Student Declaration In Respect of Individual Work

I declare that the whole of this work is the result of my individual effort and that all quotations from other authors have been acknowledged.

Dissertation submitted in partial fulfilment of the requirements of Cardiff Metropolitan University for the Degree of Bachelor of Science with Honours.

Signed:……………………………………………

Date:………………………………………………

Abstract: ***'A qualitative investigation into public perceptions, expectations and preferences regarding the role of Dietitians'***.

Background: There is currently limited qualitative research into the public's perceptions and expectations of the dietetic role. Much of the background research observed self-perception of healthcare roles, where insight into public perceptions and expectations is not observed, or has studied specific population samples rather than the general public.

The aim is gain insight into the public's perceptions, expectations and preferences regarding the role of dietitians.

Methods: Cross-sectional design using researcher-administered questionnaires to gather qualitative data and gain insight into current public perceptions, expectations and preferences regarding the role of dietitians.

Results: There was a clear split on the public's knowledge of the role of dietitians, with 48% understanding that the role involves advising on diet generally, and 44% mentioning its association with health issues and illness. Participants primarily cited overweight, obese or fat as people they would expect to be referred to see a dietitian (60%), compared to very few participants citing the need for building up or MUST score (8%). Also, when asked about what they would expect to be discussed during a consultation, only 8% mentioned patients own attitudes or goals.

Results showed an expectation of seeing dietitians in a hospital environment (84%), however, the most popular place for the public to consult with a dietitian was a GP or health

centre (42%). There was a clear preference seen for individual consultation (78%); mainly attributed to social discomfort (50%) and desire for individuality or one-to-one contact (45%). All participants expected that they would feel comfortable talking about what they usually eat and drink with a dietitian, with 78% reasoning the theme of it not being an issue for them.

Conclusions: There is an expectation that dietitians mainly work in a hospital environment, and that dietitians primarily address weight management in their role. Results also suggest that there is a lack of knowledge surrounding the broad dietetic role in nutrition support, as well as the patient-centred natural of the role.

The public preference is to have a consultation in their GP practise or health centre rather than in the hospital environment, despite the expectation of seeing them in hospital. Public prefer individual consultation. Information-giving by the referrer on group consultations may change attitudes towards these.

Keywords: perception, public, expectation, preference, dietetic role.

Introduction

The dietetic profession is relatively new in comparison to other healthcare professions, with the first UK dietitian appointed in 1924 (Gandy, 2014). The profession was the first of all allied health professions to become a graduate profession in the 1980's and in 2001, when the Health and Care Professions Council was set up, dietetics became a registered profession with the requirement of completion of an approved course (Gandy, 2014). With

this profession being contemporary, and relatively small in numbers when compared with other healthcare professions, there is limited research that asks the question of what public's perceptions and expectations are of the dietetic role. The answer to this question may aid dietetic practice and give dietitians an idea of what practice is expected and preferred by the public.

Crow et al (2002) carried out in-depth research in the UK into satisfaction with healthcare which sought to investigate methodological issues, identify determinants of satisfaction with healthcare in different settings, consider the implications of the findings for the National Health Service (NHS), and explore gaps in existing knowledge. This two-phased review analysed 176 articles from 1980 to 2000, and established that although qualitative approaches are generally more resource-intensive, they access in-depth information not captured by structured questionnaires. Results found that there is consistent evidence across settings that the single most important health service factor affecting patient satisfaction is patient-practitioner relationship. Furthermore, a study on perceptions of public health nursing consultations found that good relationships are not only sustained by pleasantness but also by honesty and directness, provided that the relationship is based on trust and sincerity (Clancy and Svensson, 2010). Further research into this subject is advocated, in particular, how consumers' expectations affect their evaluations of their healthcare experiences, investigating how expectations are formed, and research to examine the relationship between socio-demographic factors and expectations (Crow et al, 2002). This literature review was undertaken in 2002, making it less relevant in current healthcare environments thus advocating the need for a systematic up-to-date review of relevant literature.

A literature search uncovered research into how healthcare employees perceive their own job roles including a study by Drotz and Persinska (2014) focused on Lean healthcare and how healthcare workers perceived the new role in a lean healthcare setting. A grounded theory study into understanding of healthcare job role was carried out by Nissell-Tumbarello (2011) and observed the quality directors' self-perception of their role in the hospital's quality performance, and how they believe their education and experience may help them in their quality roles. Similarly, both of these qualitative studies aim to explore and contribute towards a deeper understanding of the respective healthcare-based job roles by examining self-perception rather than public perception. Investigating public perception of healthcare roles may uncover new themes and give insight into how the public view healthcare professionals.

Furthermore, Blake et al (2014) constructed a research project to assess the impact of educating medical school students regarding the role of registered dietitian-nutritionists (RNDs) and the importance of medical nutrition therapy (MNT) in the treatment of chronic disease prevention and management. This research showed that the programme led to an increased understanding by the medical students of the role RDN's play in MNT and patient care. This suggests that there is a need, even within healthcare professions, for an increased awareness of the role dietitians. The sampled population may reduce the external validity as it was not representative of the general population. Further research may uncover a need for increased awareness of the dietetic role in other populations both within and outside the healthcare sector.

Westbrook's thesis (2011) observed current awareness of sports dietitians in the US and found that only 19% of questionnaire participants were aware of the necessary Certified Specialist in Sports Dietetics (CSSD) credential. Keuhneman et al (1997) looked into the role of dietitians in an outpatient heart failure centre and found that dietitians were not active members of outpatient heart failure teams and nutrition education was not specific to the patients. The resulting implementation of nutrition practise guidelines increased the visibility of dietitians involved in the service and highlighted the contribution they could make to the centre. These guidelines are reported to have had aided reduction in admissions by 30%, hospital days by 42% and average length of stay by 17%. This suggests that knowledge of dietetic role could be important in specialist areas, potentially leading to improved patient outcomes as well as informing the evidence base.

A literature search conducted to further explore patient expectations in healthcare environments discovered a relevant dissertation carried out in a community hospital in Oregon, USA. Schneider (2003) studies customer's perceptions of dietitian services, giving insight into the patients' perceptions of the service they received. This qualitative research was two-phased in order to establish what is considered important to patients when receiving dietetic care, and then develop a survey instrument based on the first phase. The large sample size of 242, and multiple phases, is a strength of this research as it increases accuracy of data collected and makes it more generalisable to a wider population. However, this research was carried out in one location in the USA, where dietetic practices may vary to UK practices. This cross-sectional piece of research provides insight into the patients' perspective of service quality relating to hospital dietitians, and uncovered some engaging results. Schneider found that outpatient service users rated services significantly more

favourably than inpatient service users, analysis of data also suggested males were more likely to recommend services than females. Further research was recommended in order to further explore demographic and regional perceptions of service quality in dietetics (Schneider, 2003).

The aim of the proposed research is to gain insight into the public's perceptions, expectations and preferences regarding the role of dietitians.

Methods and materials

The decision to pursue qualitative study should be made on the basis of the research question. The research goal needs to be matched to the strategy that will help reach that goal (Vanderstoep and Johnston, 2009). Qualitative investigation is therefore appropriate for this research as it is generally explorative in character and enables the researcher to gain an understanding of underlying reasons, opinions and motivations (Wyce, 2011). Qualitative research often supports further research in emerging areas and may contribute to informing future practice. The currently limited amount of research in this area is, in itself, a valuable reason as to why it is an appealing area to engage with.

Study Design

Multiple social realities surround the issue of study, and the aim of this research is to gain insight into the construction of these multiple realities, thus further advocating qualitative enquiry. (Miles and Huberman, 1994). Arroll (2003) completed a cross-sectional study on the healthcare consultation, specifically screening for depression in primary care. It is

comparable to this research in that it used a cross-sectional method and verbally asked participants the questions. There is not cross-sectional study available on the public's perceptions of dietitians using a researcher-administered questionnaire, thus indicating a research need. Cross-sectional study design can gauge the current perceptions and expectations of the public on the role of dietitians, and their preferences regarding consulting with a dietitian. This was the most appropriate design for this small-scale study partly due to time and resource constraints. Longitudinal design is commonly seen in qualitative research, however, this is to observe trends over time, and with this subject a snapshot picture of the status quo is what is needed. Furthermore, this cross-sectional view can inform what further research is indicated.

Research Tool

Researcher-administered questionnaires were carried out face-to-face with all of the participants. Although this is not a common design for a research tool, it is a current and effective method which maximises response rate and reduces participant burden (Yu and Cooper, 1983). Another benefit of the researcher-administered questionnaire is that it allows the researcher to clarify points and write down the opinions and thoughts of each participant in their own words. Ali and Rafique (2015) also used a researcher-administered questionnaire in order to gather qualitative data on mothers experiences of having a disabled child in Pakistan, hence confirming that it is a tested method. One constraint of a researcher-administered questionnaire is that the data collection can be quite time consuming and it may only be appropriate for relatively small sample sizes (Ali and Rafique, 2015), however, this also makes it an appropriate choice for this research.

This data could alternatively have been collected by holding in-depth, semi-structured interviews with participants (Cleary et al, 2014). This would gather detailed reasoning behind opinions and perceptions, however, a much smaller sample size would have been collected due to resource constraints, potentially lowering external validity.

Research Participants

Participants were recruited using an opportunistic sampling method of friends and family. This was chosen due to the convenience of the method, small scale of the research, and the fact that the research aims to gain opinions, perceptions and preferences from the general public rather than a specific group.

