

CLIENT-CENTRED NUTRITION
COUNSELLING:
AN EXPLORATORY STUDY

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by

Deborah Lynn MacLellan

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ABSTRACT

The purpose of this research was to determine the meaning that dietitians ascribe to the client-centred approach to nutrition counselling and to identify the important concepts and issues inherent in this approach to practice. A two-round, reactive Delphi survey, followed by indepth telephone interviews was used to collect the data. The first round survey was sent to 65 members of Dietitians of Canada who indicated that they had advanced level counselling skills in the member database. Fifty-seven questionnaires were returned in the first round and 48 in the second round for response rates of 88% and 84%, respectively. The follow-up survey was conducted with a subsample of 25 of the Delphi participants. The raw data from these interviews were transcribed verbatim and a form of inductive, thematic analysis was used to analyse the transcripts. Results indicated that participants agreed that most of the issues identified in the Delphi questionnaire should be included in a client-centred approach to practice, however, when asked about their experience in these areas, it was clear that they had some difficulty in the implementation of this approach. Participants appeared to be struggling in their attempt to find a balance between their beliefs about what a client-centred approach 'should' be and what was possible, given the realities of their workplaces. The results of the indepth interviews suggested that participants believed that using a client-centred approach is essential for successful nutrition counselling outcomes; however how they defined that approach varied depending on the context in

which the counselling took place. In Canada, the client-centred approach is considered one of the core concepts of dietetic practice. These findings suggest, however, that no common understanding exists of what it means to counsel in a client-centred manner. Thus, there is a need to reexamine the professional standards for dietitians in Canada and to broaden this discussion to clarify the fundamental principles related to nutritional care. Even more importantly, dietitians need to find out from their clients what they believe is important in a nutrition counselling relationship.

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Chapter 1

INTRODUCTION

1.1 Background

Over the past decade, the health care system in Canada has changed dramatically. Rising costs, an aging population, changing definitions of health, and consumers' increased interest in directing their health care have resulted in significant changes in how that care is delivered (Law & Mills, 1998). All these changes have had an impact on the practice of dietetics. The focus of dietetic practice has broadened with fewer dietitians working in hospital settings and more finding opportunities in the community and in industry. With increasing access to the internet, clients have become more aware of health-related issues and more vocal in their approach to health care. For some dietitians, this change has led to uncertainty about their role in the nutritional care process.

Traditionally, dietitians have practised within the medical model of health care. We are promoted by our professional association as being the nutrition experts and our advice is considered accurate, reliable and trustworthy because it is founded on science (Dietitians of Canada, 2000). Faced with

more demanding clients, we are being forced to rethink our traditional values and beliefs and to reconsider our role as 'expert.' Although we are trained to individualize our approach to helping our clients modify their eating behaviours, how this is done likely depends on what factors the individual dietitian sees as being important and may or may not involve the client.

Unfortunately, little evidence exists in the professional literature that Canadian dietitians have spent time discussing the values and beliefs that underpin our practice. We tend to emphasize skill development and continuing education that focuses on the accumulation of knowledge rather than reflecting on what is important to us as a profession and how that influences our practice. We use terms like empowerment and client-centred but rarely look beyond the surface definition of those concepts and think about their true meaning. If we are to continue to grow as a profession, we must look beneath that surface and explore our current models of practice to ensure that they are truly meeting the needs of our clients.

1.2 Rationale

Professional standards, guidelines to protect public trust in a profession, ensure the delivery of quality professional services. The current Professional Standards for Dietitians in Canada (Dietitians of Canada, 2000) were developed by a national steering committee comprised of dietitians representing each professional association/regulatory body in Canada and a member of the public. Additional input was obtained through focus groups that included

dietitians from a variety of practice settings and members of the public in each province. The standards are based on broad professional characteristics which describe the acceptable behaviour of the professional dietitian and are considered to be applicable to all dietitians regardless of their area of responsibility or focus of practice.

The first standard of practice relates to the provision of service to a client; “The dietitian uses a client-centred approach to provide and facilitate an effective dietetic service” (Dietitians of Canada, 2000, p. 6). The client-centred approach is defined as, “The use of collaborative and partnership approaches where the client’s own experiences and knowledge are central and carry authority within the client-professional partnership. In this approach mutual respect, trust and shared objectives are fundamental” (Dietitians of Canada, 2000, p. 13).

Most dietitians would probably agree that this standard is important, would say that they do work collaboratively with their clients, and would consider that they practise in a client-centred manner. However, how that belief is actually translated into day to day practice is not always clear. As dietitian Barbara Anderson questioned in the 1998 Ryley-Jeffs Memorial Lecture, “does it mean working with the client to together determine a course of action and ensure that the client has a voice, or does it refer to the professional deciding what is in the best interest of the client?” (Anderson, 1998, p. 140).

As Ellis (1988) stated, “There is, of course, much value in the painstaking analysis of professional purpose and principles and in the

provisional defining of scope and action. But such activities are hollow if not given substance by empirical enquiry" (p. 52). Further, Cave (1988) noted the importance of using research approaches that "find ways of involving professionals in making their intuitions public" (p. 202). Although there was an attempt to involve dietitians in the development of the current standards, little discussion has occurred since then about what a client-centred approach means from the perspective of the dietitian involved in individualized nutrition counselling or how this first standard is being translated into practice. The proposed research will attempt to address these gaps and increase our understanding of the client-centred approach to nutrition counselling from the perspective of the dietitian.

1.3 Purpose

The purpose of this research was to explore dietitians' understanding of nutrition counselling. More specifically, it has clarified the meaning that dietitians ascribe to a client-centred approach to nutrition counselling, identified the concepts and issues inherent in this approach to practice and described the experiences of dietitians in its implementation.

1.4 Research Questions

1. What is the nature of the nutrition counselling process?

1.1 What do dietitians mean when they say that they provide nutrition counselling using a client-centred approach?

- 1.1.1 What are the important concepts and issues inherent in this approach to practice?
 - 1.1.2 What are the anticipated outcomes of client-centred nutrition counselling?
 - 1.1.3 How do dietitians describe their role in client-centred nutrition counselling?
 - 1.1.4 How do dietitians describe the role of the client in client-centred nutrition counselling?
 - 1.1.5 What techniques do dietitians use that make the counselling session 'client-centred'?
2. Are the nutrition counselling experiences as described by dietitians congruent or incongruent with their opinions of what makes nutrition counselling client-centred?

1.5 Definitions

- Client: An individual, family and/or substitute decision-maker who is a potential or actual recipient of the dietitian's expertise. The client is unique and diverse in needs, culture, motivations, resources, religion and perception of wellness (adapted from Dietitians of Canada, 2000, p.13).
- Client-centred approach: The use of collaborative and partnership approaches where the client's own experiences and knowledge

are central, and carry authority within the client-professional partnership. In this approach mutual respect, trust, and shared objectives are fundamental (Dietitians of Canada, 2000, p. 13).

Dietitians of Canada: Dietitians of Canada (DC) is the national organization for dietitians in Canada.

Nutrition counselling: The process of guiding a client toward a healthy nutrition lifestyle by meeting normal nutritional needs and solving problems that are barriers to change (Curry & Jaffe, 1998).

Registered Dietitian: A registered dietitian (RD or other accepted designate) is an individual who has completed the required education and training mandated by the Dietitians of Canada and who is licensed to practise dietetics in Canada by their provincial regulatory body.

Standards: Standards are minimum levels of performance against which actual performance can be compared. Standards state minimal levels below which performance is unacceptable (Dietitians of Canada, 2000, p.15).

Standards of practice: Standards of practice is an umbrella term for a group of documents that include, among others,

professional standards, ethical guidelines, entry-level competencies, provincial regulations, standards of care, and practice guidelines (Dietitians of Canada, 2000, p. 16)

Chapter 2

REVIEW OF THE LITERATURE

2.1 The Dietetics Profession in Canada

2.1.1 Historical Roots

“Dietetics in Canada began with one woman’s concern about nourishing the poor” (Brownridge & Upton, 1993, p.11). Lillian Massey Treble, considered the matriarch of dietetics in Canada, came from an exceedingly wealthy family who supported many philanthropic projects. In the late 1800's, Lillian’s father established the Frederic Victor Mission in downtown Toronto which provided training and guidance to underprivileged men and boys. Lillian, seeing the appalling home conditions in the neighbourhood, organized classes for young girls in the basement of the Mission. From this humble beginning, grew the Lillian Massey School of Household Science and Art, which was opened in 1896.

Nathaneal Burwash, then chancellor of Victoria College, was keenly interested in household science and decided that a university course in the discipline was needed to prepare women to carry on Lillian’s work in the

community. A degree in household science was established at the University of Toronto in 1902, with the first two students (Olive Patterson and Margaret Proctor) graduating in 1906. The Lillian Massey School of Household Science officially merged with the University of Toronto in 1911 to become the Department of Household Science. Similar programs were established in universities across the country over the next two decades.

Most of these early graduates found employment as teachers, either in other universities to begin new programs or in high schools. Some found opportunities with various government departments. For example, the federal Department of Fisheries, in an attempt to increase local fish consumption during the war, hired a household science graduate, Evelene Spencer, to show Canadians how to handle and prepare fish (Brownridge & Upton, 1993). Those who were interested in pursuing post-graduate training or who were interested in working in hospitals were forced to travel to the United States for American Dietetic Association (ADA) accredited internship opportunities. The alternatives were on-the-job training and, in the case of future hospital dietitians, participation in one of ten courses of uneven content and duration which were set up between 1916 and 1928 in various hospitals across the country (Lang & Upton, 1973).

The first qualified dietitian in Canada, Emma MacBeth, was employed by the Hospital for Sick Children in Toronto in 1908. Two years later, the Toronto General Hospital hired a dietitian, Helen Reed, who immediately started a

course in dietetics for nurses and three years later, a dietetic internship training program. Gradually, hospitals across the country followed Toronto's lead (Brownridge & Upton, 1993).

Dietitians were employed in the foodservice sector as early as 1907 when Ethel Eadie (a Household Science graduate from the University of Toronto) was hired as dining hall superintendent at the University of Toronto dining hall for men (Lang & Upton, 1973). Violet Ryley replaced Ethel Eadie two years later and, as a result of this experience, was hired in 1921 to manage the Bigwin Inn on Lake Muskoka, the first hotel foodservice in North America to be managed by a dietitian (Brownridge & Upton, 1993).

Dietitians also played an important role in the military during both World wars. The first dietitian (Violet Ryley) was appointed to a military hospital in February 1917 and by March of the following year, 25 military hospitals employed dietitians (Brownridge & Upton, 1993). Kathleen Jeffs also made a significant contribution to the military during World War II. In 1942, Ms. Jeffs was selected for the position of senior messing officer at Air Force Headquarters in Ottawa and was awarded the Order of the British Empire (Military) for her "important contribution to the welfare and morale of aircrew training in Canada" (Brownridge & Upton, 1993, p. 70). A memorial to Kathleen Jeffs and Violet Ryley was established in 1949 in recognition of their achievements and contributions to the dietetics profession in Canada.

2.1.2 The Canadian Dietetic Association

The Canadian Dietetic Association was established in 1935 with 80 charter members from Ontario, Quebec and British Columbia. Prior to this time, individual Canadian dietitians had been members of the American Dietetic Association, which was established in 1917. Provincial associations were created in Quebec (1924), British Columbia (1925), and Ontario (1926). There were also a few local associations in existence at this time (Toronto and Ottawa). The British Columbia and Quebec associations were formerly affiliated with ADA from their inception. The Ontario Dietetic Association (ODA), on the other hand, had linked itself with ADA but no formal affiliation existed because the majority of Ontario dietitians were opposed to compulsory membership in the American association (Brownridge & Upton, 1993). On the initiative of the ODA, a meeting of representatives from that association, the Toronto and Ottawa Dietetic Associations, the British Columbia Dietetic Association and the Quebec Dietetic Association, as well as an Alberta dietitian, met in Ottawa to discuss the possibility of establishing a national association. That meeting led to an application to the Secretary of State for Canada for a charter and the establishment of the Canadian Dietetic Association.

The bylaws of the first constitution of this new organization stated that the purpose and objective of the corporation were to:

- a. promote, encourage and improve the status of dietitians in Canada:

- by establishing standards for training dietitians;
- by raising standards of dietary work;
- by collecting and preserving data and documents relating to the same;
- by furnishing information and reports and by the publication of bulletins, pamphlets, and periodicals relating to the dietary work and proceedings of the corporation, its directors and other committees;
- and for these purposes to have power to make all necessary contracts and agreements, subject to the regulations set out in the bylaws of the corporation. (Brownridge & Upton, 1993, p. 88)

The first code of ethics for dietitians was published in the inaugural issue of the *Journal of the Canadian Dietetic Association* in 1939 and later revised in 1956 and 1975. These early codes emphasized the moral responsibilities of dietitians with a view to protect both the public and the profession from unethical conduct by CDA members (Brownridge & Upton, 1993). The code was revised again in 1987 to ensure that it was not in conflict with any of the provincial codes yet was congruent with the CDA mission statement, goals, and roles of the time. The 1987 version of the Code of Ethics was formally adopted by all ten provinces and is still in effect today.

In 1983, the CDA executive, recognizing the need for strategic planning, developed a five-year plan (1984-1989). The three main goals of the

association at that time were “to establish the dietitian as the recognized authority for nutritional care; to achieve self-regulation by implementing nationally delineated standards for education and training, a nationally developed code of ethics and nationally developed standards of practice; to cause the organization to support the professional role and career development of members” (Brownridge & Upton, 1993, p. 96). A second strategic plan (1990-1995) was more externally focussed. At that time, the focus was on leadership, research, and growth (Brownridge & Upton, 1993).

The early 90s was also a time of change for the Association. The establishment of the College of Dietitians of Ontario signalled the need for a new way of delivering services to members, ultimately resulting in the formation of a new organization, Dietitians of Canada.

2.1.3 Provincial Dietetic Associations

As previously discussed, Quebec, British Columbia, and Ontario dietetic associations were formed between 1924 and 1926. These associations were dissolved in 1935 to allow for the creation of the new national organization (The Canadian Dietetic Association). It was thought at that time that the CDA would serve all the needs of dietitians across Canada. However, in the late 1940s, dietitians became interested in obtaining legal recognition for their profession. Because, according to the British North American Act, registration of professionals fell into the realm of provincial governments, it became necessary

to form provincial dietetic associations and for each provincial group to introduce a dietitians' bill to achieve the legal status they desired (Brownridge & Upton, 1993). Thus, between 1949 and 1965, nine provincial dietetic associations were formed. Although the British Columbia Dietetic Association was incorporated in 1957, it wasn't until 1986 that it finally achieved legal status and became the British Columbia Association of Dietitians and Nutritionists.

It was the intent, initially, that each provincial association's act be similar. However, differing provincial legislation requirements resulted in some differences which, in turn, caused a lack of consistency in admission standards, titles and professional designations, and standards of practice. Unfortunately, "although the provincial associations were created to strengthen the profession and unite dietitians in the fight to obtain legal recognition, they had an opposing effect" (Brownridge & Upton, 1993, p. 112). The concern about the growing diversity among provincial associations and competition between the provincial associations and the CDA for limited financial resources and volunteer labour resulted in the Affiliation Agreement which was signed by all provincial associations and the CDA in June 1987.

An affiliation management team was set up shortly after the agreement was signed "to establish and support an interassociation consultation process" (Brownridge & Upton, 1993, p. 114). This group identified the need for developing uniform standards for undergraduate education, internship competencies, entry-level competent practice, association admission, continued

competence assurance and discipline, standards of practice, code of ethics, and clarification of roles for each level of the association. It was recognized that uniformity in registration and title would not likely become a reality in the immediate future because of the limitations imposed by provincial legislation (Brownridge & Upton, 1993).

2.1.4 Dietitians of Canada

The Canadian Dietetic Association (CDA) became Dietitians of Canada (DC) at the annual conference in Banff, Alberta, in 1996. This new national association was the result of several years of meetings and consultations with members of CDA and the provincial dietetic associations. As a result, provincial associations have either disbanded or become the licensing body for dietitians in the province and DC has become the only member-oriented association in Canada.

2.1.5 Education, Training, and Registration

Becoming a professional, qualified dietitian in Canada requires two preparatory phases. The first phase is a Bachelor's degree with major credits in nutrition, dietetics, or foodservice administration from a university offering a Dietitians of Canada accredited dietetic education program, or equivalent education acceptable to the Association. The second phase involves the successful completion of a program of supervised practical experience

accredited by Dietitians of Canada. These programs can take the form of post-graduate dietetic internships, co-ordinated, co-operative or integrated undergraduate programs, or an appropriate graduate coordinated program. An alternative route is an appropriate graduate degree plus completion of the required competencies.

Once an individual has completed these two phases of preparatory education, they must write and pass the Canadian Dietetic Registration Exam to be eligible to apply for registered status to one of the provincial registration bodies.

2.1.6 Current Roles

2.1.6.1 Clinical

The first dietitians who worked primarily in hospitals, were involved in the provision of food to patients to prevent nutritional deficiencies or to treat a particular disease (referred to as diet therapy). These early dietitians were referred to as therapeutic dietitians. In the 1980s the term clinical dietitian replaced this title to reflect the increasingly complex role that these health professionals played in providing specialized care and modifying diets to treat various medical conditions (Brownridge & Upton, 1993).

Clinical dietitians today still work in hospitals, but increasing numbers are found in community health centers, health care facilities, or home care where they may specialize in any one of a number of disease conditions (diabetes,

heart disease, weight control) or with specific stages of the life cycle (children and infants, older adults). Their primary job functions include nutritional screening and assessment, nutrition counselling and education, documentation of nutritional care plans, and nutritional care evaluation and reassessment (Mason, Wenberg, & Welsh, 1982; Winterfeldt, Bogle, & Ebro, 1998).

2.1.6.2 Foodservice Management

Dietitians have been involved in the foodservice sector since the early days of the profession in Canada when Ethel Eadie was appointed as dining hall superintendent at the University of Toronto. During the 1920s and 1930s, foodservice dietitians were found in private clubs, large companies (such as Bell Telephone and Sun Life Assurance Company), banks, department stores (such as Eatons), and private schools and colleges. Today, many companies and institutions contract with a foodservice management company to run their cafeterias and these contract foodservice companies are one of the largest employers of dietitians in Canada (Brownridge & Upton, 1993). The primary job functions of these administrative dietitians, as they have come to be called, include the supervision of food production, distribution and service, menu planning, safety and sanitation, and marketing (Winterfeldt, Bogle, & Ebro, 1998).

2.1.6.3 Community Nutrition

“Community nutrition is the branch of nutrition that addresses the entire range of food and nutrition issues related to individuals, families, and special groups with a common bond such as place of residence, language, culture, or health issue” (Winterfeldt, Bogle, & Ebro, 1998, p. 172). Dietitians who work in the community are usually referred to as public health dietitian/nutritionists or community dietitian/nutritionists.

Public health nutritionists/dietitians work primarily in community health and social service agencies to provide information and advisory services to other community agencies, professionals, and the public. Unlike the clinical dietitian, public health nutritionists/dietitians assess the nutritional needs of populations, identify community health problems, and develop health promotion strategies and nutrition education programs.

Community dietitian/nutritionists are usually public health professionals. However, in some regions of the country these individuals are primarily involved with individuals rather than communities or groups. For example, in Prince Edward Island nine dietitians, who are referred to as community nutritionists, spend the majority of their time doing individualized counselling with high-risk pregnant women.

2.1.6.4 Dietitians in Business and Industry

Increasing numbers of dietitians work in private practice or in business.

Consulting dietitians work in a wide array of settings, providing nutrition services to individuals, institutions, business and the media. Dietitians in business assist the private sector (e.g. pharmaceutical companies, food service companies) with research, product development, management, and marketing expertise.

2.1.6.5 Dietitians in Education and Research

Dietitians can also be found in the area of education at all levels; elementary and high schools, universities and colleges, professional schools and hospitals. At the secondary school level, dietitians may be involved with teacher education and integrating nutrition into the curriculum. There are teaching opportunities for dietitians at culinary institutes and technical or vocational schools offering programs for food service supervisors or hospitality managers. University teaching can be at the undergraduate or graduate level, generally focussing on one or more areas of dietetic practice. In addition to their teaching roles, university faculty members are required to conduct research. However, dietitians in other areas are also involved in research. Many food companies employ research dietitians to develop new products or recipes. Companies that manufacture infant formulas and medical nutritional products often employ dietitians to conduct research or to monitor clinical studies (Winterfeldt, Bogle, & Ebro, 1998). Health Canada employs research dietitians to monitor nutrition policies and conduct nutrition surveillance.

2.2 Nutrition Counselling

2.2.1 Definition of Nutrition Counselling

Nutrition or diet counselling has been defined in various ways. Hodges and Vickery (1989) talk about diet counselling which they define as “the total process of offering individualized guidance and allowing the client to acquire the ability to self manage his or her nutritional care, that is, dietary counselling is successfully effecting behaviour change with more healthful behaviours resulting”(p. 7). In 1997, Shetselaar stated that, “Nutrition counselling....sets the stage for optimum dietary adherence” (p. 10). According to Curry and Jaffe (1998), “Nutrition counselling is the process of guiding a client toward a healthy nutrition lifestyle by meeting normal nutritional needs and solving problems that are barriers to change” (p.1). More recently, the term ‘medical nutrition therapy’ or MNT has appeared in the literature. Curry and Jaffe (1998) state that MNT is essentially the same as ‘nutrition counselling.’ The difference is that MNT typically refers to situations where the medical treatment of disease is involved and nutrition counselling is used when the focus is on disease prevention and general good health. Regardless of the definition used, however, according to Bauer and Sokolik (2001), the ultimate goal of a nutrition counselling session is to help clients to achieve a healthier lifestyle and become self-sufficient.

Over the years, several authors have developed models of nutrition counselling to provide dietitians with a framework for nutritional care (Lacey & Cross, 2002; Rosal et al., 2002; Sandrick, 2002; Splett & Myers, 2001; Strychar, Simard-Mavrikakis, Blain, Mongeau, & Gelinas, 1997; Vickery & Hodges, 1986).

These models will be discussed in more detail in section 2.3.4.1.

2.2.2 Health Behaviour Change and Counselling Theories and Approaches

According to Glanz, Lewis and Rimer (1997), “a theory is a set of interrelated concepts, definitions, and propositions that presents a systematic view of events or situations by specifying relations among variables in order to explain and predict the events of situations” (p. 21). Health behaviour change theories help dietitians to understand why clients choose the foods that they do and the factors that influence a client's ability to make dietary changes.

Counselling theories also help dietitians to understand human behaviour.

However, in addition, they provide us with guidance in developing effective relationships with clients and in conducting effective counselling sessions.

Although many theories exist that may influence how dietitians conduct their practice, which one(s) is/are used, likely depends upon which ones they were exposed to during their education and training. A brief discussion of five health behaviour change theories and five counselling theories which have been applied to nutrition counselling follows.

2.2.2.1 Health Behaviour Change Theories

2.2.2.1.1 The Stages of Change Model

Prochaska and DiClemente's transtheoretical model (more commonly referred to as the Stages of Change model) was originally developed to understand smoking behaviour (Prochaska, Diclemente, & Norcross, 1992).

This model identifies five stages of readiness to change through which people move: precontemplation (the individual is unaware of the need to change or is not interested in making a change); contemplation (the individual is thinking about changing); preparation (the individual is actively making plans to change); action (the individual is in the process of making the desired change); and maintenance (the individual maintains the change for six months or longer) (Mhurchu, Margetts, & Speller, 1997). This model also recognizes that an individual might experience a relapse that ends the action or maintenance stage and results in the movement back through one or more of the initial stages. The Stages of Change model has been shown to be useful in assessing readiness for change at the beginning of counselling (Kasila, Poskiparta, Karhila & Kettunen, 2003), and predicting fruit and vegetable consumption in adults (Van Duyn et al., 1998). However, it has also been criticized for its simplistic approach to complex dietary behaviour (Povey, Conner, Sparks, James & Shepherd, 1999).

2.2.2.1.2 The Health Belief Model

The Health Belief Model was developed in the 1950s by a group of social psychologists at the U.S. Public Health Service in an attempt to explain why people were not participating in programs designed to prevent or detect disease (Rosenstock, 1990). Since then, the model has been expanded to include all preventive and health behaviours.

The Health Belief Model has three main components: perceived threat to

health, the expectation of certain outcomes related to the behaviour, and self-efficacy (Becker & Maiman, 1975). The perceived threat to health can be further broken down into perceived susceptibility (an individual's subjective perception of the risk to his/her health) and perceived severity (how serious an illness is thought to be) (Becker, Drachman, & Kirscht, 1972). The outcomes related to the behaviour may be positive (perceived benefits) or negative (perceived barriers). Self-efficacy refers to the belief that one can make a behaviour change (Janz & Becker, 1984). Other variables, such as education, income, sex, age and ethnic background are also considered to influence health behaviour in this model, but in an indirect manner. In dietetics, the model has been used to identify the psychosocial factors that differentiate between people who report making changes to their diets consistent with national recommendations and those who do not (Contento & Murphy, 1990), to identify characteristics associated with compliance to cholesterol lowering diets (Caggiula & Watson, 1992), and to identify barriers to fruit and vegetable consumption in a multiethnic worksite population (Cohen, Stoddard, Sarouhkhani, & Sorensen, 1998).

2.2.2.1.3 Theory of Reasoned Action

Martin Fishbein (1967) developed the Theory of Reasoned Action which provides a framework for understanding attitudes towards behaviours. There are four constructs in this framework: attitude, belief, behavioural intention and behaviour. According to this model, an individual's behaviour is directly

determined by his/her intention to perform the behaviour (Boyle & Morris, 1999). The strength of an individual's intention to perform that behaviour depends on their attitudes toward the behaviour and the influence of the social environment (opinion of others) or general subjective norms on the behaviour (Carter, 1990). In turn, attitudes and subjective norms each have two components. Attitude is a function of the individual's belief that a given outcome will occur if he/she performs the behaviour and by an evaluation of the impact of that outcome on his/her life. Subjective norm is determined by an individual's belief about what significant others think he/she should do and by whether or not the individual cares about what those others think (McKenzie & Smeltzer, 1997). Tuorila (1987) used this theory to examine attitudes, norms and intentions towards drinking milk of varying fat content; Brug, van Assema, Kok, Lenderink and Glanz (1994) used the theory to look at fat intake. In recent years, however, it has become more common to use the modified version of this theory, the Theory of Planned Behaviour.

2.2.2.1.4 Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) evolved out of the Theory of Reasoned Action. In the TPB, the construct of 'perceived behavioral control' was added to account for behaviours beyond an individual's control that may influence his/her intentions and thus his/her behaviours (Ajzen, 1991). It was postulated that an individual behaves in a certain way based on his/her motivation (intention) and ability (behavioural control) and that the greater the

perception of behavioural control, the more likely that individuals are to change their behaviour (Montano, Kasprzyk, & Taplin, 1997). The TPB has been shown to be useful for examining determinants of food choice among adults and children (Backman, Haddad, Lee, Johnston, & Hodgkin, 2002; Bogers, Brug, van Assema, & Dagnelie, 2004; Lien, Lytle, & Komro, 2002; Povey, Conner, Sparks, James, & Shepherd, 2000).

2.2.2.1.5 Social Cognitive Theory

Social cognitive theory (SCT), the cognitive version of Social Learning Theory (SLT), was originally introduced by Miller and Dollard (1941) to explain imitation of behaviour among animals and humans. However, Bandura (1986) is generally considered the leader in the development of this theory. SCT emphasizes the dynamic interaction between personal factors and environmental factors in predicting changes in behaviour. Bandura referred to these relationships as reciprocal determinism, meaning that, as the three components interact, a change in one will produce changes in the others.

Many important constructs or key concepts occur in SCT, including reinforcement, expectations, expectancies, self-control or self-regulation and self-efficacy (Boyle & Morris, 1999). Reinforcements, responses to an individual's behaviour, increase or decrease the likelihood of that behaviour recurring. Expectations refers to the ability of humans to think and thus to expect certain things to happen in certain situations. Expectancies, on the other hand, are the values that a person places on a given outcome. The concept of

self-control or self-regulation states that individuals can gain control over their own behaviour through monitoring and adjusting it. Finally, self-efficacy refers to individuals' confidence in their ability to perform a particular behaviour.

Researchers have used social cognitive theory to understand dietary behaviours in children and adults (Resnicow et al., 1997; Reynolds, Hinton, Shewchuk & Hickey, 1999; Thompson et al., 2003) and as a basis for designing nutrition intervention programs (Glanz & Eriksen, 1993; Kirby, Baranowski, Reynolds, Taylor & Binkley, 1995).

2.2.2.2 Counselling Theories

2.2.2.2.1 Behavioural Therapy

John Watson is generally considered to be the original advocate of the behavioural approach to counselling in the early 1900s (Gladding, 1991). Watson, who felt that the study of a person should be a scientific enterprise, believed that counsellors needed to abandon the psychoanalytic, introspective methods of Freud and concentrate on a more objective study of human behaviour (Burnard, 1999). Watson argued that because all human behaviour was learned it could be unlearned. The role of the behavioural therapist is to use various strategies and techniques to help clients change maladaptive or 'bad' behaviours. These strategies include self-monitoring (which allows the client to become aware of these behaviours), stimulus control (teaching the client to eliminate the cues or stimuli associated with the behaviour), and reinforcement, both positive and negative, to name a few. Contemporary

behaviour therapy places more emphasis on cognitive processes as mediators of behaviour change and thus the term, cognitive behaviour therapy, is more generally used today. Cognitive behaviour therapy has been used in dietetics in the treatment of obesity in children and adults (Epstein, Myers, Raynor, & Saelens, 1998; Rapoport, 1998) and has been suggested as being effective in helping clients achieve long term dietary change (Baldwin & Falciglia, 1995).

2.2.2.2.2 Rational Emotive Behaviour Therapy

In the 1950s, Albert Ellis combined humanistic, philosophical and behavioural therapy to form rational-emotive therapy (now known as rational emotive behaviour therapy or REBT) (Corey, 2001). The major premise of REBT is that “people contribute to their own psychological problems, as well as to specific symptoms, by the way that they interpret events and situations (Corey, 2001, p.297). The REBT counsellor allows the client to vent his/her feelings and then attempts to identify irrational thinking processes or ideas that have led to the client’s difficulties. This style of counselling is one of challenging and confronting a client’s belief system (Vickery & Hodges, 1986). The goal of therapy is to change the client’s irrational viewpoints with strong, directive and confrontational interventions. (Curry & Jaffe, 1998). A nutrition counsellor using this approach would challenge his/her clients’ irrational thinking and help them to change their negative self-talk into more positive thoughts (Snetselaar, 1997).

2.2.2.2.3 Gestalt Therapy

Gestalt therapy, developed by Frederik Perls, focuses on helping clients confront their present problems rather than looking to the past or into the future (Bauer & Sokolik, 2001). A Gestalt therapist tries to increase clients' awareness of the various factors influencing their behaviour that they have 'disowned' and helps clients to set reasonable goals to manage their problems (Snetselaar, 1997). According to Snetselaar (1997), showing clients how to self manage their conditions and take responsibility for their dietary behaviour is a practical application of this type of therapy in dietetics.

2.2.2.2.4 Solution-Focussed Therapy

Solution-focussed therapy was developed by de Shazer and colleagues in the United States in the early 1980's. It is sometimes referred to as solution-focussed brief therapy (Lewis & Osborn, 2004). In contrast to traditional theories of psychotherapy in which the emphasis is on searching clients' past experiences to look for the root of their problems, one of the key assumptions behind solution-focussed therapy is that it is generally unnecessary to understand the problem to solve it (Haley, 2000). The basis of solution-focussed therapy is a counsellor's belief in his/her clients ability to make positive changes in their lives given the support needed (Lewis & Osborn, 2004). Similar to person-centred therapy, this approach builds on the strengths that clients bring to the counselling session. The client and counsellor work together to set goals and find ways to achieve those goals.

Although I could not find any evidence in the published literature of the use of this approach in nutrition counselling, a workshop at a recent dietetic conference promoted the use of brief solution-focussed therapy (McConkey, 2003). Participants in this workshop were given worksheets to use to help them work with clients to set goals and develop action plans to achieve these goals.

2.2.2.2.5 Client/Person-Centred Therapy

Carl Rogers developed the client-centred or person-centred approach to counselling in the 1940s. He first described his new approach to counselling as being nondirective and focussed on the concerns of the patient (Rogers, 1939). He further elaborated on this idea in the book *Counselling and Psychotherapy: Newer Concepts in Practice* (Rogers, 1942). In this book, he described the nondirective approach in the following way:

The aim is not to solve one particular problem, but to assist the individual to grow, so that he can cope with the present problem and with later problems in a better integrated fashion. If he can gain enough integration to handle one problem in a more independent, more responsible, less confused, better organized ways, then he will also handle new problems in that manner. (Rogers, 1942, p. 28)

In Rogerian client-centred counselling the therapist acts as a facilitator, helping clients to explore their feelings and attitudes related to their problem areas. As clients explore these issues, they gradually come to a better understanding of themselves and thus are able to resolve the problems based on these new insights (Rogers, 1942). For this process to take place, the counsellor must provide an environment where clients are given the safety and

freedom to explore their own issues and to experience their own feelings.

Rogers (1965) outlined three necessary conditions to facilitate client-centred therapy. The first is counsellor genuineness, realness, or congruence. In other words, a client needs to know that “what they see is what they get” and that what the counsellor says reflects what he/she does. For the second, the counsellor needs to be a caring individual who perceives and accepts clients as they are. According to Rogers (1965), “when the counsellor perceives and accepts the client as he is, when he lays aside all evaluation and enters into the perceptual frame of reference of the client, he frees the client to explore his life and experiences anew, frees him to perceive in that experience new meanings and new goals” (p.48). In the third condition empathic understanding, “the client begins to experience a feeling of safety as he finds that whatever attitude he expresses is understood in almost the same way that he perceives it, and is accepted” (Rogers, 1965, p. 41).

Rogers’ beliefs about people’s ability to take responsibility for their own lives rest on two basic assumptions. The first is what Rogers (1965, p.150) referred to as the “actualizing tendency” an active process in which the individual has an inherent need to grow and develop in a positive direction. The second is that the human being is basically a trustworthy organism capable of self-understanding and of accurately evaluating external circumstances, of making constructive choices, and of acting on these choices (Nelson-Jones, 1984).

Many researchers in the dietetics profession have recommended the use

of a client-centred approach to counselling (Hawirko, Dickie & Wong, 1994; Rosal et al., 2002; Splett & Myers, 2001; Strychar, Simard-Mavrikakis, Blain, Mongeau & Gelinas, 1997; Vickery & Hodges, 1986). This will be discussed in more detail in Sections 2.3.3 and 2.3.5.

2.2.3 Nutrition Counselling Models

The approach that counsellors use probably depends on a number of factors including educational background, skill level, values and beliefs, and experiences. It is likely that no one 'right' way to counsel exists and that different approaches may be appropriate in different counselling situations. As Burnard (1999) has suggested, it is probably most useful for health professionals to develop an understanding of a wide range of counselling and behaviour change theories and test them out in their practice to see which ones suit. Burnard refers to this as the 'eclectic' approach to counselling which is reflected in the many models of nutrition counselling that have been developed over the years to help dietitians be more effective in their counselling practice. Some of these models have been developed using various counselling and behaviour change theories, while others have been developed using the expertise and knowledge of dietetic counsellors. The following discussion describes the models that have been reported in the literature over the past 20 years.

In 1986, Vickery and Hodges presented a model of nutrition counselling which outlined the roles of both the counsellor and the client. These authors

used several counselling theories in the development of their model including: cognitive behaviour therapy, client-centred therapy, rational emotive therapy, reality therapy, and transactional analysis. The first stage of their model involves the establishment of a warm and genuine relationship between counsellor and client. This appears to be the only aspect of the client-centred approach that is used. For the most part, despite the authors identification of the need for active participation on the part of the client, the other stages emphasize the role of the counsellor while the client becomes more of a passive recipient of the counsellor's knowledge. For example, in the second stage, a counsellor's role is to identify the client's nutrition-related problem and increase the client's awareness of the problem. The role of the client is to increase his/her awareness of and interest in the problem. Once this is accomplished, the counsellor identifies various techniques and strategies that the client can use to effect a behaviour change and the client selects his/her preferred option(s). The counsellor then provides education relevant to the needs of that particular client (as determined by the counsellor in the second and third stages of the model) and positive reinforcement of the desired behaviour. The client's role is to test out the various strategies and techniques identified through a process of trial and error and to gradually increase confidence in his/her ability to adopt the desired behaviour change. In the last stage of this model the counsellor ends the helping relationship and the client assumes independence. Interestingly, despite asserting that the counsellor-client relationship needs to be a partnership, at the end of their article, these authors state that "...there is an

important segment of this interaction that the nutrition counsellor needs to control, at least initially, to foster compliance” (p. 928).

In 1997, Strychar and colleagues published what they called a ‘framework for nutrition consultation’ that dietitians could use to improve their practice and dietetic students could use to learn how to counsel effectively. This framework was developed using counselling ideas and strategies from various nutrition researchers and adult education professionals rather than any specific counselling or behaviour change theories. However, in their discussion of the framework, it appears that they did use strategies from the Stages of Change model and cognitive behavioural theory. The framework consists of a six step approach to counselling which includes identifying the who, what, when, where, and why for the consultation; collecting nutritional assessment data; identifying the problem; setting goals; determining appropriate intervention strategies; and evaluating the outcome. Again, although not specifically discussed, there is some evidence of a client-centred approach in this counselling framework. The authors discuss the role of the dietitian as facilitator rather than problem solver and the importance of having a “nonjudgemental demeanour” (p.85). Further, they state that “a holistic view of the client is required” (p.86) and that “counselling goals should be determined by clients and facilitated by the dietitian” (p.86). On the other hand, they still emphasize the expert role of the dietitian in terms of “providing nutritional advice and identifying behaviour change strategies”(p.84).

In 2001, Splett and Myers published a report on a proposed model for

nutrition care that was developed through a series of facilitated discussions with dietitians and other health care professionals. In these discussions, participants were asked to describe nutrition care in therapeutic settings, identify the activities that they believed were essential for positive outcomes, and describe how they thought nutrition care could be presented in a model. The 'Nutrition Care Model' that was developed as a result of that process consists of three components: a trigger event, the nutrition care process, and nutrition-related outcomes. The trigger event is how a client comes into contact with a registered dietitian and "...is the access point for referral to nutrition care" (p. 358). The nutrition care process is defined as having five essential steps: assess, establish goals and determine nutrition plan, implement intervention, document and communicate, evaluate and reassess. The third component of the nutrition care model focuses on the outcomes of nutrition care and stresses the importance of developing relevant goals as well as the need to include 'patient-centred outcomes.' These would include such things as an evaluation of the client's quality of life, satisfaction with the care, ability to self-manage their condition, and their feelings of self-efficacy. This model was not developed with specific counselling or behaviour change theories in mind; however, it is suggested that these theories be used in planning interventions for clients. Although the importance of developing rapport with the client, tailoring the nutrition care plan to meet client's needs and preferences, and partnering with a client is discussed as being a part of this process, the emphasis in this model appears to be on the role of the dietitian in the

counselling process. There is no discussion of what role the client plays in this model, other than being able to decide whether or not to be involved or to continue with planned nutrition care.

The 'Nine-Step Nutritional Care Process,' which was developed by Mary Ann Kight and reported on by Sandrick (2002), expanded the model by Splett and Myers to include what she referred to as the 'Quality Improvement Cube.' This model is described as a "....standards-driven diagnostic, causal, and prognostic care process" (p. 428). It emphasizes the important role of dietitians in the diagnosis of nutritional problems and the need to use their expertise in treating or recommending treatment for clients. Judging by the complexity of this model, it seems to me that it would be more useful as a research tool rather than a practice-based counselling tool. Further, as is evident from the following quotation from Dr. Kight (as reported by Sandrick), it is clear that the main purpose of this model is to position the dietitian as the expert.

Without the nutrition and dietetic-specific nutritional diagnostic step the health care community and society at large will continue to be underserved by RDs since they will not be performing at their full capacity, ie. RDs will not be offering clients/patients the benefits of knowledge and the scientific power and/or command of that knowledge that rightfully belongs to our profession." (p. 429)

Continuing this discussion about the nutrition care process and using the models proposed by Splett and Myers and Kight, Karen Lacey developed a third nutrition care model to standardize the process of nutritional care for practising dietitians, undergraduate students, and dietetic interns (Lacey & Cross, 2002). Lacey's problem-based nutrition care process, which uses typical assessment

data (anthropometric, biochemical, clinical and dietary) to identify nutrition problems, includes nine steps: problem-based focused assessment, identify nutrition problems/diagnosis, identify the cause of the problem (etiology), describe the severity and supporting evidence of the problem (signs and symptoms), define desired outcomes (based on evidence), intervention (causal connection), document, evaluate short-term and intermediate outcomes, and evaluate long-term outcomes. Again, the emphasis in this model is on the role of the dietitian and there does not appear to be any consideration of the client's role in the process.

