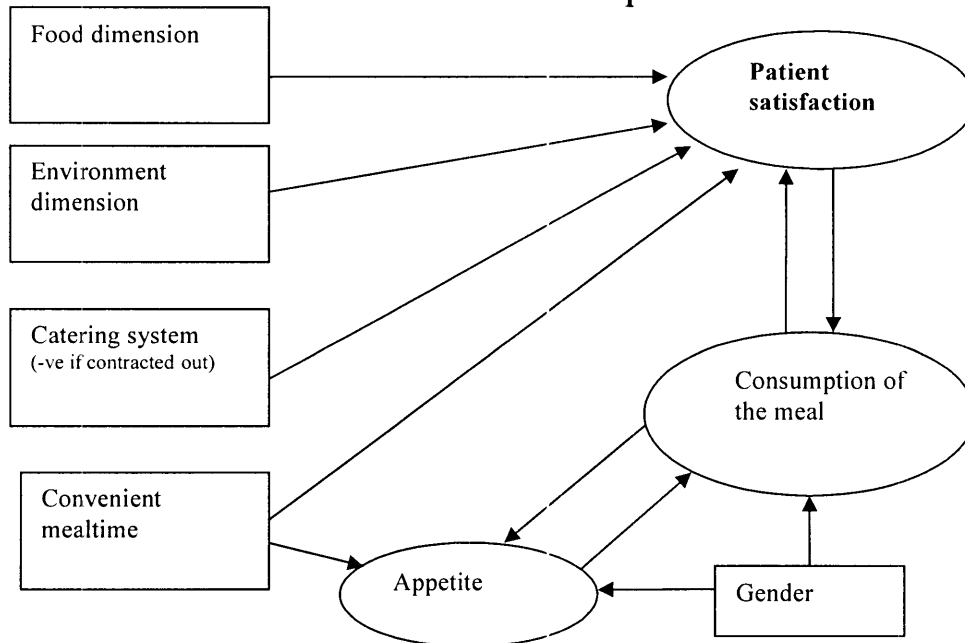
Adapted from Hwang et al. 2003, p.150.

In 2003, Watters et al. conducted a qualitative study using focus groups with 39 nurses and discharged patients in order to obtain insights and perspectives on hospital food quality. They found that the patients felt that the quality of hospital food had improved and was better than expected. The nurses, however, although they agreed that the food had improved, were less positive about its quality. The nurses also thought that the food served to patients should be more culturally appropriate, despite patients from various ethnic backgrounds reporting that they enjoyed non-traditional foods while in hospital. Watters et al. (2003) also found in this study that mistakes and menu errors upset the patients, who said they were uncertain of how to contact the food services department to give feedback.

Physical factors are not the only determinants of patient satisfaction. Bélanger and Dubé (1996) investigated patient emotions as mediators of patient satisfaction.

These authors used a questionnaire to survey 102 patients in a Canadian acute care hospital and found that the emotional experience of hospitalisation could be represented by five dimensions. These were positive emotions and arousal emotions, and three negative dimensions related to situation, self and 'other', which included feeling uncared for, frustration, loneliness and hostility. They found that the patients' perceived control over a situation, such as being able to make menu choices, strongly influenced their satisfaction with the food service. As a result of the findings of this study Bélanger and Dubé (1996) believe that hospital mealtimes could be used effectively to provide a sense of security and reassurance for patients and give some relief from negative emotions associated with hospitalisation.

2.4.4 Hospital mealtimes

As previously mentioned, food and eating, unlike any other human activities, are central to our lives. Food structures our existence from the daily pattern of meals to celebrations and rites of passage (Bell & Valentine 1997). In countries with temperate or cool climates the traditional meal pattern is three substantial eating occasions per day, maximising the opportunities for automatic controls of sufficient energy intake by the individual (Booth 1994). According to de Castro and de Castro (1989), the amount of food humans eat at a meal is correlated with the time interval between that meal and the previous meal. If the time between meals is short, then less food will be eaten at the second meal. Therefore, if people are unable to regulate their food intake by deciding when they will eat, they will regulate it by adjusting the amount eaten at the meal (de Castro & de Castro 1989).

In 1975, Mary Douglas, in her seminal work 'Deciphering a Meal', hypothesised that, in British society, food is a code and the messages encoded in food and eating are the degrees of hierarchy, inclusion, exclusion, boundaries, and the crossing of

boundaries in social relations. Douglas (1975) observed that food comes in an ordered pattern during both the day and the week, Sunday lunch traditionally being the climax of the week's menu. A further pattern of food related to feasts, holidays and celebrations overarches daily routines. According to Douglas (1975) meals may be 'early' (i.e. breakfast), 'main', 'light' or a 'snack' and the elements of each meal are a set substructure of courses. Meals are a mixture of solid foods accompanied by liquids, unlike 'drinks' which are the reverse. 'Drinks' can be served to friends, acquaintances or even strangers, but meals are reserved for family close friends and honoured guests. Sharing a meal is an expression of friendship and defines a social line between intimacy and distance. This patterning enables the meal to be recognised, graded as a major or minor event, and judged for quality (Douglas 1975).

In institutions, the providers and receivers have conflicting concepts about the nature of meals (Kowanko 1997). In hospitals, the staff perceive mealtimes as work, whereas for the patients mealtimes are a means of communication (Crotty 1988; Kowanko 1997). Meals in institutions are provided in the context of rules governing work, especially time constraints, whereas in the domestic situation meals are principally provided to meet social goals and personal tastes, needs and comforts (Pearson 1994; Batstone 1983). Batstone (1983) calls such provision of meals within a set of rules and time constraints 'functional food provision'. Functional food provision is mainly concerned with meeting nutritional requirements and is disrupted by any need to provide personalised meals (Crotty 1988). The non-nutritional role of food in the well-being of the patients also needs to be considered. However, as Pearson (1994) has remarked, this may mean manipulating the mealtime environment and challenging the biomedical model to include broader ideas about the role of food and eating.

The times meals are delivered to patients are contingent on the management of the institution, with mealtimes usually being dictated by staff work routines and rosters. Although meals usually follow the pattern described above, mealtimes in hospitals are frequently much earlier then normal. In a survey of 270 hospitals in NSW Williams (1994) found that the majority of these hospitals served lunch between 12 pm and 12.30 pm. This was found to be still the case in a repeat survey seven years later (Mibey & Williams 2002), which reported that the evening meal could be served at times within a two-and-a-half-hour period between 3.30 pm and 6 pm, the majority of hospitals serving this meal between 5 pm and 5.30 pm. Saulwick and Associates (1987, cited in Williams 1994) found from their polls that the average time of the evening meal for Australians was 6.21pm, which is considerably later than the evening mealtime in the majority of hospitals. Eighty four percent of the hospitals in Williams' (1994) survey had a gap of 14 hours or more between the evening meal and breakfast the next morning, with the greatest gap being 17 hours.

In 1970 Glew surveyed 21 hospitals in the United Kingdom and found that whereas 88% of the patients reported that meals were served at different times from home, 92% of these respondents stated that they did not mind. Patient acceptance of early hospital mealtimes does not appear to be the same today, however. Hwang et al. (2003), in their study of patient expectations and perceptions of hospital food services described above, found that the convenience of the mealtime was significantly associated with, and a strong predictor of, patient satisfaction. In a review of undernutrition in the UK, Schenker (2003) recommends that the timing of hospital meals should be revised and made more relevant to patients' customary meal patterns to improve meal consumption.

According to Zerubavel (1979), there are multiple cycles of routines within the hospital, and lack of coordination of these routines frequently results in interruptions to patients eating their meals. In an audit of 749 patients in two British hospitals, Davidson et al. (2004) found that 31% of these patients were interrupted during their midday meal. The people most commonly responsible for interrupting the patient's meal were nurses (47%), doctors and other healthcare professionals (20%) and relatives (17%). The most common reasons for the interruption were medical review, observations or procedure (37%), drug rounds (27%) and visiting time (17%). Only 31% of patients whose meals were interrupted completely finished the meal, and 10% of interrupted patients ate none of the meal at all (Davidson et al. 2004). This problem has been recognised in the United Kingdom and the implementation of protected mealtimes, or mealtimes which are not allowed to be interrupted by other hospital routines, has become a National Health Service initiative (Davis & Bristow 1999).

2.4.5 Food, disease and dietary modifications

The patient's medical condition can affect the enjoyment, and subsequent consumption, of food either by physiological or psychological means. A number of disease states alter taste perception and consequently the appreciation of the flavours of foods and beverages (Maller et al. 1980). Changes in taste acuity (hypogeusia) and unpleasant taste perceptions (dysgeusia) are common in chronic liver disease (Smith et al. 1976; Madden et al. 1997), both of which reduce the enjoyment of food, with a consequent impact on food and nutrient intake.

Cancer patients frequently experience loss of appetite, changed taste perceptions and food aversions. High protein foods such as meat, fish and poultry are less pleasant to cancer patients, with some patients having severe aversions to red meat

in particular (Vickers et al. 1981; Holmes 1993). Other foods found to be distasteful to cancer patients are coffee, tea, chocolate and citrus fruit (Holmes 1993). Cancer patients who have developed food aversions are most likely to also experience taste and smell changes (Vickers et al. 1981; Holmes 1993). Because of taste changes and food aversions, cancer patients are likely to consume less, and are therefore less likely to meet their nutritional requirements. Cameron et al. (2003) interviewed six patients having cytotoxic therapy in their qualitative study of the impact of taste changes in cancer patients. The authors found that taste changes or taste loss were experienced by all of their subjects, and this not only affected their food consumption but had a profound effect on aspects of daily living such as socialisation, eating and health.

Food odours are implicated in food aversions in cancer patients. The foods found to be most palatable to these patients are often cold foods and include fruits, vegetables and cultured dairy products (Vickers et al. 1981; Cameron et al. 2003), but some of these foods, such as salad vegetables, soft cheeses and melons, are contra-indicated for cancer patients because of their risk of contracting foodborne disease (Desmarchelier 1996; Hess 1997).

Patients with chronic renal failure undergoing dialysis can also experience taste changes. Uraemic patients often report food tasting 'dull', persistent, unpleasant aftertastes and loss of appetite. Dobell et al. (1993) administered two questionnaires to 40 patients undergoing renal dialysis and 30 control subjects. The first questionnaire asked the participants to rate their preferences for 88 foods on a nine-point hedonic scale. The second questionnaire was designed to assess the factors which influence dietary habits such as taste aversion, taste changes and social influences. It was found that dialysis patients develop food aversions, with red meat being the most unpopular food, followed by fish, poultry and sweet foods. Unlike

cancer patients, where food odours are thought to have a role in the development of food aversions (Vickers et al. 1981), alterations in taste perceptions appear to be the basis of food aversions in renal patients. Although Dobell et al. (1993) could find no direct correlation between food aversion and Body Mass Index (BMI) in end stage renal patients, these patients were more likely to be underweight than the control subjects who had normal renal function.

Dietary modification is a key element in the management of diabetes mellitus and, for the patient, represents a lifetime change in eating habits. Ferzacca (2004), in his ethnographic study of older males with non-insulin dependent diabetes, describes their feelings of confusion about a disease where food and eating are seen as being both the cause and the cure. The diet is often a source of conflict between clinicians and patients and the patients have to reconcile past relationships with food and eating with present dietary change, with perceived 'judgments of taste' on the part of the clinician often becoming an issue for diabetic patients (Ferzacca 2004).

Whether patients in hospital eat more poorly because they are on modified or restricted diets is relatively unexplored. In the Maller et al. (1980) study of consumer opinions of hospital food which was described earlier in this chapter, no difference in meal ratings between patients on unrestricted diets and patients on modified diets was found, regardless of the type of dietary modification, leading these authors to surmise that modified diets are 'better tolerated by the individual because he knows that they are better for him' (Maller et al. 1980, p. 242). Dubé et al. (1994) confirmed this finding in their patient satisfaction survey of 132 patients in a Canadian acute care hospital. No difference in satisfaction was found between patients receiving a normal diet and those receiving therapeutic diets. Similarly, O'Hara et al. (1997) surveyed 65 patients in a Canadian long-stay hospital and found that dietary modification was not predictive of patient satisfaction with the hospital

food. They attributed this finding to hospital therapeutic diets, even the texture modified diets, being made as appealing as the regular diets.

However, while Stanga et al. (2003) found the majority of the patients in their survey were satisfied with the food regardless of diet type, they did find that half of the patients receiving weight reduction and lipid-lowering diets expressed moderate dissatisfaction with the food, although the numbers of these patients were very small, being four and five respectively. Patients receiving diabetic and vegetarian diets were either satisfied or very satisfied with the menu. Overall, these results would appear to dispel the common perception that modified diets are necessarily unappealing and that patients receiving modified diets eat less because of this.

2.4.6 Food quality

Food quality is a perceptual construct relative to the person, place and time and it is subject to the influences of context and expectations (Cardello 1995). Most patients expect hospital food to be bland, unpalatable, or even revolting, a stereotype which is highly prevalent, even amongst those without direct, personal experience (Cardello et al. 1996). Paradoxically, when the expectations of the quality of the food are low, its acceptance is high, and vice versa (Cardello et al. 1996), so the negative stereotype of hospital food is one of the key factors in its generally favourable acceptance (Feldman 1962). Feldman (1962) believed that the quality of the food a person expects is a function of the situation in which it is to be consumed. For example, people expect much higher quality food in restaurants than in hospitals or on aeroplanes. This was found to be the case by DeLuco and Cremer (1990) in their telephone survey of 223 randomly selected consumers' perceptions of hospital food quality. More than half of the respondents considered restaurant food to be of better quality than hospital food, while only 12% thought restaurant food to be of poorer

quality than hospital food. For the patient in hospital the arrival of a meal may be the high point of the day, which may explain why the average patient is satisfied with less desirable food than he or she would require under other circumstances.

Holm and Kildevang (1996) studied 20 Copenhagen families using semi-structured interviews and thematic analysis to determine consumers' perceptions of food quality. They found that positive opinions about food quality were related to personal criteria such as taste and convenience, while negative comments mostly concerned the processing of foods.

McCune (1962) believes there are discrepancies between patients' and dietitians' opinions of what characterises quality in hospital food. This author believes that for patients, the quality standard is emotionally conditioned and based largely on sensory attributes such as taste, texture and appearance, while for dietitians, the standard is intellectually conditioned and is based on nutritional criteria. Although there are no recent studies which either support or challenge this view, from her own experience as a clinical dietitian, the researcher believes that dietitians' primary focus is the provision of nutritionally adequate meals for patients, whilst Hwang et al. (2003) has demonstrated that for patients, flavour, aroma, freshness and presentation are the greatest predicators of satisfaction with hospital food. Lupton's (1996) view also lends support to this argument. This author asserts that nutritionists tend to regard food as being important only in its biological role, and they consider the sociocultural aspects of food no more than an enhancement, or a barrier, to the adoption of a 'correct' diet.

2.4.7 Food safety

Many common illnesses such as diarrhoea and malaise which are ascribed to other causes are, in fact, the result of eating spoiled or contaminated food (Hess 1997).

Social and demographic changes have increased the numbers of people at risk of foodborne illness, the most vulnerable being the elderly and those who are already ill. People who are immunosuppressed either by treatment with immunosuppressive drugs or by diseases such as AIDS are also at high risk of foodborne illness. In addition, well people such as pregnant women and very young children have a greater risk of harm from foodborne illnesses than the general population (Desmarchelier 1996; Hess 1997).

In a retrospective survey of 128 notified outbreaks of foodborne disease in Australia between 1980 and 1995, more than half occurred in mass catering settings (Crerar et al. 1996). Because hospital food services cater for high risk individuals, it is imperative that rigorous food safety programs are in place to minimise the risk of outbreaks of foodborne disease and/or of infecting individual patients. The Australia New Zealand Food Authority (ANZFA 2001) recommends that potentially hazardous foods such as meat and vegetables should be maintained at temperatures either below 5° Centigrade or above 60° Centigrade and that the maximum time a food can be held between these temperatures is 4 hours. This can significantly impact on hospital food service policies and procedures as this timeframe includes serving the food and transporting the meal to the wards. Meals which have not been consumed by the patients within a designated time period from arrival in the ward should be discarded.

Although observing appropriate storage temperatures and reducing the time food is held at unsafe temperatures is sufficient to minimise the risk of contamination from most pathogenic organisms, *Listeria monocytogenes* remains a problem as this organism is able to grow at temperatures of 4° Centigrade and lower (Sutherland et al. 2003). Uncooked foods pose the greatest risk of contamination with this organism and, as large numbers of patients fall into the highest infection

risk category in many hospitals, it is recommended that all high risk foods such as paté, soft cheeses, unpasteurised dairy products, uncooked meat and seafood and products containing raw egg (Sutherland et al. 2003) should be removed from the hospital menu and salad vegetables should be sanitised in a weak solution of chlorine before serving (Nguyen-the & Carlin 1994).

The removal of high risk foods from hospital menus reduces patient food choices, particularly for patients with illness-related food aversions. For example, patients with cancer have been reported to experience anorexia and changes in the palatability of many common foods such as meat and vegetables, possibly due to food odours. Cold foods such as luncheon meats, shellfish, cheese, cottage cheese and egg salad, most of which are high risk for *Listeria monocytogenes*, have been found to be the foods most acceptable to cancer patients with food aversions (Vickers et al. 1981; Holmes 1993).

2.4.8 Social influences and eating in hospital

Historically, Habeeb (1973) found that while patients wanted company at mealtimes and wished to share the eating experience with others, the hospital's system was not conducive to this activity. De Raeve (1994) suggests nurses eat with the patients to normalise the patients' eating experience, but Habeeb (1973) found that social exchange between staff and patients at mealtimes was prohibited in the institution where she conducted her study. The staff were allowed to assist patients with their meals but were not allowed to eat with them which, in Habeeb's (1973) opinion, transformed the patients' personal experience of eating into the impersonal experience of feeding as a consequence.

Whether patients eat alone in bed or with others in a dining room setting can influence meal consumption as the social aspects of eating are extremely important.

In hospital, most patients eat in isolation (de Raeve 1994), even though the effects of the presence of other people at meals has been shown to influence meal consumption, the number of people present being independently associated with an increase in meal size and an increase in the amounts of food eaten (de Castro & de Castro 1989). This may be moderated by the mealtime environment. However, as Maller et al. (1980) found, patients confined to the ward expressed significantly more favourable opinions of the food and food service than ambulatory patients eating in the dining room. The ratings of the patients eating in the dining room were more similar to those of the staff than those of the ward-bound patients, indicating that environment (the dining room was noisy and cramped) may be more important than mood.

Wykes (1997) also advocates nurse/patient interaction at mealtimes in order to assist the patients with meals, to enable the nurses to observe what is being eaten by the patients and to informalise and develop the nurse/patient relationship. While this may be the ideal, however, studies have shown that nurses have limited time to spend with patients at mealtimes, and that the amount of care nurses can give each patient at mealtimes is ultimately related to staffing levels (Kayser-Jones & Schell 1997; Kowanko et al. 1999).

2.4.9 Nursing practices

While nurses have a commitment to both feeding and nourishing patients as part of their holistic caring role, their focus has traditionally been on food and eating rather than nutrients (Habeeb 1973). However, there is a recent trend towards nurses viewing their role in the patients' nutrition in its more clinical application of nutrition assessment and the identification of malnutrition (Perry 1997; Kowanko et al. 1999). Doering (1992) is of the opinion that nursing science has developed to

reflect the positivist philosophy which is the prevailing framework for scientific study. Consequently, the nursing role definition has shifted to a clinical rather than a caring focus, and this extends to nurses' involvement with patient nutrition.

In the early 1970s, Habeeb (1973) observed this shift in nutritional focus from caring to clinical when she described what she termed 'the medicalisation of eating'. In her study she found that nursing judgment was influenced by physicians, even in the routine task of feeding patients. The physicians' comments about patients' food and eating were interpreted by both the staff and the patients as being authoritative, consequently limiting the nurses' ability to respond to cues from the patient and discouraging them from initiating therapeutic interactions related to food and eating with their patients. For both the patients and the nurses food and eating was a medical concern rather than a personal concern.

In spite of the general belief that nutritional care, in all its forms, is an important part of the nursing role, nurses have difficulty in making it a priority above other nursing activities because of time constraints and the demands of other nursing activities (Kowanko et al. 1999). Perry (1997), however, found discrepancies between nurses' positive attitudes towards nutrition care and their documentation of nutrition-related activities in care plans. This author cites patient weights, which were often either not documented or were obviously guessed, as they were so incorrect.

More importantly, inadequate numbers of nursing staff impact on all patient care, and on the food and eating aspects of nutritional care of patients in particular. Kayser-Jones (2002) describes residents in a long-term hospital being fed quickly and forcefully, or not fed at all, because of inadequate staffing and time constraints.

In an Australian study of nurses and their attitudes to nutrition, Kowanko et al. (1999) interviewed seven nurses from medical wards in a large teaching hospital and analysed the transcripts of the interviews for themes. All of the respondents agreed that, in practice, feeding patients took low priority and was not enjoyable because of time constraints. In spite of this there was a general reluctance to change nursing routines to allow greater time for nutritional care at mealtimes, especially when it involved changes in the nurses' own meal breaks. These nurses also felt that they lacked the in-depth knowledge required to give proper nutritional care to their patients (Kowanko et al. 1999).

Assisting patients in accessing and eating their food is important in the prevention of hospital malnutrition. Positioning patients comfortably in bed, ensuring that dentures are in place, having the meal trays within the patient's reach, removing lids from containers and cutting up food where necessary are all important in optimising the patient's consumption and enjoyment of the meal. However, the ability of nursing staff to ensure that the patients are ready for the meal and to provide assistance at mealtimes is inextricably linked to adequate levels of staff (Kayser-Jones & Schell 1997) and appropriate rostering of available staff. In an observational audit of mealtime interruptions in 50 wards in three British hospitals it was found that on one quarter of the wards in the study staff meal breaks coincided with the patients' mealtimes (Davidson et al. 2004).

Even when staff are available at mealtimes there can be too many patients requiring assistance for the available staff to manage. Kayser-Jones and Schell (1997) conducted an anthropological study over four years in two nursing homes, each of the nursing homes having more than one hundred residents. The social, cultural, environmental and clinical factors that influenced eating were studied in this research. Participant observation and interviews were used to obtain information for

event analysis. They reported that staff in one institution had to assist or feed 12 to 15 patients each mealtime and that sometimes the meal tray was removed either before the patient had been fed or after the patient had received only one or two spoonfuls of food.

The attitude of staff towards hospital food is also important since it can affect patients' appetites and meal consumption. Nurses generally consider the hospital meals to be reasonably appetising, although their attitudes about their nutrition-related nursing roles vary (Kowanko et al. 1999; Isaksson 1982). Carr & Mitchell (1991) studied the mealtime nursing care given to 20 stroke patients with feeding difficulties and 20 control patients in general medical wards of two British hospitals with different food service systems. They found that the devolution of the nurses' role in serving food to patients to other non-nursing staff, in order to free the nursing staff from non-nursing duties in one of the hospitals, had a negative effect on patient care. They found that the nurses who were not involved in serving food to the patients were less likely to observe whether the patient had eaten the meal, although they concede that their small sample size limited the validity of the findings. Carr and Mitchell (1991) believe that nurses give better care to patients at mealtimes when they are more involved with the food service, even though they found in their study that patients' feeding problems went unnoticed by the nurses in the majority of cases. A later, much larger study, confirmed this finding. Pearson et al. (2003) studied the social and functional context of the meal service in ten NSW nursing homes using observational and interview techniques. These authors also found that the nurses did not see problems which were observed by the researchers and the residents. Pearson et al. (2003) stated that, whilst the staff were striving to deliver good patient care, they were not always conscious of the impact that mealtime practices had on the residents. According to Doering (1992, p. 25), 'the

empiricist viewpoint may not allow nurses to see some problems important to our discipline because those problems are not conceptualised as valid in the empiricist domain'.

2.4.10 Food and power

There are parallels between the regulation of the body and the regulation of institutions. In fact, the body is commonly used as a metaphor for the structure and function of both institutions and society (Turner 1984). In the late 19th century it was considered that the order of the mind was damaged by disorders of the digestive system, and as a consequence diet became an important aspect of the management of prisons and the political management of society (Turner 1982). In hospitals, medical regimens are still a means of governing the body (Turner 1984), and the rationalisation of eating practices and the development of the science of dietetics is, in Turner's (1982) opinion, a practical example of the relationship between the body, knowledge and power. Fischler (1988) is of the opinion that every food has medical significance in the form of a medically defined regimen and that this is probably the main means of intervening in the body, and that diet is also a means of control over the self. The community would appear to agree with Fischler as there is a tendency to view obese people and young victims of heart attacks, for example, as being responsible for their predicaments by lacking dietary control (Rose 1992).

Food is central to the management of institutions such as hospitals, schools and gaols. It is often provided at unsuitable times with minimal consent by the consumer, and its consumption can be heavily policed by staff. Mealtimes in institutions are usually dictated by work routines and staff rosters and are frequently much earlier than mealtimes at home (Williams 1994; Bell & Valentine 1997; Mibey & Williams 2002).

Power is operational in hospitals at an interpersonal level as well as an institutional level, and is a feature of everyday interactions between staff and patients (Hewison 1995). Interpersonal power in hospitals prevails because of the inequality of knowledge between the health professional and the patient. In Parson's (1951) 'sick role' model, the patient willingly surrenders power to the more knowledgeable health professionals, becoming the passive recipient of their care. Foucault's (1975, cited in Lupton 1995) view is that power relations are central to the medical encounter, and that this is largely a benevolent relationship. There is a need for the patient to have faith and trust in the doctor which is destroyed once the patient becomes a consumer with equal medical knowledge (Lupton 1995). As Lupton (1995, p. 159) puts it: 'at both the conscious and unconscious levels there is a deep-seated need to invest trust in a responsible other, modelled on the parent-child relationship'.

Nurses are generally regarded as being less authoritarian than doctors and are seen as caring and empathetic (Lupton 1995). However, as Shattell (2004) found from her review of the literature on nurse-patient interactions, nurses can exert considerable power in their everyday communications with patients. Power may be exercised in a variety of ways. It can be overt, where instructions are given by the nurse and the patient is expected to comply. Power can also be used persuasively, which involves getting patients to do things without recourse to direct commands, or by 'controlling the agenda' where routine communication between the nurse and the patient indicates that a certain action should be taken by the patient (Hewison 1995). According to Hewison (1995), power interactions between nursing staff and patients using persuasion are common at mealtimes. Doctors also exercise power over patients in the matter of food and eating, not only in the prescription of dietary regimens which the patient must follow, but in their stated expectations of whether

the patient will or will not eat, which has been seen to influence subsequent patient behaviour (Habeeb 1973).

Shattell (2004) also found from her review that nurse-patient relationships were able to be formed very quickly, were important to the patient and could have a major influence on patient care. This author believes that patients generally want to be valued and respected by the nurses and do not want to be treated like objects.

However, patients are not always impotent in the power relationship. Activities which disrupt the medical or nursing routine, such as refusal to eat, may be an attempt to gain attention and may enable patients to exert some control over the situation (Hewison 1995; Shattell 2004). Food refusal is common in young children, in people whose verbal communication is inadequate to the situation or where verbal communication has proved to be ineffective. According to Booth (1994), the more strongly the food provider is perceived to be committed to having the food accepted, the more effective is this strategy. Such behaviour is consistent with the parent-child style of communication commonly employed by nurses, which frequently involves the staff using of terms of endearment towards the patient (Hewison 1995). In Turner's (1996) view, food refusal is an act of rebellion, in contrast to force feeding which he regards as an act of external terror.

2.5   Food and society: The critical perspective

This final section of the literature review explores the *critical* perspective, or *critique* of nutrition and malnutrition in Australia, including the factors which led to the development of the Australian dietary guidelines and national nutrition policy. Public nutrition policy is designed to influence the food praxis of the population and can be regarded as a form of social control. The literature on the effects of the Australian dietary guidelines and the national nutrition policy, and the influence

these policies have on individuals, their food choices and food praxis is reviewed. The phenomenon of hospital malnutrition is explored. Hospital malnutrition, and the deteriorating nutritional status of patients in hospital, can be regarded as an outcome of patients not eating, or not eating adequately, during their hospital admissions. Understanding the sociological significance of food in hospital from the patient's perspective may aid in bringing about changes which will improve that patient's enjoyment and consumption of hospital meals and ameliorate, or even eliminate, hospital malnutrition. Finally, the chapter reviews the western biomedical model of healthcare delivery and its effect on patients and their nutrition.

2.5.1   Food, health and public policy

The word diet is derived from the Greek *diaita* which means 'mode of living'. In ancient Greece diet referred to the set of rules and general guidelines, including eating praxis, which were imposed on people to ensure their health and well-being (Turner 1995b). From a philosophical perspective, it is our duty to ourselves, and to society, to take care of our health (Telfer 1996), and a proper diet is integral to the maintenance of good health. Diets, however, are usually viewed as being both restrictive and a means of self-control (Fischler 1988). The term diet has, therefore, continued to have moral overtones because of its connection with the need to care for our health by eating prudently. Obesity, for example, has strong moral connotations in our society. If diet is indicative of self- control, then obesity is clear evidence of a situation that is out of control and, therefore, must be morally wrong (Turner 1995b). The message to society is that obesity is not only a physiological abnormality, but a form of moral deviance.

Over the past 150 years the dietary advice given to Australians has changed substantially as a result of advances in nutritional knowledge and changes in the

knowledge, beliefs and values of the Australian population with respect to food and nutrition (Santich 2005). Santich (1995b) outlines three eras of dietary advice in Australia, all of which were in response to the perceived health problems of the population at the time. The protein era of the late 19th century, the vitamin era of the first half of the 20th century and the fat era of the latter 20th century each had its own paradigm of dietary advice which was understood as being a better way of eating for the general public. Santich (2005) believes that research plays a significant role in shaping dietary advice, which in turn represents a reflection of the current eating habits and the prevailing health issues of the population. This author proposes that existing paradigms for nutrition advice and education are abandoned and new paradigms are developed when science cannot explain evidence and research findings.

The historical concept of maintaining and improving health by means of proper diet remains current, and is worldwide. In 1974 the World Food Conference passed a resolution to the effect that all world governments should formulate food and nutrition policies, the World Health Organisation following suit in 1977 by adopting a resolution to encourage all governments to develop programs to improve the nutrition of their populations (Langsford 1979; Santich 1995b). As a response to these directives, and as a consequence of the changing patterns of disease and the new public health emphasis on disease prevention, many industrialised nations, including Norway, Greece, Japan, the UK, Canada and the US formulated nutrition policies (Santich 1995b). Cannon (1992) analysed 100 authoritative scientific reports on food, nutrition and public policy published by thirty different countries between 1961 and 1991 and concluded that they showed a clear consensus on the composition of a healthy diet. The healthy diet, according to these reports, should be low in fat, especially saturated fat, low in both sugar and salt, and should contain

more complex carbohydrates and fibre in order to reduce the prevalence of coronary artery disease, cerebrovascular disease and breast and bowel cancer.

