THE SOCIAL ORGANIZATION OF DIETETICS.

by

FRANK A. DARKNELL

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ABSTRACT

The essay deals with the various factors at work which make for the disruption and the integration of dietetics, an organized occupation which attracts women with a specialized university education.

Dietitians are seen as performing so wide a range of tasks, that, while they all work with or near, or in support of food, it is difficult to see them as performing one "occupational role." Their varied tasks deploy them into a number of institutional settings which are the strongholds of sometimes conflicting value-systems. Thus by working on hospital wards and in commercial restaurants, they find themselves playing roles committed to such differing ends as treating the sick and maximizing profits.

This dichotomy of interests is reflected in the dietetic ideology, at the level of formal organization. There appears to be a negation of the unity which the ideology was meant to bring, after unofficial and official redefinitions of the ideology add moral distance to the gap already separating the hospital dietitians from the commercial people.

In spite of all this, however, the social organization of dietetics is maintained, by a number of counter-pressures which contain the disruptive influences. One of the most significant of these is held to be the common margin-

ality in which dietitians find themselves wherever they work in their varied and segregated jobs. Another, important unity factor proposed is the attempt to gain professional status, to replace what appears to be no definite status.

Professionalization, which in this case serves as a kind of collective mobility, is put forward as one of two currents of change affecting dietetics. The other, the expansion or spread of function or control, refers to the prospects for if not the pressures on dietetics to expand further into a commercial milieu.

Thus at the level of the occupational system, dietitians on one hand seem to be trying to become more like the established professions, and on the other, more involved in commercial activity. Such a situation, it is suggested, has important consequences for the definition of the profession in the study of occupations, as well as for the description of dietetics and occupations like dietetics.

The case study approach to the study of social organization has been utilized in this essay. Techniques used have included personal interviews, and analysis of documents, as well as first-hand observation of dietitians in their work.

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Department of **Anthropology, Criminology, and Sociology**

The University of British Columbia,
Vancouver 8, Canada.

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INTRODUCTION

The following is an essay on a group involved in the occupational activity of dietetics. It is a case study of dietitians working in Vancouver and purports to be a particular example of a more general phenomenon: namely the proliferation of professionalized forms of organization among certain university-level technical specialties in the occupational system.

Dietetics is examined first and at most length to determine how it maintains itself as a social organization. The pressures militating against such organization are described at length, as are the balancing factors which seem to be containing the disruptive tendencies.

Secondly, dietetics is seen as an aspirant profession, something which for this occupation involves collective mobility in terms of both the occupational and the class structure. The unique adjustment dietetics has found itself making to bring about this, is scrutinized for its effect on dietetics as well as its functions for the occupational system.

By turning sociological analysis on the situation of dietetics I hope to add something more to the growing fund of material in the area of the Sociology of Work.

The material for this essay was gained in the following ways:

(1) Personal interviews with fourteen hospital and university dietitians conducted in the city of Vancouver during the summer of 1956. The women interviewed represented more than a fifth of the total number of dietitians reported to be working in Vancouver, according to the then current rolls of the British Columbia Dietetic Association. The number represented a slightly lesser proportion of the total reported in the Census-Metropolitan Area of Vancouver according to the 1951 Census.[1] The exactness of both totals is open to question. The B.C.D.A. rolls were still tentative in the Summer of 1956 because the Association had only recently been re-organized and the recruitment of qualified dietitians had yet to be completed. Census figures for occupations of this variety are always subject to error because of the lack of control over who might call herself a dietitian when asked by the enumerator.

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1 Canada, Dominion Bureau of Statistics, Census of Canada, 1951, Ottawa, Queen's Printer, 1953, Vol.4, Table 14, pp. 14-1 to 14-86.

The interviews were forty-five minutes to an hour in length and were recorded on tape. A semi-structured type of questionnaire was used; it consisted of more than thirty questions asked with some degree of regularity. (See Appendix B). The respondents were not limited to answering the questions as presented but given freedom to talk as they pleased. Typewritten transcripts were made from all taped interviews. The tape-recordings of the interviews were made with the full knowledge and consent of the respondents in all cases.

Additional information about the fourteen women interviewed was obtained by having each fill out a face-sheet (See Appendix A). These requested facts on age, marital status, years worked as a dietitian, dates and places of training and information bearing on the occupations of parents and close relatives. The face-sheet did not request the names of the subjects and anonymity was guaranteed.

(2) Another source of data was the abundance of bulletins, circulars and other documents distributed to members by the national and the local dietetic associations, and

(3) yet another rich source was back-files of the Journal of the Canadian Dietetic Association and the

Journal of the American Dietetic Association.

(4) Finally, material was also gathered from notes and text-books collected by dietitians during their undergraduate and intern training.

The documentary sources are not exploited for their historical value, but are rather analyzed within a sociological framework for thematic and symbolic content which reflect ideologic and other aspects of the relevant social system.

Chapter One

THE SUBJECT AND THE PROBLEM

> For the profession of Medicine, for Nursing, Teaching, even for the work of dressmaking, a special training course is considered a necessity. But who practically believes that a girl who is to be married needs to be trained in the art of housekeeping....?
>
> Elizabeth Mosher, M.D.*

It will be the purpose of this chapter to clarify the questions somewhat by first placing the occupation of Dietetics in Canadian Society today. After that Chapter Two will examine in a brief way some of the elements of the social organization of dietetics, and Chapter Three will look into the institutional bases upon which the collectivity of dietitians is actually lodged.

1. Dietitians and the Occupational World.

In this culture, to a very great extent, what a man does for a living spells out who and what he is in the eyes of other people, whether or not these others

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* "The Health of American Woman," Woman: Her Character, Culture, and Calling, ed. The Rev. Principal Austin, A.M., B.D., The Book and Bible House, Brantford, Ontario, 1890, p.236.

have a special interest in him personally. Thus, among ourselves the first question likely to be asked about a stranger is not "what family?" or "what party?", or even "what religion?", but rather: "what does he do?"

This then being a work-oriented culture it happens that the primary committment of the male role is activity, if not achievement in the occupational sphere. Women's obligations, on the other hand, while stressing action or work, focus ultimately on intimate and personalized tasks of the family in the home. It follows that this essay, dealing as it does with women who in many cases, make a career in the occupational sphere, is dealing with women who are in a sense at variance with some of the norms for female action. However, the definition on this point is a changing one: both in degree and in quality. Much has been written on the phenomenon of the middle-class working woman and her comparatively recent emergence. While writers have noted that the role of the "respectable" woman at work was perhaps a deviant case in the nineteenth century, the situation has changed to such an extent that now the woman of the middle classes who does not "prove herself" with a sortie into the occupational world before marriage, is the one most likely to be judged as "unusual."[2]

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2 Mirra Komarovsky, Women in the Modern World: Their Education and Their Dilemmas, Boston, 1953, pp.48-52.

It is important to note that middle class women, in the first instances, and in the present, moved into only certain kinds of activity when they invaded the occupational sphere. In a general sense they became involved in kinds of tasks which were, or which became, amenable to being established as independent careers for ladies, among ladies. Thus the middle-class woman moved gingerly into the occupational world in at least three ways:

(1) They took on tasks which were formerly reserved for men. They infiltrated what were previously exclusively male occupational groups. Thus women went into medicine.

(2) They filled the ranks of new occupational groups -- occupations which themselves were developed or expanded as a part of the rationalizing involved in the growth of industrial society. In such groups women tended to set the style and spirit of the occupations themselves, even though the requirements of the tasks themselves, perhaps, were not necessarily such as to have been thought of as inherently feminine. The case in point here is teaching in free public schools.

(3) Finally, women moving into the labour force

on the middle-class level in some cases brought with them important components of their home-role itself. Thus the preparation of food, or the supervision of the process, one of the most basic and personal obligations of the woman in the home, is brought to an impersonal public via the occupational activity of dietetics.

From this then, it might be said that middle class ladies who established the role for the respectable woman in the labour force moved mainly into those kinds of work which could protect them from compromise. This meant going into work done mainly by women, and/or the kinds of jobs organizable into an independent career.

Turning now to the growth of dietetics, the historical fact that this activity grew out of two nineteenth century social movements which involved women, is certainly significant for dietetics today. One of the two social movements centered about a growing interest in Public Health, and with that, Nutrition.[3] The other seemed to take upon itself the dual role of taking scientific and economic methods and techniques into the predominantly rural household, and to some extent, of attempting to transform what was already indispensably there into Science and Economics. This latter movement went under a

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3 L.B. Mendel, "Nutrition," Encyclopedia of the Social Sciences, 1950, vol.11,p.412.

number of names such as Domestic Science, Household Economy, Household Science and, more recently, Home Economics. [4]

Both currents of activity contributing to the growth of dietetics -- Public Health and Domestic Science -- cut across each other in many respects; both incorporated a reform ethic in outlooks, and both drew on the expanding natural and physical sciences for their content if not their form. At the level of social structure both social movements added a number of new jobs to the occupational sphere, many of which - including that of the dietitian - were particularly suited to properly trained or educated women.

The imprint of such a heritage, as we shall see further, is very evident in the institutional bases of dietetics today. The duality of nourishment and household frugality is the one on which dietetics now rests, and incorporates the two poles which may yet pull it apart.

Turning now to the quantitative questions raised by the study, let us discuss the distribution of dietitians in Canada.

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4 Hazel Kyrk, "Home Economics, E.S.S., 1950, Vol.7, p.271.

2. Dietitians and Food.

The rationalization and standardization of nourishment that came with the phenomenon of dietetics is of course a comparatively new thing. The ideas behind it differed from those previously held with respect to food and its role in life and after-life.

Historically and culturally there has been no little variation in the criteria that men have used to govern what is allowed to enter their bodies. While this essay says nothing concerning historical variation, it will now, in a purely superficial manner, review some general patterns of food-taking which are derived from the value-orientations of a few of the sub-cultures which exist in Canada today.

The first to be dealt with is the "sacred." It exists where the use of food and drink becomes a means to life in the hereafter, where certain standards are met, and where such a goal is actively sought. The key or mediating role involved here is the priest or a similar functionary. The standards by which he judges the food are derived from an external set of beliefs and purport to determine whether or not food is appropriate to the day or time of the year, or whether it is properly consecrated and so on. Food exists in the case of this

pattern, then, not so much as nourishment to sustain present life, as to prepare for life after death.

The second pattern comes from the sub-culture of the gourmand[5] and is firmly secular in its nature. In this case, food which must meet standards of a more personal nature becomes a means to intense life in the here-and-now. "Good living," graciousness in the style of life, and sensual delight are the desired and gratifying objects in this case, and all of these, of course, lead back to an initial definition of mundane life as something desirable in itself. Our key role in this context is a chef or a master-cook; standards to be met are presumably shared by this person and the gourmand. The ultimate test is whether the former creative expert has met these standards (preferably whether he has exceeded them) in the judgment of the latter critical expert. Standards relating to spiritual purity, or nutritious value of food are of course in this case held in abeyance, for the most part. It might be said that the theme agreed upon by the chef and the gourmand is: "If not a long life, at any rate an enjoyable one!"

Taking these two alternatives as poles we could find the food orientation of the dietitian somewhere in

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5 Such a pattern is said to exist in French Canada and the uses of food at certain "ethnic" celebrations might also be cases in point.

between them. While in her case life, i.e., good health, is assumed to be desirable for its own sake, this is never fully attainable but something to be constantly worked towards.

Some of the prescriptions governing the handling of food by dietitians are similar to those of the chef. For example, those which direct her toward feeding the body of this world rather than the spirit for the next. In yet another sense, however, her criteria parallel those of the priest. Her food is expected to contribute towards an abstract state of perfection, (in this case, the definition of health as provided by Scientific Medicine) as opposed to direct, personally-defined sensual gratification, the goal of the epicurean means of the chef.

While the overall orientation of the dietitian - like that of the chef - seems to be toward secular existence, and while she is responsible for maintaining mundane life, her means to this goal are founded upon an external doctrine, like those of the priest. Further, this doctrine - Scientific Nutrition - must for the individual dietitian, usually remain an untestable, externally derived set of beliefs; something that is handed down by authority to be accepted on faith.

In brief it is probably enough to say that the dietitian, working by the norms of nutritional science with its various technical standards of nutrient propriety, seems to be sharing the goal of one of her historical sponsors, Scientific Medicine. In a phrase, it might be said that a major commitment of dietitians and dietetics is the maintenance of a long and medically healthy life, if not an intensely enjoyable one. However, it will be recalled that Scientific Medicine in the form of the Public Health movement was only one of the sponsors of dietetics. We shall see that this orientation does not escape contamination by other values representing other modes of rational organization.

3. Dietitians and their Ecological Distribution in Canada.

According to the Ninth Decennial Census of 1951[6], of the 4.8 million working - aged (14 years and over) females in Canada something like one million, one hundred thousand were at work. This meant that 23.8 percent of the working-aged women were in the labour force as compared with 82.3 percent of the working-aged men.

Out of the one million, one hundred thousand or more women who worked nearly one hundred and sixty-

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6 Canada, Dominion Bureau of Statistics, Census of Canada 1951, vol.4, pp.4-1 to 4-10, 11-1 to 11-170, 14-1 to 14-86. All census material from this volume. (See Appendices C, D and E).

six thousand or about 14 percent were designated as being professionals. It can be seen then that with a total of eleven hundred individuals, dietetics did not account for a large proportion of this group. As a matter of fact, the women in the sister profession of nursing outnumbered the dietitians by nearly fifty to one.

With only about eleven hundred dietitians in the country, the question can be asked: how are they distributed? Are they spread out, or do they tend to concentrate in certain geographic areas, and in areas which are the sites of specific kinds of social organization?

Geographically, dietitians tend to concentrate in three provinces: Ontario, British Columbia and Quebec. Eight hundred and forty-two or 76 percent of the country's dietitians in 1951 were enumerated in these provinces: 514 in Ontario, 210 in Quebec, and 118 in British Columbia.

The fact that the three provinces containing most of the country's dietitians also happen to be the three most highly urbanised provinces in the country (Ontario 70.7% population in urban area; British Columbia and Quebec 68.1 and 66.5 percents respectively) leads us to the conjecture that dietetics, for the most part goes

with "city" life, something which is quickly confirmed by examining the urban-rural break-downs in the Ninth Census. For example: 844 (or again 76%) of the country's dietitians in 1951 were counted in what the Dominion Bureau of Statistics chose to call "incorporated urban areas of 10,000 population and up," regions which contained only 51 percent of the general population. Further 711 (65% of the group) were enumerated in the fourteen "census metropolitan" areas,[7] the larger city regions, which contained 39 percent of the country's total population. Finally it should be noted that the four largest of the census-metropolitan districts contained more than half of the practising dietitians in 1951.

It follows from all of this then, that dietetics, in Canada, appears to be a highly urban phenomenon -- something not surprising, perhaps, when we remember that modern medicine and rationalized cookery find their locales in the "industrial" sectors of modern society.

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7 Montreal, Toronto, Vancouver, Winnipeg, Edmonton, Hamilton, Ottawa-Hull, Quebec City, Calgary and Windsor.

Chapter Two

A PRELIMINARY EXAMINATION OF THE OCCUPATIONAL GROUP.

> ...although we all believe marriage to be God-appointed and honorable when rightfully entered into, yet we may be thankful that we live in an age and country in which it is also considered honorable for women who choose to do so to live a single life....
>
> Edward Playter, M.D.*

1. Dietitians and Class Structure.

References was made in Chapter One to the functions of dietetics as a middle-class career occupation for single respectable women. At this point, there is quantitative data to demonstrate that this occupation continues to attract women primarily of the middle classes, and to keep women who are single. Following that we shall turn to some of the facets of organizational structure which serve to perpetuate these situations. First, here is the evidence that dietitians come mainly from middle class homes.

The first datum comes from the 1951 Census, and the second from an analysis of the writer's interview

*"The Physical Culture of Women," Woman: Her Character, Culture and Calling, ed. The Rev. Principal Austin, A.M., B.D., The Book and Bible House, Brantford, Ontario, 1890, p.241.

sample drawn in Vancouver in 1956.

The information from the census deals with level of education. According to the census enumerators the following is a breakdown of years of education reported by those who reported themselves as dietitians.

Table One

Years of Education Reported by Dietitians: 1951 Census.

Years	Number
0-4*	1
5-8**	13
9-12	78
13+	1,008
	1,100

* **
N.B. It is highly unlikely that these individuals would be included in the dietetic groups by the vast majority of dietitians who report 13 years of education. Some of those with 9 to 12 years education may still have been part of the official group as survivals of a time when in-training experience counted for more than it now does.

It would appear from the above that the vast majority of dietitians have the highest level of education included in the 1951 census tabulations of the Canadian

labour force. One thousand and eight reported thirteen or more years of school attendance, indicating that dietitians as a group are predominantly university women. When the patterns of recruitment of Canadian university women are taken into account: the class differences in views of the appropriateness of girls going on to university, together with the greater cost to the family involved, it is probably safe to assume on the basis of this census material that by far the greater number of the 1,008 dietitians with thirteen and more years of schooling come from the middle class.

However, we are able to bring to bear some additional and more specific data, from an analysis of the interview sample of dietitians in Vancouver.

The interview sample taken in Vancouver by the writer was not in the strict sense a sample. It was rather a selection of "key-informants",[8] and was designed to draw information on the various types of dietetic roles which are found in the different places where dietitians work, such as the hospitals and commercial food-services. However, the group was large enough to ensure a certain representativeness (fourteen out of less than about a hundred dietitians in Vancouver), and it can likely be assumed safely that the information regarding occupations in the

8 Marc Adelard Tremblay, "Key Informant Technique: a nonethnographic application," The American Anthropologist, vol.59, August 1957, pp.688-701.

families of the respondents occurs in a relatively random way. While the total number of dietitians interviewed for this study was fourteen, face-sheets (see Appendix A) eliciting the information about to be presented were obtained for fifteen. Because this includes the only case where a parent of one of the dietitians was in the food-production business, and because it rounds out our total number to fifteen, the writer includes it.

First, it might be pointed out that all of the individuals in this group are "qualified" dietitians in the sense as defined by organised dietetics, and in the sense that the term will be used in this essay. All are university graduates in Home Economics, all have taken an internship either at a hospital (in twelve cases) or in a commercial food service (in three cases, only one of which was taken in Canada). All but one was a member of the Canadian Dietetic Association, and the other who had interned in the United States continued to affiliate herself with the American Dietetic Association, although she was a native of Canada.

At the time that the face-sheets were filled out five of the dietitians in the group were working in commercial operations (including one who was operating a pay-cafeteria in a hospital) and the remainder were working

as hospital dietitians.

The average age of the girls interviewed was approximately twenty-five, which would probably be the average age for workers in this occupation according to the figures quoted later in this chapter. Two of the women were in their forties while none was in her thirties or fifties. The group was high in the proportion of married women included, with five of the fifteen reporting this status. The occupational data on the husbands was also used as further evidence bearing on the social class position of the dietitians.

The special table overleaf reveals occupations of significant family members of the dietitians who filled out face-sheets. In the case of the mother's occupation, the question was not asked whether the job listed was held before marriage or whether it was still held.

Table Two

Occupations: Significant Kin of Dietitians.

	Father	Mother	Brothers	Sisters	Husband
1)	Salesman	Nurse	Engineer	-	-
2)	Insurance	Officeworker	-	Housewife	Dairy field-man
3)	Teacher-Engineer	Office Manager	-	-	-
4)	Building Contractor	Housewife	Television business	Housewife	-
5)	Businessman	Housewife	-	-	-
6)	Salesman	Housewife	-	-	Salesman
7)	Office Supervisor	Housewife	Engineer	-	-
8)	Electrical Engineer	Housewife	-	Student	-
9)	Mining Engineer	Stenographer	-	Stenographer	Student
10)	Doctor	Housewife	Doctor	-	-

/cont'd....

Table Two (Continued)

	Father	Mother	Brothers	Sisters	Husband
11)	Farmer	Housewife	Ph.D. (Agriculture	Nurse and Music Teacher	-
12)	Farmer and Implement Dealer	Milliner	Farmer and Implement Dealer	-	-
13)	Mining Camp Cook and Caterer	"Helped husband"	Geologist	-	Student
14)	Tailor*	Housewife	Tailor	Lab Technician and Clerk	-
15)	Machinist	Teacher	-	-	-

* A special ethnic case: A Chinese family. As the son is also in the occupation, this case can probably be safely categorized as "small business."

It is clear from the table that the dietitians who were selected for interviewing in Vancouver in the Summer of 1956 were primarily of middle-class[9] origin or orientation. Only one of the fifteen reported her father in a distinctly "blue collar" occupation (machinist), and even in this case the mother was reported as a school teacher. The case of the tailor and the mining-camp cook and caterer should be examined to be appreciated for what they are. In the first case, the tailor was apparently the proprietor of a family tailoring business which included a son, and in the second case the individual was an entrepreneur, in the sense that he contracted to look after the food service needs of mining camps. The cases of the farmers, especially the one who was an implement-dealer on the side, are definitely not working-class roles.