Exclusion criteria included dietitians, student dietitians and anyone under the age of 18.

This study was approved by the Cardiff School of Health Sciences panel of Cardiff Metropolitan University prior to data collection, (ethical approval reference number 8591).

Procedure

This research allows for a high level of natural validity due to the unmodified and uncontrived study setting (Miles and Huberman, 1994). The questionnaire was developed in order to gain qualitative data, and so used open questions primarily. A pilot study was carried out to reduce the number of unanticipated problems and redesign the research tool to overcome the difficulties the pilot study revealed (Miles, year unknown). This was carried out on three participants and highlighted some minor ambiguities with the order and

wording of the questions. Demographic questions were moved to the back of the questionnaire and wording was improved for some questions to make sure it was clear and reduce ambiguity. Prompts were included in case the question was not fully understood, as this is a good way of standardising how participants were prompted, and a consistent, repeatable study indicates a high level of reliability and dependability (Miles and Huberman, 1994). Participants that answered the pilot questionnaire also took part in the final questionnaire.

Data Analysis

Qualitative research involves a naturalistic approach to the world, and requires researchers to interpret or make sense of phenomena in terms of the meaning people bring to them, (Denzin and Lincoln, 2011) thus making analysis of this type of data challenging. The qualitative data collected was analysed using thematic analysis to identify themes, counts and representative quotes, and where participants have listed answers, keywords have been identified and counted (Braun and Clarke, 2006). For some questions, thematic analysis has been completed twice, both within initial themes (part a) of the answer), and excluding initial themes. This method of analysing the data preserves the richness of it as much as possible and allows for the maximum number of themes to be observed within data collected. Percentages of each answer, theme or keyword have been calculated to allow for easy and clear comparison, and discussion of findings.

Results

50 participants were included in the research with a high response rate of 100%. 54% of the participants most recent or current employment was of a professional nature, whilst 32% was semi-professional and 14% was categorised as unskilled work. 56% of participants were in full time work, 18% in part time work, 6% temping, 18% retired and 2% unemployed. 32% either currently worked in healthcare or had previously worked in healthcare and 10% had previously seen a dietitian.

Table 1: Demographics table	
All participants	100% (n=50)
Of which 18-30	28% (n=14)
31-40	18% (n=9)
41-50	16% (n=8)
51-60	18% (n=9)
61-70	10% (n=5)
70+	10% (n=5)
Male	60% (n=30)
Female	40% (n-20)

For some questions, data has been analysed using counts and keywords due to the nature of answers given. The majority of participants stated more than one answer so total count will equal more than the total number of participants, and percentage calculated using actual number of participants (n=50).

Table 2: Participants understanding of the dietetic role		
Themes	**% and count**	**Representative quote**
Advising on diet generally – health issues not mentioned	48% (n=24)	P41 'Advises on what you should be eating'.

Advises people with illness/dietary problems or conditions	44% (n=22)	P14 'Advising someone who is ill on the best foods to eat'.
Primarily mentions weight loss/obesity	6% (n=3)	P1 'Helps to motivate patients to lose weight and sustain weight loss'
Miscellaneous	2% (n=1)	No clear theme

Two main themes identified in table two were advising on diet generally (with no mention of health conditions) and advising people who are ill, or have dietary problems, on their diet. This suggests that approximately 48% of participants have at least a basic understanding that the role is nutrition-related, whilst 44% acknowledge that the role is also related to dietary problems, condition and disease.

Table 3: Participants expectations of where they would see a dietitian	
Key word or words	**% and counts**
Hospital	84% (n=42)
GP/Health centre	26% (n=13)
Private clinic, private practise	18% (n=8)
Clinic – NHS/outpatients	14% (n=7)
School	6% (n=3)
Not sure, don't know, maybe	6% (n=3)
Office	4% (n=2)
Sports facility	4% (n=2)
At home	2% (n=1)

Miscellaneous:	8% (n=4)

The main location dietitians are expected to be seen are in hospitals (84%).

Table 4: Participants perceptions of who might be referred to see a dietitian	
Keyword/words (people with…)	**% and counts**
Obesity/fat/overweight	60% (n=30)
Diabetes	26% (n=13)
Want/need to improve diet/dietary problems/food-related	24% (n=12)
Health issues/illness/ well-being	22% (n=11)
Underweight/anorexia/bulimia/thin people	20% (n=10)
Recovering from surgery or illness	16% (n=8)
Cancer	10% (n=5)
Eating disorders	10% (n=5)
Heart disease/heart problems	10% (n=5)
Malnutrition/need building up/MUST	8% (n=4)
Sports person/into fitness	8% (n=4)
Mental health problems	6% (n=3)
Pregnant/mother of children	6% (n=3)
Allergies	6% (n=3)
Elderly/old	4% (n=2)

The majority of participants (60%) cited obesity, fat or overweight people as someone they thought might be referred to see a dietitian. 22% of participants cited a broad answer about general ill-health and well-being, and similarly, 24% of participants cited dietary-related or

food-related problems as someone they would expect to be referred to see a dietitian. However, many participants mentioned specific health conditions which may fit into one of these more general categories, making it difficult to analyse this question.

Table 5: Participants expectations of what would be discussed in a consultation with a dietitian	
Keyword/theme	**% of total and count**
Current diet/food/what you eat	66% (n=33)
Change/improve diet	22% (n=11)
Exercise/activity level	18% (n=9)
Improve health	18% (n=9)
Symptoms/health in general	14% (n=7)
A plan	10% (n=5)
Lifestyle/routine	10% (n=5)
Patients own attitudes/goals	8% (n=4)

The strongest theme uncovered regarding discussion within consultation, was the expectation of discussing what is currently being eaten, with 66% of participants entering that theme. 8% of participants expected to discuss patients own attitudes or goals.

Patient’s preferences on where they would like to see a dietitian was also investigated. 42% of participants said that they would prefer to see a dietitian in a GP/Health centre compared to 22% who cited home as their preference and 12% cited hospital, no preference or that their preference depended on another factor.

Overall themes of reasons for the answer given (not categorised by answer to part a) included one main theme of comfort (36%), followed by geographic location/parking charges (18%) and reasons relating to the perceived professionalism of the chosen environment (18%).

Table 6: Patient's reasoning behind preferences regarding location of dietetic consultation within groups

Group	% and Count	Themes identified within group	% and Count	Representative quote
Hospital	12% (n=6)	Specialist/important place	67% (n=4)	*P19 'Feel like it's the most important place to see them. Other doctors around. Trust hospitals more'.*
		Miscellaneous	33% (n=2)	*(All different with no clear themes)*
Home	22% (n=11)	Convenience	73% (n=8)	*P35 'Home would be best as it's convenient.'*
		More comfortable/relaxed	27% (n=3)	*P20 'More comfortable in their own environment, more likely to tell you things, less judged.'*
GP/Health centre	42% (n=21)	Middle ground – not too formal or too informal	43% (n=9)	*P31 'Less intimidating than a hospital but still a trusting surrounding'.*

		Geographic location/parking charges	24% (n=5)	*P39 'GP is closer, free parking'.*
		Miscellaneous	33% (n=7)	*(All different with no clear themes)*
Preference depends on other factor	12% (n=6)	Geographic location/parking charges	33% (n=2)	*P3 'Depends on geographic location of appointment and parking charges'.*
		Dislike for home option	50% (n=3)	*P47 'Hospital or GP as don't feel comfortable with people coming into my house'.*
		Misc	17% (n=1)	*(No clear theme)*
No preference	12% (n=6)	Benefit to self	50% (n=3)	*P43 'I would consider it necessary for my own benefit'.*
		Location irrelevant	33% (n=2)	*P14 'Location not important'.*
		Miscellaneous	17% (n=1)	*(No clear theme)*

Main findings from thematic analysis show that a 67% of participants that chose hospitals as their preferred setting reasoned that it is a specialist or important place. Another finding was the perception that GP/Health centres are a comfortable middle ground for many patients with the preferred amount of formality (43%). Those participants whose preference

depended on another factor had two themes including geographic location (33%), and a specific dislike for people coming into their home (50%).

There was a clear preference of 78% for individual consultation, compared to only 2% with a preference to group consultation. 18% said that their preference depended on another factor and 4% said they had no preference.

Overall themes of reasons for the answer given (not categorised by answer to part a) included 52% of participants expressing a desire for individuality or one to one contact. The next most prominent theme was social barriers relating to group settings such as fear of judgement and embarrassment with 38% of participants citing this is a reason for their answer to part 8a.

Table 7: Participants reasoning behind preferences regarding type of consultation within groups				
Group	**% and Count**	**Themes identified within group**	**% and Count**	**Representative quote**
Individual	78% (n=38)	Individual/personal/can open up more	45% (n=17)	*P24 'Better feedback, more specific, more precise, guarantee the information is focused on you'.*
		Less likely to lie/social judgement/embarrassment	50% (n=19)	*P6 'People will judge me, could not tell the truth in a group setting'.*

		Dislike for discussing someone else's issue	13% (n=5)	*P36 'Tailored advice, don't want to listen to what Mrs Smith is doing wrong'.*
		Miscellaneous	8% (n=3)	*(No clear themes)*
Group	2% (n=1)	*P4 'More intellect, more understanding'.*		
Preference depends on other factor	18% (n=9)	Depends on subject/education	56% (n=5)	*P13 'If for general knowledge then ok, but if private then one to one'.*
		Miscellaneous	44% (n=4)	*(No clear themes)*
No preference	4% (n=2)	*P2 'In a group you might get ideas you have not thought of'.* *P30 'I've got no worries'.*		

Main findings of the thematic analysis include the two main reasons that participants prefer individual consultations which are that they are more personal (45%) and less embarrassing (50%) than group consultations. There was also a sub-theme of a dislike for the need to listen to someone else's issue in a group setting (13%). For participants whose preference depended on another factor, the main theme for their reasoning was that it would depend on the subject or type of education with a tendency to prefer group settings for education purposes rather than personal discussions (56%).