Dietary goals are the first step towards nutrition policy and are generally written with the aim of changing the diet of the population to achieve improvements in nutritional and health status (Ringrose 1979). The key issue with public health nutrition policy is to change the dietary patterns of the population in ways which may achieve certain desirable health objectives, although Crotty (1995) is of the opinion that public nutrition policy, in doing this, constitutes a form of social control. Dietary guidelines are designed to assist consumers in making food choices which are consistent with the desired outcome of optimal health, and they should therefore be achievable. The Australian dietary guidelines made their first appearance as Dietary Goals and Targets in 1978 and were followed by the publication of a national food and nutrition policy in 1992 (Santich 1995b). Dietary guidelines are usually framed in very general terms, but the Nutrition Taskforce of the Better Health Commission, which was established in 1985, later quantified some of the Australian dietary goals and targets (Santich 1995b). Quantifying the goals enables the actual dietary intakes of individuals to be compared with ideal standards.

Dietary guidelines, whether quantified or unquantified, can take over the role of traditional eating patterns (Santich 1995b) and fulfill the function of rules for eating. Fischler (1988) has described what he calls the omnivore's paradox. Omnivores are not specialised eaters, and being an omnivore allows autonomy and adaptability in incorporating a range of foods, including new foods, into the diet. The omnivore's paradox is the tension created between eating known foods, which may be nutritionally inadequate, and unknown foods, which might be dangerous. Resolution of the omnivore's paradox is brought about by providing a framework to

guide choice. The cuisines of different cultures provide sets of rules and norms for eating which alleviate the omnivore's paradox (Fischler 1988). Patterning of meals allows the meal to be recognised and judged for its importance (Douglas 1975), and having a proper meal is an assurance of nutritional adequacy (Murcott 1982). Dietary acculturation, and an increasingly complex and globalised food supply which offers almost unlimited choice, causes uncertainty and anxiety for consumers who are no longer guided by the defined boundaries of familiar foods and a traditional pattern of eating. Dietary guidelines can be used to fulfil that role.

According to Fischler (1988) the modern demand for product information labels on foods is an expression of consumer anxiety. Consumer surveys lend support to Fischler's (1988) opinion. In a study of how consumers use nutrition labels, Shine et al. (1998) interviewed 200 Irish adults at four randomly-selected retail locations. The majority of the respondents were females aged between 25 and 40 years. The respondents were asked to cite their reasons for using nutrition labels. The most frequent response was 'to know what they were eating', followed by 'to get the best out of food' (Shine et al. 1998, p. 293). In a more recent study, Williams et al. (2004) conducted a national telephone survey of 1200 Australian adults to determine their attitudes about the safety and quality of food. These authors found that 45% of the respondents were more concerned about food safety than they had been five years previously, and a large proportion of the respondents said they checked food labels for food additives as well as for nutritional information (Williams et al. 2004).

Dietary guidelines are meant for populations, not individuals. For example, dietary guidelines aimed at reducing cardiovascular disease rates are based on what epidemiologists call the prevention paradox, which is 'a preventive measure that brings about large benefits to the community but offers little to each participating individual' (Rose 1992, p. 12). However, there is a temptation to interpret dietary

guidelines as prescriptive for individuals. Not only is it difficult, and unnecessary, for individuals to meet the dietary goals and targets, but a culture of blaming the victim can occur where an illness is perceived as being a violation of social rules concerning food consumption. Education is considered to be the most effective way of motivating change in people's food praxis (Santich 1995b), although Crotty (1993) maintains that research which clarifies the social context and the processes of domestic food provision is needed to support food and nutrition policies designed to improve the health of the public.

However, nutrition education can be confusing in the way it is delivered, especially when there is conflicting information resulting from new research. Schwartz and Borra (1997, p. S73) found that there is a 'consumer obsession with dietary fat', which attracts double the media coverage of any other nutrition or health topic in the US. These authors believe that consumer confusion about dietary fat has resulted in misperceptions about healthy eating. This opinion is shared by O'Dea (2004), who believes that current nutrition education is based on negative, problem messages which can lead to confusion and misinterpretation by the public, hindering the achievement of nutrition and health goals. In the previously mentioned study of consumer use of nutrition labels (Shine et al. 1998) also found avoidance of 'negative' nutrients to be apparent throughout the survey. These authors stated that the majority of the respondents used nutrition labels to seek out information on nutrients they wished to avoid, rather than to highlight the positive attributes of the product (Shine et al. 1998).

2.5.2 Changing the nation's diet

Although dietary guidelines and nutrition education are designed to change the dietary practices of populations, there is evidence that individual Australians have

made positive dietary changes in response to nutrition education. By the 1980s, shortly after the introduction of the Australian dietary guidelines, the national diet had decreased in fat content by more than 20%. Consumption of fruits, vegetables, cheese and milk had increased, butter had largely been replaced by polyunsaturated table margarines, and sugar consumption had decreased by 16% (Santich 1995b). This was in spite of the fact that 96% of the 730 randomly selected Melbourne residents responding to a postal survey of their awareness and compliance with the dietary guidelines said they had not heard of the Australian dietary guidelines (Worsley & Crawford 1986). The most recent data from the *Apparent Consumption of Foodstuffs and Nutrients in Australia* report (Australian Bureau of Statistics 1998-99) shows continuing significant increases in fruit and vegetable consumption and decreases in the consumption of sugars since the previous survey in 1988, indicating that public health nutrition policy does effect change on the food praxis of individuals. This trend towards healthier eating is reflected in the findings of Kennewell and Kokkinakos' (2001) study which was described earlier in this chapter. These authors compared the results of their survey of patients' food preferences with the results of a survey conducted by Williams (1988) twelve years previously in the same hospital. They found that high fat foods had declined in popularity and that the patients in the later study had a greater preference for dairy products and other nutritionally desirable items.

For individuals, however, meeting quantified dietary guidelines and recommendations in their strictest and most prescriptive sense can be quite a challenge. Two British studies measuring actual dietary intakes of dietitians and adult members of their households demonstrated that the goals of the dietary guidelines are difficult to achieve, even for committed, informed individuals (Black et al. 1984; Cole-Hamilton et al. 1986). In one of these studies 472 British dietitians

and adult members of their families kept seven-day food diaries of their normal eating habits, which were then compared with dietary goals based on the National Advisory Committee on Nutrition Education (NACNE) recommended dietary guidelines (Cole-Hamilton et al. 1986). Only 33 subjects came within 10% of reaching these goals.

In the second study Black et al. (1984) compared the dietary intakes of 42 volunteer dietitians with the same NACNE dietary guidelines. The dietitians kept weighed records of all food and drink consumed every sixth day for a period of one year. It was found that their intake of sucrose was considerably less than both the national average and the dietary guidelines recommendation but, although the dietitians' mean intake of fibre was higher than the national average, they still did not meet the NACNE goal of 30g per day. The dietitians' average fat intake was 40% of their total energy, compared with the NACNE goal of fat contributing 30% to total energy. The authors concluded that the NACNE recommendations are for the composition of the average national diet and 'cannot be applied too literally to sub-groups of the population, and certainly not to individuals' (Black et al. 1984, p. 179).

In order to determine the dietary intakes and food beliefs of Australian adults Worsley (1989) conducted mail surveys of 5,000 randomly selected residents of Adelaide and Melbourne. The response rate to this survey was 75-80%, and the age and sex distribution of the respondents was in the same proportions as the populations of Adelaide and Melbourne. It was found that the most positive attitudes towards dietary guidelines were in the middle-aged group of respondents, who were also the most concerned about being overweight. Worsley (1989) found considerable differences in food beliefs between the age groups of the respondents, the greatest differences being between the oldest (70 years plus) and the youngest (18–30 year old) groups. The oldest group reported dietary intakes that were largely

traditional in pattern and in content, and were low in snacks, takeaway foods and pasta. Respondents in this group were confident in the nutritional soundness of their diets and believed it unnecessary to change their diets. The youngest group expressed concerns about the 'naturalness' of their food, believed that their diets were more deficient in vitamins and minerals, and were more likely than the other groups to consume non-traditional foods. The younger group saw the need to improve their eating habits and endorsed the concept of a healthy lifestyle (Worsley 1989).

In the previously mentioned study by Kennewell and Kokkinakos (2001), a trend towards non-traditional foods was indicated. It was found that the patients in Kennewell and Kokkinakos' (2001) study had a greater preference for foods from various cultures, foods considered to be gourmet and novel foods than the patients surveyed by Williams (1988) twelve years earlier. These results could be a reflection of a general change in the food praxis of the community, or a difference in patient demographics in the 12 years between the two studies, or a combination of both. However, the 1995 National Nutrition Survey reported a trend towards an increasing proportion of take away and pre-prepared foods in the Australian diet (McLennan & Podger 1997), indicating that changes are occurring in the food praxis of the community. Tomlinson (1998) found similar changes in the UK. Using data from the British Health and Lifestyle Surveys of 1984/5 and 1992, this author found a decrease in fat consumption, but significantly increased consumption of 'junk' food, which is undefined in this study, but appears to be take-away food (Tomlinson 1998).

Arney and Tiddy (1992) also repeated Williams' (1988) study, using the same survey instrument in a repatriation hospital in South Australia. In this study over 95% of the 101 subjects were males of Anglo-Celtic origin over 60 years of age.

Approximately half of the subjects in this study were over 70 years of age. These authors found significantly different food preferences from Williams' (1988) younger, more ethnically diverse, subjects. Arney and Tiddy's (1992) subjects were found to have a very high preference for traditional foods such as ice cream, red meat, fruit and baked potato. They also had a preference for softer foods such as canned fruits, puddings and casseroles, which the authors attributed to the high prevalence of dentures in the study population (Arney & Tiddy 1992). The findings of this study largely concur with Worsley's (1989) findings that Australians over 70 years of age prefer traditional foods.

In another study of older people and their dietary beliefs and practices, McKie (1999) conducted 152 semi-structured interviews with rural and urban Scottish people aged 75 years and older. Similar to Worsley's (1989) findings, McKie (1999) found that healthy eating was conceptualised by elderly people as proper meals. Proper food was perceived as being fresh, natural ingredients, which were also regarded as healthy food, and these respondents expressed suspicion and dislike of convenience foods. A further study by Temple (2006) used data from the Australian Bureau of Statistics 1998–99 Household Expenditure Survey to determine the factors associated with older Australians purchasing a varied diet. The oldest group (75 years plus) was found to have the most limited dietary variety, purchasing only an average of 27 different food items, compared with the 33 food items purchased by the 55 to 64 year old group. Temple (2006) postulated that older people return to familiar foods and spend more time preparing food in ways they can manage in order to maintain control over what they eat.

Although public health nutrition policy is aimed at making changes at a population level, the significant changes in consumption patterns of the Australian population, especially the middle aged and younger age groups, to nutrition

education and the Australian Dietary Guidelines indicate that public health nutrition policy does have an impact on the food praxis of individuals. Public health nutrition education must therefore be considered as another factor which could influence the food preferences of hospital patients.

2.5.3 Hospital malnutrition

While the Australian dietary guidelines have had a significant positive impact on the food habits of the nation, malnutrition, which is frequently undetected, has emerged as a major problem in hospital patients. In their 1976 landmark paper, Bistrian et al. (1976) documented the previously unrecognised existence of malnutrition in British hospitals. Since then, many studies have subsequently confirmed the worldwide existence and continued prevalence of hospital malnutrition (Hill et al. 1977; Askew et al 1982; Metz 1982; McWhirter & Pennington 1994; Arrowsmith 1996; Braunschweig et al. 2000; Middleton et al. 2001; Lazarus & Hamlyn 2005).

There is no single definition or diagnosis of malnutrition which is a term which can refer to several conditions, including undernutrition and obesity. Physical hunger as a consequence of inadequate food intake is not malnutrition, although malnutrition can result from inadequate food intake, especially if it is frequent or prolonged. Historically, malnutrition has been thought of in the context of vitamin and mineral deficiencies, although inadequate intakes of protein and/or energy also result in malnutrition. Hospital malnutrition refers to protein/energy malnutrition, which is defined as 'lack of adequate nutrition resulting from insufficient food, unbalanced diet or defective assimilation' (Arrowsmith 1997, p. 1131).

Malnutrition has a major impact on the outcomes of medical treatment. Increased mortality and morbidity and increased length of hospital admission are

now well accepted as consequences of hospital malnutrition (Marshman et al. 1980; Metz 1982; McWhirter & Pennington 1994; Arrowsmith 1996; Braunschweig et al. 2000; Middleton et al. 2001; Kyle et al. 2005). The cost of malnutrition to the health service is also significant. Edwards and Nash (1997) estimated that the cost of treating a malnourished patient with complications is four times that of a well-nourished patient without complications. In addition, the patient's quality of life is also diminished when malnutrition is present. In a study of nutritional status and its relationship to quality of life Laws et al. (2000) nutritionally assessed 53 haemodialysis patients and compared the results with their quality of life scores. These authors found that malnourished patients not only had more admissions, longer admissions and longer average lengths of hospital stay than the better nourished subjects in the study, but they also had poorer perceived quality of life in respect of their psychological well-being and global feelings about their present life (Laws at al. 2000).

In a much larger study to determine the impact of nutritional status on quality of life, 456 patients admitted to an acute care hospital were administered a quality of life questionnaire and nutritionally assessed on admission (Ferguson et al. 1998). Similar to the Laws et al. (2000) study, it was found that the quality of life scores in all domains for the patients with malnutrition were significantly worse than those of the patients who were well nourished.

In 1987 Zador and Truswell (1987) surveyed 84 patients in the general surgical wards of a large Sydney teaching hospital and confirmed the presence of malnutrition in this hospital. Using seven indicators of malnutrition (Body Mass Index, weight loss history, triceps skinfold thickness, arm muscle circumference, haemoglobin, total lymphocyte count and plasma albumin), Zador and Truswell (1987) found that 14% of the patients were clinically malnourished, while 31% were

assessed as being at risk of developing malnutrition. This study was repeated by Naylor et al. in 1996 as a snapshot survey of the prevalence of malnutrition in all inpatients in the same hospital. Using the same criteria Naylor et al. (1996) assessed 468 inpatients. They found that 63% of the patients were at risk of malnutrition of various degrees, while 10% of all patients in the hospital were classified as being severely malnourished. The study was repeated a third time in the same hospital in 2005 by Huq et al. with 302 patients. Using the same criteria, Huq et al. (2005) found that, while the overall rates of patients at risk of malnutrition had increased to 71%, the numbers of severely malnourished patients had reduced slightly to 8%, neither change being statistically significant. This study does demonstrate, however, that the incidence of hospital malnutrition is not diminishing, and remains a major problem.

While many patients, particularly those with chronic disease, may be already malnourished on admission to hospital, it has been demonstrated that the nutritional status of all patients deteriorates during the course of the hospital stay. McWhirter and Pennington (1994) measured body weights in a series of 500 inpatients and found a mean weight loss of 5.4% of the patients' total body weight had occurred during the course of the hospital stay. The reasons put forward for this phenomenon are manifold. These include late instigation of enteral feeds, lack of assistance to patients who are unable to feed themselves and pre- and post-procedure fasting, which Eastwood (1997) found accounted for three quarters of missed patient meals. However, a decline in nutritional status as the hospital admission proceeds may also be due to the fact that patients do not like, and therefore do not eat, hospital food.

In 2003 a mealtime audit of a random sample of 382 patients in three hospitals in Sydney was undertaken, and it was found that seventy patients (18%) did not eat

their main meal (O'Loughlin 2003). The most frequently cited reason for not eating the meal was feeling nauseated or unwell, but 8.6% cited dislike of the food as the reason, and a further 5.7% ate food from home rather than a hospital meal. Todd et al. (1984) studied the food intakes of a sample of 45 patients on unrestricted, self-selected diets in two UK hospitals over a period of five days. These authors documented low protein and energy intakes overall, with a quarter of the patients failing to meet their protein and energy requirements and half of the patients consuming 10% or more of their total daily energy intakes from food from external sources. Todd et al. (1984) stated that, although the hospitals theoretically provided sufficient food for patients to meet their nutritional requirements, the quality and presentation of the food served to the patients was poor, and lack of nursing supervision and patient discomfort at mealtimes also contributed to suboptimal food intake.

Tube feeding patients does not lessen their nutritional risk. In their study of 379 enterally fed patients in a large intensive care ward, Ferrie and McWilliam (2006) found that the patients received, on average, only 72% of their total daily energy requirements, and that they received negligible nutrition for 25% of the time they were in the intensive care unit.

In both the United Kingdom (UK) and Europe, hospital malnutrition has been targeted as an area requiring immediate and drastic improvement (Allison 1999; Beck et al. 2001). Screening patients for malnutrition on admission, and during the course of the admission, is mandatory in the UK and Europe (Lennard-Jones 1992; Allison 1999: Davis & Bristow 1999; Beck et al. 2001). Several screening tools have been developed to identify malnourished patients, and some of these have been validated for use in Australian hospitals (Bauer et al. 1997; Jukkola & MacLennan 2005). Part of the British approach to reducing the incidence and severity of hospital

malnutrition is to highlight the deficiencies in hospital food provision, and to focus attention on the quality and nutritional adequacy of the food (Allison 1999). Hospital food service has traditionally been regarded as a 'hotel service' rather than an integral part of clinical care (Holmes 2004), as it is assumed that patients are equivalent to healthy, free living individuals. However, Allison (1999) believes that, in hospitals, food should be regarded as part of medical treatment. This author has developed the concept of a 'food chain' in which nutritional screening, assessment and audits, nutrition support and the provision of food which is acceptable to the patients are all part of the patient's clinical care. As de Raeve (1994) observes, the serving of acceptable food to patients is a moral issue as well as a clinical matter. In the United States of America it is also a legal matter since malnutrition in hospital is regarded as malpractice.

2.5.4 The western biomedical model of healthcare

In western society, healthcare delivery is based on the Cartesian concept that there is a fundamental division of mind and body (Capra 1983). Advances in medical science have reinforced this view that mind and body are separate and, according to some authors (Capra 1983; Lupton 1994b), modern medical practice tends to concentrate on the functions of the body and to disregard the social, environmental and psychological aspects of illness. Davis and George (1993) are of the opinion that both doctors and patients assume roles which are based on the definition of illness as a biological process rather than a result of environmental or psychosocial processes. The role of the doctor is that of a skilled practitioner who applies scientific knowledge to correct a biological abnormality, while the role of patients is to submit themselves to the physician's care (Parsons 1951; Strauss et al. 1982). According to Hawkins' (1979, cited in Davis and George 1993), patients sometimes have difficulty in obtaining information from physicians. This author found that although complex

processes were explained to patients, more common processes were frequently left unexplained.

Hospitals are complex, bureaucratic structures organised along hierarchical lines with doctors at the top of a clinical chain of command directing the patient care provided by other staff (Coe 1978). Although patients are in hospital, they are not actually part of the hospital's hierarchical structure (Coe 1978). However, there are expectations of patients in terms of the role they assume (Parsons 1951) and their behaviour and attitudes while in hospital (Coser 1962; Strauss et al. 1982). Patients are expected to be submissive and obedient and to submit uncomplainingly to treatment (Coser 1962; de Lange 1963; Brown 1999). Failure to adopt an appropriate attitude can result in the patient being labelled a 'bad patient' (Murcott 1981). In hospital, the focus is on the treatment of the illness and, according to Strauss et al. (1982), patients' needs which are unrelated to the illness being treated are frequently overlooked. Patient needs include individual food praxis and comfort foods. This is reflected in the dichotomous role of food and nutrition in healthcare. In hospitals, nutrition is generally regarded as part of the clinical care of patients (Lennard-Jones 1992; Allison 1999; Davis & Bristow 1999), whereas the production and delivery of food to patients are hotel services. According to Paterson (1981) hospital kitchens are areas which are outside the scrutiny, and presumably the interest, of the medical hierarchy.

The centrality of science in the definition, understanding and treatment of illness, and the disregard of the role social processes play in illness have resulted in numerous normal social processes being 'medicalised'. Medicalisation is the reframing of social, economic or political aspects of life into scientific and medical terms (Conrad 1992; Germov & Williams 1996) so that clinicians can better understand these aspects of the patient's condition. For example, in her study of the

relationship of the meaning of eating and illness in hospitalised patients, Habeeb (1973) described eating as being medicalised. The consequence for the respondents in the study was to remove eating from the realms of the personal and to threaten their identity.

Loss of sense of self is a threat to patients as a result of disruption from their normal social environment (Warren et al. 2000). Lupton (1994b) believes that hospital patients frequently feel alienated and vulnerable during their treatment. According to Bell and Valentine (1997) food, and their personal food praxis, has an important role in bringing familiarity and comfort to patients in the alien environment of the hospital.

2.6 Conclusion

This chapter has traced food, self, culture and healthcare institutions through the four perspectives of the sociological imagination framework. First, it has shown that people learn to eat the way they eat in early childhood from their families, and that these early influences persist throughout life. Comfort foods, or foods which impart feelings of comfort and security in stressful situations such as being in hospital, frequently have their origins in childhood experiences. Although the family has a strong influence on eating praxis, individuals have personal food preferences which are the result of a combination of factors such as culture and personal experience. Major life events, such as leaving the family and living with others, precipitate changes in the food praxis of individuals.

Second, the influence of culture on eating praxis is explored. Culture is reflected in the ways food is prepared, the spices and flavourings used in foods, the food items which are consumed in the cuisine and the combinations of foods which are served together. Moving to another country is also likely to bring about major

changes in food praxis in individuals and cultural groups as traditional foods become less available and different foods from the new country present themselves. The inverse is also true for the host nation as traditional cuisines and food items brought by the migrants become available in the community. The family's food praxis, in turn, is a reflection of the prevailing culture in which foods are consumed and incorporated into the family's diet.

Personal food praxis and culture together contribute to the individual's sense of self, and sense of belonging. In the words of Curtin (1992, p. 4), 'food structures what counts as a person in our culture'. Disorganisation of food culture will therefore disrupt the individual's sense of self.

In the context of Anglo-Celtic culture, the construct of the 'proper meal' is used as a template for judging the nutritional adequacy of the diet, and this has strong psychological connotations associated with nurturing. Although the proper meal is an Anglo-Celtic construct it is possible to apply the basic template of the proper meal to the structure of meals of other cultures. The traditional proper meal, which is the basis of hospital menus in NSW, is a code for nutritional soundness and balance in the meal. This code will be recognised by all of the Australian-born respondents and many of the overseas-born respondents as well.

Third, structural issues in the healthcare system related to the provision of food to patients were reviewed and the impact they are likely to have on patients was considered. When a person is admitted to hospital frequently, the only familiar thing, and one of the few things he or she feels qualified to evaluate, is the food. Patients bring with them their personal food preferences based on their beliefs which were acquired initially through the family and their ethnic backgrounds and which are modified, over time, by society. Hospital food services have a duty of care

to meet the nutritional requirements of each patient, and most attempt to meet the psychosocial needs of the patients to some extent as well. Hospital food services are, however, constrained by limitations such as systems of preparation and distribution of the food, as well as statutory requirements of providing safe food to the patients. Many patients are influenced by the common belief that hospital food is nutritious but not appetising, and are prepared to lower their expectations of the quality of food they will receive during their hospital stay. Patient perceptions of food quality have a strong correlation with their satisfaction with medical treatment and the hospital stay overall.

Non-physical considerations were also reviewed as part of the structural perspective of the sociological imagination framework. Power relationships within hospitals, at both the institutional and the personal level, and their implications for patient identity and autonomy were reviewed as part of the structural perspective.

Finally, from the critical perspective of the sociological imagination, the implications of public health nutrition policy, hospital malnutrition and the western biomedical model of healthcare delivery were considered. Dietary guidelines, which are intended to guide the population into making prudent food choices to optimise health, can also be used by individuals as a template for a healthy diet. As the food supply becomes more globalised and exotic foods become easily available, and traditional food patterns become more blurred, the dietary guidelines are increasingly being used in this way. Older members of the population, however, tend to be very conservative, and prefer to be guided by the traditional meal pattern, unlike younger people who are generally adventurous with new foods and eat a wide range of foods from different cultures. Hospital malnutrition, its prevalence, possible causes and implications were also reviewed as part of the critical

perspective. Finally, the western biomedical model of healthcare delivery and its potential impact on patients in hospital was reviewed.

Using the sociological imagination framework the information obtained from each individual in the particular situation of a hospital admission can be linked and practically applied to the broader context of the institution and its practices and procedures related to food. The topics covered in this literature review all have the potential to affect the food experiences of patients in hospital, and are relevant to the research questions:

1. What are the food experiences of patients in hospital?
2. What determines the food preferences of hospital patients?
3. Are patient food preferences important in determining what people eat in hospital?

The next chapter describes the methods used to explore these questions.

Methodology

But facts do not make history; facts do not even make events. Without meaning attached, and without understanding of causes and connections, a fact is an isolate particle of experience, is reflected light without a source, planet with no sun, star without constellation, constellation beyond the galaxy, galaxy outside the universe – fact is nothing.
—Russell Banks 1997, p. 339.

3.1 Introduction

The aims of this research were twofold. First, to explore the effect that hospitalisation has on the normal food praxis of individuals, and second, to describe the experience of food and eating in hospital from the viewpoint of the patient. The preceding chapter presented the literature related to food and the individual, hospital food and food service, and the impact that being in hospital has on people. This chapter discusses the methodology of the study.

3.2 Justification for the research design and methodology

Research strategy is the manner in which specific methods and techniques are used in research in order to produce the most efficient and effective means of collecting information (Layder 1993). The purpose of research is to either test existing theories, or to generate and construct new theories. The methods employed in research studies differ considerably, depending on which type of approach is used. Research which has testing existing theories and hypotheses as its primary aim has what is termed a positivist approach (Gerber 1999). Positivist research uses structured techniques of data collection and usually employs quantitative research frameworks

and methods which are designed to measure variables and test pre-existing hypotheses. This type of research is most commonly used in the physical and biological sciences, although it can also be employed in social science research.

An argument against the use of quantitative methodologies in the social sciences is that positivist techniques are unable to delve into the individual perspectives of human beings, and therefore cannot uncover the meanings they attach to situations. In addition, the values and significance humans attach to situations, and the awareness people have of their situations, can alter their behaviour and confound positivist research results as a consequence. However, positivist research can be a valuable tool in sociological research as quantitative research methods often identify the nature and relationships between observed phenomena, so it can be useful as a precursor to further research (Minichiello et al. 1999). In some cases, aspects of the theories generated by qualitative research can be investigated on larger samples using quantitative methods. Although it would be possible to conduct this research study using a positivist framework the real focus of my research was on identifying and understanding the food experiences of individual patients, the patients' perspectives, and the meanings patients attach to food and eating in the context of a hospital admission. Therefore, methodologies which are better suited to eliciting this information were explored.

The constructivist approach to research is aimed at generating new theory, or building on existing theory, rather than proving or disproving a predetermined hypothesis. In this type of research the process is flexible, allowing some aspects of the research design and sampling to be decided during the course of the project (Layder, 1993). Methods such as participant observation and unstructured interviews are frequently used in constructivist, or qualitative research. The purpose of qualitative research is to explore the interrelationships between individual beliefs,

cultural norms and social rules in a way which Morse (1992) believes is characterised by three features which distinguish qualitative from quantitative research. These are the emic perspective, the holistic perspective and the inductive and interactive process of inquiry.

The emic perspective is the process of eliciting meaning, experience and perceptions from the point of view of the participant, rather than from the researcher's interpretation of events. This requires that the researcher identifies and sets aside his or her own beliefs and values in a process known as bracketing (Minichiello et al. 1999). Without bracketing, the deductive route may be driven by the researcher's beliefs, generating invalid results in the process (Morse 1992).

Stake (2000) is of the opinion that social phenomena are influenced by numerous factors which include physical, economic, aesthetic and ethical concerns. According to Morse (1992), the holistic perspective which is inherent in qualitative research is cognisant of these influences and involves the inclusion of both the context of the phenomenon and the underlying values of the participant as an integral part of the study.

The third characteristic that differentiates qualitative from quantitative research is the inductive and interactive process which develops between the researcher and the research data. In qualitative analysis the researcher drives the analytic process which is continually informed as comprehension and insights into the phenomenon of interest are gained (Morse 1992; Braun & Clarke 2006).

Qualitative research methods are most apposite when the focus of attention is the way people understand and negotiate their life situations, as qualitative methods require the researcher to go beyond description and definition and reach the understandings the participants have of their situation. Gregory (1995) believes that

qualitative research methods are particularly appropriate for the study of food and eating, two fields which are, in that author's opinion, so fundamental to life, because qualitative methods blend the requirements of maintaining the perspectives of the individual participants with the same analytic rigour found in quantitative methods. Therefore, taking into consideration that this research project is concerned with the food and eating experiences of hospital patients, a qualitative design was considered to be the most appropriate approach.

Within the qualitative paradigm there are numerous research approaches which could be employed, including ethnography, phenomenology and grounded theory and thematic analysis.

Ethnography is an approach used to describe a cultural group and the mores associated with the culture, and to understand the characteristics of a particular social setting (Holloway & Todres 2003). It is assumed that the culture is shared by all the participants (Morse 1992; Grbich 1999c). Although sociologists have traditionally used ethnography in settings such as villages, it has been used in health research where a professional group, or even an entire institution, is regarded as a cultural group who share the same values and behaviours (Morse 1992). Ethnography could only be used in this study if all hospital patients were considered to be a cultural group. Regarding all patients as a single cultural group assumes that all patients share common values and attitudes towards food, and that food praxis will be disrupted in the same way for each individual. This is an assumption that cannot be supported as both the ethnic diversity of hospital patients and our already existing knowledge of cultural differences in food praxis (Fischler 1988; Booth 1994) would suggest that patients are not a homogeneous group with regards to food. Ethnography was therefore not considered suitable as the research design for this study.

In phenomenology the objective is to describe, interpret and understand the meanings of experiences in the everyday world from the viewpoint of the experiencing person (Holloway & Todres 2003). Phenomenology is concerned with comprehending meaning through the two realities of the actual spatial and temporal object or event and the memories and feelings associated with that object or event (Grbich 1999b). While phenomenology could be used in this research, I believed that the problem was broader than just the human meanings of food and eating in hospital. The hospital system, particularly the hospital food service system, needed to be considered in order to understand the context and impact of hospitalisation on the individual's food praxis. To exclude these elements would limit the results and the effectiveness and application of the outcomes of the research. For that reason phenomenology was not considered the most appropriate methodological approach for this research study.

In grounded theory, the focus is on the development of useful theory about how individuals and groups interact. Evidence for grounded theory is derived from actual events and the way people communicate with each other (Holloway & Todres 2003). However, according to Grbich (1999a), the development of new theory from grounded theory analysis may take many years. As the objective of this research study was to identify the major factors which affect the food praxis of hospital patients, and to implement solutions to problems which may emerge from the analysis of the data, rather than develop new theory, an alternative study design was sought.