An examination of the occupations of mothers, brothers and sisters, confirms the fact that the great majority of these dietitians came from respectable or middle class back-grounds. None of the brothers which the dietitians reported was in what might be called working class or blue collar work, as were none of the sisters. Occupa-

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9 For assignment of occupations to social classes see Bernard Barber, Social Stratification, N.Y., Harcourt, Brace and Co., 1957, Chapter 8, pp.168-185; Lewis Corey, "The Middle Classes," Class, Status and Power, ed. R. Bendix and S. Lipset, Glencoe, Free Press, 1953, pp.371-380; C.W. Mills, "The Middle Classes in Middle-Sized Cities," Sociological Analysis, ed. L. Wilson and W. Kolb, N.Y., Harcourt, Brace and Co., 1949, pp.443-453.

tions of husbands of the dietitians who were married suggest a continuing alignment with the middle classes, with all of these in university student or "while collar" positions.

It is suggested, then, on the basis of this evidence and the more general data on level of education reached by most dietitians, that dietetics is an occupation for women who come in the great majority of cases from the middle classes, and, as we have suggested, for women who intend to remain in the middle classes.

2. Dietitians and More General Reference Points of Social Structure.

The more general reference points of social structure by which it is intended to discuss dietitians and dietetics now are the usual ones of occupational affiliation, sex, age and marital status.

Unfortunately, there was neither time nor resources to submit adequate questionnaires to all dietitians in Canada in the summer of 1956 when the field-work for this essay was done. Such a project would have been doubly difficult at the time even if the money and the time had been available, because of the re-organizational flux in which people who identified themselves as dietitians in Canada were then going through.

We shall, therefore, again turn to figures from the Ninth Decennial Census of 1951 for information on these aspects of dietetics. Once again, it should be mentioned that the census figures do not necessarily cover the same group of people that the rolls of the Canadian Dietetic Association in 1951 might have revealed. This was because the enumerators were not able to control, in every case the counting of unqualified practitioners. Evidence of this is very apparent in the age distribution presented here, as it was in previously presented figures on level of education. The question of qualification is to be dealt with more adequately later on in this chapter. In the meantime, let us make do with the information from the 1951 Census.

(a) Significant Outgroup.

The fact that most dietitians are employed by other people means that they find themselves working with representatives of an out-group that has at least some control over their destinies. Of the eleven hundred female dietitians counted in 1951, only five were self-employed, four were working but for no payment, and 1,091 were working as employees of someone else. Thus our census figures show that the vast majority of dietitians work in contexts where they are in interaction to a controlling out-group.

(b) Sex.

It is hardly necessary to mention that dietetics is predominantly an occupation of females. According to the Census in 1951 there were eleven hundred and one dietitians altogether. One of these, enumerated in Windsor, but otherwise untraceable, was a man.

(c) Age.

The age-structure of dietetics in Canada is revealed in the following excerpt from a census table. The figures in the sixteen to nineteen years inclusive categories should be viewed with suspicion because the individuals represented would hardly have had enough time to complete the training necessary for qualification as a dietitian in the eyes of the rest of the group.

Table Three[10]

Age Distribution: Dietitians - 1951 Census.

Age Groups					
16-17	18-19	20-24	25-34	35-44	
1	6	231	356	287	
45-54	55-59	60-64	65-69	70	Total: 1,100
140	43	33	9	4	

10 Canada, Dominion Bureau of Statistics, Census of Canada 1951, Table 11, vol.4, pp.11-1 to 11-170.

By making a few minor statistical observations we can note that

a) 53 per cent of the dietitians enumerated were between 20 and 34 years of age.

b) 54 per cent were under thirty-five years and a corresponding 46 per cent were 35 or more.

It would appear from this that this is neither a young women's nor an older women's group because the numbers in the pre- and post- thirty-five years-of-age group do not differ a great deal. The question of the age-structure within the occupation will be considered more fully in a discussion of organized dietetics, later in this chapter.

(d) Marital Status.

While the census tables do not provide a breakdown of age and marital status together, there is a separate accounting of the latter.

Table Four[11]

Marital Status of Dietitians: 1951 Census

Married	201
Divorced	14
Widowed	59
Single	826
	1,100

11 Loc. cit.

This, then, gives us a picture of an occupation as being predominantly one of single women. From what is commonly known about women's occupational groups of this kind it is probably safe to assume that the single women are distributed evenly between the older and the younger age groups. While many of the younger women are potential losses through marriage, they are at the same time replaceable through regular recruiting processes. The following quotation from a memo prepared by the Director of a Department of Dietetics of a large hospital gives a notion of the actual extent of losses among those who graduate from the hospital's interning program.

> ....marriage takes over 50 per cent of the graduates "out of circulation" within three to five years of graduation....

In summary it could be said that dietetics as an occupational group is one that exists mainly within the context of employing out-groups; that it is, of course, a women's group with more than half of its members under thirty-five, but with that half subject to loss and replacement by marriage and recruitment. Further, single women in the group outnumber those who are married and who remain in or return to it by about four to one. Some of the factors which follow from these facts of structure, and yet contribute to them will now be discussed.

3. Functions and Contributions to Dietetic Structures.

(a) Exclusion and Inclusion.

Objective quantified data have been used to demonstrate that dietetics is primarily an occupation for women of university level and/or the middle class. Here certain facts of formal group structure are shown as being functional to or ensuring the persistence of such a situation.

According to a circular released by the Canadian Dietetic Association in January 1956, the following are the current requirements for qualifications as dietitian:[12]

> Academic qualification for a dietitian is a degree in Household Science or Home Economics with a major credit in Foods and Nutrition. This degree is given by a University whose course includes the following subjects: CHEMISTRY, BIOLOGY, PHYSICS, SOCIAL SCIENCE, ENGLISH, EDUCATION, FOODS, NORMAL NUTRITION, DIET IN DISEASE, INSTITUTIONAL MANAGEMENT.

There followed a list of the universities and colleges in Canada which offer such programs. The second requirement for qualification then dealt with was the internship. Again, quoting from the circular:

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12 The Canadian Dietetic Association, "Academic Qualifications and Training for a Dietitian," Toronto, 1956.

> The University courses may be followed by a period of training in a hospital or commercial course, acceptable to the Canadian Dietetic Association....

And here there was a list of the hospitals in Canada which offer approved intern programs, together with the one place where it is possible to take a commercial interning.

The above are requirements for recognition as a qualified dietitian by other dietitians. These are also, for the most part, the requirements for active membership in the Canadian Dietetic Association which is the dietitians' professional association. While most members receive their membership by meeting the above requirements, there are a few alternate routes.[13] All of those still open insist upon a university degree as a prerequisite; one, now closed forever, did not.

According to the C.D.A. constitution, an accredited active member of the C.D.A. must follow the pattern of study and experience described above, or get a suitable bachelor's degree plus experience as follows:-

> ...Three years diversified experience in Nutrition or Dietetics or Allied Professions which shall be attested satisfactory by a person in authority and which shall be acceptable to the Board of Directors, etc., or
>
> ...Two years experience in teaching

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13 Canadian Dietetic Association, "Constitution and Bylaws Amended", Toronto, 1954.

> which must include one course in Foods or Nutrition or Institution Administration as a full time member of a university or college staff. This experience shall be attested satisfactory by a person in authority and shall be acceptable to the Board of Directors, or,
>
> ...A master's degree in Foods or Nutrition or Institution Administration as well as one year's experience in Nutrition or Dietetics or allied Professions which shall be attested satisfactory by a person in authority and acceptable to the Board of Directors.

In addition,

> ...Active membership may be granted by the Board of Directors to a person having a university degree who has made a special contribution in the field of Nutrition or Dietetics or Institution Administration.

All of the above rules require a university degree as a minimum requirement for admission to the Association. The regulation covering members who do not possess a bachelor's degree is perhaps self-explanatory. This was officially announced by the C.D.A. in June of 1954.

> ...Active membership may be granted by the Board of Directors to a person who had Canadian educational qualifications acceptable to the Board of Directors and a minimum of fifteen years' attested by persons in authority, in the field of Nutrition or Dietetics or Institution Administration and who is recommended by two members, active or life, of at least fifteen years standing.

Such are the requirements. However, the association was ensuring that the educational level and hence the class level of its members would not be compromised even to the extent that these rather strict requirements might allow them to be, in June of 1954, by attaching the following rider:

> ...Application for such membership shall be closed on December 31, 1955.

Thus the formal organization of the dietitians in Canada works to perpetuate itself as an organization of working women who have a university level education.

Frequently, individuals come from other countries with experience in roughly equivalent fields and attempt to join the C.D.A. It is the task of the University Education Committee to scrutinize such people when they apply for membership. This committee examines their educational credentials and attempts to evaluate and compare them with the native Canadian standards reported above.

According to the Annual Report of the Canadian Dietetic Association for 1955,[14] for example, there were twenty-two such "special membership cases" considered. The Committee required of these cases:[15]

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14 C.D.A., "Annual Report - 1955", Toronto, June, 1955.
15 Ibid., page 3.

a) An official transcript of college credit.

b) A college catalogue corrected for the year corresponding to the year of graduation of the applicant.

c) Particularly in the cases of those from other lands, supporting statements of experience, etc. These are to be made out in six copies for use when sending information to Committee members and if in another language, arrangements made to have them translated.

The experience requirement for membership in the C.D.A. is not considered by the Education Committee but rather is in the purview of the Board of Directors or the Executive of the Canadian Dietetic Association.

In 1955 thirteen of the special membership cases were disposed of in favour of the applicants, and of these nine were people with training in Canadian colleges and universities. Two of the others had received some training and experience in England and the last two were from Germany and the Netherlands respectively.

Two special applicants, one from Australia and another from Germany were considered ineligible by the Education Committee. The remainder were either put aside for further consideration or declared pending.

It would appear then that organized dietetics has managed to erect a structure to screen sub-standard

and non-middle class oriented elements from its recruits. Whether this is the only way of ensuring a respectable or middle class composition for the occupational group is a general question for which the essay as a whole will not attempt to supply information.

(b) Organizational Structure.

It is now time to make a preliminary examination of some of the formal and the informal[16] organization of the dietetic association of the dietitians. This again, it is suggested, follows from the unique social structure of the group as described with data on sex, age, marital status, and, to some extent, out-group affiliation.

Formally the Canadian Dietetic Association consists of an executive, a Board of Directors (one from each geographic region of the country) a number of committees (Membership, Education, Legislation, etc.) and numbers of active and life members. It is a corporation with letters patent from the Federal Government. More details of the activities of the occupational group as a formal organization will follow in later chapters. Meanwhile there is the matter of the informal organization of the group implied when interpretation is made of some of the statistical material introduced earlier in this chapter.

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16 The distinction made in this essay between formal and informal organization is this: "formal organization" refers to enacted (in the legal sense) organization such as is consciously perpetrated by the members of the Canadian Dietetic Association. "Informal organization" on the other hand exists in the unconscious alignments that follow from similarities and differences in social status such as age, sex, rank, etc....

The quantitative data in the previous section have told us enough about the census category of dietitians, and, it is assumed about organized dietetics, to spell out the following likely aspects of informal structure.

Dietetics is divided informally, in a sense, between those women who are married, and/or relatively marriageable, and those who are not. This differentiation is, of course, a function of age, and actual marital status.

In actual figures it was noted that while fewer than two out of ten dietitians were married, fifty-four per cent were in what might be called the most marriageable age-group of under thirty-five.[17]

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17 This is a very arbitrary figure but it probably has some basis in real life. According to publications from the Dominion Bureau of Statistics (Canada Year Book, 1956, table 20, pp. 227-228) the average age of marriage for spinsters is slightly less than twenty-four. The same sources indicate that ninety per cent of spinsters who marry do so before they are thirty. Other D.B.S. sources (Vital Statistics,1953, table 40, pp. 122) show that the average age of brides remained fairly stable at twenty-five, for twenty-two years between 1921 and 1953. Remembering that dietitians form a middle class group of college women it would probably be safer to place the average marriage age for girls of that category somewhat higher. For what it might be worth, here is the marriage-situation of dietitians in the words of an informant:

> ...dietitians marry fairly late... the average: twenty-five, twenty-six, twenty-seven...Not because they don't know the man they're going to marry 'til that age -- but they have long engagements because, maybe they want to keep on working. I don't know if that's the general thing but very few marry young....

If we were to call these categories "marriage-oriented" and "career-oriented" groups, an obvious function of this type of structured dualism would be that the marriage-oriented would be less committed to dietetics than the career-oriented. On the other hand, the older, single women in the occupation would likely find considerable power, gained through experience and seniority, attached to their roles, and, further, their interest in wielding this power increasing as their growing older meant a decline in the likelihood that they would marry. It seems likely, then, that when forty-six per cent of the practising dietitians in the country are over thirty-five years of age, that the occupation is one that is dominated by older career women who are "married" to their jobs.

And it would follow also, that the younger woman who wanted to get ahead in dietetics would have to orient herself in certain ways to the values of the older group. The following remarks from a younger dietitian spell out the facts of social structure and mobility in organized dietetics:

> ...You can equip yourself to take over, and the older dietitians usually spot the ones they want and work them in.
> ...Because, if you're a single person and you've been on staff four or five years, you probably will not marry and you'll be more useful to the profession. Our promotion system has that too. For instance, I've been on the staff two years and I've been there as long as anybody, except the assistant-directors. The turn-over is so great!

And keeping in mind that this is a younger dietitian (age twenty-eight) who sees herself still with the option of marrying out:

> ...People like myself will probably be there only a year or so!

Such an orientation, of course, provokes a certain amount of resentment in those who stay and grow older; and this is summed up in these words of one senior dietitian quoted in a study of dietetics made by the dietitians themselves:[18]

> "...it is most discouraging to train girl after girl from Junior to Intermediate capacity -- only to have her leave to be married."

Although the dichotomy has been made between the career and marriage-oriented groups, this does not, of course, place all married or hoping-to-be-married women in the younger group and all the spinsters in the older group. There are, of course, a number of older married women among the senior dietitians and their role as mediators between the devoted older spinsters and the wavering younger girls would be something worth taking time to explore. The role of the girls who early (while still marriageable) become career-oriented and dedicate themselves to dietetics from the start, might also bear further study.

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18 Frances S. McOuatt, "Job Evaluation and the Dietitian," Canadian Dietetic Association, Toronto, 1954, p.12.

Echoes of the age-group conflict are persistent. Here to qmote further from the report cited previously,[19] words from older dietitians:

> The Juniors are uninterested, unwilling to work as we had to. We had to do it the hard way - why shouldn't they be willing to do the same?

And again, from the younger women:

> They don't care about us - we have no influence - no voice in what is being done by the Association.

These strains to group cohesion, of course, are not just confined to women's occupations and the problem of marriage. Inter-generational conflict of this type is common between the "old guard" and the "young turks" in practically every kind of organization. The following excerpt from a report made by a committee set up by the Canadian Dietetic Association to look into this sort of situation has parallels everywhere. It is interesting to note that those involved see the problem in terms of individual shortcomings.

> The committee was of the opinion that we as individuals are hampering our own progress....

The fact that

> ...The senior people keep complaining that they worked long hours for smaller pay than at present....

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19 Loc. cit.

and that

> ...the younger members are not willing to accept responsibility....

as seen as coincidental cases of individual shortcomings. The remedy advanced for this as is often the case puts the onus for action on the members of the C.D.A. seen by the committee as an aggregate of self-reformable people.

> ...We, as a Profession, should be progressing and looking forward, not retrogressing, after all, conditions have changed immeasurably. It is admitted that the younger members do not always have the right attitude...

It is to be noted that no direct reference is made to the senior members as committing errors. This is, after all, a report by committee members who are themselves senior or career-dietitians.

> ...but does the fault lie in part in the fact that they are not given enough authority and encouraged to accept it. Their mistakes must be used as a teaching medium, not as a threat to their progress.

The conflict between the generations within the structure of organized dietetics is noted briefly in passing at this point. It will be taken up more fully in the next section when we deal with socialization.

(c) Recruiting and Socialization.

It has been previously shown that dietitians appear to come mostly from middle-class backgrounds and that ideally, and in fact, the great majority are university graduates. It has also been mentioned that a qualified dietitian is usually required to take a year-long internship bringing the total amount post-high school education to four or five years.

If the description so far has covered only the channels of recruiting and socialization, this section will deal with the "how" of these twin processes.

A basic question here is: What are some of the mechanisms by which a supply of middle-class university women is kept going through the various stages of socialization to dietetic roles?

This will be dealt with on two levels: First, the official arrangements of the Canadian Dietetic Association to recruit girls into dietetics and from there into the Association will be described. After that, examination will be made of some of the personal reasons for going into dietetics given by the dietitians interviewed.

The Canadian Dietetic Association seeks to recruit for dietetics by directing appeals to girls in the

high schools who plan, or who, if given reason, might decide to go to college. These girls are subjected to pamphlets on the attractions of the dietitian's job and urged to take Home Economics with specialization in Nutrition or Dietetics. The special Vocational Guidance Committee of the C.D.A. tries to supplement pamphlet advertising with visits to high schools by qualified dietitians, and tours of places where dietitians work, for school girls.

The messages contained in the pamphlets is along the following lines. Under a photograph of a pleasant, wholesome and healthy-looking young girl are the following words:

> Plan to be a DIETITIAN
>
> A wide choice of careers will be yours.

The broad scope of the field is usually emphasized by a list such as the one reproduced here, showing the range of activities in which qualified dietitians work.

> Hospital, Dietitian, Nutritionist, Food Service Director, Dietitian in Armed Forces, Manager of Home Service Bureau, Dietary Consultant, Women's Page Editor, Homemaker, Home Economics Teacher.

At another point a heading stresses that

> A Dietitian's Job is Interesting.

and goes on to outline the kinds of work dietitians find themselves doing in hospitals, in social service agencies, industry, commercial restaurants, for the press and on radio and television.

"What type of girl makes the best dietitian?" asks another pamphlet,[20] and goes on to supply an answer.

> If you are energetic, have a pleasing personality and qualities of leadership; if you are interested in the science of nutrition and the art of cookery you are the type of girl which makes the best dietitian.

The same pamphlet, poses the following answer to the girl who wonders why she should submit to socialization as a dietitian rather than something else. First: the self-evident fact that

> Every girl wants her education to prepare her to live a full and happy life.

followed by the following arguments to demonstrate the utility of education as a dietitian:

> Training as a dietitian will give you specialized knowledge which offers many opportunities for interesting professional work.

Furthermore

> In hospitals, in business, in social welfare, in nutrition research, the professional knowledge and services of dietitians are increasingly in demand.

And, finally, to round-out the "sales appeal" to the young girl who wants to retain an option on marriage as well as to commit herself to a career:

> Whether you marry and concentrate on making a home... or whether you earn your own living... as a dietitian you will always enjoy the benefits of this training.

So much for the official appeal. Now for some of the motives behind the response.

The following remarks made by two dietitians explained why they personally entered the field of dietetics. Their reasons seem to indicate that in at least these cases vocational guidance through the schools produced results for organized dietetics.

> ...I had to put myself through university so I had to decide on a career right from the start...since high school I've wanted to get into dietetics. I didn't know much about it, I read a magazine article, but in high school there was a teacher who took an interest in me, and he said 'I'll get you in touch with someone in dietetics", and he did, and I talked to the person and I guess her enthusiasm spread to me so I went ahead and tried it and I haven't regretted it.

And the second girl:

> I was interested in nutrition...I took Home Economics...I was about 16 or 17. We had an advisor on the teaching staff...I was very interested in Medicine and Health. I would have liked to go in for Medicine but my family couldn't have afforded it.....

If it were possible to say that these are representative accounts of how most qualified dietitians in the interview-sample saw their recruitment, then perhaps some of the problems facing organized action and organization per se in dietetics, dealt with in later chapters, would not arise. However, the following are the typical replies to the interview question: "How did you get into this field?"

> ...I wanted to go to university, and there was just not much choice except Arts or Home Economics. I didn't see much point in taking Arts so I took Home Economics.

or

> Oh I wouldn't say I knew ever since I was in high school I wanted to get into dietetics. It's largely a matter of circumstances. I think it was because in high school you get a lot of vocational guidance courses and you hear about a lot of kinds of jobs. Occupational Therapy and Dietetics always appealed to me and "O.T." always first. But University of ----- doesn't offer "O.T." courses and Home Economics is offered and I was always interested in the Home Economics courses...

Finally, this from another girl:

> ...I thought you were going to ask me that! I wouldn't say I had any chosen calling for dietetics...

After this candor, a suggestion that perhaps this dietitian for one did not know that there were others who shared her lack of dedication:

> ...as a matter of fact, this is going to be quite different because everyone feels you should go into something for a definite reason....

and then on into the typical pattern

> ...when I went to University, I didn't know at all what I was going to do the day before I registered. I know I wanted to go to university and I knew that there were only certain courses a girl could take. So one of my brothers said: "Well, take Home Economics...

It appears then that twelve out of fourteen women in the sample indicated that they more or less stumbled upon or "backed-into" dietetics. Only the two quoted above indicated anything like the dedication at an early age reported by nurses[21] and other medically-oriented types of occupations. It is suggested that this be kept in mind when the problem of group ideology is taken up later.