Table 8: Patients reasoning behind the expectation of whether they would feel comfortable talking about what they usually eat and drink with a dietitian

Themes/keywords	% of total and counts	Representative quotes
No point otherwise/not a problem/it's a benefit to me	78% (n=39)	P23 'Because I want them to help me. It would be pointless going if I didn't want any advice'.
Honest/open/don't lie/truth/nothing to hide	22% (n=11)	P33 'No point in not telling the dietitian what I'm eating and drinking, no point in seeing if not honest'.
Not ashamed/we eat well/you've seem worse	18% (n=9)	P9 'I think I have a reasonably good diet, nothing to be ashamed of'.
Healthcare professional	10% (n=5)	P10 'Health professional, if you keep stuff away you're only hurting yourself'.
Need for rapport/as long as they were friendly/didn't feel judged	8% (n=4)	P7 'As long as they came across as understanding, compassionate, caring and not judgmental'.

The main theme identified was 78% of the participants had comparable similar reasoning as to why they would feel comfortable discussing what they would normally eat and drink with a dietitian of that it would not be a problem for them. The second most commonly cited theme, by 22% of participants, was relating to honesty, openness and not lying. 10% cited healthcare professional as a key word in their reasoning of why they would feel comfortable and only 8% suggested a need for rapport with the dietitian.

Participants were asked what qualifications they would expect a dietitian to have. 54% of participants mentioned degree in their response, however, at least 30% were unsure of their answer.

Discussion

The aim of the research was to gain insight into the public's perceptions, expectations and preferences regarding the role of dietitians.

One limitation of the data collected for this question is use of research-administered questionnaires due to presence of the researcher potentially effecting the response of the participant (Jenkins and Dillman, 1995). However, there are also benefits of the researcher being present, such as the ability to explain questions further when needed and perceived body language involved in the interview. Another limitation of this research is the sample, firstly there is only a small sample of 50 participants and secondly, the vast majority of this sample are from one county in England. This affects both the generalisability and transferability of this research. Marshall (1996) commented that open questions are often looked upon as a strength of qualitative research, however, some of these questions are ambiguous and may be interpreted in different ways. The extent of openness with some of the questions did make thematic analysis very difficult as it gathered a wide variety of answers.

Crow et al (2002) carried out a review of literature on the measurement of satisfaction with healthcare in order to assess the implications for practise. Results of Crow’s research have some contrasting finding to that of this research. Crow found that the single most important

health service factor affecting patient satisfaction is patient-practitioner relationship. Participants were asked if they would feel comfortable discussing what they would normally eat and drink with a dietitian and 100% of participants answered yes to this question. When asked to comment on a reason for the answer they had given, the main theme (78%) that arose was the reasoning that there would be no point in seeing a dietitian otherwise, P23 stated;

> *'Because I want them to help me. It would be pointless going if I didn't want any advice'.*

Only five participants (10%) cited reasons relating to the fact they are speaking to a healthcare professional and four participants (8%) voiced a need for rapport. This finding is suggestive that the main reason people would feel comfortable with talking to a dietitian, is because they see it as a benefit to themselves. Eguchi (2013) undertook large-scale research that found that satisfaction with healthcare in Japan is increasing. Similar research into satisfaction with UK healthcare would be useful to gauge the current public perceptions and for comparison to future research to see how perceptions and satisfaction change over time.

Blake et al (2014) looked specifically at medical students understanding of the role of dietitians, and eventually introduced a programme that increased the understanding of the dietetic role. Results suggest that the sample of the public population would also benefit from some education on the role of dietitians. Participants were asked what they think the role of a dietitian involves, and it provided some interesting insight into the public's perception of the dietetic role uncovering two main themes. 48% of answers included the

theme of advising on diet generally, whilst 44% of answers included the theme of dietary-related problems and illnesses. P14, of the latter theme, stated;

‘Advising someone who is ill on what to eat’.

This finding suggests that there is a need for increased awareness of the dietetic role, focusing on its close relationship to illness and health conditions. This message is strengthened by the lack of knowledge surrounding community dietetics; only 2% cited home as a place they would expect to see a dietitian, one comparable qualitative cross-sectional study on patients' perception and knowledge of anaesthesia and anaesthetists also found a need for increased awareness of their healthcare role. Results uncovered that patients who had tertiary education had a significantly higher knowledge of the anaesthetists role than those with only secondary or primary education (Eyelade et al, 2010), thus highlighting the potential research need of, and link between, education level and knowledge of job roles. Keuhneman et al (1997) uncovered the need for nutrition practise guidelines, which were implemented and reported to have improved patient care. Similarly, the public could be better informed of the role of dietitians by a simple intervention such as a poster in GP setting informing patients of how we could help them, or GP’s themselves advising potential referral patients on the role of dietitians before referring them to the dietetic service. This highlights a gap in public knowledge that may in part be due to the fact that dietetics is a relatively new and small healthcare role (Gandy, 2014).

Trim (2014) identified the need to change the public's perception of nurses and enhance the public's understanding of nurses' crucial role in healthcare and patient outcomes. Research found also explored what qualifications the public would expect a dietitian to have. Westbrook (2011) found that only 19% of participants were aware of the necessary CSSD credential, which probed consideration of what qualifications the British public would expect a dietitian to have. Findings showed that 54% of participants expected a degree (including 4% that expected a Masters), however, 30% of participants were unsure about the answer and actually expressed this. P10 stated;

> '*I'd like to think relevant qualifications, presume degree'.*

These findings suggest there is a not a high level of public understanding surrounding the qualification required to become a dietitian, which has implications regarding perceived value of a dietitians time and advice. A study on the public perception of mental health found that doctoral-level counsellors were perceived similarly to clinical psychologists and were preferred over Master's-level counsellors. Results also concluded that the public sampled were confident in Master's-level counsellors to treat less severe cases and less confident in their ability to teat serious psychiatric disorders (Fall et al, 2000). This further indicates a need for further research to gauge the public's confidence in dietitian's ability based on the level of education they perceive dietitians have.

Dietitians are expected to be seen are in hospitals (84%) primarily, followed by GP practises or health centres, cited by only 26%. However, GP practise or health centre was the most popular option of the public for where they would prefer to have a consultation (42%), and

only 12% chose the hospital location as their preferred location of consultation. A main theme behind the reasoning of this preference is that it is a more comfortable place for the patient and the preferred level of formality. P31 selected GP or health centre as their preferred choice, reasoning [that a GP Practise is];

'Less intimidating than a hospital but still a trusting surrounding'.

This is an interesting finding, and suggests that many patients may feel uncomfortable attending consultations in the hospital environment, which could have an effect on the consultation itself and on overall 'did not attend' rates. Further research into this aspect of public preference could uncover deeper insight into reasons behind why patients feel more comfortable in certain environments, and inform future practise. Also, UK research that only samples the dietetic patient population could be beneficial, similar to Schneider's (2003) insights into dietetic service quality that uncovered gender differences between ratings.

There was a 100% consensus that participants would feel comfortable discussing what they would normally eat and drink with a dietitian, with 78% reasoning that it would not be a problem for them. Interestingly, 78% of participants reported that they would prefer an individual consultation. The main sub themes suggest that one-to-one contact is desirable, as there is an ability to open up more and be more honest (45%), and social barriers and judgement is avoided (50%). P6 reasoned that one-to-one is best;

'People will judge me, could not tell the truth in a group setting'.

Results suggest that although all of the participants reported that they would feel comfortable talking with a dietitian, many would struggle to be open and honest in a group

setting. It has been acknowledged that group settings are unsuitable for some shy individuals (Gandy, 2014), however, for some patients the dislike for group consultations could be addressed by an informative letter about how they work, how big the group is, and what similarities the group will have. There was a sub-theme present of group consultations being okay as long as it is education-based. This is encouraging for the dietetic profession, and supports Crow et als' (2002) finding of the importance of patient-practitioner relationship, as it suggests that the public have trust in, and are happy to be open with dietitians.

Patient-centred care is transforming the dietetics as it recognises the importance of effective communication (Gable, 2007). Another interesting finding was that only 8% of participants cited that they would expect to discuss own goals or attitudes in a consultation with a dietitian suggesting a lack of public knowledge surrounding patient-centred care, and indicating a need for more focused research in this area, and public health message regarding this transformation of care.

To conclude this small-scale research has uncovered clear themes in public perceptions including low public knowledge surrounding the role and credentials of dietitians and discrepancies between where patients would expect to see a dietitian, and where they would prefer to see a dietitian. Results also suggest that there is a lack of knowledge surrounding the broad dietetic role in nutrition support, as well as the patient-centred care, including the role of dietitians to enable and encourage their patients to make informed decisions. Clear public preference of individual consultations was seen; mainly attributed to a desire for one-to-one, individualised contact and social discomfort within groups.