Finally, in 2002, Rosal and colleagues reported on a patient-centred counselling model that was developed using several existing theories and models including consumer information processing theory, the health belief model, the stages of change model, social cognitive theory, and behavioural self-management. In contrast to the previous three models of the nutrition care process just discussed, this is a fairly simple four step process. In step one, the dietitian uses open-ended questions to obtain relevant information about patients to help them tailor the dietary intervention. In step two, the dietitian provides personalized advice to patients to help them address their health concerns. Step three involves the provision of assistance to a patient to support their behaviour changes. This is done through motivational statements such as validating the patient's feelings about prescribed dietary changes, expressing optimism for the chances for success, tailoring counselling to the stages of change, setting goals, re-assessing self-efficacy, and developing behavioural

contracts. The final step is to arrange for follow-up and to prevent relapse. It is interesting to note here that despite the name of the model, Carl Roger's patient-centred counselling theory was not used in its development and there is no real discussion of the importance of developing a relationship with clients. The authors do state that "The use of patient-centred counselling promotes interaction and collaboration between the patient and nutritionist such that the patient is actively involved in developing an appropriate care plan, including strategies for achieving dietary goals" (p. 338); however it is not clear how that interaction and collaboration is fostered.

2.3 The Client/Person-Centred Approach in the Health Professions

The client-centred theory of counselling has evolved and been adapted since its inception in the early 1940s. Many health professions have adopted what they call a client-centred approach, especially over the past decade, as consumers have become more vocal and more interested in taking responsibility for their own health. However, how that approach is defined and implemented appears to be varied. The following discussion focuses on five health professions (medicine, nursing, occupational therapy, pharmacy and dietetics) that recommend the use of a client-centred approach to practice.

2.3.1 Medicine

In medicine, the term "patient-centred" is generally used to describe an approach to care that differs from the traditional biomedical model. Although

much has been written regarding the provision of patient-centred care (PCC), there still appears to be some confusion regarding the meaning of the term 'patient-centred' and conflicting opinions regarding the effectiveness of this approach to medical practice.

2.3.1.1 Definition of Patient-Centred Care

The term 'patient-centred' was first described by Balint as a way to understand patients as unique individuals rather than in terms of their underlying disease process (van Dulmen, 2003). Lutz and Bowers (2000) suggested that the literature describing PCC can be divided into two categories. The first defines it as the reorganization of hospital services around patient's needs (sometimes referred to as "patient-focussed care") while the second defines it as "...understanding the patient's needs, wants, priorities, preferences and expectations for health care" (p. 172). In 1993, Gerteis, Edgman-Levitan, Daley and Delbanco described PCC as an approach that "...consciously adopts the patient's perspective" and defined seven primary dimensions of patient-centred care based on research conducted with physicians, non-physician hospital staff and patients in the Boston area. These included:

1. Respect for patient's values, preferences and expressed needs
2. Coordination and integration of care
3. Information, communication and education
4. Physical comfort
5. Emotional support and alleviation of fear and anxiety

6. Involvement of family and friends
7. Transition and continuity

Stewart and colleagues (1995) developed a model of the patient-centred clinical method which identified six interlocking components:

1. Exploring both the disease and the illness experience
2. Understanding the whole person
3. Finding common ground regarding management
4. Incorporating prevention and health promotion
5. Enhancing the doctor-patient relationship
6. 'Being realistic' about personal limitations and issues such as the availability of time and resources

More recently, Mead and Bower (2000) developed a conceptual framework of patient-centredness based on a review of the conceptual and empirical literature. They identified five conceptual dimensions: biopsychosocial perspective; 'patient-as-person', sharing power and responsibility; therapeutic alliance; and 'doctor-as-person.' Mead and Bower also reviewed the literature on the measurement of patient-centredness and identified two main methodological approaches: self-report by physicians and measures involving external observation of the consultation process. Findings from those studies that attempted to measure the relationship between a 'patient-centred' approach (variously defined) and patient outcomes (such as health status or satisfaction) were somewhat inconsistent. These authors concluded that new tools were needed to measure the complex and contextual

dimensions of patient-centredness.

2.3.1.2 Models of Physician-Patient Relationships

Much of the literature on client/patient-centredness in medicine focuses on the relationships between clients and physicians and, in particular, communication and decision making within those relationships. Emanuel and Emanuel (1992) identified four models of the physician-patient relationship: paternalistic, informative, interpretive, and deliberative. In the paternalistic model, physicians, acting as guardians for their patients, are able to determine what is in their best interest. The role of the patient in this model is one of acceptance and passivity. In the informative model, the role of the physician is to provide the patient with all the information needed to make an informed decision. Once patients have chosen the intervention that they want, the physician is then responsible for implementing it. In the interpretive model, the physician provides patients with all relevant information and then works with them to determine which medical intervention would best suit their needs as determined by their values. Finally, in the deliberative model, the physician engages in a dialogue with patients to persuade them to choose an intervention that would best meet their needs. The aim of the deliberative model is to discuss not only what the patient could do, but what they should do (Chin, 2002). Emanuel and Emanuel (1992) note that, depending on the circumstances, it may be appropriate to use a different model at different times. However, their preferred approach is the deliberative model because it most

closely embodies their ideal of patient autonomy.

Charles and colleagues described a shared treatment decision-making model in which the development of a trusting relationship is critical. These authors divide the decision-making process into three stages: information exchange, deliberation about treatment options and, finally, deciding on the treatment to implement (Charles, Gafni & Whelan, 1999). In contrast to the paternalistic and informed models, in which information exchange is largely one-way and most of the information is medically oriented, the shared model is a two-way process where a physician attempts to gain a deeper understanding of the patients' personal lives that might impact on their medical condition. The relationship between the physician and patient in the shared model is seen as a partnership where both parties work together every step of the way to decide on a treatment option that best suits a patient's preferences.

2.3.1.3 Patient-Centred Care Outcomes in Medicine

The patient-centred approach, although variously defined, has been shown to increase patient and physician satisfaction with care, reduce patient anxiety and improve emotional health, and improve quality of life (Stewart, 1995, 2001). Further, despite the widely held belief that practising in a patient-centred way is time consuming, Stewart and colleagues (2000) concluded that there is some evidence that patient-centred care is more efficient and is associated with few diagnostic tests and referrals. On the other hand, following a recent review of the literature, Mead and Bower (2002) concluded that not

enough evidence existed to support the hypothesis that patient-centred consultations result in better health outcomes in primary care. They point out, however, that their review was different from that conducted by Stewart (2001) because they focussed solely on primary care settings and studies that specifically defined behaviour as being 'patient-centred.' Thus, as van Dulmen (2003) points out, it is possible that the success of a patient-centred approach may be dependent on the type of patient and the setting in which treatment occurs.

2.3.2 Nursing

Although the notion of 'patient-centred care' (often referred to as patient-focused or patient-driven) has been discussed in the nursing literature for many years, as we saw in the field of medicine, there are many different views of what it is and how it should be implemented in practice.

2.3.2.1 Definition of Patient-Centred Care

From the time of Florence Nightingale, nurses have been considered different from physicians in terms of their focus on patients and their needs rather than on disease processes (Lutz & Bowers, 2000). However, the nursing profession has evolved within the framework of the traditional, hierarchical model of medical care which has influenced practice which, in turn, has influenced how nurses define patient-centred care.

Similar to medicine, patient-centred (PCC) or patient-focused care (PFC) in nursing has been defined in both operational and philosophical terms. The operational view refers to changes within the hospital system that ensure that patients are at the center of care with services revolving around them. The philosophical approach stresses the importance of individualizing services to meet the unique needs and wants of patients (Mitchell, Closson, Coulis, Flint, Gray, 2000). In a recent publication of nursing best practice guidelines by the Registered Nurses Association of Ontario (2002), the importance of this latter approach was highlighted in their definition of client-centred care:

An approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client-centred care involves advocacy, empowerment, and respecting the client's autonomy, values, self-determination, and participation in decision making. (p. 12)

A key concept in a client/patient-centred approach in nursing appears to be that of empowerment. Several researchers have explored this issue in the nursing literature to understand how nurses define and implement it in practice. Falk-Rafael (2001) used a nominal group technique in a series of focus groups to develop what she termed a 'model of empowered caring.' In this model, empowerment was conceptualized as a process of evolving consciousness in which increasing awareness, knowledge and skills interacted with clients' active participation to move toward their actualizing potential. In 2002, Clark and Krupa who reviewed the literature and provided a summary of definitions of empowerment, concluded that all the definitions shared the following qualities: an emphasis on participation that increases personal control, the need for critical

thinking, action and power sharing, and a recognition of the need to mobilize various resources to accomplish their goals. Despite the apparent importance of this concept in client-centred practice, however, Paterson (2001) revealed that practitioners' practices are often not congruent with these tenets of empowerment. In this grounded theory study, the decision making processes of 22 clients with Type I diabetes were explored. Many participants stated that few of the practitioners that they were involved with were empowering and that although these practitioners said that they wanted clients to make their own decisions, they really wanted them to follow their professional advice. Paterson identified several barriers to the implementation of empowerment in healthcare including lack of time and the view of the practitioner as the 'expert.'

Who is in the best position to define patient needs has been the subject of much debate and discussion in the nursing literature over the years. Early nurse theorists tended to advocate for a health-provider or nurse-centred approach to meeting patients' needs and focussed on the role of the nurse in defining patient needs (Lutz & Bower, 2000). More recent nurse theorists have returned to an emphasis on the person and a focus on understanding those persons' lives from their perspective rather than a disease perspective (Neuman, 1995; Parse, 1998). Thus, in some areas at least, patient-centred care in nursing now refers to meeting needs as defined by the patient.

2.3.2.2 Human Becoming and Patient-Centred Care

In 1981, Parse first outlined a theory of nursing which she called the

'human becoming school of thought.' In this theory, she advocated for a return to nursing's roots and a shift in emphasis from defining patient's needs from the perspective of the health professional to defining needs based on the perspective of patients themselves. Those who practice according to the human becoming school of thought respect their patients' choices and see them as experts in their own lives (Bournes, 2000). Parse's theory has been used to support patient-centred nursing practice in Canada and explored by several researchers interested in improving nurse-client relationships and, ultimately, client outcomes. In 1999, Legault and Ferguson-Pare conducted a study to evaluate how nursing practice changed when the theory of human becoming was used as a guide for nursing practice in a Canadian hospital. They concluded that the use of this theory helped nurses to develop deeper, more meaningful relationships with their patients. Further, both patients and their families expressed a greater satisfaction with the care that they received.

The values and beliefs of client-centred care outlined in the recently released "Nursing Best Practice Guidelines" from the Registered Nurses Association of Ontario (2002) stem from Parse's theory and include a respect for clients' needs and wants, caring for clients as whole human beings rather than individual problems or diseases, a recognition that clients are the experts in their own lives, and a willingness to follow clients lead and allow them to define their own health-related goals.

2.3.3 Occupational Therapy

2.3.3.1 Definition of Client-Centred Care

Client-centredness has been a part of the philosophy of the Canadian Occupational Therapy profession since the early 1980s when the Department of National Health and Welfare (DNHW) and the Canadian Association of Occupational Therapists (CAOT) published the “Guidelines for the Client-Centred Practice of Occupational Therapy (DNHW & CAOT,1983). Since then, these guidelines have been updated and revised and an attempt has been made by several researchers to facilitate their implementation (CAOT, 1997; Corring & Cook, 1999; Fearing, Law & Clark, 1997; Law, Baptiste & Mills, 1995; Rebeiro, 2000; Sumsion & Smyth, 2000).

The first formal definition of client-centred practice in occupational therapy was proposed by Law et al. (1995):

Client-centred practice is an approach to providing occupational therapy which embraces a philosophy of respect for, and partnership with, people receiving services. Client-centred practice recognizes the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which a client lives. (p.253)

These authors also outlined a number of concepts that they said form the underpinning of a client-centred approach including autonomy/choice, partnership and responsibility, enablement, contextual congruence, accessibility and flexibility, and respect for diversity. Autonomy/choice refers to the right of clients to make decisions about occupational therapy service that will or will not effectively meet their needs, provided that they have received information in an

easy to understand format. Partnership and responsibility refers to the change in power that needs to take place in a client-centred practice. In the traditional medical model, the professional is the expert and takes the lead in identifying client problems and prescribing methods to resolve those problems. In a client-centred practice, the client takes a more active role in defining problems and deciding on appropriate solutions. The concept of enablement refers primarily to the role of the therapist in working with clients to achieve occupational goals that they have set for themselves. The therapist serves as a facilitator of the process, helping clients to find the means to achieve their own goals.

Contextual congruence emphasizes the need to consider the context in which clients live and the importance of clients' roles, interests, environments, and cultures. A client-centred practice is also flexible in its approach, allowing for individual differences, and is easily accessible to clients. Finally, therapists practising in a client-centred manner demonstrate a respect for the diversity of values that clients hold and do not impose their own values on clients.

More recently, the CAOT (1997) published the following definition of client-centred practice which further clarified the term client and described what an occupational therapist does when using this approach to practice:

Collaborative and partnership approaches used in enabling occupation with clients who may be individuals, groups, agencies, governments, corporations, or others; client-centred occupational therapists demonstrate respect for clients, involve clients in decision-making, advocate with and for clients' needs, and otherwise recognize clients' experience and knowledge. (p.180)

A similar definition was developed by Sumsion (1999) in the United

Kingdom using the reactive Delphi technique. In this technique, subjects are given a list of items from the literature and asked to react to it rather than generating ideas in response to an open-ended question. Four rounds of questionnaires were used with a total of 64 participants and resulted in the following draft definition:

Client-centred occupational therapy is a partnership between the therapist and the client. The client's occupational goals are given priority and are at the centre of assessment and treatment. The therapist listens to and respects the client's standards and adapts the intervention to meet the client's needs. The client participates actively in negotiating goals for intervention and is empowered to make decisions through training and education. The therapist and the client work together to address the issues presented by a variety of environments to enable the client to fulfill his or her role expectations. (p.56)

Subsequently, Sumsion conducted focus groups to further refine and develop this definition which was then reviewed by members of the council of the College of Occupational Therapists as a validating group. This resulted in the following final definition:

Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals, which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's needs and enables the client to make informed decisions. (Sumsion, 2000, p. 308)

The introduction of the term client-centred in occupational practice has been considered very successful (Gage & Polatajko, 1995). It has been broadly adopted by the profession and is now in everyday use. However, several authors have questioned whether occupational therapists have truly been able to

integrate this approach into their everyday practice. Sumsion (1993), who was the Chair of the original CAOT task force on the guidelines for client-centred practice, stated that although it was clear that most Canadian occupational therapists were aware of the model, she had concerns that many did not clearly understand its implications for practice. She wondered if therapists were truly involving clients throughout the process as the primary decision maker. She also recognized that it takes a lot more skill to facilitate clients' identification of their problems than it does for the professional to simply make that decision for them.

2.3.3.2 Barriers to Client-Centred Care

Despite the development of a series of professional practice guidelines, which were intended to provide occupational therapists with a framework of client-centred practice, interpretation of what being client-centred means, as well as its impact on the profession and its clinical practices, has been diverse and varied. When asked to describe client-centred practice, clinicians responses ranged from considering clients needs when making treatment decisions, to having clients direct the care planning process (Gage & Polatajko, 1995). In fact, at a presentation at an Ontario Society of Occupational Therapists' conference, Law (1993) told her audience that if clinicians say they're client-centred, they're probably not.

Why are occupational therapists having such difficulty implementing these guidelines? Several researchers have explored this question over the

past few years. The identified barriers include discomfort with the shift in power in the therapeutic relationship and therapist and client having different goals (Law et al., 1995; Sumsion & Smyth, 2000); a lack of time (Daly, 1993); clients who are unwilling or unable to make decisions and exercise power and therapists who have difficulty separating professional and personal values (Law et al., 1995); concerns that the client-centred approach is too demanding for clients and that a person with no relevant health training will choose unsafe or inappropriate goals (Gage, 1994); and a working environment that continues to value a traditional biomedical approach to delivering services (Gage & Polatajko, 1995). Falardeau and Durand (2002) suggest that the problem lies in the issue of who holds the power in the client-professional relationship. They outlined two types of client-centred approaches (Type I which is led by the client and Type II which is led by the interaction). They proposed that the term “negotiation-centred” be used to describe the approach led by interaction to reflect the sharing of power which occurs during the counselling relationship.

2.3.4 Pharmacy

According to Droege (2003), similar to the other health professions, the focus in the pharmacy profession has shifted towards a more patient-centred approach. The traditional role of the pharmacist was one of drug distribution and medication dispensing (Hermansen & Wiederholt, 2001). However, with the increased prevalence of drug-related problems and the recognition by pharmacists of the need to make drug-therapy safer and more effective for

clients, this role has been expanded to include more of an emphasis on developing relationships with clients and helping them solve existing and potential drug problems (Chewning & Sleath, 1996). This patient-centred approach to pharmacy practice is often referred to as 'pharmaceutical care' in the literature.

Pharmaceutical care has been defined as "...the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve the patient's quality of life" (Rossing, Hansen & Krass, 2003, p. 311). Pharmacists using this approach would be more involved with their clients/patients in making sure that the prescribed drug therapies are appropriate, effective, safe and convenient (Droege, 2003). The emphasis in pharmaceutical care appears to be on the role of the pharmacist in identifying medication problems and setting goals to address those problems. The role of the client or patient in this approach seems to be that of information provider. Thus, despite the assertion that it is 'patient-centred,' there appears to be little need for the client to be actively involved in their care.

2.3.5 Dietetics

Unlike the occupational therapy profession, the dietetics profession in Canada has spent little time discussing the meaning or the implications of the implementation of a client-centred approach to nutrition counselling practice, at least in the professional literature. An article by article review of the *Journal of the Canadian Dietetic Association* and the *Canadian Journal of Dietetic Practice*

and Research (1970-2000) revealed that although dietitians have spent some time talking about counselling and the importance of integrating psychological theory (primarily behavioural) into counselling practice, we have spent almost no time exploring the actual process of counselling from the perspective of the practising dietitian or our clients.

In the early 1970s, the focus of discussion was on what Cinnamon (1970) described as “one of the major medical trends of our times....the shifting emphasis from the curative approach in healthcare to emphasis on both preventive and curative aspects” (p. 179). The role of the dietitian was seen to be key in the promotion of health and an understanding of the relationship between diet and behaviour (called psychodietetics) critical to the successful implementation of diet therapy. Although it was recommended that each patient (most articles focussed on the role of the hospital dietitian) be considered on an individual basis, a client-centred approach, as originally proposed by Rogers, was clearly not being espoused. The focus tended to be on dietitians gaining an understanding of the various cultural, environmental, and social determinants of behaviour so that they could set appropriate goals for patients and prescribe the proper diet (Cinnamon, 1970; Hastings, 1973). At that time, the general population was not considered to be overly concerned about their health and dietitians were cautioned not to assume that “man is a rational animal” (Cinnamon, 1970, p.181). The latter assumption, in particular, appears to be in direct conflict with Roger’s belief in individuals as being capable of defining their own problems and developing their own solutions to those problems. Cinnamon

seems to be suggesting that humans cannot be trusted to change behaviours to improve their own health.

In 1979, Smiciklas-Wright and Krongl, although still recommending an individual approach to diet counselling, discussed the importance of patients' taking responsibility for their own behaviour changes. They noted that the implementation of behaviour modification theory, which is based on the premise that behaviours which result in reinforcing consequences will likely recur and those which fail to elicit reinforcing consequences will be less likely to recur, into counselling practice had produced inconsistent and disappointing results. They suggested that many health professionals were "too heavily anchored in the so called medical model which fosters dependency in a patient" (p.101). These authors recommended what they called a behaviourally based, problem-solving approach to nutrition counselling in which a dietitian helps patients to decide where dietary changes are possible and set realistic goals to achieve these changes. They referred to the dietitian counsellor as a consultant and promoted a more active role for the patient in the counselling relationship. Thus in this article we see the seeds of a more client-centred approach to practice as proposed by Rogers.

In 1985, the Professional Standards Council of the Canadian Dietetic Association developed the first Standards of Practice for dietitians in Canada (Watson-Jarvis & Murphy, 1985). At that time, the emphasis was on the dietitian as a manager of nutrition care. Nutrition care was defined as,

The process of helping people meet their nutritional needs in health or disease at various stages of the life cycle. Participants may be in food service systems management, in teaching principles of food and nutrition, in helping individuals and groups select and obtain food, in research that expands knowledge of food and nutrition, and in dietary counselling. (p.283)

Unfortunately, nowhere in this article do the authors discuss how to implement nutrition care.

In the 1980s, Schwartz, Bell, and Webber (1987) reported on a survey of outpatient diet counselling services in a British Columbia hospital. However, the researchers' interests lay in what services were being offered rather than how services were being offered or whether or not the services were effective. Brauer, Imes, and Thomson (1988) did a cost-benefit analysis of individualized nutrition counselling in a group of non-hospitalized subjects with Crohn's disease. A total of 59 subjects received counselling about once per month for six months while 66 subjects received no counselling. The aim of the counselling sessions was to normalize each subjects' nutritional status as indicated by diet records, anthropometric measurements, and laboratory data. Advice regarding food intake was given and teaching materials consisted of a one-page tear sheet of Canada's Food Guide. They concluded that the nutritional status of patients was improved as a result of the nutrition counselling and estimated a net savings to society of \$164 per person. This was determined by first estimating the costs of counselling in clinical practice (based on the number of counselling sessions, educational materials used, lab costs, and other possible costs including paper, office space, and telephone

expenses). This amount (\$355.00 per person) was subtracted from the difference in the total estimated costs associated with decreased drug use, a reduction in the number of days spent in the hospital, and days away from work between the group that received counselling and the group that did not (\$518.48). Although it would appear that the counselling approach used in this study was very directive, there was insufficient information in the report to form any such conclusions.

Schwartz (1988), recognizing a lack of information regarding client satisfaction with nutrition counselling, undertook a study to develop a tool to measure client satisfaction with ambulatory nutritional care. Unfortunately, the pilot testing of the instrument revealed that it needed additional work and no additional reports in the literature have appeared regarding the development or use of this tool.

In 1991, "A Conceptual Framework for Dietetics" was published in the *Journal of the Canadian Dietetic Association (JCDA)* (Beaudry, Lilley, & Aucoin-Larade, 1991). The model emphasizes the importance of understanding the various factors affecting food availability, food consumption, and the biological utilization of food. However, there is no discussion about how to translate this knowledge into practice. Because this model was developed to serve as the basis for the development of national standards for dietetic education and practice, perhaps it was the authors intent that this would be outlined in those standards.

In the 1990s, four articles were published in the *JCDA* related to nutrition

counselling. Murphy, Cameron, Garber, Conway, and Denomme (1992) undertook a study to determine the effectiveness of diet counselling or diet counselling plus supplements in improving the nutritional status of patients infected with human immunodeficiency virus (HIV). They concluded that diet counselling alone was just as effective, and more cost efficient, as diet counselling plus supplementation. There was no discussion regarding the approach to counselling that was used.

Wile and McIntyre (1992) also looked at the effectiveness of counselling, this time in an overweight, pediatric population. They concluded that the counselling program was ineffective in promoting weight loss. The counselling program consisted of three visits. During the first visit the dietitian conducted a nutrition assessment, discussed program goals, and provided the client with food and activity forms to complete at home. During the second visit, the dietitian reviewed the food and activity forms and gave appropriate meal plan instruction. Finally, during the third and usually last visit, weight and height were monitored, and any problems related to the meal plan were discussed. It is not clear from these authors' discussion what the role of the client (and presumably his/her parent/guardian) was in this process. However, they did comment on the high rate of attrition (51%) in the program and stated that, "little attention has been focussed on program-centred variables as possible predictors of attrition" (p. 169). They also commented that the weight-control program was not developed using the most current principles of nutrition education theory, but was designed according to current standards of nutrition practice. As previously

discussed, the emphasis in the 1985 Standards of Practice was on the role of the dietitian in managing nutrition care and little, if any, guidance was given regarding the process of nutrition counselling.

The first mention of the term client-centred care occurred in an abstract published by Hawirko, Dickie, and Wong (1994) in the *JCDA*. In that abstract, the authors discuss the expansion of the nutrition focus of the Healthiest Babies Possible (HBP) program in British Columbia to provide more “holistic client-centred services.” The authors note that “putting the client first often means changing departmental policies” (p.19). Educational strategies designed to “balance client’s priorities with our HBP agenda of preventing low birthweight” (p.19) were being used. Again, we see pieces of what Carl Rogers would have referred to as a client-centred approach in this description. Certainly the idea of putting the client first would be considered important; however, the idea of balancing priorities rather than allowing the client to set her own priorities is contradictory. The struggle to practise using a client-centred approach within the medical system is also evident here.

In 1996 the Standards of Practice were revised through a collaborative effort of Dietitians of Canada, the College of Dietitians of Ontario, and the nine provincial associations. The manual of Professional Standards for Dietitians in Canada was published in 1997; in this document the client-centred approach to dietetic practice is first discussed. (Note: this manual was reviewed but not revised in 2000). As outlined in this manual, the revised Professional Standards were based on six broad characteristics of what is meant by ‘being a

professional' and were intended to guide the daily practice of each and every dietitian, regardless of the focus of their work (i.e., administration, clinical, community, industry, public health, private practice). In determining these professional characteristics, publications from numerous professional associations (including those from occupational therapy) were reviewed. They include:

1. Professionals provide a service to the public.
2. Professionals base their practice on a unique body of knowledge.
3. Professionals competently apply knowledge.
4. Professionals maintain competence in their area of practice.
5. Professionals adhere to a code of ethics.
6. Professionals are responsible and accountable to the public for their own actions. (Dietitians of Canada, 2000, p.2)

In developing these standards, the national steering committee sought input from dietitians in a variety of practice settings and members of the public in each province. As outlined in the introduction, this committee did provide a definition of a client-centred approach; however it appears that this definition was adapted from the one developed by Law et al. (1995). Unfortunately, the content of those discussions (i.e., specifically what input was sought) is not included in the manual, nor has there been any discussion in the *Journal of the Canadian Dietetic Association* (now the *Canadian Journal of Dietetic Practice and Research*) regarding this process.

Given the paucity of information related to the practice of nutrition

counselling in the Canadian dietetics literature, I expanded the search to include articles published in the *Journal of the American Dietetic Association* (JADA) over the past thirty years. Although there were many more articles to be found on the topic, a review of those articles revealed a similar trend in thinking about nutrition counselling. There was an emphasis, particularly throughout the 1970s and early 1980s, on the need for dietitians to develop nutrition counselling skills, particularly during their undergraduate and internship education and training (Andrew, 1975; Biltz & Derelian, 1978; Danish, Ginsberg, Terrell, Hammond & Adams, 1979; Ling, 1975; McKnight & Illich, 1976; Ohlson, 1973; Pace, Russell, Probstfield, & Insull, 1984; Snetselaar et al., 1981; Zifferblatt & Wilbur, 1977). Although some evidence occurred of a belief in the need to be client-centred, the emphasis tended to be on the importance of dietitians taking responsibility for the nutritional care of their clients rather than acting as a facilitator in the nutrition counselling process. For example, Kocher (1972) describes the process of nutritional care in the following way:

Through interviews, dietary histories, questionnaires, study of the patient's chart, and conferences with other team members, we assess the patient's dietary practices in the context of his total environment. We make a plan based on this assessment and the physicians orders and correlate it with other care. We decide who will carry out all phases of this plan - the technician, the aide, the dietitian-nutritionist - and, where appropriate, recommend the role of other health professionals. We develop feedback mechanisms to evaluate the patients progress. At this time we may decide to revise our plan, reinforce it with additional counselling or involve another agency in our plan of care. (p. 18)

It is interesting to note that the "we" in the preceding excerpt refers to the professional "we" and the absence of the client in the list of those who will carry

out “our” plan.

Throughout the 1980s and into the 1990s, the focus of discussion seemed to be on learning various techniques to improve patient compliance with dietary prescriptions (Cotugna & Vickery, 1989; Gilboy, 1994; Hauenstein, Schiller, & Hurley, 1987; Lewis, Hay, & Fox, 1987). The importance of understanding the psychological aspects of nutrition counselling was also discussed (Isselmann, Deubner, & Hartman, 1993; Stuart & Simko, 1991; Warpeha & Harris, 1993). However, the emphasis appeared to be on learning techniques to quickly and efficiently evaluate “any aspects of the client’s lifestyle that will affect his or her ability to adhere to the dietary recommendations...” (Stuart & Simko, 1991, p. 39).

It was not until 1994 that an article could be found that attempted to look at the client’s perception of nutrition counselling. Three Canadians, Hauchecorne, Barr, and Sork (1994), developed and pilot tested an instrument that was designed to measure respondents’ perceptions about the effectiveness or value of nutrition counselling, assess whether dietary changes occurred after counselling and the perceived benefits of any such changes, and to reveal any unintended effects of counselling. The purpose of Hauchecorne and colleagues research was not to actually evaluate the perceptions of patients about the benefits of nutrition counselling; however it was an important step forward in terms of including the client’s voice in the evaluation of nutritional care.

In 1998, Schiller and colleagues used a modified version of Hauchecorne and colleagues’ tool to assess the outcomes of patient nutrition counselling.

They interviewed a total of 400 people, 274 (69%) who were counselled as inpatients and 126 (31%) who were counselled as outpatients. Most participants (88%) thought that the advice given to them by the dietitian was suited to their needs and that they knew what to eat after the counselling session (83%). However, nearly 40% said that they had difficulty following the prescribed diet. The main reason cited was the high cost of the foods needed. Although the authors mention the client-centred approach to counselling in their introduction, they fail to explain whether or not the participants in their study had been counselled by dietitians using this approach. The fact that almost half of the participants stated that they had difficulty following the prescribed diet due to the high cost of the foods needed is an indication that these clients were told what they needed to eat - a dietitian-centred approach.

Trudeau and Dube (1995), also Canadians, were also interested in the assessment of diet counselling from the clients' perspective. They surveyed 49 patients who consumed a therapeutic diet and who received diet counselling during their hospital stay to determine their overall satisfaction, compliance intentions, and satisfaction with four components of diet counselling (dietitian's knowledge of the patient's condition, the dietitians cognitive and affective communication skills, and the dietitian's facilitation skills). Results indicated that, from the perspective of the patients, facilitation skills and knowledge were the most important components of diet counselling. The facilitation skills considered important included involving the patient as an active partner in the counselling process, often considered a critical component of the client-centred approach.

Some evidence has appeared in recent years of a recognition of the importance of changing the way dietitians think about the process of nutrition counselling. Kiy (1998) in an article in *Topics in Clinical Nutrition*, described nutrition therapy as an “emerging speciality with the field of dietetics” (p.51). According to Kiy, “nutrition therapy is client-centred and combines the philosophy and practice of dietetics, mental health counselling and education” (p.51). She states that the relationship that develops between client and clinician is therapeutic in and of itself and is more important than any nutrition intervention needed by the client and provided by the nutrition therapist. This relationship is certainly very similar to what Rogers refers to as a “growth promoting climate.” Kiy also discusses the role of the client in the learning process and states that clients learn best when they are able to build on their interests, concerns, and experiences rather than being told what to do by the therapist. According to Kiy, “Education is a mutual experience in which both persons in the relationship give and receive, act and undergo, teach and learn” (p.56). These ideas are similar to the concepts of partnership and responsibility proposed by Law and coworkers (1995) for the practice of client-centred occupational therapy.

Kiy (1998) concludes that the philosophy that she outlines in her article will “assist dietitians in making the switch from a focus on teaching and the subject to a focus on learning and the client” (p.51). However, she fails to make any concrete suggestions as to how dietitians might be able to incorporate these ideas into their everyday practice.

It would appear from this brief review that dietitians have been struggling over the past thirty years to define their role as nutrition counsellors and to develop the necessary skills to be effective in that role. In Canada, dietitians have made a commitment as a profession to practise using a client-centred approach - but it is far from clear what that means to us as practitioners or to our clients.

2.4 Overview of Research Methods

This research study was designed to explore dietitians' understanding of nutrition counselling, specifically looking at the meaning that they ascribe to the client-centred approach. It was conducted in two phases. In the first phase, a two-round reactive Delphi survey was used to identify the important concepts and issues related to the client-centred approach to nutrition counselling as perceived by dietitians. Originally, in the second phase of the study I had planned to explore the experience of nutrition counselling from the perspective of the client. I was then going to compare what dietitians said they were doing with what the clients said they were doing to see if those experiences were congruent or incongruent with the dietitians' views of a client-centred approach. However, after one round of the Delphi survey it was clear to me that there were several issues that needed to be explored in greater depth than was possible with a mailed survey questionnaire. The decision was made at that time to drop the client interviews and focus in on the dietitians' understanding of the counselling process, specifically in relation to the client-centred approach.

Thus, the second phase of the study involved indepth qualitative interviews with a subsample of the Delphi participants.

The following two sections will provide an overview of the methods chosen to conduct the research and outline the reasons why these methods were appropriate for this study.

2.4.1 The Delphi Technique

The Delphi technique, named after Apollo's Delphic oracle, was developed by the Rand Corporation in the US in the early 1950s for a study of the likely targets and impact of a Russian bombing campaign. The method was developed because accurate information was unavailable or too expensive to obtain in an area where, in any case, subjective evaluation would also be required (Ellis, 1988).

The Delphi technique is a method for the systematic collection and aggregation of informed judgements from a group of experts on specific questions or issues (Reid, 1988). It involves a series of structured questionnaires (commonly referred to as rounds) which are completed anonymously by these experts (sometimes referred to as the panellists, participants, respondents). As originally conceived, the Delphi technique is, therefore, an iterative multistage process designed to combine opinion into group consensus (McKenna, 1994).

According to Linstone and Turoff (1975), the main reasons why a researcher would choose the Delphi technique are:

1. The research problem does not lend itself to precise analytical techniques but can benefit from subjective judgements on a collective basis.
2. The research population may present diverse backgrounds with respect to experience or expertise.
3. More subjects are needed than can effectively interact in a face-to-face exchange.
4. Time, cost, and logistics would make frequent meetings of all the subjects unfeasible.

Reid (1988) emphasized that the decision by any researcher to use the Delphi method centres around the available alternatives. A cross-sectional mail survey would give a range of opinions and judgements on the various components of client-centred nutrition counselling considered important by the respondents. However, this technique does not make any attempt to obtain consensus. A series of focus groups would also provide the data required; however, focus group members can be intimidated or inhibited from expressing their views when stronger individuals dominate the group. This disadvantage is compounded by the hierarchical structure of the health professions, when more junior practitioners may be reluctant to challenge the opinions of their superiors (Williams & Webb, 1994).

Since its inception, the approach has been adopted by researchers in many disciplines, including education and health, and many different forms have been developed. These include the 'policy Delphi' (Crisp, Pelletier, Duffield,

Adams & Nagy, 1997), the 'historic Delphi' (Ellis, 1988), the 'real-time Delphi' (Beretta, 1996; Linstone & Turoff, 1975) and the 'reactive Delphi' (Sumsion, 1999). The goal of the policy Delphi is to define a range of answers or alternatives to a current or anticipated policy problem. Unlike the conventional Delphi, generating consensus is not the prime objective of the policy Delphi. In fact, in some cases, the researcher may even request a design which inhibits consensus formulation (Turoff, 1975). The historic Delphi is designed to explain the range of issues that fostered a specific decision or to identify the range of possible alternatives that could have been posited against a certain past decision. The 'real-time' Delphi allows the researcher to eliminate the delay caused in summarizing each round of the Delphi through the use of a computer which has been programmed to carry out the compilation of the group results. This method turns the process into a 'real-time' communication system but also means that the characteristics of the communication need to be well defined before the Delphi is undertaken (Linstone & Turoff, 1975). With a 'reactive' Delphi, panellists are asked to react to a set list of statements derived from the literature rather than being asked to respond to one or more open ended questions (Sumsion, 1999).

The advantages of the Delphi technique are widely recognised. The method is flexible in that it allows considerable diversity in its application while providing for the development of consensus of expert opinions without the bias which can readily occur with comparable techniques (e.g. group discussions) (Williams & Webb, 1994). It preserves anonymity which is seen to prevent

individuals from being unduly influenced by strong personalities (Procter & Hunt, 1994). This is of particular benefit in the context of the caring professions due to their hierarchical structures and consequent tendency towards authoritarianism. It can be very inhibiting for a junior practitioner to challenge the professional view of a senior in the presence of others (Ellis, 1988). The Delphi technique is thought to encourage honest opinion which is free from peer group pressure and allow for second thoughts in privacy (Sumsion, 1998). These opinions can be retracted, altered, or added to, based on the opinions of the entire group without being influenced by stronger, more vocal, group members (Whitman, 1990). The method also formally separates the formulation of ideas from the evaluation of those ideas thus helping to ensure that ideas are not evaluated before multiple options are considered (Whitman, 1990). Taking into account the practical considerations, the Delphi technique allows the involvement of more people than can effectively interact face-to-face and reduces the cost of bringing people together (Procter & Hunt, 1994; Sumsion, 1998; Williams & Webb, 1994). According to McKenna (1994), participating in a Delphi survey can also be a highly motivating experience for participants. The feedback mechanism, where relevant material is returned to the panel members, can be a novel and interesting exercise for all concerned.

There are, however, criticisms of the Delphi technique, many relating to the claim of scientific responsibility that is often made for the method. Linstone and Turoff (1975) assert that the Delphi is more of an art than a science. Depending on how it is used and how the data are analysed, the Delphi

technique can be considered both as a quantitative or a qualitative approach.

Thus, it is subject to criticisms from researchers from both paradigms.

The Delphi technique, in its original and modified forms, has often been criticized for its lack of methodological rigour related to sample size and reliability (Reid, 1988; Sumsion, 1998; Williams & Webb, 1994), its lack of accountability which occurs due to the anonymity of responses which can lead to hasty ill-considered judgements (Goodman, 1987), and the poor response rate that characterizes the final rounds of most Delphi investigations (McKenna, 1994). There seems to be no agreement regarding the size of the panel or any recommendations concerning sampling techniques. The range of panel size seems to vary arbitrarily according to the researcher (Williams & Webb, 1994).

Researchers have also expressed concerns regarding the use of experts and how to identify adequately a professional as an expert (Hasson, Keeney & McKenna, 2000; McKenna, 1994; Sumsion, 1998). Few studies specify the criteria on which they select the experts for their panels (Williams & Webb, 1994). There is also a lack of clarity in the literature regarding the issue of consensus and how that is defined. Sumsion (1998) states that without clearly established consensus criteria, established prior to the implementation of the survey, there is the potential for researcher bias. As is the case with all survey questionnaires, the researcher will influence considerably the type of consensus that emerges in the way in which the questionnaire material is designed.

In terms of the qualitative aspects of the Delphi technique, Procter and Hunt (1994) expressed the concern that researchers may be faced with a large

and unwieldy amount of information if they are reluctant to collapse categories. The Delphi technique is also considered very labour intensive and can be time consuming depending on the number of rounds required to reach consensus.

Proponents of the method argue that many of these limitations can be addressed through careful planning (Sumsion, 1998; Williams & Webb, 1994) and that, despite the lack of standardized procedures, solutions produced by the Delphi have a high degree of acceptability to participants, probably because of their involvement in the decision making process (Pill, 1971). Response rates can be improved through the use of personalized cover letters, hand signed by the researcher, and the inclusion of return postage paid envelopes (Boberg & Morris-Khoo, 1992). It is also helpful if the researcher knows the panel members and non-responders are pursued with follow-up letters or calls (Sumsion, 1998). Clear criteria must be established for determining how the responses to each round will be tabulated and consensus should be defined at the outset of the enquiry (Dajani, Sincoff & Talley, 1979; Sumsion, 1998; Williams & Webb, 1994). A definition of the term expert must also be established.

A decision regarding how the qualitative responses to open-ended questions are to be analysed must also be made prior to the first round of the survey. The researcher must balance the need to condense the data to make it more manageable with the need to maintain the validity of the data by using the respondents' own words (Boberg & Morris-Khoo, 1992).

The Delphi technique has been used by the dietetic profession to forecast

future roles of administrative dietitians (Matthews, Mahaffey, Lerner, & Bunch, 1975), to explore the future of public health and the implications for public health nutritionists (Berenbaum, 1994) and to determine the body of knowledge required by doctoral students in nutrition education (Ferrer-Mansoori, 1995). However, it has not been used to determine standards of practice. Given the assumption that dietitians have differing opinions on what makes a nutrition counselling session client-centred, it was deemed appropriate to use the Delphi technique in the first phase of the proposed research in an attempt to gain an understanding of the important concepts and issues inherent in this counselling approach.

2.4.2 Phenomenology

Phenomenology, an approach to qualitative research, has its roots in the philosophical perspectives of the German philosopher Edmund Husserl (1859-1938). Husserl was critical of the positivist focus on an observed external reality but was unsatisfied with the mentalist view that there is no material reality. Thus, he sought to develop a rigorous descriptive science of consciousness, in which consciousness is always 'consciousness of' something (a phenomenon) and developed a method of inquiry for this purpose (Baker, Wuest & Stern, 1992; Koch, 1995). This method involved two basic concepts: phenomenological reduction and epoche. Phenomenological reduction involves breaking down a complex problem into its basic components by eliminating the researcher's prejudices about the world. Husserl defined phenomenological epoche as the

suspension of commonly held beliefs about the world (Walters, 1995). Being a mathematician, Husserl also described this process as 'bracketing' - modelled on the mathematical strategy of placing the part of the mathematical equation that is to be treated differently from the rest of the equation in brackets.