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21 Elvi Waik, "Becoming a Nurse: Socialization to an Occupational Role", Unpublished Master's Thesis, U.B.C., 1957, Chapter 5, pp.104-118.

Having dealt with official lures and personal motives of recruits, the essay presents and comments upon a statistical fact[22] bearing on current recruiting, before going on to cover briefly the stages of socialization.

The statistical fact refers to a discrepancy between the number of interns training in Canada in the year 1955-56, and the number of openings in all the intern programs. Eighty-four girls were enrolled in the various hospitals and the one department store in Canada which offer intern-training during that academic year. This covered only about two-thirds the total available openings (122). This fact, however, should be considered with two others.

(1) The C.D.A. in recent years encouraged the setting up of facilities for training dietetic interns in anticipation of the post-war expansion that they, in common with other occupational organizations, expected to come with the general expansion of business and services. However with recruiting not up as expected, surplus interning programs exist.

(2) Hospitals, which make a great deal of use of apprentice labour (i.e. nurses-in-training, medical-interns, etc.) are aware of the boost to the budget involved in

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22 C.D.A., Annual Report, 1955-56, Toronto, p.20.

having dietetic interns help with the food production. It is possible that the shortage of candidates is partly the result of the eagerness of hospital administrations to cut costs. Whatever the causes, official concern with the difference between the supply and demand for interns is to be found in the remark of one highly placed dietitian quoted in another report.[23]

> Why is recruitment falling off and why are we losing girls with adequate learning and even with some experience to other types of jobs...Will the whole set-up of professional Dietitians break down if we are unable to supply the demand?

With this sounding of official dietetic concern, the point has come where stages of socialization can be dealt with.

Perhaps the first stage of socialization proper could be identified where the girl has made her choice to take home economics at university. This is, of course, a very literal and obvious point to begin. It is misleading as well, because when the "woman-in-the-home" and "mother" parallels in certain dietetic roles are considered, it can be seen that socialization in these cases more likely began much earlier at the side of the socializee's mother. For this essay, however,

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23 McOuat, "Job Evaluation and the Dietitian", p. 11.

the first stage of socialization shall be the Home Economics course.

Examination of the data from the interview-sample suggests that the earliest stage of socialization which could be referred to as an experience shared by student dietitians was a sense of what they the students were not! This group differentiation[24] appeared to be a consequence of the fact that so many of those interviewed got into the occupation by default. Here differentiation had taken place at the level of social structure, when the appropriately, though separately, prepared young women made, or had made for them, choices of a line of study and in this case of work. For example, to repeat:

> I definitely wasn't interested in being a nurse, and I did not want to be a teacher! And I didn't think too much of an arts course because you always end up teaching in it anyway. So I proceeded to take Home Economics.

But this is not enough to differentiate the dietetic socializees. Many graduates from Home Economics schools become Home Economics teachers. Further differentiation is required in the Home Economics courses:

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24 Frank G. Vallee, Mildred Schwartz and Frank Darknell, "Ethnic Assimilation and Differentiation in Canada", Canadian Journal of Economics and Political Science, vol. 13, No.4, November 1957, pp.540-549.

> I was always interested in the Home Economic courses, and home economics, of course, leads you to dietetics or teaching and I was most interested in dietetics....

or, in more definite, if not so coherent, words:

> ...Well I took Home Economics at university because I wanted to choose something that -- that I would end up with something. I didn't take arts because I thought that I would end up with very little or nothing, because I didn't have very much in mind for a goal...Then I chose dietetics because I didn't want to teach -- it isn't a very good answer but that's what happened.

The grouping which results from this differentiation has been made up for the most part out of what was the relatively undifferentiated social category of middle-class university women with an interest in some kind of definite, respectable career. This, then is the kind of differentiation which produces social groups out of relatively undifferentiated social categories. The type of group formed here is what will be called a socializing group, which, it is suggested, soon takes on a structure similar to that of other socializing groups in professional schools. The function of such transitory generation-groups is to assimilate their members to the larger and more inclusive occupational groups. In effect these groups are like the rockets that never come back,

but which disintegrate after delivering their "pay-loads" to the appropriate levels.

The structure of the dietetic socializing group becomes increasingly apparent as the girls who "chose Home Economics" and dietetics rather than teaching, advance towards the Bachelor of Home Economics degree. The dietetic or nutrition-majors find themselves together in such courses as bacteriology, physiology, chemistry, botany and zoology, and later in foods and cookery, experimental cookery, personnel management, and in some cases, if required by the school, history of costume, interior decoration, or home management. In some of these the group and its members absorb the values and the content presented by the instructors. In others, the group, and/or the individual members might keep their own counsel. For example, here is reaction to "Home Management.

> "...but when we started to get into later years and take more Home Economic classes, I wasn't so pleased with dusting chairs and that sort of thing!"

The result is that on graduation day there is a structured group ready for the next stage of socialization, the internship.

Already, it should be noted, a certain division of inclinations is evident among the members. By now the

neophytes know that they can follow one of two forks in the road to achievement of full dietetic status. They can decide to be a hospital dietitian and work with the sick, or a food production and/or a commercial dietitian and orient themselves to the "cost-structure" and perhaps the "taste-structure" of providing food. Some may be able to make the decision at this point by enrolling as an intern in a commercial or food administration intern program. However, there is only one of these in the country in Toronto with places for a few dietetic interns, and while there are a number of them in the United States at points not too far from the border, most of the dietitians probably find it easier to postpone the decision at this point and go ahead into the second socializing group, that of the dietetic interns in the hospital.

The intern group is at a more advanced socialization stage, but it has the same transition-functions assigned to it as the previous structure. There is no need now for differentiation or splitting off of its members from broader categories of a similar nature. The members nominally committed to dietetics by the time and effort spent

> ...I was very discouraged, but I'd gone so far then that I couldn't go back....

However, now there is differentiation of the in-group represented by the socializing group from the out-group graduate dietitians, as well as by now, the very definite differentiations of the dietitians of the hospital, both interns and graduates, from other hospital roles. This of course is another way of saying that the interns are beginning to be more fully assimilated to dietetics per se.

There are some obstacles to this differentiation by the way. Dietitians and dietetic interns wear uniforms similar to those of the nurse

> ...and everyone thinks you're a nurse! Everytime they see you they're yelling "nurse ..nurse!"

The definition by members of the group that they are different, which may or may not bring with it a feeling that the group is more important than some others, emerges in the period spent in this socializing group. One of the earliest rituals for establishing a shared sense of difference, and, in this case, of greater importance is the practice of having dietetic interns lecture student nurses, and conduct laboratory sessions for them. The official purpose here is to equip the nurses to meet dietetic emergencies when dietitians are not available. The dietetic interns respond to this

situation which for a short time puts the student nurses in a dependent student position relative to them, in both positive and negative ways.

> ...when I interned in the hospital I had to teach student nurses about diets. I kind of like that...
>
> ...and when I was in the hospital I used to have the student nurses in diet labs. You wouldn't believe it but some of them couldn't even boil an egg!

and so on.

The differentiation of the dietetic socializing group from student nurses, and corresponding assimilation to the group of graduate dietitians, is certainly given impetus by the "marginal" position of the various dietetic roles in the hospital. The marginality of dietitians in hospitals and elsewhere will be discussed in a later chapter. Meanwhile, it will be enough to quote from two young ladies who recall feelings of being on the outside during their interning days. The first, expresses the theme of superiority to explain the differentiation of the dietetic group:

> ...It might be that they (nurses) resent us because we come right in as junior supervisors, where they have to go through a couple of years training (in the hospital)....

and makes open mention of the key item in structural

differentiation between nurse and dietitian

> ...of course they forget the time we put in at the university.

And the other, reacts frankly to out-group rejection which is often the other side of differentiation of the kind described above:

> I interned at the ---- hospital, and I worked there for one year, and I never felt at home at any time. I had dietitian friends and I felt alright in the kitchen where I felt I belonged.

Formal training, of course, is the formal means whereby the peer-group of dietetic interns is differentiated from the out-groups and assimilated to the occupation of dietetics. An examination of a typical intern program[25] shows how the neophyte dietitians are familiarized during the first week with the hospital structure around them, and their own places in it. Among the things they are taught then are:

> Names of key hospital personnel.
> Hospital ethics for the dietetic profession.
> Geography of the dietetic department and the hospital (by tour).
> Explanation of student diet nurses' duties.

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25 Vancouver General Hospital, Outline, Dietetic Intern Course, 1954.

The intention first, it would appear, is to familiarize the interns with their proper places by acquainting them with the existence, purposes, and values of significant out-groups. The orientation week then gives them information on their own privileges and rights, i.e.:

> Discussion of course outline and schedule of rotation.
> Explanation of time tables, hours of work, meal hours, days off, statutory holidays, vacation allowance.
> Explanation of medical services, chest X-rays. Fitting of uniforms and explanation of charges.
> Explanation of laundry regulations.
> Explanation of rating scale forms.

Next, they are given a general idea of where they will fit in to the dietetic department, the values that will guide them there, and the "machinery" they will make use of.

> Initial diet therapy instruction - use of diet manuals and weekly menus.
> Explanation of therapeutic diet records.
> Explanation of tray-cards, diet-lists.
> Explanation of daily food orders, census, ordering indent books for groceries, inventory replacements, toilet supplies, cleaning supplies.
> Observation and explanation of meal services.
> Routines of kitchen maids and Portion control.

and finally they are oriented to the key-role in the hospital: the patient.

Discussion and explanation of dietetic interns' ward service daily routines. Explanation of patient visiting.

The formal training program, which lasts nearly a year, then moves on to expose the intern socializing group to

1) Ward Service - four periods of four weeks each.
2) The Maternity Milk Laboratory - three weeks.
3) The Private Ward Pavilion - four weeks.
4) Food Production - four weeks in the Main Kitchen.
5) The Out-Patients' Department - four weeks.
6) A City Health Service - four weeks with a Public Health Nutritionist.
7) A Small Hospital - with a small dietetic department - four weeks.

In addition to the above the interns, either singly or in small groups are assigned to ten to twelve weeks relieving regular dietitians who are taking time off for holidays or vacation.

Concurrently with the above, the dietetic interns are given teaching experience as described previously, and weekly hours of instruction covering, among other things:

1. Diet Therapy
2. Hospital Administration and Organization.
3. Personnel Policies and Practises.
4. Kitchen Procedures
5. Menu Planning
6. Time and Motion Studies

7. Dietetic Department Policy Formation
8. Kitchen Planning
9. New Trends in Equipment
10. Hospital Housekeeping
11. Hospital Purchasing Policies.
12. Hospital Food Cost Accounting
13. Union Organization and Policies
14. Sanitation in Food Handling
15. Community Health and Welfare Organizations.

Finally, a concession is made to the profit-orientation side of dietetics in the hospital intern-program:

16. Catering

By passing final examinations at the end of this formal program of instruction the members of the socializing group qualify for membership in the Canadian Dietetic Association as active members. With this behind them, the members of the last pre-career socializing group become formal members of the dietetic in-group, officially, if perhaps not in the informal and the unofficial sense. The last qualification will now be considered.

It has been said that an important function of the socializing group was to differentiate its members from surrounding social structure and to assimilate them to a parent group. It has also been said that the members of the socializing groups are peers who, together as related individuals more or less take on the quantities of qualities required by the various stages of socialization that they move through. It is now suggested that differentiation from the obvious out-groupings is not the

only function of socializing groups, and likewise, that assimilation is to something more than to the group constituted by all qualified dietitians in Canada.

A latent function [26] of the socializing group of peers and age mates is the maintenance of the strata of unstable marriage-oriented younger dietitians, which, it was noted, made for a source of continuing consternation for the older career-oriented women. This function -- or dysfunction, from the point of view of dietetics as a stable organization, emerges as a result of (1) the necessary differentiation of the socializees from the socializors, who are usually older career women in dietetics, and (2) the corresponding assimilation of the individual socializees within socializing group of peers.

It can be seen from this that the younger-to-older interaction with all its unique ramifications is in effect trained into the students and interns, as it is into the instructors, during the time that the peer-group of students and interns move through the stages of socialization. Such a relationship is not thrown off like a garment by the newly accredited dietitians after graduation. This is so if only because the older, more established dietitians will not permit such a thing to happen. The

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26 Robert K. Merton, "Manifest and Latent Function", Social Theory and Social Structure, Free Press, Glencoe, 1949, pp.21-81.

newly arrived, to adapt Oswald Hall's analysis,[27] dietitian finds herself like the doctor at the beginning of her dietetic career, more or less at the mercy of the "inner sorority" of older established career dietitians. There is an important difference between the doctors and dietitians, however. The younger dietitian can escape, and is very likely to escape her subordinated position, through marriage.

4. Summary.

This chapter has considered the social structure from which dietitians are drawn together with the implications of this for dietetics and its occupational group. Among the facts considered have been social class, age, sex and marital status as these affect dietetics, and particular attention has been paid to the kinds of informal organization that the social co-ordinates of age and marital status set up. The final section of the chapter has dealt with the formal organization of dietetics including official policies of inclusion and exclusion, with the nature of the formally constituted occupational association, and methods of recruiting and socialization described at length.

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27 Oswald Hall, "The Stages of a Medical Career", American Journal of Sociology, vol.53, no.5, (March 1948), pp.327-336.

Socialization has been described in this chapter as a phenonemon through which the new dietitians as a group find themselves differentiated from out-groups and assimilated, in stages, to the in-group of qualified dietitians. It should however be noted that the dietitian in this process is not socialized to a group built on one basic role-pattern, like nurses or medical doctors. Rather they are made part of a group of allied yet dissimilar roles with little in common on the surface except the idea that, in the many contexts where they find themselves working, they can feed people or tell how to feed people more nutritiously and/or more economically than anyone else. This follows to some extent from the fact that they are trained, middle-class career women, and hence, it would seem, individuals whose word and direction are worth heeding.

Chapter Three

THE DUALISTIC INSTITUTIONAL SETTING OF DIETETICS.

> The best and purest foods of their kind should be always selected; and they will be found most economical. One should never eat much when overheated, nor when very tired. Food should always be eaten at regular intervals, and from two to three times a day. Eating between meals interferes with digestion, and in health should never be practised.
>
> Edward Playter, M.D.*

It is suggested at this point that dietetics in Canada has a dualistic orientation and institutional framework. What is meant is that dietetics finds itself working towards goals based on two types of values, one of which we shall style as medical-humanitarian, and the other as an "economic" or "commercial efficiency" value, and that both of these are supported by actual institutionalized roles and patterns played and followed by dietetians. The essay examines briefly the two institutions and their sub-cultures where the dietetic roles are to be found. Following that, in Chapters Four and

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* "The Physical Culture of Women", Woman, p.223.

five the nature of the tasks or role obligations that the dietitians in these differing settings find incumbent upon themselves will be considered. In Chapters Six and Seven an attempt will be made to describe the "contexts of relations," or the social arrangements that seem to result from the dietitians' attempts to carry out the normative commitments of their parent sub-cultures in various institutional settings.

1. The Concept of Sub-Culture.

It will be necessary at first to deal with the concept of culture, or perhaps, more specifically that of sub-culture. The term here will be narrowed down to specify what might be called task-oriented sub-cultures or special-purpose groups, because, we are dealing with a sub-culture not incidental to a physical fact like housing, or a general expressive activity like an intellectual or artistic movement, but one that is in a sense a product of the activity itself. Keeping this in mind, an exposition of sub-culture based on "residence" can perhaps be used to help establish the definition needed here. James Davie and Paul Hare,[28] introduce their paper on a college sub-culture with the following:

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28 James S. Davie and Paul Hare, "'Button-Down Collar Culture': A Study of Undergraduate Life at a Men's College", Human Organization, vol.14, (Winter) 1956, pp. 13-20.

> Every group existing through time comes to develop its own way of life or culture. Its members tend to do the same things in similar ways and to think similarly about they and others do. The term culture patterns refers to such consensus of opinion and behaviour..

Davie and Hare go on to show that because of this consensus the individual is able to know how to behave in various defined situations, and also how to expect others to behave. In other words, the individual is made aware of the correct performance of his role and of the correct performance of the other role. In other words:

> ...The culture functions as a "rule book" which defines the situation for the individual in terms of how he is expected to behave.

But here, Davie and Hare stop. Their exposition applies only to a residential culture incidental to the major activities of a college. There are activities or tasks within this culture which no doubt can be seen as the centers of other sub-cultural systems, such as the football sub-culture, the college-press subculture etc. However, there is no theoretical accounting for these because the limits of the research do not include them. Remembering, then, that "... culture functions as a rule-book" defining the situation for the individual in terms of how

he and others are expected to behave, we must carry the idea further to take in task-groups like the emergency culture of the hospital and the frugality culture of business. It is suggested in these cases that not only does the culture function as a "rule book" spelling out role performance conformity and deviance, but that the culture evaluates or ranks the relevance of the various roles according to the main task.

2. The Emergency Culture.

We now come to the question of what are defined as the main tasks of the emergency culture of the hospital, and who is it that makes the definitions? Following from this, we might ask: how relevant to these main tasks or functions of the groupings included in the emergency culture are the dietitians, according to these definitions? An attempt will be made to answer the first question immediately. The second will have to await a later chapter and a discussion of various influences on the ranking of dietitians' roles.

It is submitted now that the tasks of the emergency culture are defined by the in-group of hospital workers in a broader way than the public. However, it is also maintained that those within the in-group are always

subject to the conceptions and misconceptions of that same public.

For the purposes of this essay the in-group of the emergency culture consists of doctors, nurses, orderlies, dietitians, to mention a few of the more prominent roles. They define the following activities as basic to the main normative orientation of the group, which is the preserving and prolonging of life.

1) The in-group would define as primary to this the work in the emergency ward. This includes handling of accident victims, and of people who are suddenly sick; all cases where the patients are suddenly placed in need of the specialized skills of medical doctors and other workers if life is to be preserved or if suffering is to be alleviated. It is suggested that there would be wide agreement on this evaluation among the incumbents of the roles mentioned above.

2) The in-group would define as primary to the central purpose of the emergency culture the activity which goes on in the operating room. Here, often in a drastic way the course of nature if not of natural functioning of the human body is interfered with in an atmosphere of great suspense, drama, and ceremony.

It should be noted that the out-group -- the public -- which often has access to both of these fields of activity in the role of "case" or "patient" support these definitions of what is central to, and of what is symbolic of medicine. (A cursory examination of popular literature on medicine will quickly confirm this). The common quality that both the emergency ward and the operating room have, of course, is that in both drastic and dramatic attempts to preserve and prolong life are made. These are the settings of crucial stands against the encroachments of injury and disease on the human body, as well as ground for the mounting of counter-attacks, and campaigns against trauma and pathology. It is highly significant that while there are roles for doctors, nurses, and orderlies in the emergency-ward and the operating theatre, there is <u>none</u> for the dietitian.

3) The sophisticated in-group would define as primary the activity of the research ward. But the primacy here is of a different kind. Noting the previous distinctions we can say that the emphasis is placed on the medicinal side of Scientific Medicine in the cases of the emergency ward and the operating theatre, while in the research ward the stress is on the scientific aspect, with the efficiency ethos of the scientific experiment, operating, and the preservation of human life

following as the abstract consequence of the efficiently staged experimental treatment of a research patient who may or may not himself survive.

It would appear, then, that the research situation, while of admittedly crucial importance to Scientific Medicine, is a case lacking the dramatic emergency characteristics of the other primary situations in the emergency-culture. There is, of course, the question of suspense, unpredictability, and emergency in the scientific experiment. But this is a subtle sort of thing knowledgable only to the closest initiates involved in the experiment. The fact that it may not immediately and demonstrably affect a human being, removes it at least from the out-group's conception of activity appropriate to the "real" purposes of hospitals. Such an inherent remoteness, together with its effect upon the out-group's view, is not without its ultimate effects upon the evaluations made by some associates of dietitians within the hospital.

3. Institutional Structure and Dietetic Roles -- Emergency Culture.

There is, a certain marginality to all dietetic roles in the emergency culture. The dietitians are not the only workers who are removed by structure from the center.

One, and only one status occupies that position: the medical doctor. The dietitians then, find themselves in a class with pharmacists, X-ray and various other types of medical technicians, in this respect, if not with nurses. All of these technical specialties exist ancillary to the status and role of the doctor.

In summary, then, the social structure of the hospital places dietitians in only one of the three settings, which, might be evaluated as primary to the accomplishment of the main goals of the culture. This was in the research ward where the main purpose of the activity is the somewhat abstract one of further improving the methods for dealing with the emergencies the hospital seeks to dissipate and incorporate into its routine.

The institutional structure of the hospital, places other dietitians in positions even more removed from the emergency areas. Thus the therapeutic dietitian who works on the wards finds herself making limited and routinized contact with patients. Furthermore, while, in many cases diet-therapy might be the only treatment which will alter the course of an illness, the activity of the dietitian here is not surrounded with the drama and ceremony that are symbols or - to use the technical language of poetics - "images" to convey the significance

of the task to outsiders.