Further research into public perceptions, understanding, expectations and preferences involving larger sample sizes, over larger geographical areas would uncover deeper insights into how the public view healthcare professions, and may inform what broad public health messages are needed. Word count: 5481

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Appendices

Summary of data collected

QUESTION 1 - Have you ever seen a dietitian as a patient?	
1	Never
2	Never
3	Never
4	Never
5	Never
6	Never
7	Never
8	Never
9	Never
10	Never
11	Never
12	Never
13	Never
14	Never
15	Yes, a long time ago
16	Never
17	Never
18	Never
19	Never
20	Never
21	Never
22	Never
23	Yes
24	Never
25	Never
26	Never
27	Never
28	Never
29	Never

30	Never
31	Never
32	Never
33	Yes
34	Never
35	Never
36	Never
37	Never
38	Never
39	Never
40	Never
41	Never
42	Never
43	Never
44	yes
45	yes
46	Never
47	Never
48	Never
49	Never
50	Never

% of total and counts	
Yes	8% (n=4)
Yes, a long time ago	2% (n=1
Never	90% (n=45)

QUESTION 2 - What do you think the role of a dietitian involves?	
1	Help motivate patients to lose weight and sustain the weight loss.
2	Advise patients on what to eat and what diet they should have.
3	Helping people to understand their diet and impact it has on their health. Associate it with people that are needing to lose/gain weight.
4	Makes money out of peoples insecurity and makes money out of people who could help themselves.
5	Looks at peoples diet and helps them with issues relating to nutrition. Focuses on health issues such as diabetes and heart disease.
6	They intervene if you are clearly very unhealthy or have problematic dietary issues. They would give you a plan that would work.
7	A specialist in nutrition, knows all the food groups, able to give advice on naturally treating problems using diet/food.
8	To advise on a healthy lifestyle, to make healthy changes.
9	Assessing what a patient currently takes in, assessing needs in terms of weight, BMI and needs, looking at the difference and formulating a plan. NG tubes. People who have had bowl resections. Getting a diet right for an individual.
10	Teaching people how to eat properly.
11	To work out diets specifically for people who need specialised diets
12	Advising people on what to eat and drink. Balancing protein, carbs and fat. Amounts of food, time of day to eat.

13	Prevent overweight, ensure people eat healthily, assess requirements, diet for sports people.
14	Advising someone who is ill on the best foods to eat.
15	Give you a constructive balanced diet knowing what your complaint is.
16	Education on food intake, diet, food related illness, diet plans.
17	Teaching people to eat properly, healthily.
18	Health issues, recovery after illness, get nutrients back into body.
19	Dealing with health issues/conditions, largely coming up with meal plans for overweight.
20	Give advice on diabetes, supplements for older people, not all about doing a meal plan if overweight. Helping people make their own choices.
21	Advise on diet.
22	To advise you on your diet for special purposes.
23	Advising people on their nutritional intake.
24	Advising patients on their diet - maybe people having issues with their health.
25	Allergies, pregnant people, diabetes and other health conditions.
26	Educate on health food, eating vegetables etc.
27	Problems related to nutrition such as liver/stomach problems - dietitians try to fix this.
28	Give you dietary advice.
29	Advise on what you should/shouldn't eat, look at allergies.
30	Study fat people.
31	Someone who advises on dietary requirements for a living.
32	About diet, basically, nutrition, health.
33	Tell you about your diet, where you're going wrong and what to do.
34	Inform me about better eating habits.
35	Proving anyone from 6 months to 90 years about their diet. Fitness, exercise, what you're taking into your body - food/liquids.
36	Telling you what's good/bad. Moderation control. Help out with planning nutritious meals. Education.
37	Looking after your food habits, establish what foods you should be eating.

38	Highlighting allergies. If you have bowl problems/ailments.
39	Ask for a diary of food intake and make you eat salad.
40	Makes you eat green items and starfruit.
41	Advises on what you should be eating.
42	To balance your meals - looks at nutrition.
43	Wellbeing, to advise you on the right vitamins/supplements - sort out people with eating disorders.
44	In a hospital environment - making sure they have all the nutrients, providing supplements, assessing people with weight loss/surgery.
45	To advise people on their diet, nutrients. Consultations.
46	Check my diet, lose weight, get healthy.
47	Tells you how to eat healthy.
48	To advise patients on their appropriate diet, offer guidance, look at diabetes, eating disorders, community support, group education, assist doctors and nurses with inpatients, work with occupational therapy, involved on package of care, pharmacists, multifaceted role.
49	Advising on a healthy diet for whatever condition you have.
50	I think a dietitian could work in several different ways. For example, advising on special diets for people with allergies and other food intolerances, or those recovering from disease/surgery/malnourishment, or those who are overweight, or those aiming to optimise sporting performance.

Themes identified:

Themes	**% and count**	**Representative quote**
Advising on diet generally – health issues not mentioned	48% (n=24)	P41 ‘Advises on what you should be eating’.
Advises people with illness/dietary problems or conditions	44% (n=22)	P14 ‘Advising someone who is ill on the best foods to eat’.
Primarily mentions weight loss/obesity	6% (n=3)	P1 ‘Helps to motivate patients to lose weight and sustain weight loss’
Miscellaneous	2% (n=1)	No clear theme

QUESTION 3 - Where would you expect to see a dietitian?	
1	Private clinic, in big clinics not small clinics, hospitals

2	GP surgery, hospital
3	Hospital or GP practise
4	On planet Earth
5	At a clinic or a home practise
6	At hospital or private practise
7	At a hospital
8	In an office
9	Hospital or community or GP surgery. More likely in outpatients or hospital.
10	Hospital
11	Hospital
12	Private practise, some affiliation with the hospital.
13	Alongside a dr, in a surgery.
14	Hospital
15	Hospital
16	GP surgery, hospital
17	Hospital
18	Hospital, outpatient clinic
19	Hospital or clinic
20	Hospital or clinic
21	In a hospital
22	Hospital
23	Hospital
24	Hospital
25	Dr surgery, hospital, boots
26	Not sure, hospital probably, maybe in a kitchen.
27	Hospital, private practitioner
28	Don't know, maybe hospital
29	Maybe hospital I guess
30	Hospital
31	GP surgery
32	Hospital
33	Hospital, GP, NHS, Private clinic
34	Hospital
35	Could be channelled through GP for health reasons. Schools, children's diets. Medical sphere.
36	Schools, health clubs, sports facilities, dietitian school.
37	At the hospital, Drs, privately.
38	In a hospital, not at a clinic, in a school
39	In an office.
40	Hospital.
41	Hospital.
42	Hospital.
43	Hospital, private for sports etc., body builders.
44	Hospital or community practise/GP practise.
45	Hospital mainly, at home, community centre, GP surgery.

46	Surgery, hospital.
47	Hospital, gym.
48	Hospital, obesity clinic, private care.
49	Hospital.
50	Usually in a hospital. Sometimes in private clinics.

Themes identified: The majority of participants stated more than one answer so total count higher than number of participants, and percentage calculated using actual number of participants (n=50).

Key word or words	**% and counts**
Hospital	84% (n=42)
GP/Health centre	26% (n=13)
Private clinic, private practise	18% (n=8)
Clinic – NHS/outpatients	14% (n=7)
School	6% (n=3)
Not sure, don't know, maybe	6% (n=3)
Office	4% (n=2)
Sports facility	4% (n=2)
At home	2% (n=1)
Miscellaneous:	8% (n=4)

QUESTION 4 - Who do you think might be referred to see a dietitian?	
1	People who have heart problems, diabetes, cancer patients.
2	Diabetic patients, people in sports, people who have had surgery (head and neck for example), if they can't swallow, people with anorexia.
3	People that are in poor health because they are obese or anorexic.
4	A large overweight person.
5	People suffering from obesity, diabetes, IBS, other issues.
6	Obese people, diabetics, people with systemic problems.
7	Overweight or obese people, people with problems that can be treated naturally rather than with medication, people with a poor diet.
8	Patients with a MUST of 3 or more.
9	Overweight, underweight, cancer patients, long term illness like diabetes or coeliacs.
10	Anorexics and obese.
11	Diabetics.
12	Obese people, diabetes, high blood pressure, heart disease, cancers, brain diseases.
13	Overweight people, unhealthy people, people with bad skin, diabetics.
14	Cancer patients, overweight.
15	Somebody overweight, pale.
16	Overweight, food related illness, heart disease, diabetes.
17	Patients at risk of malnutrition, for wound healing, obesity, heart problems.