Thematic analysis is concerned with identifying themes and patterns within texts (Roberts & Taylor 2002), organising the data set (Braun & Clarke 2006) and interpreting aspects of the research topic (Boyatzis 1998). Thematic analysis, in Braun and Clarke's (2006, p. 77) opinion, is 'a poorly demarcated, rarely

acknowledged, yet widely used qualitative analytic method'. Although thematic analysis is not regarded as a specific method itself, it is frequently used as a process within other analytic methods such as grounded theory, phenomenology and discourse analysis (Boyatzis 1998). Despite its common use as a tool within other methodologies, Braun and Clarke (2006) believe that thematic analysis should be considered a method in its own right because it does not have any specific theoretical ties and it can therefore be applied across a range of different theoretical approaches. From their experience using this approach, these authors believe that thematic analysis is flexible and useful, and is able to provide rich and complex data. Thematic analysis also allows freedom in the choice of sampling techniques (Liamputtong & Ezzy 2005). Braun and Clarke (2006) argue that, although it offers an accessible form of analysis, since it does not require the detailed theoretical and technical knowledge of other approaches, thematic analysis, if applied rigorously, can both reflect reality and produce insightful analyses that answer particular research questions.

Therefore, because of the flexibility in sampling technique, the choice of theoretical framework afforded by this approach and its ability to provide rich, meaningful information, semi-structured interviews and thematic analysis were chosen for this study.

3.3 Theoretical framework: The sociological imagination

In choosing a qualitative approach for this research project, a framework which was able to link the structure of the hospital and the interactions and behaviours of individual patients was essential. Such a framework, which links individuals and institutions from the viewpoint of the individual, is the sociological imagination. The sociological imagination, developed by Charles Wright Mills (Mills 1959), is able

to distinguish between personal problems, which are the domain of individuals, and public issues, which occur in the wider social context and are related to the way society and its social institutions are organised (Willis, 1999). Mills (1959) argued that personal problems become public issues when both the correct statement of the personal problem and the solution to the problem require consideration of the broader context of society, and not just the personal situation of the individual. According to Mills (1959, p.5) the sociological imagination enables the researcher:

> to take into account how individuals, in the welter of their daily experience, often become falsely conscious of their social positions. Within that welter the framework of modern society is sought, and within that framework the psychologies of a variety of men and women are formulated. By such means the personal uneasiness of individuals is focused upon explicit troubles, and the indifferences of publics are transformed into involvement in public issues.

Thus, the distinctive feature of the sociological imagination is to clarify the relationship between the individual's personal issues and public issues at a societal level (Willis 1999).

This concept of the sociological imagination, which links the institution and the individual but keeps the individual as the central focus, has been developed by Evan Willis (1995) into a framework for sociological research by examination of four different perspectives of the research phenomenon. These four perspectives, the historical, the cultural, the structural and the critical, were discussed in Chapter Two. As the sociological imagination aims to clarify the links between individuals and institutions it was deemed appropriate as the framework for this research study.

The focus of this research was on individual patients, with the aim of exploring their food experiences in hospital from their perspectives. The ultimate goal was to determine what factors influence patients' food consumption in hospital. Applying the four perspectives of research phenomenon, it could be that the reasons patients do not eat in hospital are *historical*. That is, the patient does not like hospital food because it does not align with that individual's learned conception what is appropriate or acceptable. There could also be *cultural* reasons for the patient not eating in hospital in that the patient is from a different culture and the hospital does not, or cannot, provide foods which are culturally acceptable to that patient. Or again, the reason could be *structural* in the way the hospital system is organised which does not allow the patient to access appropriate foods, or that the foods are not acceptable when they reach the patient. Finally, the reasons patients do not eat in hospital may be explained by the *critical* perspective of the sociological imagination. The critical perspective includes the impact current public nutrition education and the western biomedical model of healthcare has on individuals.

Using the sociological imagination as a starting point for this research provided cues for areas which could be explored and ways to understand how the elements of the research might relate to each other. The sociological imagination framework also guided the study and enabled me to organise the findings of the research into meaningful information.

3.4   Setting

The respondents for this study were adults above the age of twenty years who had had at least one admission to an acute care hospital within the past twelve months. The respondents' admissions were in a total of 22 different hospitals in New South Wales. Of these, there were 13 public hospitals and 9 private hospitals. The public

hospitals included large metropolitan teaching hospitals, smaller metropolitan hospitals and rural hospitals. The private hospitals included both metropolitan and rural facilities. None of the respondents had been admitted to long stay or rehabilitation hospitals.

3.5 Sampling procedure

The sampling technique used in this research study is one which has been described by Liamputtong and Ezzy (2000) as stratified purposive sampling, and by Trost (1986) as statistically non-representative stratified sampling. Purposive sampling, according to Schofield and Jamieson (1999), requires the researcher to make decisions in advance about the criteria the participants should meet in order to fulfill the study aims. Stratified purposive sampling further refines this method to ensure that the variation, or respondent characteristics which are required by the research, are distributed throughout the sample. Stratified purposive sampling is not intended to be statistically representative, but it does guarantee variation within some of the variables. This sampling technique was chosen for this research study so that patient characteristics which could affect food praxis in hospital would not only be represented by the respondents, but that there would also be a spread of these characteristics amongst the respondents.

Following the method described by Trost (1986) a list of characteristics of hospital patients which were of interest in this research study was made before the sampling commenced. These characteristics included age, gender, country of birth and whether the subject followed a modified diet at home. Next, the most easily used characteristics were moved to the top of the list. These were age and gender, followed by dietary modification. Using these selection criteria, a total of 31 subjects

were recruited. Table 3.1 below indicates the characteristics that were represented in the sample.

Table 3.1: Characteristics of the study respondents

Age	Ages between 24 and 85 years
Country of birth	Australian-born and overseas-born
Diet	Unrestricted and modified diets
Gender	Males and females
Hospitals	Public and private
	Metropolitan and rural
	Large teaching hospitals and smaller non-teaching hospitals
Illness	Acute and chronic illnesses
Indigeneity	Aboriginals and non-Aboriginals
Length of stay	Short stay and long stay

Some of the characteristics listed above, such as 'overseas born' and 'dietary modification', have many different sub-categories within the category, such as different countries of birth and different types of dietary modifications. It was not intended to have every country of birth or every dietary modification represented in the study. Rather, the variable was considered to be 'Australian-born/not Australian-born' and 'modified diet/no diet'. The only exception to this was that two Aboriginal respondents were interviewed because a relatively large concentration of Aboriginal and Torres Strait Islanders live in the local government areas adjacent to the large teaching hospital from which ten of the respondents had been recruited (Wen 2003). Although they are Australian-born, Aboriginal and Torres Strait Islanders have very different food traditions from Australian-born people of European heritage. A demographic profile shows that the four most common countries of birth for non Australian-born residents of this area are China, United

Kingdom, Italy and Greece (Wen 2003). Respondents from each of these countries were included in the study sample.

Respondents meeting the desired criteria of acute or chronic illness and long or short length of stay were not deliberately sought out initially. Later in the data collection stage I began to recruit longer stay patients with chronic illnesses through a large Sydney teaching hospital, as it was found that the earlier recruits tended to have had acute illnesses with short hospital stays. All the participants had their admissions in acute care hospitals, and although the respondents were not recruited according to whether the hospital was public or private, metropolitan or rural or a teaching hospital, by the end of the data collection it was found that the respondents had been admitted to a range of different hospitals so no further action needed to be taken in respect of recruiting for a specific hospital type. The hospitals where the respondents had been admitted included large teaching hospitals, medium sized metropolitan public hospitals, large and small metropolitan private hospitals, rural public and rural private hospitals. Although some of the participants had very long admissions, these were in acute care hospitals. Seven of the respondents had had admissions in more than one hospital. Overall, the respondents had been admitted to thirteen different public hospitals and nine private hospitals.

Initially, participants were recruited into the research study by using the snowball sampling technique. This technique, according to Schofield and Jamieson (1999), involves using networks, with participants identifying other possible participants who meet the criteria of the research study. At first, I approached friends and colleagues who had either had a recent hospital admission themselves, or who had a relative who met the study criteria. Twelve participants were recruited to the study by this method. These participants were not asked to suggest other possible participants, but on two occasions another possible person for recruitment

to the study was suggested by the participant. However, neither one was recruited to the study because both were too ill to participate at the time.

Later, as the research advanced, specific categories of participants were required (for example, a particular age group and gender), so patients of a large Sydney teaching hospital who met the sampling criteria were recruited through the staff of the Nutrition and Dietetics Department. Ten participants were recruited to the study via this purposive sampling strategy. Of the remaining participants, four were recruited through a colleague in a large country town, and the two Aboriginal participants were recruited through another colleague. In two cases, two relatives of previous participants asked to be interviewed, and both were included in the study as they met desired criteria. The final participant had heard about the study through a colleague and requested to be included. As this participant was born overseas, was diabetic and had had two recent admissions in a private hospital, he was included in the study.

Of the 31 participants aged between 24 and 85 years who were interviewed for this study, 14 were males and 17 were females. Males and females were represented in each age cohort. Seven of the participants were born overseas and two were Aboriginal. All participants had had a least one admission to an acute care hospital in the recent past. Table 3.2 (page 105) shows the demographic profile of each study respondent.

Table 3.2: Respondent demographic profile

Age	M/F	Country of birth	Illness	Diet	Length of stay	Hospital
24	F	Australia	Chronic	Yes	Multiple short & long	Large teaching
29	M	Australia	Chronic	Yes	Multiple short & long	Large teaching
30	F	Australia	Chronic	No	Multiple short & long	Large teaching
33	M	Australia	Chronic	Yes	Multiple long & short	Large teaching
34	F	Australia	Acute	No	Three short	Private
34	F	Overseas	Acute	No	Two short	Large teaching
40	F	Australia	Chronic	Yes	Multiple short & long	Large teaching Smaller teaching Rural hospital
45	F	Australia	Acute	No	One short	Private
47	F	Australia	Chronic	Yes	Multiple short & long	Large teaching
48	F	Australia	Acute	Yes	One long, one short	Private
48	M	Australia (Aboriginal)	Acute	No	Multiple short	Rural public & rural private
50	F	Australia (Aboriginal)	Acute	No	Two short	Rural public & large teaching
53	F	Overseas	Acute	No	Multiple short	Rural public & large teaching
55	M	Australia	Acute	No	Two short	Metropolitan public
57	F	Australia	Acute	No	One short	Private
58	F	Australia	Acute	No	Multiple short & long	Private (two)
59	M	Australia	Acute	Yes	One short	Large teaching
62	F	Australia	Acute	No	Two short	Rural public
65	M	Overseas	Acute	Yes	Two short	Private
67	M	Australia	Chronic	Yes	Two short	Large teaching
68	F	Overseas	Acute	No	Two short	Large teaching
68	M	Overseas	acute	No	Two long	Metropolitan teaching
72	F	Overseas	Chronic	Yes	Multiple short & long	Large teaching
74	M	Australia	Chronic	Yes	Long & multiple short	Large teaching
76	M	Overseas	Acute	No	One short	Rural public
83	M	Australia	Acute	No	One short	Rural public
83	F	Australia	Chronic	No	Multiple short	Large teaching Private
84	M	Australia	Acute	No	Multiple short	Large teaching
85	F	Australia	Acute	No	Multiple short	Rural public
85	M	Australia	Acute	No	One short	Rural public
85	M	Australia	Acute	Yes	Three short	Large teaching

3.6   Interview schedule

In-depth interviews are a common strategy for data collection in qualitative research because, in Holloway's (1997) opinion, they provide a rich source of data. In thematic analysis, semi-structured interviews, which have a more specific research agenda and are more focussed than unstructured interviews, are commonly used. Polit and Hungler (1987) believe that the use of semi-structured interviews ensures that the topics which are important to the research are covered without compromising the depth of the information obtained. In semi-structured interviews the researcher uses an interview guide which focuses on the issues to be covered, but the participants describe their situations in their own words, and in their own time, and the sequencing of questions is not necessarily the same for each participant (Minichiello et al. 1999). According to Rice and Ezzy (1999), interviews should be regarded as discursive events in which the researcher actively encourages the participant to talk about the topic of research interest. The semi-structured interview technique, in Santich's (1994, p. 69) opinion, is particularly appropriate for the 'exploration of subjects as complex as eating habits and food preferences'. Consequently, as semi-structured interviews met the requirements of the research approach and would elicit valuable data, this data collection technique was chosen.

The semi-structured interviews for this research used the following series of prompting questions to elicit information from the respondents.

1.   Tell me what you remember about food during your childhood.

2.   Do you have any food traditions in your family? Do you have special foods for birthdays, or special celebrations?

3.   Did your food habits change when you left home for the first time?

4.   When you married did you alter your food habits to accommodate your partner?

5. There are a lot of health messages related to food and diet on television and in the press. Have you changed the way you eat as a result of this information?

6. Tell me about your food experiences in hospital.

7. How did you feel about the food in hospital?

8. Are there any particular foods that you like to have when you are sick or not feeling very well? Was the hospital able to provide these foods for you?

9. What do you think is the most important thing about food?

The questions posed to the participants were broad, and mainly open-ended, in order to reduce interviewer bias and to enhance the trustworthiness of the study. With the exception of the first question, these questions were asked in the course of the conversation where it appeared to be most appropriate, and were therefore not necessarily in the same order for all of the respondents. I found that the first question, in addition to providing valuable information for the research, helped to relax the participants as they recalled their childhoods. By the time the questions relating to food in hospital were posed, I had established good rapport with the participants, who were comfortable enough to answer the questions frankly, and in some cases, felt able to be very critical of their hospital experiences.

According to Crookes and Davies (1998), one of the functions of a theoretical framework is to guide the development of the research tool, and this was the case in this study where the interview questions were designed to draw out information related to all four perspectives of the sociological imagination. For example, the first four questions explored the historical and cultural perspectives of the research problem. Responses to these questions were intended to highlight the specific factors involved in forming the food likes and dislikes of the participants, the

changes in food praxis which had occurred during their lifetimes and the events which precipitated these changes.

The fifth question was designed to obtain information from the participants about the impact of the Australian dietary guidelines, and other nutrition education designed to promote dietary change in individuals and populations, on the food praxis of the participants. This is the critical perspective of the sociological imagination. The answers to these five questions provided background information for the next three questions which explored the structural perspective of the research framework, or the participants' food experiences in hospital.

The final question was added after the first eight interviews when I became aware that, for some of the participants, food was extremely important while, for others, it was far less so. On reviewing my journal I found I had noted that some respondents were very interested in food and eating, whilst others appeared to be quite uninterested. I felt that adding a question which would indicate the relative importance of food and eating to the participants would add further context to their responses.

3.7 Researcher's Journal

Keeping a journal has been suggested by some authors as an invaluable aid to the research process (Janesick 2000; Richardson 2000). A journal, in which I documented my observations and feelings about each individual interview, was kept throughout the course of the research project. Entries were made to the journal after each interview, and I was able to use these to review the progress of the interviews and to reflect on how well each one had proceeded, especially in relation to interview technique. For example, after reviewing the first interview, I realised that I was encouraging the participant in her responses by saying 'mmm, mmm'. Whilst the

participant did not appear to be distracted by this, I found it distracting in retrospect, and noted that I should remain silent in subsequent interviews, except when it was appropriate to speak.

I also noted in my journal that if the respondent looked to the interviewer for encouragement while answering a question, it should be given as a nod and a smile, rather than verbally. After each interview an entry was made in the journal where I recorded how well I thought I had established rapport with the respondent, and whether I had actively listened to the respondent or had missed opportunities for further exploration of a topic. The journal was also useful for making theoretical notes such as ideas and possible connections in the data.

According to Holloway (1997) researchers need to be aware of the effects of interviewer influence, which could affect the outcome of the study. I was aware that my own experience as a healthcare professional, and any pre-conceived ideas I may have as a result of my experience, could influence both the conduct of the interviews and the interpretation of the data. I therefore acknowledged these by writing what I considered to be my pre-conceived ideas and assumptions into the journal, and tried to proceed with the research without preconceptions, bias or prejudice. Acknowledging my assumptions and preconceptions made me aware of them during the interviews and the analysis, and aware that these could bias the course of the interview. This process of setting aside prior knowledge, beliefs and assumptions about the phenomenon being researched is known as bracketing (Minichiello et al. 1999). Janesick (2000) purports that one advantage of the process of bracketing is that the researcher is more likely to proceed to treat all the research data equally.

I was also aware that my position as a senior dietitian manager could inhibit the frankness of the respondents during the interviews. Therefore, at the commencement of the interviews, I informed the respondents of my position, stated that there were no right or wrong answers to the questions, and explained that the ultimate objective of the research project was to obtain valuable information in order to make recommendations for improving patients' food-related experiences in hospital. I felt that, for many of the respondents, there was a sense of relief at having someone to listen to their experiences, and that the frankness of the respondents was enhanced, rather than inhibited, by my position.

3.8   Interview procedure

The interviews for this research study commenced in February 2003, and the final interview occurred in September 2004. The interviews were conducted in a variety of settings, at the convenience of the participants. For example, interviews occurred in participants' homes, in my office, in hospital wards, in the outpatient department, in the haemodialysis unit and in one respondent's office. Each interview lasted approximately one hour. Two of the interviews were conducted over the telephone. The first telephone interview occurred because one of the participants lived in a country area and it was not possible to organise a face-to-face interview. The second telephone interview was conducted at the suggestion of the participant after three unsuccessful attempts to arrange a suitable time for us to meet. Both of the telephone interviews followed exactly the same format as the face-to-face interviews, and each lasted approximately one hour.

At the commencement of each interview I introduced myself and thanked the participant for agreeing to take part in the study. I informed the participant of my role as a dietitian manager, explained the purpose of the study, and gave the

participants the participant information sheet to read (see Appendices A and B). I then ensured that the participant understood that he or she was under no obligation either to participate or to complete the interview once it had commenced. Furthermore, the respondents who were interviewed in the hospital setting were also informed that participation in the study would not affect his or her current or future treatment in any way. Once the participant agreed to continue, he or she was then asked to sign the consent form (see Appendices One and Three). Each participant kept a signed copy of the consent form and the participant information form for his or her personal files. For the two telephone interviews, an explanation of the purpose of the research project was given at the time of first contact with the participant when the interview date was organised. The participant information and consent forms were then faxed to the participants, who completed the forms and sent them back to me prior to the interview.

Each participant was assured that confidentiality would be maintained at all times, and that all identifiable names would be deleted from the interview transcript. After each participant had signed the consent form demographic data, such as age, gender, country of birth, the reason for the hospital admission and the type of hospital in which the admission had occurred was collected. Once I was assured that the participant was comfortable and ready, the interview commenced. At the conclusion of the interview the respondent was thanked and invited to contact me if he or she remembered something else which he or she would like to add. No-one took up this offer, although one respondent requested a transcript of her interview and another requested a copy of the audiotape of his interview, and these were duly sent to those respondents.

The interviews were recorded, with the participants' permission, using a Sony M-800V microcassette recorder and the interviews were transcribed by either myself

or a professional transcriber. Each transcription was checked against the microcassette recording of the interview for accuracy as soon as it was completed. I was particularly careful that the punctuation marks were in the correct position in the transcript as the sense of a statement or sentence can easily be altered by the placement of commas and full stops. Pauses and voice inflections were also noted in the transcripts to ensure that the true sense of the responses was maintained.

Following thirty interviews it was considered that saturation of data had occurred because no new information was emerging. One final participant was included in the study at his own request because, unlike the other overseas-born males in the study, he was an overseas-born male on a modified diet. In summary, all the potential respondents approached for the study agreed to be interviewed, and all completed their interviews. Six respondents remarked that they had enjoyed the interview process.

3.9   Ethical requirements

Rice and Ezzy (1999) believe that if the ethical aspects of the research have been considered and addressed, evaluative rigour of the research project will have been achieved. Scrutiny of the research proposal by an institutional Ethics Committee, or consultation with community leaders where appropriate, are the most common means by which evaluative rigour is addressed.

Approval for the research study was sought and gained from the Human Research Ethics Committees of the University of New England (Approval number HE 02/130) and the Ethics Review Committee of the hospital to which ten of the participants had been admitted (refer to Appendices Four and Five). This hospital requires approval from its Ethics Review Committee for any research study involving patients connected with the hospital. I was required to provide consent

and participant information forms in the format approved by the hospital's Ethics Review Committee to all of the participants recruited through the auspices of this hospital. Therefore the ten participants recruited through the Nutrition and Dietetics Department of the hospital were given two consent forms and two participant information forms, one set from the hospital and the other from the University of New England. The information contained in the documents was similar, but the format was different. All participants were given their own copies of the participant consent forms signed by the both participant and myself, and the participant information sheet was retained by the participants.

In order to maintain confidentiality each participant was given a pseudonym prior to the data being transcribed and the identities of the participants were known only to me. The participants were made aware that all microcassette tapes of the interviews, computer discs containing the transcriptions and the printed copies of the interviews would be securely stored in my office where, in accordance with the National Health and Medical Research Council Guidelines (accessed 8 September, 2003), they will remain for five years, after which they will be destroyed.

3.10 Rigour and trustworthiness of the study

Rigour, according to Roberts and Taylor (2002), refers to the extent to which the findings of the research study can be relied upon as being true. In qualitative research, the concepts of validity and reliability refer to the relationship between the observer and observed reality, and whether the observer is always independent of reality (Grbich 1999b). Guba and Lincoln (1981) are of the opinion that the four major criteria which are used to establish the rigour of scientific research can be used to evaluate qualitative research if they are re-interpreted to fit the qualitative

research paradigm. These criteria are credibility, fittingness, auditability and confirmability.

The first criterion of rigour in qualitative research, credibility, has been described by several authors (Guba & Lincoln 1981; Sandelowski 1986; Roberts & Taylor 2002) as the respondents' recognition of the phenomena described in the research as being consistent with their lived experience. A common method of establishing credibility is by checking the results of the analysis with the respondents. However, Guba and Lincoln (1981) cite a number of problems with member checks, including unfamiliarity with the information presented to the respondents which can result in misinterpretation and lack of acceptance of the research results. In addition, the respondents may view the results as being biased or untrue if the results conflict with their own ideas, or do not align with a respondent's own self-interest or self- image (Guba & Lincoln 1981).

Several authors (Guba & Lincoln 1981; Sandelowski 1986; Roberts & Taylor 2002) suggest that an alternate method of establishing credibility is by recognition of the phenomena described in the research results by others who only read about it. In this research project credibility was established by member checks with two of the respondents, and also by having three colleagues within the research field review the research results. All five confirmed that they recognised the experiences of the participants as being similar to their own, or others close to them.

Fittingness refers to the degree to which the findings of the study fit into contexts outside of the study situation, as well as the extent to which other readers find relevance in the research to their own experiences (Guba & Lincoln 1981; Sandelowski 1986; Roberts & Taylor 2002). In this research study the three colleagues who read the research findings not only recognised the phenomena but

were able to supply their own examples of related phenomena. In addition, I found that some of the research findings supported the findings from previous research studies which are discussed in the Chapters Four and Five.

Auditability, the third criterion of rigour and trustworthiness, is the ability of another researcher to use the researcher's decision trail to repeat the project and arrive at comparable conclusions (Sandelowski 1986; Roberts & Taylor 2002). During the literature search, I found another qualitative study of the food experiences of hospital patients which used a similar methodology (Habeeb 1973). The results of this research study, despite the 30 year time gap, had resonance with Habeeb's (1973) study, giving retrospective auditability. The rigorous steps that were undertaken in my study, which included clarity in the participant selection criteria, audio-taping the interviews, ensuring accuracy of the transcriptions and keeping a journal record of the research process, all enhanced the auditability of the study. Because of the transparency of the decision trail, my study could be replicated by another researcher, thereby achieving prospective auditability.

The final criterion, confirmability, which is equivalent to objectivity and freedom from bias in quantitative research, is a difficult concept in qualitative research, given the value placed on the subjectivity of the responses of the research respondents (Gerber 1999). Guba and Lincoln (1981) are of the opinion that, in qualitative research, the objectivity of the data, which should be factual and confirmable, is the issue rather than the objectivity of the investigator. These authors believe that the burden of proof should therefore shift from focusing on the investigator to focusing on the information, and that this can be achieved by the researcher reporting data in a transparent fashion which enables it to be confirmed by other sources. Polit, Beck and Hungler (2001) assert that data is objective if two or more independent people review it and agree on its meaning and relevance. For this

study three colleagues reviewed the research findings and established that the analysis and the data were both factual and meaningful.

Furthermore, in Roberts and Taylor's (2002) opinion, confirmability is achieved when the criteria of credibility, fittingness and auditability have been established. The steps taken to address these criteria for this research have been described. Therefore, using Roberts and Taylor's (2002) interpretation, this study has achieved confirmability.

3.11 Methodological issues and limitations

In this study all of the respondents' admissions had been in acute care hospitals. Thus the results and recommendations of this study cannot be applied to other types of hospitals such as long-term care and palliative care hospitals, as the treatment goals, food service systems and the cultures of these types of hospitals may be very different from those of acute care hospitals. It is important to note that the purpose of this study was not to make predictions or generalisations but to provide rich, valuable data regarding patients' food experiences in hospital in order that recommendations for improving patients' food experiences in acute care hospitals could be made. Although the respondents had been admitted to a total of 22 different acute care hospitals in NSW, this is only a fraction of all NSW hospitals, and therefore the study results may not be applicable to all hospitals in either NSW or Australia.

According to Oakley (1993), interviewing participants in order to obtain research data places them in a subordinate role, with the interviewer in the position of power. I was cognisant of this, and also that my position as a senior dietitian manager could inhibit the frankness of the respondents during the interviews. I therefore took steps to ensure that the participants were not intimidated by either of

these roles. The respondents were infcrmed of my position of senior dietitian manager before the interviews commenced, and they were assured that there were no right or wrong answers to the questions. I also explained that the ultimate objective of the research project was to obtain information on which recommendations for improving patients' food experiences in hospitals could be based, and that the interviews would be treated with the utmost confidentiality. I then endeavoured to conduct the interviews as an active, empathetic listener. Although I do not believe that any of the respondents were intimidated by my position, this does not exclude the possibility that some of the respondents were inhibited in their responses.

3.12 Conclusion

Having assessed the proposed research problem in the context of numerous methodologies and theoretical frameworks, it appeared that the most appropriate approach for this research study was that of thematic analysis, employing the sociological imagination as the framework for the research. Semi-structured interviews were used as the method of data collection.

This chapter has outlined the decision trail leading to the adoption of the chosen framework and design for the research, and has described the sampling and interview process. The procedures used to address the ethical issues associated with the research were described, and finally, a discussion of rigour and trustworthiness in qualitative research, and how these issues were addressed in this research study, were presented. The next chapter, Chapter Four, describes the method of data analysis, and the first component of the findings. Chapter Five then present the second component of the research findings.

Analysis of data and results:

(1) Determinants of food preferences

If we don't know what we are eating, how do we know what we are?
—Claude Fischler 1988, p. 189.

4.1 Introduction

In the previous chapter the theoretical framework for the research study and the methodology of the study were described and justified. This chapter presents a justification for the data analysis technique, followed by the participant profile. The analysis of the research data and the themes which emerged from the data, accompanied by supporting quotes from the respondents, are presented in both this chapter and the following chapter. The results of this study are also viewed in light of the findings of previous studies discussed in Chapter Two.

The aims of this study were threefold. The first aim was to explore the effect that hospitalisation has on the normal food praxis of individuals. The second aim was to describe the experience of food and eating in hospital from the patients' perspective, and the third, and final aim was to determine the ways in which healthcare practice and food culture interact and the effect this has on patients' food consumption in hospital. From the results of this study, the researcher aimed to determine which of the historical, cultural, structural and critical factors of the sociological imagination described and discussed in the literature review have the most effect on patients'

eating in hospital, and to gain insights into the reasons patients do not eat while they are in hospital.

The following research questions were posed in order to explore the aims of the study.

1. What determines the food preferences of hospital patients?
2. What are the food experiences of patients in hospital?
3. Are patients' food preferences important in determining what people eat in hospital?

Although the data was analysed as a whole, the results of the data are presented in two chapters. This chapter presents and discusses those themes derived from the data which are related to the respondents' food praxis in their everyday lives, and the various factors which have brought about change to their eating habits throughout their lifetimes. These are related to the historical, cultural and critical perspectives of the research questions. These findings are important to the study because they provide background, context and insights for the second results chapter, which is related to the respondents' experiences in hospital and which represents the structural perspective of the theoretical framework.

4.2 Data analysis technique

Many authors have described the qualitative research analytical process (Strauss & Corbin 1998; Browne & Sullivan 1999; Ryan & Bernard 2000; Roberts & Taylor 2002). Unlike positivist research, where the aim is to quantify data, qualitative analysis is essentially the process of exploring textual data with the objective of inductively developing themes and theoretical explanations (Pope et al. 2000).

In this study, thematic analysis was chosen because, according to Braun and Clarke (2006), it does not have any specific theoretical ties and it is therefore able to

be applied across a range of different theoretical approaches including the sociological imagination approach, selected for this study. Braun and Clarke (2006) also believe that thematic analysis is able to provide rich and complex data and insightful analyses in answer to research questions.

Themes are abstract, sometimes indefinite, constructs or recurring patterns in the data (Hansen 2006). According to Braun and Clarke (2006), a theme captures something which is important in relation to the research question. In qualitative research, analytical themes, or categories, which are described by Browne and Sullivan (1999) as groups of concepts that help explain and understand the data, are derived inductively from the data (Pope et al. 2000). Themes can have a number of sub-themes which inform the overall key idea of what the theme represents. Concepts, or codes, are the ideas that underpin themes.

According to Ryan and Bernard (2000), themes may be identified before, during or after analysis has taken place. They can be derived from the literature review and the researcher's experience, or can be induced from the text. Themes can be explicit, or obvious from the text, or implicit and needing to be drawn out of the context of the data (Roberts & Taylor 2002). In this study, I did not attempt to identify themes prior to the analysis, but rather allowed all of the themes to emerge from the data. Although I have considerable experience with patients and hospital food, my perspective is that of a clinician, not a patient, and, as previously mentioned in Chapter Three, I had therefore bracketed my ideas and preconceptions beforehand in order to approach the research study with an open mind and allow the themes to be generated from the data alone. As suggested by Morse and Field (1996) a journal record of the development of themes during the analytical process was maintained. This journal, which was described in Chapter Three, and the process of bracketing, enhanced the truthfulness and auditability of the study.

After each interview the audiotape was transcribed as soon as possible. I checked the transcription of each interview for accuracy against the microcassette recording before the analysis process was commenced. Manual, rather than computer assisted, analysis was chosen for this research study. The use of manual analysis of data is supported by Roberts and Taylor (2002), who believe that the method chosen for data analysis is entirely a matter of preference for the researcher. Pope et al. (2000) are of the opinion that, although qualitative analysis software packages are useful in the management of research data, and have many potential benefits, the task of finding the links between theory and data and defining appropriate structures for the analysis is still dependent on the skill of the researcher. As the data set was not overly large, I believed that the data could be managed effectively without the aid of a computer analysis package, and that more meaningful and rich data would be obtained by manual analysis.