The dietitian in the main kitchen of the hospital, farther removed from the goings-on in the emergency culture, is placed by the hospital structure even farther out from the focus of values about the preservation of life.

In fact, like her sisters who work in the administrative positions in a large hospital dietetic organization, and those who look after hospital pay-cafeterias with their unique sideline of catering to nurses' teas, the main kitchen or production dietitian plays a role that is really part of the structure following from the frugality culture in which a major part of dietetics exists. We shall now discuss this other side of the dual orientation, and the double institutional basis of dietetics.

4. The Frugality Culture.

The frugality culture is also a part of the hospital. Hospitals which seek to combine the healing of the sick within an operating budget are, of course, not the only kind of agency in modern industrial society depending for their persistence on the configuration of values that this term is meant to cover.

The frugality culture is a set or norms oriented towards the main goal of preserving and prolonging what might be called the "financial well-being" of an activity involving monetary costs.

Operating within the frugality culture we again find an in-group and an out-group, each with its own conceptions, of differing degrees of sophistication, when it comes to defining the appropriateness of activities relative to the achievement of the main goal. Again there is "feed-back" from the in-group to the out-group and vice versa affecting the respective views and evaluations of participating members.

The prominent structured roles of the institution of business which operates within the frugality culture include of course managers, intermediate administrators, staff specialists such as accountants, and various sub-managerial supervisors. These, then, are a few of the significant others who view and evaluate the dietitian and her relevancy to the basic goal of the system in this setting.

The following activities, it could be suggested, would rank high, in evaluations made by these people, of the importance for the maintenance of the financial health of the enterprise of food production.

1) The in-group would judge as primary the activity which goes on in the production areas of the enterprise, in this case the kitchen. Dietitians certainly play important roles in kitchens.

2) The in-group would define as basic the kind of activity which goes on at the point where the product or service reaches the consumer -- or customer. Dietitians find themselves operating in this area of the frugality culture.

3) The in-group would define as essential the kinds of work done with paper and ledger-books, in offices well removed from both product and consumer. In large organizations dietitians play roles as administrators on a full-time basis.

It should be noted that the out-group or public in a business-oriented society such as this one, usually has access to the above fields of activity via more roles than that of consumer. For this reason, business methods, far from having the air of a mystique such as surrounds some of the more technical specialties, are distributed throughout the social system in many roles by the kind of socialization to which most members are exposed. For this reason we can say that North American culture generally places much emphasis on the

values of frugality culture.[29] It then follows that there is possibly more agreement between the in-group and public definitions of the importance of the work that the dietitians are doing in the social structures operating within the frugality culture.

5. Institutional Structure and Dietetic Roles - Frugality Culture.

Dietitians generally find themselves playing roles at one of three levels of management in this area. In nearly all cases, they are responsible to a higher level of management, and in the case of the senior dietitian the superiors are laymen or non-dietitians.

The senior level role is situated so that it dominates all lower levels of a dietary department. It then is in a key position in the institutional structure to implement the norms of the frugality culture.

The intermediate level dietitian in a large dietary organization finds herself at the usual mid-management level of administration. She has charge of a section or a division of the organization or she may be assigned a staff function such as "personnel". Ideally the senior level dietitian -- often called the Director --

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29 A pointed example perhaps: the moral importance attached to "solvency" - both personal and corporate.

co-ordinates her department through these intermediate roles.

The junior level dietitian, a role assigned the beginner, is at the actual production or service level. The institutional structure here places the dietitian in direct contact with the food produced, the sub-management worker-roles and the consumers.

6. Summary.

The purpose of this chapter has been to demonstrate the double normative and institutional basis on which the occupation of dietetics appears to rest. It will be remembered that this bifurcated identity is traceable in a historical sense to the merging of the social movements of Nutrition and Home Economy. Now, in a structural sense, it can be seen that dietetics exists within the settings of two institutions which are well established in this culture. There will be some discussion of the normative basis of organized dietetics itself in a later chapter.

The next two chapters will deal with the tasks or obligations incumbent upon the various roles of dietitians within the institutional structures that exist in the emergency culture and the frugality culture

respectively. After that, Chapters Six and Seven will examine the social situations which are a function of the participation of the dietitian in the various areas where she finds her work awaiting.

Chapter Four

THE CONFIGURATION OF TASKS I: THE EMERGENCY CULTURE

> ...I remember one or two patients who were dying. All they would eat would be shrimps...they probably wouldn't get that at home!

1. Tasks Associated with Treating the Sick and the Near-Sick.

Ideally the routine of the hospital exists as a factor of control -- control of a number of otherwise unmanageable things, only one of which is sickness. The temperature-taking at 6:30 a.m., the giving (and withholding) of meals and nourishments at specified times, the regular sweeping and cleaning of wards, the limitations on visitors, the lights-out at ten-thirty; all are attempts to control what have been defined as important variables in the basically experimental situation that the treatment of disease by Scientific Medicine involves. The ideal laboratory situation in this case is probably more often approximated than seen either by the patients, or by the hospital workers involved in the necessary rituals, or for that matter by the physicians.

To the patient the hospital routine is immediately compared with his every day world. The differences significant to him are most likely to be given most weight. The fact of altered diet, or fasting, will, it is suggested, not seem so noteworthy to him as events which seem peculiar to the hospital situation; such as the morning thermometer, the request for a urine sample, the needles and the various other compromises with privacy; in short, the numerous things which are not the routine of his ordinary life. This is not to say that therapeutic variations in the patient's food supply will not be defined by him as important. It is saying rather that such will be treated as annoyances and not as traumas, which is the case for certain other elements of the hospital or emergency routine.

To the dietitians who enter the emergencies of the patients as part of their own (and the hospital's) work-a-day routine, the patient exists, necessarily, as a unit of the work of a long day.[30] This can mean directly, as in the case of a therapeutic dietitian, indirectly for the costing or production dietitian, or abstractly as in the cases of the director of dietetics of a large hospital.

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30 The conception of "emergency" and "routine" relative to medicine, which is relied on so heavily here are to be found worked out in Talcott Parsons, "The Case of Modern Medical Practise", The Social System, Glencoe, Free Press, 1954, Chapter 10.

Impersonality is, of course, not entirely the order of all of the dietitians' roles. With those who do have contact with patients, other values operate.

> And if there's a special case like a seriously ill patient, or a terminal case, we really cater to them. If they want a rare steak we order it, and they often want things that way....

Let us now examine some of the dietetic roles which form part of the institution of Scientific Medicine located in the emergency culture of the hospital.

(a) The Research Dietitian.

The research dietitian's task exists as a specialized contribution to an activity important to the continued existence of Scientific Medicine, and, in a narrower sense, to the maintenance of the position of the hospital in which it is carried on. For Scientific Medicine the staging of the experiment has more than the functions of ritual (even though it possibly becomes this in the eyes of the dietitian and others who are not in a position to appreciate its results immediately). For a hospital, on the other hand, medical experiments have a definite function. They are the rituals which must be supported to ensure prestige.

The specialized contribution of the research dietitian is one of a number of such contributions made by a group of associated research workers.

> Yes, (I am) part of the research unit. We have our own lab-techs, and the doctors, the internes, the nurses, and the dietitians are all part of the research team. My work is entirely different from the other dietitians at ---- Hospital.

Thus the tasks of the research dietitians are different in nature from those of other dietitians. Their specific duties follow. Specifically, the research dietition is called on to do two things:

(1) maintain an important element of control in a medical experiment; or, under the watchful eye of the medical research director:

(2) manipulate a variable in this kind of situation which involves a living organism that happens to be a human being.

An important obligation of the dietitian in this role is to organize the food supply for the research project towards the above ends, and this task begins invariably with the maintenance of controls.

> All our food is kept separate; it's all especially canned food for the research unit and it's bought in yearly lots from one growing area and the ordering of it is quite finicky....

Working as she does with a team of associated experts, the research dietitian sometimes can rely on the specialized assistance of a team co-worker to help her establish controls.

> ...then we send one can out of each case to the lab to be analyzed. Everything we use is analyzed in the lab.

But this does not lighten appreciably the task that falls within the dietitian's own specified field of competence.

> We get a new shipment of bread in and -- well, everytime we change the set-up you've got to change all the figures on all your sheets.

In addition to the task of ordering and standardizing the <u>kinds</u> of supplies of food for research project, the dietitian has another task. She must try to standardize the <u>quantity</u> of nourishment that the human subject actually takes in. She is responsible for what is called the research patient's "food-intake".

> The diets are all very carefully calculated, certain things have to be kept constant each day...that has to be done for each patient.

and, so long as the dietitian is on hand:

> We visit patients at each meal.... if there's something they can't

> eat, you just have to make up their intake. You've got to keep constant check on them all the time; they're supposed to have certain things at certain times.

If she is away for a day:

> ...all (plate) returns are kept. If they are <u>any</u> they have to be weighed and tabulated and in that way I can tell how much the patient ate the day before, so I chart the intake....

All of which perhaps could be summed up in this pithy comment by another research dietitian:

> They (the doctors) tell me what they want and I have to make sure the patient takes it!

The parallel with the mother-role revealed here is perhaps striking, notwithstanding the setting of the experiment and the underlying purposes of scientific method. We have in this another reminder that the roles of some dietitians resemble segments of the usual home-roles of women. Yet another part of the job with domestic overtones is the obligation to bring the work of the "household help" up to the requirements of the standards set for the household.

This involves the perennially uncontrollable human variable -- and in this case usually a number of

them. The dietitian is the only member of the research team who must control and account for the contributions of a fringe group of non-professional workers. The lay-worker, who is not working at the level of the dietitian and her professional associates, is, of course, not so likely to be imbued with the necessary values ensuring constant compliance with the demands of that level. Hence, according to one research dietitian, when it comes to kitchen maids:

> I think one of the really important things is honesty -- particularly up here. I point out to them when they come that everyone makes mistakes, and so long as they admit these mistakes, it's alright. We'll have to allow for it. As long as we know!

The vulnerability of the dietitian in her attempt to standardize food intake, is, of course, very real. She is fully aware of the consequences of a mistake for the research work being carried out.

> ...mistakes are rather frowned upon... It can throw out a whole month's work if you make one mistake...

But of course, it should not be assumed that mistakes originate only in the kitchen. Errors are made at the professional level by team co-workers, even by those higher up. All slip-ups of this nature present the

team and the dietitian with special problems.

> Well, we had one mistake a couple of days ago. I was going through the records and discovered that the doctor had ordered -- or thought she had ordered, a certain amount of calcium to be given to the patient, and it turned out he had been getting a calcium mixture which was about ten per cent of what he should have been getting. It was a mistake that had been going on for over a month which was all of a sudden discovered. That sort of thing you can't do anything about it. All you can do is record the reaction correctly and change it from now on.

Thus it is the role of the research dietitians with her associates on the medical research project to try to standardize the situation of the medical experiment by eliminating the uncounted and the unaccountable variables. An attempt has been made here to outline the main tasks of the dietetic role in this regard. In a later chapter, the essay will return to the situation of the research project to examine it as a context of relationships and as a phenomenon with broader sociological implications for the dietitians involved and for the occupational activity of dietetics itself.

(b) The Therapeutic Dietitian.

Diet-therapy is a task common both to the research dietitian and the therapeutic dietitian. The

difference which becomes immediately apparent is that while the research worker is usually in a small isolated ward giving special diets to all of her research patients, the therapeutic dietitian is responsible for general food service for scores of patients only some of whom get special diets.

The therapeutic dietitian, then, has a dual responsibility: one of a general and the other of a specialized nature. She must facilitate the movement of the regular meals from the production areas to the patients, and upon the receipt of a special order from the physician, plan and call for a "therapeutic variation", for the special-diet case. The therapeutic dietitian's centers of operation are an office where she attends to her food orders and other paper work, and a ward kitchen or "pantry" from which the patients' trays are distributed at meal-times.

The system of decentralized food service, commonly in use in large hospitals, should be explained. Food is prepared at one main kitchen serving the entire hospital and moved in insulated carts to the outlying ward kitchens. When it arrives, the hot or cold foods are served onto plates which are placed on trays already made up and labelled with the patient's name, dietary peculiaries,

room, and bed-number. This operation constitutes an important supervisory task in the ward dietitian's role. It is here that she, like the research dietitian, is confronted with, among other things, the vagaries of kitchen maids.

> When we go in at seven our main job is to check our kitchens and see that all our staff are in and all the food is in....

Next comes the routine of paper in the office at the other end of the ward.

> ...then we have to check our charts to make sure that the diabetics are getting the correct intake...then we check the diet-lists against the diet-cards...check to make sure that our patients are still there....

Thus alert to the subtraction that signals the end of another routinized emergency, the therapeutic dietitian moves to accomodate those who are entering the emergency culture.

> (I)...pick up any new diet orders that have come in overnight, and visit the patients and explain their diets to them....

And all of these individual emergencies the therapeutic dietitian organizes into the sequence of her day's work, noting in passing those whom on this particular day will

experience crises:

> ...and we check on those who aren't having trays that morning, like the patients going to the operating room.

And sometime, while all of this is going on, she must find time to

> get all the food for the next day ordered...(from the Main Kitchen).. (and) get everything arranged so the maids can work smoothly....

not to mention

> ...during lunch, supervise the trays as they go out and answer the nurses' questions---like if they want to know if So-and-So can have another bowl of soup.

In summary, then, there are three main tasks in the therapeutic dietitian's role: (1) ordering food from the master menu of the Main Kitchen, (2) ordering special diets from the diet kitchen, and (3) seeing that the nourishment gets into the patient. The similarity between this and the research dietitian's task is easily seen; both are concerned with the actual provision of nourishment for patients. We will now examine two medically-based roles where the task is to provide nourishment in the abstract sense. We will look at the case of the out-patient dietitian and that of the public health agency nutritionist.

(c) The Out-Patient Clinic Dietitian.

In a sense an out-patient clinic is an "immigration station" at the boundary marking off the emergency culture from the everyday world. Often, though not inevitably, it is a point of transfer of public assistance (in this case medical charity) to the receiver. In either case it exists more or less as a place to report for those who are not fully accorded the status of healthy individuals in the everyday world.

For the professional community, the clinic is a coming together of doctors, nurses, dentists, social workers, and a dietitian -- each with the specific function or speciality of his or her professional role. The medical doctors, and dentist give their time without fee while the regular complement of nurses, social workers, the dietitian, and a medical records staff are supplied by the hospital.

As was mentioned above the out-patient dietitian provides nourishment in an abstract sense, through the teaching of good nutrition principles. She has interviews with patients and tells them what to do. She tries to teach them how to eat so that they will get better, or so that at least their conditions will not be made worse.

> They (patients) consist of obese patients -- a lot of them -- and

> some diabetics. In fact all diabetics are nutrition cases, it's practically synonomous.

The quotation reproduced here does not exhaust the possible types of patient which might be referred to the out-patient dietitian before or while being, in effect, on "parole" from the hospital. Some of the other well-known types of malady requiring dietetic supervision are, of course, cardiac and gastro-intestinal cases.

The out-patient dietitian receives the patients referred to her at a desk in an office, and as such represents a departure from the other dietetic roles described. in the case of a training hospital, she often has a dietetic intern observing. I was permitted to sit in on one of these patient interviews and diet-explanations, as they are called, and here is an excerpt from field-notes taken down immediately after.

> I took leave of Miss ---- and went over to the Out-Patient Clinic to see Miss --- She was busy with a patient in her office, with a dietetic intern sitting by observing. I prepared to leave, but she came out into the hall and asked me if I'd like to see how she did her work. I followed her into the office and was introduced to the intern with the explanation that I was studying dietitians for a Master's thesis.

"Now Miss" (to the patient, plump and fortyish) the out-patient dietitian continued, "you say you sometimes go over to your mother's to eat. What do you eat over there? Just the things that are on this list?"
"Well, I try to, but---"
"Does your mother know about you having to take off weight? I mean does she know there are some things you shouldn't eat?"

As it turned out the patient had been eating quite a number of the things that she shouldn't have, while over at her mother's. But it went further than that.

"...How about the things you eat at home? Anything you might be eating that's wrong?"
"Well, I like to take a little lemon juice with molasses and hot water in the morning. Is that all right?"
Both dietitians smiled.
"Well now! You should keep away from the molasses. That's not very good. Do you take it for constipation?"
(My presence might have been a factor. I tried to look interested in the heading tabs of a file of cards).
"No --- I just like to have it..."
"The molasses is something you shouldn't have," said the out-patient dietitian. "How much do you take every morning?"
"About a tablespoon with lemon and hot water."
"Well, you just leave out the molasses --"
"Is the lemon all right?"
"Oh sure! The lemon is fine! You just take the lemon with hot water."
"Miss --- made a note and then closed the patient's file.
"All right, Miss (Patient). You remember to take the lemon and hot water alone and we'll see you next week."

A full grasp of the formal requirements of the role of the out-patient dietitian might be gained by examining a list of the sorts of things dietetic interns are expected to observe when they spend a month of their intern year in the out-patient dietitian's office. The following is from an outline for a dietetic intern's training course at a Western Canadian hospital.

> Attendance at clinics held in main out-patients' department for cardiac, gastro-intestinal and diabetic cases.
>
> Attendance at maternity out-patients' clinic.
>
> Opportunity for more complete knowledge of pathological conditions in relation to diet.
>
> Patient interviews and diet-explanations.
>
> Opportunity for observation and understanding of the inter-related roles of the doctor, nurse, dietitian and social worker in a functioning medical team.
>
> Calculation of costs of normal and commonly used therapeutic diets.
>
> Preparation of a patient case-history.
>
> Opportunity for realization of the dietary problems of patients in low income groups.

Noteworthy here, perhaps, is the fact that the out-patient clinic dietitian associates with co-workers in a medical team like some of the other dietetic roles discussed. It should be noted too, the out-patient

dietitian must remember that she often deals with patients in "low income groups", who have special dietary problems. Thus the admonition that the dietetic intern must learn something about "calculation of costs of normal and commonly used therapeutic diets".

It is here where the tasks of the out-patient dietitian blend imperceptibly into those of the next dietetic role.

(d) The Public Health Nutritionist.

The role of the nutritionist could be said to be another which is assigned the promotion of nutrition by means of education. Thus the public health nutritionist must be a combination of teacher and saleswoman.

While the nutritionist is removed from the emergency culture of the hospital, she is, with her public health worker allies often attempting to operate on an emergency footing in the everyday world.

During her month spent at the public health agency working with the qualified dietitian who is a nutritionist, the novice-dietitian finds the following experiences awaiting her. Again we quote from the previously cited course outline for dietetic interns.

> Opportunity to gain some understanding of community health and welfare organizations, and the function of the nutrition service within such organizations.
>
> Preparing food budgets for families on low incomes. Home visits with public health nurses and social service workers.
>
> Observation and participation in Child Health Center clinics.
>
> Field trips with food inspectors and sanitarians.[31]
>
> Assistance to nutrition consultant on special projects concerning nutrition education.
>
> Interviews with families and individuals for purposes of interpreting nutritional information and attempting to improve poor food habits.

There appears to be, then, some duplication in the roles of the nutritionist and out-patient dietitian. Both provide a certain amount of direct across-the-desk diet instruction and explanation for people who are not completely sick if sick at all. The basic difference between the two roles is that the nutritionist is not held so close to her office by the boundaries of the emergency culture of the hospital. Her role calls upon her to be a mobile educating agent. In some ways she is like an evangelical missionary, an agent of preventative medicines, who ranges far and wide among the rich and the poor (and apparently particularly among the poor)

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31 Sanitary Inspector.

to carry out her task of providing good nutrition.

Two explanations of the mobile and educational aspects of the public health nutritionist's role are suggested by the following individuals. The first is a former public health nurse who had worked in a large city health service with nutritionists.

> I knew what they were up against. It was the same with the nurses -- You had to sell an idea. You weren't treating patients in a hospital in public health work!

A second more negative evaluation comes from a dietitian who happened to pick on the nutritionist as representing the kind of work in dietetics she did not like. Her feelings incidentally were not necessarily shared by many of the other dietitians interviewed.

> I interned and I know what I don't want! I like the therapeutic work, but when it comes to being a nutritionist like Miss ---- at the Health Service ... she has to go around and speak to those various groups who are <u>not</u> interested in diets. She has to <u>sell herself</u> and sell nutrition!

The public health nutritionist, then, if these descriptions fit, seeks to perform tasks which may be described variously as educative, proselytizing, or selling. There have been suggestions that in many cases, the last is the most cogent term -- as perhaps it might

be in what has now and then been alarmingly characterized as a sales-oriented culture. However, what is important here is the allegation that the nutritionist, upon occasion, does not attempt to "sell" nutrious food, but herself first and then the food. Such promotion of "good nutrition" by means of the use of the nutritionist as a legitimizing symbol brings us close to another type of role included within the fold of organized dietetics, which could hardly be said to be pursuing the broad social goals of dietetics. Referred to here is the dietitian in commercial "public relations", the test-kitchen dietitian or Home Economist as she is often known. A description of this last role will await the development of the general subject of dietitians who are paid primarily to make money for other people, or at least to save it for them.