18	Health issues, people who need building up.
19	Overweight people
20	Overweight people, underweight, underweight babies.
21	Someone with a disease, pregnant, elderly.
22	Overweight, ill people, diabetes, thyroid, overweight-related diseases.
23	Diabetes, fat people, thin people, allergies or underlying condition that affects food.
24	Somebody that might have health issues underlying, and dietary problems.
25	People that need to know what to eat.
26	Problem with fast food, if you are ill and need to change to something healthier.
27	Fat people, including hormone imbalances.
28	Eating disorders, recovering from illness.
29	Allergic people, fat people, bulimic, financially struggling people on a budget.
30	Someone overweight.
31	Overweight, bowel complaints, stomach complaints, children.
32	Diabetes, obese people, anorexic.
33	Anyone, obesity, anorexia, bulimia.
34	Obese, eating disorders.
35	When issues such as obesity, general wellbeing, people with operations, pregnant women.
36	People that live unhealthy lifestyles, want to improve their eating.
37	People that might be slightly overweight, people that have an allergy.
38	Anyone with mental health problems, Prada Willi syndrome, obese, operation, trying to change diet, health regimen, sports person.
39	Short people - too short for weight, referrals from opticians.
40	People with dietary problems.
41	Overweight.
42	Illness.
43	Old people, surgery, mother of children, fat people.
44	People that have had surgery, fussy eaters, eating disorders, MUST score of 2 or higher.
45	Wide range of people, diet can be a factor in a lot of people’s health so anyone that will benefit from a change in their diet.
46	Obese people, underweight, maybe on the borderline? Into health and fitness or running.
47	Eating disorders, mental health problems.
48	Diabetes, eating disorder patients, mental health problems, surgical patients, cancer patients, sports person or athlete.
49	Overweight people, post op patients, fear of hereditary conditions e.g. heart disease.
50	Anyone who needs guidance on their diet due to their specific health concern or lifestyle.

Themes identified: (Most participants stated more than one answer so total count higher than number of participants % worked out using actual number of participants = 50)

Keyword/words (people with…)	% and counts
Obesity/fat/overweight	60% (n=30)
Diabetes	26% (n=13)
Want/need to improve diet/dietary problems/food-related	24% (n=12)
Health issues/illness/ well-being	22% (n=11)

Underweight/anorexia/bulimia/thin people	20% (n=10)
Recovering from surgery or illness	16% (n=8)
Cancer	10% (n=5)
Eating disorders	10% (n=5)
Heart disease/heart problems	10% (n=5)
Malnutrition/need building up/MUST	8% (n=4)
Sports person/into fitness	8% (n=4)
Mental health problems	6% (n=3)
Pregnant/mother of children	6% (n=3)
Allergies	6% (n=3)
Elderly/old	4% (n=2)

Miscellaneous answers – only cited by 1 participant

- Fear of hereditary conditions (eg, heart disease)
- Maybe on the borderline?
- Fussy eaters
- Short people – too short for weight
- Referrals from opticians
- If they can’t swallow
- For wound healing
- Underweight babies
- People with bad skin
- Coeliac
- High blood pressure
- People with systemic problems
- People with problems that can be treated naturally rather than with medication
- Brain diseases
- Thyroid
- Hormone imbalances
- Bowel complaints
- Stomach complaints
- Financially struggling people on a budget
- Children
- Prada Willi syndrome

QUESTION 5 - How long would you expect a consultation to last? (converted to minutes where applicable)		**middle**	**greatest**	**lowest**
1	Depends on the situation	NA	NA	NA
2	30 minutes	30	30	30
3	15 minutes	15	15	15
4	Depends how much it costs	NA	NA	NA
5	30 minutes	30	30	30
6	45 minutes	45	45	45
7	20 minutes	20	20	20
8	20 minutes	20	20	20

9	First one would be longer, maybe 60 minutes, then 30 minute follow ups	60/30	60/30	60/30
10	15 minutes	15	15	15
11	30 to 60 minutes	45	60	30
12	120 minutes	120	120	120
13	Depends how much work needs doing, 5 minutes to 60 minutes variable	27.5	60	5
14	Depends on severity of condition	NA	NA	NA
15	Depends on severity of complaint	NA	NA	NA
16	30 minutes	30	30	30
17	10 minutes	10	10	10
18	30 minutes	30	30	30
19	30 minutes	30	30	30
20	30 minutes	30	30	30
21	60 minutes	60	60	60
22	Depends, no more than 60-120 minutes	90	120	60
23	30 minutes	30	30	30
24	20 minutes	20	20	20
25	60 - 90 minutes	75	90	60
26	120-180 minutes	150	180	120
27	60 minutes	60	60	60
28	15 minutes	15	15	15
29	60 minutes	60	60	60
30	Not sure	NA	NA	NA
31	No idea, over a period of weeks maybe	NA	NA	NA
32	I wouldn't know	NA	NA	NA
33	30-60 minutes	45	60	30
34	15 minutes	15	15	15
35	Depends on what the issues are, maybe an hour, over a period of time	60	60	60
36	30-60 minutes	45	60	30
37	30-60 minutes	45	60	30
38	60 minutes	60	60	60
39	20 minutes	20	20	20
40	20 minutes	20	20	20
41	120 minutes, depends on the problem though	120	120	120
42	30 minutes	30	30	30
43	30 minutes for initial appointment then less after	NA	NA	NA
44	Depends how thorough, 40 minutes	40	40	40
45	Initially 20 minutes, ideally more, but with NHS limits, repeat 10 minutes	20/10	NA	NA
46	20 minutes minimum	20	20	20
47	Depends on how ill they are	NA	NA	NA
48	15 minutes in NHS, 60 minutes in private	NA	NA	NA
49	60 minutes initially, follow up 30 minutes	60/30	NA	NA

50	I imagine 30 to 45 minutes?	37.5	45	30

Theme – using middle values where possible, excluding multiple values	**% and count**
Less than 30 minutes	24% (n=12)
Between 30 minutes and 60 minutes	30% (n=15)
60 minutes and over	20% (n=10)
Depends on the problem/condition/severity/thoroughness/cost/situation	20% (n=10)
Different times given for initial and follow up	8% (n=4)
Unsure/don't know/maybe	8% (n=4)

Average estimated time for a consultation: Value not used if participant has given more than one value. When given a range for example 30-45 minutes, a middle value has been taken.

Average estimated time for a consultation excluding initial and follow up data, using middle values when a range given (minutes)	43.65	
Average estimated time for a consultation excluding initial and follow up data, using greatest values when a range given (minutes)	48.38	
Average estimated time for a consultation excluding initial and follow up data, using lowest values when a range given (minutes)	39.19	
Average estimated time for a consultation using data for initial and follow up times only (minutes)	Initial: 46.66	Follow up: 23.33

Table showing averages taking ranges into account		
middle	**greatest**	**lowest**
30	30	30
15	15	15
30	30	30
45	45	45
20	20	20
20	20	20
15	15	15
45	60	30
120	120	120
27.5	60	5
30	30	30
10	10	10
30	30	30
30	30	30
30	30	30
60	60	60
90	120	60
30	30	30
20	20	20
75	90	60
150	180	120
60	60	60
15	15	15
60	60	60
45	60	30
15	15	15
60	60	60
45	60	30
45	60	30
60	60	60
20	20	20
20	20	20
120	120	120

30	30	30
40	40	40
20	20	20
37.5	45	30
43.64865	48.37838	39.18919

Table showing averages when initial and follow up answers given	
initial	**follow up**
60	30
20	10
60	30
46.66667	23.33333

QUESTION 6 - What measurements would you expect to be taken in a consultation with a dietitian?	
1	10% from weight value originally.
2	weight, height.
3	BMI, cholesterol, skinfold, a day's diet.
4	Head size, waist size.
5	Waist size
6	Neck, arms, bust, waist, hips, thighs, ankles.
7	Blood pressure, heart rate, weight, height, BMI
8	Weight, BMI, body fat percentage.
9	Weight, height, BMI, waist circumference.
10	Waist circumference, arm circumference, skinfold.
11	Diet history.
12	Blood analysis, urine analysis, hair analysis, faeces analysis, blood pressure, ECG, barium swallow.
13	Height, weight, BMI, waist circumference, work out kcals.
14	Body mass index.
15	Weight in comparison to height.
16	24 hour recall, lifestyle, alcohol. Weight, BMI.
17	Weight, height.
18	Weight, height, blood pressure.
19	Weight, height, BMI.
20	Weight, height, waist measurement.
21	BMI.
22	Height, weight, BMI.
23	Height and weight, waist.
24	Blood pressure, kcal intake, what you eat, exercise history, BMR.
25	Weight, body fat, skin conditions, circumference.
26	Maybe blood, to check allergies, what you are eating.
27	Blood results, age.
28	Waist circumference, blood pressure, cholesterol, % body fat.
29	Weight, height. BMI, blood pressure, cholesterol, %body fat.

30	Height, waist circumference.
31	I don't know. Maybe diet plan, maybe food.
32	Measurement of food.
33	All your vital stats.
34	Height, weight, BMI.
35	Age dependent, weight, body mass, % muscle.
36	Salt intake, sugar intake, waist to hip ratio, BMI.
37	Height and weight
38	BMI, waist circumference, allergy test, blood sample, blood pressure, urine sample, stool sample.
39	BMI, height, weight, age.
40	Big ones.
41	Weight, height, body mass, full medical.
42	Around the middle, weight, height, blood pressure.
43	Wee sample, blood, weight, BMI.
44	Weight, height, tummy circumference, arm measurement.
45	Height, weight, blood pressure, skinfold, BMI.
46	height, weight, fat, age, BMI.
47	Waist measurement, what they eat.
48	Weight, height, thigh measurement, blood pressure, cholesterol.
49	I would expect measurements to have already been taken, blood pressure, urine sample, weight, height.
50	Height, weight, maybe waist, maybe skin fold tests to estimate body fat %.