Husserl's work was carried on by Martin Heidegger who took the phenomenological approach in a new direction. In contrast to Husserl, who focussed on the description of an individual's lived experience in isolation from the person's world, Heidegger's hermeneutic phenomenology is based on an existential perspective which considers that an understanding of a person cannot occur in isolation from that person's world (Walters, 1995). Others have also taken Husserl's ideas and developed and adapted them, with the result that there are now many forms of phenomenology: reflective/transcendental phenomenology, dialogical phenomenology, empirical phenomenology, existential phenomenology, hermeneutic phenomenology, social phenomenology, and psychological phenomenology, to name a few (Creswell, 1998).

Although there are fundamental differences among the various forms of phenomenology, the ultimate purpose of phenomenological research is to discover the essence or central underlying meaning of the phenomenon under study. According to van Manen (1997), "phenomenology is the systematic attempt to uncover and describe the structure, the internal meaning of structures, of lived experience" (p. 10). He also suggests that phenomenology "offers us the possibility of plausible insights that bring us in more direct contact with the

world” (van Manen, 1997, p. 9). He described phenomenological research as “the study of lived experience, the explication of phenomena as they present themselves to consciousness, the study of essences, the description of the experiential meanings we live as we live them, the attentive practice of thoughtfulness, a search for what it is to be human, and a poetizing activity” (p. 19). The hallmark of phenomenology is the intense reflection on the phenomenon under study to determine the “nature of the things themselves” (Caelli, 2000, p. 375).

The process of phenomenological research is one of questioning. It requires substantial reflection, readiness, openness and immersion on the part of the researcher to arrive at this essence (Morse & Field, 1995). To do a phenomenological study, van Manen (1984) stated,

The experience must be recalled in such a way that the essential aspects, the meaning structure of this experience as lived through, are brought back, as it were, and in such a way that we recognize this description as a possible human experience, which means as a possible interpretation of that experience. (p. 7)

The primary method of data collection in phenomenology is the in-depth interview that often takes the form of dialogues with oneself and one’s research participants (Moustakas, 1990). Interview questions are generally broad, open-ended and designed to avoid influencing the respondent’s answer. Sample sizes are typically small, ranging from five to fifteen participants, in keeping with the aim of illuminating the richness of individual experience (Baker et al., 1992). Because the participants need to be individuals who have experienced the phenomenon under study, sampling is purposive in nature.

Although several approaches to data analysis have been described in the literature, the steps are generally similar (Creswell, 1998). The first step is usually immersion in the data as a whole. In the case of taped interviews, this is achieved by listening to the tapes and by extensive reading and rereading of the transcripts (Morse & Field, 1995). The researcher then reflects on these data and looks for significant statements which are transformed into clusters of meanings or themes. This process is generally conducted for each participant individually (intraparticipant analysis) and then the researcher looks for commonalities among participants (interparticipant analysis). The third phase of data analysis involves seeking interrelationships between the themes and using quotations from the interviews to “provide a realistic and accurate portrayal of the phenomena for the reader” (Morse & Field, 1995, p 212). The final step is to describe the essence of the experience.

Creswell (1998), discussing the issue of establishing methodological rigour in phenomenology, outlined eight verification procedures which include prolonged engagement and persistent observation in the field, triangulation, peer review or peer debriefing, negative case analysis, clarifying researcher bias, member checks, thick description, and external audits. Creswell uses the term verification instead of validity to underscore that qualitative research is a distinct approach requiring its own quality criteria.

Although dietetic researchers have used qualitative methods, no studies could be found that specifically used a phenomenological approach. However, this approach has been used extensively by the nursing profession to study “the

elusive concepts that characterize nursing concerns in practice ..." (Oiler, 1986, p. 80). Caelli (2000) asserts that "the American approach [to phenomenology]has the ability to foster an understanding of many of the complex and perplexing conditions in which humans find themselves and thus address nursing's central concern, which is caring for people" (p. 374). Caelli describes this "American approach" as differing from the traditional European approach (based on Husserl and Heidegger's philosophies) primarily in regards to the emphasis on experience and the role of culture within each form. Traditional phenomenology focuses on "prereflective experience" and, as such, "requires that descriptions of experience be sought as it occurred before reflection" (Caelli, 2000, p. 369). In contrast, "a considerable amount of phenomenology in the American mode has demonstrated that the focus is on exploration and description of everyday experience itself" (Caelli, 2000, p. 369). In terms of the role of culture, traditional phenomenology seeks to "describe the universal or unchanging aspects of phenomena as free as possible from the cultural context" (Caelli, 2000, p. 371). In American phenomenological research, however, participants' experiences are explored within the context of their culture. According to Caelli (2000), "this position results from more recent philosophical thinking about the role of culture and the recognition that it is impossible for humans to think aculturally because our understandings of the world are constructed by the language and traditions of our heritage" (p. 371).

Because few studies have specifically explored the experience of nutrition counselling from the perspective of the dietitian and none has described the

meaning of a client-centred approach, it seemed appropriate to use indepth interviews informed by phenomenology for the second phase of this research.

Chapter 3

RESEARCH METHODS

3.1 Research Orientation

Quantitative and qualitative research methods are two distinct approaches to understanding and knowledge, each with its own set of beliefs, assumptions, and values. The quantitative approach is supported by the positivist or scientific paradigm, which leads to regard the world as made up of observable facts. Quantitative research studies strive to uncover causal explanations for observed and physical events (Achterberg, 1988; Chapman & MacLean, 1990). In contrast, a qualitative approach is supported by the interpretivist paradigm which portrays a world in which reality is socially constructed, complex, and everchanging (Glesne, 1999).

Qualitative researchers are interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experience they have in the world. "The key concern is understanding the phenomenon of interest from the participants' perspective, not the researchers" (Merriam, 1998, p. 6).

Most qualitative researchers recognize the virtue in using a variety of research approaches (Firestone, 1987; Glesne & Peshkin, 1992; Patton, 1990). As Glesne and Peshkin (1992) stated, "Different approaches allow us to know and understand different things about the world" (p. 9). Achterberg (1988) stated that distinctions between qualitative and quantitative data may not be as clear in practice as they are in theory. She cites food frequency data, which contains both quantitative and qualitative aspects, as an example.

In the first phase of this study, the Delphi technique was used to identify the important issues related to client-centred nutrition counselling from the perspective of dietitians. As previously mentioned, the Delphi technique can be considered both as a qualitative or a quantitative approach depending on how it is used and how the data are analyzed. In this study, a combination of both types of data were gathered. The quantitative data allowed the researcher to identify the range of opinions on a particular issue and to determine the stability of the responses. The qualitative data added depth to the quantitative data and allowed the participants to consider the thoughts and opinions of their peers in formulating their responses in subsequent questionnaires.

The second phase of the study used a qualitative approach, informed by phenomenology, to further explore the experience of nutrition counselling from the perspective of a small subsample of the Delphi participants. Specifically, indepth interviews, designed to uncover the meaning that clients give to the nutrition counselling process, were used.

3.2 The Researcher's Story

One of the major differences between the qualitative and quantitative approaches to research is the stance that a researcher must take during data collection and analysis. In quantitative research, the goal is to control the situation, thereby reducing the effect of researcher bias. In qualitative research using a phenomenological approach, the researcher is expected to openly acknowledge her opinions about the topic under study and bracket those subjective opinions while analysing and interpreting the data. Thus, the following section outlines the experiences, values, and beliefs that I bring to this research project.

I am a 50 year old Canadian dietitian, currently an Associate professor in the Department of Family and Nutritional Sciences at the University of Prince Edward Island (UPEI). I have been a dietitian since 1984 and practised in acute and long-term care prior to joining the faculty at UPEI. While actively practising, my major duties were administrative; however I did do some inpatient and outpatient counselling as well.

I always felt inadequate and unprepared as a counsellor. Initially, I thought that it was because I did not become a dietitian via the traditional route. I obtained a Masters degree in Nutrition and then worked for two years under a registered dietitian, which allowed me to apply for membership in the Canadian Dietetic Association. However, in talking with colleagues, I realized that I was not alone with my doubts. Most dietitians I talked to had only limited exposure to counselling theories in their undergraduate education. During internship, they

sat in on counselling sessions given by dietitians, and had several opportunities to practise while being observed during that time. However, they too felt unprepared to deal with the complex issues associated with food and eating that so many patients/clients brought to a counselling session. It was particularly frustrating to attempt to counsel patients as they were putting their coats on to leave the hospital and go home.

Over the years I went to a variety of workshops related to counselling - primarily designed to teach counselling skills and techniques to help us motivate our clients and improve dietary compliance (a word I have come to hate). I learned all the jargon (rapport building, selective reflection, client-centred care) but when I tried to apply what I had learned I was never very satisfied with the results. I always felt like something was missing.

Not until I starting teaching clinical nutrition at UPEI did I begin to realize what that something was: a deeper understanding of what that jargon meant. When you have to teach those concepts you need to truly understand them - and I realized that I did not. Even more disturbing, I realized that I had never really given any thought to what I was actually doing - how my values and beliefs affected my practice. Unfortunately, I am not alone. In talking to dietitian colleagues across the country, I have become increasingly disturbed by the fact that we often pay lip service to concepts like empowerment, rapport building, and client-centredness. We use these terms freely without giving much thought to what we actually mean by them.

This dissatisfaction came to a head while I was involved in the evaluation

of the PEI Prenatal Nutrition Intervention Program. As part of that study, we surveyed both the nutritionists who delivered the program and their clients. As expected, the nutritionists told us that they used a client-centred approach to practice and felt that they did a very good job of “tailoring their nutrition advice” to the needs of their clients. We heard a slightly different story from the clients. They told us that, although they were satisfied with the program, they felt frustrated when the nutritionists “told them to eat foods that they could not afford.” How can we say that we are using a client-centred approach when we are telling clients what to do? Perhaps, as nutrition professionals, we have different ideas of what this means?

Thus, I come to this study with some firmly held beliefs about professional practice. I believe that it is important to think about what we mean when we say that we are using a particular approach to practice. I believe that, as a profession, dietitians have not spent enough time exploring our values and beliefs and that we often pay lip service to our professional standards. Finally, I believe that we need to have a common understanding of our values and beliefs in order to guide future practice. It is my hope that this research will be one small step in this process.

3.3 Research Design

The research was conducted in two phases. In the first phase, I used a reactive Delphi technique to identify the important concepts and issues related to the client-centred approach to nutrition counselling as perceived by dietitians.

Two rounds of the Delphi were conducted. After a preliminary analysis of the data from the first round of the Delphi survey, it was clear that there were several issues that required a deeper level of exploration than could be achieved using a self-administered mail questionnaire. Thus, the second phase of the research was conducted using indepth interviews, influenced by phenmenology, with a subsample of the Delphi participants.

Ethical approval for this study was granted by the University of Saskatchewan Advisory Committee on Ethics and Behavioural Sciences Research and the University of Prince Edward Island Research Ethics Board.

3.4 Phase One - The Delphi Survey

3.4.1 Sampling

The sampling objective for this phase of the research was 50 dietitians.

The following criteria were used to select the sample:

- a registered dietitian and a member of Dietitians of Canada
- current role involves individualized nutrition counselling
- has indicated that he/she has advanced-level counselling skills

A search of the Dietitians of Canada member database identified a total of 330 dietitians who indicated they had advanced level counselling skills. A letter of invitation to participate in the Delphi survey was sent to all of these dietitians via email rather than just a random sample due to concerns about getting enough participants for the study. The researcher sought clarification from Dietitians of Canada to ensure that this was an appropriate use of the

member database and received permission for its use. The letter of invitation outlined the sampling criteria and informed potential participants about the study and what their involvement would entail, as recommended by Hasson, Keeney and McKenna (2000). These authors suggest that failure to prepare the sample could adversely affect response rate in ongoing rounds. Thus, potential participants were told exactly what they were being asked to do, how much time they were expected to contribute, that the results would be confidential, and how the information they provided would be used. The letter of invitation also explained that the sampling objective was 50 dietitians and that if greater than that number indicated an interest in participating then a random sample would be chosen.

3.4.2 Method

Given the large amount of data related to the client-centred approach to occupational therapy practice, and the assumption that the concepts inherent in this approach to practice identified by dietitians would be similar to those identified by occupational therapists, a reactive Delphi method was used for this phase of the research study. That is, the first questionnaire was developed using a list of possible components of client-centred practice obtained through a search of the literature, primarily that of the occupational therapy profession. It was recognized that this approach could bias the responses or limit the available options; however, response rates to open-ended questionnaires tend to be lower than those to structured questionnaires (Uhl, 1983). Further, it was

felt that a more open-ended approach would necessitate the use of a smaller sample and the identification of dietitians with expertise in client-centred nutrition counselling. Because no standardized screening form exists to identify such individuals, a more structured approach, with a larger group of dietitians, was used.

The first round questionnaire was divided into four sections (Appendix A). Part I invited the participants to state their opinion on the identified components of client-centred nutrition counselling, using a five-point Likert scale (1=Strongly disagree, 2=Partially disagree, 3=Neither disagree nor agree, 4=Partially agree, 5=Strongly agree). Part II asked the participants to respond to the same issues from the perspective of their actual work experience, again using a five-point Likert scale (1=Never, 2=Seldom, 3=Sometimes, 4=Usually, 5=Always). This second part was used to determine if the participants' beliefs were congruent with their practice. The order of the questions in Parts I and II were different so that participants were not led to answer the same question in the same way. As well, participants were invited to comment in the spaces provided after each subsection and to suggest other issues for discussion. Part III of the questionnaire invited participants to identify any components of client-centred nutrition counselling that they thought were missed, and Part IV was a request for demographic information including age range, educational background (university, internship and post-internship), practice area, and number of years of counselling experience. The questionnaire was pilot tested with 15 dietitians in Prince Edward Island with nutrition counselling experience who

were not included in the study database to ensure clarity of the instructions and questions and to determine the length of time required to fill out the questionnaire. Minor wording changes were made to the questionnaire based on this feedback.

In the second round of the survey, participants were sent a report of the results of the first round (Appendix B) and a copy of the second round questionnaire (Appendix C). The report listed each item in the first round of the survey with the median response, the interquartile range (IQR) and a summary of the qualitative comments underneath. The second round questionnaire included nine items from Part I of the first round questionnaire. These items were included either because there seemed to be a lack of consensus regarding the importance of the concept to client-centred practice or because participants' comments indicated a misunderstanding of the concept. The median, IQR, and the participant's first round response were included under each item. No items were included from Part II of the first round questionnaire (What is your experience?) because it was assumed that the participants' experiences would not have changed in such a short period of time. Participants were asked to review the group results and comments and to indicate the extent to which they agreed or disagreed with each component by circling the corresponding number on the 5-point Likert scale (described above). Participants were again invited to provide comments. In particular, participants whose first round response was more than one unit away from the median were asked to explain their answer.

In addition, four items were included in the second round based on

participants' suggestions in the "What's Missing?" section of the first questionnaire. These items addressed the issues of barriers and facilitators to using the client-centred approach to delivering nutrition counselling services, assessing the client's readiness for change, and the ability to do follow-up counselling.

Following analysis of the results of the second round survey, the stability of responses to each item was determined by calculating the percentage of participants who either did not change responses or who changed only 1 category between rounds. Because over 90% of participants met this criteria, it was decided to terminate the Delphi survey after two rounds. The participants were sent a copy of the summary report of the second round (Appendix D) and were thanked for their participation in the study.

3.4.3 Data Analysis

The quantitative results from the first round questionnaire were analysed using STATA 7 to determine the median responses and interquartile range for each item. The interquartile range, a measure of spread or dispersion, is the difference between the 75th percentile and the 25th percentile. The qualitative results were transcribed verbatim and initially analysed using content analysis to identify recurring themes. These results were then combined with the results from the indepth interviews and analysed using inductive thematic analysis, informed by the work of Miles and Huberman (1984), Seidman (1998), Morse and Richards (2002), and Thomas (2003), as described in section 3.5.3.

3.4.4 Verification of the Data

In terms of assessing the validity of the Delphi survey, Goodman (1987) has suggested that the use of participants who have knowledge of and an interest in the topic may help to increase the content validity of the Delphi and the use of successive rounds of the questionnaire helps to increase the concurrent validity. Face validity was assessed by pilot testing the questionnaires with a group of dietitians having similar characteristics to the proposed panellists. However, the validity of the results are ultimately affected by the response rates (Hasson et al., 2000). Several measures were used in attempt to ensure an acceptable response rate. The sample was adequately prepared for the study so that they knew what they are committing themselves to when they agreed to participate. Written instructions were included with each round of the survey, along with letters thanking the participants for completing the survey. Reminder letters were also used to enhance response rates. Potential participants were also told that if they chose to participate in the survey, they would receive a summary report of the study's findings. According to Eggers, Hubbard and Jones (1998), "If the individuals know that participation will result in the receipt of information that is considered professionally valuable, they may be more likely to devote time to a study that does more than benefit the researcher" (p. 64).

3.5 Phase Two - Indepth Interviews

3.5.1 Sampling

Participants in the second round of the Delphi survey were asked if they were interested in participating in a telephone interview to have an indepth discussion of some of the issues raised in the Delphi process. Twenty-seven of the second round Delphi participants indicated an interest in an interview. Of these, twenty-five were able to be contacted and interviewed.

3.5.2 Method

Indepth interviews, informed by phenomenology, were used for this phase of the research. It is recognized that there are many forms of phenomenology and that “different schools use different terminology and approaches to analysis” (Morse & Field, 1995, p. 154). For the purposes of this research, the psychological approach, which focuses on the meaning of individual experiences, was used. According to Creswell (1998), the central tenets of psychological phenomenology are:

To determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions, general or universal meanings are derived, in other words, the essences of structures of the experience. (p. 54)

Nine open-ended questions (Appendix E) were developed based on the qualitative comments from the Delphi participants and were used to guide the interview. They were pretested with a group of 4 dietitian colleagues at the University of Prince Edward Island to ensure clarity of the questions. The

interviews ranged from 30 minutes to two hours in length and were tape recorded with participants' permission.

3.5.3 Data Analysis

The interview tapes were transcribed verbatim for each subject. Inductive, thematic analysis, informed by the work of Miles and Huberman (1984), Seidman (1998), Morse and Richards (2002), and Thomas (2003) was used to analyse the data. To begin, each interview transcript was read in its entirety to allow me to become familiar with the content and gain a holistic understanding of what the participants were saying. Next, each interview transcript was examined individually, line-by-line, and coded using open coding. This resulted in an initial list of 93 themes. These themes were then grouped under broader theme areas (categories) using the interview questions as a guide. The excerpts from the interviews that corresponded to each of these categories were filed in computer files under the name of the assigned category. These separate files were then read individually to search for subtopics and new insights. Throughout this process, I wrote memos to help me step back from the data and make some sense of what the participants were telling me. Categories and themes began to emerge simultaneously with data analysis and writing.

As part of the data analysis process, I brought together a group of seven expert dietitian counsellors on PEI for a group discussion to help me understand what my participants had said and the implications of what that meant for

dietetic practice. I had spoken to this group prior to starting my research and knew that they were interested in the topic of client-centred nutrition counselling. These individuals were contacted via email and invited to participate in the discussion group. All seven agreed to come. I presented the preliminary results of my research to the group and invited their comments throughout. The feedback that I received from this discussion group assisted me in the analysis of my data.

3.5.4 Verification of the Data

There is an ongoing debate in the literature regarding the standards for assessing the quality of interpretive or qualitative research; however, Lincoln and Guba's (1985) criteria for examining the trustworthiness of a study remains the most quoted (Whittemore, Chase, & Mandle, 2001). Trustworthiness is a term that refers to the extent to which a qualitative study can be viewed as worthy of confidence and attention (Lincoln & Guba, 1985). The criteria for trustworthiness include credibility, transferability, dependability, and confirmability. Lincoln and Guba have refined and developed these standards over the years in response to this debate. In 1989, they added 'authenticity' criteria which include fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity (Guba & Lincoln, 1989). A qualitative study is said to be 'fair' if it includes the viewpoints of all stakeholders. Ontological and educative authenticity refer to the importance of sharing knowledge and raising awareness with the research while catalytic and

tactical authenticity point to the need to foster social action (Creswell, 1998). More recently, Lincoln (1995) identified what she referred to as 'emerging criteria' for judging quality in interpretive research. According to Creswell (1998) these emerging criteria are "...based on three new commitments: to emergent relations with respondents, to a set of stances, and to a vision of research that enables and promotes justice" (p. 195).

Although there appears to be no consensus in the literature regarding the 'best' way to judge the quality of qualitative research, Tobin and Begley (2004) have suggested that the most important aspect is for qualitative researchers to be clear about how and why they choose specific criteria. Thus, for this research I chose to use Lincoln and Guba's (1985) original criteria for trustworthiness (credibility, transferability, dependability, and confirmability) as described in the following paragraphs.

Credibility refers to whether or not a researcher has established confidence in the truth of the findings for the research participants and the context in which the study was undertaken (Lincoln & Guba, 1985). It is subject-oriented and not defined prior to the study by the researcher. The researcher's job is to represent the data so that people who have shared the experience under study would immediately recognize the descriptions (Krefting, 1991). Lincoln and Guba (1985) propose several strategies for ensuring credibility including prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, and member checking. In this study, credibility was established by peer debriefing and member

checking.

Peer debriefing provides the researcher with an external review of the research process (Creswell, 1998). According to Lincoln and Guba (1985), a peer debriefer acts as the 'devil's advocate' and helps the researcher to explore ".....aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (p. 308). In this study, colleagues at the University of Prince Edward Island who have expertise in qualitative methods and the researcher's faculty advisor at the University of Saskatchewan served as peer debriefers. Further, the analytic categories and preliminary interpretations of the data were presented to a group of dietitians on PEI with experience in nutrition counselling to fulfill this criterion.

Member checking is considered by Lincoln and Guba (1985) to be the most crucial technique for ensuring the credibility of one's findings. It is the process by which "the data, analytic categories, interpretations, and conclusions are tested with members of those stake holding groups from which the data were originally collected" (Lincoln & Guba, 1985, p. 314). To satisfy this criterion, transcripts of the interviews were sent to the participants for their feedback to ensure the accuracy of the content and to give them the opportunity to add or delete any part of the interview.

Transferability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Lincoln & Guba, 1985). It is a researcher's task to provide thick description of the data to make judgements about the transferability of the results (Krefting, 1991). The researcher has

provided a full description of the study design and methods and discussion of the results for the reader to judge transferability.

The third criterion of trustworthiness is dependability. According to Marshall and Rossman (1995), dependability is a process in which the “researcher attempts to account for changing conditions in the phenomenon of study, as well as, changes in the design created by an increasingly refined understanding of the setting” (p. 45). To address the issue of dependability, Krefting (1991) recommends that variability be trackable and traced to identified sources (eg. participant fatigue, increasing insight of the researcher, finding participants). The researcher needs to ensure that there is a clearly defined data trail that outlines the researcher’s decisions, choices and insights throughout the research process in order to meet this criteria. For this study, the researcher kept a personal journal and a methods log to track sources of variability in this study from both an objective and subjective standpoint.

Confirmability refers to the degree to which the findings are strictly a function of the research subjects and conditions of the research and not of other biases, motivations, and perspectives (Krefting, 1991). These criteria are addressed by prolonged contact with the research subjects or by using long periods of observation (Morse & Field, 1995). Guba (1981) described the audit strategy as the major technique for establishing confirmability. Six categories of records can be included in the audit: raw data (interview transcripts), data reduction and analysis products (quantitative summaries, condensed notes, working hypotheses), data reconstruction and synthesis products (thematic

categories, interpretations, inferences), process notes (procedures and design strategies, trustworthiness notes), materials related to intentions and dispositions(study proposal, field journal), and instrument development information (pilot forms, survey format, schedules) (Lincoln & Guba, 1985). To ensure the confirmability of this research, the researcher documented all stages of the process. A flowchart of the steps followed in the research process is included in Appendix F.

Chapter 4

DELPHI SURVEY OF DIETITIANS' OPINIONS AND EXPERIENCES OF CLIENT-CENTRED NUTRITION COUNSELLING

4.1 Introduction

This chapter outlines the results of the first phase of the research in which a two-round Delphi survey was conducted. The focus of this chapter is on the quantitative results from the Delphi survey. The qualitative results (participants' comments) will be discussed in Chapter Five in conjunction with the results of the indepth interviews that were conducted in the second phase of the research.

4.2 Round One

4.2.1 Sample Demographics

Of the 330 dietitians who met the sampling criteria, 65 agreed to participate in the study (20% response rate). Because the Delphi technique takes time and ongoing commitment, it was expected that there would be a small number of individuals who would be willing to participate. Thus, rather

than choose a random sample of the 330 eligible dietitians, the decision was made to send a letter of invitation to participate to the entire pool so that the sampling target of 50 dietitians would be achieved. Further, it was originally proposed that if more than 50 dietitians indicated an interest in participating a random sample of 50 would be chosen. However, it was decided that all those who indicated an interest in participating would be sent a survey questionnaire to allow for the anticipated loss of participants between rounds.

The first round survey was mailed out in January 2002. After three weeks, a follow-up letter and second questionnaire was sent to the dietitians who had not returned their surveys by that time. Fifty-seven of the 65 individuals returned useable surveys (88% response rate). Of the eight dietitians who did not return the first round survey, one decided not to participate due to an illness in the family, two indicated that they were too busy, and the others could not be contacted.

Table 4.1 shows the demographic characteristics of the participants in the first round of the survey. All were female with the majority (81%) being between 30 and 50 years of age. Most identified clinical (56%) or private (42%) as their main area of practice. Approximately half (51%) indicated that they had been in their current position for more than 10 years, while one-third (32%) had been in their current position for fewer than five years. The majority (79%) of participants had been practising dietetics for more than 10 years. Only 3 (5%) were relatively new to the dietetics profession with fewer than five years of experience.

Table 4.1. Demographic characteristics of Delphi survey participants

Demographic Characteristic	Round 1 (n=57)		Round 2 (n=48)	
Age (years)				
< 30	2	3.5%	2	4%
30 - 40	21	37%	18	37.5%
41 - 50	25	44%	20	42%
51 - 60	9	16%	8	17%
Dietetic practice area				
Community/public health ¹	12	21%	7	14.5%
Private practice	24	42%	21	44%
Long term care	2	3.5%	2	4%
Clinical practice	32	56%	27	56%
Other	8	14%	5	10%
Years in current position ²				
< 5	18	32%	18	37.5%
5 - 10	12	21%	11	23%
> 10	29	51%	21	44%
Years in dietetic practice				
< 5	3	5%	3	6%
5 - 10	9	16%	8	17%
>10	45	79%	37	77%

¹ Participants could check off more than one area of practice

² Two participants checked more than one category because they are currently in two different positions and have been in those positions for differing lengths of time

Participants were also asked about their training/education in nutrition counselling during their undergraduate education and dietetic internship and since they started practising dietetics. Over half of the participants (n=35; 61%) indicated that they had some training in nutrition counselling during their undergraduate education. As shown in Table 4.2, of this 61%, most described this training as consisting of either a whole course in nutrition counselling (n=14;

40%) or a topic in a nutrition undergraduate course (n=17; 48.6%). The majority of respondents classified this training as theoretical in nature (n=29; 82.8%). However, many also indicated that they had been able to observe a nutrition counselling session (n=19; 54.3%) or had the opportunity for hands-on practice (n=23; 65.7%). Four participants checked the 'other' category. One specified that this training involved a clinical placement at a local hospital as part of a course, one said that it was part of a communications course, one said that she had on-the-job training, and the fourth said that it was 'part of university.'

Table 4.2. Undergraduate training/education in nutrition counselling

Description of training ²	Participants ¹		% of Total Sample (n=57)
	n	%	
Whole course in nutrition counselling	14	40%	24.6%
A topic in a nutrition undergraduate course	17	48.6%	29.8%
Workshop on nutrition counselling	6	17.1%	10.5%
Other	4	11.4%	7.0%

¹ Thirty-five of the fifty-seven respondents indicated that they had training in nutrition counselling during their undergraduate education

² Respondents could check off more than one answer

Also shown in Table 4.2 is the percentage of the total sample who had some training/education in nutrition counselling during their undergraduate

education. Fewer than 25% of the total sample reported that they had a whole course in nutrition counselling at the undergraduate level and fewer than one-third (29.8%) had it as a topic in an undergraduate course.

The majority of participants (n=48; 84.2%) indicated that they had training in nutrition counselling during their dietetic internship.¹ As shown in Table 4.3, of this 84.2%, most identified that this training consisted of the observation of a nutrition counselling session (n=39; 81.5%) or hands-on practice (n=43; 89.6%). Three participants checked the 'other' category. One specified that this training/education involved the observation of other disciplines. The second said that she had a session with group work in the community, and the third said that she had a half day theory and applied seminar on nutrition counselling. In terms of the total sample, Table 4.3 also shows that most participants had either hands-on practice (75.4%) and/or the opportunity to observe a nutrition counselling session (68.4%).

¹ It is important to note here that there were some participants (n=9; 15.8%) who stated that they had no training/education in nutrition counselling during their dietetic internship.

Table 4.3. Training in nutrition counselling during dietetic internship

Description of training ²	Respondents ¹		% of Total Sample (n=57)
	n	%	
Workshop on nutrition counselling	11	22.9%	19.3%
Observation of a nutrition counselling session	39	81.5%	68.4%
Hands-on-practice	43	89.6%	75.4%
Other	3	6.3%	5.3%

¹ Forty-eight of the fifty-seven respondents indicated that they had training in nutrition counselling during their internship

² Respondents could check off more than one answer

The majority of participants (n=39;68.4%) had also taken additional training/education in nutrition counselling since they started practising dietetics. As indicated in Table 4.4, for most (n=30;76.9%), this training/education took the form of a nutrition workshop. However, some had taken more formal training, either through a graduate nutrition counselling course (n=5;12.8%) or distance education (n=4; 10.3%). Nine participants (23%) checked off the ‘other’ category for this question. When asked to specify what type of additional training/education in nutrition counselling this involved, participants had a variety of responses including graduate adult education courses, continuing education on the job, and self-directed learning. Table 4.4 also illustrates that almost one-third of the participants (n=18;31.6%) stated that they had not taken any additional training in nutrition counselling since they started practising dietetics.

Table 4.4. Training in nutrition counselling during practice

Description of training ²	Respondents ¹		% of Total Sample (n=57)
	n	%	
Graduate nutrition course	5	12.8%	8.8%
Workshop on nutrition counselling	30	76.9%	52.6%
Distance education nutrition course	4	10.3%	7.0%
Other	9	23.1%	15.7%

¹ Thirty-nine of the fifty-seven respondents indicated that they had additional training/education in nutrition counselling since they started practising dietetics

² Respondents could check off more than one answer

Participants were also asked if they had taken any additional training/education in counselling in a discipline other than nutrition and again, the majority (n=39;68%) indicated that they had. This additional training/education was taken in a variety of disciplines including psychology, education, adult education, public health, naturopathy, medicine and nursing.

4.2.2 Quantitative Results

4.2.2.1 Part One - Opinion

In the first part of the round-one survey questionnaire, participants were asked their opinion on possible components of client-centred nutrition counselling using a five-point Likert scale (1=Strongly disagree, 2=Partially disagree, 3=Neither disagree nor agree, 4=Partially agree, 5=Strongly agree).

As shown in Table 4.5 and indicated below, there was strong agreement (median = 5, IQR = 5-5) that dietitians 'should' include eight of the 18 items (1,2,4,5,6,7,11 and 17):

1. Provide nutrition services designed to meet the needs and wants of clients.
2. Act as facilitators to enable clients to achieve their nutrition-related goals.
4. Consider the context in which clients live in developing nutrition care plans.
5. Demonstrate respect for clients' opinions.
6. Work with clients to develop mutually agreed upon goals.
7. Build on the strengths and resources that clients bring to a nutrition counselling session.
11. Create an environment where clients feel accepted and understood.
17. Provide clients with enough information to make informed decisions.

A further eight items (8, 9, 10, 12, 13, 14, 15, 16) had a median response of either four or five with an interquartile range of 4-5 indicating slightly less agreement among participants regarding the importance of including these concepts in a client-centred approach to practice:

8. Tailor educational materials to the needs and wants of individual clients.
9. Allow their clients to identify their own nutrition-related issues.
10. Accept clients' decisions whether they agree with them or not.
12. Advocate on behalf of their clients.
13. Assess clients on an individual basis rather than use a set protocol for

nutritional assessment.

14. Allow clients to choose from a variety of strategies to help them change their eating behaviours.
15. Allow clients to develop their own nutrition behaviour change goals.
16. Involve clients in all stages of the nutrition care process as the primary decision maker.

Finally, two of the items (3, 18) had median responses of two or three (partially disagree or neither agree nor disagree) with broader interquartile ranges indicating a lack of agreement regarding their importance or relevance in a client-centred approach to practice. These items stated that the dietitian should:

3. Only provide clients with the information they want to have.
18. Recognize that clients are the experts when it comes to their own nutrition-related issues.

Table 4.5. Delphi survey round one quantitative results

Item	IQR		Median	
	Part I	Part II	Part I	Part II
1. Provide nutrition services designed to meet the needs and wants of clients.	5 - 5	4 - 5	5	4
2. Act as facilitators to enable clients to achieve their nutrition-related goals.	5 - 5	4 - 5	5	4
3. Only provide clients with the information they want to have.	2 - 4	2 - 4	2	3
4. Consider the context in which clients live in developing nutrition care plans.	5 - 5	4 - 5	5	5
5. Demonstrate respect for clients' opinions.	5 - 5	5 - 5	5	5
6. Work with clients to develop mutually agreed upon goals.	5 - 5	4 - 5	5	5
7. Build on the strengths and resources that clients bring to a nutrition counselling session.	5 - 5	4 - 5	5	5
8. Tailor educational materials to the needs and wants of individual clients.	4 - 5	4 - 5	5	4
9. Allow their clients to identify their own nutrition-related issues.	4 - 5	4 - 5	4	4
10. Accept clients' decisions, whether they agree with them or not.	4 - 5	4 - 5	5	4
11. Create an environment where clients feel accepted and understood.	5 - 5	4 - 5	5	5
12. Advocate on behalf of their clients.	4 - 5	3 - 5	5	4
13. Assess clients on an individual basis rather than use a set protocol for nutritional assessment.	4 - 5	4 - 5	4	4
14. Allow clients to choose from a variety of strategies to help them change their eating behaviours.	4 - 5	4 - 5	5	4
15. Allow clients to develop their own nutrition behaviour change goals.	4 - 5	4 - 5	5	4
16. Involve clients in all stages of the nutrition care process as the primary decision maker.	4 - 5	4 - 5	5	4
17. Provide clients with enough information to make informed decisions.	5 - 5	4 - 5	5	5
18. Recognize that clients are the experts when it comes to their own nutrition-related issues.	2 - 5	3 - 5	3	3

4.2.2.2 Part Two - Experience

When asked their experience in relation to these issues (Part Two), the responses to three of the items (5, 9 and 13) remained the same as shown in Table 4.5. The median responses for eight of the items (1, 2, 8, 10, 12, 14, 15, 16) changed from “strongly agree” to “partially agree” and the IQR for eight items (1, 2, 4, 6, 7, 11, 12, 17) broadened indicating that, although participants still thought that these concepts are important in a client-centred approach to practice, they were not always able to implement them in their workplaces. Participants’ comments (to be discussed in Chapter Five) indicated that the reality of their workplaces (lack of resources and time primarily) did not allow them to be as client-centred as they thought they ‘should’ be. The IQR for item three (only provide clients with the information they want to have) remained the same between both parts of the questionnaire but the median response changed from 2 (partially disagree) to 3 (neither agree nor disagree). In contrast, the median response to item 18 (recognize that clients are the experts when it comes to their own nutrition-related issues) remained the same (neither agree nor disagree) but the IQR narrowed from Part I to Part II of the survey. These differences were again reflected in the comments provided which indicated that participants were struggling with these issues.

4.2.2.3 Part Three - Additional Items

In Part Three of the first round, survey participants were asked to comment on any aspects of client-centred nutrition counselling that they thought

had been missed in the questionnaire. The following items were suggested: informed consent (how that is obtained from clients in a counselling session), benefits and barriers to client-centred nutrition counselling, the impact of context of the counselling (e.g. inpatient vs outpatient, acute care vs chronic care), clarification of 'wants' and 'needs,' the importance of assessing a client's readiness to change, and the need for follow-up counselling. Based on this feedback, four additional items were added to the second round survey questionnaire. The other issues were addressed in the indepth interviews in Phase II of the research.

4.3 Round Two

4.3.1 Sample Demographics

The second round survey was sent to the 57 participants who completed the first round of the survey. Similar to the process used in the first round, a follow-up letter and second questionnaire was sent to any participants who had not returned their questionnaires after three weeks. This resulted in the receipt of 48 useable second round questionnaires, for a response rate of 84%. Of those nine individuals who did not participate in the second round, one was unable to complete the survey due to illness, one went on maternity leave, one had moved and could not be found, and six could not be reached for follow-up.

A comparison of the demographic profile of participants in the first and second rounds of the Delphi survey (Table 4.1) showed no real differences in terms of age or years in dietetic practice. In the second round, slightly fewer

participants indicated that they practised in the community and had been in their current position for more than 10 years and slightly more had been in their position for fewer than five years. However, this difference is unlikely to have made any significant impact on the results of this survey. It should be noted that the Delphi process does impose a heavy burden on participants and it is not unusual for participants to drop out before all rounds are completed.

Participants in the second round of the survey were asked to provide some additional demographic information on the type of counselling they did.² When asked about the average length of time that they were able to spend with a client in an initial counselling session, over half (26;55%) indicated that they spent between 46 and 60 minutes with 32% (n=15) spending greater than 60 minutes. Almost all (n=44;94%) said that they usually saw clients for follow-up. Of these, forty-three percent (n=19) indicated that this follow-up visit was typically fewer than 30 minutes long. Forty-one percent (n=18) said that they spent between 30 and 45 minutes with a client for follow-up. Most participants (n=36;77%) said that they spent more than half of their worktime in individualized counselling sessions.

4.3.2 Quantitative Results

4.3.2.1 Part One - Opinion

The first part of the second-round Delphi questionnaire included nine

²Note: one participant did not provide this information thus the percentages presented are based on data from 47 participants.

items from the first part of the round-one survey. As discussed in Chapter Three, these items were included either because there seemed to be a lack of consensus regarding the importance of the concept to client-centred practice (items three and 18) or because participants' comments suggested a misunderstanding of the concepts (items nine, 10, 12, 13, 14, 15, 16). Results of this survey are shown in Table 4.6. There was no change in the median response for any of the items between rounds one and two. For some of the items, the IQR became smaller, indicating a trend towards agreement among the participants.

Table 4.6. Delphi survey round two quantitative results

Item	IQR	Median
3. Only provide clients with the information they want to have.	2 - 3.5	2
9. Allow clients to identify their own nutrition-related issues.	4 - 5	4
10. Accept clients' decisions whether they agree with them or not.	4 - 5	5
12. Advocate on behalf of their clients.	4 - 5	5
13. Assess clients on an individual basis rather than use a set protocol.	4 - 5	4
14. Allow clients to choose from a variety of strategies to help them change their eating behaviours.	5 - 5	5
15. Allow clients to develop their own nutrition behaviour change goals.	4 - 5	5
16. Involve clients in all stages of the nutrition care process as the primary decision maker.	4 - 5	5
18. Recognize that clients are the experts when it comes to their own nutrition-related issues.	2 - 4	3

4.3.2.2 Part Two - Additional Items

As previously stated, four items were added to the second round Delphi questionnaire based on feedback from participants in the “What’s Missing” section of round one. The first item asked participants if they had experienced any barriers to delivering nutrition counselling services using a client-centred approach. Forty (83.3%) of the participants indicated that they had. Participants were then presented with a list of potential barriers and asked to check as many as they thought were applicable. They were also given the opportunity to identify other barriers not included in the list. The most frequently cited barriers to delivering client-centred nutrition counselling were unrealistic client expectations (n=24;60%), limited time allocated for nutrition counselling (n=23;57.5%), family member’s expectations (n=17;42.5%), client’s educational level (n=15;37.5%), and doctor’s expectations (n=15;37.5%). When asked to identify the factors that help them use a client-centred approach to delivering nutrition counselling services, 73% (n=35) of participants indicated past positive experiences with the approach. Working as part of a team that used a client-centred approach was also seen as helpful by more than half of the participants (n=35;73%). Several participants (n=7;14.6%) commented that being in private practice and “doing their own thing” allowed them the freedom to practise in this manner.

As shown in Table 4.7, participants “strongly agreed” that they should assess a client’s readiness for change. Comments indicated that this was a critical component of client-centred practice and that dietitians would be wasting

time if it was not considered. Many participants referred to Prochaska’s Stages of Change model when talking about this item. There was less agreement that a client-centred approach is possible with one client appointment. This issue was pursued in greater depth in the interviews discussed in Chapter Five.

Table 4. 7. Delphi survey round-two extra questions quantitative results

Item identification	IQR	Median
1. Assessing clients’ readiness for change is a critical component of client-centred practice.	5 - 5	5
2. A client-centred approach is possible with only one client appointment.	2 - 5	4

The differences in responses between Parts I and II of the first-round and second-round questionnaires were reflected in participants’ comments which indicated that many of them were struggling with their beliefs about the client-centred approach and their ability to implement those beliefs in practice. These issues were pursued in greater depth in the indepth interviews and are discussed in more detail in Chapter Five.

4.4 Discussion

The overall purpose of this research was to explore dietitians’ understanding of nutrition counselling. More specifically, it was designed to clarify the meaning that dietitians ascribe to the client-centred approach to

nutrition counselling, identify the concepts and issues inherent in this approach to practice, and describe the experiences of dietitians in its implementation. A reactive Delphi survey was conducted with members of Dietitians of Canada, who self-identified as having advanced level counselling skills, in an attempt to achieve these objectives.