Chapter Five

THE CONFIGURATION OF TASKS II: THE FRUGALTY CULTURE.

> ...we would earnestly urge that a practical training in the management of a house, from dish-washing to bread-making shall be given to every girl as part of her general education.
>
> Eliza M. Mosher, M.D.*

1. Tasks Associated with Kitchens and Budgets.

The kitchen and the budget represent areas of further scope for the trained ability to maintain strategic controls, an ability claimed by the dietitian as a result of her familiarity with economics and the scientific approach to problems generally. In other words, the kitchen and its operating budget offer certain scope for her training in what is called scientific management.

The task of the dietitian in the kitchen, in its broadest sense, is to take the classical factors of production --- in this case the operating budget, "raw" food, kitchen-help, and kitchen machinery -- and to control and combine them in such ways as to be able to vary at will the quality and quantity of "goods" produced.

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* "The Health of American Women," Woman, p.239.

The role of the dietitian here, of course, has parallels too numerous to count in an industrialized society that involves so much rationalized production. However, the fact that dietetics is involved a great deal in the problems of mass production means that dietetics thereby exposes itself to the values inherent in such patterns, as an earlier chapter has suggested.

It would be worthwhile at this point to look into the kitchen and note the technique which the dietitian utilizes in carrying out her tasks there.

Because control of cost is one of the primary obligations of the production manager, the dietitians have had to adopt the methods of modern accounting to their own special area. As a result the dietitian keeps a close eye on her purchasing methods, the cost of service to the consumer, the costs of meals eaten by employees, the kinds of things offered on her menu, and the size of the actual portions or units turned out. One of her basic tools in this task is a standardized, costed recipe. As the name suggests the standardized recipe is an attempt to control, among other things, the cost of the units of production, so that the results of the combination of the factors of production can also be rationally calculated in terms of cost. There is, however,

another aspect of the production process which the dietitian tries to control or standardize with yet another method of record-keeping.

The accounting techniques used in this case are the food quality rating-sheet and the tasting panel, and these represent rational attempts to capture some of the more elusive and intangible factors involved, not only in the art of cookery but in the subjective ranges of individual tastes.

The food quality rating-sheet attempts to measure the pleasure involved in seeing and tasting a particular food. It usually asks the individual to rate the "external appearance", and the "internal appearance", and also the "flavour". Ratings within these categories are often on a scale from one to ten. For example:[32]

Directions for use of score card for plain cake:

Standard	10	No detectable fault. Highest possible score
Excellent	8-9	Of unusual excellence, but not perfect
Good	6-7	Average good quality.
Fair	4-5	Below average, slightly objectionable.
Poor	2-3	Objectionable, but edible.
Bad	0-1	Highly objectionable, inedible.

32 Bessie B. West and Levelle Wood, Food Service in Institutions, 2nd ed., New York, John Wiley, 1945, p.25

It is interesting to note, perhaps, that according to the standard proposed in this textbook for student dietitians, the only kind of food termed "inedible" is otherwise characterized as "bad" and "highly objectionable", and is the kind rated at the very bottom of the scale. The concept of inedibility would appear to refer to that quality of the food which would make the eating of it do more damage to the health than good. Equally interesting is what happens at the other end of the rating scale. The superlatives used even for that food which earns the highest possible rating ("Standard 10") are of a very reserved nature. They are in keeping with the tone of a scientific scale, of course, but in addition they perhaps reveal the kind of orientation towards the qualitative aspects of food that the rational scientific approach of the dietitians engenders.[33]

An interesting question to raise here is at what levels of the scale might different kinds of dietitians refuse to serve food? One could imagine that a commercial or catering dietitian, who must market her products (more about whom later) might find herself forced to reject foods at higher levels on the scale than perhaps

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33 There is somehow no provision made here for expression of a sentiment as extravagant as the French "Magnifique", or even the lower-keyed native American "Yum". One wonders whether or not the levelling-off of the superlatives available in such a level-headed scale could have the lateht function of levelling down the performance?

residence dietitians with their captive consumers. Certainly "commercial people" as the dietitians call them, would cut off at higher levels than the hospital people, who, working closer to the nourishment ethic would probably be the first to score some of their "bland" creations in the next-to-inedible range and assign them a "2-3" score.

The rating-sheet is only one phase of the dietitians' attempts to rationalize, and make into an applied science the routine reproduction of the desired qualities of nourishment, palatability and economy in food. Its use in an unsystematic way, of course, would negate much of its value, if the experience in product research of other production directors has any bearing.

The following excerpts from the textbook by West and Wood are self-explanatory.[34]

> The evaluation of a good product on the basis of such a rating-sheet by one person is subject to the errors of personal bias and preference....

Furthermore:

> Ways have been devised by which the volume of a cake, for example, can be determined by exact measurement, as can the resistance to pressure or pull. Research has provided instruments for the appraisal of

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34 Ibid., p. 26.

> color, but as yet, no such facilities are available to evaluate flavour...

Hence, "scientific cookery" has had to respond to these deficiencies as best it can under the circumstances.

> The use of a tasting panel composed of several persons informed on the standards of a satisfactory food product, tends to average out some of the human errors....

The standardized recipe, the rating-sheet and the taste panel, therefore, are rationalized techniques whereby the dietitian seeks to trap the pièce de resistance for use in a regular and predictable way. It is, in a sense, an attempt to routinize an accomplishment that in the terminology of Max Weber would be described as "talented" or charismatic.[35]

Standardized recipes are obtained in a number of ways. Food suppliers appear ready to supply a limitless number and variety of them (standardized by qualified dietitians in their own test-kitchens) which call for the use of their products. In addition, the dietitian seems to be expected by her peers to show a flair for discovery or creativity at this point and to constantly increase her files of tested and costed recipes through search or experiment. Here are the instructions that one dietitian,

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35 H.H. Gerth and C.W. Mills, ed., "The Sociology of Charismatic Authority," From Max Weber: Essays in Sociology, New York, Oxford University Press, 1946, pp. 245-252.

leaving her production kitchen for a smaller one and family life, passed on to her successor:

> When there is nothing else to do there are always recipes to cost. A new recipe should be tested three times -- each time by a different person if possible -- before it is put on the standard recipe card. When it is standardized it can be costed on the back of the card....

The essay turns now to the purposive or intended functions which the standardized recipe and other techniques of rational control are meant to serve in the organization of the good-production factory which is the dietitian's kitchen. It must be kept in mind that the setting up and maintaining of such techniques in a systematic way involves some of the major skills in the repetoire of the dietitian's role.

The manifest or intended function of the standardized recipe dealt with above is best explained in these words from the dietitian's text-book cited previously:[36]

> ...For the many helpers who may not be inspired cooks, the use of recipes carefully tested as to the quantities or weights of various ingredients, methods of combining, cookery process, the time required, and number and size of servings has been found essential to obtaining standard products.

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36 West and Wood, op.cit., p.26.

Furthermore

> ...A food service...would be sadly hampered if the only way to serve a cake that had won an appreciative patronage was to have always in the kitchen the one and only person who knew how to make it...

Two other techniques, utilized by the dietitians are intended to manipulate the labour component of the production process. These are the pre-planned menus and the staff work-lists.

The menus, pre-planned in some cases for months ahead, are meant to provide another detailed guide for the cooks, whether these are of the "inspired" variety or not. The menus are there to guide them to the appropriate recipe cards in the recipe file. From there on the standardized recipe takes them on through their day.

Work-lists perform a similar function for the rest of the kitchen staff. They organize the jobs of these people in hour-by-hour detail throughout the day. Thus, with cooks using standardized recipes according to the dictates of pre-planned menus, and the rest of the kitchen workers deployed by work-lists into vegetable room, fish-room, pot-sinks, dish-room, or into store-rooms and account books, the production dietitian is able

to retire to her office and plan new policies, new routines, and new ways to control and vary the machine, while the existing machine hums on. This machine will be examined from the standpoint of the context of social relations that is set up with it in a later chapter. Until then a note might be made of the comments of one of the young ladies interviewed, on the possible extent to which the rationalization of the kitchen might go:

> ...There was an article in Restaurant Management a couple of months ago on the completely mechanized kitchen...you need only two or three technicians to keep it going.... We heard a report on it at our food managers' meeting a couple of weeks ago.

Now, a description of the tasks assigned to two kinds of dietitians whose work-roles keep them near the kitchen. First: the production dietitian in the large hospital, who is the specialist who must see that the food gets out to the wards, and second: the residence dieitian who is responsible for the feeding of inmates of an institution who are nominally in good health. This latter role is not of such a specialized nature as the first, and includes the service of the good to the consumer as well as the production of it, and the administrative work behind that process.

(a) The Production Dietitian.

One could say that the production dietitian finds her tasks at the periphery of the emergency culture of the hospital, and well inside the frugality dominated sphere which includes the administrative organization of the hospital and the rest of the world of goods and services. Thus the production dietitian's role has parallels with other maintenance services in the hospital such as the provision of necessary drugs, power, heat, cleaning services, laundry, and so on. However, like the pharmacist, and unlike some of the others, the production dietitian operates at a relatively sophisticated level of control because of the relation of her product to the key role in the hospital: the patient.

If one were to compare the tasks of the production dietitian with those of the research and therapeutic dietitians on the wards the following points might be noticed.

Whereas the ward dietitians play roles in the emergency culture that require a routinization of patients' emergencies, the main kitchen dietitians seek to incorporate the routine of the hospital into their own routines. The maintenance of this routine quite naturally involves them

in their own kinds of emergency.

> ...last Friday one of the cooks slipped up and the dessert was ruined. Of course you never find out about these things until it's ready to load the carts.

The basic nature of the obligation and/or expectation affecting the role is also different in an important respect. Whereas the ward dietitians, and other routinizers of other peoples misfortunes, are admonished to do "all that is humanly possible under the circumstances" to carry out their tasks, the kitchen dietitian like other players of routine maintenance producing roles are expected to "get things done no matter what the circumstances" -- in short they're expected to produce!

Nominally, the production dietitian has a long list of supervisory obligations to keep the machinery of production running. However, in practice, the production specialist might find herself tied down for much of her time to one or two large tasks. Perhaps the best way to illustrate this situation is to present the list of the things a production dietitian-in-training is expected to learn according to the prospectus quoted earlier, and then compare this with the way the production dietitians inter-

viewed reported on how they spend the day.

Training for the specialized role of the production dietitian comes about half-way through the one-year interning course. Here are some of the things she is exposed to:

> Practical experience in preparation of salads, baked goods, soups, sauces, meats, vegetables.
>
> Therapeutic variations.
>
> Instruction in the preparation of good orders.
>
> Acquaintance with the organization of work-schedules for cooks and main kitchen personnel.
>
> Supervision of distribution of food to wards and cafeterias.
>
> Checking returns of supplies.
>
> Experience in standardization of recipes.
>
> Experience in calculating recipe costs.
>
> Instruction in the use of kitchen equipment.
>
> Supervision of kitchen housekeeping.
>
> Cafeteria and small lunch-room operation.
>
> Assistance with preparations for catering for various functions.

And now we turn to the interview material to outline some of the daily tasks of the production dietitians in a large hospital.

> ...we start our orders and each of us has a special kind to do...We go to the separate sections of the kitchen on the main floor and in the basement areas, taking inventory of what we have on hand....After that you do some adding and subtracting from your original calculations and write what you need down on the proper order sheet and hand them in, and they're signed and sent on. That's roughly what we do in the morning, but there are all sorts of other things that come up.

While the ordering and checking in of the grocery supply of a large urban hospital is understandably a large assignment requiring a great deal of the time of production dietitians, the other obligations to which they are heir require attention as well. In the afternoon at another hospital:

> ...I work on the menus for the coming week. Actually, we do our menus about three weeks ahead at ---, but we're always working on them....

While yet another explained

> I take care of the equipment too --- make sure it's operating, and if there's anything that needs to be fixed, I call the maintenance people. I'm the one who has to decide if it's really broken or not!

And another summed it up

> And then we do a lot of other little things....Oh yes! we taste the food at ten-thirty and three!

which meant specifically in this case:

> I mean we go around and watch it being cooked and taste it, and check to make sure the cook is following the recipe all right.

Though, often as not, according to this self-confessed dietetic-deviant:

> Oh yeah! During the morning your're supposed to taste, but sometimes it's hard to get around to it!

One of the production dietitians summed up her job by comparing it to that of the therapeutic dietitian:

> It's very different from the therapeutic dietitian where people look in a book and say: "Well, we are supposed to do it <u>this</u> way!" You might be able to make a list of the therapeutic dietitian's jobs but you couldn't do that in food production!

While such an assessment of the therapeutic dietitian's job might not be wholly without bias, it suggests grounds for further comparison of the ward dietitians with the production girls. If the role of the research dietitian - as was suggested previously - has parallels in the nursery of the home, and that of the therapeutic dietitian at the family dinner table, then

that of the production dietitian is surely the one where the woman is queen of her own: in the kitchen.

> Oh, I like ordering, and I like the place where I work....I like the office -- we have a nice office now -- and I like the kitchen; it's got all the best and latest equipment.

(b) The Residence Dietitian.

We now consider the case of a dietetic role which is concerned with the total operation of a food service. This is unlike the production dietitian's work in that it is not confined to kitchen work, although that is a large part of the job. The residence dietitian is responsible for every phase of the operation in purchasing, processing and placing before her consumers all or most of the regular food they take in. The residence dietitian is not able to say, like this kitchen dietitian:

> It's my responsibility to get the food out of the kitchen in the best condition possible; to see that it is hot and attractive... But once it leaves the kitchen, I'm not responsible for it....

Referring to the dietitians' text-book[37] once again, here is an outline of the many duties of the residence dietitian, or of any dietitian who finds herself in full responsibility

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37 West and Wood, op. cit., p. 325.

for a dining system.

(1) Administration:

> ....departmental policy-making; employing, training, holding and welding together of staff; planning work schedules, and outlining work procedures for all workers...

and (2) on the budgetary side:

> ....financial management, budget-making, food-cost control, keeping records, and making financial reports; buying food and equipment according to specification....

and (3) the dietary chores:

> ....quantity food production, including meal-planning, and supervision of production and servicing units....

(4) the general requirements of housekeeping:

> ....maintaining sanitary standards throughout the department.

and finally

(5) the more diffuse obligations of the executive roles:

> ....and evaluating the effectiveness of the department in all its varied contacts, within and without the organization....

Thus far some general short-term tasks and obligations, which are part of the role of the residence dietitian have been sketched in. Let us turn now to a number of its major goals.

The residence dietitian, in a sense, finds

herself between the two main orientations of dietitians: health and economy. In other words, she finds herself in a status which occupies the meeting ground of the two major institutionalized patterns which underlie her occupational activity.

In one sense, she is responsible for the continuing good health of the people who are compelled to eat her food. In another, she is responsible for carrying this out within the context of a balanced budget. There appear at first to be two variables involved: nutrition and economy. However, it becomes evident that under the conditions of normal health with the consumers in a less passive state than when they are sick in the hospitals, it is often necessary to add something to make sure that they take their daily nourishment. This something is palatability.

Palatability becomes a goal here because when residents leave food uneaten on the plate it cannot be excused (as is sometimes the case with the therapeutic dietitian) on the grounds that the state of health of the patient is responsible. Nominally, the residents of the dormitories or the institution are in normal health. A rejection of the dietitian's food constitutes that and

The enigma of palatability for the residence dietitians is in a sense encountered by all who become involved in "quantity cookery" or large-scale rationalized food production. However, it appears that in this case the food producing executives work with several added factors against them. The first of course, is that the diners are "captive",i.e. they are forced to eat the food by virtue of the fact that it is most efficient from the point of view of operation of residence facilities that all residents purchase meal passes and eat at a central dining hall. The second is the virtual impossibility of pleasing all comers with any one menu or any one sequence of menus, something to which dietitians are often forced to restrict their meal-pass customers, for reasons of economic efficiency imposed from without.

Finally, there are sometimes unpredictable results for even the best-intended attempts to carry out quantity cookery in a "scientific" way. Evidence of the difficulties involved in carrying out such a task is found in an apparent division of opinion among the dietitians themselves. The difference, it will be noted, is along "official" and "unofficial" lines -- one of many such differences in dietetics dealt with in this essay. For the unofficial view, here are the words of one working residence dietitian:

> The food isn't going to be the same as the students have it at home. It isn't that it isn't so when it starts out. But you just can't cook for six hundred people and have it taste the way the students expect it should. They just don't understand....

A more official opinion comes from a former director of food services at a university, who also instructed future dietitians in the university's school of Home Economics. The comment appeared in the official journal of the Canadian Dietetic Association and was possibly intended to cope with unofficial beliefs of the nature just quoted.[38]

> The concept that the quality of food prepared in large quantities is different to that prepared in small quantities is unscientific....

This is naturally intended to carry some weight with scientifically-oriented dietitians. A number of points were made to back up the initial statement.

> ....it fails to take into consideration the relationship between method of preparation, nutritive value, palatability and attractiveness and ignores the possibility of faulty institutional procedures.

The deficiency then, according to this writer, lies in the machine which is still amenable to perfection. What-

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38 E.D. Leroux, "Food Production", The Journal of The Canadian Dietetic Association, vol.16, no. 2 (June 1954), pp.15-17.

ever the case, the attempt to satisfy several hundred people during any one meal is an understandably formidable task, considering restricted menus and the countless variables represented by staff, cooking methods, time, delay in serving, and others equally difficult to bring under complete scientific control.

The operation of the kitchen on a budget then represents one of the basic patterns of the frugality culture in dietetics. It also, of course, reflects an important segment of the home-role of the woman.

The following section will deal with dietitians who deal in a free market. Some of them are in charge of feeding large groups of people, others market food in more abstract ways.

2. Tasks Associated with Marketing.

So far we have dealt with dietitians whose obligations towards the consumers of their services or products were of two types. We have seen the dietitians on the wards in the hospital who in certain cases must "dose" patients with food according to the orders of the doctor who is treating the case. We have also considered some of the roles, specifically the production and the residence dietitians, whose task it is to provide a regular

supply of food to a waiting table. We now turn to a task that has no parallel in the housewife's role (unless we consider the case of the church bazaar). This is the commercial dietitian who is expected to solicit and sell her product.

"Commercial people", as they are called within the dietetic group, must please a customer rather than supply food to a resident or nourish a patient. Completely out of the picture now are the routine controls which confine the consumer of the product half-naked and helpless in a ward, or financially bound to the dining hall. Tempting sensuality is the only bond on the nourishment-needing customer, and in this role it is the task of the dietitian, ideally, to provide an ever ready and an ever fresh supply of that.

There are four main types of activity that commercial people in dietetics find themselves doing. We shall deal in some detail with only two of them. These are:

1) Restaurant work.

2) Special Catering- often done in conjunction with restaurant work.

3) Food merchandising, i.e., dietitians manage and sell bakery products, etc., in the context of a department of a larger retail organization.

4) Public relations work. Here the the dietitian lends her name and her dietitic skills to the development or marketing of foods promoted by large food-producing concerns, trade associations, or government agencies.

(a) Commercialism, the Hospital Cafeteria, and Catering.

It follows from the more general remarks above that an important task for the commercial dietitian is to bear up in the face of a dilemma that springs from two sources. During her training and role-socialization the dietitian is subject to indoctrinization with the nutrition as well as the economy ethic, and while this may make her aware that the customer is often "wrong" in his eating habits, she must be prepared to accept the merchandising dictum that he is "always right" at the cash-register. Operating, as she does, in a competitive, commercial setting, she learns too that the most crucial measure of her own competence, professional or otherwise, is a continuing, if not an increasingly healthy balance on the books of the firm which employs her.

The commercial dietitian is particularly prepared for this practical world of costs, cooks and kitchens if she has taken a commercial or a food manager's internship course, rather than the hospital training. This is not

likely if she trained in Canada (which most Canadian dietitians have done) because, it will be remembered, there is only one commercial intern course offered here, with (in 1956) openings for no more than half a dozen girls at a time. This compares with more than a hundred openings in hospital programs.

A few Canadian girls take commercial internships in the United States. One of these explained the difference between the hospital and commercial training.

> We were shown right away that our kind of interning was different from the hospital course. They stressed food as a <u>business</u> right from the first day on. . . . The first thing Miss --- said in her first lecture to us was: "Food is your <u>stock in trade</u> -- don't you ever forget it!"

With such an orientation the commercial dietetic trainees were then informed that one of their main tasks was to push back frontiers, not of sickness, but

> . . . We were reminded that it wouldn't be the same for us as it was for the dietitians in hospitals. They told us we'd probably be moving into fields where men had the monopoly and that we would meet with more opposition, and that we were going to have to prove ourselves. . . .

While the specific tasks of producing and marketing food would be accomplished by putting into use

some of the business-like methods described at the beginning of the chapter, the dietitian's self-assigned mission, as she moves into these newer fields is implicit in these replies by commercial dietitians who were asked the advamtages an employer of this kind of specialist might expect to realize. The first comment is from a teacher of future dietitians who once managed a sizeable commercial food service herself.