Themes identified: (Most participants stated more than one answer so total count higher than number of participants % worked out using actual number of participants = 50)

Keyword/words	**% and counts**
Weight	54% (n=27)
Height	46% (n=23)
Body mass index (BMI)	42% (n=21)
Waist measurement/circumference	30% (n=11)
Blood pressure	22% (n=11)
Diet	18% (n=9)
Body measurements - other	14% (n=7)
Fat measurements/% body fat	12% (n=6)
Skinfold	8% (n=4)
Blood - other	8% (n=4)
Urine sample	8% (n=4)
Cholesterol	8% (n=4)
Faeces/stool sample	4% (n=2)
Allergy-related	4% (n=2)

Other miscellaneous answers – cited by one person:

- Hair analysis
- Heart rate
- 10% from weight value originally
- ECG
- Barium swallow
- Lifestyle
- Alcohol
- Skin conditions
- Exercise history
- BMR
- All your vital stats
- Age dependent
- % muscle
- Salt intake
- Sugar intake
- Big ones
- Full medical

QUESTION 7 - What would you expect to be discussed in a consultation with a dietitian?	
1	Important to talk about problems that the patient has, discuss how the patients' health can be improved - put a plan in place with a target result.
2	Your diet, food.
3	Eating habits, exercise routines, good practice of what they should be doing, health ramifications, and continued plan of care.
4	Where you work, how much you earn, are you single/married, religion.
5	Diet, what you eat, how much exercise you get, sleeping habits, habits in general - smoking, drugs, ambitions, education.
6	Daily routine, from time you wake up. Exercise routine, amount of hours spent online.
7	Food habits, size of meals, calculation of kcals, quantities of each group.
8	What kind of changes they would like to make, give the patient information.
9	Current lifestyle, diet history, current exercise, who make meals, who does shopping.
10	Dietary routine, risks in diet and how to avoid them.
11	Food, lifestyle.
12	Current state of health, lifestyle, normal intake, smoking, drinking, exercise.
13	What food and drink you have, exercise, hereditary problems.
14	Eating habits, specifically if you are on a dairy diet or gluten free.
15	Eating habits, regularity of eating.
16	What goals they want to achieve having discussed intake, can they cook etc.
17	How they can improve their diet - either with more or less foods, maybe what supplements they like.
18	Ways of putting you back on track, getting you healthy, putting nutrients into the body.
19	Food plans, ways of dieting, putting on weight when previously failed.
20	Symptoms you've got (if ill), food choices, depends what's wrong.
21	Current diet, medications, what they hope to achieve.
22	A plan - the causes of why you're there and how to rectify.
23	Current diet, tips to change your diet.
24	Things to include in your diet and things to alter. What habits to look out for.
25	No idea.
26	What it means to be a dietitian.
27	Lifestyle, food, what's the issue, related to something I eat, complex - dietitian is not just an advisor - it's about healthcare as well.

28	What you currently eat, food mix, balance of carbs.
29	What you needed to eat, minimum of size etc., units of alcohol, smoking, exercise.
30	Not sure - depends what the questions were.
31	Current dietary habits, future dietary habits.
32	Food.
33	Your diet and what would be best for you.
34	My diet, present diet.
35	Find out about your diet, if not the right thing then education. Medical conditions of people maybe.
36	Current diet and ways to improve that. Myths of healthy eating, salt, sugar, fat, saturated fat intakes.
37	What sort of treatment they could give you.
38	Food habits, daily diet or food diary, symptoms.
39	Ailments
40	Diet.
41	Lifestyle, how much you eat, drink, smoke.
42	Food and drink.
43	Food, quantities, supplements, education on food.
44	Portion sizes, food chart - in spoons how much you have eaten, what it is you eat.
45	Food that you eat and ways to change or improve it.
46	Depends on the issue. If obese, encouraged to diet, if underweight, encouraged to build up diet.
47	Meal plan, what they eat every day, what they should be doing better.
48	Current eating habits, kcal intake, exercise regimen, how to improve, a plan may be discussed i.e. amount of protein, carbs and a follow up scheduled.
49	Religion, ethnic background, family history, current diet, where you live, income, living conditions, physical ability, activity level, drink, hobbies, solvent drug abuse.
50	Foods, diet, cooking, and attitudes toward those.

Keyword/theme	**% of total and count**
Current diet/food/what you eat	66% (n=33)
Change/improve diet	22% (n=11)
Exercise/activity level	18% (n=9)
Improve health	18% (n=9)
Symptoms/health in general	14% (n=7)
A plan	10% (n=5)
Lifestyle/routine	10% (n=5)
Patients own attitudes/goals	8% (n=4)

QUESTION 8a - Where would you prefer to see a dietitian? (Options: Hospital, home, GP/Health centre, no preference, preference depends on another factor)		
QUESTION 8b - Please explain why you have chosen the above answer.		
ID NUMBER	**8a**	**8b**
1	GP/health centre	More experience if working in a GP practise/health centre.
2	At home	Wouldn't have to go up the road then to the health centre, far easier and more convenient. You might not be well enough to go to the GP.
3	Preference depends on another factor	Depends on geographic location of appointment and parking charges.

4	At home	Because that means I don't have to go out - it is more comfortable.
5	GP/health centre	Because I would feel more comfortable at a surgery, I don't feel it is as intrusive as them coming to my home.
6	Preference depends on another factor	Any professional environment - hospital or GP/health centre.
7	Preference depends on another factor	Not at home as that would be expensive for the NHS.
8	Preference depends on another factor	Depends of geographic location of appointment and parking charges and availability.
9	Hospital	Wouldn't like people coming to the house.
10	GP/health centre	Because if its treated at source and proactive rather than reactive that would be good for the NHS.
11	GP/health centre	Not distracted by home, hospital too formal.
12	GP/health centre	Don't like hospitals as they are full of sick people. The gp surgery is less threatening - people aren't walking around in gowns etc.
13	GP/health centre	Point of focus. Expect to clock in for a health check.
14	No preference	Location not important.
15	Hospital	Fit and able and can join the queue.
16	GP/health centre	Because its closer to home, going out for a purpose, reason.
17	GP/health centre	I relate the hospital to my own work environment so I wouldn't personally want to go there for an appointment and I don't need a home visit.
18	GP/health centre	Too much own environment at home, hospital too clinical, health centre is ok.
19	Hospital	Feel like it’s the most important place to see them. Other drs around. Trust hospitals more.
20	At home	More comfortable in their own environment, more likely to tell you things, less judged.
21	At home	Because its convenient.
22	At home	Easier.
23	At home	More convenient.
24	Hospital	More specialist - GP seems more general.
25	At home	Because I am lazy.
26	GP/health centre	Would want to know/ask what is wrong in surgery.
27	Hospital	If I go to hospital I know I can go a few meters and see someone else, everything is there.
28	GP/health centre	GP seems sensible, at home you might open the fridge door.
29	GP/health centre	Have to pay to park at the hospital.
30	No preference	I'm easy, wherever it was, if needed.
31	GP/health centre	Less intimidating than hospital but still a trusting surrounding.
32	GP/health centre	Professional, it's a specialty.
33	No preference	Doesn't make any difference.
34	At home	I'd be more relaxed at home.
35	At home	Home would be best as its convenient.
36	GP/health centre	So I don't have o clean up the house, also more formal as you have to go out and see them. Hospitals are busy/crowded and people coughing.
37	GP/health centre	More one on one, especially if you know your doctor.

38	GP/health centre	Hospitals too clinical for my liking, you see old people.
39	GP/health centre	GP is closer, free parking.
40	Preference depends on another factor	Depends on who is seeing.
41	GP/health centre	More comfortable than being in a hospital, more familiar.
42	GP/health centre	Nearer to home.
43	No preference	I would consider it necessary for my own benefit.
44	No preference	Used to hospital - maybe better assessment at home.
45	At home	For convenience.
46	At home	More relaxed atmosphere - more likely to open up. Not a white coat scenario.
47	Preference depends on another factor	Hospital or GP as don't feel comfortable with people coming into my house.
48	Hospital	You know if you need tests you will be taken upstairs straight away, home I would feel guilty using NHS resources.
49	GP/health centre	GP surgery is more local.
50	No preference	I am able to travel easily should the need arise.

Selection	**% of total and count**
Home	22% (n=11)
Hospital	12% (n=6)
GP/Health centre	42% (n=21)
Preference depends on another factor	12% (n=6)
No preference	12% (n=6)

Overall themes excluding answers to question 8a):

Theme	**% of total and count**	**Representative quote**
Most comfortable place	36% (n=18)	P5 ‘Because I would feel more comfortable at a surgery, I don't feel it is as intrusive as them coming to my home’.
Geographic location/parking	18% (n=9)	P49 ‘GP surgery is more local’.
Related to the professionalism of the environment	18% (n=9)	P19 ‘Feel like it’s the most important place to see them. Other drs around. Trust hospitals more’.
Not concerned about location/benefit to self	12% (n=6)	P50 ‘I am able to travel easily should the need arise’.
Convenience	12% (n=6)	P35 ‘Home would be best as its convenient’.
Dislike for people in home	8% (n=4)	P47 ‘Hospital or GP as don't feel comfortable with people coming into my house’.

