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"WITHIN OUR CONDITIONS": PERCEPTIONS OF NUTRITIONISTS ABOUT GASTRONOMY IN A UNIVERSITY HOSPITAL

"DENTRO DAS CONDIÇÕES QUE A GENTE TEM": PERCEPÇÕES DE NUTRICIONISTAS SOBRE GASTRONOMIA EM HOSPITAL UNIVERSITÁRIO

"DENTRO DE LAS CONDICIONES QUE NOSOTROS TIENE": PERCEPCIONES DE NUTRICIONISTAS SOBRE GASTRONOMÍA EN HOSPITAL UNIVERSITARIO

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ABSTRACT

Objective: This paper proposes a reflection on the meanings attributed to hospital gastronomy, regarding the experience of nutritionists who work both in the production of meals and in the clinic at a university hospital. **Method**: From a qualitative perspective, semi-structured interviews were conducted with 15 nutritionists. **Results**: The content analysis showed categories related to the cost of gastronomy in face of the subsequent budget cuts and the resignification of the concept. **Conclusion**: A new gastronomic perspective was unveiled that, in the face of financial adversities, valued the habits of patients and in synergy with dietotherapic needs built a possible alternative based on the dialogue between the technical team and the patient.

Descriptors: Collective Feeding; Diet; Nutritionists; Hospitals; Humanization of Assistance.

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RESUMO

Objetivo: O presente trabalho propõe uma reflexão sobre sentidos atribuídos à gastronomia hospitalar, considerando a experiência de nutricionistas que atuam tanto na produção de refeições, quanto na clínica em um hospital universitário. **Método**: Partindo de uma perspectiva qualitativa, realizou-se entrevistas semiestruturadas com 15 nutricionistas. **Resultados**: A análise de conteúdo evidenciou categorias relacionadas ao custo da gastronomia frente aos subsequentes cortes orçamentários e a ressignificação do conceito. **Conclusão**: Desvelou-se uma nova perspectiva gastronômica que frente às adversidades financeiras, valorizou os hábitos dos pacientes e em sinergia com as necessidades dietoterápicas construiu uma alternativa possível pautada no diálogo entre equipe técnica e paciente.

Descritores: Alimentação Coletiva. Dieta; Nutricionistas; Hospitais; Humanização da Assistência.

RESUMEN

Objetivo: Este trabajo propone una reflexión sobre los significados atribuidos a la gastronomía hospitalaria, considerando la experiencia de nutricionistas que trabajan tanto en la producción de comidas como en la clínica de un hospital universitario. **Metodo**: Desde una perspectiva cualitativa, se realizaron entrevistas semiestructuradas con 15 nutricionistas. **Resultados**: El análisis de contenido mostró categorías relacionadas con el costo de la gastronomía en vista de los recortes presupuestarios posteriores y la reformulación del concepto. **Conclusiones**: Se dio a conocer una nueva perspectiva gastronómica que, ante la adversidad financiera, valoró los hábitos de los pacientes y, en sinergia con las necesidades dietéticas, construyó una posible alternativa basada en el diálogo entre el equipo técnico y el paciente.

Descriptores: Alimentación Colectiva; Dieta; Nutricionistas; Los hospitales; Humanización de la Asistencia.

INTRODUCTION

The maintenance and/or recovery of the nutritional status in the hospital environment is a challenge for the Nutrition and Dietetics Services. [1] Part of this reality is linked to the low rate of acceptance of hospital meals, in view of the attribution of negative senses, such as savorless, tasteless, cold, restrictive, among others.[2] This perception may be associated to the dietotherapic need for physical and/or chemical modification of the preparations, but also to physiological changes in the palate of patients, as a result of the pharmacological treatment itself.[3] The appreciation of biological concepts in nutritional assistance at the expense of the sensory aspects and symbolic meanings of food can also be connected to the low acceptance of the diet, as well as intra-hospital malnutrition itself.[4-6]

In an attempt to change this perspective, the hospital food services have been implementing the concept of gastronomy to the production routine[3]. Taking the same as a set of actions, training and development of hotel techniques aimed

at the humanization of health institutions[4], in promoting comfort to patients during their recovery.

Despite the benefits described in the literature such as significant improvement in the acceptance of diets and reduction of the remaining intake, Brazilian studies point out the cost of its implementation as the main challenge of its execution in health institutions, especially in public.[5-7] Mixed hospital services usually implant hospital gastronomy (HG) in the care of private healthcare patients[8] to the detriment of the public healthcare ones.

The implantation of hospital gastronomy is, even today, a challenge considering that the service needs to provide the dietotherapic prescription regarding micro, macronutrients and physical consistency in an attractive meal. Acknowledging the importance of the nutritional state for the patient's recovery, as well as the complexity of factors related to "eating" in the hospital environment, the objective of this work was to understand the senses attributed to gastronomy from the perspective of nutritionists who work in a public hospital.