The analytic process occurred in two distinct phases. The first phase was the identification of the concepts which underpin the themes, and the second was the mapping of related concepts and development of themes.

After I had checked each interview transcript for accuracy, I then read it in order to become thoroughly familiar with the contents. A second reading of the transcript allowed me to mark sections of the text which represented key ideas, or concepts. These sections of text were cut from a second copy of the transcript and placed in piles according to the key ideas, or concepts, they represented. Individual piles were then stored in envelopes marked with a word or phrase which represented that particular concept. As each new transcript was reviewed more sections of text were added to the envelopes, or a new envelope was started when a new concept presented itself.

After eight interviews had been completed a further question was added to the interview schedule. The question, 'what do you think is the most important thing about food?', was added as I realised there were differences in attitudes towards the importance of food between respondents, and I considered that this question might provide more context for the subjects' responses. At this point the grouping of related concepts into potential themes was commenced. Some themes were quite explicit, for example, the early influences on patients' eating praxis, and the changes in eating praxis on leaving home. However, in the case of another theme, food and health, although it appeared to be explicit, this theme required further work to elucidate its significance. All of the respondents had answered an interview question in which they were asked if they had made dietary changes as a response to public nutrition education. Some of the respondents had made changes, whilst others had not, and there did not appear to be any consistency in the responses. I then constructed a table which charted the age and gender of the respondent against the positive or negative response to the question. A pattern related to the ages of the respondents was evident, and the significance of the responses then became clear. The same pattern of age-related differences then became apparent in all the themes related to early influences on eating praxis. Later in the analytical process, however, the themes with the provisional titles *early influences*, *leaving home* and *acculturation*, together with a theme related to dietary change as a response to nutrition education, were considered to be sub-themes of an overarching theme called *Change and evolution*. This finding became an important element of the research study as it provided an explanation for some of the findings in the section of the study related to the respondents' time in hospital.

Other themes, however, were not immediately obvious and were derived inductively from the data, after a period of time and reflection. As an example, a

number of respondents had described difficulties they had experienced in hospital which were related to food. Initially, individual examples of difficulties were in different concept bundles related to special diets or food quality or menus until, after many readings of the concept bundles, I realised that the respondents were all talking about problems they were having in hospital which were not being addressed, and also about the solutions they were finding for dealing with these problems. At this point I grouped them all together as a theme, which was later considered to be a sub-theme, named *The 'work' of patients*. This theme was elucidated for me when I returned to the literature and found a study (Strauss et al. 1988) which described the ways patients manage coexisting illnesses and other physical problems which were not being treated in the hospital. The findings of this research study concurred with the findings of Strauss et al. (1988), further contributing to the fittingness of this research study.

As the interviews and analysis proceeded, alterations were made to the concept bundles. These were expanded, collapsed or redistributed as new data was collected and new concepts and themes were formed. At the conclusion of the analytic process a map describing the relationships between the concepts and themes was drawn up. At this point four of the themes were considered to be sub-themes of another, overarching theme which was called *Change and evolution*, and four other themes became sub-themes of another theme, *Well, the doctors know what they are doing*. The remaining two themes, *It's not normal* and *Food is more than just something to eat*, were considered to be discrete themes, without sub-themes.

For this research study the process of thematic analysis of the data was similar to the 'pile on the kitchen table' method described by Roberts and Taylor (2002, p. 430). The following is a summary of the steps taken in the analytical process.

Step 1:   Following each completed interview two copies of the page- numbered transcript were made, one as a master copy and the other as a working copy.

Step 2:   After checking the transcript of the interview for accuracy I re-read the transcript of the interview in its entirety, bearing the research questions in mind, to become thoroughly familiar with the content.

Step 3:   Sections of the text that were thought to represent concepts were grouped together if they appeared to be connected. Each text fragment was marked with the respondent's pseudonym and the transcript page number for cross checking.

Step 4:   Text fragments which were considered to be related in some way were stored in envelopes with provisional labels describing the concepts they represented.

Step 5:   A list of concepts was made, and as each interview was analysed I reviewed the concept list to see if there was an overlap of ideas. Some of the concepts were able to be collapsed together and renamed, or were subsumed by other concepts.

Step 6:   At the completion of the data collection the text fragments in concept bundles were re-read, and the concept list and contents were reviewed.

Step 7:   Related concepts were then grouped into themes. The original transcripts were re-read to ensure the consistency of the themes in the context of the respondents' responses.

Step 8:   To establish trustworthiness of the data the themes were written up, with supportive quotes, and sent to three colleagues and two of the respondents for their opinions.

At the completion of the analysis four themes and eight sub-themes had been induced from the data. These are set out in Table 4.1 below:

Table 4.1: Themes and sub-themes in the data

Theme one	Change and Evolution	
	Sub-theme one	Always 'The Official Roast' on Sunday
	Sub-theme two	All of a sudden I was free to eat whatever I wanted
	Sub-theme three	And the change, looking back, was remarkable
	Sub-theme four	The food/health nexus
Theme two	It's not normal	
Theme three	Well, the doctors know what they're doing	
	Sub-theme one	The 'work' of patients
	Sub-theme two	You can't be too critical of the whole affair
	Sub-theme three	The medicalisation of eating
	Sub-theme four	Starvation in the midst of plenty
Theme four	Food is more than just something to eat	

In this chapter, only Theme 1, *Change and Evolution*, and its four sub-themes will be discussed. The remaining themes and sub-themes will be discussed in Chapter Five.

4.3   Respondent profile

Thirty-one respondents were interviewed for this research study. As previously discussed in Chapter Three, the respondents were chosen using a stratified purposive sampling technique in order to provide a diverse range of participants.

In the study sample there were fourteen males and seventeen females aged between 24 and 85 years. Seven of the respondents were born overseas and two were Aboriginal. The remaining 22 respondents were Australian-born, of European origin. All respondents had had a least one admission to an acute care hospital in the recent past. Thirteen of the respondents had dietary modifications. A summary of each respondent with details of age, gender, country of birth, reason for admission and dietary status is provided in Table 4.3 (page 127). Respondents' names have been changed to ensure confidentiality.

Males and females were represented in each decade of life between the ages of 24 and 85. Table 4.2 below shows the age and gender distribution of the respondents.

Table 4.2: Age and gender distribution of the respondents

Age range	21-30	31-40	41-50	51-60	61-70	71-80	81-90
Males	1	1	5	3	3	1	2
Females	1	2	1	3	2	2	4
Total	2	3	6	6	5	3	6

Table 4.3: Respondent profile

Name	Age	Gender	Country of birth	Reason for admission	Diet
Tracey	24	F	Australia	Cystic fibrosis	Yes
Anthony	29	M	Australia	Cystic fibrosis, diabetes	Yes
Simone	30	F	Australia	Breast and bone cancer	Yes
Trevor	33	M	Australia	Home TPN, familial adenopolyposis (FAP)	Yes
Roberta	34	F	Australia	Two confinements	No
Roisin	34	F	Ireland	Three confinements	No
Marie	40	F	Australia	Severe Crohn's disease, home TPN	Yes
Colleen	45	F	Australia	Laparotomy	No
Carol	47	F	Australia	Severe Crohn's disease	Yes
Maxine	48	F	Australia	Pneumonia, high risk pregnancy	Yes
Roger	48	M	Australia (Aboriginal)	Motor cycle accident	No
Olive	50	F	Australia (Aboriginal)	Gastric surgery	No
Christine	53	F	England	Fractured wrists	No
Edward	55	M	Australia	Bowel and cardiac investigations	No
Anne	57	F	Australia	Severe diverticulitis	No
Sandra	58	F	Australia	Total hip replacement	No
Ian	59	M	Australia	Myocardial infarction	Yes
Shirley	62	F	Australia	Total knee replacement	No
Herman	65	M	Germany	Gastric bypass	Yes
John	67	M	Australia	Bowel cancer	Yes
Marina	68	F	Greece	Knee replacements	No
Len	68	M	China	Major bowel surgery	No
Anna	72	F	Russia	Home TPN	Yes
Brian	74	M	Australia	Multiple myeloma and chronic renal failure	Yes
Paulo	76	M	Italy	Hip replacement	No
Roy	83	M	Australia	Acute cholecystitis	No
Doris	83	F	Australia	Chronic back pain	No
Tom	84	M	Australia	A fall	No
Jessie	85	F	Australia	Cardiac and respiratory problems	No
Philip	85	M	Australia	Fractured leg	No
Bill	85	M	Australia	Cardiac problems	Yes

4.4 Results

4.4.1 Theme one: Change and evolution

An overarching theme of change in the eating patterns of Australian-born participants, both as individuals and as a population, emerged from the analysis of the interviews. This theme, *Change and evolution*, draws together the four sub-themes related to early influences on eating habits, changes in personal food praxis as a result of leaving home, the effects of the introduction and availability of foods from other cultures and the influence of public nutrition education on the food praxis of the respondents. Ripe (1993) believes that the food habits of Australians are in a phase of rapid transition, that what Australians eat today is very different from what was eaten ten years ago, and that this is a measure of cultural change in our society. This theme, *Change and evolution*, supports Ripe's (1993) view, with the responses presented in this chapter illustrating the ways the respondents' individual food praxis has changed over time, while at the same time demonstrating that a change in the food culture of the community can be traced.

4.4.2 Sub-theme one: *Always 'The Official Roast' on Sunday*

This sub-theme is related to the first two interview questions: 'tell me what you remember about food during your childhood' and 'do you have any food traditions in your family? Do you have special foods for birthdays, or special celebrations?' From the data, a picture emerged of traditional Anglo-Celtic eating patterns in childhood among the Australian-born respondents of all ages. 'Meat and three veg' was typically the basis of family meals, with roast dinners featuring for Sunday dinners and more celebratory meals. A change from sourcing foods from the garden to buying them from the supermarket was also evident. The older respondents

described their families growing their own fruits and vegetables, and all the foods eaten by the family being prepared at home:

> *The women of those days were a little bit different to today, I think. Children would go out and get blackberries and my aunty or Mum would bake blackberry pies and different things like that, where they don't seem to do it these days. They go and buy a Sara Lee or something. [John, aged 67]*

The proper meal is an Anglo-Celtic construct which refers to a meal consisting of meat and gravy, potato and accompanying vegetables (Murcott 1982). The proper meal is recognised by the diner as being the epitome of nutritional soundness as well as being symbolic of the nurturing aspects of family meal preparation (Lupton 2000; Kemmer 1999). Although proper meals are still a feature of the eating praxis of Anglo-Celtic Australians, the younger respondents described more foods, and a greater variety of foods, which are often pre-prepared, being purchased. This trend towards an increasing proportion of take- away and pre-prepared foods in the Australian diet was noted in the 1995 National Nutrition Survey (McLennan & Podger 1997).

To illustrate the changes which have occurred over time five of the Australian born respondents, representing three different generations in age, recalled the food served at home during their childhoods.

Philip, who was born in 1921, describes his family meals:

> *Sundays we'd always have a roast dinner There were seven of us in the family and you'd sit down every Sunday. There would be a hot roast. Summer or winter! [Philip]*

Ian and Anne, who were born in 1945 and 1946 respectively, remember food being grown and prepared at home.

I grew up in the bush, and from time to time my father worked on farms, and we would occasionally live out on farms he was working on. We'd pretty well have meat for most meals, and the occasional vegetable, usually what was grown. And I remember one of my friends, his mother had a wonderful vegetable garden, and we used to go and pinch carrots and radishes and eat them. Pull them out of the ground and eat them, which was wonderful. We had a pretty reasonable collection of fruit trees next to where we lived, and I've always eaten a lot of fruit. In fact until I left home, when I was fifteen I think, our diet and our food was still pretty much the same. It was a lot of meat cooked in a lot of fat and vegetables boiled to bits, basically. [Ian]

The two boys had to go out with my father and the fellow in the garden and work hard all morning picking lemons and bringing buckets of rhubarb and all sorts of stuff which we were then expected to be cooking. A baked dinner on Saturday lunch time, and cakes and biscuits and scones for morning tea. And cooking up the rhubarb and juicing the oranges, and so forth. And the fascinating thing was the baked dinner which was, for a number of reasons, on a Saturday. [Anne]

Sandra, who was also born in 1946, had similar experiences:

There was a ritual around getting ready for tea and setting the table and helping to do the vegetables and those sorts of things. There were a lot of grills and roasts, and Sunday was always a roast lamb or chicken, or something of that nature, and lots of vegetables. [Sandra]

Simone, born in 1984, remembers changes in the repertoire of family meals from standard meat and vegetables to more exotic dishes:

Initially, my parents did the meat and three veg, very ordinary, very staple sort of English-type diet. Stuff like curry, casseroles, savoury mince, all that sort of stuff. Then at some point when I was about eight or nine they got into cooking Asian type food and we had Chinese quite a bit. [Simone]

Tracey, who was born in 1980, remembers a menu based on simple meals:

Mum tended to only cook things that were easy, because of a very busy schedule ... basically meat and vegetables for dinners. We grew up on breakfast cereals and toast, and only if it was very convenient and easy to throw together. [Tracey]

The centrality, and importance, of meat and three vegetables and the Sunday roast is highlighted by Marie's description of her family having *'always a roast, The Official Roast, on a Sunday'*. The Sunday roast dinner mentioned by all of the Australian-born respondents in the repertoire of family meals exemplifies Murcott's (1982) construct of the Anglo-Celtic proper meal and Douglas' (1975) observation that the Sunday roast is the climax of the week's menu. In Santich's (1994) study of the food beliefs and attitudes of 49 Australian-born women, more than three-quarters of the respondents reported 'meat and vegies' as the standard weekday evening meal, which represented good, wholesome, natural food to them.

The overseas born respondents, however, had different childhood food experiences. Both Paulo and Herman, who grew up in post-depression, post-war Europe, remember food deprivation:

I was born in the Depression, and then the war. And after that things never improve, and I left there. And the food ... we may have been short, but we had to eat bread made on corn, not all the time, sometimes there wasn't enough of wheat, enough for the family, you know. Si, Mama did the cooking. We eat everything. We grow vegetables, you know, cabbage, and potatoes and everything. We never bought a thing there, except pasta, and not everyone could afford this pasta. [Paulo]

I was born 1940. There was war in Europe, in Germany, and ah, Mum didn't give me the food I needed to have to grow up as a healthy young boy. Mum gave us the food which she could get hold of. [Herman]

Christine, who was born in post-war England, also recalls food deprivation as a result of the social circumstances of her family:

I knew we were underprivileged 'cause we used to get free lunches at [school]. You got tickets instead of paying your one and sixpence. I just remember I was very tiny but I ate a lot because we never ... at home we just had, like, bread and jam, and stuff like that, so our main meal was lunch time. So, that's the kind of food ... was school food ... which in the fifties was pretty awful. But I ate it, and ate lots of it! [Christine]

In contrast to the Australian-born respondents in the same 20 to 40 year age group, who were exposed to foods from other cultures at home, Roisin experienced a very limited range of foods during her childhood:

Potatoes featured very heavily in our die', being Irish. So we had mashed potatoes, boiled potatoes, baked potatoes. The other childhood things that featured, I remember, were baked beans and sausages and fish fingers, and those sorts of sustainable growing up childhood things. I think, being Irish, we weren't terribly adventurous with food from a different culture so it was a long time, I was well into adolescence, before I experienced, like, Chinese food or Indian food, or anything like that. So we basically had meat and three veg and desserts of fruit and angel delight and very, very English staple food. [Roisin]

The childhood food experiences of two Aboriginal respondents were quite different from each other. Olive's family continued to live the traditional hunter-gatherer lifestyle of her people:

We didn't know what take-away food was. We lived off the land. I can recall being young. My dad used to take all of us for a walk on Saturday morning and we'd all have tin cans and paper bags and that, and we'd set snares that would catch our parrots for parrot soup. On the way going out there we would pick different berries, blackberries, and all the different types of fruits on the vine. We collected gum off trees, and we would eat it on the way. So we would be eating, and collecting, and bringing it back. On the way back home we would pull up and pick up our catches from the snares. [Olive]

Although she no longer has a traditional bush food diet, Olive likes her children to know and appreciate this way of eating. In doing this Olive is affirming her identity as an Aboriginal person (Renzaho & Burns 2006):

I mean I don't eat witchetty grubs today because we haven't got a way of going out, well we've got a way, I suppose, if we wanted to, but because we've got other ways of eating today it's not something that we actually go and do. But I know that when I was working, and when I was doing home visits, I'd go out and if there was a gum tree along the road I'd pull up and pick the gum off it and take it home and introduce it to my kids and say 'this is what we were eating', and give them a taste. I mean they didn't like some of it, but it was just saying 'look we ate this, and it's really nice you know'. [Olive]

However, Roger, the other Aboriginal respondent in the study, grew up eating Anglo-Celtic fare:

Yep, but I suppose back in those times when there wasn't much money around you could only eat what you could actually afford. And that's what we mainly lived on, you know, just the old fried bread and the um ... you know, we were lucky enough to get a roast on a Sunday, if that was permissible, as far as money goes. [Roger]

Roger took nutrition education very seriously, particularly in relationship to reducing salt, fat and cholesterol, because of the high incidence of cardiovascular disease in Aboriginal people. He liked to eat bush foods whenever he had the opportunity, both for health reasons and to recapture his heritage:

I try and get an emu, if I can, but if they're not cheap at the butcher's shop then I'll try and get it if someone's been out bush and got kangaroo. I'll try and keep some kangaroo in the fridge. Yep, I'm very much in ... and you'll find that a lot of us younger ones will, well my age anyway, are trying to go back to eating more traditional type foods. More so than the western type of food, because of the leanness of it all.

The respondents' stories of their childhood eating patterns are significant in the context of their later experiences in hospital. It is clear from their stories that the older respondents continue to eat the traditional Anglo-Celtic 'meat and vegies' of their childhood and that they, particularly the men, generally dislike and distrust new foods. It can be expected that, as hospital menus tend to follow the traditional Anglo-Celtic meal pattern (Williams & Brand 1989), this group will not have difficulties with the style of food served in hospital. By contrast, the middle-aged and younger respondents have been exposed to a wide variety of foods and have broad food horizons. These two groups are also very familiar with the traditional Australian meal pattern, so it could be anticipated that they would find the food served in hospitals familiar, and acceptable, regardless of its style. These assumptions will be further discussed in the following chapter.

4.4.3 Sub-theme two: *All of a sudden I was free to eat whatever I wanted*

This sub-theme relates to the third and fourth interview questions: 'did your food habits change when you left home for the first time?' and 'when you married did you alter your food habits to accommodate your partner?' Whilst the type of food eaten at home in childhood forms the foundation of lifetime food habits, leaving home and living with others precipitates changes in food praxis for most people (Worsley 1988; Lupton 1996; Caplan 1997; Craig & Truswell 1995; Kemmer et al. 1998). For the older generation of Australians in this study, however, leaving home did not involve much change in meal praxis. For the male respondents, moving out of home meant boarding with another family or joining the Armed Services, rather than living independently. In either case the food was much the same as at home:

I was down in Victoria for a while. I was at the hotel there, so it was good food there. More roasts than I suppose I was used to. And from there I went in the Army. It was similar things, though more stew and less fruit and vegetables [Bill, aged 85]

I lived at home, in fact, until very early 1942 when I joined the Navy, and the food was no problem there. It was very straightforward sort of food. But it was good. Good edible stuff, you know. [Tom, aged 84]

Roy	*But then, when I was about twenty I joined the Army. And everyone used to complain then, but it was solid food.*
Interviewer	*What was different about the food in the Army? Why did people complain?*
Roy	*Well, if it wasn't cooked right. Or if there was something wrong with it. It wasn't bad. Well, it was more or less the same [as at home]. They used to have a sort of a porridge, and boiled eggs mainly. Didn't fry a lot. They had boiled eggs, and a bit of bacon or meat with it. But they had good meals, you had plenty to eat. You wouldn't starve.*

The two older Australian-born women interviewed in the study both stayed at home until they married, after which they cooked for their families in the same way as their mothers had cooked although, unlike their mothers, both respondents used recipe books:

I made those foods the way she [Mum] made. The only thing that I did a bit different to Mum was because we had recipe books, and friends exchanged their recipes. And I would've cooked, I suppose, more cakes and lamingtons and slices than Mum could have afforded to cook in those days. [Jessie]

Well, I'd done Home Science at school and, of course, I always had a Commonsense Cookery book. We'd always have rump steak one night, and you'd have cutlets or chops, or a baked dinner. And I'd make meat pie, and oh, just the general meat and vegetables. And, of course, we always had dessert. It wasn't a meal unless you had dessert, you know. You'd make baked custard, or bread and butter custard, and banana custard and jelly, and those types of things. [Doris]

The middle-aged and younger respondents, however, described major changes in their personal food praxis coinciding with leaving home for the first time. Leaving

home not only represented an opportunity to experiment with new foods but also independence in making decisions about what they would eat.

Edward, who was 55 years old at the time of the study, left home when he was aged 18:

> *I never really cooked for myself before and I found that's where I started to cook things I liked to do, and things I liked to eat. Life changed.*

Roisin and Roberta, who were both aged 34 at the time of this study, also left home at 18:

> *That made a huge difference because all of a sudden I was free to eat whatever I wanted. [Roisin]*
>
> *When I left home you cook more, and you buy stuff that you want to buy. Whereas when you're at home ... you know Mum's prepared the meal and you sit and eat it, whereas when you move out you can then buy and cook what you want. So it's just the fact that you probably changed, that you're doing your own shopping now, you're doing your own cooking, You've got different parameters in terms of meal preparation. [Roberta]*

While Edward learned to prepare and cook his own meals, Roisin could not see the sense in cooking for herself, so she relied on pre-prepared foods:

> *Buying and cooking food for one person seemed like such a waste of time, so I started eating soy foods and any sort of easy, convenience-type foods. [Roisin]*

Roberta, like the older women in the study, had learned to cook from her mother, and was a keen cook. Santich (1995a) posits that learning to cook at home positively affects women's attitudes towards cooking, which in turn affects their willingness to modify their eating habits in response to nutrition education. In a series of interviews conducted with 49 Australian-born women aged between 19 and 74

years, Santich (1995a) found that positive attitudes towards the preparation of food appeared to be age related, with the older women in the study enjoying cooking while the younger women generally found it a chore. The availability of pre-prepared foods has contributed to the loss of cooking skills and has also affected the structured pattern of daily eating, the modern trend being discontinuous snacking, or grazing, because foods are always ready and available (Caplan 1997). According to Caplan (1997), grazing, which is sometimes called eating without meals, has the effect of desocialising eating.

In Lupton's (1996) survey of the food preferences of adults of various cultural backgrounds it was found that all the participants had experienced major changes in their food habits since leaving home, particularly if they had grown up eating standard Anglo-Celtic food. While there were no participants in Lupton's (1996) study over 65 years of age, the responses of Lupton's (1996) respondents are consistent with the findings in this research study of the respondents of similar ages. Lupton's (1996) respondents believed that trying new foods was symbolic of their willingness to be innovative and adaptable. Therefore, it is reasonable to conclude that the younger respondents in this research study will be similarly adaptable and willing to try the style of food served in hospital, even if it is different from the food they normally eat. This hypothesis will be discussed in the following chapter.

4.4.4 Sub-theme three: *And the change, looking back, was remarkable*

Whilst changes were occurring in the food habits of the middle-aged and younger subjects because of leaving home, another force, dietary acculturation, was also bringing about change, especially for the post-war generation and the migrants. The effects of dietary acculturation on the food praxis of the respondents was evident

from their responses to the third and fourth interview questions, even though there were not any specific questions related to this phenomenon.

Acculturation is the transition of one cultural group to another. Dietary acculturation is usually a two-way process, which brings about changes in food praxis to both the host population and the migrant group (Satia et al. 2000). From the respondents' stories, a transformation is evident in the food habits of the Australian-born respondents from plain meat and vegetables to eating and enjoying foods from other cultures, particularly as the respondents' ages decreased. Chinese restaurants have been in Australia since the 1840s, and have been very common in the suburbs and country towns since the 1960s (Ripe 1993). Chinese food is now clearly regarded by the respondents as basic, everyday Australian fare. Similarly, Italian cuisine, especially pasta, has also been adopted into the Australian diet. What is regarded as typical Australian food now encompasses dishes from many other cultures:

> *I had to learn more about cooking when I got married, but I didn't find it hard. I knew already how to do the basics ... a baked tea and lasagne, spaghetti bolognaise and some Chinese dishes. So I just added. [Marie]*

An overall change in the food habits in the Australian community is clearly demonstrated in the subjects' responses. While the older respondents, especially the males, still preferred very traditional Anglo-Celtic food, and were unwilling to experiment with new foods, the generation born immediately after World War II enthusiastically experimented with foods from other cultures and adopted them into their culinary repertoires. The twenty- and thirty-year-olds, who are the children of the post-war generation, have grown up with a wide variety of ethnic foods as part of their normal, everyday diets and are therefore very accustomed to ethnic foods.

The following responses, however, are typical of the older male respondents:

I don't like these Asian foods they've got today, particularly garlic. Draw the line on that. [Bill]

Tom	Well, we were pretty keen on the Chinese food. Some of the others you mentioned I've never even tried. I've never tried them.
Interviewer	Never tried them. So you're pretty conservative in what you like to eat?
Tom	Well, we tend to get what we know we like. Yes.

By contrast, Sandra describes the excitement of her post-war generation in experimenting with new foods and tastes:

In the sixties there were lots of exciting things happening. We had access to all the burgeoning restaurants, all the different sorts of foods. Things that were then happening across the city, right in the middle of the city, so we were becoming a little more adventurous in what we were eating in terms of food from other cultures. [Sandra]

Although Edward, like most of the Australian-born respondents, had been exposed to Chinese food from the local restaurant, his interest in food from other cultures developed when he was invited to the homes of school friends who had different ethnic origins:

It was the old basic Chinese down the road type thing, take-away. And we'd go down there and eat. There was always the rice and steamed dim sims and chow meins, and whatever. Ah, the Chinese food, that was the start of it. Then I went to school with a lot of Greeks, Italians and I think it was a couple of Polish. A lot of different ethnic backgrounds. And I started eating, you know, sort of get invited to their places after school. You'd go home to their places and you'd start eating their food. And that's where it all started, I think. [Edward]

Dietary acculturation for the host nation occurs because of exposure and access to new foods. Brian's response encapsulates the introduction and incorporation of

foods from other cultures into the mainstream of Australian food habits, and the enthusiasm Australians had for experiencing new tastes:

> *Well, I suppose it was largely the times we lived in. And it could be the advent of migration. I know in 1954 migration was coming more a major thing, and all those various European cuisines were coming into Australia. Australia was a pretty isolated place up until the war – with our lamb and vegies, and rabbit on a Saturday night, and no chicken except at Christmas. And the change, looking back, was remarkable. [Brian]*

For migrant groups dietary acculturation tends to be a more passive process, driven primarily by issues such as availability of ingredients (Satia et al. 2000) and this was certainly the case with the overseas-born respondents. Anna was born in Russia and migrated to Australia as a child. Her response illustrates the way food acculturation can occur from a migrant's perspective. Traditional foods are adapted by substituting local ingredients, the adaptations then becoming the traditional foods:

Interviewer	*You said that you came from Russia, via China. Your grandmother was cooking and feeding the family, and she did Russian food. Did some of the Chinese influence creep in to your family food habits?*
Anna	*Yes, yes they did. Not so much in my family, but in my aunt's family. They preferred Chinese food to Russian food, so they ate a lot of Chinese and cooked a lot of Chinese. But how it's crept in is, in China we probably didn't have too many potatoes, but we had a lot of rice, so if we ate beef stroganoff, even in Australia, we'd serve it up with rice. We would not serve it up with buckwheat or potato, as they would in Russia. So a lot of our meals were served up with rice, rather than potato or the equivalent. Umm, soya sauce was a very big element in our cooking. For instance, we have Russian dumplings that the Russians eat with sour cream, and we did too. But we also ate them with soya sauce and my grandchildren now will*

only eat them with soya sauce. They won't eat them with sour cream. So yes, the answer to that is yes, and occasionally we would have a Chinese meal, but predominantly my grandmother cooked Russian, whereas my aunt cooked Chinese.

In the same way that the Australian-born respondents were experiencing dietary acculturation by exposure to new cuisines, Herman was trying and enjoying new foods before he migrated to Australia in 1981, so he found the cuisine in Australia very much to his taste:

When I was travelling the world as a young architect and engineer, I all of a sudden started to like Italian food, French food, Thai food, even African food! And when I came to Australia the food was totally different [from 'heavy German food'] here. So I liked it here. [Herman]

Len and Paulo arrived in Australia in the 1950s before the explosion of ethnic cuisines in the community, and both of them had a difficult time with the food. Unlike Herman, who came to Australia in 1981 when ethnic foods were commonplace, they did not like the local food and both had difficulty purchasing ingredients to cook their traditional dishes:

Interviewer	*But didn't you know how to cook Italian food?*
Paulo	*No, well there wasn't any to cook, you know.*
Interviewer	*Were you able to buy the raw ingredients? Were you able to get pasta and olive oil?*
Paulo	*No olive oil. Then was Joe Hanna (the shop owner). We start to deal with him.....beautiful! We start to get the spaghetti from Brisbane through him. And olive oil.*

The following response by Len illustrates the addition of new foods, the retention of traditional foods and the substitution of ingredients described by Renzaho and Burns (2006) in their study of African migrants:

Ah, in terms of using the ingredients, yes, there are changes. Certain things we can't get in here, maybe have to adapt. For instance, hardly any Chinese vegetables. We use cabbage. We use a lot of … ah … what you call the ah … cauliflowers. So now it depends, every now and then we might shop around. I say in our weekly meal we might have Chinese vegetables some night, we have the local vegetables another night, and so on. [Len]

The two female respondents who were born in Europe, Anna and Marina, were both passionate about food and cooking. Although they both arrived in Australia in the 1950s, unlike Paulo and Len who are similar ages, they embraced new cuisines, and the food of their new country.

But, when pass the years … and I try many Australian things [food]), I love it. … I'm not say 'no'. It's very nice. And, um … when I have my family, I cook some Australian things, but, I cook the Greek things, too. [Marina]

Because we're [Russians] sort of very close to the Scandinavians I guess we were very much into smoked salmon and herring and any kind of fish that had been salted or preserved in some way or other. I grew up on this food. I grew to love it. I grew to learn how to cook it, and I fed it to my own family. But also, as an adult, my taste varied and I tried other cuisines, which I loved just as much. [Anna]

All of these stories are consistent with the literature on dietary acculturation (Kosmides 1980; Hadj 1988; Satia et al. 2000; Wahlqvist 2002; Renzaho & Burns 2006). The host country is exposed to new ingredients and new cuisines from the migrant group which then become incorporated into its daily fare, while the migrant group adapts its cuisine because of unavailability of ingredients, and because their

children adopt the cuisine of the host nation. According to Ripe (1993), Australians have become some of the most eclectic eaters in the world.