> They are hiring somebody who is scientifically trained in the production of food -- and in other subjects allied to the food field. If they take a lay person they usually find that they only know part of the field!

The next is from a commercial dietitian working in the field.

> Well, a dietitian is trained in the first place to be economical. That's important in a food department. And she has been trained in psychology and therefore has done a lot of labour relations and can help. . . and is adept at solving problems. Well, her training in general has been beneficial for a restaurant operator. . . . She knows all the sizes of cans and packages. . . .

For discussion of a specific case of a commercial dietitian the focus shifts back to the hospital and the task of the dietitian who looks after the pay-cafeteria. The pay-cafeteria administers to the food needs of staff

members who are in the hospital in the role of workers rather than patients.

The dietitian in this case might appear, in a sense, as an anomaly in the overall dietetic organization of the hospital because of the relative remoteness of her tasks from the problems of health endangered by illness and injury. Furthermore, her role is similar in many ways to that of other frugality-oriented production dietitians in the kitchen.

Recognition of the differences in orientation and tasks performed in the cafeteria of the hospital is contained in this remark by the Head Dietitian of a large hospital in Vancouver:

> We look on the cafeteria as a sort of public relations operation for our dietetic department. That's where the staff and the doctors and visitors get a chance to try out the food.

Further, an indication that the cafeteria was seen by the dietitian within it as involving tasks distinct from the other kinds of hospital work is implicit in these words of a commercially trained dietitian who worked for a time in a hospital cafeteria:

> Hospitals depress me! All the time I worked there I used to try and forget I was in one. It was hard with all the nurses and orderlies

> sitting around in their operating-room clothes.

One of the tasks attached as a side line to the work-role of the hospital cafeteria dietitian is one that seems to shed some light on the dietitians' attitude towards giving their public "what it wants". This is the task of catering, which the cafeteria dietitian takes on for the benefit of groups associated with the hospital who want to put on such things as parties and teas.

Catering can involve the serving of everything from full course dinners to the exotic fare of cocktail parties. It is at times like these that the dietitian is most likely to feel called upon to emulate the colorful gustatory triumphs of the French food specialists and to draw deeply from their files of standardized recipes, their trained knowledge of colour and so on. It is significant that in work like this where dainty, tasty tidbits are required, a great deal of the production is done by hand, often by one particular member of the kitchen staff who seems to have a "flair" for that sort of thing.

Catering is apparently not exclusively the concern of the cafeteria dietitian in the hospital setting -- at least "catering" as the word is used in the dictionary sense, meaning "to purvey food and/or enter-

tainment". The following remark from a therapeutic dietitian illustrates how the rigid nutrition orientation is likely to give way on the wards when faced with certain everyday facts.

> . . . If there's a special case like a seriously ill patient, or a terminal case, we really cater to them. I remember one case where all he would eat would be shrimps. They probably wouldn't get that at home!

(b) The Dietitian in Public Relations, and the Home Economist.

In the description of the role of the public health nutritionist it was suggested that the incumbent dietitian was often called upon to exploit her own personality in order to present the message of good nutrition. This was identified as the process -- well known in the popular culture -- of selling the product by first "selling the 'self' to the customer". It was also suggested that this method could be rationalized as an educational technique.

In the case of the dietitian in the public relations setting (who is often called a "home economist"), the situation has both similarities and differences of importance.

The similarity is that the dietitian in either case must be able to convince employing interests, i.e.,

private industry, public utilities, government agencies, etc., that she is capable of selling herself as a personality to a mass audience via the media of radio, television, publications, or through personal appearances.

The difference is that the dietitian in the role of a public relations worker or home economist is herself used by the interests outside organized dietetics as a symbol of legitimization for those of the latters' activities which fall within the purview of dietetics. What this means simply is that a qualified dietitian hires herself out to a commercial or trade organization to help promote a product.

A report on a job survey carried out by the Canadian Dietetic Association[39] notes that while there are not many dietitians working in jobs like these, the kinds of firms and agencies for which they do work are numerous. The survey notes that members of the C.D.A. are employed by dairies, food manufacturers, government agencies, public utilies, and trade associations, to mention a few. Apparently the immediate task often assigned the dietitians in these jobs is to help with promotion and advertising campaigns designed to stimulate demand for,

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39 McOuat, Job Evaluation, pp. 8-9.

or, in current usage, "increase public acceptance of" the products or services of such organizations. The dietitians working in these areas might draw upon their stores of dietetic knowledge to help create new products in a test-kitchen. They might help produce promotion material for existing products, or they might simply lend their presence or scientific halo to help legitimize a product or service from the standpoint of health or economy. Some specific projects assigned the dietitians in settings such as these might require them to to do all three of these things.

Chapter Six

RELATIONAL CONTEXTS I: FUNCTIONS OF A DIVERSITY OF EMERGENCY CULTURE TASKS.

> My plan would also be never to act without the sahction of the doctor-in-chief respecting the diets I mean to introduce; and I would not interfere in the slightest degree with any former department, or displace a man from his duty except for incapacity, insubordination, or bad conduct.
>
> Alexis Soyer*

1. The Relational Context of the Emergency Culture.

The quotation above is attributed to the person who found himself with the job of supervising the first diet kitchen ever established in a hospital. Alexis Soyer was a "noted chef" and the diet kitchen was said to have been established in 1855 at Scutari during the Crimean War by none other than Florence Nightingale.

Be this as it may, it is time to examine some of the relationships established between dietitians, nurses, and the ever present "doctors-in-chief", which accompany the attempts of dietitians to carry out their various tasks in the hospital. First, the essay will

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* Edith Barber, "A Culinary Campaign", Journal of the American Dietetic Association, vol. 11, 1935, pp.89-98.

deal with the situation of the dietitians who are most involved in the emergency culture. Then, the enquiry will turn to the case of the food production dietitians and move from there on out of the hospital setting to the farthest reaches of what has here been called the frugality culture.

It will be demonstrated first that the dietetic roles in the emergency culture exist in various kinds of marginality. While some of them, like the research dietitian, perform tasks and establish relationships with patients and associates in a similar manner to doctors, the very <u>specificity</u> of their specialized functions often serve to limit their access to and acceptance in the sub-culture of sickness and healing.

(a) Research Dietitians and Research Teams.

The research dietitian is usually segregated from the other roles in the dietetic bureaucracy of the hospital. The role is segregated in a way similar to that in which the entire research team -- doctor, nurse and others working on the project -- are segregated from the rest of the hospital organization.

> It's a little ward and they have one resident doctor who has a fellowship in medical research; and one nurse -- a full "R.N." -- and then there's me.

or, in another girl's words:

> (It's) . . . part of the research unit. We have our own lab-techs, and the doctors, the interns, the nurses, and the dietitians are all part of the research team.

The dietitian in such a setting finds herself with certain responsibilities, if not corresponding powers.

> If they needed something for the research-project, I'd probably be expected to move heaven and earth to get it!

Along with the segregation of the research workers from the regurlar routine of the hospital goes the segregation of facilities necessary to the laboratory situation.

> All our food is kept separate. It's all especially canned food for the research unit, and it's bought in yearly lots.
>
> . . . and we have our own little kitchen and there are only six patients so we cook our own food. And we're quite proud of our food!

The research dietitian is thus established as one who helps maintain controls over the experimental situation, and, in some cases, the one who -- under direction -- manipulates the experimental variable (i.e., quality and quantity of food given the patient). At another level of analysis it can be noted that this relationship to the research situation and the research team is maintained in

a number of ceremonial ways.

> I also attend ward-rounds with the doctors in the research unit. . . .

and

> When the doctors come in, like Dr---, who is head of the unit, you converse with him on what we're going to be doing and how it involves the diet.

This sort of thing is in striking contrast to what happens to the ordinary therapeutic dietitians when it comes to doctors as the next section will clearly show. Even more out of line with the kinds of relationships involving ordinary ward dietitians and doctors is another routine of the research dietitian with important ritualistic functions:

> We have a seminar that takes an hour and a half on Thursday mornings. If there's any interesting person in town they're asked to give a paper on what they're doing. They come and give a seminar, and then the resident presents the cases on the (research) ward. We do this once a week. We're all in on it. I take my dietetic intern.

This was how the dietitian in this case explained her reasons for participating in this important ceremony of scientific research:

> I go for my own interest, and to

> keep up with things on the research unit.

And the role she plays and its place in the ceremony:

> They ask me questions occasionally, but you must remember that these men are specialists in their various fields.

Brought together with the dietitians in the seminars and on other occasions are the special nurses of the research project, who, incidentally are always full graduates and not student-nurses. The solidarity that develops between the dietitian and the nurse is another thing that seems unique to the research unit.

> . . . and the nurses are quite good! They tell me if there are any complaints. They usually know where they can get hold of me.

In fact the entire situation of doctors, nurses, dietitians and other research workers seems to generate morale:

> It's just that we'll never ever know enough, and you can spend day and night studying it. I'm very fortunate in that I'm with men: doctors and nurses that are really interested in medicine and their professions. It's rather stimulating for all of us! Their enthusiasm radiates -- you can feel it!

But all this, of course, is largely a description of the dietitians' reactions to the formal relationships inherent in the research situation. There are latent

functions of this particular structure as well, and the analysis will now shift to them.

Up to now the description has concentrated upon the extent of the dietitian's incorporation into the research situation. The examination now moves to the exclusion of her role from the same situation. It must be remembered that the dietitian is called into the research in the nominal capacity of specialist. She does not in any way plan or direct the research, and the ultimate responsibility, even for her special area, falls upon the shoulders of the medical doctor. At the other end of the social scale the dietitian finds herself working across another barrier separating her role from that of the non-professional kitchen workers, people with another set of sub-cultural values, distinct, if not sometimes opposed, to those of the research situation. The product of this is the unique sort of alienation of the "man in the middle".

> And all through this you're involved with personnel -- your own kitchen maids and your own maintenance people. And it's quite interesting, you see, because of all of these levels. You have a kitchen maid who may not speak English, or might not be capable of doing anything but washing dishes and maybe reading what's written on diet-slips, up to the doctor who is so interested in medicine it's his whole life.

Thus cut off by the facts of social structure at both ends of the system, the dietitian is left to think her own thoughts and make her own evaluations of some of the things she sees. What she sees she sometimes attempts to judge by the scientific standards in which she was trained. Other times the evaluation becomes what amounts to be a layman's criticism of what the director of the research -- the medical doctor -- appears to be doing.

> From what I've seen of doctors in research, they tend to think of the patient as a robot and they don't necessarily -- they aren't necessarily interested in the patient at all. The fact that he's getting several needles a day and his veins are breaking down doesn't seem to matter, so long as they're getting their little results on the paper, you know!

Though, often, after such an outburst the dietitian will move back into her own area of specific competence where she is on safer ground.

> . . . sometimes they'll order such weird and and wonderful diets for a poor old man of eighty-four, it just doesn't make sense in that way. . . .

And because this sort of thing, if it happens, can lead to difficulty in maintaining the experimental controls for which the dietitian has immediate responsibility:

> . . . and it looks wonderful on paper but

> maybe your patient won't eat it,
> so it's no good!

the counsel of the dietitian prevails:

> . . . but then we can usually talk them
> out of it -- explain things to them.

On many occasions, however, as a subordinate (and as a relative layman in contrast to the medical-director of the research) she must stand aside and keep her own counsel entirely. For example, in this case one of the research dietitians put into words a fundamental value conflict of scientific medicine and then takes sides.

> They (doctors) will be talking about
> him in all these very fancy words which
> may sound very ominious to him. I don't
> think things should be discussed in
> front of a patient. I think it's cruel!

The moral conflict here, of course, is the collision of the rational, universalistic values of science and particularistic or humanitarian values associated with the meaning of the word "medicine". The establishment of a scientific medicine brings them together. Further, it is submitted that the words of the research dietitian here are also the words of the "person" and the "woman" roles which in this case appear to be invading the research context. From the point of view of the outside observer, what the dietitian is accusing the doctor of in this case might be an accurate account. In their research roles with the

guinea-pig patients, the doctors might well feel free, consciously or unconsciously, to pursue the universalistic goals of their field in the most openly efficient way neglecting the physician's obligation to keep a good "bedside manner". However, even after making judgements like these the dietitian in this case went back to a scientific rationalization to back up her more humanitarian misgivings.

> . . . and it's bad psychologically too, because he might not be half as sick as he might imagine after he has heard all the complications. . . .

The second latent function of the structure of the research dietitian's role reminds us once again that scientific work is carried on in a particular kind of social order.[40] It will be recalled that the manifest function of the dietitian in research is to control or standardize the quality and quantity of the food taken orally by the experimental patient.

> Like when the doctor says that you've got to give the diet so much sodium a day it's up to you to work it in and make sure it's palatable for the patient so that he gets the usual quantity of salt that he likes having each day.

However, it appears that one of the latent functions of the dietitian in this social setting is to control

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40 See R.K. Merton, "Studies in the Sociology of Science", Social Theory and Social Structure, Free Press, Glencoe, 1949, pp. 295-395.

the movements of patients out of research ward beds.

> You have to suit the patient or they won't stay up here. They have to give their permission. They're asked and it's explained to them what the set-up is. It's not necessarily for <u>their</u> good. It might be for other patients in twenty years time.

And further, another unofficial assignment of the research dietitian calls on her to coax new patients <u>into</u> research beds:

> As a matter of fact it's rather a drawing card -- the food -- because we have our own little kitchen and there are only six patients so we cook our own food so naturally it's nicer. And we're quite proud of our food and everyone says "Oh yeah! The Research Unit gets tenderloin" and that sort of thing. And so it compensates for the extra needles and things that they have to put up with.

And giving full rein to her pride in her powers of culinary attraction:

> That's one thing, we're quite proud of our food, and our service is quite nice, it's always hot and it's nicely served.

We see here, then, the emergence of a structure that supports scientific research in a free society which upholds values of self-determination and individual worth. In another place and time an S.S. man might have recruited the human guinea-pigs for a medical experiment. This is not

an alternative open to these experimenters, however, and the dietitian is assigned the task of recruiting patients for the research ward by tempting them with better food.

While the dietitian who works on the project officially plays a role which has an important technical specificity, and while unofficially she is assigned another which is important, though less specific and less technical in the clearly rational sense, still her role is marginal. Not only is she segregated in the hospital setting from the rest of the dietetic bureaucracy, but like some of the other minor medical specialists, like the nurse, the project lab-technician and perhaps others, she finds herself also kept back from the main stream of what is going on, which is the preserve of the medical director and his colleagues. This is in spite of the privileges extended to her involving ward-rounds and a place at the seminar table.

It is submitted, therefore, that this pattern of apartness reveals the marginal position of the dietitian. She is marginal - though ancillary - first to the main action of the research, and marginal in the second place to the dietetic organization of the hospital.

The first kind of marginality becomes apparent in the ability, if not the tendency, for the research dietitian-person-woman to stand apart from the reserach situation and

and make contaminating value-judgements. The second kind of course could be expected to follow from the special privileges, and the special deprivations, that segregation and isolation in the work of the research unit involves. It is not enough in itself for the dietitian to be an associate of the nurse, the lab-technician, the X-ray technician and whatever other specialists happen to be on the team, to remove her from the possibility of feeling isolated -- or so it would seem. Her membership of the team, while it provides her with some of the pleasanter stimulations of prestige and team spirit during working hours, is not a thing which goes beyond the research work. Aside from the immediate purposes of the project, the various associated specialists (who are assigned individually and who often resign as individuals) have few reasons for identifying with the team. Instead each has his own professional "family obligations"; his own haven to return to.

The research dietitian has been described as functionally marginal in a unique way both to hospital dietitics and to the research work to which she has been assigned. At the same time, it should be kept in mind that this dietetic role is the closest to what has been referred to as one of the most central activities of the emergency culture (See Chapter Three).

(b) Therapeutic Dietitians and Doctors and Nurses.

The research dietitian is not the only dietitian who finds herself at the edge, or on the outside, of things, and, perhaps, personally isolated. The analysis of the relational context now turns to the case of the therapeutic dietitian whose marginality seems even more apparent.

The marginality of the therapeutic dietitians who work on the wards does not stem from lack of integration with the other dietitians in the hospital; it is most clearly demonstarted in the apparent removal of the dietitian from what is really being done for the patients in the wards.

It will be recalled that the task of the therapeutic dietitian is to be responsible for scores of patients often spread over a number of wards. Some of these patients receive special diets, and require the therapeutic dietitians special contribution to the emergency culture. Most do not, however, and merely need a routine attention which multiplied by a great number of beds means a great deal of work. A consequence of this is that the therapeutic dietitian is kept busy supervising large-scale food service to such an extent that her contact with the individual patients is forced into a highly structured and exceptionally restricted frame.

Here is the prescribed and the described routine, according to the official instructions of a hospital dietary department and the explanatory comments of a practising thera-

peutic dietitian.

1) Read the diet order carefully. 2) Consult Kardex File to find out patient's bed number and type of diet: full, light, soft or fluid. 3) Visit patient and a. give patient a brief explanation of main points of diet. b. discuss between meal nourishment. c. Ask patient about his food preferences.	First of all we get the diet-order (from the doctor). You find out what the patient's room number is; what type of diet he is on. Then immediately, if possible, we visit the patient and explain about the diet. What we're supposed to do and so on. We don't go into too much detail. That comes later....
4) Fill out a diet record (green sheet) and put sheet in patient's chart between doctor's order and nurses' notes. 5) Read diagnosis from patient's chart.	Then we take the diet back to the office and write up the diet.... Then afterwards we fix up the Kardex file.
6) Fill out a slip for the therapeutic diet book. 7) Write all diets up-to-date. 8) Order extra food if necessary. 9) Change Kardex.a. Use a yellow flash (tab marker) and write the kind of therapeutic diet in the right hand space on card. b. Change between meal nourishments.	Then we make a note on the patient's chart saying we've seen the patient and commenced the diet as ordered....
10) If you receive a diabetic diet order follow the above procedure and also a. visit patients again after the diet is calculated so the patient will know what he is going to receive.	We try to visit every therapeutic (patient) at least once a week and see how they're coming along.

The full procedure outlined above applies to patients who are getting special diets. Patients who are not get a cursory but time-consuming visit and are taken care of from then on by the food service system. It can be seen then, that even in the case of special diet cases the dietitian is related to the patients by a highly formalized arrangement which could and does put considerable distance between the roles involved. Between the patient and the dietitian in the hospital stands the doctor, the written diet-order, the office Kardex File, a consultation of the hospital diet manual and a "brief diet explanation". What, if any, informal interaction might take place between the reciprocating roles here seems to be limited by the facts of time and the dietitian's obligations to the other patients on the wards. It would seem reasonable to assume that something more in the way of such informal contact with the patients might bring the dietitian closer to the "inside" of the medical treatment. However, after contact with the patient has been established in this instance, the personal relationship is all but terminated by the incorporation of the case into the hospital's dietary routine. In other words, once again there is a routinization of the emergency in such a way that the dietitian's final relationship with the patient becomes largely a matter of written order, records, and files. It is suggested that these facts operate in this way to place the dietitian at the periphery of the treatment of human illness and to assign

her to another kind of marginal status. The essay now turns to evidence of dietitians' reactions to this, and then goes on to demonstrate the therapeutic specialist's marginality to other aspects of the emergency culture.

A consequence of marginal association with the patients and corresponding limitations on knowledge of their conditions is the possibility of making a mistake in judgement of their needs for professional and other kinds of concern.

> ...in approaching a patient, sometimes they'll describe things and you have to know when they're painting a picture a bit and when they're describing exactly what it is....

The situation is complicated again by the fact that the dietitian as a woman has non-professional role-obligations and sympathies capable of being played upon.

> ...if you're not careful you can become quite hardened, with all the pain and misery around. You have to strike a happy medium somewhere. If you find that every moan or word of unhappiness gets you down, well, it's just not the job for you. You have to see something bright and realise that these people <u>are</u> being helped. But there's always the problem of becoming really hardened to it all and not caring....

The other danger, of course, is that is she were to abandon herself to these extra-rpofessional role obligations this

would affect the ideal performance of her role as diet-therapist. Furthermore:

> ...there are some who are chronic complainers and you have to know when -- how far to cater to them and when not to....

But at the same time:

> ...I might see a patient and think: Well! he's putting it on, sitting there wheezing and complaining -- and then it might be brought up in a conference that he <u>really is</u> a sick man.

Here the therapeutic dietitian acknowledges the limitations of her knowledge, and goes on to admit the marginal position of her role in the emergency culture in this way:

> ...of course the dietitian really doesn't have as much contact with the patient in comparison with the nurses or doctor. You can't know.

or

> Well, you don't know what he (the doctor) has in mind, and you don't know the condition of the child. You don't know yourself much about it.

The dietitian's exclusion from the central course of the patient's treatment follows from her segregation from

the interaction between the doctor, nurse, and patient. The nurse often follows the doctor while he makes his rounds to see his patients, but the therapeutic dietitian (except in the research ward) never does this. She waits for the diet-order -- if he makes one -- to come to her office. Ideally it comes as a written prescription, but often as not it is relayed informally through the ward nurse.