The demographic profile of these participants indicated that the majority were in clinical or private practice. According to the most recent Dietitians of Canada employment survey (Dietitians of Canada, 2000), most (54%) Canadian dietitians work in clinical practice with only 15% in private practice. The larger numbers of private practice dietitians in this survey might reflect their interest in providing services designed to meet clients' needs and wants (one of the key concepts identified in the Delphi survey as being important in a client-centred approach to practice). It may also be that these dietitians thought that participating in this research might help their business by clarifying what this approach to practice looks like and finding out what other dietitians in Canada are doing in this area. The fact that so many of the Delphi participants were in private practice may also help to explain why the average length of time spent in counselling sessions (both initial and follow-up) was higher than expected, given that one of the most frequently cited barriers to delivering client-centred nutrition counselling was limited time. It is obviously in private practice dietitians' best interests to spend more time with their clients as they typically charge on an hourly basis, but, as several of them indicated, they also have the flexibility to do this. On the other hand, many of the participants who identified themselves as

clinical dietitians reported that they were able to spend an hour or more with clients in the initial visit. Further, almost all of them were able to have a follow-up session, although this was typically fewer than 30 minutes long. Thus, it may be that the concern about the lack of time available for counselling is related to participants' sense that there are not enough hours in the workday to see all the clients that they would like to see, rather than a concern about the amount of time they have to spend with each client. However, there are several other possible explanations for these findings. It may be that participants overreported the length of time they spent in a counselling session due to a perception that this was more 'client-centred.' It may also be related to participants' definition of 'clinical dietetics.' As discussed in Chapter Two, the term 'clinical dietitian' replaced the term 'therapeutic dietitian' in the 1980s and, at that time, it was most common to find a clinical dietitian working in a hospital setting (Brownridge & Upton, 1993). Today, many dietitians who work in the community (community health centres, home care, diabetes education centres) refer to themselves as 'clinical' dietitians because they work primarily with clients with disease conditions (Winterfeldt, Bogle, & Ebro, 1998). It is likely that these 'clinical' dietitians would have more time to spend with clients than a 'clinical' dietitian working in an acute care hospital setting. Thus, the finding that participants spent a higher than expected average length of time in a counselling session may reflect a limitation of the questionnaire. In retrospect, I believe that it might have been more helpful to have asked participants to more specifically identify their area of practice and workplace setting.

The finding that over one-third of participants had no training in nutrition counselling during their undergraduate education and 16% had none during their internship is of concern. This may be a reflection of the age of the participants in this study because most were over 30 years of age and had more than 10 years of experience. The two participants who were under the age of 30 and had fewer than five years of experience both reported that they had whole courses in nutrition counselling at the undergraduate level and hands-on experience during their internship. This might suggest an increased emphasis on nutrition counselling in dietetic education in the last five years although the sample size is too small to state this conclusively. It may be, however, that these results reflect differences in the interpretation of the questions participants were asked about their education/training and their perception that I was asking only about 'formal' education delivered by a professor or preceptor (in the case of internship). For example, one participant checked 'no' to the statement "Did you have any training in nutrition counselling during your internship?" but wrote the following quotation underneath, "*Emphatically NO! We were told we would figure it out as we went, that you either could establish rapport and counsel or you could not!*" Thus, it is apparent that this participant did have some exposure to nutrition counselling during her internship but was not given any formal training or instruction. Perhaps a more open-ended question asking participants to describe their experience with nutrition counselling during their internship would have yielded more positive results.

The results of the Delphi survey indicate that participants strongly agreed

with almost half (n=8) of the concepts identified in the questionnaire. For the most part these results are not surprising given that many of these items would be considered 'motherhood and apple pie' issues. For example, people would be unlikely to disagree with the statements, "In client-centred practice, dietitians should demonstrate respect for clients' opinions' or 'In client-centred practice, dietitians should provide clients with enough information to enable them to make informed decisions' or 'In client-centred practice, dietitians should create an environment where clients feel accepted and understood.' Further, several of these eight items reflect the knowledge statements and/or competency standards that govern dietetic education in Canada at the undergraduate and internship levels and thus it would be expected that practitioners would agree with them.

Although participants agreed or strongly agreed with a further eight items in the questionnaire, the interquartile range for the responses to those items was slightly broader indicating some differences in opinion regarding the importance of these issues in a client-centred approach to nutrition counselling. This may have been due to differing perceptions of the meaning of some of the words in those items. For example, it was apparent from comments in the first round of the survey that the terms 'advocate,' 'set protocol,' and 'nutrition care process' were not universally understood. The word 'allow' was also of concern to a number of participants as comments indicated that the term suggested an imbalance of power in the client-dietitian relationship. This may have caused some participants to disagree with items containing this word or to rate them

lower on the scale than they would have if the word 'allow' had not been used. However, it is likely that this also reflects participants' concerns about implementing these concepts in practice. When asked (in Part Two of the questionnaire) about their experience in these areas, it is clear that this was a struggle. Participants used phrases like "*it depends*" and "*as much as I can*" or "*as much as possible*." This struggle will be discussed in more detail in Chapter Five.

Two of the items in the Delphi survey generated a considerable number of comments, had median responses of three or less and much broader interquartile ranges indicating some disagreement regarding their importance in a client-centred approach to practice. Again, this may have been due to differing perceptions of the meaning of the items. For example, some participants appeared to interpret item three (Only provide clients with the information they want to have) as meaning that they would not offer any additional information based on their assessment of the client's needs and thus rated the item a one or a two. Others seemed to take a slightly different viewpoint in that they recognized this as being important in a client-centred approach (and thus rated the item as either a four or five) but stated that they would 'offer' additional information as needed.

Interestingly, there was no change in the median response or the interquartile range for seven of the nine items included in the second round of the Delphi survey. In the case of items three and 18, although the median response remained the same, the interquartile range narrowed slightly indicating

a trend towards agreement. One of the unique aspects of a Delphi survey is that participants are able to review the comments made by the rest of the group and use these comments to further think about the issues. Reading the thoughts of others allowed participants to see that there were different ways to interpret these statements. Thus, some participants likely changed their rating of these issues based on these comments. Unfortunately, not all participants who changed their ratings provided comments to explain their rationale.

Many participants in this study indicated that they had experienced barriers such as unrealistic client expectations and limited time available for delivering nutrition counselling services using a client-centred approach. This finding is similar to that of Sumsion and Smyth (2000) and Wilkins, Pollock, Rochon and Law (2001) in the occupational therapy profession, where client-centred practice has been a part of their standards of practice for over twenty years. These authors found that lack of time and resources as well as the therapist and client having differing goals were significant challenges to implementing this approach. They also both suggested strategies that could be used to overcome the barriers. Sumsion and Smyth (2000) found that having management and peer support was the most highly rated suggestion. Continuing education and having adequate time to learn how to practise in a client-centred way was also rated highly. Wilkins and colleagues (2001) identified strategies in three categories: at the level of the system, the level of the therapist, and the level of the client. Similar to the findings of Sumsion and Smyth, they identified the need for developing a culture in the organization

which supports client-centred practice and the need for ongoing education to increase practitioners' knowledge and understanding of what practising in a client-centred manner looks like. Interestingly, when asked to identify factors that facilitate the use of a client-centred approach to practice, participants in the Delphi survey indicated that working as part of a team that supported its use was helpful. Of concern, however, is the fact that there were participants in the study who had little or no education/training in nutrition counselling during their undergraduate education or dietetic internship. Further, about one-third of participants had not had any additional training/education in counselling since they started their practice.

As alluded to throughout this discussion, participants provided extensive comments to further elaborate on their rating of the items in the Delphi questionnaires. In many cases, these comments suggest that there were differences in how participants interpreted the statements and pointed out the fact that many of them were not 'black and white' issues that could be easily addressed with a mail survey. They often revealed a disconnect between what participants thought they 'should' be doing in a client-centred approach to nutrition counselling and what they were actually able to accomplish in practice. Further, despite the fact that participants either strongly agreed or agreed with most of the concepts in the Delphi questionnaire, there also appeared to be a disconnect between their quantitative rating and the comments provided. Thus, although it was originally proposed to use only a Delphi survey to accomplish the objectives of this research, it became clear that it was important to explore

some of these issues in greater depth by conducting indepth interviews with participants. Ending the research at this point would have been premature and may have led to inappropriate conclusions. The results of these indepth interviews, along with the comments made by Delphi participants, are discussed in Chapter Five.

Chapter 5

DIETITIANS' PERCEPTIONS OF WHAT IT MEANS TO USE A CLIENT-CENTRED APPROACH TO NUTRITION COUNSELLING

5.1 Introduction

Dietitians in Canada have been mandated to practise using a client-centred approach. However, it was clear from the comments provided by the Delphi participants that what this meant is not clearly defined. Thus, a second phase was added to this research in an attempt to clarify some of the issues that were raised in the Delphi survey. The qualitative data from the Delphi survey and the indepth interviews were then combined and analysed using inductive thematic analysis, as described in section 3.5.3. This chapter presents the results of that analysis.

5.2 Sample Demographics

Twenty-five of the 27 Delphi participants who indicated an interest in the indepth interviews were contacted and interviewed. Sixty percent of these dietitians were 41 years of age or older (15/25) and most (76%) had been

practising dietetics for more than 10 years. Over half (56%) were in clinical practice. Eight (32%) indicated that they were in private practice and the rest indicated an “other” area of practice (program development and evaluation consulting, industry, geriatric assessment unit). Just over half (52%) indicated that they had training in nutrition counselling in their undergraduate education, while 48% said that they had not. Seven (54%) of those who indicated that they had this training said that they had taken a whole course in nutrition counselling. The others (46%) said that it was a topic in a course or that they had attended a workshop on nutrition counselling. Most of the participants (88%) stated that they had training in nutrition counselling during their dietetic internship. This training mainly took the form of hands-on practice (76%) and/or observation of a nutrition counselling session (72%). The majority of participants (80%) indicated that they had taken additional training/education in counselling (either in nutrition or another discipline) since they started practising dietetics. Most (75%) said that this took the form of workshops (diabetes education, motivational interviewing); however several indicated a more self-directed approach (continuing education in journals/manuals, reading books and journals for effective strategies and practising this information to see what works). One had taken a course in psychosynthesis counselling and two had graduate degrees in adult education, nutrition and/or psychology.

Participants were also asked questions related to the length of time that they were able to spend with clients in a counselling session. The majority

(72%) indicated that they typically spent greater than 45 minutes in an initial counselling session. Only one indicated that she spent fewer than 15 minutes with clients initially. Most of the participants (88%) stated that they typically saw clients for follow-up. These follow-up sessions were typically between 30 and 45 minutes long. Two participants indicated that they typically spent greater than 1 hour in a follow-up counselling session.

The majority of the participants in this study (68%) stated that they spent most of their time with individualized counselling (greater than 50% of their time). The others indicated that half of their work time was spent in group counselling and the other half counselling individuals.

5.3 Results and Discussion

Ten key theme areas or categories emerged from the data from the qualitative comments from the Delphi survey and the telephone interviews including: meeting needs and wants, role of the dietitian, role of the client, setting goals, decision making, client as 'expert', techniques/strategies, context, building a relationship, and benefits.

5.3.1 Meeting Needs and Wants

Three statements in the Delphi survey related to meeting client needs and wants:

1. In client-centred practice, dietitians should provide nutrition services

designed to meet the needs and wants of clients.

- 2. In client-centred practice, dietitians should only provide clients with the information they want to have.
- 3. In client-centred practice, dietitians should tailor educational materials to the needs and wants of individual clients.

As discussed in Chapter Four, there was strong agreement that the first statement was important. However, less agreement occurred about the issues of only providing clients with the information they want to have and tailoring educational materials to meet the needs and wants of clients. As shown in Table 5.1, their comments reflected several concerns related to issues of client knowledge, professional responsibility, context, and the realities of the workplace.

Table 5.1. Meeting needs and wants

Delphi Survey		Indepth Interviews
Opinion	Experience	
<ul style="list-style-type: none">• Basic to client-centred counselling but..."clients don't always know what they don't know"• Professional responsibility• Context dependent	<ul style="list-style-type: none">• "Try" "Always.. trying:• Barriers/realities of the workplace• Always meet the needs but not necessarily the wants	<ul style="list-style-type: none">• Who defines the needs?• Struggling to find a balance..'real' medical needs and clients' perceived needs

For several of the participants in the Delphi survey, meeting client wants and needs defines client-centred care and is the only way that they expect clients to be successful in making positive nutrition behaviour changes. However, many of them also voiced a concern that clients do not always recognize what they 'need' to know and may need more information than they 'want' to have in order for them to make an informed decision about their nutritional care. As one participant stated, *"Often they don't know what they actually need or want and some guidance or extra information is required and helpful."* For some, client wants were seen as potentially unrealistic, unhealthy, or unsafe. Comments suggested that it is the professional responsibility of the dietitian to ensure that clients' do not harm themselves. For example, one stated,

Part of a dietitian's professional responsibility is to make assessments that will help determine what is in the best interests of the client. The dietitian must attempt to find a balance if needs and wants conflict that both the client and the dietitian are comfortable with.

It was clear that this really is not a black and white issue and that how much information is provided depends upon the situation as the following quotation illustrates:

I find this is context dependent. In my work I find people ask for physiologic information because that is more socially acceptable but there are many issues to be raised during a session. Nevertheless, I always return to what a person asked for, then reiterate the additional points that arose for discussion during our conversation as a means of closure to the session.

Participants' comments were slightly more tentative when asked what their actual experience was. They used words such as "sometimes", "try," "usually," "generally," and "it depends." Several participants indicated that they always design their service to meet client needs, but not necessarily wants. Needs and wants were not seen as synonymous and there was evidence of a paternalistic view of the importance of the expert-defined needs as illustrated by the following quotation. *"I feel I am the health care expert and I tell them what they need to know. They may or may not choose to listen but generally I believe they want this information unless told they 'have to' by their doctor."*

Although most of the participants indicated that tailoring educational materials to the needs and wants of clients is important, especially in relation to learning styles, literacy, and cultural considerations, the reality of practice is that there isn't enough time and money to do this for every single client. *"As much as possible. However, current staffing levels and lack of administrative support can make this a challenge."* *"This is sometimes easier said than done given limited time and resources."* Despite these challenges, many participants talked about how they individualize their handouts and modify existing resources to fit their clients' needs. *"I don't use preprinted diet sheets or meal plans - everything is individualized."* *"I use a simple variety of materials as a base and then use my laptop to individualize handouts."* *"Although I use preprinted materials, I revise/change and otherwise mutilate them as appropriate when seeing clients."*

When asked to describe client-centred nutrition counselling, participants in the indepth interviews repeatedly referred to “meeting client needs and wants”. However, some indecision occurred around who determines these needs and the difference between wants and needs. When participants talked about the ‘needs’ identified by the client, they generally referred to them as ‘perceived needs’ or ‘wants.’ Needs that the dietitian identified were generally referred to as medical or health needs. As previously discussed, many participants considered these expert-defined needs as most important and the struggle to find a balance between meeting these ‘real’ medical/health needs and ‘perceived’ client needs appears to be causing some concern.

One participant talked about her struggle to find a balance between “...wanting to address what the client wants to know.....trying to back off from giving them detailed information.” This struggle was also evident in the seemingly contradictory responses that several participants gave when talking about client-centred practice. For example, one said,

For me client-centred counselling is focussing on the client, what their needs are. But at the same time evaluating....what their needs are from their perspective and then doing an assessment of what I feel their needs are from a medical/health perspective. They might not see the need but it would be my job to bring that to their attention and maybe help them focus on that.

It is interesting to note that although she started out talking about focussing in on the needs identified by the client, she ended up by talking about redirecting the client to focus on the needs identified by the dietitian.

The words ‘need’ and ‘want’ are deceptively simple and we often use

them interchangeably. Needs are generally defined as deficiencies: the gap between what is and what should be (Witkin & Altschuld, 1995) while wants usually reflect the desire for something, which may or may not reflect a discrepancy of any type (Berenbaum, 2004). Many different types of needs have been identified in the literature. Issel (2004) identifies four types of needs including expressed, normative, felt or perceived, and comparative or relative. Expressed needs are those that people can articulate and that are expressed by behaviour. Normative (sometimes referred to as expert-defined or prescribed) needs are usually based on what the ideal or standard is from a health perspective. Felt or perceived needs reflect people's preferences or what they think their needs are. Comparative or relative needs identify differences between individuals or groups. They ".....demonstrate a difference that is interpreted as one group having a need relative to the other group" (Issel, 2004, p. 116). In the context of a nutrition counselling relationship, needs are generally thought of as problems or conditions that put people at nutritional risk or cause them to be less healthy than they could be. For example, a client with Type I diabetes 'needs' insulin to live. When it comes to diet 'needs' however, there is a lot more room for interpretation because so many factors influence dietary behaviour. What will work for one client may not work for another because diet needs are very much context-dependent. The idea that how needs are defined depends on the context of the situation has been discussed in the literature and it has been suggested that this may help to explain the difficulty in differentiating between needs and wants (Schroeter,

2004). “Needs’ can mean different things to different people depending on the context in which those individuals live (i.e., their socioeconomic status, prior experiences with nutrition counselling, culture, education). Further, there may be differences between the needs that clients perceive themselves as having (felt needs) and those needs defined by experts (normative or prescribed needs) as shown in a study by Misskey, Moss, Lee and Hill (1985). These researchers found no relationship between mothers’ felt needs for information on a variety of nutrition-related topics and their prescribed needs based on an assessment of their nutrition knowledge or their children’s food intake as compared to Canada’s Food Guide. According to Green and Kreuter (2005), it is important to discover ‘common ground’ by bringing together these various needs to come up with a plan that will have an effective outcome. Most of the participants in this study seemed to be struggling with how to find this ‘common ground,’ a struggle that may be related to concerns about the facilitation process, as discussed in the next section.

5.3.2 Role of the Dietitian

Four statements in the Delphi survey related to the dietitian’s role in client-centred nutrition counselling:

1. In client-centred practice, dietitians should act as facilitators to enable clients to achieve their nutrition related goals.
2. In client-centred practice, dietitians should allow their clients to identify their own nutrition related issues.

3. In client-centred practice, dietitians should provide clients with enough information to enable them to make informed decisions.
4. In client-centred practice, dietitians should advocate on behalf of their clients.

Table 5.2 illustrates the difficulties that participants had in their attempt to describe their role as facilitators, their concerns related to providing ‘enough’ information to ensure informed decision making , and their confusion regarding their role as ‘advocates.’

Table 5.2. Role of the dietitian

Delphi Survey		Indepth Interviews
Opinion	Experience	
<ul style="list-style-type: none"> • Facilitator role is important but...must also educate • Allow clients to identify their own issues but... what if they choose the ‘wrong’ ones? • Clients must be informed but.... how much is enough? • Advocacy important but what does it mean? 	<ul style="list-style-type: none"> • Facilitator.... it depends... • Easier with practice • Time is a barrier • Allow clients to identify their own issues... but it depends • Informed decisions... how much is enough? • Advocacy... not much opportunity for this; time limiting factor 	<ul style="list-style-type: none"> • Facilitator but... Need to direct/steer the client • Need to give advice... not 100% client-centred

5.3.2.1 Facilitation

As discussed in Chapter Four, Delphi results indicated strong agreement that dietitians should act as facilitators in client-centred practice. A facilitator

was seen as someone who encourages client involvement in the counselling process, consulting with clients rather than dictating to them. Working with clients to facilitate their decision making and goal setting processes was seen as being more effective than simply telling people what they needed to do as illustrated by the following comments. *“A facilitator, I think, tends to get the client involved in the decision making process which tends to get better results than simply telling them what they should do.” “We are not here to set the goals - but to help the client to choose which of his/her goals can be met/are realistic and to facilitate that process.”* However, two of the dietitians cautioned that we can't forget our role as educators and that *“....it is important to also provide information as well as guide the process of change.”*

When asked if they act as facilitators in their practice, several participants indicated that it depends on the situation (client's medical condition, client's readiness to change, whether or not follow-up was possible). A couple of participants said that they did not do this when they started in practice but as they have gained experience they felt more comfortable in the role of facilitator. *“With increased years of service I have recognized my facilitation role more clearly. When I started in practice I don't think that I recognized it or was very comfortable with it.”* The main barrier to this approach was seen as lack of time as this quote suggests, *“Once in a while time limits make this harder to achieve.”*

Interview participants also talked about their role as a facilitator, but at the same time several of them indicated that it was sometimes necessary for

them to direct or steer the client. This is exemplified by the following quotation:

Well I think the role is to support the client's needs and in some ways facilitate the identification of their needs They have come to an expert wanting assistance so there has to be some guiding or assisting or, if I dare say, directing even, that is going on by the dietitian to sort of manage the process. I think that we have all been in those meetings with clients that if you were to let the client 100% manage the session it could potentially get ugly in terms of the length or the types of issues that the person starts to pour their heart out about.

Another participant had a similar comment which suggested a concern about letting go of her role as 'expert' and a belief that the facilitation process involves the relinquishing of control to the client:

I think that it [facilitation] has to do with really allowing the client to direct the meeting....so really meeting their needs, not having an agenda. Which is something that a lot of us struggle with when we go into a consultation.....I mean I don't think that I totally believe in a 100% client-centred approach because I think as professionals we need to give a bit of our advice somehow....I mean sometimes you read about the client-centred approach and you're not really giving any advice at all.....So I do think we need to have, not so much an agenda but some things that we need to relay to the client. You know, we have to put on them our expertise in a sense.

Participants in the indepth interviews were asked a direct question about their role in a client-centred nutrition counselling session and, interestingly, many of them struggled to answer it. For example, one participant said, *"I guess...the dietitian's role? I guess, probably mainly as a facilitator in getting....and an educator as well. A teacher. You know, the role...I guess...is to provide the information and in a format that will work for the person."* Another said, *"What do you mean? I can't imagine what you mean."* As previously stated, this might suggest that dietitians have not given a lot of thought to this

issue. On the other hand, many of the participants did talk about their role as facilitators. However, as was evident in the comments from the Delphi survey, there appeared to be some hesitation regarding the effectiveness of this role and concern that 'just' facilitating was not enough. This thought is exemplified by the following quotation,

I struggle with this in a way. I mean I don't think that I totally believe in a 100% client-centred approach because I think as professionals we need to give a bit of our advice somehow....I mean sometimes you read about the client-centred approach and you're not really giving any advice at all. Not to the extent that we would anyways...So I do think we need to have, not so much an agenda but some things that we need to relay to our client. You know, we have to put them on our expertise in a sense. But I guess, you know, really letting them know that they own the consultation.

Similar issues have been identified in the occupational therapy profession. In a study examining barriers to client-centredness conducted by Sumsion and Smyth (2000), the fourth highest ranked barrier was "The therapist has difficulty facilitating the client's identification of their own goals" (p. 19). Wilkins and colleagues (2001), in a study exploring the difficulties in implementing client-centred practice, identified the challenges that practitioners were facing in trying to shift from the more traditional approach to service delivery to one that was considered more 'client-centred.' This shift requires the development of facilitation skills such as negotiation, collaboration and consultation; many of the study participants did not feel that they had those skills. Further, there was a lack of recognition of the need for a shift in power in the client-practitioner relationship that is needed to be 'client-centred.'

5.3.2.2 Identification of nutrition-related issues

There was also strong agreement by Delphi participants that dietitians should allow clients to identify their own nutrition-related issues. However, their comments suggested concern about letting clients do this solely on their own. In part this appeared to be related to concerns that clients may not be aware of the issues or that they may have incomplete or inaccurate information as illustrated by the following comments. *“What if they don’t see the obvious ones?”*

The client may identify nutrition-related issues, however they may or may not be related to the health issue at hand. Many clients already have information from the doctor, internet, alternate sources and have preconceived ideas of what they need to deal with and changes in relation to their nutrition.

Although it was recognized that involving clients in the counselling process increases the likelihood of success, participants talked about their professional responsibility to ensure that clients are aware of “all” nutrition-related issues and that they are fully informed. *“As long as informed - it is our responsibility to make them aware of all nutrition related issues.” “Practitioners may identify issues that the client is not interested in dealing with at this point in time, but acknowledging them is important in informed decision making.”* As one participant in the second round of the Delphi survey indicated, the concerns that were raised may have been related to differing interpretations of the statement.

The patient should identify their own issues - i.e., the RD should not prevent this or interfere with the process. Many interpreted this as ‘only’ their issues. The statement does not say that. Of course the RD should also help the patient identify all nutrition-related issues. That would be another statement.

Again, as previously discussed, this may be related to concerns about

the role of a facilitator and reflect a belief that using a client-centred approach means that the dietitian only responds to the issues that a client brings to a counselling session. Only one participant talked specifically about counselling as involving a partnership approach in which the dietitian respects the client's input yet takes a more active role in the process. *"Many clients are not aware of the wide range of issues at work. I respect their opinions and questions but consider part of my role is to raise awareness, only then would I feel comfortable....this is a partnership."*

When asked if they allowed clients to identify their own nutrition-related issues in their practice, there was again an undercurrent of hesitation in their comments. Many said that how much this is done depends on the issue and client. *"Depends on the situation - in hospital vs outpatient clients are inherently different."* *"Some clients are knowledgeable in nutrition and can identify their issues, others can identify them more specifically after given education in specific aspects of nutrition, while others need to be given specific instruction as to what issues are related to them."* Another factor contributing to the hesitancy to allow clients to identify their own nutrition-related issues might be related to the dietitian's area of practice. As one participant said, *"Responses appear to be from hospital based setting as opposed to private practice (i.e., fee for service). We have to work as a negotiator with clients."* In an acute care setting, it is common practice for dietitians to assess a client's condition and then make a decision on his or her behalf. Although they generally interview the client and attempt to individualize the care plan based on the client's input, for

the sake of expediency it would be rare for the dietitian to allow clients to identify their own nutrition-related issues due to the nature of their work environment.

5.3.2.3 Providing information

Participants in the Delphi survey strongly agreed with the statement related to providing clients with the information needed to make informed decisions and comments suggested that they saw this statement as a very important obligation. *“Yes - we have an ethical obligation to inform them before they can make an informed decision.” This is an important part of the profession. Education is a large part of the dietitian’s role.* However, they also recognized barriers to this process. *“There are barriers to accomplishing this though, eg. Time, attention span of client, ensuring they aren’t put into “information overload.”* Avoiding what they referred to as “information overload” was a concern for several of the participants. *“..... must avoid information overload, which results in undue stress, i.e., the RD must select appropriate information, at the right time. This is a challenge but is an important responsibility.” “Like Goldilocks, clients need not too much, not too little info. Judging how much info will be “just right” is our challenge!”* There appeared to be some disagreement as to who decides how much is “just right” however. Some of the comments inferred that it was up to the dietitian to decide. *“The RD ensures the informed part, the client decides.”* Others indicated that it is the client’s role to decide when enough is enough. *“That would depend on the*

client and their level of change - some clients would become very frustrated and angry if they perceived I was giving "enough." I listen to the client and they will tell me verbally or nonverbally when they have had "enough."

In practice, the participants indicated that they try to do this *"as much as possible"* and gave a couple of examples of how it is done. *"Start with basics and build on it on subsequent visits. It is an education process and we should not overwhelm them with information."* *"Sometimes to allow behaviour change goals to be made a step-wise approach is necessary. I may hold back some info to give at a subsequent session to prevent distraction from an immediate goal."* A couple of the participants talked about clients who seemed to want them to make decisions for them. *"Once again, some clients are capable of making suitable decisions, but not all and some prefer you do that on their behalf. But I always provide adequate teaching and information in every session."* This raises the question, who decides what is adequate? Do you provide that information even if the client doesn't seem to want it? One participant made an interesting comment that reflects this dilemma. *"In our efforts to move to "empowerment" and "client-centredness" I am concerned that we are not giving enough information in all cases - we have an ongoing discussion about this in my work area."*

The importance of communication and the changing role of health professionals in the decision making process has received increasing attention in the literature in recent years (Charles, Gafni & Whelan, 1999; Lee & Garvin,

2003). Bensing, Verhaak, van Dulman and Visser (2000) referred to communication as “the royal pathway to patient-centred medicine” (p. 1). However, shifting towards a model of shared decision making involves a shift in the power dynamic between the practitioner and client that not all health professionals are comfortable with. This issue will be discussed in more detail in section 5.3.5.

5.3.2.4 Advocacy

Although the Delphi participants agreed that dietitians should advocate on behalf of their clients, they expressed some confusion regarding what advocacy meant and what it would look like in practice. Several participants identified advocacy as something they would do with other members of the healthcare team to make sure that the client received appropriate care or to help clients navigate the complexities of the healthcare system. This understanding is illustrated by the following quotations:

Many clients don't understand the medical system or social services. We can do a lot in this area for clients.

Dietitians can help patients be heard and understood via clear communication re patients plans on reports to the MD and other health professionals. They should also recognize when another professional discipline is needed by the client and should make access available.

However, participants also indicated that whether or not they advocated on behalf of their clients depended on the situation/client. *“Depends on what the client needs/wants are and if you agree.” “Potentially - depends on situation.”* Some participants thought that their role was to help clients advocate for

themselves. *"Clients need to advocate for themselves. You need to encourage them to do so and give them the information to do it."* There also seemed to be some confusion as to what the term "advocate" really means. *"In what way? To some extent - as long as it is within the scope of nutritional practice."* *"...perhaps it comes down to how one interprets 'advocate' - appropriately? When necessary? Always?"*

Because of this apparent confusion, this item was included in the second round of the Delphi survey. It was again clear that several participants were not sure what 'advocacy' meant. *"To tell you the truth, I'm not exactly sure how this fits in, or what it would mean."* *"How to interpret advocate?"* One participant indicated that she had never had to advocate. Some participants indicated that it depended on the issue/client as to whether or not they would do this and that it was important to help clients advocate on their own behalf. *"Depends on the issue."* *"Within the realm of nutrition issues if they wish us to."* *"This is a skill clients need to develop. I would give them the tools and support to do it themselves."* A few talked about how advocacy is an integral part of client-centred practice and dietitians' professional responsibility. *"I don't think advocacy and client-centred practice is mutually exclusive. Where necessary and appropriate the dietitian has a responsibility to advocate."* *"When needed, I believe this is a professional and moral obligation."*

Interestingly, when asked how often they advocated on behalf of their clients in their practice, several indicated that there wasn't much opportunity to

do this. *“Rarely” “When appropriate - it happens so seldom in my practice.”* A few mentioned the realities of practice as a barrier. *“Time is a limiting factor.” “As much as possible considering the limitation of hospital settings.”*

Participants talked about specific activities that they did to advocate for their clients and gave examples of when they thought advocating was important.

“Communicate directly with the physician or other referring sources to discuss strategies which can benefit client.” “Yes, in dealing with our facilities food services department. Yes, on occasion if a physician’s order needs to be changed, in my opinion. Seldom in a community context (with school, employer etc.).” Few indicated that they thought it was something integral to their

practice. This apparent confusion surrounding the role of dietitians as client advocates may stem from our professional association’s advocacy approach in which the emphasis is on promoting the position of the dietitian. This position is evident from the following participant when asked what the term advocacy meant to her:

I don’t know. I think that it’s a term we use, we’re going to advocate, we’re going to advocate. And I don’t really think that it’s being effective. What the term means to me is that we will...oh what’s the word I’m looking for...try and make ourselves more visible and try to make ourselves more important as a whole in our profession, to whoever we are targeting.

Although it certainly makes sense that a professional organization would advocate on behalf of its members, advocating with and for clients is also considered to be an important part of client-centred care in occupational therapy (CAOT, 1997) and nursing (Registered Nurses of Ontario, 2002). Thus, there

appears to be a need for a broader discussion of the role of dietitians as advocates in a client-centred approach to care.

5.3.3 Role of the Client

Since the focus of the Delphi survey was on the dietitian's role in client-centred nutrition counselling, the role of the client was only indirectly addressed in the questionnaire. However, participants' comments indicated that they recognized the client as the primary decision maker and goal setter. At the same time, many of them said that the level of involvement depends on the client and qualified their comments with 'it depends' or 'sometimes.' They also emphasized the need for guidance from the dietitian as exemplified by the following comments, *"My experience in this area is that the practitioner needs to provide some examples and guidelines to help the client begin."* *"Most clients do not know where to start! [Need to] offer starting points."* Some comments seemed to suggest a lack of trust in their clients' ability to make their own decisions and develop their own goals. For example, one participant said, *"...sometimes I'll do this as long as it's within reason. The proper direction to go. If they are at a loss, they need my help."*

Originally I had planned to follow up with client interviews in order to gain a deeper understanding of how clients viewed their role in client-centred nutrition counselling. Since that phase of the research was substituted with indepth interviews with dietitians, those individuals were specifically asked to talk about the client's role. Table 5.3 illustrates the struggles and concerns that

participants had in their attempt to define this role.

Table 5.3. Role of the client

Delphi Survey	Indepth Interviews
<ul style="list-style-type: none">• Primary decision maker and goal setter but....it depends on the client	<ul style="list-style-type: none">• Ultimate decision maker but...concern about 'letting go'• Struggling to define the client's role

Most of the interview participants stated that clients are the ones who have to make the decisions and they make those decisions based on the information that the dietitian provides. Again, however, I got the sense from several of the participants that they really did not know how to articulate the role of the client. For some, this confusion was exemplified by hesitation in their speech as they tried to come up with a response. Others talked about struggling with this issue and spending time thinking about it a lot. It may be that they really have not given a lot of thought to the role of the client. It might also be something to do with a lack of trust in their clients' abilities to make dietary changes; perhaps based on their own personal experiences. Several participants referred to the need for clients to be open and honest as exemplified by the following quotations:

The client's role is to be open and honest. And be willing to make some changes.

And I think their role is to provide us with insight into what their situation is so that we can help them as much as we can. And also I think be

honest with us as far as what they're willing to change and what they are not. What they are capable of doing and what they are not. And I think just making an effort to pursue whatever lifestyle change they are willing to do.

Interestingly, Corring and Cook (1999), in their study of individuals who had experience with the mental health service delivery system and had been counselled by an occupational therapist, found that “not being believed by the therapist” was one of the participant’s major concerns (p. 75). Thus, the need to be ‘open and honest’ on both sides would appear to be important in a client-centred approach.

This hesitation and struggle may also be related to a concern about completely letting go of the process. For example, one participant said, *“But I pretty well let them be the final decision maker on goals that are set.”* The words “pretty well” suggest a lack of comfort with letting clients make the final decision. Although there is considerable discussion in the literature about clients taking a more active role in their healthcare, this topic was not something that the interview participants really talked about except in relation to the need for clients to provide them with the information needed to help them understand the clients’ condition. *“Well again, to bring their own situation, their own knowledge about their lifestyle, their choices, their ways of dealing with change...”* And *“Their role is to teach me who they are and what their issues are and what their barriers are and just what their life is so that I have a good understanding of them.”*

It is probably not surprising that participants in this study were somewhat

hesitant in their responses related to the role of clients in a client-centred approach to counselling. This issue has not been explored in the published literature in any depth. If dietitians are truly interested in practising in a client-centred way, it will be critical to find out from clients what client-centred care means to them and how they see their role in this approach.

5.3.4 Setting Goals

Two statements in the Delphi survey related to setting goals, both of which had median responses of five or strongly agree:

1. In client-centred practice, dietitians should work with clients to develop mutually agreed upon goals.
2. In client-centred practice, dietitians should allow clients to develop their own nutrition behaviour change goals.

It is interesting that participants rated both these statements as 'strongly agree' because one refers to a mutual process in which the dietitian works with the client to develop goals and the other gives clients the responsibility of developing their own goals. This apparent contradiction may again be related to a disconnect between what participants' believe about the client-centred approach and what they were able to do in practice or it might be related to the struggle to understand their role in the goal setting process in a client-centred approach. This observation is illustrated in participants' comments as shown in Table 5.4.

Table 5.4. Setting goals

Delphi Survey		Indepth Interviews
Opinion	Experience	
<ul style="list-style-type: none">• Mutually agreed upon or...developed by the client?• RDs steer and client sets goals	<ul style="list-style-type: none">• Important but.. many barriers	<ul style="list-style-type: none">• Struggling with roles.. Client sets their own goals but...RD ensures they are safe and realistic• RD and client develop goals...negotiation process• Physician has the 'ultimate' goal

Many participants indicated that working with clients to develop mutually agreed upon goals was an important aspect of client-centred practice and that it was essential for successful outcomes. However, they also talked about the difficulty in actually developing goals in practice. *“....sometimes I have found this is more difficult than it sounds.”* They also talked about the need to compromise and/or negotiate with clients to develop goals that the dietitians felt the clients could achieve. *“Compromise and consensus are important with goal development. If the goals established are just the RDs goals then it is less likely that the client will take ownership and responsibility in actioning the goal.”* The need to compromise was also mentioned in relation to the context in which the counselling takes place (i.e., private practice or an institutional setting).

This is so basic to human behaviour, why is it ignored sometimes? Because life gets in the way, e.g. limited time to spend with the client. I have to wrap something up now - do we compromise? Probably - especially in institutional versus private practice. Sometimes the latter can be more flexible.

A few participants indirectly addressed the issue of who develops the goals in the first place. They talked about client “buy-in” which seems to imply that the dietitian is trying to “sell” them on a goal rather than developing goals together. Another participant said, “*RDs steer and client sets goals.*” At face value, this comment appears like an attempt to direct the client. If you are steering the process you likely have a goal or an end result in mind. Again, however, this awareness is likely due to the realities of the workplace as mentioned above. It takes time to negotiate goals with clients. It also takes skill as exemplified by the following quotation:

...a plan for clients to realistically achieve what clients are willing to work on in dealing with their conditions - sometimes this tends to be more dietitian-driven than client-driven - there is an art to working with clients in client-centred practice.

In their practice, many participants indicated that it was not always possible to take the time necessary to develop mutually agreed upon goals. Other barriers that were identified included submissive clients who just want to be told what to do, clients who don't know how to set a goal and working with groups. Perhaps as a result of these barriers, several participants acknowledged that they directed the process more than they might like to. “*I try to do this but suspect I may push in a preferred way - aimed at effective outcome for the client.*” “*I sometimes steer their decision making.*” “*Usually I suggest what would be a good goal and ask them if it seems workable to them.*”

Participants’ struggle to define their role in the goal-setting process was evident in the hesitancy in the responses to the statement “...dietitians should

allow clients to develop their own nutrition behaviour change goals.” Although several participants indicated that clients were more likely to make necessary dietary changes if they develop their own goals, many also stated that clients needed their help. In some cases, this help took the form of providing the client with the information needed to make an informed choice.

Clearly they need to do this but in an informed way. What good is a behaviour change goal if it's totally ineffective. This emphasizes the give and take partnership of client-centred counselling. The RD ensures the 'informed' part - the client decides.

However, in other cases there appears to be more of a directive role.

“Sometimes I'll do this as long as it's within reason. The proper direction to go.

If they are at a loss they need my help.” A few participants voiced the concern

that clients sometimes try to set what they believe were unrealistic goals and it

was their role to help them set more achievable goals. I suspect that this

position speaks to their sense of professional responsibility but also to their

need to assert themselves as the ‘nutrition expert.’ My thought was reflected in

participants’ comments in the second round of their survey where there was

more of an emphasis on their responsibilities as professionals . *“If clients lack*

insight they may have unrealistic goals, eg. I want to lose 50 pounds.” Then my

job is educating about the consequences of such a goal.” “...if clients want to

develop a goal that is detrimental to their health, then it is incumbent upon the

RD to inform clients of the negative results that are likely to develop - thus the

RD is very much working against client's goal in that scenario.” This quotation

suggests a level of concern about dietitians protecting themselves, possibly

against future lawsuits. I think that there is also a concern that if we 'let' clients do this by themselves then there really isn't a role for dietitians. As one participant said, *"If they could do this independently they would not be in a dietitian's office."*

When asked if they allowed clients to develop their own nutrition behaviour change goals, participants again commented on the need for the dietitian to provide help or guidance in goal setting but several added qualifiers to their statements such as "it depends" or "try to." *"Try to do this. Again will sometimes give them ideas to choose from if they need some help/time constraints."* A number of other participants talked about the problems of time and the realities of the workplace as exemplified by the following quotes. *"Given time constraints, I usually assist in formulating a menu of goals from which the client can choose or prioritize."* *"Develop implies a time frame. This does not work in hospital. It is absolutely necessary with eating disordered clients but I help them with differing possibilities."*

Only a few of the indepth interview participants specifically addressed the process of goal setting. However, again there was evidence of struggling with who controls the process. Several participants referred to clients as 'being in the driver's seat' in terms of setting goals. At first glance, this statement gives one the impression that the client is in control. If someone is in the driver's seat of a vehicle, he or she determines where that vehicle goes, how fast it gets there, and what direction it takes. However, it was clear from the comments that some participants felt that the dietitian's responsibility was to help steer the

process to make sure that clients made the 'right' decisions and choose 'appropriate' goals. *"The client makes decisions and choices and determines a plan of action, remaining in the driver's seat. However, the dietitian will need to assist in defining realistic and achievable goals."* Some of the participant's comments seemed to suggest that it was the physician's role to set the goals.

So I think the physician's goals need to be brought up front and told to the client, this is what your physician is looking for. And if the client is saying I'm only willing to work on that, fine, we'll work on that as long as it is a step towards the ultimate goal.