However, despite the enthusiastic adoption of foods from European and Asian cultures by the majority of the respondents, none of the non-Aboriginal respondents spoke of adopting or incorporating Australian bush foods into their diets, and this is also consistent with the literature (Ripe 1993; Satia et al. 2000). Even though foods such as kangaroo meat, bush tomatoes and wattle seeds feature on restaurant menus and are able to be purchased relatively easily, bush foods do not seem to have become an integral part of the everyday Australian diet.

The change in the food praxis of the Australian population as a whole, however, has indeed been remarkable. In the 1950s, as Paulo found, pasta was virtually unprocurable. Forty years later pasta was reported to be the fastest growing grocery item in Australia, with Australians consuming around three kilograms of pasta per head per annum (Ripe 1993).

In response to the research question 'what determines the food preferences of hospital patients?', the significance of the changes brought about by acculturation in the food praxis of individuals is that most of the respondents have broad food horizons, and therefore should find most of the foods they are likely to be served in hospital familiar to them. The inclusion of foods from other cultures on hospital menus should also reinforce the dimensions of comfort and caring for overseas-born patients (Bell & Valentine 1997; Lupton 1996). The adoption of new foods into the diets of most of the respondents, except for the older males who disliked foreign food, is indicative of their flexibility and willingness to try new things.

4.4.5 Sub-theme four: The food/health nexus

This sub-theme relates to the third interview question: 'there are a lot of health messages related to food and diet on television and in the press. Have you changed the way you eat as a result of this information?' Public health nutrition is designed to bring about changes in the food praxis of populations in response to the prevailing health issues of the population (Santich 1995). The respondents in this study identified both positive and negative connections between food and health. On the positive side, food was seen as a promoter of health, and a means of maintaining good health and avoiding diet-related illnesses such as diabetes and cardiovascular disease. Some of the respondents had the experience of close family members with diet- related illnesses:

Roger *I've made a lot of changes to what I eat and how I cook.*

Interviewer *That sounds very positive.*

Roger *Yeah, I think we've got to. When you look at the incidence of heart disease and diabetes in the Aboriginal community, if I was doing what a lot of them are doing out there, well, I'd have heart disease, I'd have diabetes.*

Christine, who was born in England but migrated to Australia as a twenty-year- old, made the following comment:

I've absorbed the whole thing about low fat everything. My mother died of heart disease. You know what high fat can do to your system, so I'm very nutrient aware. [Christine]

Food was also seen as essential to restoring health during periods of illness:

Mum always used to say 'if you have good plain food and you get sick you've got a bit of constitution to fight an illness'. That's the way she looked at it. [Jessie]

On the negative side, food praxis, and sometimes the food itself, was seen as a direct cause of illness:

> *About seven and a half years ago I started getting sick, not realising I had Crohn's disease. It took a while before it got picked up. I've always thought I was a good eater and never heard of this disease. I knew I never had enough fruit, so I thought my problem was I didn't eat enough fruit. [Marie]*

The majority of the respondents were aware of the healthy eating messages promoted in the media, and many had responded by making some changes in their diets. As with the willingness to try new foods, there was an age differential in readiness to make dietary changes, the middle-aged and younger respondents being more likely to have responded to nutrition education by making dietary changes, and having a more extensive interest and knowledge of food and nutrition. For example, two respondents, Jessie and Philip, both in their eighties, saw no need to make changes in their diets:

> *Interviewer   Over the years there's been a lot of health messages that have been in magazines and the press ...*
>
> *Jessie   I don't take any notice, dear, of those things. I eat what I like ... and how I like, and when I like, if you know what I mean.*

And:

> *Interviewer   Over the last number of years there's been a lot of health messages related to food.*
>
> *Philip   Yep.*
>
> *Interviewer   Do you think that this had made any impact on what you eat?*
>
> *Philip   No, I don't think so.*

Worsley (1989) found in his survey of one thousand Australians living in Melbourne and Adelaide that the dietary intakes reported by Australians aged 70 years and older tended to be very traditional, including few pre-prepared foods, novel foods or pasta. A similar finding was made in the United Kingdom twelve years later by Tomlinson (1998), who also found that older people were more likely to eat vegetables and dislike pasta and junk food. In addition, Worsley (1989) found that the 70-plus age group did not regard the Australian Dietary Guidelines as being important, and thought it unnecessary to change their diets, which they believed were already healthy and natural. The responses of the older respondents in this research study are consistent with this finding.

Len's response, for example, is typical of the 50 to 70 age group that Worsley (1989) found in his study to have the most positive attitudes towards the Australian Dietary Guidelines and the most concerns about fat and energy intakes, and being overweight:

> *And everyone now is getting to the stage where we are in the sixties, so it is much better for all of us to eat healthier food than what we used to eat before. [Len]*

The greatest difference in attitudes to food and diet was found by Worsley (1989) to be between the oldest (70 years plus) and the youngest (18 to 30 year old) groups. While the older group were confident that their diets were healthy and provided everything they required, the youngest group expressed concerns about the naturalness of their food, and saw their diets as too processed and artificial and lacking in vitamins and minerals. They were more likely to consume novel and non-traditional foods than other age groups, and they saw a need to improve their eating praxis, endorsing the concept of a healthy lifestyle. Similar concerns were expressed by the younger respondents in this study:

We probably eat a bit more chicken than we used to, and when we eat meat we try to eat better cuts. We try and eat fish a bit more often because we've got two kids, and Omega and those kinds of things, and try to take some of the saturated fats out of the diet. You know, I don't eat a lot of really bad foods. I always have the vegies and fresh fruit and meat, and so I suppose we probably changed a bit, eating more fish and chicken rather than red meat. [Trevor, aged 33]

The younger respondents in this study also expressed concerns about the soundness and nutritional value of the food they consume. The following quote from Anthony illustrates his opinion on take-away food:

Anthony   *A lot of pizza people ... deliveries ... turn up here every day. I cannot see why people order ... spend on ... pizzas to be delivered to a hospital, when what they're getting is probably what put them in here.*

Interviewer   *How do you mean what they're getting is what put them in here?*

Anthony   *Well, what is on a take-away pizza? It's a plate of rubbish! I don't know why they're ordering it in, when they're probably in here for something that's in their stomach, or they got from eating things that they're ordering out for. You know what I mean. I know that the food that I eat in the hospital has gone through rigorous amounts of things to find out everything that's in what you're eating. There is not going to be any harm in what you're going to be eating. Whether you taste it or not, it's not going to hurt you!*

Other younger respondents were interested in experimenting with health foods:

When I moved out of home I cooked all different sorts of meals. The food was a lot more wholesome and nutritional. I actually started getting into more organic food, which I'm into now. It was a lot more healthier, moving away from quick convenience food to food that you had to actually cook from scratch. [Tracey, aged 24]

Similar attitudes and concerns about processed and pre-prepared foods are prevalent in the community. Santich's (1994, 1995a) respondents interpreted good food as being natural, unprocessed and home made, because the consumer knows exactly what it contains. A national survey of the attitudes of 1200 Australian adults about the safety and quality of food also found significantly increasing levels of concern in Australian consumers about food processing, particularly in relation to food additives and chemicals, which are generally believed to be harmful to health (Williams et al. 2004).

Nutrition education messages were sometimes found by the respondents to be inconsistent and confusing. Shirley, who has made very few changes in her diet, remains confident that she and her family eat well. She comments on the fickleness of popular diets:

> *As I say we really stick to the basic meats and vegies but ... they [popular diets] seem to vary. Fads don't worry me. We just eat the normal, you know. The fads come and go and what's good for you this week is not the next. [Shirley]*

Roisin had a good knowledge of nutrition but still found confusion surrounding nutrition education messages:

> *There's lots of conflicting information. I've taken notice of nutrition for myself, and what's been in the press about food and the various Hollywood diets and that sort of thing. Weight is a particular issue which I've had to address. I've heard of the healthy pyramid and my understanding of that has evolved in the last few years. Between the good fats and bad fats – it's not just minimising fats but what type of fat. Just because it's a good fat doesn't mean that it's not fattening. [Roisin]*

O'Dea (2004) believes that current nutrition education is based on negative, problem messages and is aimed at avoiding negative outcomes of imprudent eating such as

heart disease and cancer. Such inverted messages can lead to confusion and misinterpretation. For example, many people now consider that all foods containing fat and cholesterol are bad, and as a consequence many nutritious foods are unnecessarily avoided, or even eliminated from their diets. Schwartz and Borra (1997, p. S73) found that in the US, nutrition communications about dietary fat, which attract twice as much media coverage as any other nutrition or health topic, have fostered a 'consumer obsession with and confusion about dietary fat', and that this has itself created obstacles to healthy eating. These authors report that public interest in reducing dietary fat is not accompanied by sufficient individual knowledge to allow consumers to translate interest into action, and that conflicting information and reports, and the negative nature of nutrition information, which did not inform consumers of what they should be eating, resulted in consumer misunderstanding (Schwartz & Borra 1997). This same confusion was demonstrated by the respondents in this study.

4.5 Conclusion

The overall theme, *Change and evolution*, demonstrates how the food praxis of individual respondents has altered over time and how this reflects changes in the food praxis of the Australian population. The sub-themes in this chapter are related to influences on changes in personal eating praxis as a result of leaving home, the adoption of a much greater variety of foods and different cuisines as they became available in the community and the response to public health nutrition education.

The change process was stratified by age group, very little change having occurred with the oldest respondents whilst major changes in food praxis are evident with the middle-aged respondents. The youngest cohort of respondents is used to eating a wide range of foods and cuisines. Eating habits are developed and

modified over a lifetime and reflect a multitude of influences, from early childhood habits to current nutritional advice and the contemporary environment (Santich 1994). These findings provide a backdrop for the way individual respondents cope with their food experiences in hospital, and an indication of how important personal food praxis is for the patient in the strange environment of the hospital which is discussed in the next chapter.

In summary, the study findings reported in this chapter established that the older respondents are very conservative, continue to eat within traditional food patterns, prepare their own foods and use very few new or novel foods. This group was young in the era when nutrition education was positively and prescriptively delivered, they know what is in the food which they prepare themselves, and they are confident that what they eat is nutritious. The older respondents were found to be the most conservative in all aspects of dietary change. They continue to eat traditional Australian fare which has altered very little in response to moving out of home, marriage, exposure to foods of other cultures or health promotion messages.

The middle-aged group of respondents, or the generation below the older respondents, grew up with the foundation of traditional eating patterns to guide their food praxis. Their leaving home coincided with the explosion of ethnic restaurants in the cities, so this group expanded their food horizons considerably once they became independent. The respondents in this group are the ones who are most likely to respond to public health nutrition education and are also the group most likely to use the Australian Dietary Guidelines to assist their food choices.

The youngest group has had the least experience of traditional Anglo-Celtic eating patterns to guide their food choices, and the most exposure to new foods and pre-prepared foods. This group showed the most uncertainty about their diet and

the quality of the foods they eat and are the group most likely to embrace alternative eating patterns such as vegetarianism or organic foods. The youngest respondents consume a great variety of foods, both traditional and novel, and also consume the most processed and pre-prepared foods. They also have the most concerns about the nutritional quality of the food supply and are the group most interested in nutrition, and the most knowledgeable, but they also have the least confidence in the soundness of the foods they eat.

Although this study is focused on individuals and the determinants of their food habits which may impact on their food experiences in hospital, the changes in food praxis of the Australian population as a whole became apparent during the course of the data analysis. Knowledge of the food habits of populations has significant value in the study as some hospitals are specialised to accommodate specific age groups and menus should be tailored to meet the needs of these patients. The extent of dietary changes in individuals, and their willingness to try unfamiliar foods, may be an important factor in their food experiences in hospital. This will be explored in the second part of the analysis and results in Chapter Five.

Analysis of data and results: (2) Food in hospital

Whatever the nutritionist finds in his laboratory must fare through the complex field of social forces in order to meet the intended result – ingestion of nutrients by the people.
—Ravindra Khare 1980, p. 534.

5.1   Introduction

The previous chapter presented and discussed the analysis of the research data and those themes derived from the data which are related to the respondents' food praxis in their everyday lives, and the various factors which have brought about change to their eating habits throughout their lifetimes. These factors are related to the historical, cultural and critical perspectives of the research questions. This chapter presents the study findings related to the food experiences of the respondents during hospitalisation. The study findings presented and discussed in this chapter are largely related to the structural perspective of the sociological imagination framework.

5.2 Results

As stated previously in Chapter Four, at the completion of the analysis four themes and eight sub-themes had been induced from the data. These are set out in Table 5.1 on the following page.

Table 5.1: Themes and sub-themes in the data

Theme one	Change and Evolution	
	Sub-theme one	Always 'The Official Roast' on Sunday
	Sub-theme two	All of a sudden I was free to eat whatever I wanted
	Sub-theme three	And the change, looking back, was remarkable
	Sub-theme four	The food/health nexus
Theme two	It's not normal	
Theme three	Well, the doctors know what they're doing	
	Sub-theme one	The 'work' of patients
	Sub-theme two	You can't be too critical of the whole affair
	Sub-theme three	The medicalisation of eating
	Sub-theme four	Starvation in the midst of plenty
Theme four	Food is more than just something to eat	

The first theme, *Change and evolution*, and its four sub-themes were presented and discussed in Chapter Four. The remaining three themes, one of which also has four sub-themes, will be presented and discussed in this chapter. The first of the themes discussed in this chapter, Theme Two, *It's not normal*, documents the opinions, experiences and frustrations of the respondents with the food and food service in hospital.

Theme Three, *Well, the doctors know what they're doing*, overarches four sub-themes. In this theme it becomes clear that the respondents changed their normal behaviour in order to be consistent with the behaviours expected of patients. The discussion shows the impact of these changes in behaviour, and the impact of the

hospital system on the food praxis of the respondents. The first of the sub-themes, *The 'work' of patients*, describes the food-related problems the patients experienced during their hospital admissions, and the solutions they found to their problems. In the second sub-theme, *You can't be too critical of the whole affair*, the patients' attitudes towards the hospital food service and meal delivery systems are described. *The medicalisation of eating*, the third sub-theme, demonstrates how meals and eating in hospital have become a medical function rather than a personal or social function. The final sub-theme, *Starvation in the midst of plenty*, shows how patients experience hunger, and how their nutrition can be compromised as a result of current medical practices. The overall theme, *Well, the doctors know what they're doing*, and its four sub-themes are drawn together by the roles and behaviours of the patients and staff in acute care hospitals.

The fourth and final theme in this chapter, *Food is more than just something to eat*, looks at other, non-nutritional, aspects of food and meals in hospital from the perspective of the patients.

5.2.1 Theme Two: *It's not normal*

Theme two is related to the structural perspective of the sociological imagination framework. This theme is linked with questions 6, 7 and 8 in the interview schedule: 'Tell me about your food experiences in hospital', 'How did you feel about the food in hospital?' and 'Are there any particular foods that you like to have when you are sick or not feeling very well? Was the hospital able to provide these foods for you?'

All of the respondents interviewed for this research study had had at least one recent admission to an acute care hospital, although some of them also referred to their experiences in previous admissions. The hospitals included both public and private hospitals in metropolitan and regional areas. The respondents were

generally aware of the practical constraints imposed on hospital food services, and the limitations of catering for large numbers of people. Those who had had admissions in regional hospitals were also aware that the food was no longer cooked in the hospital's kitchens, but was prepared in central production units in other centres, which they felt resulted in a reduction in the quality of the food:

> *But now there's no kitchens in the hospitals and they're cooking it somewhere else, and it's reheated when it comes to you. And if there's anything I can't stand it's reheated food. Ah, it's awful. It's absolutely disgusting and disgraceful. [Jessie]*
>
> *I am informed that all the food that comes to Armidale is produced outside, perhaps at Newcastle. It comes up by refrigerated transport and is processed in the kitchen here. I think you should use more local products. Maybe they'd cost more by doing it that way but I think you'd get a better quality meal by having it prepared locally than mass produced somewhere else. [Philip]*

The respondents perceived considerably less flexibility in the system when the food was produced externally and brought into the hospital, and this had a significant impact on patient care. Marie, who has had many admissions to both regional and metropolitan hospitals, described one problem resulting from the lack of a kitchen when new patients, especially those on therapeutic diets, are admitted to her local regional hospital:

> *Shoalhaven now gets their meals from Port Kembla, so all that stuff gets delivered during the day. So if someone comes in, he might be a diabetic or something else, there's nothing there for them. [Marie]*

Marie also described similar difficulties experienced by post-operative patients in getting something that they feel like eating:

When you first come into hospital and you have your operation, you don't order your first lot of meals [yourself]. It takes a couple of days before you actually get some menus, and get to see stuff you want. You don't like it, you don't enjoy it, and so you let the nurses know and they ring up the kitchen. And they [the kitchen] say 'this is all we've got left'. And I know that it's just something that people have got to understand. It's really hard. You've got to accept what you get. [Marie]

In the above quote, Marie refers to the delay which occurs in most hospitals between the patients selecting from menus and then receiving their chosen meals, which is usually for the following day, as well as the inability of the kitchen to provide something different at short notice because this hospital receives only what has been ordered in advance, as they no longer cook on site. This time lag between choosing the meal and its delivery to the patient poses other problems, especially when the patient is quite ill:

You might plan your food for the week, but it's not a matter of what you feel like, whether you feel ill or not. If you feel ill then you make the food especially, according to what you want at the time, and how you are at the time. So it's not normal. Hospital isn't normal, and food isn't normal in hospital, and there isn't any way they can make it normal. Not and feed the whole place [meaning the whole hospital]. [Carol]

Shirley had similar experiences and she thought that having a choice at the point of serving the meal might help:

I think the decision making, when you're not well, I think probably, just if the meal was brought to you, either a cold or a hot meal, you could have your choice there. But I feel you get juice and teas and coffees ...too much! [Shirley]

Most of the respondents were able to make their own meal choices from a menu, and this was appreciated and, for some, provided a diversion and even some excitement:

> They'd come around with the menu and you'd ask the person in the next bed, 'Oh, what are you having?' It was a bit of a conversational thing with the other people in the wards. [Christine]
>
> You'd get the menu in the morning, I think it was the day before, and you'd tick off what you'd have for breakfast, lunch and dinner, and that was always a bit of a novelty. And it's like flying overseas. You get the menu and it sort of whets your appetite. [Roberta]

Due to the practicalities of tallying the menus in order to determine the quantities of food to be ordered, it is common practice in most hospitals for the patients to make their menu selections for the following day, rather than for the same day, even when the food is prepared on site. In their survey of the food services practices of 93 hospitals in NSW, Mibey and Williams (2002) found that the majority of the hospitals surveyed required the patients to make their menu selections between 12 and 48 hours in advance of the meal. However, the respondents in this study found it odd to be making their menu choices so far ahead:

> What I found funny about that is that how are you going to know what you want the next day? [Christine]

The quantity of food served at the meal was a difficulty for many of the respondents who found large serves daunting, and having the entire meal presented at once, rather than course by course, had a negative impact on their appetites. Sandra, who was confined to her hospital bed for a month, describes her feelings:

> And having to eat in bed all the time is also not natural. And when you're in bed, if you think of yourself at home, and you've been unwell and somebody brings you something to eat in

bed, you don't have the whole meal thing. You just have something that's manageable in bed, and in hospitals you don't have that. You've got the whole kit and caboodle, the whole lot. Whether you've got soup and a meal and a dessert and bread and butter and, you know ...[Sandra]

Opinions of the quality of the food served in hospital varied, as would be expected, as the respondents had admissions in a number of different hospitals with different menus, and different types of food service systems. As was discussed previously in Chapter Two, the stereotype of hospital food is that of insipid institutional cooking and the patients' expectations of hospital food are consequently low (Cardello 1995; Cardello et al. 1996). The respondents in this study also had low expectations of hospital food, and were generally surprised that the quality of the food was better than they had anticipated, as can be seen in the following quotes:

If you went into a place like a hospital you didn't go in expecting the thing to provide home cooked type meals, and so I suppose I wasn't looking for very much. [Tom]

By and large I'd say the meals, for institutional meals, are pretty good. They're not a patch on what you get at home, but you couldn't expect them to be. [Philip]

But really, the quality of the food, for the way it has to be cooked, I think is excellent. I really think anyone that complains about it, well, they've never been hungry. [Shirley]

The quality was better than I had anticipated. Better than school dinners, which is what I would parallel hospital food with. I'd say maybe I've eaten fifty percent of my school dinners, but I ate ninety to hundred percent of my hospital meals. [Roisin]

The two older male overseas-born respondents, Paulo and Len, both had difficulty with hospital food, and they refused to eat it. The comfort foods of their cultures (pasta for Paulo and congee for Len) were not available, and they also thought that the quality of the hospital food they served to them was very poor:

What happened was there was the time when I had the operation. I was not on solid food for six days, I think, and on the seventh day they served me a piece of fish I would normally have thrown it out. I ate it all. I was so hungry! And after that, no way! No way would I eat any of the food! [Len]

I was operated ... same day when I went in, and after that I couldn't eat ... I told them ... it was you know, they used to bring food ... but oh God, it terrible, you know. It was all beans and a bit of fish, there was plenty there, fish, boil fish, boil everything. [Paulo]

Both men solved the problem by having their wives bring home cooked food into the hospital for them.

Roisin's comparison of hospital food and her rating of it as superior to school dinners is interesting, as the respondents in Cardello's (1995) study of the quality and acceptability of foods rated school food above military food, hospital food and airline food, in that order. The highest expectation of quality and acceptability was for home-cooked meals (Cardello 1995), which was clearly the case with the respondents in this study as well.

Feldman (1962) believes that the most significant reason for the discrepancy between the general public's perception of hospital food and patients' actual opinions of it is the vast improvement in hospital food and the way it is prepared and served. Yet, according to this author, stereotypes persist, even when the reality of the situation has been different for many years. Although Feldman (1962) stated this opinion more than forty years ago, as the responses in this study indicate, patients still have low expectations of hospital food quality today.

However, hospital food service systems have evolved and improved considerably since Feldman (1962) made that statement. Hospital kitchens no longer cook all of the food served to patients. Many food items such as breakfast cereals,

canned fruit, biscuits, desserts, cheese, flavoured milks and other menu items that are served in hospitals are purchased items in the same individual serve packages that are commonly used on airlines and in cafeterias, or can even be bought in supermarkets for home use. The appearance of many of the food items served in hospital, and the food items themselves, are therefore familiar. As Colleen observes, familiar foods bring some degree of normality to the abnormal situation of being in hospital:

> *They had canned fruit, peaches and pears, that came up in their little pull-off tetra things. It was the SPC type. It was recognisable, and I think that probably goes a long way to helping people get their mind around it, that this is not **mass** produced food that is like you're in a rotation. You know, assembly line ... [Colleen]*

Meals in hospital, however, were regarded by the respondents as eating rather than dining, and clearly did not bring the same enjoyment as meals at home, or in other settings. Some of the respondents who had been in private hospitals where alcohol was an option with meals found this either unnecessary, or unappealing:

> *And they offer wine, which I don't personally think that's necessary in a hospital. I think if you're in hospital you can forgo your wine. But I just wonder what we're doing offering wine. Why do we offer wine in a hospital setting? Is it to make people feel more like they are more at home? [Colleen]*
>
> *There was wine with dinner at night, if you wanted it. But dinner was at 5 o'clock, and it felt a bit obscene sitting up there at 5 o'clock, drinking on your own. [Sandra]*

Hospital mealtimes, as mentioned by Sandra, are often very different from mealtimes at home, and the three main meals tend to be served in a shorter time frame than normal, leaving a long period before breakfast. According to de Castro and de Castro (1989), if humans are unable to choose when they eat they regulate

their intake by adjusting the amount of food ingested at the meal. The quantity of food eaten at a meal is directly correlated with the length of time which has elapsed since the previous meal (de Castro & de Castro 1989). Less food is eaten if the time period between meals is short. Doris, Christine and Jessie all disliked the daytime meals being served close together, and the long overnight fast:

Well, we'd have our evening meal at five or five fifteen. You'd no sooner had your evening meal, and the next thing you were having the supper. And then there was nothing else until eight o'clock in the morning. It was really bad. [Doris]

Breakfast didn't come 'til like 7.30 or eight and then you're having lunch at eleven. It obviously fitted in with the organisation's needs, which is fair enough. I was glad that the dinners were fairly early because you tended to fall asleep anyway by eight o'clock. So it seemed to be a long time from dinner to breakfast, which tended to be on the later side. [Christine]

Tracey, who has a chronic illness which requires regular admissions to hospital, has her normal routine disrupted by the timing of the meals in hospital:

Breakfast seems to be far too early. Lunch isn't too bad, but dinner's at like five o'clock! I never have dinner at five o'clock at home. I don't have it 'til like seven o'clock at least. It's just weird! It puts me out of whack. I think that might be to cater for the older people in here. They must wake up early and go to bed early. Whereas I'm the other way around. [Tracey]

These observations are consistent with Mibey and Williams' (2002) findings from their survey of food service departments in 93 NSW hospitals. The median times for serving the main meals were found to be 7.30 am for breakfast, 12 noon for lunch and 5.15 pm for the evening meal, and the median time lapse between the evening meal and breakfast was over 14 hours. Only one fifth of the hospitals in this survey served an early morning beverage.

In this current study, the respondents found that eating in the presence of visitors, far from being enjoyable, caused stress and had a negative impact on their consumption of the meal. Sandra and Carol, both of whom had had many hospital admissions, describe the effects of having a visitor present during the mealtime:

> *And if you've got visitors, or you've got somebody there with you, you tend not to want to eat. You're confined to bed and you're in an awkward position and you're trying to eat off these trays that have got these high, hot things on, sometimes it can be very difficult to actually sit and eat in a proper position. So you tend to have a bit, put it aside, not pursue it. And it's not an enjoyable um, eating ... process. It's not something where you can sit down and you feel, you know, ready for it. You eat because ... you thought you were hungry. [Sandra]*
>
> *It's difficult when somebody's there because you feel inhospitable because they think of you as a host in hospital. You can't pull up a pew and get them to eat as well. I say 'go down and get something to eat and come back. We can eat together, otherwise go away' because you know it's not right eating in front of somebody ... and besides they wouldn't want to eat what you're eating anyhow. And you don't want to eat it, so most patients eventually just push the food away. [Carol]*

This finding is consistent with some of the findings in a study by Davidson et al. (2004). In their audit of interruptions during patients' mealtimes, these authors found that 31% of the 839 patients in the study had their mealtimes interrupted, although none of the patients who were able to eat in a communal dining room were interrupted. Furthermore, 48% of the patients who had their meal interrupted did not finish eating the meal.

Habeeb (1973) found that the respondents in her study wanted company at meal times, and wished to share the eating experience with others. This is in contrast to the findings in this study where the respondents found the presence of visitors at the

mealtime unwelcome, and their presence inhibited the respondent's consumption of the meal. This finding is also contrary to de Castro and de Castro's (1989) study which showed a positive correlation between the number of people present at the meal and the quantity of food consumed by the patient. However, none of the respondents in this study reported being in a situation where they were able to eat communally with the other patients, and nobody expressed a desire to do so.

Mibey and Williams (2002) found in their survey of hospital food services, that the majority of patients in NSW hospitals ate their meals either in bed or at the bedside. Coe (1978) believes that eating alone in bed intensifies the status of being a patient and the abnormality of being in hospital and, according to Parsons (1951), being sick absolves patients from normal social obligations. All of the patients interviewed in this study were admitted to acute care hospitals where, unlike some long stay facilities, it is unusual for patients to eat communally at tables. Sharing a meal is an expression of friendship, and defines the social line between intimacy and distance (Douglas 1975; Lupton 1996). Acutely ill patients, being exempt from social interactions, may prefer to keep that social distance between themselves and their fellow patients, or may not be well enough to make the effort to be social. Coe (1978) also believes that confinement by restricting mobility also isolates the patients from other patients, although this isolation may be desired by the patients as they may not wish to engage in the culture of the hospital.

As previously mentioned, this theme, *It's not normal*, is concerned with the structural perspective of the sociological imagination framework. The experiences of the respondents demonstrated the effect the hospital food service system has on patients and their food consumption. Although the respondents recognised that the situation of being in hospital is abnormal, and they did not actually expect it to be normal, most of them experienced difficulties because they perceived hospital food

service systems to be inflexible and unable to respond to patients' immediate needs. Having to make food choices in advance when the patients did not know how well they would be feeling when that meal arrived, having the entire meal presented at once instead of course by course, and not being able to obtain an alternative choice if the previously chosen meal turned out to be unsuitable were all cited by the respondents as deterrents to eating. The social aspects of eating were not only missing, but did not appear to be desired by the respondents. However, the respondents were generally fairly satisfied with the quality of the food and only two respondents, Paulo and Len, disliked the hospital food so much that they would not eat it at all. Both Len and Paulo were in the older age group of respondents, which this research study found to be very conservative in their food preferences and less willing to try unfamiliar foods. Both of these respondents were born overseas and tended to eat the foods of their own cultures at home, so the predominantly Anglo-Celtic menus of the hospitals did not meet their needs. The two older overseas-born women in the study, Anna and Marina, did not have the same issues with hospital food as Paulo and Len, possibly because they were both very interested in all food and cooked foods from many different cuisines. The older, Australian-born subjects in the study, while they were conservative in the foods they would eat, had their needs met because the hospital menus are based on traditional Anglo-Celtic meals:

I guess it would be harder for people coming from a different culture to us, as to what sort of foods that they would be offered, because I saw nothing on the menu at the hospital I was in that would accommodate a strongly European background, for example. It was very much Australian cuisine. [Colleen]

I know we can't have a great choice, but I think there should be a choice on what sort of foods are available because there's a lot of people out there who cannot stomach some of the food that's actually being put on the menu. And therefore you get the family starting to bring food in. Especially people from ethnic backgrounds. They don't cater for people from ethnic

backgrounds at all. Even people like us, with us being Aboriginal people, they don't cater for people like that. They've just got the ordinary, basic – your meats and your vegetables, and that's it. [Roger]

5.2.2 Theme three: *Well, the doctors know what they're doing*

This theme, *Well, the doctors know what they're doing*, is concerned with the structural and critical perspectives of the sociological imagination framework used in this research study, drawing together the different aspects of the respondents' admissions described in the four sub-themes. The focus of this theme is the impact that the structure of the hospital hierarchy and the medical system has on patients and their food praxis. Lupton (1994b) describes patients as placing their trust in the medical profession and preferring to hand over responsibility for their treatment to the doctor, and this is evident from the responses.

Four sub-themes contributed to the development of the overall theme. The first sub-theme, *The 'work' of patients*, demonstrates the ways that patients negotiate the hospital system, its shortcomings, rules and regulations in order to meet their physical needs, and to maintain some personal autonomy. The second sub-theme, *You can't be too critical of the whole affair*, shows that the respondents have adopted behaviours that are consistent with expectations of the patient role. The third sub-theme, *The medicalisation of eating*, shows how eating in hospital has become a medical function rather than a personal or social function, and how this is consistent with the western biomedical model of healthcare. The final sub-theme, *Starvation in the midst of plenty*, outlines the consequences of medicalising eating on patients and their nutrition.