METHODS

It is a qualitative study that sought to understand, in the social discourses produced by nutritionists, the different senses attributed to HG. Conducted out with professionals from the Nutrition and Dietetics Service of a university hospital in the city of São Paulo - SP, the data collection took place in the month of January 2017, after approval by the Ethics in Research Committee (co-substantiated nº 1.741.697).

Developed from the following steps: (1) theoretical research; (2) field work and (3) analysis and interpretation of empirical data, the theoretical research included a review of the literature related to the theme, while the field work corresponded to the interviews with the professionals of the sector. By means of a semi-structured script, interviews with the professionals were conducted, lasting approximately 30 minutes in the hospital space itself. They were recorded, coded (N01 to N15) to maintain confidentiality and transcribed for further analysis.

The script directed the research to aspects related to professional training and the perception relation about HG. As support, a field diary was used in which relevant information was recorded. Regarding the interpretation of the data, we opted for the content analysis (CA) considering Bardin's[8] perspective, who sought to understand the characteristics and structures present in the transcribed material. At first, a pre-analysis of the

material was carried out: consisting of reading and re-reading the corpus in view of the need to organize the findings of the field. This moment allowed the apprehension of the relevant structures and central ideas, which were also configured as empirical categories: 1- the financial limits of the application of gastronomy and 2- a resignification of the concept of gastronomy in the hospital context.

Subsequentely, a horizontal and exhaustive reading of the narratives was then performed. From the transcripts, similar parts were separated to establish connections between the categories or direction units. After the analysis of sorting and classification, the task of grouping the classifications followed, seeking to understand and interpret what was exposed as more relevant and representative by the group. During the interpretation of the findings it was necessary to return to the theoretical reference, because the relationship between the data obtained and the theoretical foundation was essential to the interpretation.

RESULTS AND DISCUSSION

Characterization of the field and research participants

The Nutrition and Dietetics service (NDS) of this hospital unit is performed through its own management service, with centralized production and distribution through thermal cars. The work of nutritionists is divided between the activities performed in the areas of clinical nutrition and collective feeding in order to serve 258 beds. The NDS team consisted of 15 nutritionists, 7 cooks, 57 kitchen assistants and 4 general service assistants, totaling 83 employees. Approximately 1000 large meals/day were produced and distributed as follows: 300 in the cafeteria for hospital employees, 580 for patients and 120 for companions. An average of 95 snacks were also produced for parents or caregivers of children in the emergency room and 300 formulas, water and breast milk for the pediatrics service.

All nutritionists of the NDS participated in the study (n=15). All professionals were female, with an average age of 52 years (35-59) and 24 years of service (3-36). In relation to graduation, there was a predominance of performance in the state of São Paulo itself. The median length of professional training was 29 years (12-37).

Considering the object of analysis and the average time of training of professionals, it is interesting to note that it has been a short time since the curricular matrixes of nutrition began to privilege

programmatic contents related to gastronomy. The very insertion of the discipline in the grid maintains a close relationship with the historical transformations that indicated the attribution of positive value to quality and sophistication in the presentation of food. In this sense, many professionals already inserted in the field of collective food felt the need to meet a market demand, seeking training in the area. [10-11]

It is important to consider that the SND of the unit in question, although public, experienced a period marked by activities that privileged the professional improvement of nutritionists and food handlers. By offering specialization courses in the area of gastronomy and cooking, as well as encouraging the development of recipes, techniques and the acquisition of equipment to manage the service. It was a period of convergence of financial resources and institutional actions: the memories of the participants mark this moment as a 'watershed' in relation to the application of HG.

The cost of hospital gastronomy: difficulty or creative possibility?

The concept of gastronomy is linked to the concept of hospitality[12], being considered a "competitive advantage" among units serving the segment. Besides this issue, the implementation of gastronomic techniques promotes a greater acceptance of the meal served, contributing to the adequate nutritional intake[13] and patients health.

Part of the work that describes GH reveals processes of high investment in implementation and maintenance, considering the replacement of disposable packaging for dishes and tableware, the use of more sophisticated products and more complex cuts and culinary techniques, the disposition of decorative ingredients and personnel to perform loans and training. [6,14-16] Even among the women interviewed, the strong presence of this perspective can be seen in one or another narrative:

> "We still can't implement what I know of gastronomy here, what I had in the other service I worked... Although we are careful to have a varied meal, in the concept of gastronomy here, nowadays I don't see it". (Participant N13)

Thus, the cost represents an important dimension and demands from the Nutrition professional the capacity to adapt to adverse conditions, mainly resulting from the financial crisis experienced by the Brazilian population in recent years.[7] Several industries were required to review and restructure their services, which included adjusting material and employee costs. [6] The hospital itself, as a unit linked

to the public university, was impacted and needed in this new context to review priorities in health care.