Others referred to goal setting as a negotiation process between themselves and their clients, finding a balance between what clients see as important from their perspective and what dietitians see as important from their perspective.

This position is exemplified by the following comment:

And so, you know, I guess what I see is our role is to find a balance between allowing their knowledge of themselves and their situation and so on to be part of the goal setting and all the rest of that, in balance with us being able to give information about, assuming that you want to improve your blood sugars or want to improve your blood cholesterol as well, this is what you could do differently to achieve that.

Again, these findings are similar to those of Sumsion and Smyth (2000) in their study on barriers to client-centred practice. The top three barriers they identified related to goal setting: "the therapist and client have different goals," the therapist's values and beliefs prevent them from accepting the client's goals" and "the therapist is uncomfortable letting the client choose their own goals" (p. 19). These authors suggest that further research is required to identify strategies to overcome these barriers; however, the first step would be to recognize a problem exists and to acknowledge the struggle that health

professionals are experiencing in moving towards a model of care that shifts the balance of power to clients.

5.3.5 Decision Making

Two statements in the Delphi survey related to the decision making process, both of which were rated as five or strongly agree:

- 1. In client-centred practice, dietitians should accept clients' decisions whether they agree with them or not.
- 2. In client-centred practice, dietitians should involve clients in all stages of the nutrition care process as the primary decision maker.

However, as shown in Table 5.5, participants had some concerns about how to do this and still fulfill their professional obligations. They also suggested that their level of involvement in the decision making process would vary depending on the context in which the counselling was taking place.

Table 5.5. Decision making

Delphi Survey		Indepth Interviews
Opinion	Experience	
<ul style="list-style-type: none">• Absolutely but... struggling with client autonomy and professional responsibility• Accept does not equal agree• As long as the client is informed• Control issues	<ul style="list-style-type: none">• Difficult in practice	<ul style="list-style-type: none">• It's their decision but... sometimes you need to be more rigid• I know what needs to be done

In response to the first statement, comments ranged from “*Absolutely*” to “*Fine for some issues, not for others...*” Most of the participants recognized that they had no choice but to accept a client’s decision. “*It is their process, not mine.*” “*What else can you do? I can give my rationale and ask them to consider it, but I can’t force someone to take my advice.*” However, several stated that it was their professional responsibility to ensure that clients had sufficient information to base that decision on and that they recognize potential safety/health concerns. “*One always has to accept another’s decision whether harmful or not, but it should be pointed out to the client potential harm which could result.*” A couple of participants talked about the complexity of this issue and the difficulty in letting go.

This is difficult - the letting go of the reasons why a client may choose to not make any nutrition changes that relate to health.

Very complex, no simple answer. On one level, yes - accept and respect their decision at that point in time. It is the individual’s prerogative. Yet recognize their decisions can change over a period of time (even within the counselling session) with new information, perceptions, support and suggestions. Best if both the counsellor and the client remain open to the possibilities and can discuss them without being judgmental or adversarial.

This item was also included in the second round of the Delphi survey. Most comments this time related to the dietitian’s professional responsibility or role in the decision making process. Again, ensuring that clients are making informed decisions is important and part of a dietitian’s role. If the client makes a decision that we can’t agree with, our professional responsibility is to document and inform other members of the health care team. “*It is their*

personal right to make decisions about their health care. Our job is to inform them and provide support...” “Decisions can be accepted as long as the client is making informed decisions. If harmful to their health, RD keeps detailed documentation and informs MD and other members of the health care team as to the client’s choices.”

A couple of the participants talked about how ‘accepting’ a client’s decision did not necessarily mean that you ‘agreed’ with it and that they could agree to disagree. *“Accept does not [mean] equal agree.” “Can agree to disagree but this must not be done in a negative way.”* One participant said that perhaps the word should be ‘respect’ a client’s decision rather than ‘accept’ because that word seemed to be causing some controversy.

Several participants talked about how hard this was to do in practice. *“This is hard - usually this relates to clients wanting to be way more restrictive and prescriptive than I am advising.” “This is very hard - but I always have to remind myself to let go - it is their life and their choice.”* In some cases, participants said that they had to agree to disagree. *“Yes - for the most part. There have been times though when I have openly told the patient I disagree with them. I suppose you can disagree but still accept the client’s decision.”* I think that this last statement captures at least part of the reason why some of the participants were hesitant in completely agreeing with this statement. As some of the participants said, *“we can’t make clients’ decisions for them and they are ultimately the ones who have to accept the consequences of those*

decisions.” So dietitians really have no choice but to accept a client’s decision. However, it is our professional responsibility to ensure that our clients’ are making informed decisions. Further, if they have a concern for patient safety or risk of a health-related issue as a result of those decision, dietitians need to protect themselves by documenting the discussion and, if appropriate, following through with the client’s physician. *“As long as client’s decision is not harmful to the client.” “I accept my client’s decisions if they are informed decisions. If that decision is detrimental to their health, I document the counselling session in detail and share info with their physician...”*

In regards to the statement about involving a client in all stages of the nutrition care process as the primary decision maker, most comments from participants in the Delphi survey were qualified with words such as *“sometimes,” “it depends,”* and *“as much as possible.”* At least one participant wasn’t certain what was meant by “all stages” and I suspect that this is one of the reasons why the comments reflected the need to consider the clients context when deciding how much to involve them in the nutrition care process. *“Sometimes, however, clients who are not cognitively capable to make their own care decisions need a proxy to act on their behalf.” “The client is almost always the primary decision maker. Exceptions are clients who are overwhelmed or unable to clearly intellectualize the concept of goal setting. However, the client will always be involved or considered in the process and at all stages of it.”* It is interesting to note that this participant used the words “involved or considered.” There is obviously a difference between involving clients in a process and considering

their interests when going through a process and it is clearly easier to accomplish the later. There seemed to be a bit of a struggle related to control issues coming through some of the comments. For example, one participant said, *“They are the people that will have to do the work that is needed for the “wanted” change to happen. Therefore, they need to be in control.”* While another said, *“Inform them of necessary changes, why and how they relate to their condition, as well as expected outcome. Review process and progress regularly and make changes as needed.”* In the first case, the client is seen as having the power to make the necessary changes while in the second case it appears to be the dietitian who is in control.

In the second round of the survey, several participants reacted quite strongly to the comments given in the first round. The following statement captures this best.

It goes without saying that demented/comotose clients would not be expected to be involved in decision making! Where there is competence mentally and psychologically, clients must be involved otherwise we are simply dictators. This does not mean clients decide on detailed decisions on tube feeding etc., rather they are actively involved in the decision to tube feed and informed of changes as they occur.

Again, I think part of the problem with this statement (involving clients in all stages of the nutrition care process as primary decision makers) was the use of the words “all stages.” It appeared from some of the comments that participants interpreted this to mean that clients have to be involved in everything that dietitians would do, including calculating TPN or nutrient requirements. This confusion is exemplified by the following statement.

I agree the client needs to be in control/charge of the decisions but not all the steps of the nutrition care process are necessary for the client. This would make the job impossible to do. I sometimes do 5-6 assessments daily plus teaching. The calculations and plans are (I think) not necessary for the client - unless they ask.

Another terminology problem was that participants did not have a clear idea about what constitutes the “nutrition care process.” *“I’m not sure how this can be otherwise, but it depends on what you mean by ‘nutrition care process.’ I take it to include all aspects of food purchase/pre/eating because I’m not with the client 24-7.”* When I think of the ‘nutrition care process’ I think of the steps of assessment, planning, implementing and evaluating. This dietitian seems to be thinking of the ‘eating’ process. This points to a need to examine all the terms that dietitians use as health professionals on a daily basis to ensure that there is a consistent understanding of them.

In practice, participants again referred to “trying” to ensure clients’ understanding but being constrained by the realities of practice. *“Not always practical given the constraints of time, working with other professionals.” “This is not always possible, often because they are sometimes too sick to cognate and make decisions.”* A few talked about a shared or mutual decision making process. *“We work together and reassess at 2 week intervals.” “Tends to be more mutual than client being the primary decision maker. More responsibility on the client making decisions providing they have the background knowledge and information to make decisions.”* Again, however, at least one participant was not sure what the statement meant. *“As much as I think is expected -*

question needs clarification for me.”

In general, participants in the indepth interviews agreed that clients were the ones that made the final decisions about their care. However, depending on the situation, some participants felt that they needed to take a more active role in convincing clients to change their minds. As one participant said, *“If you have a critically ill patient you are going to be more rigid, aggressive, pushy...”* In at least one instance, it was clear that there was a real reluctance to ‘allow’ clients to make the final decision but they were resigned to fact that there wasn’t much else they could do.

I would definitely be directing the therapy in that I would know what needed to be done. But if the client didn’t want to go there, and after having explained what to do about it, the client still didn’t want to go there, well there isn’t much I can do.

There is some discussion in the occupational therapy literature on whether or not a client-centred approach should involve a complete shift in responsibility for directing the decision making process to the client. Sumsion (1993) describes a client-centred approach in which the client directs the process and makes all the decisions and the therapist provides information and accepts the those decisions. *“If we truly have incorporated this model into practice then the client is the one directing the treatment and making the decisions”* (Sumsion, 1993, p. 7). More recently, Falardeau and Durand (2002) have challenged that view of client-centredness and suggested what they refer to as a ‘Type II’ client-centred approach in which both the client and the therapist have roles in the decision-making process. They state that a client-

centred approach led by the client puts therapists in a passive role and limits their ability to help the client. Their 'Type II' approach, on the other hand, "...puts the accent on interdependence, partnership, and negotiation" (Falardeau & Durand, 2002, p. 140). Again, however, the authors recognized that this approach takes time, a resource that many participants in this current study stated was in short supply.

As previously mentioned, there is much emphasis in the literature on the importance of shared informed decision making in a client-centred approach to practice (Charles, Gafni & Whelan, 1997, 1999; Weston, 2001; Whitney, McGuire & McCullough, 2004). In this model of decision making, both the health care professional and the client are actively involved in the process and the decisions that are made are mutually agreed upon through a process of negotiation and collaboration (Charles, Gafni & Whelan, 1997). However, there are many challenges to the implementation of this approach in practice which help to explain some the difficulties participants in this study were experiencing. Say and Thomson (2003) noted that the main concern was related to lack of time and the difficulty in determining patient preferences in the short time frame that is available for a consultation. Godolphin, Towle and McKendry (2001), in a study of the challenges of implementing this model of decision making in family practice in medicine, concluded that physicians did not have the negotiation skills required and recommended additional training at the undergraduate level. This problem may also be a concern in dietetics because learning how to negotiate with clients may or may not be addressed adequately

within the current communication courses available at the undergraduate level. Finally, Weston (2001) noted that *"If physicians are truly to connect with patients and partners in care, they must change their mindset and develop skills to involve patients in meaningful ways"* (p. 438). If dietitians do not accept clients as equal partners in the counselling process, they will find it difficult to engage them in a shared decision-making process which appears to be important in a client-centred approach.

5.3.6 Client As 'Expert'

Two statements in the Delphi survey related to recognition of the client as having 'expertise':

1. In client-centred practice, dietitians should build on the strengths and resources that clients bring to a nutrition counselling session.
2. In client-centred practice, dietitians should recognize that clients are the experts when it comes to their own nutrition-related issues.

Participants strongly agreed with the first statement and, as shown in Table 5.6, most thought that recognizing clients as experts was basic to nutrition counselling and necessary to facilitate learning and to achieve successful outcomes. *"Not to do so would be foolish!" "A given-who could ever question this but a person who is not client-centred?" "In order to produce a behaviour change it works quicker (and ultimately easier) if one uses/builds on the client's strengths."* Although participants recognized that time is a barrier, they also acknowledged that practising in this way can ultimately save time. *"Takes time*

to get to know our clients but can save time in the long run.”

Table 5.6. Client as ‘expert’

Delphi Survey		Indepth Interviews
Opinion	Experience	
<ul style="list-style-type: none">• Building on client strengths and resources is basic to nutrition counselling but... time is a barrier• The word ‘expert’ evoked strong feelings	<ul style="list-style-type: none">• Try to build on client strengths but..could do a better• Absolutely to.... absolutely not!• Time is a barrier	<ul style="list-style-type: none">• Interestingly...only specifically addressed by a few participants..• Co-experts• Compliance vs empowerment• Many focussed on their ‘expertise’

When asked if they were able to recognize client expertise in their practice, comments again reflected the fact that it is important to build on client strengths and resources in a counselling session. However, several mentioned lack of time as a barrier. *“....as much as I am aware of within the time constraints of the job” “..I find this is challenging occasionally due to time but it is easier at follow-ups where there is less info provided and more goal setting/encouragement”* Several participants indicated that they tried to do this but recognize that they could do a better job at times. *“Sometimes I don’t always learn enough about their strengths and resources and could do this better.”*

The second statement had a median response of three (neither agree nor disagree) and caused the most discussion among Delphi participants. Comments ranged from, *“If this was the case then why are they in your office?”*

to “A given - who could ever question this but a person who is not client-centred?” The word “expert” seemed to evoke strong feelings and some confusion. For example,

I am not sure about this statement...taken to the extreme this could mean that the client is not provided with information they require for their nutrition issues. Anorexics/bulimics may be perceived to know a lot about nutrition but their “expert” care has often put them in the hospital with nutritional status that is not compatible with life. We all have clients that come to appointments as “experts” that inform the dietitian of their views on nutrition. Sometimes it is important to realize this is a front for not being ready to hear some information. If the above statement means they can identify the concerns that brought them to the appointment or their goals for the appointment then I totally agree.

Some participants were just not comfortable referring to clients as experts. *“I think that they are the ultimate decision maker but not the ‘expert.’ There is too much quackery out there to let people be the ‘expert.’ They would make dangerous decisions.” “They can make informed decisions but they may not always be the best decision or be the expert one.”* Others talked about a meeting of “two experts.” *“The client is an expert in aspects of their own life however the dietitian is the expert in nutrition-related issues and it is because of this that she is needed to counsel clients in this area.”*

This item was included in the second round of the Delphi study and participants had quite strong reactions to the comments in the first round. Again, some participants stated quite clearly that they are the experts as exemplified by the following:

We are the experts - similar to MD - we must clarify this LOUD and CLEAR to dissuade other so-called health experts ‘dabbling’ in our discipline.” “I could never even slightly agree to this. Whenever I am

giving even a general nutritional education session to the public or even other health care professionals I always see the light bulbs going on in people's faces with the comment, 'I didn't know that.' It is the dietitian who is the expert and it is that expert advice that the clients or our healthcare dollar is paying for!

It is clear from this comment that being an 'expert' is part of who this dietitian is as a professional. However, most participants recognized that 'expertise' is broader than technical knowledge and skills and that clients also brought an expertise to the counselling relationship that needed to be considered. *"Their expertise is in their food patterns, knowledge, barriers and strengths. Mine is advising on optimal nutrition for their current health." "They are the experts with regards to their needs/feelings/beliefs. I as RD need to understand where they are "at" and provide correct nutrition information that would meet their needs and possibly challenge their beliefs or misconceptions."*

I think that the following comment captures this best:

I do not understand some of the comments made. Of course clients may not have the nutrition or health care system/service knowledge of a dietitian but health and nutrition knowledge alone does not expertise make. I interpret this statement as, clients know best what will work in their lives when it comes to eating behaviour, thus are the experts with regard to their nutrition-related issues. Many of the comments conveyed a "dominance of those with the most technical knowledge" view that I found troubling. I stick by my view that I have many tidbits of advice I could offer but until clients share insights about what is feasible/desirable in their lives all of my tidbits are irrelevant/useless.

When asked what they did in their practice, comments ranged from absolutely to absolutely not, while others took the middle road and indicated that it depends on the issue. *"We can only know our own bodies!" "I don't feel clients are experts in their nutrition-related needs. They come to me to learn*

usually.” “Not always but I do respect what issues they have chosen.”

Comments also indicated that the participants were concerned about the misinformation available to clients and how this might affect their decisions.

“Many do not have any idea about nutrition and nutrition issues. They have heard a lot about food - from media, internet etc. that has shaped their thoughts.” Again, there was evidence of a struggle with the word ‘expert.’ For example, *“I recognize that they are experts in their own life experiences and in their behaviours. I recognize they can be knowledgeable in their own nutrition-related issues, but the dietitian is the expert.”* This struggle is probably not surprising given the emphasis in dietetic education on the importance of sound, scientific (i.e., quantitative) evidence. Dietitians are socialized to be ‘nutrition experts’ based on scientific knowledge and understanding of nutrition ‘facts’; we have spent many years trying to distance ourselves from our home economics roots with its emphasis on ‘women’s work’ (Liquori, 2001). We have also spent many years struggling to define our profession and establish ourselves as ‘the best source’ of nutrition information. This struggle has intensified over the past few years because increasing numbers of alternative health practitioners have started to dispense nutrition advice.

Interestingly, only two participants specifically addressed the issue of expertise in the indepth interviews, both of whom were involved with diabetes education. One participant talked about her expert knowledge and the client’s expert knowledge and trying to balance those two types of knowledge in the goal setting process.

Well, again, it is sort of who is the expert on what? Again, I'm speaking mostly from the diabetes perspective, but we know, more than most people that come for us, about how different foods are going to affect their blood sugars. And, you know, we deal a lot with heart health because people with diabetes are at great risk and all that. So, we know more than most people who come to us, although some people have done a whole lot of reading before they come. You know, heart healthy eating and all that. So we have that information to offer them. And we may have some problem solving skills or whatever to offer them as well. But ultimately what we don't have is an expertise in their life and their situation. And so, you know, I guess what I see is our role is to find a balance between allowing their knowledge of themselves and their situation and so on to be a part of the goal setting and all the rest of that, in balance with us being able to give information about, assuming that you want to improve your blood sugars or want to improve blood cholesterol as well, this is what you could do differently to achieve that.

Finding that balance was a challenge for this participant and I sensed a bit of a struggle in her attempt to value the client's input as opposed to the expert 'technical' knowledge of the dietitian when she referred to "*allowing their knowledge of themselves and their situation and so on to be a part of the goal setting.....*" There appeared to be a concern that having to include or recognize the client's expertise might take away the dietitian's ability to provide all the information that he/she felt necessary. This ambivalence was exemplified by the following quotation from the same participant,

But in practice it is so difficult to find a balance between, yes, wanting to address what the client wants to know. And if they're not in sort of preparation or action stages of change mode, trying to back off from giving them detailed information. And just try to meet them where they are at and all those good things. But part of...I guess there are some staff here who still feel fairly strongly, and I guess I'm a bit on the fence still, that there are certain basic pieces of information that people need to make informed choices. That we are professionally obliged to make sure they have those pieces of information, and then they get to choose.

The second participant also talked about a meeting of two experts.

“Because I am the expert on the nutrition part of it or diabetes part of it, they are the expert in the life. We are trying to put the two together.” However, in this interview there was more of a sense of a partnership approach and a working together rather than the ‘give and take’ approach described above.

And you’re bringing two separate bodies of knowledge and you are going to blend them and make them into one system, which is where the person is going to move to. So it’s taking two pieces of knowledge. You have to work together to bring that into a new understanding or a new set of knowledge that the person would work from. And so that’s why you can look at both the client and the educator as being change agents. They are changing your understanding of who they are. You are changing their understanding of what the disease is or diet or whatever. And hopefully you’ll come up with both people having a better understanding of what the new definition is of the person’s lifestyle or what they are going to change.

There is a growing body of literature that suggests the need to recognize the expertise that clients bring to a health care relationship to improve the quality of care and develop mutually agreed upon goals (Bissell, May & Noyce, 2004; Lee & Garvin, 2003; Say & Thomson, 2003). At the same time, however, it is recognized that there are many barriers in accomplishing this paradigm shift (Bissell, May & Noyce, 2004). It is not easy to move from an approach that focuses on the transfer of information from the health professional ‘expert’ to one that involves more of an exchange of information and dialogue between provider and client (Lee & Garvin, 2003). It is also not clear whether clients are ready to take on more responsibility for their health care. As Bissell, May and Noyce (2004) discovered, clients had difficulty understanding what negotiate, discussion, and partnership meant and were more comfortable with the traditional doctor-patient relationship in which they were typically told what to do.

Thus, the struggle that participants in this study expressed in regards to the recognition of client expertise reflected issues that other health professionals are also experiencing.

5.3.7 Techniques/Strategies

Two statements in the Delphi survey related to the strategies that dietitians use in client-centred practice:

1. In client-centred practice, dietitians should assess clients on an individual basis rather than use a set protocol for nutritional assessment.
2. In client-centred practice, dietitians should allow clients to choose from a variety of strategies to help them change their eating behaviours.

Although participants 'strongly agreed' that they should assess clients on an individual basis 'rather than' use a set protocol, comments suggested that a combination of both was the best approach. As shown in Table 5.7, they saw the set protocol as providing the structure or framework for the assessment so that important information was not missed, but they recognized that clients needed to be treated as individuals. *"Assessing clients on (an) individual basis is important but you need some assessment tool as a guide."* *"These shouldn't need to be mutually exclusive. We all have "protocols" in our heads even if we are varying them based on the individual we are working with."* A few participants had quite strong opinions about the importance of individual assessment. One said, *"Strongly believe in this point."* Another stated, *"This is one of the most (if not the most) important aspect of nutrition counselling. It*

promotes success for the client. It shows that the dietitian has a better understanding of the ‘human’ condition. It sets apart excellence from those that choose to remain average (or less than).” It is not clear from these responses, however, whether or not participants still used a ‘set protocol’ to guide their consultations. This ambiguity might be a result of differing interpretations of what a “set protocol” would look like. This point was evident in a few of the responses, both in the first round and the second round surveys. *“I assess on an individual basis but use set guidelines or protocol to guide my assessment. I’m not sure I understand this statement.”* (First round comment) *“What does “set protocol” mean? If it’s asking if I follow a stiff, ordered checklist the answer is no. I vary and question deeper in areas that appear significant and pertinent yet there is a certain degree of standard questioning in nutrition assessment.”* (Second round comment).

Table 5.7. Techniques/strategies

Delphi Survey Opinion	Experience	Indepth Interviews
<ul style="list-style-type: none"> • Important to individualize but...a set protocol provides a framework • What is a ‘set protocol’? • Choice of strategies... Who decides? How much? 	<ul style="list-style-type: none"> • Barriers... realities of the workplace 	<ul style="list-style-type: none"> • Directive vs nondirective approaches

In both the first round and second round responses, participants recognized that individualizing their approach took more time and is not always

possible in their workplaces. *"In the perfect world, all clients (in my opinion) would have individual assessment, but in the current work reality that I face daily, this will not happen. Then the use of set protocol can serve as a tool to identify those at high risk."* (First round). *"Clients are assessed individually and many have multiple health problems - there are guidelines for nutritional assessment - often not deviated from due to time constraints - (recognizing that this often takes away from true client-centred)"* (Second round). This struggle to balance the need to follow standards of care or practice with the belief that all clients are unique and need to be treated individually was evident in several other participants' comments. *"...at the same time honouring standards of care/practice..a bit of a juggling act sometimes."* (First round). *"I have always struggled with the idea of a set protocol being the base of nutritional assessment. I believe that a nutritional assessment is more useful, realistic and usable if an "individual basis" approach is used. However, I do believe that 'protocols' can help ensure more consistent care."* (Second round).

Many participants indicated that they used a combination of a set protocol and individualization when conducting a nutritional assessment, mainly to ensure that they covered everything that they felt was important to cover. *"I have developed protocols, but I only refer to them to make sure I've covered all the things I need to. Every client is absolutely a valued individual with unique distinctions to me."* *"This isn't an and/or question. We do both - some standard assessment steps plus individualized. The individualized assessment is an*

essential element of client-centred services." The realities of their particular practice setting, however, sometimes restricted their ability to do this. *"Not enough time due to heavy case load."* *"Hospital time constraints sometimes mean supplements automatically for hip clients."* One participant identified the need to use protocols in order to *"....stay relevant to other health professionals I work with."* This is an interesting comment and one that suggests a perceived need to prove dietitians worth to other health professionals as a valuable member of the health care team.

Only one participant indicated that she used a set protocol on a regular basis. *"I usually follow a set protocol which applies to most of my clients. I seldom vary it."* It is difficult to interpret this statement given that there appeared to be some confusion around the term 'set protocol.' On the one hand, it might imply that this participant dealt with clients with similar conditions (i.e., diabetes) on a regular basis and thus had developed a guide or 'protocol' to ensure consistent care. She may still 'individualize' that care based on a client's needs. On the other hand, it may suggest a rather rigid approach to care in which all clients were dealt with in the same way, despite their differences.

Interestingly, there is increasing emphasis in the dietetics literature on the development of models of nutritional care that ensure the delivery of standardized services (Lacey & Cross, 2002; Sandrick, 2002). These models are seen as necessary in order to create a *"standard set of measures that could be incorporated into outcomes research to demonstrate positive outcomes and*

allow comparison of research studies" (Lacey & Cross, 2002, p. 579). This need to provide evidence of dietitians effectiveness as health care professionals in the current climate of evidence-based practice appears to be in competition with the need to be 'client-centred' and helps to explain, in part, the struggle that participants in this study conveyed through their comments.

For the most part, the participants agreed that having choices was important for successful outcomes and that different clients might need a different strategy to deal with similar problems or concerns. *"Personal choice is fundamental to effective behaviour change."* *"Success is much more likely when strategies match the client."* However, only a couple of participants talked about this as being a two-way conversation or negotiation process between the client and the dietitian. For example, *"....negotiate with strategies -allow client to feel he or she is part of this session - a team approach."* *"There is always a choice. Therefore, a client-centred RD will assist in identifying the needed variety of strategies."* And even with these comments it is not clear who is identifying the strategies to be used in the first place. Most participants identified themselves as the one who identified the strategies. *"I decide which strategies to offer. The client makes a choice."* *"I tell them what I recommend and they tell me what is feasible given their situations at home, work etc."* Several stated that it was important for them to present only a few of these strategies to their clients so that they weren't overwhelmed with information. *"The wise counsellor will narrow the range of choices to those deemed most likely to work best for that*

client. Then the client chooses or commits. Too many choices (i.e., too wide a variety of strategies) is not helpful for most clients. We can help to focus.” “I present choices that I think would work best then fine-tune along with the client. Too much choice is confusing.” The question that this statement raises for me is if a dietitian does not present all the options, is this really allowing the client choice? On the other hand, maybe the way the statement is worded implies that dietitians have the strategies and their role is to present those to clients so that they can choose the one that they think will work best for them. This understanding was certainly evident in some of the comments from the second round of the survey. This probably depends on a client’s background (education, culture, nutrition knowledge, reason for coming to the dietitian etc.) and what I have been calling the ‘realities of practice.’ One participant summed this situation up nicely by saying,

I agree that clients need to have a variety of strategies to choose from; however the complexity of this must be determined based on the clients’ ability to understand and make choices which must be determined during the interview by the dietitian. Time may also play a factor in the amount of variety discussed.

When asked what they did in their practice, comments reflected a more balanced or flexible approach than what participants described as their ‘ideal.’ Participants gave specific examples of what they might say in an interview to help clients choose a strategy. *“I feel comfortable with this myself - here are a few ideas. Do any of these feel okay for you? Vs You should do this and this.”* *“I sometimes use phrases such as ‘do you think you could do/try this?’ or*

'maybe you could do/try this if y [participant's word] happens.' These comments seem to indicate a rather passive role for the client in that the dietitian identifies the possible strategies rather than the client or the client and dietitian together. On the other hand, one participant identified a concern with the word 'allow' and suggested that clients sometimes do take a more active role. *"Allow language - I don't have that kind of control. They often set their own strategies."* I think that this ties in with the struggle that some of the participants had with the word 'expert.' Because dietitians are the nutrition 'experts' some may feel that it is their role to have all of the answers to clients' nutritional issues and thus come up with the potential strategies that they can use. Others may feel more comfortable in recognizing the expertise that clients bring to the relationship and work in partnership with their clients to identify potential strategies. However, again several identified the difficulty in doing this within the constraints of their workplaces. *"Takes time to do this, though! (Which is not always practical or possible)" "A variety of treatment strategies as offered by our clinic or within each program."*

In the indepth interviews, I asked participants to talk about the techniques and strategies that they used in their counselling to make it client-centred. As was the case when I asked them to talk about their role and the role of the client in the client-centred approach, many participants had difficulty answering this question. I had to repeat it several times and, in some cases, reword the question to help them understand what I was asking. In those cases, I asked the participants to describe what they did in a typical counselling session. Analysis

of this data suggests that participants used two main approaches to counselling. The first appeared to be similar to the client-centred approach advocated by Carl Rogers (1965) and what Vickery and Hodges (1986) referred to as a 'nondirective' approach. This primarily involves the development of a trusting, accepted relationship between the dietitian and the client. Interactions between the dietitian and client involve a back and forth approach and two-way communication. Two participants, in particular, talked about what they do in a counselling session in a way that suggested a primarily nondirective approach. They used phrases such as *"I just sort of invite people....so tell me about yourself."* and *"....we talk, talking mainly. And we talk about what's going on in the present moment. So what is the client bringing to the session. And then everything kind of evolves from the conversation."* What these participants seem to be doing is trying to really understand the client. According to Vickery and Hodges (1986) when discussing client-centred counselling, "In order to assist the client, the counsellor needs to understand the client's perceptual world" (p. 40). This understanding comes from really listening to the client and checking that understanding with the client if a dietitian is unsure. These participants demonstrated this approach when they said, *"And it's exhausting because I'm really seeking understanding. I'm seeking clarification. I'm seeking meaning in what is said and what is unsaid. And I'm questioning in just trying to come to a deeper understanding."* and *"We talked about whatever and then we went on and talked about these other things. So are you, you know, is that okay? Have we addressed the things that you want addressed?"*

Both of these participants dealt with particularly vulnerable populations in terms of their health status and both have done additional training/education to develop their counselling skills. This background likely has influenced their approach to counselling.

The second approach that emerged from the data was much more 'directive' in that the participants were leading or controlling the process. Vickery and Hodges (1986) describe the 'directive' approach as being very much a one-way approach where the focus is on the counsellor telling the client what they need to do. For example, one participant said,

Well, in my opinion, and I've done this in my work as a counsellor, is set the tone from the beginning. So even though it is a client-centred thing, like the process that I've followed I'd always have a one hour initial appointment with a person before any advice was exchanged.

Another said, *"....when people come to visit they know that this is what I do. I give them a three...a three visit, which is a pretty standard assessment, work on the follow-up based on the assessment and then a follow-up with the third visit.*

These two approaches were not mutually exclusive in that sometimes participants would use both. For example, one participant said,

I guess I find, like I would first of all,.....more information about the person and their current lifestyle. And I would ask them I would also ask them, you know, what's going to work for you? Or after I've suggested something, you know I'll say, 'Is that going to work for you?'

So in this case, the participant started out by exploring a client's world (a nondirective behaviour) but then talked about suggesting something (offering a treatment) which would be considered a directive behaviour (Vickery & Hodges, 1986). Several participants indicated that their approach differed depending on

the client and that in some situations they needed to be more directive. This is exemplified by the following quotation:

I mean, I guess....if you have someone unconscious in the hospital and needs TPN, they're not going to have any input whatsoever in their treatment. So obviously in those situations there is no client-centredness other than trying to give them what they need.

Holli and Calabrese (1991), in their discussion on the use of directive and nondirective counselling, indicate that directive counselling is generally used when a client is not aware of the problem or doesn't know anything about it. The nondirective approach is said to be appropriate when the client is aware of the problem and is seeking out help from the counsellor. Participants in this study appeared to be struggling with trying to find a balance between these two approaches and reconciling their beliefs about what a 'client-centred' approach should look like with what they were actually able to accomplish within the confines of their workplaces. Several participants talked about the challenges involved in trying to be more flexible and spending time with clients to get to know them better. As one participant stated,

Try to get them to communicate a little bit more to see where they are at. But boy, it's hard. It's very time consuming to do. And I think that is one of the other barriers too. You often don't have the time to maybe dedicate as much to it as we would like.

5.3.8 Context

Only one statement in the Delphi survey related to the context of counselling:

1. In client-centred practice, dietitians should consider the context in which

clients live in developing nutrition care plans.

As would be expected, the median response to this statement was five or strongly agree. As shown in Table 5.8 comments indicated that all the participants agreed that this is a necessary part of client-centred care and that it is needed to help clients be successful and achieve their nutrition-related goals. Participants mentioned the need to be realistic and to tailor the counselling to meet individual needs several times. *“Must be realistic when mapping out a plan. Client has a bigger chance of success if he can do it within context in which they live.” “Plans are worthless if they aren’t tailored to living situation.”*

Table 5.8. Context

Opinion	Delphi Survey	Indepth Interviews
	Experience	
<ul style="list-style-type: none">• Necessary to achieve successful outcomes• Need to be realistic• ‘Tailored’ care	<ul style="list-style-type: none">• Sometimes difficult to do...• Client resistance• Realities of the workplace	<ul style="list-style-type: none">• Physical setting• Hospital setting but need to be more rigid, efficient, aggressive• Need to ‘make’ the client realize the importance of dietary changes ‘needed’• What does ‘context’ mean?

When asked whether they were actually able to accomplish this goal in practice however, participants’ comments reflected the realities of their workplaces and the fact that clients aren’t always willing to share the information

needed to individualize the nutrition care plan. *"This is sometimes difficult to assess depending upon the available info. Some patients are reluctant to provide too many details on their living conditions, especially finances."* One participant indicated that she didn't always feel comfortable doing this and that *"...this took some time to come to grips with...that my counselling advice could differ greatly from one client to another for the same concern."*

In the indepth interviews, I asked participants whether or not they felt the context of counselling influenced their approach. Some participants answered this by talking about the importance of the physical environment. *"Well I think that you have to put a lot of emphasis on the appearance of the room."*

I think that the appearance of the office is really, really important.....My office is....I've had a decorator. And it's pleasant. And my whole office faces the south and there is a lot of light....So I think the whole office has to be inviting and pleasant.

For the most part, however, they addressed this question by comparing counselling in a hospital setting with counselling in other settings (outpatient, private practice). Although most of the dietitians said that it is possible to be client-centred in a hospital setting, they generally agreed that it is difficult. Patients in hospital tend to be sicker and stay for shorter periods of time than was the case in the past. Trying to talk to patients about their diet is difficult when they are focussed on their current illness and what the doctor/nurse has just told them.

I found a difference when you see clients on the floor versus seeing them as an outpatient. Because there is just so much going on. They are often in crisis situations; they just learned they have diabetes and they don't know what to focus on anymore. They are often in denial

and it is not the best way to provide education. As opposed to an outpatient clinic where you are not as rushed. You have more time, although you are still limited in time, the fact that the client comes, and he is not in pyjamas, he is ready to, he is more inclined to learn I found. Yes...the setting makes a big difference.

This poses a dilemma for dietitians who see that it is critical for patients to make dietary changes immediately to improve their health but who also believe in a client-centred approach where it is ultimately up to the client to make his/her own decisions. What do they do in these cases? As illustrated by the following quotation participants talked about being more rigid, efficient, aggressive, imparting survival information, and doing the counselling in stages - all in an attempt to “make” the client realize how important it is to make the dietary changes and all the while still purporting to be using a client-centred approach.

I have found that even if you have a critically ill patient in front of you you need to have a client-centred approach but you are going to be more rigid and say, you know, look, that if you don't do that you may die. You have to be more efficient but the client has to make the decision as well. You may be more aggressive in terms of providing information, well...not providing information, but you may be more pushy.

I think that this apparent contradiction speaks to the struggle that dietitians who want to be client-centred have in trying to balance what they see as their professional/ethical obligation to “treat” the client’s illness with the realities of the healthcare system and their belief that clients should be making their own decisions/choices about their care. This struggle was certainly evident in the following quotation [responding to the question, How do you think the context of counselling influences your ability to deliver nutrition counselling services in a client-centred manner?]:

Well, yah, I'm not sure that it needs to. Uhm...because you know, if your initial interaction with them is still trying to find out their concerns and what they feel they need and so on I....I mean I guess one example away from the diabetes field is that if you have someone unconscious in the hospital and needs TPN, they're not going to have any input whatsoever in their treatment. So obviously in those situations there is no client-centredness other than trying to give them what they need. But...so I guess it depends to a great extent on how much....but I mean even with medications where lifestyle doesn't get impacted or whatever, where the doctor would prescribe something or whatever I guess I still feel that the patients in hospital or emergency or something, that one would hope that the person would still be consulted to some degree about, yes I'm going to consent to this treatment. Again, you know, if you are going to save their life by doing something immediately without talking to them I think that you are obliged to do that. But if there is a little time to discuss what this is all about I think that ideally you would do that.

One of the participants, who worked both as an inpatient and outpatient dietitian, admitted that she didn't do the client-centred (she referred to it as client-focussed) part in the hospital.

So I think my approach differs in that the client-focussed part is not going to happen in that setting. It is going to happen later. When, you know, people are waiting an hour and a half to see me and the doctor - 5 minutes is all they get. But the follow-up does happen later.

For the counselling to be "client-focussed," this participant found it necessary to have sufficient time with the client, something that was generally not possible in a hospital setting.

I think that ultimately it is about creating an environment where the person feels comfortable enough to share openly....I think that it has to do with the warmth of, the tone that the dietitian would set as a counsellor.....it is very difficult to be client-centred in a hospital.

Two other participants identified the idea that the interpersonal or 'human' skills that the dietitian brings to the counselling session are important in

a client-centred approach.

Because I think that even if I was called to the patient's bedside probably the only variables that would be that much different would be the patient is perhaps ill or in pain or didn't have the attention span because they were in hospital. As opposed to being in outpatients when I assume they are going to be more alert and feeling better. So that might affect, say the amount of time I'm able to spend with a patient as an inpatient. That might influence the amount of information that I give. But I don't think that I would really practice any differently. Because again, it is just part of my philosophy.

Because it comes back down to how you are with clients. How you are in relationship. The content, the background nutrition knowledge, it could be anything. But ultimately what it comes back to is who you are as a practitioner and what you bring to their experience.

In looking at the various responses to this question, I recognized that the context of counselling can mean so many different things to different people. As I have just discussed, for some it refers to the physical environment where the counselling is taking place. This place can be as specific as the type of room and furniture available or more broadly refer to the setting (in hospital, outpatient, private practice). The context can also include the source of referral and why the client has been referred (illness, health promotion) because context impacts on the client's readiness to change. I also think that context can refer to where the client and dietitian are coming from, their cultural backgrounds, education, and experience because all of these factors can influence how counselling is done. For example, a few of the participants talked, in an indirect way, about the influence of a particular event in their professional lives that changed the way that they looked at their practice. One in particular had a very powerful story about her brother who was diagnosed with a rare liver disease

and died within a few months. The dietitian had put him on a very restrictive diet, despite his prognosis. When this participant went to visit her brother he told her that he “...*would love a chicken leg and some peas*” but he was not allowed to have it because of his diet prescription. So she contacted the dietitian to ask her to allow her brother to eat whatever he wanted in the last months of his life. The response from the dietitian was, “*well...to tell you the truth, I’ve never met your brother...well, his disease and the dietary restriction that he is on is so restrictive and he’s dying. And the whole situation kind of unnerves me, so I haven’t met him yet because he has just been so sick.*” The participant’s initial response to this response was outrage and anger but then she started to question her own practice and whether or not she too avoided people because of their medical situation. She had to admit that she did and, as a result, she went on to study adult education and changed her approach to counselling as illustrated by the following,

What I spend my time doing now is figure out what this is all about for somebody. And then...the way that I talk from then on in...what I try to do is mimic the language people use....And so for me, that’s what client-centred means is to figure out what is the meaning of eating or feeding for this person or their family and try to offer up what I can....and I have rarely found people who I would say are harming themselves with what they eat.

What is evident in this quotation is the trust that this participant has in her clients’ ability to make decisions about their care and an emphasis on the importance of eating food rather than restricting nutrients in supporting better health. It also speaks to the importance of building a relationship with clients and respecting the expertise that clients bring to that relationship.

5.3.9 Building a Relationship

Two statements in the Delphi survey alluded to the importance of building a relationship with clients:

1. In client-centred practice, dietitians should demonstrate respect for clients' opinions.
2. In client-centred practice, dietitians should create an environment where clients feel accepted and understood.

As would be expected, both these statements had median responses of five or strongly agree. As shown in Table 5.9, participants saw respecting clients' opinions as essential to gain clients' respect and trust. However, several noted that respecting clients' opinions does not mean that they always agree with them. If they believe that a client's opinion is wrong or potentially unhealthy/unsafe *".....it is the responsibility of dietitians to gently try to redirect or get the client to see other possibilities."* Interestingly, one participant talked about the importance of actively demonstrating respect.

Easy to overlook that this is active, not passive, ie. Sometimes RD can think 'of course I respect my client's opinions' but in fact they don't. This cannot be a mental exercise only. Demonstrating respect forces RD to confront him/herself and question whether she is really respecting client's opinions - or just giving lip service to the idea.

The notion that "demonstrating respect" is an active process and is difficult to do in practice was reflected in the comments from participants when asked about whether or not they respect their client's opinions in their practice. Although the participants again commented that this is *"....a must if we want to gain client's trust and cooperation,"* several indicated that they are not always

able to achieve this goal. They used words such as “try to” “not always but I’m trying,” “I hope to do this,” and “..as much as I am able.”