5.2.3 Sub-theme one: *The 'work' of patients*

Many of the respondents reported food and food service related problems and difficulties during their hospital admissions. Problems ranged from cold soup, to finding a grub in the broccoli, to not being able to get a diet change actioned and not liking the food at all. As previously discussed in Chapter Two, nurses are frequently no longer involved in serving food to patients and, in the opinion of Carr and Mitchell (1991), the mealtime care of patients has suffered as a consequence. Carr and Mitchell (1991) believe that the patients' food-related problems are either unnoticed by staff, or passed off as someone else's responsibility. A recurring motif in this study was the lack of ownership of meal-related problems by hospital staff, which left the patients to solve their problems themselves:

If there was a problem, that was somebody else's problem. And the patient's problem was trying to find someone who would actually deal with whatever their issue or problem was. [Sandra]

Anne's experience of being left, unnecessarily, on a diet of beef broth, jelly beans and an icy pole three times daily for her entire 12 day admission, and her lack of success in getting her diet changed even though it had been sanctioned by her physician, was an extreme example of the difficulty of getting a simple problem fixed, which should not have occurred in the first place:

Nobody seemed to be able to deal with it It just seemed to be my problem, and in the end I got to the point where I was doing things that I shouldn't have done. But blow, I was hungry! [Anne]

In most hospitals the delivery of food to the patients' bedside has been devolved to domestic or food services staff (Mibey & Williams 2002), who may not have the same understanding and commitment to patient care as the nursing staff, and have

limited authority and ability to solve problems. In addition, in some hospitals, there appeared to be a lack of an efficient system for solving mealtime errors:

> *The nurses had absolutely nothing at all to do with the food services. And it wasn't just because they were busy and they weren't interested. They didn't have any authority. If you said to the nurse 'look, this meal isn't what I ordered and the person who delivered it has gone away,' they would have to ring and get somebody from the kitchen to come up and talk to you. They couldn't deal with your problem. And it just seemed to be a very unwieldy and unworkable situation, and they weren't working together. [Sandra]*

Some of the respondents spoke of the dietitians providing advocacy for their needs. These were either very long stay patients or patients who had frequent admissions and were well known to the dietetic staff

> *At one stage I was off food for five months and then they started to feed me again and I was getting meat and vegetables, and I thought 'where's the soft diet, because I can't just go from water and liquid'. And I'm the one that's always had to follow it up. I'm the one that's always had to say to the girl that comes around taking your menu 'could I see the dietitian please?' And of course when I did see the dietitian it would be changed. [Anna]*
>
> *I mean the dietitians have always been really good to me. Especially if you've been in for a long time and you see the same menu. [Trevor]*
>
> *This time has been complicated by the fact that my mouth is very sore, so anything hot or acidy is really hard to eat. Fortunately there's dietitians around and they've helped a lot with telling me what choices I have, because sometimes the standard choices are not going to meet your requirements because you've got a sore mouth. [Simone]*

Anselm Strauss and his colleagues (1982) described what they have termed 'the 'work' of patients'. Acutely ill patients are assumed to be passive and compliant people who are being actively treated by medical and nursing staff. However, patients may have coexisting illnesses or other physical problems which are not

being treated in hospital, so the patients must become engaged in the management of these conditions themselves. Such body maintenance activities were also termed 'patient work' by Strauss et al. (1982). According to Strauss et al. (1982), patient work can include many self-care activities such as bathing and toileting, medical tasks such as keeping still for a procedure, recording fluid intake and output, turning off alarming enteral feeding pumps and even attaching themselves to dialysis machines. The latter examples of patient work are nurses' work which the patients do themselves, with permission, as patients are often trained to manage quite complicated technology in their homes and are not always as medically naive as the staff would assume.

In this study the respondents were doing food-related patient work of all types. Most of the respondents had the opportunity to fill in menus for forthcoming meals, and having a choice and doing this type of work was something that was universally enjoyed. Sometimes the respondents were asked to do the work of staff. Maxine, a vegetarian, was bedridden for three months in a hospital that did not normally provide vegetarian meals. She was requested by the hospital staff to find suppliers of vegetarian dishes for the hospital to purchase for her:

> *They said 'is there anywhere in Sydney that you know that we could start buying vegetarian food for you?' [Maxine]*

Some patient work is regarded by the staff as illegitimate. According to Strauss et al. (1982), illegitimate work involves patients taking matters into their own hands, such as self-medicating and engaging in activities which the staff consider to be inappropriate, or where instructions or obligations are ignored. Some of the respondents in this study engaged in illegitimate work when they were unable to meet their needs by legitimate means. For example, Carol, a former nurse who has

had multiple admissions to hospital, had very specific needs regarding food. She ignored the embargo placed on her entering the ward kitchen because of her MRSA (multiple resistant staphylococcus aureas) status and prepared food for herself. In her view she was justified in breaking the rules because she was doing nurses' work:

> *You know I'm not even allowed to go into the patients' kitchen because I'm MRSA? I might breathe in there! I've given up on that restriction. I just go in anyhow. If I had to ask the nurses to do everything for me it just wouldn't get done! [Carol]*

Similarly Marie took matters into her own hands and reheated her cold soup in the microwave, even though she is aware that this practice is not allowed:

> *So I just heat it up in the microwave. I know you're not supposed to re-heat them, but I do. [Marie]*

Like Carol, Marie was very used to being in hospital. She also performed some nursing work by feeding another patient

> *They'd (the plates) always be boiling hot and you had to warn the patients, especially the elderly, 'You can't touch it for a while'. You couldn't actually touch the plates they were so hot and I used to actually help feed someone because the nurses were just too busy. And I used to get the serviette for them and said 'Look the plates really hot. Just put that there if you need to hold it'. [Marie]*

Patients who were not happy with the food found a variety of ways to solve their problems. Both Sandra and Paulo found that the carafe of water at the bedside became stale and unpalatable during the course of the day and each found a different way of dealing with the problem:

> *Hospital water from a jug by the side of your bed becomes just foul after a while. My husband had got me a little container of lemon juice. If you put that in a jug of hospital water, it helps. Helps you get it down. [Sandra]*
>
> *They said to drink up plenty water. I said, 'Oh I can't drink that water.' Oh God, it tasted terrible. So she [his wife] brought some tank water, you know. [Paulo]*

Having food brought in from home, or from outside, was a common solution to the problem of either not liking the food or obtaining a comfort food which was not available:

> *No way would I eat any of the food. My wife bring in the food to the hospital, or sometime my brother come along and he went out and buy something for me to eat. [Len]*
>
> *And every time my husband came in to visit me he'd come via the coffee shop on the ground floor of the hospital and bring me a cappuccino, so I was getting my coffee fix anyway. [Sandra]*

The respondents who had frequent, or lengthy, admissions found that networking with staff helped them get what they wanted:

> *In this hospital I have a lot, lot of friends. And they always look after me. And I never have a problem, you know. And they always said to me 'if you don't like a thing, I'll give you the other one', you know. But, I'm not have problem, I'm all right. [Marina]*
>
> *So you have to lobby a bit. You have to organise, use networks to organise what you want. [Sandra]*
>
> *Everybody's going to whinge that there's something on [the menu] that they don't like, or something they've got at home that they like to eat a lot of. But everybody's got that [a comfort food] you know. If I want Vegemite here (in hospital), I'll get Vegemite. If I want whatever I want, I'll get it. [Anthony]*

But, as Anna remarked, the patient has to be well enough to do it:

But, it takes energy to negotiate. It takes a lot of energy, it takes you being well. Not well enough to go home, but well enough to do it. So, say in the first two weeks following an operation, you're not really up to doing that and you're not getting the right food. Because you're just not seeing the dietitian, you're on morphine ... probably for the first ten days you're out to it ... and you look at the tray and you push it away because the right things aren't on it. And it's only when you start sitting up and getting up and walking that you start doing stuff. [Anna]

In one case the nursing staff did get involved with the patient's problem and went to considerable effort on a very personal level to help her. Maxine, the vegetarian who had a 100-day admission in a hospital that could not cater for her dietary requirements, talks of her experience:

The nursing staff got to know me quite well. They'd never had a patient for that long. They then decided that they would start to cook. When they came on duty they would bring my dinner with them. [Maxine]

Although the respondents either found a solution to their particular problem, or decided that their admission would be short and they could therefore put up with it, the fact remains that patients have to deal with their problems themselves, and this should not be necessary. Sandra sums it up in her description of her struggle to get an egg for breakfast:

It was just a pity that you almost had to fight for it. You had to go through this process of being anxious and feeling as if you had to argue with people. [Sandra]

5.2.4 Sub-theme two: *You can't be too critical of the whole affair*

In spite of the fact that most of the respondents had difficulty with either the food or the food service, very few of them complained, and in fact most of the respondents found excuses for the shortcomings of the system which had failed to meet their

needs. More than forty years ago Feldman (1962, p. 328) observed that 'most patients tend to be extremely reasonable and forgiving. If they happen to find the food distasteful they attribute this to the problems involved in preparing and serving properly balanced meals for a tremendous number of people with variable needs during a short time period'. The situation appears to be the same today, as the respondents in this study were extremely understanding and forgiving of hospitals' shortcomings. During the interviews many of the respondents reminded the researcher of the limitations of the system that was failing them. The following are quotes from the respondents, including some who have chronic illnesses which require frequent admissions to hospital, and some who engaged in illegitimate patient work.

Roberta and Christine spoke about the quality of the hospital food:

> *And it's all budgetary, and it's nutrition based, and there's so many criteria that you can't be too critical of the whole affair. And I appreciate that. [Roberta]*
> *You can't come to a hospital that's got thousands of people to feed and expect it to be high quality. I don't think it would be much better in a private hospital, quite frankly. [Christine]*

Carol and Simone refer to the difficulties of providing menu items which meet individual tastes:

> *You can't whip up a stir fry for somebody, even though a stir fry's easy to do for a lot of people, it's not easy to do for an entire hospital. I realise the logistics involved. [Carol]*
> *I understand that you're catering to a wide body of tastes when you are catering in a hospital and you can't meet everybody's needs, like everybody's preferences. [Simone]*

Brian was extremely ill and had a very lengthy hospital admission. He had taste changes as a result of his medical condition, and understandably became fussy with

his food. Although the hospital did not provide the food he fancied, he did not voice his dissatisfaction:

> *I was sick of being in hospital and food was just another irritant, as it wasn't what I wanted. But I accept the fact that there's a whole mass of people who have to be fed the same thing and you can't really say 'right, here we are, this is a ...' [Brian]*

Roisin was post-natal and feeling quite well. The hospital where she gave birth tried to make the maternity ward as home-like as possible by having queen size beds in the rooms and allowing the fathers to room in with mother and baby. Mealtimes, however, still fitted in with hospital routine:

> *Every meal was probably an hour to an hour and a half earlier than I would have it at home. But I understand that there's constraints. You know, serving up time. And it's such a huge hospital where many people have to be fed. [Roisin]*

Len, who was born in China, disliked hospital food intensely. He was craving for congee, a rice porridge which is the first food given to most Chinese babies and a popular illness food for Chinese adults:

> Interviewer   *Do you think if they'd had something like that [chicken congee] you might have eaten it?*
>
> Len   *I think so, because when she (his wife) bring me some of the food, she bring that. We cook at home and bring it in ourself. But don't forget you [the hospital] can't do that (make congee), because not many people eat that.*

And finally Olive, who had specific likes and dislikes in food, did not expect the hospital to cater to her idiosyncrasies. She organised for her family to bring in food or, if she was feeling well enough, went out and bought food from the nearby shop

herself. This is her response when asked whether she thought the hospital had a duty of care to provide food that patients will eat:

> *Well, I felt they did, and I still feel they do, but I just wonder whether they have the capacity to do it, you know. And I'm not defending the hospital, don't get me wrong. [Olive]*

The attitude of most of the respondents is summed up by Sandra in the following quote:

> *Most people who go into hospital think 'Well, you know, look I'm not starving to death. A couple of days without what I would like to eat isn't going to hurt me'. And most people just put up with it. [Sandra]*

Not only were the respondents forgiving, they were also reluctant to complain, even when things went badly wrong for them. There was a fear that, by complaining, they would be labelled bad patients. The following is a quote from Anne, whose efforts at getting her upgraded diet had failed and, by her tenth day on clear fluids, was starving:

> *They had excuses, and people would change the roster, and that was all very well, but I felt like I was complaining. I don't like to complain, but I was hungry. I felt like a bad patient because I like to do the right thing and conform. And here I was put in a situation where I just ... You're lying in bed churning ... Apart from everything else you're just plain hungry! [Anne]*

Olive, who is a nurse, explained why she made her own arrangements about getting food from outside rather than asking the hospital to provide the food she liked and would eat:

Well, I know that if I didn't like some of the hospital food I wouldn't eat it. I wouldn't really complain about it because I don't think you could change things, and maybe there was a fear too that you'd be labelled a whinger. [Olive]

And Brian, who was so ill and in hospital for such a long time, could not bring himself to voice his dissatisfaction:

I don't think I ever condemned the food. They might say I'm a moaning patient, and I'm only telling you because you asked me to. I don't like people who complain and moan. [Brian]

According to DeLange (1963) the processes of hospitalisation systematically undermine the individual's self-image, and it is the maintaining of self-image that is a major factor in patients' behaviour in hospitals. The ease with which an individual behaves appropriately as a patient, in DeLange's (1963) opinion, is dependent on the extent to which the patient's behaviour and the staff's definition of the patient role coincide. It is also contingent on the extent to which this role is compatible with the individual's self-image. Coe (1978) believes patients adjust to being in hospital either by withdrawal, aggression, integration or acquiescence, and that most patients respond to hospitalisation by being acquiescent. The respondents in this study were acquiescent, although some of them were forced into some illegitimate activities, not only to solve problems, but in order to maintain their self-image and a degree of independence:

Carol   *They have you on nil by mouth for weeks. It's not fair, and you resent it because somebody's dictated how it's going to be, and you really don't have any say in it, and you have no way of controlling it.*

Interviewer   *So you really feel that you are in a situation where you don't actually have any control over what's happening to you?*

Carol   *In the beginning no, I didn't. But I've worked out other ways to maintain*

control. Got to be individual. I think anybody does. Any long term patient works out other ways to do it, whether it's just individual behaviour or methods of coping, you'll work it out. Or go insane. One of the two. You've got to.

In Parsons (1951) classic model of the sick role, being a good patient comes with the obligation of obedience to doctor's orders. According to Murcott (1981), from the perspective of the hospital staff, good patients fit into the routine of the hospital and do not cause trouble. Uncooperative patients who are critical and question medical judgment, and patients who demand more than their fair share of nursing time, are considered to be bad patients. The respondents in this study not only expressed their desire to conform and behave as good patients, but also their fear of being labeled a bad patient. As patients in acute care hospitals are extremely dependent on the staff, it can only be surmised that the consequence of being a bad patient is some kind of retribution, or poor service, by the staff, although none of the respondents made any direct reference to this. Pearson et al. (2003), in their study of mealtime practices in 10 nursing homes in northern NSW, also found that the residents were reluctant to complain about the food, and did not want to be labeled a 'whinger'.

5.2.5 Sub-theme three: *The medicalisation of eating*

The respondents in this research study clearly regarded mealtimes as eating rather than dining, as many of the small social and physical pleasures associated with food and eating were absent, and the events surrounding meals and eating were somewhat distressing for a few of the respondents. From the analysis of the data it became apparent that, in hospital, eating appears to have become a medical function rather than a social or personal event. Brown (1999) stated that the biomechanical model of illness, which focuses on the body rather than the person, forms the basis of our healthcare system. As a result of this preoccupation with the body, the term

'clinical' has come to encompass numerous social and everyday activities within the hospital because, according to Murcott (1981, p. 133), 'it is 'the clinical' which welds a gamut of disparate activities together as modern medical work'. Zadoroznyj (1999 p. 86) describes medicalisation as 'a process by which human experiences are redefined as medical problems'. The purpose of medicalisation, according to Zadoroznyj (1999), is to put a wide range of health-related social, psychological, political and economic problems into a framework in which they can be understood by clinicians. Conrad (1992) believes that, having defined a problem in medical terms, then medical treatment is mandated as a consequence.

There are several ways in which the medicalisation of eating was manifested in this study. Eating was medicalised by directly controlling what the patient was allowed to eat by prescribing a diet. Informal dietary advice to the patient was also given by medical, nursing or dietetic staff, and this was taken as authoritative. A further way in which eating was medicalised was by the recording and calculation of food intakes by the nurses and/or dietitians:

> *I'm simply starving. I said 'I can't understand why I need to starve. I know I can only have fluid and I know you're measuring intake, output, and all the rest of it, but why can't I have some more please?' [Anne]*

The ultimate form of medicalised eating is total parental nutrition (TPN), where artificial solutions of nutrients are pumped into a large vein in the patient's body, bypassing the gastrointestinal tract, and the need for normal food, entirely. Marie, Anna and Trevor were all maintained almost exclusively on TPN, and were able to eat very little food. Here they talk of their feelings about not being able to eat normally, and the restrictions imposed on their lives as a result of having TPN at home:

It's been hard ... I get really angry sometimes. I get very annoyed with the machine sometimes. I've got to be on it at five thirty in the afternoon to at least eight thirty in the morning, so you've got to prepare yourself for it. Then it will play up. It will get air in the line in the middle of the night and it wakes you with bip, bip, bip. But then I've realised it's saving me. [Marie]

It's been a long process and I did have counselling in the beginning to come to terms with it. I am most definitely dependent on the TPN. When all my veins collapse and I can't have TPN, I couldn't see myself living longer than two weeks because first of all, I can only eat a very small amount per day and secondly, I don't absorb it. But food is still very important to me simply because I can have so little of it, and so I now only eat beautiful and wonderful things I'm going to enjoy. [Anna]

When you go on TPN, probably the first two weeks is the hardest. And then it gets to a point where your hunger and all that is satisfied by TPN. I think the biggest thing I miss is being able to go out and have a meal with a couple of friends. I can still go out, but I can't have the meal. So you sit there, and you kind of like feel like someone on the side just, you know, watching. You don't feel part of it. [Trevor]

However, the most common form of medicalised eating in hospital is keeping the patient either nil by mouth or on a fluid diet because of surgery or tests. In the following quotes, dietary prescription refers to the patients being on fluids post-operatively, or for acute abdominal pain. Several of the respondents were on therapeutic diets for the management of diabetes, renal disease and so forth, but these were not mentioned by the respondents in this context, and in fact were rarely mentioned by the respondents at all. The following five respondents, one of them a veteran of multiple medical and surgical admissions, describe their feelings about being kept nil by mouth:

I don't think they gave me much to eat the first day. Or the second day. I don't think I got

anything to eat for a couple of days. I had about three days there, and then it was time to go

home. [Roy]

I think it was a CT scan first, then a MRI. On the third day they put me on light meals,

which is soup and jelly and ice cream and fruit juices. Then I had to go for more tests so I was

nil by mouth again, but I actually really wasn't feeling hungry at the time. And that went on

like that for the eight days, and the last day I had a solid meal. [John]

When I've been on steroids I feel hungry and it actually makes me really angry to be nil by

mouth. You resent it because somebody's dictated how it's going to be and you really don't

have any say in it, and you have no way of controlling it. [Carol]

Well, I wasn't really sure what was going on internally, so I thought 'well, the doctors know

what they're doing'. I felt that I could eat more. The clear fluid diet is not good. I don't think

anybody enjoys that. [Edward]

Although the respondents accepted their dietary restrictions, they were not happy about it. In fact several expressed their anger and frustration. Even so, all the patients complied with their diets, which is consistent with Coe's (1978) theory that patients in acute care hospitals tend to submit to medical authority because of confidence in the decisions of the medical staff. However, for some of the respondents in this study, the clinician's dietary prescription over-rode the patient's 'wisdom of the body', especially where the patient had a chronic illness and was a much better judge of his or her ability to eat. Marie, who has had multiple medical and surgical admissions, relates her experiences of being prescribed a fluid diet:

That was the hardest time. I used to hate it, because I used to feel like it was making me

worse. They used to keep you on fluids for a long, long time. They used to say 'try and let

your bowel heal', but the longer they left me on fluids the worse I seemed to get. It would take

me longer to get back onto food. I said 'No, put me on earlier. Let me have soups first or a bit

of a jelly, then some bread.' [Marie]

Colleen also felt ready to eat after her surgery, but she accepted the staff's decision to continue with nil by mouth because she had confidence in their clinical decisions:

> *For the first couple of days I felt my body getting better. I was thinking if I could only have this clear broth, clear fluids. I thought I could probably progress to something else that evening, but they said no. I guess they're health professionals who were advising this. [Colleen]*

Trevor thought that he was able to regulate his own diet sensibly, and was frustrated that he was denied the opportunity:

> *I know when I can and can't eat, and I want to have the choice, rather than be so restricted. I suppose sometimes I get frustrated in terms of thinking 'oh, I'm coping with this and I'd really like to try this or that, or whatever'. [Trevor]*

Similarly, Shirley had to struggle to get the milk she knows from past experience settles her stomach, though in this case medical authority worked to her advantage:

> *I love my milk, and that's one thing they say when you're nauseated you shouldn't have. But in my case milk settles me every time. We had arguments about that in the hospital. They just said 'no, I'm sorry you can't have milk'. And when the doctor came and I explained the situation he said 'give it to her'. [Shirley]*

Medical authority was also required for Len to have alcohol which was offered on the menu in his hospital:

> *The funny part was I was looking at the menu and I say 'how come they don't serve you beer, they seem to have beer in there?' They said 'the doctor has to allow you.' [Len]*

The patients themselves used the lack of, or alternatively, the return of their appetites as a barometer of their recovery, many of the respondents gauging their

return to health by the state of their appetites. Once they became hungry, or felt like eating normally, they judged they were well enough to go home:

> *I knew that it was time for me to go home when I woke up and I was starving. [Colleen]*
>
> *I mean if you're well enough to be hungry you're probably well enough to go and find yourself something to eat, then you could come back here for it [meaning her home which is one block from the hospital]. It's not the first time I've come back here and cooked myself something because I was hungry and there was nothing there. If you're sick you're probably not hungry anyhow, if you're not well enough to do it. [Carol]*

Conversely, as Carol mentioned above, if the patients were feeling sick they did not expect to be able to eat:

> *I only ate a little bit of it because I couldn't eat. I was too sick to eat anything very much. [Jessie]*

Habeeb (1973) also found that her respondents used eating as a barometer of wellness/illness but in a slightly different context from the respondents in this study. Habeeb's (1973) respondents used minor changes in appetite as cues to the changing state of their health, and the physician's opinion about the patient's appetite, whether it was getting better or worse, was interpreted by both the patient and the nursing staff as being a significant indicator of either improvement or deterioration in the patient's medical condition. The nursing staff accepted the physician's opinion as fact, and assumed the patient's appetite would meet the physician's expectations.

5.2.6 Sub-theme four: *Starvation in the midst of plenty*

In the respondents' quotes in the previous sub-theme it can be seen that several of them were hungry, even starving, in hospital. All of the respondents who reported being hungry had been nil by mouth, or on a fluid diet, for tests or surgery. For John

and Anne this period of semi-starvation continued for eight and ten days respectively, after which they were discharged from hospital. Neither of them had a full meal during their admissions. Brownridge (2002) is a Canadian clinician who wrote from the perspective of her experience as a patient. This author recounts a similar experience of having fluids for six days post-surgery and receiving her first self-selected meal on the day of her discharge.

Christine had to fast for almost two days because her surgery was delayed:

> *Because of the timing of the operation, I missed out [on meals] which, was very frustrating 'cause I was in a lot of pain and I'd been fasting for this operation. I came in on Saturday morning and I fasted, and at eight o'clock at night they came around to say it wasn't going to happen. So I was starving ... and all they could find me was, literally, was some dried bread and packets of cheese and a cup of tea. And that was my dinner. And then I had to fast again, and the operation, again, wasn't till 6 o'clock that night. [Christine]*

Eastwood (1997) found in an audit undertaken in a Scottish university hospital over a period of two weeks that patients missed 25% of all meals. Furthermore, post-operative fasting accounted for three-quarters of all meals missed in the surgical unit of that hospital and this was exemplified by Bill and Ian in this current study:

> *With the valve by-pass, that was done on Monday. Well, they gave me some food on Wednesday lunchtime, which was tropical fruit salad, I think. So I gobbled it up. I didn't have any more 'til Friday night. They were feeding me through a tube. So I lost 10 kilos in six days there. [Bill]*
>
> *They took me back to intensive care after the stent and I had this huge vomit. So for the next two days I didn't get any food at all, just water. And then it was clear jelly, and all that sort of stuff. So I think it was only the last day that I was there that I actually had any hospital food. [Ian]*

In this study, Edward, Colleen, Christine and Marie all thought they could have eaten solid foods more quickly than they were allowed, and they all reported that they were hungry before their diets were upgraded following their procedures.

Several of the respondents in this study including Marina, Jessie, Anna, Len, Marie and Carol said that they had no appetite, and did not eat, if they were feeling unwell. A study by Hirsch et al. (1979) in the late 1970s supports this finding. Hirsch et al. (1979) audited plate waste over a two-week period in an American university hospital and found that 15% of all meal trays were returned untouched by patients who said they were too ill to eat. More recently, Eastwood (1997) also cited the patient being ill as a cause of missed meals, although the numbers of patients missing meals for this reason are not reported in the study.

In an observational study of one hundred nursing home residents who were not eating well, Kayser-Jones (2002) found that some of the residents were hungry. Due to inadequate staffing levels, the staff did not have time to feed the complete meal to the residents who needed feeding assistance, many of whom had developed malnutrition. In this current research study none of the respondents were unable to feed themselves. However, Christine needed some assistance in opening packages and cutting her food as she had both wrists in plaster. Here she talks about the difficulties of unwrapping her sandwich after she had been to theatre to have her wrists plastered:

> *I found that there was no one to help me because it was at night and, you know, I don't want to ring the nurses to help me. Even the cheese wrap ... it took me forever to open that because this arm was already in plaster and then they re-did this one twice. I found that really difficult, not being able to access the food, it all being wrapped and no-one there to help me. [Christine]*

Fasting for procedures is not only detrimental to the food intakes of patients eating meals but also to patients on tube feeds. In a study of 379 enterally fed patients in a large intensive care ward, Ferrie and McWilliam (2006) found that the patients received, on average, only 72% of their total energy requirements, and had negligible nutrition for 25% of the time they were in the intensive care unit. The most common reason for the patients' enteral feeds being suspended was preparation for extubation, which often did not eventuate (Ferrie & McWilliam 2006).

Hospital malnutrition is a significant problem which contributes to patient mortality, morbidity and increased lengths of stay (Metz 1982; McWhirter & Pennington 1994; Arrowsmith 1997). The cost of malnutrition to the health service is also significant. Edwards and Nash (1997) estimated that the cost of treating a malnourished patient with complications is four times that of a well nourished patient without complications. Pennington and McWhirter (1994) found that a series of 500 patients in a British hospital had a mean weight loss of 5.4% of total body weight, and presumably a concomitant decline in nutritional status, during hospitalisation. This is the equivalent of a weight loss of 3.5 kilograms in a patient weighing 65 kilograms on admission to hospital.

In 1859 Florence Nightingale (1859 (1980)) wrote that 'thousands of patients are annually starved in the midst of plenty'. The findings of this research study indicate that, in 2006, patients are still being starved. The experiences of the respondents in this research study, who were kept on nil by mouth or fluid diets for lengthy periods, often either unnecessarily or because of poor coordination of procedures, gives some indication of how this can still occur.

5.2.7 Theme four: *Food is more than just something to eat*

The final theme that emerged from the analysis of the results is the role of meals and food in hospital that is unrelated to nutrition. These are the historical and cultural perspectives of the sociological imagination framework and are related to the following interview questions: 'Tell me about your food experiences in hospital', 'Are there any particular foods that you like to have when you are sick or not feeling very well? Was the hospital able to provide these foods for you?' and 'What do you think is the most important thing about food?'

According to Telfer (1996, p. 37), 'food and eating, at any rate, are what they are and often many other things as well, and we often value them because they are these other things, not because the food tastes good'. Despite the fact that the respondents thought food and eating in hospital was not normal, food remains one of the few aspects of the hospital experience that is familiar to the patients. In Pearson's (1994) opinion, the non-nutritional role of food in the well-being of patients should be considered, even if it entails challenging the biomedical model to include broader ideas about the role of food and eating in hospital. One of the respondents, Philip, recognised the importance of the non-nutritional role of food:

> *Ah, patient satisfaction with meals and everything else has a lot to do with their recovery rate. [Philip]*

There are a number of different ways in which food and eating can be important to the patients' psychological well-being. Food and eating can be a comfort, a distraction, a marker of time. Sandra, Anne and Ian all commented on the importance of food as a distraction from the concerns of being ill and in an unfamiliar place:

Because food can be such a distraction from what you're in hospital for I really don't think it's something that the bean counters of these hospital organisations should trifle with. [Sandra]

*And there was this psychological thing -- the **only** thing happening in my life was food. [Anne]*

If I had to spend another week in hospital, when I wasn't so scared and so ill, I think the food would have been very important. Um, yeah, we do try to make it do things that it won't do, and that has to be pretty important, I suppose, to somebody who's sitting around all day in hospital. And for a lot of them the highlight of the day is their three meals really. [Ian]

On many occasions the hospital food failed to meet the patients' psychological needs. The hospital was unable to provide comfort foods for some of the respondents, either because the particular food desired was not available, as happened with Len and his Chinese congee, or because the quality of the food itself was unacceptable:

It's all the added pressures, the things that you're not doing that you'd otherwise be doing, overlaid with the fact that you're in hospital unexpectedly, and in pain at the time. So the food could have helped, and it didn't. It wasn't worth looking forward to. [Anne]

In Simone's case her comfort foods were prohibited for medical reasons:

Particular crisps ... sort of chips-type stuff ... and some chocolate bars occasionally. They're probably the main ones. And Coke. I'm not allowed to drink Coke at the moment because my heart's racing. [Simone]

Mealtimes in hospital are something to look forward to during the day when patients do not have much to occupy them:

A lot of the time, well nothing happens. Time stretches when nothing happens and you know, you can't read, you can't concentrate very well, so when nothing's happening you're kind of

looking forward to five o'clock when the food's there. And if it's late people ask 'Oh, where's the food?' [Christine]

Carol also talked about mealtimes being used as a virtual clock and, in this context, she also expressed her anger about being nil by mouth:

Hospitals are boring. It's not just in hospital though, that mealtimes punctuate the day. You ask anybody when somebody phones and they'll say 'Oh, it was just before lunch' ... so it's a way of marking time ... a way of dividing the day so that you know, without saying exactly what time it was, roughly when it was. It gives you a beginning, middle or end of the day, or something like that. When you're stuck in hospital, especially if you're nil by mouth, meal times assume a big significance, especially if you're hungry too, because everyone else is being fed, and you're not, and the meal times go on around you and you're not somehow involved. To begin with you start saying 'Oh that was before lunch' ... and eventually you end up marking your time some other way, because meals are not yours anymore. It's not your right to mark time with them. [Carol]

According to Pearson (1994), the social importance of events such as mealtimes in the daily routine of healthcare institutions has been eroded, so that food is no longer part of the caring process of patients. Pearson (1994) cites the conflicting concepts of the nature of food provision of the providers and receivers of food as part of the cause. Batstone (1983) has described the provision of meals in a context of time constraints and rules governing work as functional meal provision, as opposed to meal provision in the domestic situation which is focused on meeting social needs and personal goals, tastes and comforts. Hospital meals are functional meals in that the times the meals are served suit entrenched routines and industrial considerations such as staff shifts. Habeeb (1973) documented the effects of functional meal provision and concerns with managing tasks within a limited timeframe in her study of the relationship between eating, illness and identity in a

group of patients in an American long-term hospital. This author found there was a dissonance between the mealtime goals of staff and patients. For the nursing staff, the emphasis was on the completion of tasks in a limited period of time, whilst the patients sought social interaction and affirmation of their personhood.