Themes identified once separated into groups:

Group	% and Count	Themes identified within group	% and Count	Representative quote
Hospital	12% (n=6)	Specialist/important place	67% (n=4)	P19 ‘Feel like it’s the most important place to see them. Other doctors around. Trust hospitals more’.
		Miscellaneous	33% (n=2)	(All different with no clear themes)
Home	22% (n=11)	Convenience	73% (n=8)	P35 ‘Home would be best as it’s convenient.’
		More comfortable/relaxed	27% (n=3)	P20 ‘More comfortable in their own environment, more likely to tell you things, less judged.’
GP/Health centre	42% (n=21)	Middle ground – not too formal or too informal	43% (n=9)	P31 ‘Less intimidating than a hospital but still a trusting surrounding’.
		Geographic location/parking charges	24% (n=5)	P39 ‘GP is closer, free parking’.
		Miscellaneous	33% (n=7)	(All different with no clear themes)
Preference depends on other factor	12% (n=6)	Geographic location/parking charges	33% (n=2)	P3 ‘Depends on geographic location of appointment and parking charges’.
		Dislike for home option	50% (n=3)	P47 ‘Hospital or GP as don’t feel comfortable with people coming into my house’.
		Misc	17% (n=1)	(No clear theme)
No preference	12% (n=6)	Benefit to self	50% (n=3)	P43 ‘I would consider it necessary for my own benefit’.
		Location irrelevant	33% (n=2)	P14 ‘Location not important’.
		Miscellaneous	17% (n=1)	(No clear theme)

QUESTION 9a - What kind of consultation would you prefer? (Options: Individual, group, no preference, preference depends on another factor)				
QUESTION 9b - Please explain why you have chosen the above answer.				
ID NUMBER	**9a**			**9b**
1	Individual			Group is not interesting as its not about me.

2	No preference		In a group you get ideas that you might not have though of.
3	Individual		I would be seeing a dietitian for me, a unique individual, and I want my consultation tailored to me and my needs. And I'd be embarrassed in a group setting and might not provide accurate information because of social judgement.
4	Group		More intellect, more understanding
5	Individual		Because I have a speech impediment and don't like talking in front of a group.
6	Individual		Because people will judge me, could not tell the truth in a group setting.
7	Individual		Less likely to be honest if in a group.
8	Individual		Wouldn't want to discuss with other people.
9	Individual		Should be one to one. Wouldn't mind group education, then one to one to tweak to individual needs.
10	Individual		Because its more personal.
11	Individual		Gets muddled in a group setting.
12	Individual		Might discuss embarrassing things
13	Depends on another factor		If for general knowledge then group is ok, but if private then one to one.
14	Individual		Because it would be individual to my problem.
15	Individual		I'm seeing her relative to my problem, not someone else's.
16	Individual		Could be embarrassing in a group.
17	Depends on another factor		Education is ok in a group, but need following up to be individualised.
18	Individual		Private, their own problem, more answers, open up a lot more.
19	Individual		More private and personal. Less inclined to lie about things. No fear of judgement. More helpful as more specific/individual.
20	Individual		Private, don't want everyone knowing what's wrong.
21	Individual		Be easier to discuss things rather than have an audience.
22	Individual		Things you might not want to discuss in front of others.
23	Individual		Don't want any other people in with me.
24	Individual		Better feedback, more specific, more precise, guarantee the information is focused on you.
25	Individual		Some people want to keep things quiet.
26	Depends on another factor		If to learn then group is ok, if about own health, individual.
27	Individual		Its about me, my health, don't want to share lifestyle with everyone.
28	Individual		If group thing, can't be bothered to go along, one to one feels like your getting direct advice.
29	Depends on another factor		If diabetic or ill, want one to one, losing weight may be ok group.
30	No preference		I've got no worries.
31	Individual		Confidentiality (personal habits).
32	Individual		More personal.
33	Individual		Personal.

34	Individual	I would like the one to one contact.
35	Depends on another factor	One on one initially at least, maybe group later when being educated.
36	Individual	Tailored advice, don't want to listen to what Mrs Smith is doing wrong.
37	Individual	Tell more personal things.
38	Depends on another factor	Depends on if its as an inpatient or outpatient.
39	Depends on another factor	Depends on how many people there are, could be intimidating if a big group, prefer one to one.
40	Individual	They gang up on you in a group.
41	Individual	You would achieve more.
42	Individual	More personal.
43	Individual	Want to address my own issues, not everyone else's.
44	Individual	If you're shy group setting might be difficult.
45	Individual	Get more attention on specific needs and requirements, group is more appropriate for general discussion or after goals have been set, motivator.
46	Depends on another factor	Depends on urgency of why I needed it - may say less in a group, not give thoughts.
47	Individual	Dietitian can give you the focus, no need to discuss other people.
48	Individual	Because some people in a group don't need to be there and that would be a waste of my time.
49	Individual	If I was talking about personal stuff, I wouldn't want to share it.
50	Depends on another factor	If grouped with people with a similar health concern I think the information would be relevant to me. If in a completely mixed group there might be lots of information which was not relevant to me.

Selection	**% of total and count**
Individual	76% (n=38)
Group	2% (n=1)
Preference depends on another factor	18% (n=9)
No preference	4% (n=2)

Overall themes excluding answers to question a):

Theme	**% of total and count**	**Representative quote**
Desire for individuality and one to one contact	52% (n=26)	P15 'I'm seeing her relative to my problem, not someone else's'.
Social barriers including honesty judgement and embarrassment	38% (n=19)	P7 'Less likely to be honest if in a group'.
Group setting ok in some situations	20% (n=10)	P17 'Education ok in a group, but need following up to be individualised'.

Sharing of ideas/knowledge	8% (n=4)	P2 ‘In a group you get ideas you might not have thought of’.
Miscellaneous	10% (5)	No clear themes

Themes identified once separated into groups:

Group	% and Count	Themes identified within group	% and Count	Representative quote
Individual	78% (n=38)	Individual/personal/can open up more	45% (n=17)	P24 ‘Better feedback, more specific, more precise, guarantee the information is focused on you’.
		Less likely to lie/social judgement/embarrassment	50% (n=19)	P6 ‘People will judge me, could not tell the truth in a group setting’.
		Dislike for discussing someone else’s issue	13% (n=5)	P36 ‘Tailored advice, don’t want to listen to what Mrs Smith is doing wrong’.
		Miscellaneous	8% (n=3)	(No clear themes)
Group	2% (n=1)	P4 ‘More intellect, more understanding’.		
Preference depends on other factor	18% (n=9)	Depends on subject/education	56% (n=5)	P13 ‘If for general knowledge then ok, but if private then one to one’.
		Miscellaneous	44% (n=4)	(No clear themes)
No preference	4% (n=2)	P2 ‘In a group you might get ideas you have not thought of’. P30 ‘I’ve got no worries’.		

QUESTION 10 - What qualifications would you expect a dietitian to have?	
1	Experience is more important than the qualification sometimes. Some certificate should be expected.
2	A degree.
3	I'd expect them to have a PHD as it is a specialist subject.
4	A BTEC.
5	Diploma in dietetics.
6	Masters.
7	Masters.
8	A degree, same as band 5 nurse.
9	A degree.
10	I'd like to think relevant qualifications, presume degree.
11	A formal qualification.
12	University degree level, BSc.
13	Unsure what the levels of training are.

14	Not sure what the relevant qualification might be.
15	Intense course covering a multitude of subjects with relation to nutrition.
16	Degree.
17	Unsure - think a degree is required.
18	Understanding of the body. In-depth as dealing with people's lives.
19	Standard university degree course.
20	No idea.
21	Don't know. Maybe a degree.
22	I don't know.
23	A degree.
24	A degree in dietetics.
25	A dietitian one, maybe a degree.
26	PHD level, very complex job and in-depth training needed.
27	Same as a Dr - really complex job and need to know about everything, understand results of blood, body, food.
28	Degree in dietary assume it would be a degree as everything is.
29	Not sure if it needs to be a degree, maybe in dietary.
30	Rigorous exams.
31	Nursing degree.
32	Wouldn't have a clue.
33	The ones that they need.
34	Studied biology and some form of health qualification.
35	A degree or educational route. Maybe specializing to become a dietitian.
36	Degree/educational certificate/fitness qualification.
37	Degree in dietology.
38	Degree.
39	Degree handy to get through interview.
40	Driving license.
41	Nurses certificate, maybe a bit more than a nurse.
42	Doctor's certificate.
43	Human biology, chemistry, math, English, qualified nurse or medical qualification.
44	Qualified dietitian with a degree, biology and chemistry at level 3.
45	Degree, further qualifications on the job.
46	Unsure, hope that she would have qualifications in the field.
47	I don't know, maybe nutrition, don't know what's available.
48	Degree in nutrition or sports science, released their own programme.
49	Degree.
50	Degree in Dietetics – 4 years.