Table 5.9. Building a relationship

Opinion	Delphi Survey Experience	Indepth Interviews
<ul style="list-style-type: none">• Essential but...are we actively respecting client's opinions?• Respect does not equal accept	<ul style="list-style-type: none">• Difficult in practicerealities of the workplace	<ul style="list-style-type: none">• Recognition of the need to develop but.... Do we know how to do this?

Respecting the rights and opinions of others is important in any relationship. However, as identified by participants in this study, respecting the choices and opinions of clients does not necessarily mean that accept them. As Falardeau and Durand (2002) point out, the concept of respect is very complex and its definition depends on many factors. Law, Baptiste and Mills (1995) refer to respect in terms of having a high regard for the autonomy, values and culture of clients. However, there are limits to respecting the autonomy of clients, particularly in health care relationships where a level of risk is attached to potentially ‘unsafe’ choices that they might make (Falardeau & Durand, 2002).

Creating an environment where clients felt accepted and understood was again identified as being essential to build trust, develop rapport, and to increase the likelihood of success. “Effective solutions and realistic goals are not likely to be identified without this..” “Essential to developing rapport.” “This

is a crucial defining element of my practice. It is the place from which all of my work originates.” Two participants mentioned that the realities of practice made accomplishing this goal difficult at times. *“Sometimes it will take a few sessions to accomplish this. It may be difficult to develop a ‘positive therapeutic alliance’ in a first session.” “Not always possible with lack of space/privacy sometimes (sharing offices etc.).”*

In practice, it was clear again that, although the participants thought that creating an environment was an essential component of client-centred practice, they were not always able to accomplish it. Comments such as *“I try,” “As much as I can,” “When allowed to by the client,” “Within the restrictions of the work environment,” “I like to think it usually happens,”* or *“Hard to do in a hospital bed!”* again reflect the realities of practice. However, participants also recognized the importance of doing the best they could with what they had available and having good communication and interpersonal skills. *“Basic empathy can be achieved anywhere.” “Start with being a good listener - it helps. Office straight, organized, attractive and appealing.”*

5.3.10 Benefits

None of the statements in the Delphi survey specifically addressed the issue of the benefits of a client-centred approach to nutrition counselling although there comments that indicated it was considered to be a more effective approach. *“The more we involve the client, the better the outcome.” “Effective*

solutions and realistic goals are not likely to be identified without this." *"Only then can we expect better compliance and desired outcome."* Participants in the indepth interviews were asked about the benefits of delivering nutrition counselling services using a client-centred approach and, again, many of them talked about effectiveness and success. They saw the client-centred approach as a way to motivate clients to 'stick to' the nutrition care plan. *"Based on my experience, when you find a way to motivate the client, using your client-centred approach, the client is more eager to stick to it, commit to it, than if you just sort of give a set of recommendations."* As is evident in this quotation, the 'old' approach to which they compared the client-centred approach was primarily an information giving, prescriptive approach to care. Another participant described her change in approach. *"...And I can speak from experience here too because I've had a real shift in how I've changed in my practice in 20 years. Definitely when I started practising I came from the compliance model and I told people what they should do."* It is interesting that this participant referred to the 'old' approach as being the 'compliance model' when one of the comments from the Delphi survey (stated above) indicated that the client-centred approach resulted in better 'compliance.' This apparent contradiction was also evident in comments from several of the interview participants. For example, one stated (when talking about the benefits of the approach), *"..... if you find a way to involve your client, if your client is at the center, if your client is involved in the decision making, the compliance is better."* Another recognized that the word

compliance is an problem, but used it anyway. *“Compliance - you know, the evil word. Patients are more likely to buy into a plan that they have had a role in creating.”* The word ‘compliance’ really does not fit with the partnership approach that these dietitians were talking about when they referred to client involvement in the decision making process and having a role in creating the nutrition care plan. Again, this position speaks to the struggle that these dietitians were having in translating their beliefs about client-centredness into practice. Within the medical model of healthcare, in which many of these dietitians work, when a physician sends a client to a dietitian there is an expectation that the dietitian will ensure ‘compliance’ with the dietary recommendations.

As a result of increasing awareness of the problems related to the use of the terms ‘compliance’ and ‘adherence’ in health care relationships, health professionals are being encouraged to develop ‘concordance’ with their clients (Bissell, May & Noyce, 2004). Concordance has been defined in various ways but essentially it describes an approach to the provision of health care that actively seeks out the views of clients as ‘experts’ in their own lives and involves the development of a therapeutic alliance where mutual decision making and goal setting can occur (Bissell, May & Noyce, 2004; Vermeire, Hearnshaw, Van Royen & Denekens, 2001). This is an interesting concept and one that might be useful to explore in dietetics, given that many of the participants in this study recognized the problems with the use of the terms ‘compliance’ and ‘adherence’ but did not appear to know what to replace them with.

Participants in the indepth interviews also referred to the client-centred approach as providing the dietitian with job satisfaction. As one participant stated,

I think that for a dietitian who has been in practice for a long time, it is much more challenging and rewarding. Just churning out a standardized counselling hour after hour doesn't do it for me. So I think that is something enlivens our work and allows us to grow and progress in our own professional development.

Others talked about the benefits to the dietitian in terms of a shift in responsibility and a feeling of relief. One participant noted:

You are not left feeling that you have to do all the work for every person who comes through the door. That ultimately it is their responsibility and by offering them into and, you know, trying to establish rapport and offer to problem solve if they want that or whatever. You've opened the door but ultimately they have to decide how far in they are going to walk or if they are going to leave things for a while. So from a professional point of view I think that it takes a lot of the stress out of the situation. You are free to just say "I'm here, what do you need? You know, on those safety issues. And after that it is over to them.

This comment seems to suggest the view that a client-centred approach results in a complete handing over of responsibility to the client rather than a partnership approach in which the dietitian acts as a facilitator in the process.

This understanding may stem from the lack of confidence in the facilitation process as previously discussed. It may also stem from the perception that a client-centred approach is completely client-driven and that a dietitian's role is primarily support. This position would fit with the view of 'client-centredness' as originally proposed by Carl Rogers but does not appear to fit with more recent definitions as described in Chapter Two.

5.4 Conclusion

I had hoped that the indepth interviews would provide me with a deeper understanding of what dietitians do when they provide nutrition counselling to clients and what makes that counselling client-centred. Because our professional standards document stipulates that dietitians practice using a client-centred approach, one would assume that there would be a common understanding of what that means. The results of this research clearly identify that this is not the case.

When I was educated in the 1970s, nutrition counselling was conducted using a very prescriptive or 'dietitian-centred' approach. We were expected to learn how to counsel patients by observing others. Most dietitians were employed in hospital settings and the clients were either 'counselled' at the bedside or were referred for outpatient counselling after discharge. Dietary changes needed would be identified by the dietitian based on a nutritional assessment, which was often done with very little input from the patient. The dietitian (or in some cases the physician) would set the nutrition-related goals (often in the form of a diet prescription) for the client, based on the client's nutritional needs as determined in the assessment process. The strategies used to meet these goals would typically take into consideration the client's lifestyle, socioeconomic and cultural status, and other psychosocial and demographic factors that might impact nutritional health, but again, they were usually identified by the dietitian. This approach earned our profession the nickname "the food police." Because dietitians often focussed on telling our

clients what 'not' to eat, there was generally a fairly negative impression of what a dietitian was.

As a dietitian, I became increasingly frustrated with this reputation and the lack of success I was having with clients. The majority of my clients in the outpatient setting had cardiovascular diseases and diabetes and came to me for weight loss counselling. My colleagues and I spent a lot of time talking to these clients, telling them what their nutrition-related problems were and giving them suggestions as to how to change their diets to lose weight. We then complained to each other when our clients failed to comply with our suggestions.

Despite a growing sense of awareness of the ineffectiveness of this approach, it continued to be used. There were probably a number of reasons for this but for me it provided a structured framework to use and ensured that clients got the full benefit of my education and training. It also fit with the medical model of healthcare which is where many dietitians continue to work.

In the last 20 years or so there has been a growing recognition that dietitians cannot make people change their eating behaviours by telling them what we think is best based on our nutritional assessment. More clients have chronic conditions that require lifelong dietary changes and who want to be involved in the management of their conditions. This requires a different approach. It also requires an understanding of health behaviour change theories and how to help clients to learn to self-manage their conditions. The standards for dietetic education and training in Canada have been updated and

changed to reflect these requirements. Despite these changes, however, it appears that not all dietitians are comfortable with the more nondirective approach that is necessary to promote long lasting dietary behaviour change.

The results of this study suggest that dietitians are struggling to reconcile their understanding of a 'client-centred' approach to nutrition counselling with the realities of their workplaces. Although they recognize the need to 'let go' of professional power and recognize the expertise that clients bring to a nutrition counselling relationship, there is a concern that we are letting go of our professional responsibility as dietitians if we don't tell clients everything we know (and therefore everything we think they need to know) in order to make informed decisions about their nutritional care.

The analogy of who is in the driver's seat comes to mind when reflecting on participants' comments. All the dietitians I interviewed recognized that the client is the ultimate decision maker (the driver) and that the dietitians' role is to facilitate the counselling process so that clients are able to make those informed decisions. However, some seemed to want to be able to steer or direct the process more than others. On the one hand, some were happy being in the passenger's seat and providing assistance based on where the client wanted to go while others seem to wanted to have one hand on the steering wheel so that if a client started to go off in a direction that they did not think was the 'right' one they could put them back on course.

It appears that for most dietitians, client-centredness exists on a continuum and that, depending on the context (where they work, the type of

client they have, how much experience they have as dietitians, the type of education/training they have) and the realities of their workplaces (time, resources) they are able to be more client-centred at times and more dietitian-centred at other times.

Although no clear definition of client-centred nutrition counselling emerged from this study, it was obvious that participants were struggling in their attempts to actively involve their clients in the nutrition care process. They recognized the need to move beyond the role of information provider to facilitator of behaviour change but not all participants were comfortable in that role. This discrepancy may be a result of inconsistencies in their education as identified in this study. Several participants stated that they had no training or education in nutrition counselling, either at the undergraduate level or during internship. However, there appeared to be an underlying concern related to the transfer of power in the dietitian-client relationship which needs to be addressed by the dietetic profession.

The results of the discussion that I had with the group of seven expert dietitian counsellors on PEI confirmed my thinking in these areas, particularly in relation to the struggle that study participants appeared to have in trying to balance their sense of professional responsibility with wanting to meet clients' needs. The discussion group agreed that this struggle is not a black and white issue and suggested that this struggle is likely more intense if a client has a condition that is considered more life threatening. We spent a considerable amount of time discussing the issue of 'expertise' because study participants

had such strong opinions on it. The discussion group all agreed that because of the way dietitians are typically educated (in the medical model) we do tend to value technical knowledge (or expertise) over any other form of knowledge (i.e., personal knowledge). In regards to the issue of 'needs vs wants,' the discussion group also all agreed that they struggled with this issue all the time - knowing that they need to understand clients' needs but also knowing that sometimes those needs are really 'wants.' Knowing the difference and how to address client 'needs' while still doing their job is an ongoing balancing act.

As Townsend (2003) notes in her article on the issues of power and justice in the occupational therapy profession, it is not really surprising that therapists are struggling in their attempts to be client-centred given that "...occupational therapy is not a powerful profession and the clients/consumers we serve also lack power..." (p. 82). The dietetics profession is also not a very powerful profession and dietitians have had to work hard to position themselves as valued members of the health care team. This struggle appears to have influenced our approach to care and our ability to work as equal partners in a counselling relationship with our clients. Dietitians' challenge now is to acknowledge that we are struggling with these issues and encourage broader discussion of the values and beliefs that underpin our approach to practice.

Chapter 6

SUMMARY AND CONCLUSIONS

6.1 Introduction

The purpose of this research was to explore dietitians' understanding of nutrition counselling. More specifically, it attempted to clarify the meaning that dietitians ascribe to the client-centred approach to nutrition counselling, to identify the concepts and issues inherent in this approach to practice, and to describe the experiences of dietitians in its implementation. A two-round, reactive Delphi survey, followed by indepth interviews, contributed to the findings. Results indicated that dietitians have no one definition of client-centred nutrition counselling and that how they interpret this concept depends on many factors. While the study sought to better understand the client-centred approach to counselling, the findings of this study have raised as many questions as they have answers.

6.2 Research Questions

The following section will outline the research questions and present the answers to those questions based on the research findings.

1. What is the nature of the nutrition counselling process?

In general, the results of this research suggest that how dietitians counsel their clients varies depending on the context in which the counselling session takes place (i.e., client's medical condition, client's readiness to change, whether or not follow-up is possible, hospital or outpatient setting). The educational and practice experiences that a dietitian brings to the counselling session also influences her approach. However, it was clear that dietitians' are struggling in their attempt to be client-centred (however they define it) in what is still, in practice, mainly a paternalistic healthcare system. The following subquestions address this issue more specifically.

1.1 What do dietitians mean when they say that they provide nutrition counselling using a client-centred approach?

There is no one answer to this question based on the results of this research. All the dietitians in this study believe that they practise using a client-centred approach, yet many of them talked about what they do in quite different ways. When asked to define client-centred care, most participants in the indepth interviews talked about meeting clients' needs. However, several participants struggled with the issue of whose needs were most important and expressed concerns about giving clients only what they perceived they needed (generally referred to as 'wants'). This position was seen as potentially unsafe and unethical and a "letting go" of their professional responsibility. The fact that

some of the participants had a very difficult time articulating their definition of a client-centred approach to care highlights the need for a broader discussion of this issue. This problem will be discussed in more detail in section 6.4.

1.1.1 What are the important concepts and issues inherent in this approach to practice?

The results of the Delphi survey indicated that participants strongly or partially agreed with 15 of the 18 concepts identified from the literature as being important in a client-centred approach to practice. These concepts indicated that dietitians should:

- A. Provide nutrition services designed to meet the needs and wants of clients.
- B. Act as facilitators to enable clients to achieve their nutrition-related goals.
- C. Consider the context in which clients live in developing nutrition care plans.
- D. Demonstrate respect for clients' opinions.
- E. Work with clients to develop mutually agreed upon goals.
- F. Build on the strengths and resources that clients bring to a nutrition counselling session.
- G. Tailor educational materials to the needs and wants of individual clients.
- H. Allow their clients to identify their own nutrition-related issues.
- I. Accept clients' decisions, whether they agree with them or not.
- J. Create an environment where clients feel accepted and understood.

- K. Advocate on behalf of their clients.
- L. Assess clients on an individual basis rather than use a set protocol for nutritional assessment.
- M. Allow clients to choose from a variety of strategies to help them change their eating behaviours.
- N. Involve clients in all stages of the nutrition care process as the primary decision maker.
- O. Provide clients with enough information to enable them to make informed decisions.

It was clear, however, from the comments from the participants that these concepts were not universally understood. For example, several participants indicated that they were not sure what was meant by the term 'nutrition care process' and some were confused by the term 'advocate.' Further, many of them talked about their struggle to implement these concepts in their practice due, primarily, to time restraints and other resource issues.

1.1.2 What are the anticipated outcomes of client-centred nutrition counselling?

This study suggests that being client-centred is considered essential for helping clients' make dietary changes that are relevant and realistic. Many participants talked about seeing change happen when they used this approach. They understood involving clients in the decision making and goal setting processes as being more effective than simply telling clients what they needed

to do. Participants thought that their clients would be more likely to take ownership of the goals and commit to change when they had input into identifying what was needed. At the same time, however, a few participants used the word 'compliance' when talking about the benefits of the client-centred approach, suggesting that clients' obey or give in to their suggestions. This thought highlights the struggle that many of the dietitians in this study appear to be experiencing in letting go of their 'expert' power to work in a partnership relationship with their clients.

Participants in the indepth interviews also saw the client-centred approach as beneficial for themselves in terms of increased job satisfaction. They talked about this approach as being more challenging and rewarding and stated that the successes that they were able to achieve gave them more recognition and credibility. Interestingly, one participant stated that she was not convinced that the client-centred approach to counselling was any better in terms of client outcomes but the fact that she felt better about it had convinced her of its value. This participant, and several others, talked about a sense of relief in terms of not having to take the blame when clients did not make the dietary changes that a physician might see as necessary. The client-centred approach was seen as putting the responsibility for change back on the client so that if change did not happen it was not the dietitian's fault.

1.1.3 How do dietitians describe their role in client-centred nutrition counselling?

Many participants struggled to clearly define their role in this approach to practice. This struggle might suggest that dietitians have not given a lot of thought to this issue. On the other hand, it might relate to a lack of understanding of what the client-centred approach involves and the struggle that many of them seem to be experiencing between their beliefs about client-centred practice and their ability to convert those beliefs into practice given the context in which they work.

Although participants strongly agreed that dietitians should act as facilitators in client-centred practice, at the same time, they hesitated in being 'only' a facilitator because some interpreted this position as being too passive. These participants expressed the need to direct or steer the client at times and to provide information as well as guiding the process of change. Providing information and ensuring that clients are fully informed was seen as critical and part of a dietitian's professional responsibility. Thus there appeared to be some confusion about the term 'facilitator' and what that involves and a concern that in 'true' client-centred practice the dietitian responds only to what the client wants or asks for and does not intervene if she thinks that there are nutrition-related issues of which the client is unaware.

Participants also struggled with their role in problem identification, goal setting, and decision making. Again, although there was general agreement that dietitians should allow clients to take the lead in these areas, participants expressed concern about letting clients do so solely on their own. This appeared to be due, at least in part, to concerns that clients may not be aware

of important health issues (as identified by the dietitian) or that they may have incomplete or inaccurate information. Some participants also stated that they felt that not all clients want to be involved in their care, rather they want to be told what to do.

Although the Delphi participants agreed that dietitians should advocate on behalf of their clients, they expressed some confusion regarding what 'advocacy' really meant and what it would look like in practice. Several participants stated that they did not know how to interpret 'advocate' and one said that she never had the opportunity to advocate in her practice. On the other hand, a few participants talked about how advocacy was an integral part of client-centred practice and the professional responsibility of dietitians. This apparent contradiction may be due to barriers in the workplace, particularly in relation to time. However, confusion regarding the use of this term may also be related to Dietitians of Canada's use of the 'advocacy model' of practice which is really more about promoting the profession rather than working on behalf of the clients dietitians serve. This issue will be discussed in more detail in Section 6.4.

1.1.4 How do dietitians describe the role of the client in client-centred nutrition counselling?

It was evident from the results of this study that many of the participants had not given a lot of thought about the role of the client in a client-centred

approach to nutrition counselling. Most of them stated that the client is the one who has to make the decisions but there was a real concern about making sure that those decisions were informed by the information that the dietitian provided. Further, although there has been considerable discussion in the literature in the last several years about clients taking a more active role in their healthcare, this was not something that the interview participants really talked about, except in relation to the need for clients to provide information needed to help dietitians understand a client's condition. Although they used words like 'negotiation' and 'partnership' and 'working with' clients, there was a hesitation and struggle evident in how they talked about actually doing this in practice, perhaps from a lack of trust in their clients' ability to make the 'right' choices or decisions or a concern about completely letting go of the process. Although some participants acknowledged the expertise that clients bring to the counselling relationship, others seemed more reluctant to relinquish control of the counselling relationship and saw a need to establish themselves as the 'expert.'

1.1.5 What techniques do dietitians use that make the counselling session 'client-centred?'

Most participants indicated that they used a set protocol to provide the structure or framework for the initial assessment, so that they did not miss valuable information, but they recognized that clients needed to be treated as individuals. Thus they said it was important to individualize or tailor the counselling session for each client to increase the chances for success. They

also recognized that this approach took more time and was not always possible in their workplaces due to heavy caseloads, lack of resources and/or support. Further, there was some confusion around the term 'set protocol' and some participants struggled with the notion of letting go of the structure to allow for the flexibility needed to provide individualized care.

Many participants had difficulty describing more specifically the techniques and strategies that they used in a counselling session to make those sessions 'client-centred.' However, a close examination of the data revealed two quite different approaches. The first one was a mainly nondirective, flexible approach to counselling in which the development of a therapeutic alliance between the counsellor and client was key to success. The second was a more directive or counsellor-driven approach. In this approach, the dietitian took a leadership role and controlled the process, following a standardized process with little emphasis on the development of a trusting relationship between the client and counsellor. These approaches are not mutually exclusive because, depending on the context of the counselling, dietitians may be more directive in certain situations and more nondirective in others.

Because 'client-centredness' is increasingly being advocated as the preferred approach to care, it is tempting to try to identify the specific behaviours that one must engage in to demonstrate this approach. The ability to define specific behaviours holds appeal because it would provide a form of instructional guide or model to follow to ensure the delivery of quality care to our clients. When I set out to do this research this was one of my goals. However, I

now believe that this may be problematic. The results of this study suggest that there is no single definition of client-centredness and no one right set or combination of behaviours or activities that describe it. The client-dietitian relationship changes over time. Client and dietitian preferences regarding involvement in the nutrition care process may also change over time. Perhaps more important than describing specific techniques or strategies or trying to develop a model of client-centred care would be to agree on certain fundamental principles around dietitians approach to care. This will be discussed further in Section 6.4.

2. Are the nutrition counselling experiences as described by dietitians congruent or incongruent with their opinions of what makes nutrition counselling client-centred.

For the most part, the counselling experiences described by the dietitians in this study were incongruent with their opinions of what makes nutrition counselling client-centred. This was due primarily to lack of time. Participants recognized that it takes more time to actively listen to what clients have to say and respond to their needs than it does to have a preset agenda and just tell clients what they need to do. Although client-centred nutrition counselling was seen as being more effective, some saw it as being less efficient than the more traditional dietitian-centred approach (in which the dietitian makes all of the decisions and leads the process) because it is so open-ended. This lack of efficiency was a problem for some participants due to the need to provide

quantitative outcome indicators and monthly statistics for administration. Expectations were also mentioned as a barrier. Some participants stated that their clients expect them to hand out a diet sheet and to be told what to do. Others stated that physicians expected the dietitian to make sure that clients comply with their dietary prescription. Because many dietitians still practice in very traditional workplaces where the physician is the ultimate decision maker, they find it difficult to take a more flexible, individual approach to goal setting with clients. The dietitian's area of practice also appeared to be a barrier to the client-centred approach to nutrition counselling. It was particularly problematic in a hospital setting where resources are very limited and clients are often referred on their way out the door. Although most participants indicated that they thought it is possible to be client-centred in an acute care setting, almost all of them recognized the difficulties associated with counselling in this setting. Despite these difficulties, however, the dietitians in this study hesitated to suggest moving their counselling services out of acute care. This belief appeared to be due to a concern that their clients would not receive any nutrition counselling at all if this was the case.

6.3 Summary of Major Research Findings

1. **There was no one definition of the concept of client-centred nutrition counselling.** How this concept is interpreted depends on the context in which counselling takes place.
2. **There was general agreement that meeting the needs and wants of**

clients is important in a client-centred approach to practice;
however, how those needs are defined and whose needs are most
important is less clear. Dietitians are struggling to balance meeting clients' needs and wants and making sure that they are fulfilling their professional responsibility to fully informed their clients.

3. The dietitians in this study believed that practising in a client-centred way is essential for successful counselling outcomes.

Despite the finding that no consensus occurred on what client-centred counselling looks like, there was general agreement that it was necessary to help clients make relevant and realistic dietary behaviour changes.

4. Dietitians' are struggling with the concept of 'expert' and recognizing the expertise that clients bring to a nutrition counselling relationship.

There was general agreement that clients' know themselves best and that it is important for dietitians to understand their clients so that they can individualize their counselling approach. However, not all dietitians were comfortable with accepting that this client knowledge represented a certain kind of expertise.

5. Using a client-centred approach to practice increased job

satisfaction for dietitians. Seeing their clients make positive dietary changes and not feeling the weight of responsibility for ensuring that those changes were made was rewarding for these dietitians. They also felt that this approach to practice brought them more recognition and

credibility as a profession.

6. **Dietitians struggled with their role as facilitator of dietary behaviour change.** Some dietitians saw the facilitator role as being too passive and were concerned that if they just facilitated the process the client may not be fully informed. They identified the need to be more directive at certain times and with certain clients and to provide information in addition to guiding the process of change.
7. **The role of the client in client-centred nutrition counselling was unclear.** Although there was general recognition and agreement that the client is the ultimate decision maker and that clients need to be a part of the counselling process in order for them to take ownership of their issues, dietitians were struggling with how to involve clients in the process.
8. **Dietitians are struggling to find a balance between using structured protocols for nutritional assessment and counselling and using a more flexible, individualized approach that focuses on client's needs.** Dietitians in this study identified the need to individualize their approach to counselling. At the same time they were under pressure in their workplaces as a result of an increased emphasis on evidence-based care and shrinking healthcare budgets. Using set protocols provided for more consistent care; however it is less personalized than an approach which allows for the development of a trusting relationship between the

counsellor and the client.

6.4 Recommendations

It is my hope that the insights and knowledge generated by this study will benefit the dietetics profession and, ultimately, the clients we, as dietitians, serve. Towards this end, this section of the thesis outlines recommendations for further action in three areas: dietetic education, practice, and research.

6.4.1 Recommendations for Dietetic Education

It was clear from the results of this research that inconsistencies exist in the way that dietitians are educated in Canada, particularly in regards to nutrition counselling. Some of the participants in this study stated that they had no training or education in nutrition counselling during their undergraduate or internship experiences. As a profession, dietitians talk about the importance of knowing how to counsel clients to help them make difficult changes in their dietary behaviours; however it appears that this has not been translated into the educational standards (the knowledge statements for undergraduate programs and competencies for internship) that are used to guide dietetic education in Canada. Further, despite the emphasis on the development of communication skills both at the undergraduate and internship levels, many of the participants in this study were not comfortable in their role as facilitators. Because the knowledge statements that are supposed to guide the development of undergraduate dietetics programs in Canada do not mention the importance of

facilitation skills, this is perhaps not surprising. Of even more concern, however, is the fact that counselling is not even mentioned in the knowledge statements. It is left up to individual university programs across the country to include, or not include, counselling theories and the development of counselling skills (such as facilitation, negotiation, advocacy, partnership, and relationship building) as they see fit. Counselling is mentioned in the competencies for the entry-level dietitian that are used to guide the dietetic internship level experience. However, how these competencies are achieved likely varies from internship to internship and the experience that an intern may have differs across the country. This fact was certainly evident in the responses that study participants gave when asked about their training in nutrition counselling during internship. These competencies were developed in order to allow for a broad range of experiences and the development of transferable skills. Unfortunately, however, in many cases they are not clearly defined and there is a lot of overlap among them. For example, counselling is listed as one of several 'communication skills' including advocacy, negotiation, lobbying, interviewing, teaching, and facilitating. Counselling is more than just a communication skill and it clearly involves facilitation. It may also involve advocacy, negotiation, interviewing, and teaching.

As a result of these findings, I have the following recommendations for dietetic education in Canada:

- 1. Dietitians need to reexamine the knowledge statements to ensure that the importance of developing skills and knowledge related to**

nutrition counselling is clearly identified. At the present time, the emphasis in the knowledge statements is on the principles of communication, education, learning, and behaviour, which may or may not include theories related to counselling and the facilitation process. For the most part, this lack has translated into curricula that offer communication and/or nutrition education courses. A recent search of the websites of undergraduate dietetics programs in Canada revealed a few that offer a course specifically addressing nutrition counselling. It is likely that nutrition counselling is addressed as a topic in other courses (i.e., nutritional assessment and/or clinical nutrition); however, it is recommended that consideration be given to developing separate courses on nutrition counselling at the undergraduate level.

2. **Dietitians need to reexamine the competency statements to ensure that the development of counselling skills (including facilitation) is identified as a critical component of practice.** Because counselling is such a critical role for dietitians, it should be a separate competency rather than one of many communication skills that need to be demonstrated 'when appropriate.'
3. **The knowledge statements and competencies should be reviewed 'as a whole' rather than as separate documents.** There are some inconsistencies between these two sets of guidelines for dietetic education which may be contributing to the difficulties that dietitians are

experiencing in trying to deliver client-centred nutrition counselling services. For example, in the knowledge statements, the term 'client-focussed' is used. In the competency guidelines, there is no direct reference to either a 'client-focussed' or 'client-centred' approach to service. Rather, there is an indirect reference to including clients as active partners and collaborating with clients. Reviewing these guidelines together would help to ensure that the competency statements build upon the knowledge statements and reflect the progression to a higher level of practice.

4. **Undergraduate dietetic educators should be encouraged to continue to monitor and update their curricula and to use a variety of approaches to teaching and learning to ensure that students are actively involved in learning.** Perhaps just as important as what is included in the curriculum at the undergraduate level, is how that curriculum is delivered. The traditional lecture-based approach to teaching reinforces the notion that people learn best by being told what to think and know. This approach also reinforces the notion of 'expertise' in that the professor is seen as the one who holds the knowledge and the student is seen as the passive recipient of that knowledge. Adults generally learn best by doing, thus it is important to continue to review and evaluate the approaches that are used to educate dietetic students in order to ensure that they are actively engaged in the learning process. In turn, this will help student learn how to involve their clients in a

counselling session. One concern of many university instructors is that it is not possible to cover all of the course content if they use active learning methods in their classrooms. Perhaps one way to overcome this misconception, and to provide those instructors with some concrete suggestions, would be to have an ongoing networking session at the annual Dietetic Educators meeting. At those sessions, those instructors who have already been successful in incorporating active learning techniques into their curriculum could be invited to share their ideas with others.

5. **Dietetic internship coordinators should enhance opportunities for hands-on practice of counselling skills during internship.** Although the purpose of the internship experience is to allow for the development of skills, some participants in this study stated that they only had the opportunity to observe a nutrition counselling session. This may be a result of the lack of emphasis of the importance of counselling skills in the competency document or it may be a function of time. It is recognized that it is a significant challenge for internship coordinator to ensure that interns meet all the required competencies in a short time frame. Mentoring dietetic interns to become effective counsellors does take time; however, without hands-on practice there is no opportunity for these interns to learn from their experiences. It may also be helpful for interns to be a recipient of counselling. This practice would help them to identify what it is like to be the 'client' and perhaps develop an

understanding of the need to respect the 'expertise' that clients bring to a counselling relationship.

6. Dietetic students should be encouraged to become critically reflective practitioners. Being an effective counsellor involves more than just good communication skills and having 'expert' nutrition knowledge. It is also important to understand how to develop a therapeutic relationship with clients and actively respect the knowledge and skills that they bring to that relationship. Developing the facilitation skills that are required to be an effective counsellor takes time and practice. Although dietetic educators can help students to start to develop these skills during their undergraduate and internship experiences, they need to continue to build upon them in practice. Thus, it is important to instill in students, starting at the beginning of their dietetic education, the importance of being critically reflective practitioners. They need to examine early on in their education who they are and what they bring to a counselling relationship. What are their biases and how do those biases affect interactions with clients? Dietetic educators can do this by building in opportunities for self-assessment and encouraging the use of reflective journals.

6.4.2 Recommendations for Dietetic Practice

If practising in a client-centred manner is truly important dietitians need to start to discuss what this means to our profession and to ask ourselves pointed

questions about what we do on a day-to-day basis. Do we truly believe that it is possible to involve clients in all aspects of care as equal partners? Do we respect the expertise that they bring to the counselling relationship? Are we ready to work in partnership with our clients? What does 'working in a partnership relationship' look like? To this end, I have the following recommendations for dietetic practice.

1. There needs to be a broader discussion of the values and beliefs that underpin client-centred care in dietetics.

It was clear from the results of this study that there is currently no consensus regarding the definition of client-centred care and many participants struggled in their attempt to define what it meant to them. Other professions, particularly occupational therapists, have spent years discussing this issue. Dietitians have been mandated by our Professional Standards document to use a client-centred approach, but we really have not had the opportunity to explore our values and beliefs related to this issue as a profession. This will not be an easy task.

However, because it is a professional standards issue, it would make sense for the Professional Standards Advisory Committee of Dietitians of Canada to take a lead role, perhaps as part of the reexamination of the Professional Standards for Dietitians in Canada document. Again, however, it would be important to review these standards in conjunction with the guidelines for dietetic education in Canada to ensure

consistency.

2. Dietetic practitioners need to be encouraged to be critically

reflective. This study provided participants with the opportunity to challenge their current thinking about how they practise on a day-to-day basis and several stated that they enjoyed the opportunity to reflect on that practice. However, all dietitians need to become more critically reflective about how we practise. We then need to share those reflections with each other at workshops, conferences and in our workplaces. Only through active debate and discussion will we be able to identify the underlying assumptions that guide our practice and ultimately, improve the quality of services that we offer our clients.

3. It is time to take a serious look at dietitians role as counsellors in

acute care settings. It was recognized by almost all study participants that practising in a client-centred way takes time. The reality is that in most acute care settings there are fewer dietitians and precious little time to develop a relationship with clients. Further, clients who are acutely ill are generally not ready for nutrition counselling in hospital. Dietitians in these settings are forced into providing clients with 'survival' information with the hope that this will meet clients' immediate needs. Participants in this study voiced the concern that giving up a counselling role in hospitals might leave clients without any access to nutritional guidance and support. Further, although only one participant in this study voiced a concern about losing dietitian positions if we suggest moving out of the

acute care setting, it is likely that this concern is shared by others. Thus, it would be important to advocate for increased dietetic services in the community before we relinquish this health-care role.

6.5 Further Research

As I stated earlier, this study has raised more questions than it has provided answers. There is much more work to be done in the area of professional practice and what it means to deliver nutrition services using a client-centred approach. It is clear that there currently is no common understanding of what this approach looks like, perhaps an impossible quest given the nature of our profession. We work in diverse areas and deal with clients from a variety of backgrounds, all with different needs. We also come from different cultural and family backgrounds and have different educational and professional experiences which shape the way that we practice. Having said this, however, we do need to have a common understanding of our professional standards in order to deliver nutrition services effectively and how to help our clients cope with nutrition-related problems and make dietary behaviour changes that will improve their health.

Most importantly, however, dietitians need to find out what our clients think it means to be 'client-centred.' What do they need and/or expect from us? Do they want to be involved in the decision making and goal setting processes or would they rather we did that? What do clients perceive as the barriers to decision making and what would help them to adopt a more active treatment

decision making role? We also need to have a better understanding of why our clients' have different treatment preferences and what meaning they ascribe to those preferences. Ideally, this research would involve qualitative, indepth interviews with clients who have had the experience of being counselled by a dietitian. This type of research could potentially provide useful 'vignettes' of client experiences that could be used as teaching tools, allowing for discussions regarding aspects of effective and ineffective counselling practices.

It would also be interesting to explore the issue of 'expertise' in dietetics. How do dietitians become 'experts' in nutrition and what impact does that status have on the way that we practice? Many participants in this study talked about how their approach has changed as they gained experience in nutrition counselling. A phenomenological study, using a three-interview process as described by Seidman (1998), that explores the progression from novice to expert (Benner, 1984) would help to uncover the differences in how dietitians practise at each stage of the continuum. Again, this type of research could potentially provide some powerful stories of dietetic practice that could be used as teaching tools.

6.6 Significance of the Study

To be effective, professional standards must be clearly articulated, understood and valued by the profession they are meant to serve. Although the current Professional Standards for Dietitians in Canada have existed for over five years, it would appear from the results of this research that at least one of

those standards is not clearly understood and that there is no common understanding of what it means to provide nutrition counselling services using a client-centred approach. More importantly, however, it has uncovered the struggle that dietitians are experiencing in trying to implement their beliefs about what makes counselling effective in workplace environments that are not conducive to developing therapeutic relationships with clients. Thus, it opens the door for future discussions on what dietitians believe in and value as nutrition counsellors and, ultimately, to the development of more effective counselling relationships with our clients.

6.7 Conclusions

Few dietitians would argue that providing client-centred care is not important. However, it is also important to recognize that this issue is complex, and one that requires dietitians to take a closer look at how we are educated and socialized as dietitians in Canada. Dietitians have spent many years trying to position ourselves as the 'nutrition experts' and we teach our students to use scientific evidence to make clinical decisions, following a medical model of practice. We then ask dietitians to be 'client-centred' without having a common understanding of what that truly means. Thus it is not surprising that many of the participants in this study were struggling with this issue. As previously mentioned, when I originally set out to do this research, I planned to find out from dietitians, using a Delphi survey, what they meant when they said they used a client-centred approach to nutrition counselling. I was then going to

explore the experience of nutrition counselling from the perspective of the client and compare what dietitians said they were doing with what the clients said they were doing to see if those experiences were congruent or incongruent with the dietitians' views of a client-centred approach. However, after one round of the Delphi survey it was clear to me that there were several issues that needed to be explored with the dietitians in greater detail than was possible with a mailed survey questionnaire. Thus, the decision was made to drop the interviews with the clients and focus in on the dietitians' understanding of the counselling process, specifically in relation to the client-centred approach. Twenty-five of the Delphi participants agreed to talk to me about their practice and share their stories. I think that this fact in itself illustrates the interest that dietitians have in talking about what they do and the need to spend more time as a profession in discussing our professional role identity. The insights that these stories provided added a layer of complexity onto this study that made it challenging to answer the research questions that I originally set out to answer. However, I believe that sharing the results of this research may open the door for future discussions about the nature of our profession and lead to improvements in the way that we deliver our services to clients.

References

- Achterberg, C. (1988). Qualitative methods in nutrition education evaluation research. *Journal of Nutrition Education*, 20, 244-250.
- Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behavior and Human Decision Processes*, 50, 179-211.
- Anderson, B. (1998). Reflection on practice: Dietitians as partner or expert? *Canadian Journal of Dietetic Practice and Research*, 59, 138-142.
- Andrew, B. (1975). Interviewing and counseling skills. *Journal of the American Dietetic Association*, 66, 576-580.
- Backman, D., Haddad, E., Lee, J., Johnston, P., & Hodgkin, G. (2002). Psychosocial predictors of healthful dietary behavior in adolescents. *Journal of Nutrition Education and Behaviour*, 34, 184-193.
- Baker, C., Wuest, J., & Stern, P. (1992). Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing*, 17, 1355-1360.
- Baldwin, T., & Falciglia, G. (1995). Application of cognitive behavioral theories to dietary change in clients. *Journal of the American Dietetic Association*, 95, 1315-1317.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bauer, K., & Sokolik, C. (2001). *Basic nutrition counseling skill development*. Toronto, Canada: Wadsworth.
- Beaudry, M., Lilley, S., & Aucoin-Larade, L. (1991). A conceptual framework for dietitians. *Journal of the Canadian Dietetic Association*, 52, 77-79.
- Becker, M., Drachman, R., & Kirscht, J. (1972). Motivations as predictors of health behaviour. *Health Services Reports*, 87, 852-862.
- Becker, M., & Maiman, L. (1975). Sociobehavioral determinants of compliance with health and medical care recommendations. *Medical Care*, 8, 10-24.
- Benner, P. (1984). *From novice to expert. Excellence and power in clinical nursing practice*. Don Mills, Ontario: Addison-Wesley Publishing Company.

- Bensing, J., Verhaak, P., van Dulmen, A., & Visser, A. (2000). Communication: The royal pathway to patient-centred medicine. *Patient Education and Counseling*, 39, 1-3.
- Berenbaum, S. (1994). *Possible futures for public health: Implications for continuing professional educational needs of public health nutritionists*. Unpublished doctoral dissertation, Walden University, Minneapolis MN.
- Berenbaum, S. (2004). *Nutrition program planning and evaluation course manual*. Saskatoon, SK: University of Saskatchewan.
- Beretta, R. (1996). A critical review of the Delphi technique. *Nurse Researchers*, 3 (4), 79-89.
- Biltz, P., & Derelian, D. (1978). Changing dietitians attitudes toward client counselling. *Journal of the American Dietetic Association*, 73, 239-241.
- Bissell, P., May, C., & Noyce, P. (2004). From compliance to concordance: Barriers to accomplishing a re-framed model of health care interactions. *Social Science & Medicine*, 58, 851-862.
- Boberg, A., & Morris-Khoo, S. (1992). The Delphi method: A review of methodology and an application in the evaluation of a higher education program. *The Canadian Journal of Program Evaluation*, 7, 27-39.
- Bogers, R., Brug, J., van Assema, P., & Dagnelie, P. (2004). Explaining fruit and vegetable consumption: The theory of planned behaviour and misconception of personal intake levels. *Appetite*, 42, 157-166.
- Bournes, D. (2000). A commitment to honoring people's choices. *Nursing Science Quarterly*, 13(1), 18-23.
- Boyle, M., & Morris, D. (1999). *Community nutrition in action. An entrepreneurial approach* (2nd Ed). Toronto: West/Wadsworth.
- Brauer, P., Imes, S., & Thomson, A. (1988). Economic impact of nutrition counselling in patients with crohn's disease. *Journal of the Canadian Dietetic Association*, 48, 231-240.
- Brownridge, E., & Upton, E. (Eds.).(1993). *Canadian dietitians making a difference*. Toronto: The Canadian Dietetic Association.