In this research study, in contrast to Habeeb's (1973) findings, there was no sense that the respondents wanted social interaction at mealtimes, possibly because the respondents were all in acute care hospitals, whereas Habeeb's respondents were in longer stay facilities. In addition, some of the respondents in this study had been extremely ill during their admissions, and many of them expressed the view that when they were well enough to eat they were also well enough to go home, so it is possible that they did not seek social interaction during the hospital admission at all. Carol gives her views on social interaction in hospital:

> *It's just such an abnormal social situation. And there's nobody [who] can make it right. You're a caged animal for a start. You haven't got any say in your visitors, and it makes you feel ungracious if you say that you don't want them to be there. If you're well enough to want them there, you could probably go somewhere with them. You could walk with them and change the parameters of the social cage that you're in. But if you're sick and you've got somebody there harassing you, you just want them to go away so you can be sick by yourself. [Carol]*

5.3   Conclusion

In this chapter three themes and four sub-themes have been described. All of these themes show that the structural perspective of the sociological imagination framework had a major impact on the food praxis of the patients in this study. Hospital routines and medical practice frequently result in patients not eating, or eating poorly. However, it was clear from the data that the respondents had adopted the role of the patient, and were anxious to comply with medical treatment. They

were also reluctant to complain in case they were labelled as 'whingers'. However, for most of the respondents, their personal needs in terms of comfort foods were not met and they had to undertake patient work in order to get the food they wanted to eat. The respondents also had do patient work in order to solve their problems with the food service of which, in many cases, the staff were unaware. Despite their desire to be good patients, many of the respondents were forced into illegitimate work to achieve this end. A most important finding of this study was that many of the respondents experienced hunger during their admission, and that this was avoidable in some cases. In the context of the prevalence of hospital malnutrition this finding has great significance.

The following chapter presents and discusses the major conclusions of this research study. The implications for policy and practice will also be discussed and recommendations for further research into this topic will be identified.

Discussion, Conclusions and Recommendations

> *Ever since Galileo, Descartes and Newton our culture has become*
> *so obsessed with rational knowledge, objectivity and quantification*
> *that we have become very insecure in dealing with human values*
> *and human experience.*
> —Fritjof Capra 1983, p. 350.

6.1   Introduction

The aims of this study were to explore the effect that hospitalisation has on the normal food praxis of individuals, to describe the experience of food and eating in hospital from the patients' perspective, and to determine the ways in which healthcare practice and food culture interact and the effect this has on patients' food consumption in hospital. The following research questions were formulated in order to explore the effects of hospitalisation on personal food praxis:

1. What determines the food preferences of hospital patients?
2. What are the food experiences of patients in hospital?
3. Are patients' food preferences important in determining what people eat in hospital?

The preceding two chapters described the findings of this research study, which are encapsulated in a number of themes and sub-themes. In this chapter the results of the research study are discussed and explained in the context of the sociological imagination, existing theory and the findings of other research studies. In addition, implications for policy and practice arising from the research findings will be identified and discussed. Finally, recommendations for further research will be made.

6.2 Personal food praxis: Findings from Chapter Four

The findings which are reported in Chapter Four relate to the historical, cultural and critical perspectives of the sociological imagination framework which guided this study. In this chapter the influence of family, culture and public nutrition education on the development of personal food praxis were explored.

The major finding from Chapter Four was the evolution in the food and eating praxis of the individual respondents in this study which extends to the broader community. For example, food praxis was traced from the traditional, Anglo-Celtic eating patterns of the older Australian-born respondents, and the limited variety of foods available to the pre-war generations, to the revolution in food and eating in Australia, which commenced with the influx of migrants with their traditional cuisines after the Second World War. Adoption of foods from these new cuisines, together with increasing diversity in the food supply due to technology and the willingness of the community to experiment with new cuisines has, according to Ripe (1993, p. 6), resulted in the forging of a 'uniquely Australian culinary identity'. Chapter Four documented the processes involved in adopting new foods into the culinary repertoires of those Australians whose families have been here for several generations, and the adaptation of their traditional foods by the migrant Australians, from the viewpoint of the respondents. These represent the historical and cultural perspectives of the sociological imagination framework.

Public health nutrition, which represents the critical perspective of the sociological imagination framework, has also had some influence in determining the food praxis of both individual respondents and the community. Differences in attitudes towards healthy eating, and increasing concerns about diet and the food supply in terms of meeting nutritional requirements, were evident in this study,

especially with the younger respondents. It was found that the older generation, particularly the men, remained very conservative in their eating patterns but were confident that what they ate was sound, healthy and nutritious. The older, overseas-born male respondents were also very conservative in their eating habits and tended to eat the traditional foods of their cuisines. The two older female respondents who were born overseas were much more willing to include a wider variety of foods into their diets.

It was also found that the next age group, the respondents who were born around the mid-twentieth century, were the group that adopted ethnic foods into their diets so enthusiastically. This group also responded to the health and nutrition recommendations of the Australian Dietary Guidelines by making changes to their food praxis, such as reducing dietary fat. The youngest respondents, those in the 20 to 40 year age group, were found to have the most interest in, and knowledge of, nutrition but had the least confidence that the food choices they make are healthy, and that the food supply is sound. It can be argued that the younger generation is not only uncertain of the origins and soundness of the food supply but, as Fischler (1988) asserts, are consequently uncertain of who they are in a cultural sense because they do not know the genesis of their food. Fischler (1988) believes that cultural uncertainty is expressed as a willingness to experiment with alternative diets and the desire for informative food labelling, and both of these were evident with some of the younger respondents in this study. Ripe (1993), on the other hand, sees the shift away from Australia's British culinary legacy, by the incorporation of new foods and elements of other cuisines into the diet, as the driving force in creating an Australian culinary identity.

Sokolov (1992, cited in Ripe 1993) is of the opinion that the globalisation of world cuisines represents the greatest period of culinary transition the world has

seen since Christopher Colombus introduced foods from the New World. In Fischler's (1988, p. 289) opinion, the globalisation of the food supply and the expansion of industrialised food production, which has resulted in food being less identifiable by its taste, texture, smell and origins, is responsible for cultural uncertainty, or the 'disturbance of modern identity'. According to Lupton (1994a), food culture is such a strong marker of the identity of groups, and of individuals within those groups that, as Fischler (1988, p. 289) says, 'if we don't know what we are eating, how do we know what we are?'

As consumers know increasingly less about what they are eating, the levels of anxiety and insecurity about food escalate. Consumer insecurity is manifested by rumours, campaigns and even panics about food. Recent examples are the debate around genetically modified food sources, and consumer panics related to bovine spongiform encephalitis (BSE or 'mad cow disease') and the consumption of beef and the risk of contracting avian influenza from eating poultry. The demand for ingredient labeling of foodstuffs is also a consumer reaction to uncertainty and insecurity, as is the increasing interest in adopting regimes such as vegetarian, macrobiotic and organic diets, which Fischler (1988, p. 291) sees as an attempt to 'reintroduce a normative logic into everyday eating'. The youngest respondent in this study, Tracey, ate organic foods and would not eat casseroles or foods where she could not identify the ingredients. Some foods, in her opinion, 'looked processed', so she would not eat them either.

Fischler (1988) believes that consumer uncertainty is the result of cultural identity being de-structured by the globalisation of the food supply. This author believes that coherent rules of behaviour, which integrate food, will restore meaning and re-structure identity for consumers. Whether dietary guidelines can take over the function of traditional eating patterns as a guide to eating for the younger

generations, or some other rules for eating emerge in the 21st century remains to be seen.

6.3   Food and eating in hospital: Findings from Chapter Five

In Chapter Five the food experiences, attitudes and behaviours of the respondents during their time in hospital were analysed and described. Three themes emerged from the data: *It's not normal; Well, the doctors know what they're doing;* and *Food is more than something to eat.*

The major finding from the first theme, *It's not normal*, was the inability and inflexibility of hospital food service systems in meeting patients' needs with regards to food and eating. This theme documented the respondents' experiences with hospital meals and the hospital food service, and their thoughts and opinions on matters such as the quality of the food, timing of meals, eating in bed and eating in the presence of visitors. It was found that the majority of the respondents in this study were generally satisfied with the quality of the food, which either met or exceeded their expectations.

The oldest Australian-born respondents in the study, as a consequence of their conservative attitudes towards food and their traditional food praxis at home, were very familiar with the type of food they received in hospital, since Australian hospital menus are based on the traditional Anglo-Celtic pattern of three daily meal events (Williams & Brand 1989). These respondents recognised these traditional Anglo-Celtic patterns of meals, and the 'proper meals', consisting of meat, potato and vegetables, which form the basis of Australian hospital menus (Williams & Brand 1989; McClelland & Williams 2003). The few times these respondents expressed dissatisfaction was with the quality of the food rather than the type of food, which was generally very familiar to them.

Similarly, the few times the middle aged and younger respondents expressed dissatisfaction was also related to the quality of the food, as these groups are familiar with a very broad range of foods, which they also include in their everyday diets. Having said that, the respondents in all age groups were generally satisfied with the quality of the food, which they found to be better than they had expected. This finding concurs with the literature on patient satisfaction with hospital meals (Cardello et al. 1996; Lau & Gregoire 1998; Hwang 2003).

The respondents who had the most difficulty with hospital food were two older, overseas-born men who found both the quality of the food and the foods available to them highly unsatisfactory, and the system insufficiently flexible to provide them with foods they liked and would eat. These findings concur with the findings in Chapter Four which showed that the older respondents ate a limited variety of foods and were less willing to try new foods.

Other patients, particularly those who had regular admissions, also found the system inflexible and unable to respond to their particular needs. They, and the long-stay patients, suffered from some menu fatigue since most hospital menus are designed on a two-week cycle (Mibey & Williams 2002). Overall, the respondents believed that food and eating in hospitals is not the same as food consumed in the domestic situation, nor did they expect it to be the same. Cameron et al. (2003), in a small qualitative study of six South Australian patients undergoing chemotherapy, also found that their respondents did not regard food in hospital as normal. Although there are some published studies of patient satisfaction with hospital food (Maller et al. 1980; Bélanger & Dubé 1996; Lau & Gregoire 1998; Stanga et al. 2003), none of these studies were conducted in the context of the patients' age or country of birth, so it is not known whether other researchers have found differences in satisfaction levels with hospital food related to age or ethnicity.

Four sub-themes contributed to the development the second theme, *Well, the doctors know what they are doing.* In this overarching theme the ways patients understand the social rules of the hospital environment, and either conform to these rules or circumvent them, was shown. It was also shown that maintaining a degree of independence helped the respondents preserve a sense of self in the unfamiliar environment of the hospital.

The major finding of the first sub-theme, *The work of patients,* was the staff's lack of awareness and lack of ownership of the patients' mealtime problems. It was apparent that almost all of the respondents experienced food-related problems in hospital, but the staff seemed to be either unaware of their problems, or would not take ownership of them. In one study of the mealtime care of stroke patients, Carr and Mitchell (1991) found that when nurses are not involved in the meal service they are less likely to notice patients' feeding problems, a finding which is consistent with the results of this research study, where not only the nurses but none of the hospital staff seemed to be aware of the patients' difficulties.

The findings of the Pearson et al. (2003) study concur with this finding. In an observational study of meal services in ten nursing homes, these authors found that the nurses did not see problems which were observed by the researchers or reported by the residents. Non-nursing staff are also involved in the distribution of patient meals in many hospitals (Mibey & Williams 2002), and these staff members may not be attuned to the patients' needs. In the Kowanko et al. (2001) investigation of the energy and nutrient intakes of patients in an acute care hospital, the authors cited two factors which they believed contributed to the patients' poor nutrient intakes. These were the variable ability of food service staff to communicate with patients and to understand their individual needs, and the nurses' lack of time which prevented them from assisting and encouraging patients with their meals.

In this study the respondents found a variety of ways to solve their own mealtime problems. For those respondents who had a single, brief admission, it was often easier to put up with the problem than to try and tackle it, but for the long stay patients, and those who had frequent admissions, finding ways around their difficulties assumed enormous importance, as it sometimes meant the difference between eating and not eating.

The major finding of the second sub-theme, *You can't be too critical of the whole affair*, was that patients may not always report the difficulties they are having with their meals to staff who could assist them. While the staff appeared to be unaware of the difficulties patients were experiencing with their meals, the respondents were also reluctant to complain. It was evident that the respondents had assumed patient roles and were compliant and accepting of the failures and flaws of the system.

According to Cardello (1995) and Feldman (1962), understanding and forgiveness is typical of hospital patients who would, in other settings, undoubtedly complain about the same food, and the same lack of service. Studies of patient expectations of food quality (DeLuco & Cremer 1990; Cardello 1995) show that their expectations of hospital food are low, while other studies (O'Hara et al. 1997; Stanga 2003) show that patient satisfaction with hospital food is generally high. Whether this difference between expectations of hospital food quality and patient satisfaction with the food was due to differences between expectations and reality, or patients' reluctance to complain, was not addressed in these studies.

The respondents in this study were anxious to be good patients, and were reluctant to voice their dissatisfaction when things went wrong. These findings are congruent with the findings of Pearson et al. (2003) in their study of the social and functional contexts of the meal service in ten Australian nursing homes. These

investigators found that the residents d:d not like to ask the nurses for anything because they believed the nurses to be busy, and also because they did not want to be viewed as complaining.

The key finding of third sub-theme, *The medicalisation of eating*, was the loss of the personal dimensions of food and eating for hospital patients. This sub-theme documents the transformation of the social and personal activity of eating into a medical function. What the patient eats, when it is eaten, and even how it is ingested, is subject to clinical prescription and surveillance. Eating, which is one of the few familiar and personal things for patients in the hospital environment, was removed from the respondents' control. According to Conrad (1992), medicalisation can be viewed as a form of social control, one which contributes to the loss of patient autonomy.

The major finding from the fourth sub-theme, *Starvation in the midst of plenty*, demonstrated the impact that standard pre- and post-procedure protocols have on both patient comfort and nutritional status. The respondents missed out on food because of these protocols. This sub-theme presents the most significant finding of this study. For example, many of the respondents reported being hungry, even starving, while in hospital, not because the food was unacceptable, but as a result of the physical deprivation of food as a consequence of standard medical practices. Although they were sick, these respondents were hungry and would have eaten, had they been allowed. Even Len, who hated the hospital food, ate a meal he would not normally have eaten because he was starving after fasting for several days. This finding is supported by the findings of Eastwood's (1997) study, which showed that pre- and post-operative fasting in surgical wards accounted for 75% of the meals which were missed by the patients. Patients who are being artificially fed are also subject to food deprivation as a result of standard medical practices. In a recent

study, Ferrie and McWilliam (2006) found enterally fed patients received negligible nutrition for 25% of the time they were in the intensive care unit, and that anticipation of extubation, which did not always eventuate, was a common reason for suspending the enteral feeds.

As previously mentioned, hospital malnutrition is a significant problem which contributes to patient mortality, morbidity and increased lengths of stay (Metz 1982; McWhirter & Pennington 1994; Arrowsmith 1996). Both the human cost of malnutrition in terms of mortality, morbidity and diminished quality of life (Laws et al. 2000) and the monetary cost of malnutrition to the health service are significant (Edwards & Nash 1997). Recent studies have shown that malnourished patients score lower in respect of spiritual/psychological well-being and global feelings about their life situation than well nourished patients (Ferguson et al. 1998; Laws et al. 2000). In terms of the cost of malnutrition to the healthcare system, Edwards and Nash (1997) estimated that the cost of treating a malnourished patient with complications is four times that of a well nourished patient without complications.

In another prospective study of the nutritional status of 404 patients in an American university hospital, Brunschweig et al. (2000) found that the patients whose nutritional status declined during their hospital admission had significantly higher hospital charges compared with well nourished patients of the same age, gender and diagnosis. These authors hypothesised that the patients' nutritional status declined during the hospital admission because of malabsorption or compromised food intake as a result of their illness. None of the studies on hospital malnutrition reviewed for this research study specifically cite hospital pre- and post-procedure fasting and nutritionally inadequate fluid diet protocols as possible contributors to the decline in patient nutritional status during hospitalisation. The implications of these potential contributors will be discussed further in this chapter.

The major findings from the final theme, *Food is more than just something to eat,* are the importance of mealtimes in acute care hospitals in providing structure to the patients' day, and the potential of hospital mealtimes for affirming patients' personal identity. This second finding has particular significance for patients who have frequent admissions or long admissions.

Food is more than just something to eat highlights both the non-nutritive role of food in the hospital setting, and its importance to the respondents in maintaining a sense of independence and a degree of normality in hospital. The respondents found that menu selection provided diversion from boredom and that mealtimes structured their day, albeit that the mealtimes were very different from their normal mealtimes at home. Some studies (Habeeb 1973; Pearson et al. 2003) have shown that patient mealtimes have an important social function in hospitals and can be used to facilitate patient/staff and patient/patient interaction. In this research study, however, there was no indication that the respondents sought social interaction with either the staff or the other patients, and it was found that the presence of visitors at mealtimes was unwelcome. The reason for these differences possibly lies in the fact that all the respondents in this study had their admissions in acute hospitals whereas the studies by Habeeb (1973) and Pearson et al. (2003) were both in longer term care facilities.

Both Habeeb (1973) and Pearson et al. (2003) found that mealtimes were important in maintaining personal identity, and this was also found to be the case in this study. Comfort foods were important for a number of the respondents, although there was no expectation that the hospital should provide these specific foods if they were not normally on the hospital menu. The respondents with chronic illnesses who had frequent hospital admissions were well-organised in obtaining their food requirements during hospitalisation. Other respondents were too sick to eat, or were

not in hospital long enough to find food an important identity issue. Almost all of the patients with chronic illnesses which required frequent and/or lengthy admissions engaged in illegitimate patient work in order to meet their needs and maintain some degree of autonomy.

6.4 Discussion

The overall findings which are presented in Chapter Five as three separate themes can be drawn together and understood holistically when viewed in the context of the biomechanical model of illness which forms the basis of the hospital system in western societies (Capra 1983; Davis & George 1993; Lupton 1994b; Grbich 1999a). From the analysis of the research data, five interrelated and interdependent factors which determine patients' eating praxis in hospital became apparent.

The first of these is the structure of acute care hospitals and the power differential between patients and staff imparted by this structure which serves to undermine patient autonomy. The second factor is the respondents' adoption of the acquiescent role expected of patients in acute care hospitals. The third factor which affects patients' food praxis in hospital is the affirmation of institutional authority and the further undermining of patient autonomy by 'medicalising' non-medical events such as eating. The fourth factor which impacts on patients' food praxis in hospital is the change in the traditional focus of professions such as nursing and dietetics from the social aspects of practice to the more scientific paradigm valued by the biomechanical model of illness. The effect this change has had on staff, who are less attuned to non-medical events than previously, and the resulting lack of advocacy for patients in the mundane aspects of eating, is evident.

Finally, the ambiguous and dichotomous position of food and nutrition in the hospital structure detracts from the status and perceived value of food for the

patients, causes confusion about the ownership of food-related problems and exacerbates the patients' difficulties in getting these problems solved. These phenomena create a dissonance between the concerns of patients and the concerns of the staff about the purpose of food and eating in hospital, and consequently contribute to the staff's lack of awareness of the problems the patients are experiencing. These five factors which determine patients' eating praxis in hospital will be discussed in the following sections.

6.4.1 The structure of acute care hospitals

In this research study all the patients' admissions were in acute hospitals, so only the acute hospital model will be discussed. In acute care hospitals the goal of treatment is cure, so it is assumed that patients will be treated, and then will go home and resume their normal lives (Lupton 1994b). Acute care hospitals are complex, bureaucratic structures organised along hierarchical lines with doctors at the top of a clinical chain of command directing the patient care provided by other staff (Coe 1978). According to Coe (1978), the requirement for decisive action in emergencies is used as justification for this social structure. The formality of the authority system makes informal communication between doctor and patient difficult as, according to Coser (1962) and Lupton (1994b), social distance is necessary in order for the staff to maintain professional authority. Davis and George (1993) also believe that patients have difficulty in obtaining information and cite Hawkins' (1979) study which found that whilst complex processes were explained to patients, more common processes were frequently left unexplained. In Coe's (1978) opinion, these factors act in varying degrees to erode the patient's self-image and, in doing so, accelerate the loss of patient autonomy.

According to Lupton (1994b) and Bell and Valentine (1997), patients' notions of temporality are also changed as hospital routines dictate that everyday events, including mealtimes, are at very different times from their normal routines. Having to conform to hospital routines, and having no control over their eating, sleeping and other everyday personal activities, also reduces the patients' autonomy. This sociological model is typical of acute care hospitals. The goals for patients in long term and terminal care hospitals are very different, and consequently, the hospital culture and expectations of patient behaviour are also very different.

Although patients are in the hospital, they are not actually part of the hospital hierarchical structure and, according to Coe (1978), most patients in acute hospitals are not in hospital long enough to absorb the culture. However, Turner (1995) believes that patients do develop an informal culture of their own as a survival strategy in the unfamiliar and alienating environment of the hospital. This informal culture not only helps patients cope with being in hospital, but contributes to their sense of well-being (Turner 1995) and, according to Davis and George (1993), it can sometimes increase their power. In this study there were small examples of an informal patient culture. For example, Marie, a very experienced patient, warned other patients in the ward of the hot plates and then assisted them with their meals, and Christine and her fellow patients discussed the menu while making their meal choices.

6.4.2 The patient role

Loss of sense of self is a threat to patients as a result of displacement from their normal social environment (Warren et al. 2000). When people are admitted to hospital their clothing is taken away, they are given a hospital number and they are put into beds which are identical to every other bed in the ward (Lupton 1994b).

They have no choice in their fellow patients on the ward and, according to Brown (1999), they are expected to submit to touching, and other more invasive interventions, in areas of the body which are normally very private. Lupton (1994b) believes that hospital patients frequently feel alienated and vulnerable during their treatment, and this was evident in this current study.

In hospital, patients are removed from the familiarity of their own environments and separated from their families and friends. If the admission is unexpected the patient may have had to leave unfinished business. Patients are thus faced with the difficulty of understanding their new role as a patient, their illness and a number of strangers in an unfamiliar environment, when they are at their most vulnerable.

Coe (1978) and Lupton (1994b) believe that by being systematically stripped of their individuality and their identity, the status of the patient is changed from being an individual to being one of many. The purpose of this depersonalisation, according to Coser (1962), is to create a proper atmosphere which is free from other distractions for the management of the patient. The diagnosis of the patient's disorder also defines the patient, and indeed, according to some authors (Brown 1999; Grbich 1999a), patients are sometimes referred to by healthcare staff in terms of their illness, a further example of depersonalisation.

In 1951 Parsons outlined the patient role, its obligations and its exemptions. This model is still applicable to patient behaviour 55 years later. According to Parsons (1951), the patient's illness must first be legitimised by the doctor, after which the patient is exempt from normal social obligations and interactions, on the condition that they recover as soon as possible and do not malinger. Although patients are exempt from their normal social responsibilities, according to Warren et al. (2000) they must agree to abide by the implicit rules of the hospital ward. Patients are also

expected to obey doctors' orders and to submit to 'those to whom they have delegated their care' (Strauss et al. 1982, p. 979). In acute care hospitals the staff expect the patients to be passive, as they are assumed to be too sick to make decisions or do anything for themselves. Coe (1978) asserts that this expectation of patient passivity, compliance and cooperation is justified by the patient's motivation to recover as soon as possible. In their ethnographic study of an acute hospital ward Warren et al. (2000) found that the patients were anxious to fit in and not be a bother, and that one of the implicit rules of the ward was patient cooperation.

Coser (1962) and Coe (1978) both describe differing attitudes of patients towards their hospitalisation which affect their acceptance of these expectations, and their ultimate adjustment to the patient role and being in hospital. According to these authors, patients with a *primary* orientation see the hospital as a place which will take care of them and fulfil all their immediate requirements. These patients are more likely to adapt to the sick role and accept the norms of the hospital as their needs are being met. They are therefore more likely to be 'good' patients.

On the other hand, patients with an *instrumental* orientation view the hospital as a place where specific, well defined tasks need to be accomplished in order to achieve the goal of their recovery. These patients are less likely to relinquish their autonomy, and as a consequence, are more likely to be classified by the staff as 'bad' patients (Murcott 1981). According to Lupton (1994b), acute care hospitals require conformity to rigid rules and routines, and obedience, compliance and passivity in patients. Despite this requirement, Coser (1962) believes hospitals make no formal provision for enabling patients to maintain some degree of self-image. It would appear from the findings of this study that one area in which the patient could retain some autonomy is eating, but the patients' control of this area has also been removed by transforming eating into a medical function.

In this study the depersonalisation of the respondents on admission to hospital, and their adoption of the patient role, impacted on their food-related behaviour. In many cases the respondents described situations where the hospital system failed them very badly, but they were unwilling to complain as they were reluctant to be viewed as 'bad' patients or 'whingers'. According to the literature, to be a 'good' patient it is necessary to be compliant and uncomplaining (Warren et al. 2000; Lupton 1994b; Strauss et al. 1982). The respondents complied with medical instructions regarding their dietary prescriptions, sometimes against their own better judgment, even though several of them were experiencing hunger. For example, Anne and John were either nil by mouth or on fluids for more than a week. In Anne's case it was initially because of her medical condition, and then because of a system failure which meant she did not receive her upgraded diet, but John was on a nutritionally inadequate fluid diet for eight days because he was having a series of procedures. He should have been able to eat as there is no scientific evidence to support prolonged starvation prior to procedures, whereas there is evidence that peri-operative nutrition support is safe and has better outcomes for the patient (Bowling 2004; Jaunch 2004; Ljungqvist 2004). Alternatively, the procedures could have been coordinated to minimise the time the patients fasted or received inadequate fluid diets. In both cases, the patients received minimal nutrition for more than one week. To further compound John's situation, he was already being treated for malnutrition.

In this study the respondents displayed both primary and instrumental orientations, which explains the differences in attitudes and behaviours amongst them. For example, Sandra, Carol and Marie all had instrumental orientations, in that they were more assertive, were prepared to undertake illegitimate work and were generally more successful in getting their needs met, while respondents such

as Christine, Edward, Colleen and John, who had primary orientations, were prepared to be uncomplainingly accepting. In addition, Warren et al. (2000) found that experienced patients were able to negotiate the system better than other patients, and this was certainly found to be the case in this study. Carol, Marie, Anna, Trevor, Anthony and Tracey, who all had frequent admissions, were very well organised and knew how to get the foods they required.

6.4.3 The medicalisation of eating

In the hospital setting, the reframing of the mundane aspects of food and eating into scientific and medical terms not only helps clinicians' understanding of these aspects of the patient admission, but also reinforces the authority imparted by the institutional hierarchy by placing food and eating under medical control. The foundation of the Australian hospital system is the biomechanical model of illness with its positivist conceptual paradigm, where the focus is on the body rather than the person (Capra 1983; Davis & George 1993; Lupton 1994b). In Capra's (1983) opinion, the continuing advances in medical science, particularly the increasing knowledge of physiology and biochemistry at cellular levels, focus attention on the physical aspects of medicine, so clinicians concentrate on the physical functioning of the body and tend to devalue the social, environmental and psychological aspects of illness. Therefore, in order to be understood and controlled in the hospital environment, these aspects of illness, which include many everyday activities such as eating, have to be 'medicalised', or reframed in medical terms. According to Germov and Williams (1996, p. 105) a consequence of this bias towards the scientific aspects of medicine is that 'sociological insights fail to penetrate into biomedical areas'.

Conrad (1992) believes that medicalisation can occur at three levels: the conceptual, the institutional and the interactional. At the conceptual level a social or economic problem is defined in medical terms. At the institutional level, the hospital adopts a medical approach to treating non-medical problems, while interactional medicalisation occurs as part of the clinician–patient relationship. Examples of all three aspects of medicalisation were seen in this study in the general approach to food and nutrition adopted by the staff, hospital nutrition-related procedures and protocols, and the dietary advice given to the respondents by the staff.

Perhaps the most insidious aspect is institutional medicalisation which, according to Conrad (1992), allows routine everyday work to be accomplished by non-medical staff while the physician maintains overall control. Institutional medicalisation, in the protocols for pre- and post-procedure fasting, meant that patients were often hungry and/or received inadequate nutrition. Conrad (1992) asserts that patients are not necessarily passive in the process of medicalisation and can, in some cases, actively participate. This did not appear to be the case in this study, as all of the respondents accepted the physician's decision that they continue to fast, even when they felt they could eat. However, some of the respondents did express their confidence in the doctor's decision despite the fact that they were not happy about it.

6.4.4 The 'caring' professions

Institutional medicalisation, according to Conrad (1992), allows the work of non-medical staff to be under the control of the doctors at the apex of the hospital hierarchy. Grbich (1999a) is of the opinion that, despite this, some health professionals have gained limited professional autonomy, and have achieved restricted recognition of their expertise by the medical profession because of the

biomedical knowledge and skills they possess. One such professional group is dietitians who, according to Grbich (1999a, p. 208), have 'struggled for autonomy from medical control in Australia through an emphasis on an education strategy directed towards the importance of cultural and social aspects of good nutrition'. Although there was some evidence in this study that dietitians had an understanding of the patients' psychosocial needs, and provided advocacy for them in this regard, the dietitians were still either unaware of the implications, or did not challenge, conventional protocols which allowed the patients to be hungry. DeLuco and Cremer (1990), in their study of consumer perceptions of hospital food and dietary services, found that the patients thought the dietitians were helpful in providing foods that they liked to eat, but the dietitians had low visibility to the patients. The results of this research study support the findings of DeLuco and Cremer (1990) in that those respondents who had contact with the dietitians found them very helpful, but the dietitians had low visibility in that not every respondent had the opportunity of contact with a dietitian.