Key Findings:

Keyword/words	**% of total and count**
Degree level	50% (n=25)
Maybe/unsure/don't know	30% (n=15
PHD/doctors certificate	8% (n=4)

Nurses qualification	8% (n=4)
Masters	4% (n=2)

QUESTION 11a - Would you feel comfortable discussing what you normally eat and drink with a dietitian? (Option: yes, no, unsure)		
QUESTION 11b - Please explain your reasoning for your answer to the above question.		
ID NUMBER	**11a**	**11b**
1	Yes	I came for help and I need to be honest with the dietitian. They can't help if the patient isn't honest.
2	Yes	If they don't know they wouldn't be able to put me on another diet.
3	Yes	I've been referred for the good of my health, and I'd expect that with the range of people you see, my diet wouldn't shock you.
4	Yes	Because that's why you hire one.
5	Yes	If it helps me to help my own health areas it is worth doing.
6	Yes	If it’s in my favour and going to help me - wouldn't want other people there influencing what I say.
7	Yes	As long as they came across as understanding, compassionate, caring and not judgmental.
8	Yes	Because I try to be healthy.
9	Yes	I think I have a reasonably good diet, nothing to be ashamed of.
10	Yes	Health professional, if you keep stuff away you're only hurting yourself.
11	Yes	It isn't private as you can eat out in public.
12	Yes	I think I eat a (predominantly raw) whole food, plant based diet which is the healthiest diet to have.
13	Yes	Beneficial to myself. In order for them to evaluate and assess and get the right information back.
14	Yes	Because I would want to know the answer.
15	Yes	As that is the point of seeing the dietitian.
16	Yes	Lead a healthy lifestyle, might be areas missed out.
17	Yes	Yes if I felt I could trust them and they were friendly.
18	Yes	You've gone for help, so you have some issues you are dealing with and need to be open and honest.
19	Yes	Because if you want the help you need to do your part. They would deal with people in a worse situation than me so wouldn't feel judged.
20	Yes	Can't help unless they know the facts.
21	Yes	Because I don't care.
22	Yes	You need to be honest as you're going there because something is wrong.
23	Yes	Because I want them to help me. It would be pointless going if I didn't want any advice.
24	Yes	I know more than the average person about health. Not embarrassed about eating habits. Interested in it so I like talking about it.
25	Yes	There's nothing I don't eat.
26	Yes	No point in not being honest.
27	Yes	That's why I'm here, no point in lying about it.
28	Yes	Not worried, quite happy to share the information, wouldn't be happy if they told me I was wrong.
29	Yes	Not that bigger deal. Would be fairly close to the truth.
30	Yes	I just tell the truth.

31	Yes	I think if I had a problem that they could help overcome it's to my benefit to be honest and open.
32	Yes	They're a professional.
33	Yes	I know I'm overweight and need to do something about it.
34	Yes	No point in not telling the dietitian what I'm eating and drinking, no point in seeing if not honest.
35	Yes	Don't see myself seeing one, but wouldn't be a problem if I needed to.
36	Yes	Nothing to hide, not unhealthy person, need to get accurate results.
37	Yes	Don't know.
38	Yes	Specialist subject, hope to get a good resolution.
39	Yes	No point in seeing them otherwise.
40	Yes	We've all got to eat.
41	Yes	Because we eat reasonably.
42	Yes	I am happy to be open.
43	Yes	I'd admit to what I have, alcohol intake etc.
44	Yes	Might feel uncomfortable or ashamed or lie if under pressure, there is an embarrassment factor.
45	Yes	I would always try to be very honest with all healthcare professionals, cheating yourself if you're lying to them.
46	Yes	Because I need some advice.
47	Yes	They are a professional and can tell you what you're doing wrong.
48	Yes	I've had many invasive procedures, so talking about food is not an issue.
49	Yes	I've got nothing to hide.
50	Yes	I have few social barriers.

Key findings: **100% said yes**

Themes/keywords	**% of total and counts**	**Representative quotes**
No point otherwise/not a problem/it's a benefit to me	78% (n=39)	P23 'Because I want them to help me. It would be pointless going if I didn't want any advice'.
Honest/open/don't lie/truth/nothing to hide	22% (n=11)	P33 'No point in not telling the dietitian what I'm eating and drinking, no point in seeing if not honest'.
Not ashamed/we eat well/you've seem worse	18% (n=9	P9 'I think I have a reasonably good diet, nothing to be ashamed of'.
Healthcare professional	10% (n=5)	P10 'Health professional, if you keep stuff away you're only hurting yourself'.
Need for rapport/as long as they were friendly/didn't feel judged	8% (n=8)	P7 'As long as they came across as understanding, compassionate, caring and not judgemental'.

Question 12 - Which of the below categories do you identify as? (Options: Male, Female, Other, Prefer not to say)	
1	Female
2	Male
3	Male

4	Male
5	Male
6	Female
7	Female
8	Female
9	Female
10	Male
11	Female
12	Male
13	Male
14	Male
15	Male
16	Female
17	Female
18	Male
19	Female
20	Female
21	Female
22	Male
23	Female
24	Male
25	Male
26	Female
27	Male
28	Male
29	Male
30	Male
31	Male
32	Male
33	Male
34	Female
35	Male
36	Female
37	Male
38	Male
39	Male
40	Male
41	Male
42	Female
43	Male
44	Female
45	Male
46	Female
47	Female

48	Female
49	Male
50	Male

QUESTION 13 - please circle the appropriate age range (Options: 18-30, 31-40, 41-50, 51-60, 61-70, 70+)	
1	31-40
2	51-60
3	31-40
4	41-50
5	41-50
6	18-30
7	18-30
8	18-30
9	51-60
10	18-30
11	51-60
12	51-60
13	61-70
14	70+
15	70+
16	41-50
17	41-50
18	61-70
19	18-30
20	51-60
21	31-40
22	41-50
23	18-30
24	18-30
25	18-30
26	18-30
27	18-30
28	51-60
29	51-60
30	61-70
31	31-40
32	31-40
33	31-40
34	61-70
35	61-70
36	18-30

37	41-50
38	31-40
39	41-50
40	51-60
41	70+
42	70+
43	51-60
44	41-50
45	31-40
46	70+
47	18-30
48	18-30
49	18-30
50	31-40

QUESTION 14 - Are you currently employed? (Options: Full time, Part time, Retired, Unemployed, Temping)	
1	Full time
2	Full time
3	Full time
4	Full time
5	Retired
6	Unemployed
7	Part time
8	Full time
9	Retired
10	Full time
11	Part time
12	Full time
13	Full time
14	Retired
15	Retired
16	Part time
17	Part time
18	Full time
19	Full time
20	Part time
21	Part time
22	Full time
23	Full time
24	Full time
25	Full time

Demographics table	
All participants	100% (n=50)
Of which 18-30	28% (n=14)
31-40	18% (n=9)
41-50	16% (n=8)
51-60	18% (n=9)
61-70	10% (n=5)
70+	10% (n=5)
Male	60% (n=30)
Female	40% (n-20)

26	Tempting
27	Full time
28	Full time
29	Full time
30	Retired
31	Full time
32	Full time
33	Full time
34	Part time
35	Retired
36	Full time
37	Full time
38	Full time
39	Full time
40	Tempting
41	Retired
42	Retired
43	Part time
44	Part time
45	Full time
46	Retired
47	Full time
48	Full time
49	Full time
50	Tempting

Totals	**% of total and counts**
Full time	56% (n=28)
Part time	18% (n=9)
Temping	6% (n=3)
Retired	18% (n=9)
Unemployed	2% (n=1)

QUESTION 15 - What is your current job role? If retired or unemployed, what was your most recent job role?		**Category of job (see key below)**
1	Lawyer in Almaty, Kazakhstan	1
2	Theatre support worker	3
3	Project Manager - building industry	1
4	Renewable energy engineer - systems designer	2
5	Probation officer (qualified social worker)	1
6	Lingerie maker	2
7	Office manager and resource administrator	1
8	Elderly rehabilitation nurse	1
9	Specialist diabetes and endocrinology research nurse	1
10	Managing director - Brewery	1
11	Independence support worker	3
12	Chartered surveyor property consultant	1
13	Property landlord	1
14	Civil engineer - estimator	2

15	Insurance	2
16	Psychological therapist	2
17	Nurse - surgical ward	1
18	Heavy goods vehicle driver	2
19	Endoscopy receptionist	3
20	Teaching assistant	2
21	Vetinary nurse	1
22	Carpenter	2
23	Math teacher	1
24	PHD student/student teacher of economics	1
25	Store manager - Phone shop	1
26	Waitress	3
27	Bar manager	1
28	IT programme manager	1
29	IT consultant	1
30	Plumber	2
31	Team boat building leader - Sunseeker	2
32	Postman	3
33	Bathroom fitter for elderly and disabled	3
34	Restaurant manager	1
35	Scrap metal operations management	1
36	Costume student	2
37	Project manager - marine engineering	1
38	Teaching assistant and beer handler	3
39	Custody police officer	1
40	Construction - machine operator	2
41	Contract repairs manager - aviation	1
42	Nursery nurse	2
43	Aerial erector	2
44	Surgical nurse	1
45	Director of company	1
46	Hotel and holiday flats owner	1
47	Workforce coordinator - human resources	2
48	Head of Mandarin - Grammar school	1
49	Biomedical technician	2
50	Lead Project Manager	1

Job category	**Job category number**	**Number of participants and % of participants**
Professional	1	54% (n=27)
Semi-professional	2	32% (n=16)
Unskilled work	3	14% (n=7)

QUESTION 16 - Have you ever worked in healthcare? (Options: Yes, Never, Yes - a long time ago)	
1	Never
2	Yes
3	Never
4	Never
5	Never
6	Never
7	Never
8	Yes
9	Yes
10	Never
11	Yes
12	Never
13	Never
14	Never
15	Never
16	Yes
17	Yes
18	Never
19	Yes
20	Never
21	Yes
22	Never
23	Yes
24	Never
25	Never
26	Never
27	Never
28	Never
29	Never
30	Never
31	Never
32	Yes
33	Never
34	Never
35	Never
36	Never
37	Never
38	Yes
39	Never
40	Never
41	Never
42	Yes
43	Never

44	Yes
45	Never
46	Never
47	Yes
48	Yes
49	Yes
50	Never

Totals	**% of total and counts**
Yes	32% (n=16)
Yes – a long time ago	0% (n=0)
Never	68% (n=34)