- Brug, J., van Assema, P., Kok, G., Lenderink, T., & Glanz, K. (1994). Self-rated dietary fat intake: association with objective assessment of fat, psychosocial factors and intention to change. *Journal of Nutrition Education*, 26, 218-213.
- Burnard, P. (1999). *Counselling skills for health professionals* (3rd Ed). Cheltenham, UK: Stanley Thorne Publishers Ltd.
- Caelli, K. (2000). The changing face of phenomenological research: Traditional and American phenomenology in nursing. *Qualitative Health Research*, 10, 366-377.
- Caggiula, A., & Watson, J. (1992). Characteristics associated with compliance to cholesterol lowering eating patterns. *Patient Education and Counseling*, 19, 33-41.
- Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE.
- Carter, W. (1990). Health behavior as a rational process: Theory of reasoned action and multiattribute utility theory. In K. Glanz, F. Lewis, & B. Rimer (Eds.). *Health behavior and health education. Theory, research and practice* (pp. 63-91). San Francisco: Jossey-Bass Publishers.
- Cave, R. (1988). Consultative methods for extracting knowledge about professional competence. In R. Ellis (Ed.), *Professional competence and quality assurance in the caring professions* (pp. 199-229). New York: Chapman and Hall.
- Chapman, G., & MacLean, H. (1990). Qualitative research in home economics. *Canadian Home Economics Journal*, 40, 129-134.
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). *Social Science and Medicine*, 44, 681-692.
- Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science and Medicine*, 49, 651-661.
- Chewning, B., & Sleath, B. (1996). Medication decision-making and management: A client-centred model. *Social Science and Medicine*, 42, 389-398.

- Chin, J. (2002). Doctor-patient relationship: From medical paternalism to enhanced autonomy. *Singapore Medical Journal*, 43(3),152-155.
- Cinnamon, P. (1970). Man as patient. *Journal of the Canadian Dietetic Association*, 31, 179-184.
- Clark, C., & Krupa, T. (2002). Reflections on empowerment in community mental health: Giving shape to an elusive idea. *Psychiatric Rehabilitation Journal*, 25(4), 341-349.
- Cohen, N., Stoddard, A., Sarouhkhani, S., & Sorensen, G. (1998). Barriers toward fruit and vegetable consumption in a multiethnic worksite population. *Journal of Nutrition Education*, 30, 381-386.
- Corey, G. (2001). *Theory and practice of counselling and psychotherapy*. Toronto: Brooks/Cole.
- Corring, D., & Cook, J. (1999). Client-centred care means that I am a valued human being. *Canadian Journal of Occupational Therapy*, 66, 71-82.
- Contento, I., & Murphy, B. (1990). Psychosocial factors differentiating people who reported making desirable changes in their diets from those who did not. *Journal of Nutrition Education*, 22, 6-14.
- Cotugna, N., & Vickery, C. E. (1989). Student dietitians' experiences with dietary compliance. *Journal of the American Dietetic Association*, 89, 1301-1302.
- Creswell, J. (1998). *Qualitative inquiry and research design. Choosing among five traditions*. Thousand Oaks, CA: Sage Publications, Inc.
- Crisp, J., Pelletier, D., Duffield, C., Adams, A., & Nagy, S. (1997). The Delphi method? *Nursing Research*, 46, 116-118.
- Curry, K., & Jaffe, A. (1998). *Nutrition counselling & communication skills*. Toronto: W.B. Saunders Company.
- Dajani, J., Sincoff, M., & Talley, W. (1979). Stability and agreement criteria for the termination of Delphi studies. *Technological Forecasting and Social Change*, 13, 83-90.
- Daly, M. (1993). Overcoming the barrier of words. In M. Gertais, S. Edgman-Levitan, J., Daley, & T. DeBance (Eds.), *Through the patients eyes* (pp. 72-95). San Francisco: Jossey-Bass.

- Danish, S., Ginsberg, M., Terrell, A., Hammond, M., & Adams, S. (1979). The anatomy of a dietetic counseling interview. *Journal of the American Dietetic Association*, 75, 626-630.
- Department of National Health and Welfare & Canadian Association of Occupational Therapists. (1983). *Guidelines to the client-centred practice of occupational therapy*. Ottawa, ON: Minister of Supply and Services Canada, Cat. No. H 39-33/1983E.
- Dietitians of Canada. (2000). *Professional standards for dietitians in Canada*. Toronto, ON: Dietitians of Canada.
- Droege, M. (2003). The role of reflective practice in pharmacy. *Education for Health*, 1, 68-74.
- Eggers, R., Hubbard, O., & Jones, C. (1998). Practical considerations for conducting Delphi studies: The oracle enters a new age. *Education Research Quarterly*, 2, 53-66.
- Ellis, R. (Ed.). (1988). *Professional competence and quality assurance in the caring professions*. New York: Chapman and Hall.
- Emanuel, E., & Emanuel, L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association*, 267, 2221-2226.
- Epstein, L., Myers, M., Raynor, H., & Saelens, B. (1998). Treatment of pediatric obesity. *Pediatrics*, 101(3), 4554-571.
- Falardeau, M., & Durand, M. (2002). Negotiation-centred versus client-centred: Which approach should be used? *Canadian Journal of Occupational Therapy*, 69, 135-142.
- Falk-Rafael, A. (2001). Empowerment as a process of evolving consciousness: A model of empowered caring. *Advanced Nursing Science*, 42(1), 1-16.
- Fearing, V., Law, M., & Clark, J. (1997). An occupational performance process model: Fostering client and therapist alliances. *Canadian Journal of Occupational Therapy*, 64, 7-15.
- Ferrer-Mansoori, B. (1995). Essential knowledge for a doctoral degree in nutrition education. *Journal of Nutrition Education*, 27, 32-37.
- Firestone, W. (1987). Meaning in method: The rhetoric of quantitative and qualitative research. *Educational Researcher*, 16, 16-21.

- Fishbein, M. (Ed). (1967). *Readings in Attitude Theory and Measurement*. New York: Wiley.
- Gage, M. (1994). The patient driven interdisciplinary care plan. *Journal of Nursing Administration*, 24, 26-35.
- Gage, M., & Polatajko, H. (1995). Naming practice: The case for the term client-driven. *Canadian Journal of Occupational Therapy*, 62, 115-118.
- Gerteis, M., Edgman-Levitan, S., Daley, J., & Debanco, T. (Eds.)(1993) . *Through the patient's eyes* (2nd Ed.). San Francisco: Jossey-Bass Publishers.
- Gilboy, M. (1994). Compliance-enhancing counselling strategies for cholesterol management. *Journal of Nutrition Education*, 26, 228-232.
- Gladding, S. (1991). *Group work. A counselling specialty*. New York, NY: Macmillan Publishing Company.
- Glanz, K., & Eriksen, M.. (1993). Individual and community models for dietary behaviour change. *Journal of Nutrition Education*, 25, 80-86.
- Glanz, K., Lewis, F., & Rimer, B. (1997). *Health behaviour and health education. Theory, research and practice* (2nd Ed). San Francisco, Jossey-Bass Publishers.
- Glesne, C. (1999). *Becoming qualitative researchers* (2nd Ed). New York: Addison Wesley Longman.
- Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers*. New York: Longman.
- Godolphin, W., Towle, A., & McKendry, R. (2001). Challenges in family practice related to informed and shared decision-making: A survey of preceptors of medical students. *Canadian Medical Association Journal*, 165, 434-435.
- Goodman, C. (1987). The Delphi technique: A critique. *Journal of Advanced Nursing*, 12, 729-734.
- Green, L, & Kreuter, M. (2005). *Health program planning: An educational and ecological approach* (4th Ed.). Toronto: McGraw Hill.

- Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review Paper*, 29, 75-91.
- Guba, E., & Lincoln, Y. (1989). Fourth generation evaluation. Thousand Oaks, CA: Sage Publications.
- Haley, T. (2000). Solution-focused counseling with a sexual abuse survivor. *Guidance and Counseling*, 15, 18-22.
- Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*, 32, 1008-1015.
- Hastings, J. (1973). The role of the nutritionist in the community health centre. *Journal of the Canadian Dietetic Association*, 34, 143-155.
- Hauchecorne, C., Barr, S., & Sork, T. (1994). Evaluation of nutrition counselling in clinical settings: Do we make a difference? *Journal of the American Dietetic Association*, 94, 437-439.
- Hauenstein, D., Schiller, R., & Hurley, R. (1987). Motivational techniques of dietitians counselling individuals with Type II diabetes. *Journal of the American Dietetic Association*, 87, 37-42.
- Hawirko, L., Dickie, J., & Wong, B. (1994). Expanding professional horizons to provide client-centred care. *Journal of the Canadian Dietetic Association*, 55 (Supplement), 19.
- Hermansen, C., & Wiederholt, J. (2001). Pharmacist-patient relationship development in an ambulatory clinic setting. *Health Communication*, 13, 307-325.
- Hodges, P., & Vickery, C. (1989). *Effective counselling strategies for dietary management*. Rockville, Maryland: Aspen Publishers, Inc.
- Holli, B., & Calabrese, R. (1991) *Communication and education skills: The dietitian's guide* (2nd ed). Philadelphia: Lea & Febiger.
- Issel, L. (2004). *Health program planning and evaluation. A practical systematic approach to community health*. Mississauga, ON, Jones and Bartlett Publishers.
- Isselmann, M., Deubner, L., & Hartman, M. (1993). A nutrition counselling workshop: Integrating counselling psychology into nutrition practice. *Journal of the American Dietetic Association*, 93, 324-325.

- Janz, N., & Becker, J. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11, 1-47.
- Kasila, K., Poskiparta, M., Karhila, P., & Kettunen, T. (2003). Patients' readiness for dietary change at the beginning of counselling: A transtheoretical model-based assessment. *Journal of Human Nutrition and Dietetics*, 16, 156-166.
- Kirby, S., Baranowski, T., Reynolds, K., Taylor, G., & Binkley, D. (1995). Children's fruit and vegetable intake: socioeconomic, adult-child, regional, and urban-rural influences. *Journal of Nutrition Education*, 27, 261-271.
- Kiy, A. (1998). The philosophy of nutrition therapy. *Topics in Clinical Nutrition*, 13, 51-62.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21, 827-836.
- Kocher, R. (1972). New dimensions for dietitians in today's health care. *Journal of the American Dietetic Association*, 60, 17-20.
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45, 214-222.
- Lacey, K., & Cross, N. (2002). A problem-based nutrition care model that is diagnostic driven and allows for monitoring and managing outcomes. *Journal of the American Dietetic Association*, 102, 578-589.
- Lang, M., & Upton, E. (Eds.) (1973). *The dietetic profession in Canada*. Toronto: The Canadian Dietetic Association.
- Law, M. (1993). *Law's vision*. Paper presented at the 3rd annual provincial conference and AGM of the Ontario Society of Occupational Therapists, London, ON.
- Law, M., Baptiste, S., & Mills, J. (1995). Client-centred practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy*, 62, 250-257.
- Law, M., & Mills, J. (1998). Client-centred occupational therapy. In M. Law (Ed.), *Client-centred Occupational Therapy*, (pp. 1-18). Thorofare, NJ: SLACK Incorporated.

- Lee, R., & Garvin, T. (2003). Moving from information transfer to information exchange in health and health care. *Social Science and Medicine*, 56, 449-464.
- Legault, F., & Ferguson-Pare, M. (1999). Advancing nursing practice: An evaluation study of Parse's theory of human becoming. *Canadian Journal of Nursing Leadership*, 12(1), 30-35.
- Lewis, T., & Osborn, C. (2004). Solution-focused counseling and motivational interviewing: A consideration of confluence. *Journal of Counselling Development*, 82, 38-48.
- Lewis & B. Rimer (Eds.). *Health behavior and health education. Theory, research and practice* (pp. 161-186). San Francisco: Jossey-Bass Publishers.
- Lewis, N., Hay, A., & Fox, H. (1987). Evaluation of a workshop model for teaching counselling skills to nutrition students. *Journal of the American Dietetic Association*, 87, 1554-1556.
- Lien, N., Lytle, L., & Komro, K. (2002). Applying theory of planned behaviour to fruit and vegetable consumption of young adolescents. *American Journal of Health Promotion*, 16, 189-197.
- Lincoln, Y. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, 1, (3), 275-289.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- Ling, L. (1975). Guidelines for diet counselling. *Journal of the American Dietetic Association*, 66, 571-575.
- Linstone, H., & Turoff, M. (1975). *The Delphi method. Techniques and applications*. Don Mills, Ontario: Addison-Wesley Publishing Company.
- Liquori, T. (2001). Food matters: Changing dimensions of science and practice in the nutrition profession. *Journal of Nutrition Education*, 233, 234-246.
- Lutz, B., & Bowers, B. (2000). Patient-centred care: Understanding its interpretation and implementation in health care. *Scholarly Inquiry for Nursing Practice: An International Journal*, 14(2), 165-187.
- Marshall, C., & Rossman, G. (1995). *Designing qualitative research* (2nd Ed.). Thousand Oaks, CA: Sage Publications, Inc.

- Mason, M., Wenberg, B., & Welsh, P. (1982). *The Dynamics of clinical dietetics* (2nd Ed). Toronto: John Wiley & Sons.
- Matthews, M., Mahaffey, M., Lerner, R., & Bunch, W. (1975). Profiles of the future for administrative dietitians via the Delphi technique. *Journal of the American Dietetic Association*, 66, 494-499.
- McConkey, N. (2003, May). *Brief solution-focused counselling: How to shift from problem talk to solution talk™* Presentation to the Dietitians of Canada Annual Conference. Calgary, Alberta.
- McKenna, H. (1994). The Delphi technique: A worthwhile approach for nursing? *Journal of Advanced Nursing*, 19, 1221-1225.
- McKenzie, J., & Smeltzer, J. (1997). *Planning, implementing and evaluating health promotion programs. A Primer* (2nd Ed). Toronto: Allyn and Bacon.
- McKnight, M., & Illich, I. (1976). Growth process in nutrition counselling. *Journal of the American Dietetic Association*, 69, 505.
- Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science and Medicine*, 51, 1087-1110.
- Mead, N., & Bower, P. (2002). Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Education and Counseling*, 48, 51-61.
- Merriam, S. (1998). *Case study research in education: A qualitative approach*. San Francisco: Jossey-Bass.
- Mhurchu, C., Margetts, B., & Speller, V. (1997). Applying the stages of change model to dietary change. *Nutrition Reviews*, 55, 10-16.
- Miles, M., & Huberman, A. (1984). *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills, CA: Sage Publications.
- Miller, N., & Dollard, J. (1941). *Social Learning and Imitation*. New Haven, Conn: Yale University Press.
- Misskey, E., Moss, G., Lee, E., & Hill, L. (1985). A comparison of three needs-assessment methods. *Journal of Nutrition Education*, 17, 143-146.

- Mitchell, G., Closson, T., Coulis, N., Flint, F., & Gray, B. (2000). Patient-focused care and human becoming thought: Connecting the right stuff. *Nursing Science Quarterly*, 13(3), 216-224.
- Montano, D., Kasprzyk, D., & Taplin, S. (1997). The theory of reasoned action and the theory of planned behaviour. In K. Glanz, F. Lewis & B. Rimer (Eds.), *Health behaviour and health education. Theory, Research and Practice* (2nd Ed). (pp. 85-112). San Fransisco, CA: Jossey-Bass, Inc.
- Morse, J., & Field, P. (1995). *Qualitative research methods for health professionals* (2nd Ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Morse, J., & Richards, L. (2002). *Readme first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage Publications.
- Moustakas, C. (1990). *Heuristic research: Design, methodology and applications*. Thousand Oaks, CA: Sage Publications, Inc.
- Murphy, J., Cameron, D., Garber, G., Conway, B., & Denomme, N. (1992). Dietary counselling and nutritional supplementation in HIV infection. *Journal of the Canadian Dietetic Association*, 53, 205-208.
- Nelson-Jones, R. (1984). *Personal responsibility dounselling and therapy. An integrative approach*. London: Harper & Row Ltd.
- Neuman, B. (1995). *The Neuman systems model* (3rd ed.). Norwalk, CT: Appleton & Lange.
- Ohlson, M. (1973). The philosophy of dietary counselling. *Journal of the American Dietetic Association*, 63, 13-14.
- Oiler, C. (1986). Phenomenology: The method. In P. Munhall & C. Oiler (Eds.). *Nursing research. A qualitative perspective* (pp. 69-84). Toronto: Prentice-Hall Canada, Inc.
- Pace, P., Russell, M., Probstfield, J., & Insull, W. (1984). Intervention specialists: New role for dietitian's counselling skills. *Journal of the American Dietetic Association*, 84, 1357-1360.
- Parse, R. (1981). *Man-living-health: A theory of nursing*. New York: Wiley
- Parse, R. (1998). *The human becoming school of thought: A perspective for nurses and other health professionals*. Thousand Oaks, CA: Sage Publications.

- Paterson, B. (2001). Myth of empowerment in chronic illness. *Journal of Advanced Nursing*, 34(5), 574-581.
- Patton, M. (1990). *Qualitative evaluation and research methods* (2nd Ed.). Newbury Park, CA: Sage Publications.
- Perry, C., Baranowski, T., & Parcel, G. (1990). How individuals, environments, and health behavior interact: Social learning theory. In K. Glanz, F.
- Pill, J. (1971). The Delphi method: Substance, context, a critique and an annotated bibliography. *Social Planning and Science*, 5, 51-71.
- Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (1999). A critical examination of the application of the transtheoretical model's stages of change to dietary behaviours. *Health Education Research*, 5, 641-651.
- Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (2000). The theory of planned behaviour and healthy eating: Examining additive and moderating effects of social influence variables. *Psychology and Health*, 14, 991-1006.
- Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.
- Procter, S., & Hunt, M. (1994). Using the Delphi survey technique to develop a professional definition of nursing for analysing nursing workload. *Journal of Advanced Nursing*, 19, 1003-1014.
- Rapoport, L. (1998). Integrating cognitive behavioural therapy into dietetic practice: a challenge for dietitians. *Journal of Human Nutrition and Dietetics*, 11, 227-237.
- Rebeiro, K. (2000). Client perspectives on occupational therapy practice: Are we truly client-centred? *Canadian Journal of Occupational Therapy*, 67, 7-14.
- Registered Nurses of Ontario, (2002). *Client centred care*. Toronto, ON: Registered Nurses Association of Ontario.
- Reid, N. (1988). The Delphi technique: Its contribution to the evaluation of professional practice. In R. Ellis (Ed.). *Professional competence and quality assurance in the caring professions* (pp. 230-254). New York: Chapman and Hall.

- Resnicow, K., Davis-Hearn, M., Smith, M., Baranowski, T., Lin, L., Baranowski, J., Doyle, C., & Wang, D. (1997). Social-cognitive predictors of fruit and vegetable intake in children. *Health Psychology, 16*, 272-276.
- Reynolds, K., Hinton, A., Shewchuk, R., & Hickey, C. (1999). Social cognitive model of fruit and vegetable consumption in elementary school children. *Journal of Nutrition Education, 31*, 23-30.
- Rogers, C. (1939). *Clinical treatment of the problem child*. Boston: Houghton Mifflin.
- Rogers, C. (1942). *Counselling and psychotherapy: Newer concepts in practice*. Boston: Houghton Mifflin.
- Rogers, C. (1965). *Client-centred therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.
- Rosal, M., Ebbeling, C., Lofgren, I., Ockene, J., Ockene, I., & Hebert, J. (2002). Facilitating dietary change: The patient-centred counseling model. *Journal of the American Dietetic Association, 101*, 332-338.
- Rosenstock, I. (1990). The health belief model: Explaining health behavior through expectancies. In K. Glanz, F. Lewis, & B. Rimer (Eds.). *Health behavior and health education. Theory, research and practice*, (pp.39-62). San Francisco: Jossey-Bass Publishers.
- Rossing, C., Hansen, E., & Krass, I. (2003). The provision of pharmaceutical care in Denmark: A cross-sectional survey. *Journal of Clinical Pharmacy and Therapeutics, 28*, 311-318.
- Sandrick, K. (2002). Is nutritional diagnosing a critical step in the nutrition care process? *Journal of the American Dietetic Association, 102* 427-431.
- Say, R., & Thomson, R. (2003). The importance of patient preferences in treatment decisions - challenges for doctors. *British Medical Journal, 327*, 542- 545.
- Schiller, M., Miller, M., Moore, C., Davis, E., Dunn, A., Mulligan, K., & Zeller, P. (1998). Patients report positive nutrition counseling outcomes. *Journal of the American Dietetic Association, 98*, 977-982.
- Schroeter, D. (2004). *Needs assessments in evaluation*. Retrieved from the CS Evaluation website on January 22, 2005: <http://www.cs-evaluation.com/daniela.html>

- Schwartz, N. (1988). Development of a scale to measure client satisfaction with ambulatory nutritional care. *Journal of the Canadian Dietetic Association*, 49, 163-168.
- Schwartz, N., Bell, A., & Webber, N. (1987). Survey of outpatient counselling services in BC hospitals. *Journal of the Canadian Dietetic Association*, 47, 225-231.
- Seidman, I. (1998). *Interviewing as qualitative research. A guide for researchers in education and the social sciences* (2nd Ed.). New York: Teachers College Press.
- Smicklas-Wright, T., & Krondl, M. (1979). Dietary counselling and the behavioral sciences. *Journal of the Canadian Dietetic Association*, 40, 99-103.
- Snetselaar, L. (1997). *Nutrition counseling skills for medical nutrition therapy*. Gaithersburg, Maryland: Aspen Publications.
- Snetselaar, L., Schrott, H., Albanese, M., Iasiello-Vailas, L., Smith, K., & Anthony, S. (1981). Model workshop on nutrition counseling for dietitians. *Journal of the American Dietetic Association*, 79, 678-682.
- Splett, P., & Myers, E. (2001). A proposed model for effective nutrition care. *Journal of the American Dietetic Association*, 101, 357-363.
- Stewart, M. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal*, 152, 1423-1433.
- Stewart, M., Brown, J., Weston, W., McWhinney, I., McWilliam, C., & Freeman, T. (1995). *Patient-centred medicine: Transforming the clinical method*. London: Sage Publications.
- Stewart, M. (2001). Towards a global definition of patient-centred care: The patient should be the judge of patient centred care. *British Medical Journal*, 322, 444-445.
- Stewart, M., Brown, J., Donner, A., McWhinney, I., Oates, J., Weston, W., & Jordan, J. (2000). The impact of patient-centred care on outcomes. *Journal of Family Practice*, 49, 796-804.
- Strychar, I., Simard-Mavrikakis, S., Blain, E., Mongeau, L., & Gelinas, M. (1997). A framework for nutrition consultation: A step by step approach. *Journal of the Canadian Dietetic Association*, 59, 84-89.

- Stuart, M., & Simko, M. (1991). A technique for incorporating psychological principles into the nutrition counseling of clients. *Topics in Clinical Nutrition*, 6, 32-39.
- Sumsion, T. (1998). The Delphi Technique: An adaptive research tool. *British Journal of Occupational Therapy*, 61, 153-156.
- Sumsion, T. (1993). Client-centred practice: The true impact. *Canadian Journal of Occupational Therapy*, 60, 6-8.
- Sumsion, T. (1999). A study to determine a British occupational therapy definition of client-centred practice. *British Journal of Occupational Therapy*, 62, 52-58.
- Sumsion, T. (2000). A revised occupational therapy definition of client-centred practice. *British Journal of Occupational Therapy*, 63, 304-309.
- Sumsion, T., & Smyth, G. (2000). Barriers to client-centredness and their resolution. *Canadian Journal of Occupational Therapy*, 67, 15-21.
- Thomas, D. (2003). *A general inductive approach for qualitative data analysis*. School of Population Health, University of Auckland.
- Thompson, V., Baranowski, T., Cullen, K., Rittenberry, L., Baranowski, J., Taylor, W., & Nicklas, T. (2003). Influences on diet and physical activity among middle-class African American 8- to 10-year-old girls at risk of becoming obese. *Journal of Nutrition Education and Behaviour*, 35, 115-123.
- Tobin, G., & Begley, C. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.
- Townsend, E. (2003). Reflections on power and justice in enabling occupation. *The Canadian Journal of Occupational Therapy*, 70, 74-87.
- Trudeau, E., & Dube, L. (1995). Moderators and determinants of satisfaction with diet counseling for patients consuming a therapeutic diet. *Journal of the American Dietetic Association*, 95, 34-39.
- Tuorila, H. (1987). Selection of milks with varying fat contents and related overall liking, attitudes, norms and intentions. *Appetite*, 8, 1-14.
- Turoff, M. (1975). The policy Delphi. In H. Linstone & M. Turoff (Eds.), *The Delphi method. Techniques and applications* (pp.84-100). Don Mills, Ontario: Addison-Wesley Publishing Company.

- Uhl, P. (1983). Using the Delphi technique in institutional planning. In P. Uhl (Ed.), *New directions for institutional research* (pp. 81-94). San Francisco: Jossey-Bass.
- Van Dulmen, S. (2003). Patient-centredness. *Patient Education and Counseling*, 51, 195-196.
- Van Duyn, M., Heimendinger, J., Russek-Cohen, E., DiClemente, C., Sims, L., Subar, A., Kreps-Smith, S., Pivonka, E., & Kahle, L. (1998). Use of the transtheoretical model of change to successfully predict fruit and vegetable consumption. *Journal of Nutrition Education*, 6, 371-380.
- van Manen, M. (1984). *"Doing" phenomenological research and writing*. Edmonton, Alberta: University of Alberta Press.
- van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd Ed.). London, ON: The Althouse Press.
- Vermeire, E., Hearnshaw, H., Van Royen, P., & Denekens, J. (2001). Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics*, 26, 331-342.
- Vickery, C., & Hodges, P. (1986). Counseling strategies for dietary management: Expanded possibilities for effecting behavior change. *Journal of the American Dietetic Association*, 86, 924-928.
- Walters, A. (1995). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing*, 22, 791-799.
- Warpeha, J., & Harris, J. (1993). Combining traditional and nontraditional approaches to nutrition counselling. *Journal of the American Dietetic Association*, 93, 797-800.
- Watson-Jarvis, K., & Murphy, A. (1985). Standards of practice. *Journal of the Canadian Dietetic Association*, 46, 282-284.
- Weston, W. (2001). Informed and shared decision-making: The crux of patient-centred care. *Canadian Medical Association Journal*, 165, 438-439.
- Whitman, N. (1990). The committee meeting alternative: Using the Delphi technique. *Journal of Nursing Administration*, 20, 30-36.
- Whitney, S., McGuire, A., & McCullough, L. (2004). A typology of shared decision making, informed consent and simple consent. *Annals of Internal Medicine*, 140, 54-59.

- Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative Health Research*, 11, 522-537.
- Wile, H., & McIntyre, L. (1992). Weight control counselling in children: Is it effective? *Journal of the Canadian Dietetic Association*, 53, 168-171.
- Wilkins, S., Pollock, N., Rochon, S., & Law, M. (2001). Implementing client-centred practice: Why is it so difficult to do? *Canadian Journal of Occupational Therapy*, 68, 70-79.
- Williams, P., & Webb, C. (1994). The Delphi technique: A methodological discussion. *Journal of Advanced Nursing*, 19, 180-186.
- Winterfeldt, E., Bogle, M., & Ebro, L. (1998). *Dietetics practice and future trends*. Gaithersburg, Maryland: Aspen Publishers, Inc.
- Witkin, B., & Altschuld, J. (1995). *Planning and conducting needs assessments*. Newbury Park, CA: Sage Publications.
- Zifferblatt, S., & Wilbur, C. (1977). Dietary counseling: Some realistic expectations and guidelines. *Journal of the American Dietetic Association*, 70, 591-595.

Appendix A

Client-Centred Nutrition Counselling Study

Delphi Survey

Round One Questionnaire

The purpose of this survey is to identify the important aspects of the client-centred approach to nutrition counselling and to answer the question - **what makes a nutrition counselling session client-centred?** There are no right or wrong answers and all responses are confidential. Please do not put your name anywhere on the questionnaire or the return envelope.

Part I What is Your Opinion?

This part of the survey consists of a number of statements about client-centred nutrition counselling. Please circle the number which most closely describes **how you feel** about each statement using the following scale:

- 1 = Strongly disagree
- 2 = Partially disagree
- 3 = Neither disagree or agree
- 4 = Partially agree
- 5 = Strongly Agree

After each statement there is a space for you to discuss your answer. Please take some time to consider providing comments as they are extremely important. In the next round of the survey, the comments provided by all of the participants will be included with the questionnaire. This will give you the opportunity to see what your peers have to say about each statement and to consider the thoughts of others in responding to the next questionnaire. **Your written opinion is critical to this process!**

In client-centred practice, Dietitians should:

		Strongly Disagree				Strongly Agree
1.	Provide nutrition services designed to meet the needs and wants of clients.	1	2	3	4	5

Comments:

In client-centred practice, Dietitians should:

	Strongly Disagree				Strongly Agree	
2.	1	2	3	4	5	
Act as facilitators to enable clients to						

Comments:

	Strongly Disagree				Strongly Agree	
3.	1	2	3	4	5	
Only provide clients with the information that they want to have.						

Comments:

	Strongly Disagree				Strongly Agree	
4.	1	2	3	4	5	
Consider the context in which clients live in developing nutrition care plans.						

Comments:

	Strongly Disagree				Strongly Agree	
5.	1	2	3	4	5	
Demonstrate respect for clients' opinions.						

Comments:

In client-centred practice, Dietitians should:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
Work with clients to develop mutually agreed upon goals.						

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
6. Build on the strengths and resources that clients bring to a nutrition counselling session.						

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
7. Tailor educational materials to the needs and wants of individual clients.						

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
8. Allow clients to identify their own nutrition-related issues.						

Comments:

In client-centred practice, Dietitians should:

	Strongly Disagree			Strongly Agree		
9.	1	2	3	4	5	
Accept clients' decisions, whether they agree with them or not						

Comments:

	Strongly Disagree			Strongly Agree		
10.	1	2	3	4	5	
Create an environment where clients feel accepted and understood.						

Comments:

	Strongly Disagree			Strongly Agree		
11.	1	2	3	4	5	
Advocate on behalf of their clients.						

Comments:

	Strongly Disagree			Strongly Agree		
12.	1	2	3	4	5	
Assess clients on an individual basis rather than use a set protocol for nutritional assessment.						

Comments:

In client-centred practice, Dietitians should:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
13.	Allow clients to choose from a variety of strategies to help them change their eating behaviours.					

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
14.	Allow clients to develop their own nutrition behaviour change goals.					

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
15.	Involve clients in all stages of the nutrition care process as the primary decision maker.					

Comments:

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	
16.	Provide clients with enough information to enable them to make informed decisions.					

Comments:

In client-centred practice, Dietitians should:

		Strongly Disagree				Strongly Agree	
17.	Recognize that clients are the experts when it comes to their own nutrition-related issues.	1	2	3	4	5	

Comments:

Part 2 What is Your Experience?

It is recognized that it is not always possible for dietitians to practice in the way that they would like to due to barriers in the work environment. Therefore, in this section of the questionnaire you are asked to circle the number which most closely describes your **actual work experience** using the following scale:

- 1 = Never
- 2 = Seldom
- 3 = Sometimes
- 4 = Usually
- 5 = Always

Your responses to these statements will help us to understand how the client-centred approach to nutrition counselling is implemented in your practice. Again, after each statement there is a space for you to discuss your answer. **Your written opinion is critical to this process!**

In my practice as a dietitian, I:

	Never					Always
1.	Tailor educational materials to the needs and wants of individual clients.	1	2	3	4	5

Comments:

	Never					Always
2.	Act as a facilitator to enable my clients to achieve their nutrition-related goals.	1	2	3	4	5

Comments:

	Never					Always
3.	Consider the context in which my clients live in developing nutrition care plans.	1	2	3	4	5

Comments:

In my practice as a dietitian, I:

	Never				Always	
4.	1	2	3	4	5	
Create an environment where my client feel accepted and understood.						

Comments:

	Never				Always	
5.	1	2	3	4	5	
Accept my clients' decisions, whether I agree with them or not.						

Comments:

	Never				Always	
6.	1	2	3	4	5	
Work with clients to develop mutually agreed upon goals.						

Comments:

	Never				Always	
7.	1	2	3	4	5	
Build on the strengths and resources that my clients bring to a nutrition counselling session.						

Comments:

In my practice as a dietitian, I:

		Never				Always
8.	Only provide my clients with the information that they want to have.	1	2	3	4	5

Comments:

		Never				Always
9.	Advocate on behalf of my clients.	1	2	3	4	5

Comments:

		Never				Always
10.	Assess clients on an individual basis rather than use a set protocol for nutritional assessment.	1	2	3	4	5

Comments:

		Never				Always
11.	Allow my clients to choose from a variety of strategies to help them change their eating behaviours.	1	2	3	4	5

Comments:

In my practice as a dietitian, I:

		Never				Always
12.	Allow clients to identify their own nutrition-related issues.	1	2	3	4	5

Comments:

		Never				Always
13.	Demonstrate respect for my clients' opinions.	1	2	3	4	5

Comments:

		Never				Always
14.	Recognize that my clients are experts when it comes to their own nutrition-related issues.	1	2	3	4	5

Comments:

		Never				Always
15.	Allow my clients to develop their own nutrition behaviour change goals.	1	2	3	4	5

Comments:

In my practice as a dietitian, I:

		Never				Always
16.	Provide nutrition services designed to meet the needs and wants of my clients.	1	2	3	4	5

Comments:

		Never				Always
17.	Provide my clients with enough information to enable them to make informed decisions.	1	2	3	4	5

Comments:

		Never				Always
18.	Involve my clients in all stages of the nutrition care process as the primary decision maker.	1	2	3	4	5

Comments:

Part 3 What is Missing?

In the space below, please include any aspects of client-centred nutrition counselling that you think we have missed.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Part 4 Demographic Information

The following information is requested for the purposes of statistical analysis only. This information will **NOT** be used to identify individual respondents and will be kept strictly confidential.

1. What is your sex?

- Female 1()
- Male 2()

2. In what age group are you?

- < 30 years 1()
- 30 - 40 years 2()
- 41 - 50 years 3()
- 51 - 60 years 4()
- 60+ years 5()

3. In what area of dietetics do you currently practice?
(Please check all that apply)

- Community/Public Health 1()
- Private Practice 2()
- Long Term Care 3()
- Clinical Practice 4()
- Other 5() Please specify _____

4. How long have you been in your current position?

- < 5 years 1()
- 5 - 10 years 2()
- > 10 years 3()

5. How long have you been practising dietetics?

- < 5 years 1()
- 5 - 10 years 2()
- > 10 years 3()

Please note that questions 6 through 12 relate to the training/education that you have had in nutrition counselling only. Questions 13 and 14 relate to any training/education that you have had related to counselling in general.

6. Did you have any training in nutrition counselling in your undergraduate education?

Yes 1() -----> Please go to question 7
No 2() -----> Please go to question 9

7. Which of the following best describes this training:

Whole course in nutrition counselling 1()
A topic in a nutrition undergraduate course 2()
Workshop on nutrition counselling 3()
Other 4() Please specify _____

8. Which of the following best describes the content of this additional training:
(Please check all that apply)

Theory 1()
Observation 2()
Hands-on practice 3()

9. Did you have any training in nutrition counselling during your dietetic internship?

Yes 1 () -----> Please go to question 10
No 2 () -----> Please go to question 11

10. Which of the following best describes this training:
(Please check all that apply)

Workshop on nutrition counselling 1 ()
Observation of a nutrition counselling session 2 ()
Hands-on practice 3 ()
Other 4 () Please specify _____

11. Have you taken any additional training/education in nutrition counselling since you started practising dietetics?

Yes 1 () -----> Please go to question 12
No 2 () -----> Please go to question 13

12. Which of the following best describes this additional training/education: (Please check all that apply)

Undergraduate nutrition course ()
Graduate nutrition course ()
Nutrition workshop ()
Distance education nutrition course ()
Other () Please specify _____

13. Have you taken any additional training/education in counselling in any other discipline (ie. education, psychology)?

Yes 1 () -----> Please go to question 14
No 2 () -----> End

14. Please describe this additional training/education.

Thank you for taking the time to complete this survey. Please return the questionnaire in the enclosed postage paid, self-addressed envelope **by January 31, 2002.**

Appendix B

Client-Centred Nutrition Counselling Study

Delphi Survey

Round One Questionnaire Results

Part I What is Your Opinion?

In the first round questionnaire you were asked to give your opinion on various issues related to client-centred nutrition counselling. The median and interquartile range (IQR) for the responses to each question have been calculated and are printed below each statement. The median is a measure of the “typical” response. It is the mid-point of the range of responses. Fifty percent of the responses fall on or under the median and 50% fall on or above the median. The IQR is a measure of the variability of responses. Fifty percent of the responses fall on or between the upper and lower numbers of the IQR. The comments have been grouped and summarized. They are shown, in no particular order, below the corresponding statement.

The scale used in the questionnaire is shown at the top of each page

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

1. In client-centred practice, dietitians should provide nutrition services designed to meet the needs and wants of clients.

Median = 5

IQR = 5 - 5

- * this is the definition of client-centred
- * many studies show that what the client wants is quite different from what the “care provider” thinks they want
- * sometimes you give them what they want - it may not be what they really need or what you think they need, but they feel they “need” it and sometimes that is important
- * what is the point of delivering a service that does not meet the client’s needs?
- * clients feel more empowered if their needs are met
- * patients needs and wants should direct/inform the sessions
- * the RD is the service provider and his/her professional responsibility includes using his/her expertise to inform clients on physiological/nutritional needs - but client may need additional time to develop confidence to effect the change - sometimes clients know part of this and it will be a “want” - sometimes clients won’t - and it becomes a “need” - our role is to encourage a trust with that personal expertise
- * you may need to use professional judgement if needs/wants conflict - in such cases it is our responsibility to increase their awareness regarding the problem so they can reassess what the “wants” are in light of new information
- * there needs to be reasonable boundaries
- * one would not provide services harmful to the client or that fall beyond our scope of practice even if the client wanted them
- * challenging to sort this out - who defines the needs? - the professionals (RD, MD) or the client?