Doering (1992) believes that professions which have traditionally focussed on the social aspects of patient care, such as nursing and dietetics, are increasingly adopting the logical positivist orientation of scientific study valued by medicine. Given Grbich's (1999) view that biomedical knowledge is a pre-requisite for achieving professional autonomy, this is perhaps not surprising. Evidence of such change has been demonstrated by Duff (1990), who traced the development of nutrition from its traditional social science focus to a predominantly positivist science through changes in the style of an Australian nutrition journal over five decades of publication. Duff (1990) argues that reliance on scientific method diverts attention from the social, economic and political conditions which impact on the

nutritional health of individuals and the community. In other words, the art of nutrition has been subsumed by the science of nutrition.

According to Doering (1992), nursing has also seen an increased focus on science which, in the author's opinion, has been to the detriment of the social aspects of nursing. By concentrating on the clinical aspects of patient care, many important but non-clinical events may be overlooked, as seems to be the case in this study when the staff seemed to be unaware of the patients' non-medical problems. In this study a dissonance between the concerns of the health professionals and the concerns of the patients was evident, with regard to the service and purpose of meals and eating in hospital. The healthcare professionals were busy and focused on completing tasks, and they regarded the main purpose of patient meals to be to supply adequate nutrition, whereas for the patients the food itself was the focus, and the meal was frequently the highlight of the day. While the endpoint for both the patients and the staff was the same –the consumption of the meal – the patients sought the comfort of familiarity of the structure of the meals, and the diversion that meals brought to the hospital day.

6.4.5 Food and nutrition in the hospital structure

As stated earlier, acute care hospitals are bureaucratic structures organised along hierarchical lines with doctors in charge of patient care, including the care provided by other staff. However, there are areas of work in the hospital, which Turner (1995) calls the backstage, which fall outside of the medical chain of command. Turner (1995) cites hospital kitchens as being typical of backstage areas which are characterised by the performance of dirty work by low status staff, and which usually have hierarchical structures of their own. According to Paterson (1981), hospital kitchens are invisible areas where it is unusual for medical and

administrative staff to venture, so they are largely immune from scrutiny, control and hierarchical observation. Despite their invisibility, Mennell et al. (1992) argue that hospital kitchens are still subject to control by the medical hierarchy. For example, the timing and sequence of hospital activities, which are largely artificial and are based on industrial and social conventions which suit the hospital hierarchy rather than the patients, impact on the timing of the work of the kitchen (Mennell et al. 1992). The patients' mealtimes, and therefore the routines of kitchen work, have to fit in with hospital routines.

Furthermore, according to Zerubavel (1979), there are multiple cycles of routines within the hospital which frequently run concurrently and independently of one another, without any attempt at coordination. Zerubavel (1979) believes the lack of any temporal coordination between the daily cycles of patients' meals and doctors' medical rounds frequently results in the coincidence of patient mealtimes and ward rounds, with interruptions to patients eating their meals. Lupton (1994b) is of the opinion that disruption of patients' normal temporality results in further diminution of their status, since patients have no choice in the disruption or interruption of their time. Although none of the study respondents mentioned mealtime interruptions, I am aware, from my own clinical experience that interruption of patients' mealtimes for ward rounds and procedures is a common occurrence in acute care hospitals.

In an audit of 749 patients in two British hospitals, Davidson et al. (2004) found that 31% of patients were interrupted during the midday meal, and that only one third of these patients completely ate their meals after being interrupted. Ten percent of interrupted patients ate none of the meal at all. This problem has been recognised and addressed in the United Kingdom where protected mealtimes, or mealtimes which are not allowed to be interrupted by other hospital routines, has become a National Health Service initiative (Davis & Bristow 1999).

Because hospital catering occurs in a backstage area outside of the medical hierarchy and beyond medical control, it is generally considered to be a hotel service (Allison 1999; Davidson et al. 2004). Nutrition, on the other hand, having been medicalised, is regarded as a clinical function (Lennard-Jones 1992; Allison 1999; Davis & Bristow 1999). In my view, hospital food services and nutrition cannot logically be separated, as patient nutrition is dependent, first and foremost, on the quality, variety, safety and nutritional soundness of the food the patients receive. The expertise of both food service managers and dietitians is required to achieve this end, so there should be strong and formal links between these two services if they are not combined as one service.

In most Australian hospitals, however, the lines of reporting of the food service staff and the nutrition and dietetics staff are different (Beck et al., 2001). Food service staff commonly report though a corporate services stream, whilst nutrition and dietetics staff almost always report through a clinical stream. Dividing the responsibilities for food production and nutritional care is not conducive to a holistic approach towards the provision of food for patients by the staff. In an ethnographic study of the relationship between hospital caterers and dietitians Donelan (2000, p. 123) found that in the United Kingdom these two groups have traditionally had a 'critical but uncertain relationship', stemming from the different values, ideals and beliefs each group brings to their practice, which the author believes results in significant interprofessional issues. According to Donelan (2000, p. 123), these interprofessional issues are responsible for 'working tensions between these two groups which have the potential to adversely affect the quality of feeding of hospital patients'. This author further states that differences in training and professional status appear to be a cause of tension between dietitians and hospital caterers.

Similar differences in training exist between Australian dietitians and food service managers, although there are no local studies of the relationships between the two groups. However, Mibey and Williams' (2002) study of food service trends in NSW hospitals found that one-quarter of the managers of hospital food service departments had no formal qualifications at all, in contrast to all Australian dietitians who are educated at a tertiary level. Mibey and Williams (2002) also reported a trend towards dietitians managing hospital food services, their survey showing that dietitians are in charge of food services in almost 10% of NSW hospitals with more than 100 beds. Whether the integration of food service practices and nutrition practices is brought about by dietitians managing food service department or by cooperative partnerships between nutrition and food services, the recognition of food provision as a critical aspect of patient nutrition and patient care by the hospital hierarchy and hospital staff, needs to be addressed.

6.5   Major conclusions

Having analysed the data and discussed and justified the findings of this study, answers to the three research questions are provided in the following section.

6.5.1   What determines the food preferences of hospital patients?

This study found that the normal, personal food preferences of patients do not appear to be altered during their hospital admissions. Respondents still turned to certain, individually specific foods for comfort, but they did not expect the hospital to provide these comfort foods for them. None of the respondents expressed any desire or expectation of anything other than the foods people normally consume at home.

The patients who seemed to suffer most from not being able to obtain their preferred foods in hospital were two older, overseas-born men, Paulo and Len,

although they did not expect to find these foods on the hospital menu. They did not like hospital meals because of the quality of the food. Herman, a third overseas-born male in much the same age group, had no difficulty with the hospital food, which he reported enjoying because he was more acculturated to a variety of ethnic foods than the other two respondents. The Australian born respondents had no complaints about the actual menu items, and considerable discussion around the reasons for this finding was made earlier in this chapter.

Therefore, in answer to the first research question, 'what determines the food preferences of hospital patients?' it would appear that the major factors which influence food praxis are a combination of family food habits and the availability of foods in the community, overlaid by the advice on healthy eating disseminated in the community. The degree to which each of these determinants of food praxis influences each individual appears to be different, depending on their age. An understanding of this phenomenon by clinicians and food providers in hospitals is essential if the psychosocial needs of all patients are to be met.

6.5.2 What are the food experiences of patients in hospital?

In this study the answer to the second research question can be summarised in the words of one of the respondents: *'it's not normal'*. Despite this, hospital food is becoming more normal in that a great deal of it is now purchased from commercial companies rather than cooked in hospital kitchens. Many of the food items currently served in hospitals are in the same portion-control packages used in cafeterias, airlines and even at home, and are therefore quite familiar to most of the patients. The respondents, however, thought that having the entire meal served at once instead of course by course, was not normal.

One of the most difficult aspects of food in hospital for the respondents in this study was making their menu choices well in advance of the meal. As patients cannot predict how well they will be feeling the next day, their menu choices may not always be appropriate when the meal finally arrives. In addition, the times at which the meals are served in hospital were also a problem for the respondents in this study. Some of the respondents found the three main meals too close together, and the gap between the evening meal and breakfast the next morning too long. Furthermore, several respondents remarked on the unnaturalness of sitting up in bed eating dinner alone at 5 o'clock in the evening.

The other common and too frequent experience was the difficulty most of the respondents had with food service-related problems during their admissions, and the lack of awareness and lack of assistance from the staff. Most of the respondents had to find ways of solving their own problems. There are two reasons for this, both of which are supported by other studies First, patients do not want to bother the nursing staff and are therefore reluctant to complain and to ask for help. This, according to Warren et al. (2000), is an implicit understanding of appropriate patient behaviour in acute care hospitals. Second, hospital staff do not appear to be attuned to patients' mealtime difficulties, as was found by Carr and Mitchell (1991) and Pearson et al. (2003) in their studies of mealtime nursing care.

6.5.3 Are patients' food preferences important in determining what people eat in hospital?

The findings in Chapter Four showed that the respondents aged 60 years and under were used to a very wide range of foods. These respondents had no problems with the menu items served in the hospital. All of the hospitals where the respondents had their admissions had selective menus which offered patients choice, as did all of the hospital in NSW surveyed by Mibey and Williams (2002). Although many of the

respondents had comfort foods, which were often not able to be supplied by the hospital, there was no indication there were insufficient menu choices available to the patients to the extent that personal likes and dislikes would play a part in the patient not eating a meal. The only exception to this was the two older overseas-born male respondents, who refused the hospital meals and had their wives bring in meals from home. Therefore, the results of this research show that patients' food preferences are generally not the most important factor determining what patients eat in hospital. Although patient food preferences do not appear to be the most important factor, it is still important that there is choice, and adequate choice, provided on hospital menus, in order for patients to select foods which meet their physical and sociocultural needs, and to give patients some degree of autonomy during their hospitalisation.

Two factors appeared to be the main influences on what the patients ate, and whether they ate anything at all. These are the patient's state of health, and specific medical policies and practices related to pre- and post-procedure fasting. The first of these factors, the patient's state of health, appears to be critical in determining whether the patient will eat at all. When the respondents were feeling very ill they did not want to eat, and furthermore, they did not expect to be able to eat. In fact they used the state of their appetite as an indicator of their state of health, believing that return of appetite was a signal that they were ready for discharge.

The next most influential factors in determining what patients eat were pre- and post-procedure fasting practices. Respondents in this study were kept on nil by mouth, or inadequate fluid diets, for considerable periods of time, even when it was safe for them to eat and they were hungry and wanting to eat. These practices can have a significant impact on the patient's nutritional status, as well as the patient's physical comfort. It is well documented that patients' nutritional status deteriorates

during the hospital admission. Common practices such as pre- and post- procedure fasts, which account for the majority of missed patient meals (Eastwood 1997), and fluid diets which are nutritionally inadequate contribute significantly to this phenomenon.

6.6 Summation in the context of the theoretical framework of the study

Taking an overall view of these findings in the context of the sociological imagination framework which guided this research, it must therefore be concluded that issues related to the critical perspective of the sociological imagination, particularly the biomechanical model of healthcare which includes the social structure of the hospital and the patients' acceptance of medical practices, have the major influence on patients eating in hospital. It should be recognised that, in the hospital hierarchy, no single person is the source of power as organisational power is embedded within roles rather than within individuals. According to Willis (1995), individuals are linked to institutions by the fulfilment of roles, and these roles are fairly deterministic. The respondents in this study were playing out the roles demanded of them by their position as patients in the social structure of the hospital. For the respondents, adopting the behaviour expected of a patient, according to Warren et al. (2000, p. 235), 'contributes to the preservation of self by enabling the person to maintain a positive identity'. The respondents in this research study were able to maintain their identities to some degree through their food praxis, except where it was interrupted by food-related medical practices. In Chapter Two the distinction was made between structure, where the actions of individuals are constrained and created by social structures, and agency, where the actions of individuals create social structures. It can therefore be concluded that, in this study,

the social structure of the hospital was responsible for the actions and behaviours reported by the respondents.

Three issues related to the structural perspective of the sociological imagination also had a negative influence on the patients' food praxis during hospitalisation. These were the power relationships within the hospital which the biomedical model of healthcare predicates, the hospital meal service, and the times at which the meals are served in hospital.

Lupton (1994b, p. 161) asserts that in western society, 'health, illness, disease and death are inextricably linked with social processes and can't be removed from the socio-cultural settings in which they are experienced'. Structural issues and power relationships can be changed, but it must be recognised that the basis of power relationships within hospitals is a deeply ingrained critical issue, that of the biomechanical model which underpins western medicine and medical practice. The biomechanical model also encourages a positivist bias in the education and practice of health professionals, thereby undervaluing the psychosocial aspects of the illness experience. Although the scientific aspects of nutrition are held in some regard in the treatment of patients (Lennard-Jones 1992; Allison 1999; Davis & Bristow 1999), the preparation of the food which provides the nutrients required by the patients is an area which has low status in hospitals (Paterson 1981; Turner 1995; Allison 1999). Heldke (1992) and Gregory (1995) believes that food preparation has always been considered to be part of the female domestic world and does not fit into any philosophical category. According to these authors, cooking has consequently always been regarded as irrelevant, which may also contribute to the lack of status of food service departments in the structure of the hospital.

One study, Habeeb (1973), has been referred to several times during the course of this thesis. This was a study of the relationship of the meaning of eating and illness in hospitalised patients using grounded theory methodology. Although this study was conducted in 1973, over thirty years ago, Habeeb's (1973) findings have strong resonance with the findings of this research study. For example, the following quote sums up the findings of both research studies:

'A closer look at the supposedly routine event of eating reveals that crucial identity concerns are being enacted. Both the clinical nursing staff and the patients play a part, but they seem to exist in different worlds. They each define the eating situation differently. Both patients and staff enact their specific roles within the structure of the hospital. They are subject to the same frustrations related to mealtime routines, time schedules, and impersonal atmosphere. They participate in the same events, but their individual identities as patient or staff influence the meaning they attach to specific facets of the complex business of eating in the hospital' (Habeeb 1973, p. 40).

Doering (1992 p. 31) believes there are 'other ways of knowing', such as intuitive knowing and holistic, contextual, phenomenon-centred knowledge, which focus on personal experience and where the 'humanness of a relationship between two beings is not diminished or lost'. Such other ways of knowing enable health professionals to understand the patient's perspective of the illness experience, and enable them to respond accordingly. Until there is a shift in focus where the psychosocial aspects of illness are of equal value to the logical, positivist philosophy, the worlds of the patients and the staff will remain separate.

6.6 Implications for policy and practice

No research study is complete or worthwhile without some proposed actions for policy and practice. Although the solution to the ultimate problem found in this research, namely the power exerted by the western medical model, is beyond the scope of any one individual or even one institution, there are a number of strategies which are achievable and which would improve patient care. The following recommended actions are related to structural issues within the hospital and it is recognised that, depending on the institution and the power relationships within the particular facility, they can be easily, or not so easily, achieved.

6.6.1 Hospital malnutrition

While some patients are already malnourished on admission to hospital, studies have shown that the nutritional status of patients declines as the hospital admission progresses (McWhirter & Pennington 1994; Kyle et al. 2005). Consequently, a two-pronged approach needs to be taken to reduce the incidence and severity of hospital malnutrition. First, where pre-procedure fasting is a necessity, tests which require fasting should be scheduled together, or at least coordinated, to minimise the period of fasting. Second, malnourished patients need to be identified on admission so that nutrition support can be initiated, and the nutritional status of all patients needs to be monitored during the hospital stay in order to identify patients whose nutritional status is declining.

Policies should be developed in all hospitals making malnutrition screening of all patients mandatory on admission and at regular intervals during the patients' admission. There are several simple screening tools which can be used to identify malnourished patients and patients at risk of malnutrition, and some of these have been validated in Australian hospitals (Bauer & Capra 1997; Jukkola & MacLennan

2005). Patients at risk of malnutrition should then be referred to the dietitians for further assessment and appropriate nutritional support.

In addition, evidence-based policies regarding the maximum time patients can remain with inadequate nutrition should be developed, and regular or ongoing audits of the length of time patients remain with minimal or no nutrition should be conducted. Conducting ongoing audits, or having a system which flags patients who have exceeded the maximum allowable time for patients on nil by mouth or nutritionally inadequate fluid diets, will not only prompt appropriate action in providing nutrition support for the patient but will also create awareness in the staff of the importance of adequate nutrition for patients.

6.6.2 Patient menus

The findings from Chapters Four and Five show the differences in food preferences between older and younger patients, and indicate the importance of an understanding of the food needs of patients of various ages and cultural groups. It is recommended that that this knowledge be applied to the design of patient menus. Hospital menus should be designed with knowledge of the demographics of the patients within the hospital, so that an understanding of the specific requirements of the patient groups within the facility can be addressed when the menu is planned. If the hospital caters for a broad range of age groups and nationalities, the menu should have enough choices at each meal, and enough flexibility in providing items outside of the menu to provide for the needs of all patients.

6.6.3 Patient menu selections

It is further recommended that food service practices are altered so that patients can make their menu selections as close to the following meal as is practicable for the institution. By reducing the gap between selecting meals and receiving them, the

patients will not have to predict how they might be feeling at the time their selected meal arrives. The introduction into many hospitals of information technology programs for menu management enables food service departments to have the information they require for forecasting the ordering and production of meals earlier than by manual methods. This should enable a reduction in the time between patients selecting their menus and the delivery of the meals.

In addition, given that patients are ill, and the course of illnesses can be somewhat unpredictable, there needs to be more flexibility in the system for last minute changes to accommodate the patient's condition at the time of the meal service, and for out-of-hours snacks to be available to the patient. This is a particularly important consideration for hospitals which do not have production kitchens. There are various ways of providing food for patients other than at mealtimes. Provision of basic foods such as bread and spreads at the ward level, or snack boxes which can be accessed by the nursing staff for the patients are two viable options.

6.6.4 Patient-friendly mealtimes

Hospital policies regarding the times meals are served to patients need to be reviewed in some facilities, particularly if the evening meal is served very early and there is a considerable time lapse before breakfast the following morning. With many hospitals using cook-chill systems the difficulties of rostering staff are considerably lessened. Changing the times meals are served to patients will impact on nursing routines and rosters as well as other hospital practices, and I recognise the enormity of the task, and the industrial issues that this entails. I also recognise that in large hospitals it can take up to one hour to serve and distribute meals to all of the patients, so meal times can never be ideal for every patient in these hospitals.

Nevertheless, the benefits of normalising meal hours for patients, and reducing the length of the overnight fast in particular, should outweigh the short term difficulties in making such changes in most cases.

6.6.5 Protected mealtimes

A policy regarding protected mealtimes, or times during which patients are not disturbed by medical or nursing rounds, interviews or procedures or are taken from the ward for any reason, should be implemented in all hospitals. Protected mealtimes are designated periods when all ward activities cease in order for the patients to eat their meals in a relaxed environment. Protected mealtimes would also allow the nursing staff to give their full attention to patients who need assistance with their meals. By allowing patients to eat their meals without interruptions the hospital is affirming the importance of food and eating, as well as creating a more relaxed and normal eating environment for the patients.

6.6.6 Staff focus on mealtimes

The importance of meals, not only for their nutritional value but also to enhance the social and psychological aspects of the meal for the patient, should be reinforced with all hospital staff. In hospitals with dietitians and diet technicians, patient-focussed mealtime care for all patients needs to be emphasised as being of equal importance with nutrition therapy. All hospitals need to have designated staff, nurses, dietitians, diet technicians and food service personnel who have the time and responsibility to develop rapport with the patients and be more attuned to their needs with regard to the food. Clarification of the roles of various staff with regards to the meal service should facilitate this process.

6.6.7 Meals from home

For numerous reasons, patients will always have food brought in from home. Given the food safety risks involved in transporting and reheating food and the susceptibility of sick people to foodborne illnesses, guidelines and policies for food from outside the hospital, and information regarding the safe handling and transportation of meals from home to hospital need to be developed. Food from home should be recognised as an important part of some patients' nutrition if the hospital is unable to provide acceptable meals for particular patients. Food from home also has nurturing connotations which are important to both patients and their families.

6.7   Recommendations for further research

One of the features which became apparent in this study was the lack of research studies in many areas related to the non-scientific aspects of food in hospitals. Crotty's (1993) statement that there is little overlap between the scientific and social aspects of nutrition needs appears to be justified. Given the enormous impact that meals, mealtimes and the food service were found to have on the respondents in this study, the lack of research in these areas needs to be addressed.

6.7.1   Evidence-based pre- and post-procedure fasting practices

This study has highlighted the negative impact that fasting and nutritionally inadequate fluid protocols has on patients. Therefore, the first recommendation for further research is for a national survey of pre- and post-procedure fasting and fluid diet practices in hospitals and the evidence which supports these practices. Following this, evidence-based best practice guidelines for pre- and post-procedure fasting and fluid diets should be established. At present there is little or no evidence to support traditional fasting and fluid diet practices.

Although it is known that patients become malnourished during hospitalisation, there is very little information regarding the reasons for this decline. Therefore, it is recommended that investigation into the cause of this phenomenon could assist in preventing or reducing the extent and severity of hospital malnutrition. It needs to be noted that such a study would be difficult as there are many possible contributory causes including fasting, poor appetite, inadequate food consumption and the disease process itself, which in some cases may substantially increase the patient's nutritional requirements. Correlating the length of time patients receive inadequate nutrition support with the patient's nutritional status on admission and on discharge may be a starting point for investigating this phenomenon.

6.7.2 Food, patients and acute care hospitals

Gregory (1995) believes that qualitative research methods are very appropriate for the study of food, especially where the focus of attention is on the ways in which people negotiate life situations. There is a paucity of qualitative studies related to the psychosocial aspects of food and nutrition in acute care hospitals which presents many opportunities for further research in this field. For example, further exploration of how patients feel about the medicalisation of eating would be very worthwhile in gaining further insights into the experiences of patients in hospital.

6.8 Conclusion

In this chapter, the research questions posed in Chapter One have been answered, and the major conclusions of this research study have been identified and discussed. The results of the research were then discussed in the context of sociological theory, which lends support to the findings. Implications for practice and policy were identified and discussed, as well as suggestions for further research. The use of the sociological imagination theory as the theoretical framework for the research study

assisted the researcher in making connections between the experiences of individuals and hospital practices and culture. This framework also enabled the researcher to draw together the many aspects of food, nutrition, patients and hospitals into a coherent account.

As previously mentioned, hospital malnutrition has been recognised since the 1970s (Bistrian et al. 1976). However, despite its recognition the prevalence of hospital malnutrition is not diminishing (Huq et al. 2005). The motivation for this study was the desire to find out what determines the food preferences of hospital patients, and whether the experiences patients have in hospital affect their eating. The answers to these questions have provided important information for improving patients' food intake in hospital and, ultimately, for achieving a reduction in the prevalence and severity of hospital malnutrition. The provision of food in hospitals has evolved from a largely domestic function to a complex, multi-faceted business. Nutrition, on the other hand, has shifted from its traditional social science orientation to a scientific, clinical focus, and the links between nutrition and food provision in hospitals have become more tenuous as a result of these changes. The separation of food and nutrition in hospitals, in my opinion, has been to the detriment of the holistic nutritional care of patients.

The literature related to the development of personal food praxis and the provision of food in hospitals was reviewed in Chapter Two, and from this review it became evident that there is a paucity of research regarding hospital food service and the sociology of food in hospitals. Only one study (Habeeb 1973) was found which addressed sociological issues and eating in hospital from the patients' perspectives. The lack of both recent and local research in this area provides justification for this study.

The results of this study show that there are a number of factors which determine patients' food consumption in hospital. Studies also show that personal food praxis is not always the most important determinant of what patients eat in hospital. This study found that the hospital system, which includes food service practices, medical practices and the orientation of the staff, appears to have the most influence on patients' food consumption.

Florence Nightingale (1859 (1980)) believed that food was as important as fresh air for sick people. In more recent times the importance of food as an aid to recovery and the status of food in hospitals have diminished, to the detriment of patients. Re-establishing the importance of food in hospitals where as much emphasis is placed on the art of nutrition as there is on the science of nutrition would greatly improve both the personal comfort and clinical outcomes of patients.

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Appendix A

UNE Information sheet and consent form for participants

UNE Information Sheet and Consent Form for Participants

This study is aimed at determining the impact of hospitalisation and/or medical treatment on the food habits of individuals. The information obtained from the study will be used to improve policy and practices which determine the food intake of individuals in hospitals and/or the community.

The researcher is Jennifer Ravens, a student in the Doctor of Health Services Management program, who can be contacted in the Department of Nutrition and Dietetics, Royal Prince Alfred Hospital, telephone and it 9515 7861. Her principal supervisor is Associate Professor David Plummer, School of Health, Education and Professional Studies, University of New England, telephone 02 6773 3333. Any questions regarding procedures undertaken in this study can be directed to Professor Plummer. It is anticipated that the study will be completed at the end of 2003 and that the results will be available from the researcher after that time. In the event that the study results are published the identities of study participants will not be revealed and will not contain information that could potentially indicate the identity of any participant.

As a participant in the study you will be asked to agree to a tape recorded interview of approximately 1-2 hours duration. Although the interview will be tape recorded and then transcribed to computer disc the interview records will be coded so that your identity will be protected. The research records will be secured in locked files and destroyed after a period of five years.

You are asked to volunteer for this study but if you choose not to participate there is absolutely no penalty. If you do volunteer to participate you are free to withdraw your consent and discontinue the interview at any stage. Once again, there is no penalty for withdrawing from the study.

During the interview you will not be asked any questions of an extremely personal or sensitive nature and you will not be forced to answer questions. In the unlikely event that you are disturbed as a result of participating in the study Dr Helen McCathie, Department of Psychology, Concord Repatriation General Hospital (telephone 02 9767 6794) will be able to provide appropriate and independent counselling.

I.. have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that the research data gathered for the study may be published, provided that my name is not used.

....
Participant   Date

....
Investigator   Date

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE02/130 Valid to 31/12/2004).

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services, University of New ENGLAND, Armidale, NSW 2351

Telephone: (02) 6773 3449 Facsimile (02) 6773 3543 Email: Ethics@metz.une.edu.au

Appendix B

RPAH Information for participants

RESEARCH STUDY INTO "HEALTHCARE AND THE SOCIAL SIGNIFICANCE OF FOOD"

INFORMATION FOR PARTICIPANTS

You are invited to take part in a research study into Healthcare and the Social Significance of Food. We wish to find out how important particular foods and eating patterns are to you and how much these are disrupted by hospitalisation or medical treatment.

The study is being conducted by Jennifer Ravens, Area Director of Nutrition and Dietetics, to fulfil the requirements for a doctoral degree at the University of New England. The study is being supervised by Associate Professor David Plummer.

If you agree to participate in this study, you will be asked to take part in an interview which will last approximately one hour. You will be asked about your food habits and preferences. You will not be asked questions which are of a personal or distressing nature. The interview will be tape recorded and transcribed to paper but your identity will be known by the primary researcher only.

All aspects of the study, including results, will be strictly confidential and only the investigators named above will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are in no way obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, please be assured that it will not affect your medical treatment or your relationship with medical staff. Of the people treating you, only Jennifer Ravens will be aware of your participation or non-participation.

When you have read this information, Jennifer Ravens will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on 9515 7861. This information sheet is for you to keep.

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Central Sydney Area Health Service. Any person with concerns or complaints about the conduct of a research study can contact the Secretary on 02 9515 6766.

Appendix C

RPAH Participant consent form

RESEARCH STUDY INTO "HEALTHCARE AND THE SOCIAL SIGNIFICANCE OF FOOD"

PARTICIPANT CONSENT FORM

I, ... *[name]*

of .... *[address]*

have read and understood the Information for Participants on the abovenamed research study

and I have discussed the study with Jennifer Ravens.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the identities of the participants in the research study will not be revealed.

I hereby agree to participate in this research study.

NAME: ....

SIGNATURE: ....

DATE: ....

NAME OF WITNESS: ....

SIGNATURE OF WITNESS: ....

Appendix D

UNE Ethics approval

THE UNIVERSITY OF NEW ENGLAND

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: A/P D Plummer/Dr M Cruickshank/Ms J Ravens
                                  School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE: Healthcare and the Social Significance of Food: The
                                  Clients' Perspective

COMMENCEMENT DATE: 1/7/02

COMMITTEE APPROVAL No.:   HE02/130

APPROVAL VALID TO: 31/12/03

COMMENTS:

The Committee approved this application with the following conditions:

(i)   The Information Sheet for Participants to appear on the appropriate UNE School letterhead.

(ii)   Two copies of the combined Information Sheet/Consent Form to be provided to participants.

(iii)   The researchers to elaborate on how participants are recruited i.e. how the potential participants
        are identified and how they are initially approached.

The Committee suggested that 1-2 hours is a long time for an interview and that the researchers may
wish to refine this to about 1-hour's duration.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.
For approval periods greater than 12 months, researchers are required to submit an application for
renewal at each twelve-month period. All researchers are required to submit a Final Report at the
completion of their project. The Renewal/Final Report Form is available at the following web address:
http://rs-nt-10.une.edu.au/Home/V_2_1/ecforms.html

Researchers are to respond to any conditions associated with the HREC Approval within 20 normal
UNE working days (under normal circumstances). After this time if no response has been received the
HREC Approval may lapse.

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that
researchers must report immediately to the Human Research Ethics Committee anything that might
affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed
changes in the protocol, and any other unforeseen events that might affect the continued ethical
acceptability of the project.

                                                          Fiona Prater
30/5/02   Secretary

Appendix E

RPAH Ethics approval

ADDRESS FOR ALL CORRESPONDENCE
RESEARCH DEVELOPMENT OFFICE
ROOM 608A, LEVEL 6, BUILDING 82
ROYAL PRINCE ALFRED HOSPITAL
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766
FACSIMILE: (02) 9515 7176
EMAIL: lesley.townsend@email.cs.nsw.gov.au
REFERENCE: X03-0031

5 March 2003

Ms J Ravens
Department of Nutrition and Dietetics
Level 2, Building 12
Royal Prince Alfred Hospital

Dear Ms Ravens,

Re: Protocol No X03-0031 - "Healthcare and the social significance of food: The clients' perspective"

The Executive of the Ethics Review Committee, at its meeting of 27 February 2003, considered your correspondence of 26 February 2003. In accordance with the decision made by the Ethics Review Committee, at its meeting of 12 February 2003, approval is now granted to proceed.

You are asked to note the following:

- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in February 2004.

- This approval relates to the ethical content of the study only, and you are responsible for the following:

  - negotiating individual arrangements with the Heads of service departments in those situations where the use of their resources is involved, and

  - arranging an identity pass for any researcher who is not employed by the Central Sydney Area Health Service. You and the researcher should present yourselves at the Security Department, Building 12, Royal Prince Alfred Hospital with a copy of this approval letter.

- If you or any of your co-investigators are University of Sydney employees or have a conjoint appointment, you are responsible for informing the University's Risk Management Office of this approval, so that you can be appropriately indemnified.

Yours sincerely,

Lesley Townsend
Secretary
Ethics Review Committee (RPAH Zone)

HERC\APP03-03