> "What we have been going through, unfortunately, for the last two years, is that (...) it comes with a spending cut, so the rectory passes to the superintendent who passes to each division the need for spending cuts. In 2014, we already went through [a reduction of] 20% of our spending, last year [2015] plus 10%, last year [2016] plus 10%; so, as much as we want, we have to enter the budget that (...) provides us with... a lot of things we had to change in relation to the menu, because of precisely these costs that we have to try to make available to us. This is something that diminishes a little our possibility of changing some things, and acquiring different things for the patients". (Participant N11)

In the speeches of the interviewees, the issue of cost reduction was widely pointed out as a marker of the process of transition from what "was" and what "has become" the SND.

> "I think HG here has already been applied much more than it is now, in which I see that there is the application but, depending on the resources this was a little interrupted: you can improve the appearance of the preparations". (Participant N04)

The service to patients is performed in disposable containers that have internal partitions that separate the hot preparations (accompaniment, main dish and garnish). The salads are served in separate containers, as pointed out by the participant N05: "But we are not able to put the salad on a plate and the other way. And the broth in another way. And the dessert in another way, separate... We have limitations in that sense"

The use of disposables is the most plausible alternative for the logistics of distribution, collection and sanitation of items, since the process involves not only labor costs, but also the ergonomic implications for cuppers, considering some limitations for operations involving heavy objects as described by participant N06: "There have been many restrictions in recent years, on account of money, now there will be even more, because of the decrease in employees, nutritionists, so it will get even more complicated here to work".

The budget adjustments are related to the directions attributed by some informants to HG, who report that the reduction in the unit cost of meals and snack offerings did not alter the degree of patient satisfaction, considering the quality topics evaluated by the hospital.

> "I took part in a work on patient satisfaction and they always complimented a lot. One, because of the public we serve, is not a sophisticated public, it is a medium to low level public; they are not so demanding and they only like that most trivial food: rice, beans, and what we serve was very well evaluated". (Participant N06)

> "From the latest evaluations of patients, it's been good, see? And I think it even surprises us... the staff has spoken well, and so, in fact, it doesn't compromise quality, that's more, it doesn't give an extra up on what can be offered." (Participant N10)

The team's effort to serve colorful and harmonious meals prepared from low-cost ingredients demonstrates a creative action to face the challenges imposed by the economic crisis.[7] In addition to the variety of the menu and the use of aromatic herbs, new senses are attributed to HG, such as the guarantee of microbiological safety and respect for the food culture of specific social groups.[5]

> "(...) but so, we try to encourage new flavors, the colorful dish, so I see that the staff is very concerned when assembling the dish, the menu at meal, making the menu colorful, diverse, our soups always have three types of vegetables, two types ... so we try to be varied flavors and spices too, adapting more to the taste of the Brazilian population". (Participant N10)

> "Considering our conditions, comparing in general, I think there's something we've always done here that's one too many concerns. We use a lot of condiments, which is something you can do, and I know that some public hospitals end up not doing it. But unfortunately, a lot more than that we can't do." (Participant N12)

Resignification of the concept of hospital gastronomy: a question of care

> "Let's not think about gastronomy in terms of sophistication, let's think when we adapt dietary/culin techniques to the needs of the patient, both in terms of acceptance and the exceptions of dietotherapy that each patient has. Apart from that, I think that another important aspect is that you bring maximum comfort to this patient... to think that one of the few things that give pleasure to the patient who is hospitalized is the food..." (Participant N14)

The narratives show a differentiated look at the supply of food, beyond the supply of nutrients. The attribution of the importance of gathering information on the habits and food preferences of patients in order to avoid inadequate food intake, reinforces the perception of 'eating' as a social act, linked to the subject's own memories and identity, through which habits and cultural practices capable of providing pleasure are passed.[17]

> "I think that studies and training, not only for employees, but also for nutritionists (...) and one thing I kept and saw that this is really a flawed thing: that a clinic nutritionist, sometimes she forgets that what is in his role, and he is asking to prescribe for the patient, is a meal, is food, is a moment of comfort for the person and everything else. And on the other hand, the nutritionist of production forgets that he is a health professional, and that he has to worry about these options as well: 'Ah, let's exchange the margarine for olive oil at the meal', she's not just thinking about nutritional quality, she's thinking about health. (...) So this issue of the production nutritionist not giving attention to health, and the clinic nutritionist remembering that she doesn't have to look only at health, but she has to see the meal as a good part, I think this is an important part to work, so yes, when people are aware of all this, they will really think about everything else, including food, temperature to administer, taste, and everything else". (Participant N12)

The acceptance of hospital meals emerges as a question of evaluating the quality of service.