> ...usually it goes from doctor to nurse to dietitian. He might just tell her the patient needs a "bland" diet. Well there are three kinds of bland diets and the nurse might not know... So the dietitian has to find the doctor.

Removed as she is from the doctor's actual decisions affecting her, the dietitian further displays this marginality in her assessments of the doctor.

One of the questions in the interview schedule was designed to look into the nature of the relationship of the doctor and the dietitian (See Appendix B, Question no. 10). It as a semi-projective type of query in which the dietitians were asked to describe the ideal doctor from the point of view of the dietitian. The assumption behind this kind of question is that in describing the "ideal doctor" the respondent contributes two kinds of information: first, the nature of the ideals as conceived by the respondents, and second, the various types and degrees of deviance or the

ways in which the concrete cases are reported as falling short of those ideals.

As it turned out there were interesting and extensive similarities between the ideal images and the modes of deviance reported in the replies to the question. Furthermore, in a sense, both the ideals and the deviance seemed to involve two levels. The dietitians were apparently describing not only ideal and deviating doctors, but ideal and deviating men. An idea of how the dietitians interviewed feel about doctors generally is evident, perhaps, in the general tone of criticism running through their recorded references to both ideal and deviating medical men. Here is one of the more candid evaluations:

> Well, an ideal doctor is one
> who knows what he's prescribing.
> Some of them don't.

And another, in more gentle terms:

> ...so an ideal doctor is one who
> would follow the diet and change
> it when necessary and if he doesn't
> know what the diet is he should consult
> the dietitian and find out.... So an
> ideal doctor is one who knows <u>what</u> the diet
> is going to do. Whether it's eatable....

Accompanying this technical sort of ideal there was usually a technical criticism of deviating from the ideal.

> ...some of them put patients on

> a diet and forget about them --
>
> never change them....
>
> ...some... will go ahead and prescribe a diet... whether the diet's suitable, whether it's practical, or whether the patient can eat it. He'll just go ahead and prescribe it....

And in this vein sometimes the criticism was even more trenchant:

> ...a lot of them don't know anything about diets. And they don't ask either! So many of them do more harm than good! Actually!.... The patients can't eat the diet and they're very unhappy, and they lose weight rather than put it on....

And as one older dietitian summed things up:

> ...they should know more about diets than they do. They don't get <u>nearly enough</u> training.

It would seem that the dietitian, from her vantage point at the edge of the treatment situation, draws boundaries about the doctor's technical competence when he moves into what she defines as her sphere of spcialization. Many of the younger dietitians of the kind that have been elsewhere called "marriage-oriented" expressed the opinion that the younger doctors exhibit more interest and ability in dietetics than do the older men. The following comments from an older dieti-

tian however offer no support for this:

> And the young doctors think that
> if they don't know what to do
> about a patient: put him on a diet!
> And some of them have no idea what
> they're putting him on!

Furthermore:

> .... I think that the young ones
> are faddier for one thing.
> They get a notion about a diet
> and put everybody on it!

The shortcomings of the doctors raise what would appear to be important problems. The technical solution offered by the dietitian recognizes her role as a consulting specialist.

> Our aim to get get the doctors
> to consult the dietitian. When they first
> come as interns they're told where
> the dietitian's office is .... We try
> to encourage them to come and to get
> the habit of consulting the dietitian....

So much for the "technical" assessment of the distant doctor by the dietitians who work on the wards. The dietitians' comments seemed to imply an image of themselves as being spcialists in their own area of medicine, and of course in a sense as rivals to the medical doctors. They see the facts before them as demonstrating their own superiority of knowledge, training and experience in the special field of dietetics --

an area of mdeical techniques for which few doctors seem to have the time or the inclination to know thoroughly. It follows from this, in the reasoning of the dietitians, that the doctor who fails to consult them in this special area is failing in his obligations to scientific medicine and to the patient.

It was suggested above that it was also possible for the observer to detect another level of interaction involving the dietitian and the doctor. The focus now shifts to show the two as woman and man and, it is suggested this helps further to point up the marginality of the dietetic roles in the hospital situation. This other level of interaction is seen when additional themes running through the ideals formulated by the respondents are put together. Here, for example, is one young dietitian's conception of the kind of doctor she "idealizes":

> I like a doctor with an
> inquiring mind -- You know!
> Who's not afraid to try
> something new -- but who
> keeps a very close chekc
> on the patients to make sure
> that it's going alright.

And similarly a few selected criticism of some doctors' deviations from the ideal. It will be noted perhaps that this dietitian seemed hesitant about making

claims on the busy man's time.

> ...I think a doctor should at any time--
> well not at any time because they've
> got so many other things -- but be willing
> to take the time to discuss the patient's
> welfare so far as his food is concerned
> with the dietitian -- ....

To another occurred the disturbing thought that her services were capable of being dispensed with and that she personally might be rejected:

> Quite frequently -- and this is a
> terrible thing to say -- you get
> the idea that the patient doesn't
> really need the diet and he (the
> doctor) is ordering it because
> it's the routine thing to do.[41]

The dietitians feel that the doctor should take more time to familiarize himself with her services because

> Usually, if the doctor takes the time
> to get to know the dietitian, he'll
> take the time to come down and discuss
> things, and that way you can do a
> lot more for him and his patients.

As proof, one attractive younger dietitian reported

> There were some who were very
> interested in diet-therapy, and
> when they would come around you'd
> have really interesting talks. I
> enjoyed that so much! I think
> doctors and dietitians should work
> close together because dietitians can

---

[41] An action to be brooded over perhaps, as the wife might over the perfunctory kiss of the "busy" husband.

> learn so much from the doctors, and most of the times they don't know anything about diets.

But structure intervenes. The diet-slip and the nurse stands between the therapeutic dietitian and the doctor who is at the center of the treatment situation. Sometimes forgetting to excuse the doctors for haste and ignorance of the proper ways of handling dietitians, the women complained in piquant womanly ways.

> Doctors naturally look down on dietitians. I think they look down on nurses too! They seem to think the dietitian should be at their beck and call!

and

> ...Unfortunately some people don't know what to expect of dietitians.... Yes! Doctors don't. Younger doctors know how to use the dietitian properly.... I think some of them are a little afraid....

In summary, the essay has attempted to portray the dietitian in her marginal position within the area where she lays her strongest claim to association with medical matters. After pointing out some of the limitations that the tasks of the dietitian place of her participation in the primary area of research in the emergency culture, evidence has shown that the dietetic role on the regular wards also operates at a

distance from the main activity, and from the main agent of that activity, in the treatment of sickness.

An attempt has been made to show the therapeutic dietitian as a sometimes frustrated technical specialist offering services which are not, from her professional point of view, fully appreciated or adequately made use of. Through all of this it has been suggested that there runs another thread. Underlying the whole situation of the dietitian and the doctor are the very real facts of sex, and this becomes all the more evident when we bring the nurse into the picture.

Compared to the nurse-role the therapeutic dietitian finds herself not only apart from the decisions of the doctors per se but excluded from the primary grouping in which the decisions are often made. She finds herself in the most unstable corner of a triangle, both because hers are the technical services often dispensed with if the condition of the patient worsens (i.e. intravenous feeding repalces oral feeding), and because, like the governess in comparison to the wife[42], hers is the woman's role with the least institutionalized support. Again the relative closeness of the nurse to the patient adds to all of this. It will be recalled that while the dietitians see that the food is served, the actual passing of it to the patients is usually in the hands

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42 This useful analogy to the "triangle" was suggested to the writer by Elvi Waik.

of the nurse (or student nurse if in a training hospital). This, of course, permits solidarities to develop between the patient and the nurse, often at the expense of the dietitian, if complaints about food are involved. Finally, the dietitian's marginality is demonstrated over and over in the hospital routine by the fact that nurses' obligations to patients transcend the situations that require the dietitian. This is clearly seen by the dietitians, as comments like the following reveal:

> ...because if those nurses are too busy to take the trays into the patients because somebody is dying, well that's more important! But then all the food gets cold and so you're blamed.... It's a ticklish problem!

The contention here, then, is that the role of the dietitian on the hospital ward is in a marginal position though in a different way from that of the research dietitian. Two of the most important facts of the therapeutic dietitian's marginality is her relative removal from the treatment situation, and her relative dispensability, particularly if the state of health of the patient is not at a level where nourishment can be taken orally. (The therapeutic dietitians, of course, make a genuine contribution to the alleviation of pain and sickness, although it is one that is not always capable of dramatic demonstration.) The girls will sometimes sum up

their feeling of being on the outside with sentiments like those expressed in the following words:

> ... I don't think there is anything else except possibly that your recognition just isn't there.... for what you're generally doing....

The dietitian working in the outpatient-clinic is mentioned as the last of what have been called the dietitians of the emergency culture, i.e., those that work with sick or nearly sick people. Her marginality can perhaps be best described as having parallels with that of the research dietitian. She works with a group of associated specialists, and she too is called in to treat only <u>part</u> of the patient. Now and then a patient is turned over to her, but control of the case is still the option of the doctor. The clinic, like the research project of the research dietitian, is more the work-place of the dietitian than the "home" of like-thinkers.

In summary it can be said that the dietitians who work on the hosiptal wards with the other medical roles of doctor, interne, nurse, and orderly find themselves in a marginal position to the commonly defined and evaluated

main currents of the emergency culture. While the dietitian's moral obligations and her institutionalized tasks direct her to stand by ready to apply the techniques of nutrition through oral feeding, the facts of illness and emergency in the emergency culture often rule out her services as irrelevant. Emergency feeding by intravenous techniques is a thing arranged for by others.

The nurse and the orderly, on the other hand, are constantly at the side of the doctor when he does the important work of the emergency culture. They go where he goes usually, and are given things to do. Finally, when dietitians are abed with the rest of the world that works by day and sleeps by night, it is the nurses and the orderlies and the interns (if not the doctors) who keep the bedside vigil and who stand by to meet the oncoming ambulance.

Chapter Seven

RELATIONAL CONTEXTS II: FUNCTIONS OF A DIVERSITY OF FRUGALITY CULTURE TASKS.

> The young wife has a theory that she must oversee her household so she makes regular visits to kitchen and storeroom... It is soon discovered, however, by those under her that her ideas upon household matters are crude and impractical, and this knowledge, makes them insolent and domineering. This she resents, and discharges one or more....
>
> Eliza Mosher.*

1. The Isolation of the Food Production Dietitians.

The marginality of the dietitians in the emergency culture is, upon reflection, a marginality based on the kind of fringe jobs they hold. It is experienced by the dietitians as a sort of alienation from the central goings-on in the hospital setting. The dietitian engaged in food production on the other hand is to a large extent the chief agent of what the food producing machinery is producing; however, she finds herself standing apart from the social world that this involves. In the frugality culture the marginality of the

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* "The Health of American Women", Woman, p.240.

dietitian comes with the fact that here she is the leader, with authority linking her and yet keeping her at the edge of the world of her subordinates. The dietitian in the factory culture of food production then, experiences the isolation of the manager.[43]

It was noted earlier that the job of the good production dietitian, whether in the main kitchen of a hospital, in a university residence, or in a commercial restaurant, commonly involved some sort of compromise between at least three values. She held her job by virtue of the fact that she was proficient in balancing economic efficiency, nutrition and to a certain extent, palatability.

A previous chapter, too, touched on the techniques dietitians use in a highly rationalized system for producing food. It was noted that these techniques served to organize kitchen tasks and the workers performing them into systematized, predictable productive activity.

The essay now looks more closely into the context of relationships involving dietitians and their kitchen

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43 The production dietitian would also be in a position to experience the marginality of job-type too, especially if she were in a setting where other lay-managers were associated with her. The case of the test-kitchen or Home Economist kind of dietitian, to be treated next, is a striking example of this.

workers which follows from the system thus set up.

The food production plant, an important focus of values and a major segment of the institutional structure of the frugality culture brings together people of two separate social class sub-cultures in a very formalized way. These are the dietitians who have been identified as middle-class or middle-class oriented, and the kitchen workers. As a group these latter people - the cooks, bakers, waitresses, kitchen-maids, and scullery workers - are recruited from the social classes below that of the university-trained dietitian. If they have had any formal training it has been through traditional appreticeship or vocational schools, while in many cases the skills involved have been picked up on the job. During the time of the field work for this essay, many of the kitchen workers were recent immigrants from Europe[44] (whom the dietitians often described as "good" or "obedient" workers).

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44 It is interesting to note the functions of the food preparation industry as a mechanism for moving new immigrants into the Canadian occupational system. Both the construction industry and the commercial kitchens of Canada appear to serve the functions of taking the newly-landed "raw" immigrant (the one who hasn't yet learned English) and starting him on the assimilative process by first integrating him into the job structure at a place where he can "get his feet down". The food preparation industry has a number of advantages over the construction industry: It is not seasonal, it takes either sex and workers

The differentiation of the dietitian from her workers, which is based on class and education differences and supported by the structure of the work-place, gets further leverage from the fact that the quality in the human parts of the production machinery cannot be readily standardized. As a result the dietitians in the production jobs constantly complained about "personnel." The complaints ranged from a general, moralistic criticism about the general type of person who worked in the kitchen to more specific complaints explaining how this or that worker didn't do the job as laid down in the work-lists, the standardized recipes, or the pre-planned menus.

The first sort of criticism, the general moralistic complaint, leaves little doubt as to where the dietitians place their workers on the social scale. For example:

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are fed and kept warm. The construction industry of course, while seasonal, offers better payment. Data along these lines is contained in various studies and field-notes in the possession of the Research Division, Canadian Citizenship Branch(Ottawa), where the writer is at present employed. Other information pertaining to the special functions of the Greek restaurant industry in absorbing Greek and Macedonian immigrants is also in the hands of the Canadian Citizenship Branch. See particularly, Kay LaFlamme & Mildred Schwartz, "Red Cross Study of 'Iron Curtain' Greek Children", or Asen Balikci, "Remarques sur la structure du groupe ethnique bulgare et madeconien de Toronto."

> The workers there were a lower type.
> Of course their wages were low....
> Staff turn-over was a big problem.

or

> ....and you have people who just can't
> seem to think. Just can't seem to
> understand. Of course it's different
> at university where you meet people
> who are able to understand....

and again alluding to the educational criteria of social differentiation:

> I came across someone once in North
> Van who didn't even read or write.
> I had to sign her in and sign out
> for her at night.

The otherwise "good", "obedient" immigrant workers do not escape invidious classifications of this kind.

> Your staff consists of all types....
> people who don't even speak English.

It might be added that in the course of the field-work for this essay and for a previous study of kitchen social organization[45] dietitians pointed out that their personnel problems were added to by the fact that the kind of worker attracted or channelled by agencies to food production included alcoholics, narcotics users, and not a few rehabilitation cases from jails,

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45 "The Sociology of a Camp Dining Hall", Term essay for Sociology 410, University of British Columbia, Spring, 1955.

penitentiaries and mental institutions. It is then suggested that the moralistic criticisms of her staff indicate that the dietitian sees clearly the facts of social class which supplement the differentiation of herself from her subordinates.

But this is a two-way process. The workers for their part have a role to play in maintaining the gap between themselves and their lady manager. They are quite aware, of course, that she has been to university and holds her superior status partly because of that. She is the one with the ultimate power. She nominally controls the facilities and resources of the kitchen (although a selected study of kitchen social organization is likely to turn up an interesting unofficial power structure too); she has the power to hire and fire. The staff, therefore, pay deference to her in her superior role. The dietitian might be twenty-two, only a day past graduation, but every member of the staff, man and woman, aged sixteen to sixty-five will call her "Miss Purves" or "Mrs. Diller", and she will call them "John" or "Helen", or "Rose", or "Harold".

A function of the fact that the dietitian is the marginal outsider or stranger in the eyes of her workers

is the pattern wherein the kitchen workers, particularly the women, make use of her as a counsellor. This seems to be particularly prevalent in the kitchen setting. Even the youngest girls among the respondents mentioned it. In a tone of amazement one twenty-four year old assistant production dietitian reported:

> It would really surprise you what some of these people will tell you. The most <u>personal</u> things!....And women old enough to be my mother!

The older dietitians seemed more used to this, like this blase senior supervisor in her forties.

> You usually hear about them (personal problems)...I mean you aren't smart if you don't....It's boring but you have to listen to them....

Or, this supervisor of a university dining hall, who openly expected to be confided in.

> ...Most of them will tell you what's bothering them sooner or later... of course there are some who think they are smart and won't!

Most of the dietitians rationalized their role as counsellors along the following lines:

> It's no trouble to listen to their problems. It helps to adjust them to others on the staff. If you can get to the bottom of the problem you can often help.

The dietitian, then, further maintains her marginality and apartness from her staff by making herself accessible as a counsellor. This she sees as having the manifest function of contributing to the efficient operation of the system of cookery for which she has responsibility. In addition this seems to give her an opportunity to satisfy what David Riesman[46] has suggested is a "...growing desire to be serviceable to others..." something associated with the esteem in which professional roles appear to be held to-day. The taking on of the counsellor's role, of course, has the latent structural function of forcing the dietitian to stand even further back from the workers as a group, even while apparently moving closer to the individuals who have given her their trust. Thus the pressure to become the object of confidences reinforces the marginality of the position, and the isolation of the person of the dietitian.

For their part, the fact that kitchen workers of all ages seek to discuss their personal problems with dietitians further demonstrates how the workers recognise the apartness of the dietitians. It would be interesting to know what sort of image of the dietitian would move women old enough to be the mothers to confide in women

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46 Riesman, David, "New Standards for Old: From Conspicuous Consumption to Conspicuous Production", Individualism Reconsidered, Glencoe, Free Press, 1954, p.223.

young enough to be the daughters. The hypothesis here is that the workers are responding in part to what they believe is the superior wisdom that goes with a higher educational level and higher class standing, as well as to the fact that members of the middle-class are strangers and 'outside'.

It will be recalled, however, that not all workers take their troubles to the dietitian ("...some, who think they are smart, etc....") and that most of those who do are women. This might be explained by the additional hypothesis that those workers who in effect prefer to play down the status difference between the dietitian and themselves, that is, those who subscribe to sentiments of equality, would not want to establish a dependency relationship with the dietitian by making her their mother-confessor. With men the case would seem to be even more clear-cut. The male workers would be faced from the beginning with what Everett Hughes calls a status-dilemma.[47] Being males they find themselves in a mixed system of matriarchy and bureaucracy, where authority is wielded by a woman and often a woman younger than themselves. It is suggested then that the men might find it more difficult to relinquish

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47 "Dilemmas and Contradictions of Status", American Journal of Sociology, vol.50, (March 1945), pp. 353-359.

their institutionalized superiority of sex, even though they might feel a need for an outside ear, if not a sympathetic one. What sorts of conflicts such a situation engenders in men, particularly, perhaps, in men who go from the work-place to their homes, wives and daughters, promises yet another interesting line of research.

Another indication of the barrier that marks off and establishes the marginality of the dietetic role is to be found in the marriage patterns of dietitians. While the evidence to be offered here is anecdotal rather than statistical it is suggested that the point to be made is established by the description of a deviant case.[48]

First: it will be remembered that the interview group included five married women, all of whom had husbands from the same general middle-class status level as themselves. None of them was married to male kitchen-workers.

Second: all of the respondents were asked a general question about the kind of men that dietitians usually marry. Most described men with middle-class occupational standing, and while one reported an acquaintance from a small town who had married a "childhood sweetheart" with a blue-collar job (auto-mechanic),

48 For a discussion of deviant case analysis in statistical studies see Patricia L. Kendall, and Katherine M. Wolf, "The Two Purposes of Deviant Case Analysis,"eds. Paul F. Lazarsfeld and Morris Rosenberg, The Language of Social Research, Glencoe,Free Press,1955, pp.167-170.

none reported that she knew of a dietitian who had married one of her staff members.

Third: several informants outside of the formal interviews reported on the marriage patterns of a group of dietitians who had worked for the food services of a university over a period of several years. During that time out of a dozen or more women, about half had married and all but two of those had left their jobs. Those who married, all married men with the expected middle-class level jobs: i.e., chemist, forestry-engineer, dentist, etc. Three had married men who formerly worked for them in their kitchens, but these men were students at the university at the time working part-time to supplement their educational budgets. The deviant case, or rather the two deviant cases, revolved about the person of one head cook who was described as "strikingly handsome", with a wife and several children, and a background in the Air Force. For the first case involving the handsome head cook the essay must depend largely on hearsay.

For the second, more actual facts were forced into the open.

The first case involved a reported liaison between the cook and the dietitian in charge of the particular establishment where they both worked. Rumour and gossip

over this alleged incident appeared to be given credence when the dietitian suddenly resigned and moved to another part of Canada, where she subsequently married and left dietetics.

The next year, according to informants, with a new dietitian and the same head cook, there seemed little cause for rumour or gossip to develop. The year passed apparently without incident and the first evidence of untoward behaviour between the new dietitian and her head cook came when neither returned from their vacations as expected, and the head cook's wife complained to the Chief Dietitian that she had been deserted. Upon this the Chief Dietitian was reported to have wryly commented:

> Well, that goes to show that you shouldn't let everyone take their holidays at the same time.