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

2. **In client-centred practice, dietitians should act as facilitators to enable clients to achieve their nutrition-related goals.**

Median = 5 IQR = 5 - 5

- * RD must translate theory into practice
- * clients live the goals and ultimately have to make the changes, not the dietitian
- * we work in partnership with clients to develop realistic and achievable nutrition goals and to facilitate that process- but clients need to remain in the "drivers seat" and be able to decide what they choose to do or not to do
- * overall "health" related goals and perhaps not just nutrition?
- * a facilitator gets clients involved in the decision making process -this tends to lead to better results than simply "telling them" what they should do
- * we can't make anything happen, can only help facilitate changes
- * the word facilitator suggests a role of negotiator, coach, resource person and counsellor.
- * encourages more and better communication between clients and the RD
- * we can't forget that we are also educators - important to also provide info to increase awareness of information gaps as well as guide the process
- * dietitian still needs to set up a certain degree of goals as per Mds request - many clients need slightly more than a facilitator ie. need more specific goals set for them

3. **In client-centred practice, dietitians should only provide clients with the information that they want to have.**

Median = 2 IQR = 2 - 4

- * a very advanced skill - we want to provide everything at once in case we never see them again - we need to be able to give them what they seek when they seek it - layering on additional info as appropriate
- * this is the true definition of client centered but some info may have to be offered
- * RD's responsibility is to tell clients about things that are vital to health and well-being - it is then up to the client to choose
- * when the information makes a difference to their medical condition I would provide the educational materials so that they can make an informed decision
- * hard to say you've made a "fully informed" decision if people only tell you what you want to hear
- * that could be highly unethical, especially if there was some information that the client needed to have - it depends on the situation (not a black & white issue)
- * while theory tells me giving information that isn't wanted accomplishes little, there are times when a client's safety depends on giving information they didn't know they needed
- * some clients aren't aware of information they should have - "they don't know what they don't know" and may need more information to make a decision
- * in some cases I feel compelled not to give people what they want to have
- * one can sometimes predict what they will likely need so to save time I give them what they will likely need

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

4. **In client-centred practice, dietitians should consider the context in which clients live in developing nutrition care plans.**

Median = 5 IQR = 5 - 5

- * necessary to achieve any results/success
- * realistic solutions that “fit” the client’s family, home and work circumstances will enable the client to implement change more easily and help maintain change!
- * proposing too many large changes too fast will be a deterence to compliance
- * often the most overlooked factor when developing a care plan
- * no point in discussing a gourmet menu if they cook on a hot plate!
- * should be an integral part of our assessment
- * home environment, language, employment, culture, and education all will help shape type of goals that client is able to achieve to improve self-efficacy
- * not generally the main issue in setting up plans but cannot be ignored
- * can’t always get a very broad context
- * not only context in which they live (physical space, SES, etc.) but psychological context

5. **In client-centred practice, dietitians should demonstrate respect for clients’ opinions.**

Median = 5 IQR = 5 - 5

- * “demonstrating” respect forces RD to confront her/himself and question whether she is really respecting client’s opinions - or just giving lip service to the idea
- * likely to increase the chance that communications will remain open and honest
- * respect does not have to mean pretending to agree with everything the client says - however, without respect, the level of trust can be threatened and the counselling less meaningful
- * to fail to assess the client’s opinions will fail to uncover important beliefs and priorities as well as misconceptions that threaten a successful outcome
- * mutual respect fosters trust, increases our credibility
- * if the client is dead wrong, it is the responsibility of a dietitian to gently try to redirect or get the client to see other possibilities
- * working from where the client is in his/her attitudes for change will enable the client to slowly (but eventually) take positive steps toward a larger dietary goal
- * even if the opinion is not accurate or even healthy, it should be respected and every effort should be made to work within that framework

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

6. **In client-centred practice, dietitians should work with clients to develop mutually agreed upon goals.**

Median = 5 IQR = 5 - 5

- * this is the essence of client-centred practice
- * a must to be successful
- * very important that the client be involved in the setting of goals and agree to each one
- * takes more of the RD's time and energy than dictating a plan; but much more positive response to changing nutrition behaviours when the goals are agreed upon and arrived at together
- * If client has weak "buy in", there is a decreased chance of meeting goal
- * compromise and consensus are important with goal development
- * sometimes this is more difficult than it sounds
- * often one has to negotiate a goal that comes between what is going to benefit the client the most in the shortest time and what the client is willing to do
- * the counsellor helps the client shape goals that are in the best interest for their health
- * Rds steer and client sets goals

7. **In client-centred practice, dietitians should build on the strengths and resources that clients bring to a nutrition counselling session.**

Median = 5 IQR = 5 - 5

- * must always emphasize the resources that client already has and build on them
- * especially since the client is the one who will be doing the work
- * need to start at the point where the client shows or communicates a stage of readiness to learn
- * evaluate how much the client knows rather than assuming how much they know
- * a given - who could ever question this but a person who is not client-centred?
- * using clients' own perceptions on what needs to be changed in their diet and how it can be achieved is far more effective than the counsellor's solutions to the same problem
- * also increases the trusting and collaborative alliance
- * a counselling session occurs between 2 experts - the practitioner is an "expert" in his/her area. The client is the "expert" on themselves and their challenges, bonuses and limitations
- * most people are extremely resourceful and know their bodies better than anyone else
- * sometimes difficult in short sessions to realize client's strengths and resources

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

8. **In client-centred practice, dietitians should tailor educational materials to the needs and wants of individual clients.**

Median = 5 IQR = 4 - 5

- * to ensure comprehension and ease of implementation
- * literacy aspect is crucial to consider - however this takes awareness training. Expectations are much higher than reality dictates - also takes training
- * most materials have to be individually tailored to some degree
- * literacy, diversity, social and psychological factors must be considered
- * client wants can certainly be accommodated as long as they do not go against what their medical condition requires
- * sometimes the client has no idea what they need and it is the responsibility of the professional to provide it
- * depends on type of material (general pamphlets etc - no; customized meal plan, etc. - yes)
- * may not be able to in some tube feeding situations where clients body needs a certain level of calories but plan would certainly be individualized to their situation
- * difficult to get educational materials to match all clients but why use materials if the client is unable/unwilling to use the format
- * current staffing levels and lack of administrative support can make this a challenge, but it is a goal worth working towards
- *which we do very badly, given our passion for mass produced, impersonal materials
- * this includes determining when and what kind of materials are appropriate - they are wasted if wrongly used to replace personalized teaching/counselling

9. **In client-centred practice, dietitians should allow clients to identify their own nutrition-related issues.**

Median = 4 IQR = 4 - 5

- * must be a 'negotiation' between client and dietitian
- * what if they don't see 'obvious' ones?
- * client doesn't have the full picture - RD must help them find the relevant nutrition-related issues and then let the client prioritize them in an informed way
- * it is our responsibility to make them aware of all nutrition related issues
- * I don't like the word "allow" - this is a partnership
- * in my experience this does not work well - many clients are not aware of the wide range of issues at work
- * most of the time they need help
- * not necessarily - (e.g. hospital pt with an albumin of 22 is not in a position to identify this issue) - they may choose how they want to address it within the constraints of the hospital environment
- * sometimes one can achieve a beneficial outcome by addressing client's concerns even if they don't appear to be the major issue
- * counsellor may bring clarity and focus

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

10. **In client-centred practice, dietitians accept clients' decisions, whether they agree with them or not.**

Median = 5 IQR = 4 - 5

- * part of our profession to give our view - not push it - just offer it
- * RD must be up front when there is a disagreement and must explain to the client why she disagrees - but final decision is with the client
- * you could not refuse to accept a client's decision and still consider yourself "client-centred"
- * provided they know the risks
- * they are the driver
- * yes, but also try to understand why they made that decision
- * if a decision made by the client is deemed harmful or negative I would not accept that
- * most people are extremely resourceful and know their bodies better than anyone else
- * if this adversely affects their health, the RD must carefully document the information
- * dietitians can choose not to work with clients based on differences in philosophy
- * very important with eating disordered clients - but always leave the door open for dialogue
- * no simple answer - on one level, yes - accept and respect their decision at this point in time. Yet recognize their decisions can change over a period of time - best if both the counsellor and client remain open to the possibilities and can discuss them without being judgemental or adversarial

11. **In client-centred practice, dietitians create an environment where clients feel accepted and understood.**

Median = 5 IQR = 5 - 5

- * effective solutions and realistic goals are not likely to be identified without this
- * comfort is critical for open sharing of information
- * RD's need to be "excellent listeners" and validate a client's feelings/attitudes/beliefs/values
- * acceptance of client where they are at is one of the primary requisites for a workable relationship
- * essential to developing rapport
- * sometime it will take a few sessions to accomplish this
- * means de-institutionalizing our space as much as possible no matter where we work
- * if client doesn't trust you to understand them he/she will be concentrating on that and not the message you are trying to convey

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

12. In client-centred practice, dietitians advocate on behalf of their clients.

Median = 5 IQR = 4 - 5

- * depends on the situation - may come down to how one interprets "advocate" - appropriately? when necessary? always?
- * to some extent - as long as it is within the scope of nutritional practice
- * this should be the role of all health care providers
- * or help clients to advocate on their own behalf
- * may require educating other health professionals on client-centred practice principles
- * depends on what the client needs/wants are and if you agree
- * only occasionally does the dietitian need to be a direct advocate for an individual client

13. In client-centred practice, dietitians assess clients on an individual basis rather than use a set protocol for nutritional assessment.

Median = 4 IQR = 4 - 5

- * especially for clients who are newly arrived from another country, eating disorder clients
- * a combination of both is best
- * set protocol makes life simpler for RD and a starting point for assessment
- * guidelines must be followed, required information must be obtained - what you do with that information must be individualized
- * none of my patients have just one nutrition-related problem and protocols don't respect this
- * protocols can help ensure more consistent care
- * some amount of structure is necessary for the RD to manage time and to accomplish professional obligations
- * in the perfect world all clients would have individual assessment - but in the current work reality this will not happen

14. In client-centred practice, dietitians allow clients to choose from a variety of strategies to help them change their eating behaviours.

Median = 5 IQR = 4 - 5

- * negotiate with strategies - allow client to feel he/she is part of this session
- * clients must be made aware of choices and allowed to follow one best suited to their character/culture/lifestyle etc.
- * personal choice is fundamental to effective behaviour change
- * a client-centred RD will assist in identifying the needed "variety of strategies"
- * decision-making may be too stressful for some clients
- * too much choice is confusing
- * this might be dependant on time
- * the wise counsellor will narrow the range of choices to those deemed most likely to work best for the client - we can help to focus

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

15. **In client-centred practice, dietitians allow clients to develop their own nutrition behaviour change goals.**

Median = 5 IQR = 4 - 5

- * if they are independant enough - if not must try to develop these together
- * clearly they need to do this but in an informed way
- * this emphasizes the give and take partnership of client-centred counselling - the RD ensures the "informed" part - the client decides
- * the practitioner needs to provide some guidance to help client begin - many do not have a comfort level in this area
- * empowers the client to take responsibility for their own health
- * I set up importance and direction but let them decide how much change they can manage realistically
- * sometimes I'll do this as long as it's within reason - if they are at a loss they need my help
- * the less prescriptive we can be the better
- * yes - even though their goals may not proceed as quickly as MD would like

16. **In client-centred practice, dietitians involve clients in all stages of the nutrition care process as the primary decision maker.**

Median = 5 IQR = 4 - 5

- * we will definitely see more change this way
- * not in assessment, calculation, interpretation and evaluation of clinical data - trying to explain the care process would be monumental
- * may be instances where the client may not have the knowledge/background to be the #1 decision maker
- * not always possible given time constraints and the "demands" of other professionals
- * client must feel like an equal in the process of change
- * depends on the type of client (adult, child, teen), acute care or level of crisis
- * some clients prefer decisions made for them
- * this needs to be the prerogative of the counsellor and be adjusted based on the client's comprehension and ability to relate to their personal health
- * most of the time I would agree with this statement but sometimes clients resist what in the end they are sometimes grateful for

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

17. In client-centred practice, dietitians provide clients with enough information to enable them to make informed decisions.

Median = 5 IQR = 5 - 5

- * ultimate goal should be to render client as independent as possible
- * the RD ensures the informed part, the client decides
- * we have an ethical obligation to inform before they can make an informed decision
- * information is what brings change - RD cannot dictate/tell a client what to do without enough information
- * there are barriers to accomplishing this though - time, attention span of client, ensuring they aren't put into "information overload"
- * RD must select appropriate information at the right time
- * this is assuming clients are prepared to receive this information
- * depends on the client and their level of change - some clients would become very frustrated and angry if they perceived I was giving "enough"
- * in principle I agree, in reality I think truly informed consent is impossible
- * clients need not too much, not too little info - judging how much info will be "just right" is our challenge

18. In client-centred practice, dietitians recognize that clients are the experts when it comes to their own nutrition-related issues.

Median = 3 IQR = 2 - 5

- * if this was the case they why are they in your office?
- * we need to provide professional advice/guidance as well
- * a counselling session occurs between 2 experts - the practitioner who is an "expert" is his/her area and the client is the "expert" on themselves and their challenges, barriers and limitations
- * the client is not always informed enough to be considered an "expert" but their previous knowledge/experiences should be acknowledged
- * depends on the clients level of self-awareness
- * they are the ultimate decision maker - but not the "expert." There is too much quackery out there to let people be the "expert." They would make dangerous decisions.
- * not necessarily - they are the person that needs to change with guidance and are the best one to decide which of the options are best for them
- * it is important to provide them with scientifically proven data, but it is up to them what choice they make
- * certainly clients are experts at what is their usual food pattern, what changes may be easy or hard to make.
- * the client is the expert over themselves (usually) but I tend to disagree that they are the "experts" over their nutrition issues.
- * yes - most of the time - however there are some clients who don't recognize their own best interests (ie. those with eating disorders)

Part 2 What is Your Experience?

In this section of the first round questionnaire you were asked to circle the number which most closely described your actual work experience using the following scale:

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

The median and interquartile range (IQR) for the responses to each question have been calculated and are printed below each statement. The comments have been grouped and summarized. They are shown, in no particular order, below the corresponding statement or group of statements.

1. In my practice as a dietitian, I tailor educational materials to the needs and wants of individual clients.

Median = 4 IQR = 4 - 5

- * every client is different
 - * as long as the wants to not go against the needs
 - * exceptions to 'always' are some life-threatening situations or unrealistic client expectations
 - * my clientele is stable so don't have to do much 'tailoring'
 - * generally 'add in' comments on to prepared handouts
 - * time constraints, economic limitations, lack of storage space, and human resources make this a real challenge
 - * in a hospital setting only basic education is practical
 - * difficult in group settings - we try to tailor this material to the 'average' needs and wants

2. In my practice as a dietitian, I act as a facilitator to enable my clients to achieve their nutrition-related goals.

Median = 4 IQR = 4 - 5

- * depends on the number of return visits - often have only one session with clients
 - * try with each patient but some are used to a more traditional 'education' mode
 - * comes with experience
 - * exception might be unsafe or impractical nutrition-related goals
 - * if client is medically unstable some goals may be difficult to reach mutual agreement
 - * sometimes have to start clients off with goals that I have set for them in the sake of time and client's abilities/skills - the follow-up then will nearly always be as a facilitator
 - * varies according to where I'm working
 - * sometimes entails narrowing a client's focus - setting goals in order of priority, restructuring goals to emphasize realism

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

3. **In my practice as a dietitian, I consider the context in which my clients live in developing nutrition care plans.**

Median = 5 IQR = 4 - 5

- * sometimes not relevant as I work in a pay-for-service environment - my clients are usually working class
- * otherwise our profession would be creating more barriers for the client to have to deal with
- * sometimes this means making assumptions that may or may not be correct
- * always - the information provided will mean nothing if it doesn't suit their lives
- * a basic part of assessment
- * important in developing realistic, achievable care plans
- * sometimes difficult to assess depending on the available information - some patients are reluctant to provide too many details

4. **In my practice as a dietitian, I create an environment where my clients feel accepted and understood.**

Median = 5 IQR = 4 - 5

- * if this doesn't happen the session is useless!
- * this is very time consuming
- * unless you directly ask the client their feedback on this one you would not know 100%
- * when allowed to by the client - there are people who will not provide enough information to help create an environment of trust
- * empathy, listening, valuing and respect are all important in the process
- * due to large caseload it is sometimes a challenge to develop a relationship of trust
- * hard to do in a hospital bed - but basic empathy can be achieved anywhere
- * definitely a challenge when working with adolescents - must take the time to establish rapport before anything else can be accomplished

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

5. **In my practice as a dietitian, I accept my clients' decisions, whether I agree with them or not.**

Median = 5 IQR = 4 - 5

- * don't think that I have been faced with this black/white situation
 - * counterproductive to insist a client follow advice if he/she disagrees
 - * shows respect for clients as individuals
 - * exception - when children's health is affected by caregiver's decision
 - * it is important for them to know I disagree and make sure they are aware of consequences
 - * as long as I know they have all the information
 - * as long as the decision is not harmful to the client
 - * this is hard - usually relates to clients wanting to be more restrictive and prescriptive than I am advising
 - * if decision is detrimental to their health I document in detail and share information with the MD
 - * as a professional I may respect their decisions but find it hard to agree all of the time
 - * sometimes will try to change their decisions with education

6. **In my practice as a dietitian, I work with clients to develop mutually agreed upon goals.**

Median = 5 IQR = 4 - 5

- * most clients like to be involved
 - * try to do this but suspect I may push in a preferred way
 - * not always possible in the acute care setting
 - * elderly/immigrants often used to being 'submissive' and will say 'just tell me what to do'
 - * sometimes patients have no idea how to set a goal
 - * happens to a smaller degree in a group setting
 - * this is the only good use of my time and theirs
 - * sometimes patients/clients want too much and I have to point out that is not realistic
 - * don't always discuss goals in a way that fits with this statement
 - * time is a limiting factor

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

7. In my practice as a dietitian, I build on the strengths and resources that my clients bring to a nutrition counselling session.

Median = 5 IQR = 4 - 5

- * challenging due to time
- * most creative way to succeed
- * no sense in trying to get clients to do something they are incapable of doing
- * building self-confidence is a common challenge - it is my duty to help clients identify strengths that may not be apparent to them
- * many people prefer throwing themselves into the hands of an 'expert'
- * will empower the client

8. In my practice as a dietitian, I only provide my clients with the information that they want to have.

Median = 3 IQR = 2 - 4

- * complicated item! My responsibility includes helping them identify what they need to know
- * I provide much more than they know about
- * sometimes clients need your direction as they are unclear why they are even coming to see you in the first place
- * usually have an agenda that I would like to cover as well - this is usually fairly consistent with what my clients want
- * often will provide information to try and aid decision-making and allow for informed choice
- * we may be obliged (legally and ethically) to provide clients with information they don't want to keep them safe
- * this is the lazy way of doing your job - dietitians need to facilitate learning and help client to see beyond what they know already
- * I am the health care expert and I tell them what they need to know - they may or may not choose to listen
- * you don't know what you don't know
- * sometimes I only get one chance with a client so I like to make it worthwhile
- * would not force information on them but ask if they are aware of other relevant information
- * this is negotiated based on client's essential need to know for health

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

9. **In my practice as a dietitian, I advocate on behalf of my clients.**

Median = 4 IQR = 4 - 5

- * not much opportunity for this
- * if they need me to and will accept me intervening on their behalf I definitely become their advocate
- * time is a limiting factor
- * important aspect of nutrition counselling and the profession
- * advocacy often means using assertiveness training for clients so they can advocate for themselves
- * as much as possible considering the limitation of hospital settings
- * barrier is very much limited social work availability
- * mostly to other family members, Mds, Ministry of Health, foodservices
- * seldom in a community context - the dietitian may provide info but the direct advocacy is the responsibility of the client or others

10. **In my practice as a dietitian, I assess clients on an individual basis rather than use a set protocol for nutritional assessment.**

Median = 4 IQR = 4 - 5

- * use the same assessment sheet but then go in different directions depending on the client
- * must use both - some standard assessment steps plus individualized. The individualized assessment is an essential part of client-centred services
- * a set protocol applies to most of my clients - I seldom vary it
- * a challenge when professional standards require certain assessment criteria to be measured, recorded and evaluated
- * hard to assess everyone individually in a group
- * some diet modifications are too 'cut and dried' to allow much individualization and assessment
- * clients are individuals and therefore need to be treated on an individual basis
- * use protocols in order to stay relevant to other health professionals
- * protocols are important to provide guidance and to set standards for the profession
- * not enough time due to heavy case load

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

11. **In my practice as a dietitian, I allow my clients to choose from a variety of strategies to help them change their eating behaviours.**

Median = 5 IQR = 4 - 5

- * I explain the different approaches and invite them to choose ones best suited for them
 - * choice is empowering and an effective motivator
 - * may be dependant on specific health issues - but where possible I encourage the client to drive the process
 - * takes time to do this though
 - * depends on how involved patients want to be
 - * sometimes there is no option- eg. for diabetes they cannot skip meals even if they stay within allotted kcal
 - * not necessarily a variety but definitely more than one
 - * I don't like the word 'allow' - I don't have that kind of control

12. **In my practice as a dietitian, I allow clients to identify their own nutrition-related issues.**

Median = 4 IQR = 4 - 5

- * I help them to put things into workable goals as well
 - * my strategy is to supply the input and then 'draw out' the issues after the client has processed the information within the context of their own lifestyle
 - * within reason - if child has dramatic weight loss and the caregiver is most interested in iron status, I will address both issues
 - * often help them along in this process to speed things up
 - * except if unwilling or unable to
 - * with informed decision making qualifier
 - * I encourage rather than 'allow'
 - * empowers the client
 - * often clients don't realize what their issues are - need probing
 - * depends on the situation - in hospital vs outpatient clients are inherently different
 - * I allow for expression of opinions, experiences, perceptions, concerns, etc. but usually help client through a process of prioritizing issues

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

13. **In my practice as a dietitian, I demonstrate respect for my clients' opinions.**

Median = 5 IQR = 5 - 5

- * a must if we want to have clients trust and cooperation
- * actions speak louder than words - treat your patients the way you wish to be treated
- * fundamental to the therapeutic relationship
- * the times I have the greatest difficulty with this is when they are using 'alternative' methods which I believe are harmful
- * this can be challenging in social situations

14. **In my practice as a dietitian, I recognize that my clients are experts when it comes to their own nutrition-related issues.**

Median = 3.5 IQR = 3 - 5

- * they are usually coming to me for nutrition help so I feel I am the expert with the advice - but they are the experts in the approach
- * it is presumptuous to think I would know what is best in my clients' situations
- * clients are not the experts in their nutrition-related issues - they come to me to learn usually
- * this assumes they are informed
- * depends on the client (age, issue, education)
- * I recognize they can be knowledgeable in their own nutrition-related issues but the dietitian is the expert (exceptions - a type 1 diabetic who has had the disease for many years or those with Crohn's disease)
- * I respect a client's feelings of 'expertise' but feel it is important to educate them about nutrition issues - ultimately it is their choice what they do with the information
- * not always - but I do respect what issues they have chosen
- * many clients do not know what the issues are and cannot be experts
- * they are the 'experts' with regards to their process and limitations but sometimes need to challenge perceived barriers/misconceptions

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

15. **In my practice as a dietitian, I allow my clients to develop their own nutrition behaviour change goals.**

Median = 4

IQR = 4 - 5

- * it is rare that this can be done by clients alone - it is a team activity in practice
- * the informed decision process is important to consider here
- * would help to facilitate this process
- * don't like the word 'allow' - I encourage and support my clients
- * sometimes I don't agree with the patient's goals but they have to make the best decision for themselves at the time
- * depends on their motivation
- * this does not work in hospital
- * with significant input from the counsellor
- * given time constraints I usually assist in formulating a menu of goals from which the client can choose or prioritize

16. **In my practice as a dietitian, I provide nutrition services designed to meet the needs and wants of my clients.**

Median = 4.5

IQR = 4 - 5

- * needs - yes - patients don't always want the recommended changes/counselling
- * I always design nutrition services to meet needs and wants - not sure whether they always actually meet the needs and wants
- * as much as the time and limitations of my job allow
- * constrained often by requirements of clinical practice guidelines and requests from physicians
- * clients often admit they do not know what it is they need in order to achieve what they want
- * always the goal as this increases the rate of success
- * less so in group sessions
- * this is mutually negotiated based on whether client has realistic needs and wants based on nutritional concerns
- * always try to meet the needs but 'needs' and 'wants' are not synonymous
- * I am so used to only providing what I know is available given own and team's time constraints

1 = Never 2 = Seldom 3 = Sometimes 4 = Usually 5 = Always

17. **In my practice as a dietitian, I provide my clients with enough information to enable them to make informed decisions.**

Median = 5 IQR = 4 - 5

- * we should not overwhelm them with information
- * without enough information informed decision is precluded
- * some of my clients are demented and without support and they seem to cope with 'rules' rather than anything more nebulous
- * when time is limited I sometimes shortcut
- * a step-wise approach is sometimes necessary - I may hold back some information to give in a subsequent session to prevent distraction from an immediate goal
- * knowledge gaps can occur if inadequate follow-up
- * in our efforts to move to 'empowerment' and 'client-centredness' I am concerned that we are not giving enough information in all cases
- * fine line between overload and enough to help them
- * no time in one consultation

18. **In my practice as a dietitian, I involve my clients in all stages of the nutrition care process as the primary decision maker.**

Median = 4 IQR = 4 - 5

- * they are the driver after all
- * not for assessment, calculations
- * in group sessions this is not really possible
- * if competent to make decisions - some clients I have to decide what is best (vegetative state, tube feeding)
- * it is a shared decision making process
- * many clients may want me to make decisions for them
- * depends on their wants, needs, motivation - a lot of factors to consider
- * probably this is done less in the early stages of contact with them than later
- * yes - with nonhospital clients
- * time may limit - summary of needs and wants for future may be provided and then approved by the client
- * team discussions may not include the client

Appendix C

Client-Centred Nutrition Counselling Study

Delphi Survey

Round Two Questionnaire

As you may recall, a Delphi survey involves a series of structured questionnaires with feedback of findings, providing participants with information that reflects the opinions of the entire group. This allows participants the opportunity to “hear” the opinions of others and reconsider the issues based on this additional information. The median and interquartile range (IQR) was determined for each question in the first round of the survey. The median represents the “typical” response. It is the mid-point of the range of responses. 50% of the responses fall on or under the median and 50% fall on or over the median. The IQR is a measure of the variability of the responses, 50% of the responses fall on or between the upper and lower numbers of the IQR. In addition, all of the comments provided were grouped and summarized and analyzed to determine the variability in responses. Based on this analysis, the following items from the first round of the Delphi survey have been selected for your reconsideration.

Part I What is Your Opinion?

After reviewing the group results and comments from Part I of the Round One questionnaire, please indicate the extent to which you agree or disagree with each statement by circling the corresponding number on the scale (explained below) which follows each statement. If you wish to comment, there is space provided below each question. The median, interquartile range (IQR) and your first round response are listed under each question.

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

In client-centred practice, Dietitians should:

		Strongly Disagree				Strongly Agree
3.	Only provide clients with the information that they want to have.	1	2	3	4	5

Round 1 responses: Median = 2 IQR = 2-4 Your response = ____

Comments:

In client-centred practice, Dietitians should:

		Strongly Disagree				Strongly Agree
9.	Allow clients to identify their own nutrition-related issues.	1	2	3	4	5

Round 1 responses: **Median = 4** **QR = 4-5** **Your response = __**

Comments:

		Strongly Disagree				Strongly Agree
10.	Accept clients' decisions whether they agree with them or not.	1	2	3	4	5

Round 1 responses: **Median = 5** **IQR = 4-5** **Your response = __**

Comments:

		Strongly Disagree				Strongly Agree
12.	Advocate on behalf of their clients.	1	2	3	4	5

Round 1 responses: **Median = 5** **IQR = 4-5** **Your response = __**

Comments:

		Strongly Disagree				Strongly Agree
13.	Assess clients on an individual basis rather than use a set protocol for nutritional assessment.	1	2	3	4	5

Round 1 responses: **Median = 4** **IQR = 4-5** **Your response =**

Comments:

In client-centred practice, Dietitians should:

		Strongly Disagree				Strongly Agree
14.	Allow clients to choose from a variety of strategies to help them change their eating behaviours.	1	2	3	4	5

Round 1 responses: **Median = 5** **IQR = 4-5** **Your response = __**

		Strongly Disagree				Strongly Agree
15.	Allow clients to develop their own nutrition behaviour change goals.	1	2	3	4	5

Round 1 responses: **Median = 5** **IQR = 4-5** **Your response = __**

Comments:

		Strongly Disagree				Strongly Agree
16.	Involve clients in all stages of the nutrition care process as the primary decision maker.	1	2	3	4	5

Round 1 responses: **Median = 5** **IQR = 4-5** **Your response = __**

Comments:

		Strongly Disagree				Strongly Agree
18.	Recognize that clients are the experts when it comes to their own nutrition-related issues.	1	2	3	4	5

Round 1 responses: **Median = 3** **IQR = 2-5** **Your response = __**

Comments:

Part III What’s Missing?

The following questions are based on the comments made by participants in the “What’s Missing?” section of the first round questionnaire.

1. Have you experienced any barriers to delivering nutrition counselling services using a client centred approach?
- 1.1 Yes -----> Please go to question 2
- 1.2 No -----> Please go to question 3
2. Which of the following **barriers** to delivering nutrition counselling services using a client-centred approach have you experienced? Please check as many as are applicable.
- ☐

limited time allocated for nutrition counselling
- ☐

reduced patient stays
- ☐

lack of money to develop individualized counselling resources
- ☐

unrealistic client expectations
- ☐

limited private space available for nutrition counselling
- ☐

lack of support for “client-centred care” by department managers/supervisors
- ☐

inability to provide follow-up counselling sessions
- ☐

mental stability of the client
- ☐

client’s education level
- ☐

cultural differences of clients
- ☐

lack of training/education in client-centred care
- ☐

family member’s expectations
- ☐

doctor’s expectations
- ☐

other, please specify _____

3. What factors help you to use a client-centred approach to delivering nutrition counselling services?
- ☐

supportive supervisors/managers
- ☐

training/education provided by employer
- ☐

past positive experiences using a “client-centred” approach
- ☐

working as part of a team that uses a “client-centred” approach
- ☐

other, please specify _____

Please circle the number which most closely describes how you feel about each of the following statements. After each statement there is a space for you to discuss your answer. Please take some time to consider providing comments as they are extremely important.

4. Assessing the client's readiness for change is a critical component of client-centred practice.

Strongly disagree 1 2 3 4 5 Strongly agree

Comments:

5. A client-centred approach is possible with one client appointment.

Strongly disagree 1 2 3 4 5 Strongly agree

Comments:

Part IV Demographic Questions

The following additional demographic information is requested to help us gain a better understanding of the type of counselling that you do. This information will not be used to identify individual respondents and will be kept strictly confidential.

1. What is the average length of time that you are able to spend with a client in an initial nutrition counselling session?

< 15 minutes	1()
15 - 30 minutes	2()
31 - 45 minutes	3()
46 - 60 minutes	4()
+ 60 minutes	5()

2. Do you typically see patients for follow-up?

Yes 1() -----> Please go to question 3
No 2() -----> Please go to question 4

3. What is the average length of time that you are able to spend with a client in a follow-up nutrition counselling session?

< 30 minutes	1()	
30 - 45 minutes		2()
46 - 60 minutes		3()
+ 60 minutes	4()	

4. Which of the following best describes your nutrition counselling practice?

Mostly (+50% time) individualized counselling sessions	1()
Mostly (+50% time) group counselling sessions	2()
Half individualized and half group sessions	3()
Other	4()

Please specify _____

Thank you for taking the time to complete this survey. Please return the questionnaire in the enclosed postage paid, self-addressed envelope by **May 10, 2002**.

Appendix D

Client-Centred Nutrition Counselling Study

Delphi Survey

Round Two Questionnaire Results

In Part I of the second round questionnaire you were asked to review the group results and comments from selected questions from Part I of the round one questionnaire and indicate the extent to which you agreed or disagreed with each statement by circling the corresponding number on the scale (explained below) which followed each statement. The median and interquartile range (IQR) for the responses to each question for both rounds of the survey have been calculated and are printed below each statement. The median is a measure of the “typical” response. It is the mid-point of the range of responses. Fifty percent of the responses fall on or under the median and 50% fall on or above the median. The IQR is a measure of the variability of responses. Fifty percent of the responses fall on or between the upper and lower numbers of the IQR. The comments from round two have been grouped and summarized. They are shown, in no particular order, below the corresponding statement.

The scale used in the questionnaire is shown at the top of each page.

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

3. In client-centred practice dietitians should only provide clients with the information that they want to have.

Round 1: Median = 2

$$\text{IQR} = 2 - 4$$

Round 2: Median = 2

$$\text{IQR} = 2 - 3.5$$

* this does not say provider will not provide info client wants - ONLY is the key word. How you go about providing additional info is a separate but related issue

- * you can tailor a session to provide what is wanted but must first determine if the client has sufficient knowledge to make decisions about what they need/want to know

* I still feel the client drives the session but needs to make an informed decision about what they "want to have." Provision of info based on "want" can be done near the end after info has been given to help them make informed decisions

* some clients do not know what information they want/need due to a lack of understanding

- * we have a professional responsibility to provide adequate info for a balanced decision

* sometimes clients ask for what they think they should have, out of expectations based on past experience - when it can be quite inappropriate

- * client may be “testing” dietitians knowledge/experience

* I still feel that the dietitian is the expert on nutritional information and assessment and would have a very difficult time not informing clients of facts or other choices

* this is somewhat difficult to capture. I often use my knowledge if needs and wants clash. It is my responsibility to increase awareness, yet respect "wants" of the client. I try to be respectful of the client's desire yet at the same time if I feel it does not serve their best interest I try to create ambivalence thereby shifting the client

* I find this is context dependent.

- * always answer client's questions, but go beyond that as a responsible RD when you see the client has an obvious and unhealthy balance

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

9. **In client-centred practice, dietitians should allow clients to identify their own nutrition-related issues.**

Round 1: Median = 4 IQR = 4 - 5
Round 2: Median = 4 IQR = 4 - 5

- * in private practice we have to work as a negotiator with clients
- * pt should identify own issues. RD should not prevent or interfere with this process. Many interpreted this as "only" their issues - of course the RD should also help pt identify all relevant nutrition-related issues - that would be another statement
- * often my clients don't identify issues. My job is to raise issues for them to consider and get their buy-in for doing something about them
- * if you have determined the patient is aware of all the issues - it must be their decision as to what they feel they can change/do at this time
- * remember ethics and provide enough info for informed choice. "Allow" should be "encourage."
- * assumes client is able to make an informed decision and I am able to give them info to do so. I feel ethically bound to provide info for safety and disease prevention
- * they can choose priorities and what they are capable of doing at a particular time but they still need to know what is important
- * this concept is important to ensure the client is involved with spearheading the direction/course of their behaviour change - this greatly increases success level.
- * sometimes when they bring their lab reports the MD has already pointed out their nutrition-related issues - then the RD would have a good idea which direction to take the client
- * I agree there are usually multiple issues to discuss but first and foremost clients' nutrition issues must be addressed - even if only to put them in perspective relative to other issues

10. **In client-centred practice, dietitians should accept clients' decisions whether they agree with them or not.**

Round 1: Median = 5 IQR = 4 - 5
Round 2: Median = 5 IQR = 4 - 5

- *ensure that pt is aware of risk factors of their decision, document in case of legal issues and finally discontinue services
- * absolutely - this is "client-centred." Again, this statement does not speak to what else the RD should do - get client to enlarge on his/her understanding, perspective, reasons - this would enable RD to be clear as to whether it is an "informed" decision
- * we cannot force anyone to do otherwise but if they are engaging in risky business we can state our objections and reasons why
- * we will never fully understand the whole picture as well as they potentially can.
- * it is their personal right to make decisions about their health care-our job is to inform them and provide support
- * I would say "respect" client's decision (rather than "accept")
- * again, this is context dependent. In my work I often disagree with clients decisions but I accept them because they serve emotional and psychological purposes
- *depends on level of risk and how well informed and knowledgeable the client is. Most of us would likely keep trying to influence them in some way toward better choices for themselves

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

12. **In client-centred practice dietitians should advocate on behalf of their clients.**

Round 1: Median = 5 IQR = 4 - 5

Round 2: Median = 5 IQR = 4 - 5

- * this should be with the client's OK - discretion is needed
- * I'm not exactly sure how this fits in, or what it would mean
- * when needed - I believe this is a professional and moral obligation
- * after having some clients manipulate the system I would not answer 5 to this question
- * this is a skill clients need to develop - I give them the tools and support to do it themselves
- * I disagree that advocacy needs to be done "only occasionally" as per comments. Few clients have the familiarity with the health care system required to advocate on their own behalf
- * depends on your meaning of advocate. Dietitians can represent the needs of clients to others but would not often be the ones to plead on behalf of individual clients. Our scope is nutritional practice, others have more responsibility for advocacy (clients themselves, Mds, social workers, community supports)
- * need more info on what dietitian would advocate for? To whom? May be very situation specific

13. In client-centred practice, dietitians should assess clients on an individual basis rather than use a set protocol for nutritional assessment.

Round 1: Median = 4 IQR = 4 - 5

Round 2: Median = 4 IQR = 4 - 5

- * need to personalize nutrition assessment along side traditional protocol to avoid competition from other individuals encroaching on our discipline (chiropractor, naturopath)
- * set protocol ensures standardized approach, ensures thoroughness, quality control.
- * a set protocol provides a base to start
- * dietary history form is set, but what you do with the information is individual
- * what does “set protocol” mean? If its asking if I follow a stiff, ordered checklist the answer is no. I vary and question deeper in areas that appear significant and pertinent yet there is a certain degree of standard questioning in nutrition assessment
- * I have always struggled with the idea of a set protocol being the base of nutritional assessment. I believe a nutritional assessment is more useful, realistic and usable if an “individual basis” approach is used. However, I do believe “protocols” can help ensure more consistent care. I also think that in ICU, tube feedings and TPN there must be a protocol set for nutritional assessment. Therefore a combination of both is best.
- * if protocol means obtaining all relevant info then of course one would use it. However if this protocol means a preset questionnaire that misses several necessary points then do not use it. All clients have to be assessed individually when they enter the office alone.

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
 4 = Partially agree 5 = Strongly Agree

14. **In client-centred practice, dietitians should allow clients to choose from a variety of strategies to help them change their eating behaviours.**

Round 1:	Median = 5	IQR = 4 - 5
Round 2:	Median = 5	IQR = 5 - 5

- * I usually have 2 main strategies working with a client. Too many choices similar to too much nutrition communication in the media can lead to confusion and absence of clarity
- * all research points to this being the best approach
- * choice depends on clients needs - some clients may benefit from choice where other clients have a medical belief where the health provider makes all decisions
- * this is a key element to me because it is a basic principle of adult education.
- * I tell them what I recommend and they tell me what is feasible given their situation
- * need some variety to suit different personalities but not too many that it becomes confusing
- * this is misleading - not all counselling is for behaviour change - where behaviour change is the goal strategies must be appropriate for the individual
- * I always negotiate with clients re their food likes/dislikes - but I have always known the goals for the reason the client has come
- * if clients are having difficulties making decisions, then the wise RD would provide a limited choice or provide one strategy and ask the client if they would try it

15. **In client-centred practice, dietitians should allow clients to develop their own nutrition behaviour change goals.**

Round 1:	Median = 5	IQR = 4 - 5
Round 2:	Median = 5	IQR = 4 - 5

- * again, negotiator role - elicit client as a team player - make him/her think that they are the driver but the passenger is assisting with navigation
- * with my help/support of course
- * this statement does not infer that the RD doesn't play a role in setting the stage for goal setting therefore I absolutely agree
- * if they could do this independently they would not be in the dietitians office
- * I feel the choice is theirs but developing goals is usually a joint effort between client and dietitian
- * in my experience clients choose appropriate goals, therefore developing their own goals is the way to go. I agree with the comment that we don't "allow" anything - "offer" clients the opportunity to choose perhaps?
- * sometimes one has to persuade client to start with a smaller goal - thus the RD is not allowing client to develop own goals - however by the same token, that client will still be working toward the goal they want.
- * this is not always possible in a "one visit only" setting
- * in the client-centred approach - the dietitian needs to outline the possibilities - clients often do a lot better when they are part of the decision process.

1 = Strongly disagree 2 = Partially disagree 3 = Neither disagree or agree
4 = Partially agree 5 = Strongly Agree

16. **In client-centred practice, dietitians should involve clients in all stages of the nutrition care process as the primary decision maker.**

Round 1: Median = 5 IQR = 4 - 5

Round 2: Median = 5 IQR = 4 - 5

- * some of it is quite time consuming and beyond some clients. Again, very individual.
- * informed decision making is necessary for this also and that is our role - to provide the info in order to let the client make informed decisions
- * they can choose the "how" of what needs to be done. I inform of the "why"
- * important the we define the nutrition care process as needing client input. All stages involve 2 sides - one side the professional's nutrition knowledge and input and the second side is the client's knowledge and input of self and lifestyle.
- * depends on the type of client and the level of crisis
- * many clients prefer professional advice in decision making
- * I agree the clients needs to be in control of the decisions but not all the steps of the nutrition care process are necessary for the client - this would make the job impossible to do
- * clients must be involved otherwise we are simply dictators. This does not mean clients decide on detailed decisions on tube feeding etc., rather they are actively involved in the decision to tube feed and informed of changes as they occur
- * I'm not sure how this can be done otherwise, but it depends on what you mean by "nutrition care process."

18. **In client-centred practice, dietitians should recognize that clients are the experts when it comes to their own nutrition-related issues.**

Round 1: Median = 3 IQR = 2 - 5

Round 2: Median = 3 IQR = 2 - 4

- * we are the "experts" - similar to MD - we must clarify this LOUD and CLEAR to dissuade other so-called health experts dabbling in our discipline
- * wording is the issue - the client knows best what he/she is interest in/wants to learn about/thinks he/she's affected by. I can only give a 5 for this after client issues have been identified. The RD would then fill in, counsel, fine-tune and clarify. The statement does not exclude this latter input - other comments seem to have rated lower perhaps on the assumption that this was not included? I can see many assumptions still being made about what this statement includes/excludes
- * they know the inside story of their experience - we may know more of the outside story. Both are important to consider
- * they are the expert in their own issues - this statement doesn't infer that they are the expert in knowledge, decision making etc.
- * they are not the expert until we make them the expert. They lack balanced, credible info
- * I could never even slightly agree to this - it is the dietitian who is the expert and it is that expert advice that the clients or our healthcare dollars are paying for.
- * many of the comments conveyed a "dominance of those with the most technical knowledge" view that I find troubling. Of course clients may not have the nutrition or health care system/service knowledge of a dietitian but health and nutrition knowledge alone does not "expertise" make.

Part II What's Missing?

Summary of Results

Most participants have experienced barriers to delivering nutrition counselling services.

The top 5 barriers identified were:

- limited time allocated for nutrition counselling
- unrealistic client expectations
- client's educational level
- family member's expectations
- doctor's expectations

Participants identified that past positive experiences using a client-centred approach was the most helpful in helping them to use this approach to delivering nutrition counselling services. Working as part of a team that uses a client-centred approach was also identified as being very helpful.

Most participants strongly agreed that assessing the client's readiness for change is a critical component of client-centred practice. However, there was some disagreement regarding whether or not a client-centred approach is possible with one client appointment. One participant commented that "at least one follow-up appointment is necessary to ensure that implementation is a success" while another stated that "whether the client visit is 15 minutes or 2 hours - you can address (if only briefly) client's ideas, feelings, and expectations as well as any issues related to patient function that may be related to nutrition."

Appendix E

Indepth Interview Guiding Questions

- How would you define 'client-centred' nutrition counselling?
- What kinds of techniques or strategies do you use when delivering nutrition counselling services?
- What do you think are the benefits of delivering client-centred nutrition counselling services? (ie. how are the outcomes of a client-centred nutrition counselling session different than those of a dietitian-centred nutrition counselling session)
- What do you think are the barriers of delivering client-centred nutrition counselling services? (ie. what makes it difficult?)
- The issue of "informed consent" was often raised by participants in the first round of the Delphi survey. In your practice, how do you ensure that a client is making an informed decision? (ie. how do you know if a client has made an informed decision; what would convince you that a client understands all the necessary implications)?
- The issue of whether or not it is possible to deliver client-centred care if you are unable to do follow-up counselling with a client was also raised by participants in the first round of the Delphi survey. What do you think? Would your approach to counselling be different if you knew that you only had one opportunity to talk with the client? How?
- Many participants in the first round of the Delphi survey indicated that their approach to counselling differs depending on the context. For example, whether the client sought out or was referred to counselling or whether you are in a community clinic or a hospital setting will have an impact on your approach. How do you think the context of counselling influences your ability to deliver nutrition counselling services using a client-centred approach? (Do you think that it is possible to deliver client-centred care in a hospital setting? with critically ill patients?)
- What do you think the role of the family is in client-centred care?
- One of my goals for this project is to develop something that can be used by dietitians to improve their practice. If you could have one thing that would help you improve your ability to deliver nutrition counselling services in a client-centred manner - what would it be?

Appendix F

Research Process Flow Chart