> "We see an activity that we do a lot with interns, trainee team, checking the food acceptance, because that is what we will see the recovery of the patient, the acceptance of

> our service, which I think is the main ... satisfaction, and everything else ... so this is done in partnership with the production staff ... we give a feedback (...) so we try to give this feedback to see how is the acceptance. (Participant N10)

In the impossibility of sophisticated services, a process of resignification of the concept of HG is perceived: the team has incorporated the dimension of 'care' and the respect for the patients' eating habits to the aspects of gastronomy. For Hartwell et al.[18], Considering the hospital meal experience, in decreasing order of importance are the social, personal and situational factors, they also reinforce that improving the quality of food and the efficiency with which it reaches the patients should be the most important objectives of the hospital food service.

> "We have a patient who is not elitist, from a private hospital, who is used to a hotel. So, within our target audience, they have accepted, because our food is usually very home-made, closer to what they do at home. And what I understand is that our patient likes the home-cooked food... It's the closeness of his everyday life, and not inventing very different things that he doesn't know, it's you getting closer, with what he would eat at home". (Participant N11)

The perceptions of the interviewees present small divergences, which, despite pointing out subjectivities, do not produce incongruities in themselves, on the contrary, they show aspects sometimes disregarded in the scope of HG research, such as the search for quality, even in simple and low-cost genders.

> "What I need to do back there so that the food we can do, which is not too big, works: I have to serve something that is of good quality". (Participant N01)

> "Within the conditions we have, we always look like this, every day we make a different sauce, so that the menu [less] varied; There's a monthly rotational menu, so every month this menu rotates and we try to improve a sauce on a daily basis, or try some new seasoning, especially for those patients who eat without salt, so we put a herb in the rice, make a different seasoning, leave a lemon, make a vinaigrette without salt, to see if the patient accepts it better, then we try to adjust it there, as best we can". (Participant N11)

For the informants the predominant perspective of the concept of HG may be insufficient if time is not devoted to nutritional attention in view of the fact that the acceptance of the hospital meal is influenced by the symptoms and organic interferences resulting from diseases, pharmacological treatment and emotional aspects. [19]

> "I think they have many factors that interfere. It's different when you're taking 5 different medications and have to eat. A very clear example of this is orthopedic patients. Sometimes they admit the biker, who has had an accident. The guy eats very well at home, he comes here and doesn't eat anything: it's not because of the food at the hospital; he has antibiotics, he has anti-inflammatory drugs, he has a gastric protector, he is bedridden, he has pain, so sometimes it's not the food that's the factor, he doesn't eat it's not because he didn't like it, it's because he really, at that moment, has no conditions to eat". (Participant N05)

Gastronomy must be beyond the application of techniques or the use of crockery. It must include the promotion of the individual's well-being and consider it important in the recovery process.

Taldivo and Santos[20] also state that the acceptance of hospital meals is related to the offering of preparations, which by replacing ingredients to meet the restrictions inherent to the pathologies, remain tasty and have adequate visual appearance. The authors emphasize that home meals, similar to those that patients have in their homes, provide greater hospitality.

> "So he has a general diet prescribed, and he's not getting it, so I go there and offer changes. "Okay... What if instead of rice and beans we send you some pasta? What if instead of meat I send you chicken? What if instead of me giving you regular food, I give you soup today? Maybe you'll make your digestion more relaxed? Can I change your dessert? Would you prefer a jelly instead of a fruit? Then we have the autonomy to do it. And we try to do it... We'll go to our limit." (Participant N05)

The nutritionist's action must go beyond the screening and classification of nutritional risk and also include the evaluation of eating habits and the promotion of meal intake. In this aspect, the dimensions that emerged from the narratives reinforce the need to redirect nutritional attention to patients beyond the sophistication of the service. In other words, the concern with the nutritional value or with the cost of the preparations cannot override the care with the patient. Professionals should maintain constant attention to the production of attractive meals that are close to the eating habits of the diners. Otherwise, there is an effective risk that the food will not fulfill its biopsychosocial role.

CONCLUSIONS

From the interviews analysis, a resignification in the concept of HG was found as a result of economic adaptations continuously faced. Although the use of gastronomy is in some cases considered an expensive practice, it is possible to apply it in public hospitals. Gastronomic techniques are important and contribute to the change in the stigmatized concept of "hospital food"; however, HG is not restricted to them. The experience of professionals points to a closer approach of the service to the patient and the adaptation to his/her habits and eating practices, so that the care in nutritional attention respects desires and preferences, and values it in its totality, considering the culture, as well as the clinical picture. This perception of HG can provide a more creative way to face the financial adversities that hit the collective food segment, especially in the public

service. As a limitation of the study, it is noteworthy to be performed in a single hospital unit. The need to extrapolate the analysis to other states and also to hospitals in the private network is highlighted.

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