In this case, according to my informants, the dietitian was never heard of or from again by any of her sister dietitians.

The anecdote here, then is offered as evidence of the fact that when dietitians and kitchen workers bridge the social gap between their roles, such a union takes place in a setting of deviance from various institu-

tional norms. While it is true that the dietitians here and the head cook found themselves in conflict with norms supporting marital status, it is also true that they had first to discount the institutionalized authority patterns of the work-place by which they were beset every working day, before breaking into the fabric of the kinship structure. It is suggested that the breaking of the "incest-taboo" here implicit in occupational authority supported by social class differences,[49] is a substantial hurdle, which once passed over gives the partners-in-crime solidarity to help each other over other barriers.

The utility of the anecdotal evidence used here has been to show that deviations from norms basic to dietetic and other systems of authority have far-reaching consequences. The cases referred to suggest that the gap between the dietitian and her male kitchen workers is such, that known attempts to bridge it have resulted in situations where the dietitians have felt compelled to retire from the scene of the incident, and even from the occupational group itself. If there is validity in the interpretation then, this would further establish the dietitian's marginality in the setting of food prepara-

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49 Cf. Marion J. Levy, "Some Questions about Parsons' Treatment of the Incest Problem," British Journal of Sociology, vol. 6,(1955) esp. pp. 284-285, for suggestions as to the use of the concept of incest to cover a range of tabooed sexual relationships.

tion, and her isolation as a leader from her followers as a group.

The preceding data has been offered to establish that the dietitian who works as the head of a food-producing machine,i.e., a kitchen preparing food for people on a mass production scale, is segregated and marginal to the machinery which she sets up and keeps going, and even to the human elements of that machinery. The marginality of the good production dietitian, then, is different from that of the therapeutic dietitian and the research dietitian. It is the marginality of the manager and the leader. The essay will now turn to the case of the dietitian working as a home economist to show how she, like the research dietitian, experiences the unique marginality of the expert.

2. <u>The Marginality of the Pioneer</u>.

Some reference has been made to the fact that dietitians who move into the commercial sectors of the frugality culture are invaders or pioneers. The marginality of the dietitian invading the commercial restaurant field, with its established institutionalized roles held by non-university trained managers, stewards, and chefs, perhaps needs no discussion. The marginality of

the dietitian who sets up and operates commercial test-kitchens for advertising companies or food manufacturers is another thing. Here she is really breaking new ground, by establishing forms of organization and services which were not there before. This sort of work is commonly done by the dietitian who finds work as a Home Economist, as described in the chapter outling the configuration of tasks in the frugality culture.

The three general tasks assigned to the dietitians in this type of commercial work are: developing new food products for the employer, experimenting and discovering new ways to use employers' present food products, and working out ways to more effectively promote employers' current products. In the first two of these situations the dietitians work and find themselves in a position similar to other kinds of research directors in organized industry. Formal research is frequently a comparatively new thing in established industrial organizations, and its personnel must often stand at the margin for a comparatively long time, until the last of the representatives of the old order die off, retire, or are won over. In the case of the dietitians who work in advertising agencies, the situation is similar. Womens' Services Bureaus are comparatively

new things to the advertising agencies which have already been established long enough to develop their own traditional ways of trying to cope with the problems for which new experts claim to have specific technical expertise. The case to be cited here involves the third kind of test-kitchen service, the kind that the advertising agencies have begun to take on. The examples given refer to concrete instances in Toronto, and the source is an advertising trade journal.[50]

According to this source the test-kitchen is meant to be another "agency service" for the food-manufacturing client. The main purpose of these kitchens is not to develop new products for the client but rather to develop new ways of putting over the client's existing products. Here is how the writer of the article in the trade journal describes a visit to a number of agency test-kitchens.

> Touring the four Toronto bureaus (of womens' services) I butted into discussions on the problems of parsley that photographs black, and custard that photographs white. I ate grass-green cakes and shocking-pink cookies ---they look so well in black and white photographs!

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50 Alison Hunt, "What Cooks in Ad Agency Kitchens", Marketing, January 24,1958, pp. 18-19.

> ...I found out how to shine apples with furniture polish and where to buy holly in June.[51]

And as for the relationships between dietitians running ad agency test-kitchens and those in food manufacturers' test-kitchens:

> One thing...all the...home economy department directors stress is that they do not substitute for a client's own home economy bureau.

Rather, the relationship is non-competitive and complementary:

> The Home Economist for a cake flour company may develop a pretty cake recipe that makes a wonderful-looking cake. But the agency Home Economist knows that this exciting cake will look garish in roto-colour. So she has to suggest ideas for an alternative.

Again, the evidence of the marginality of the dietitians position here comes in the complaints about the hardships involved in pioneering -- that is, in establishing a new idea in a context where the other

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51 The role of cosmetician to uneaten foods is not played only in test-kitchens sponsored by private industry. The writer has watched test-kitchen dietitians, employed by the Department of Fisheries at Ottawa, apply coloured oils and waxes to carefully prepared displays of cooked fish, in order to preserve its appearance while under the photographer's lights. This was in connection with the department's campaign to get more Canadians to eat more fish.

participants might be inclined to feel that they got along very well the old way. Quoting again from the article in the trade journal, here is evidence of the resistance to the new specialists and their new idea:

> A few agency men still think of home economy bureau staff as females fiddling about with souffles and appear surprised to find the director of womens' services minus an apron.

However, even when just " a few agency men" refuse to take the test-kitchen dietitians seriously the troubles are not over.

> You have to fight for your kitchen! Lock the door. Keep out office staff who want to make tea and the president who wants lunch prepared for the board..

And sometimes where the "native" culture is too strong for the pioneers:

> ....And, regrettably, there are other agencies where a kitchen was built and equipped only to degenerate into a bar....

The home economists or test-kitchen dietitians, then, have their own peculiar marginal status where they work, their own feelings of non-acceptance, lack of understanding, recognition and the like. It seems that any one of the dietitians, in any of her institutional

settings - research, therapeutic, production, commercial food service, test-kitchen work and so on- finds it part of her role to stand back, stand apart, or stand alone from other roles involved in the work. One dietitian described the general position of dietitians of the hospital in these words, and reflection suggests that the comment could be stretched to describe dietetic roles in many other working contexts:

> You're sort of a filler....You spread yourself over all the cracks...

This outsideness or apartness of the dietetic roles was summarized in another way and compared to those of other "newer" professions by Everett Hughes in a letter to the writer.

According to Dr. Hughes[52] the dietitians are like many of the other "newer professions" in that they are caught "between a practical world" of cooks, administrators, and school officials who don't always recognise the uniqueness of the dietitian's specialty, and a "scientific world" of chemists, physiologists

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52 Everett C. Hughes, Letter to the writer, 12 June,1956.

and others, who regard the dietitian as of a "distinctly lower order."

But the lot of dietetics is not all of a negative order. It shall presently be demonstrated that marginality of the dietitian in her working role has positive functions for the unity of dietetics as an occupational group.

Chapter Eight

REWARD AND DEPRIVATION.

> Two-thirds of the human family are laborers, either of brain or muscles. One-half of the whole is woman, and the question presents itself, what is the per cent of women as laborers, and as wage-earners, and what is the accredited value of that labor?
>
> Minnie Phelps *

1. The Structure of Rewards and Deprivations.

(a) Monetary Rewards and Deprivations.

After considering the nature of the institutional contexts which support dietetics, it might be worthwhile to examine the structure of personal rewards and deprivations which are more or less officially recognized as affecting all role-incumbents at the motivational level. The analysis is most readily begun by an account of the monetary rewards allocated to dietetic jobs in the differing institutional contexts.

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* "Women as Wage Earners", Woman, p.51

According to a mailed questionnaire[53] survey done in 1956 for the Canadian Dietetic Association by Research Associates of Toronto, dietitians in Canada generally were being rewarded and deprived financially in the following manner:

> ...less than 5% earn less than $2,500; 45% are between $2,500 and $3,500; 31% from $3,500 to $4,500; nearly 20% over $4,500.

Relative reward and deprivation might be judged here by comparing these salaries with the average annual salaries of women in different broad types of occupations in the country in October 1954. It might be worthwhile to keep in mind that the figures from the Dominion Bureau of Statistics[54] should probably be scaled up somewhat because of the eighteen months that

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53 This was a rather remarkable mailed questionnaire in that 699 of 834 forms were returned in a usable condition. The distribution between institutions was as follows: 5% from hospital dietitians, 15% from commercial dietitians in private business, 13% from government dietitians, 13% from women in universities and schools, 2% from social service dietitians, and 1% miscellaneous. It is suggested by the writer that if there is any overloading in the sample it is slightly in favour of the non-hospital dietitians.

54 Canada, Dominion Bureau of Statistics, "Average hours and earnings of male and female wage earners for the last week of October 1954," Canada Year Book, 1956, pp. 747-748.

elapsed between the DBS survey and the dietitians' survey, a period marked by a notable expansion in the Canadian economy and an accompanying rise in wage levels. Whatever the necessary adjustments, it might be noted that female salaried employees and female office workers, probably the two most comparable groups, were earning an average annual salary of less than $2,400. The dietitians' survey, of course, shows fewer than five per cent of the women at this level. Unfortunately, there is no breakdown from D.B.S. on average earnings of college-educated women, a category with whom more meaningful comparisons might be made.

The above was, of course, the overall picture for those who replied. The survey went on to refine the analysis:

> "The salary picture of course varies radically by every angle...Type of employer, region, city-size, responsibility and experience."

Most germane to our picture here is what the report says about the distribution of the high and the low salaries among dietitians employed in differing institutional settings. First, the lowest salary ranges -

under $3,000 - account for (in the words of the report);

> ...27% in hospitals, but less than 12% in private business, 9% in government, 14% in universities and schools...

and correspondingly, the highest salaries - those $4,500 and over - account for less than 7% of the hospital jobs, 38% of the jobs in private business, 21% of the government jobs, and 45% of the jobs for dietitians in universities and schools.

It would appear then, that as far as higher salaries are a lure, the jobs outside the hospital setting would be the ones to attract the interest of new recruits even if competition for such jobs left most of them in hospital posts. But let us go further into this matter.

(b) Other Built-in Rewards and Deprivations.

We turn now to another kind of reward-structure, i.e., the structure of rewards and pains appreciated by the individual dietitians in a more subjective way. Here we find a number of interesting things. For example, when the dietitians in the interview-sample were asked to talk about the attractive features of their work, their replies, as might be expected, broke down into groups according to the kinds of work they were doing.

Dietitians whose work placed them in the emergency culture, that is those who worked on the wards of hospitals, in the out-patient clinic, or in the Public Health Office stressed the fact that they were "meeting people", working alongside co-workers whom they respected, and learning new things.

> I'm meeting people all the time, and everyone is different. And you're always uncovering something new and interesting.....
>
> and I liked patient contact..... going and visiting patients that are on these diets, because you learn an awful lot from going to see them...I think it's the most interesting part of dietetics.....
>
> ...I guess it's the patients, and seeing that you're doing something for them, and coming into contact with the doctors, with the medical team....

and this particular dietitian went on to add:

> ...The whole hospital atmosphere I like. And I thought, when I was in school, I always thought of being a nurse. I guess this is as close as I could get to being a nurse....

Down in the Main Kitchen, the rewards were more in keeping with the work done there.

> What do I like about my work? Oh... I like the people...I mean I like the cooks, they're very easy to get along with....Oh, I like ordering, and I like the place I work in...I like the office -- we have a nice office now -- and I like the kitchen.....

> There's quite a bit of satisfaction in the job, although you don't necessarily always satisfy everybody. There's quite a bit of satisfaction about ordering the food and seeing it properly prepared and properly served.....I mean it's quite interesting to see a side of beef come in and see that it's properly cut up.....

This girl introduced a comparison from outside dietetics:

> ...You can see what you're doing; it's not like sitting typing out something all day. I'm not saying that we always do good but we do manage to do something for somebody. It gives you a feeling of accomplishment.

Deeper into the frugality culture the rewards were of a more administrative nature and reflected the orientation towards frugality goals. Here are quotations from replies by a number of commercial dietitians:

> Well, I like the part about being your own boss.....

It will be recalled that residence and commercial restaurant dietitians work as relatively independent

managers, where they are responsible for food production and service, more often than as specialists in a bureaucratically organized dietary department where they concentrate on one aspect of the food service. To continue with the same respondent:

> ...I like the accounting side
> of it. All the angles you have
> to go through to show a profit.
> You know! Using your left-overs;
> cutting down on your staff;
> cutting waste; seeing the whole
> picture as it were....

Another, seizing more firmly on the executive component of food production administration:

> I like to see a banquet go over.
> I like to see the food going out
> ... all in military precision
> if you like to call it that...
> and see it going out looking
> good, and I like to see ah....
> well it looks so nice.....

Back to the first commercial respondent now for the more creative side of the picture, together with the rewards that come with the appreciation of the consumers:

> I like trying out new foods, I
> like to see the looks on people's
> faces if they really like something;
> if something appeals to them.
> Like they remark that "the salad is
> very colourful." I think maybe that's
> made their day a little better.

And from the second commercial dietitian, remarks on the pleasures involved in making arrangements for special dinners and parties.

> I like to work with the students. The students that is who have to arrange their parties and things like that. They oftentimes don't know too much about it and it's nice to help them and tell them. And it's often nice to have a party go over successfully and have someone tell you so.

The set of subjective deprivations of dietitians is also patterned according to the type of activity in which individuals find themselves. For example, the dietitians on the wards in the hospitals complained first about some of the consequences of the routinization of personal crises.

> ...often the job can be depressing. I mean there are some days when nothing bright seems to happen. I mean your patient died, or is unhappy, and the nurses are complaining.... I know somedays I feel so low I'd like to jump out a window...

Or, the failure of the significant others to appreciate the unique contribution made by the dietitians:

> ...everybody's an expert on food. That's the whole thing! If they don't know anything about anything in a hospital, everyone knows all about food!

Or, just the routine:

> ...Well, I think the humdrum -- the humdrum of writing diets gets you down once in a while.... I think that routines like that, ordering, writing diets, visiting patients - the same patients - all the time gets a bit wearing at times.

or the lack of opportunity to hear their food praised:[55]

> ...Sometimes you just long for someone to say "Oh! the baked potatoes were done nicely today!" but no! all they'll say is "They were hard again!" and never mention when they're good. Mind you, you appreciate the complaints -- then you can do something about them -- but it certainly is nice to get a compliment once in a while!

It is the therapeutic dietitians working on the wards who are responsible for the food service to patients, and who absorb most of the complaints about the food, whether these come directly from the patients or are relayed through the nurses or student nurses. Production dietitians in the main kitchen report other kinds of deprivations. The personal strains here, of course,

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55 It is a hospital dietitian's maxim, by the way, that says that when people are sick the first thing they complain about is the food.

would not be solely the heritage of the food production dietitian in the hospital, but appear to follow from the kinds of work that food production entails anywhere in the frugality culture. First, the less pleasant by-products of attempts to perfect and keep running a "machine" for producing food. The first respondent found she was annoyed by flaws in the technical perfection of the machine.

> Well there's one thing I don't like. I've worked in three different hospital kitchens and each one of them has a different set of food tables. They're not out-of-date or anything, but they're inconsistent.

The second production dietitian presented the negative argument to the girls who listed "working with people" as one of the pleasant things about their work.

> ..And I don't like straightening out staff problems, and I don't like fighting with them; arguing with them when something has to be done. And I don't like the -----Womens' Club (regular catering customers). They're a bunch of terrible, terrible women.

A third, who worked in a university residence dining hall went further in spelling out some of the difficulties in dealing with staff.

> ...we don't have any qualified supervisors on the job. Say like the engineers; they have foremen out on the job....in an awful lot of the cases the engineer doesn't have to go near the workers.....

This dietitian went on to explain that often supervisors were appointed but that they fell short of the mark.

> ...these people don't have the qualities that are necessary for a supervisory position. And they're often not very good at all--- You have to worry about every little thing right down to the last detail.

Finally, perhaps this production dietitian was echoing the words of many who are responsible for the maintenance of production machinery. The words in this case reflect more the strains of soul-searching than of technical problems involving the machine.

> Sometimes I wonder when I come home at the end of a week: "Well what did I do?" But when you think back on it you can remember that I solved this problem and talked to that person, and I laid the ground-work for that. It doesn't stand out in your mind when it's done, but it takes up all your time.....

Commercial dietetics, with its somewhat differently structured situations involves differing rewards and deprivations to the individuals concerned. It was mentioned earlier that commercial dietitians were often called upon to move into new fields: to pioneer where dietitians, and women, had never been in control. The hardships of carving out new areas for dietetics is not necessarily a thing that is embraced without qualms by all commercial dietitians. This girl was asked what advice she would give to girls starting out in commercial dietetics.

> Well, I'd avoid getting into places that had never had a dietitian or were run by a business layman who might give you a bad time particularly when you haven't got all the answers at your finger-tips.....

Where the dietitian has managed to gain a foot-hold in the commercial world, the problems of maintaining boundaries sometimes produces strains. For example: what to do with the holders of higher offices in the organization who take a personal interest in the food, and forget institutionalized limitations on their authority.

> They (superiors) often have their own ideas about food - the foods they like and think are good. If they don't like them sometimes they don't think they should be served. They don't have too many sound ideas.....

While dietitians in the emergency culture and the various compartments of the frugality culture seemed equally ready to find things pleasant and unpleasant in response to the questions on the interviewer's schedule, the pleasures and pains of the two polar cases -- the hospital ward dietitian and the commercial dietitian -- do establish a number of things.

First, the pleasures of the therapeutic dietitian were of a distinctly medical kind. The girls said they were pleased by contact with people, sick and well, professional and lay. They also liked their jobs because they were "learning", and learning was a thing that to them seemed to be worthwhile in itself, an orientation certainly not out of place in what is basically an experimental context, that of medical science.

However, the pleasures involved in hospital ward dietetics were of a more controlled nature -- appropriate to the "controlled" ethic of science perhaps.

None of the hospital girls reported her pleasure with the abandon of the commercial miss whose words failed her as she described the food going out "...all in military precision", or the other who talked so unreservedly about "all the angles you have to go through to show a profit!"

Likewise the deprivations were appropriate to the task. The hospital ward girls reported the depressing aspects of their proximity to suffering and death. They also complained of the boredom involved in working as a functionary - as part of a machine, differing from the production dietitians who were bored sometimes running their machines. Further, the ward dietitians bitterly reported the hurt they felt when they were criticized for the food they had to serve but had no part in preparing, because it all came from a centralized kitchen.

Production dietitians - that is, dietitians who work in mass food production kitchens -- either in the hospitals or anywhere mass produced food is needed -- complained about deficiences in their production systems - particularly those involving the negative side of "dealing with people", both staff and customers.

Finally the commercial dietitians reported on the strains involved in maintaining their avant garde

status in the field of commercial food production. Laymen in superior administrative positions perhaps unknowingly infringe upon their area of specific competence by suggesting items for incorporation into the planned menus; and other outsiders - apparently male -- are perhaps inclined to challenge the right of university-trained women to claim food production as exclusively their area of specialization.

Chapter Nine

GROUP IDENTITY: THE PROBLEM OF IDEOLOGY.

> Members of the Canadian Dietetic Profession, arm-in-arm with medical authorities....must carry the banner of Good Nutrition and Good Health to a multitude of people in a multitude of ways every day.....
>
> Your Stake in Public Relations*

1. The Ideology of Dietetics.

(a) The Function of an Occupational Ideology.

The assumption is made that any occupational group which is to maintain cohesion and organization requires an ideology. An ideology, if satisfactory from the point of view of the group, exists to legitimize what the group has done, and to justify the future course as well. Such legitimizations and justifications, which have stabilizing functions for the group, are often attempts to describe the purpose of the occupation in

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* Handbook on public relations techniques published in aid of campaign by the Canadian Dietetic Association to gain "full professional status", Toronto, 1954, p.8.

the broadest social sense, and such description is intended to satisfy questions on this score raised by group members, members of association groups, or by the general public.

Ideologies are often formulated in occupations -- particularly new occupations -- by the formal association. The unifying and stabilizing functions of such a group rationale are clearly seen by those most active in the organizing of the formal occupational association, and much time and thought is given to selecting the appropriate set of symbols to be used in setting up moral terms of reference of this nature.

(b) The Ideology of the Dietitians.

A typical technique for asserting the group's implications for that which lies outside is to portray the group as steadily working towards a widely accepted goal. The Canadian Dietetic Association has attempted to formulate an ideology of this type.

It will be recalled that the dietitians find themselves both the inheritors of a double moral legacy and the incumbents of roles in one of two moral systems; the emergency and the frugality cultures. The primary

goal of the emergency culture is, of course, the preservation of human life. The orientation of the frugality culture would appear to be the maximization of efficiency in production and ultimately, perhaps with the help of the "invisible hand" of traditional economic theory, the betterment of social living.

The humanitarian goal of the emergency culture appears to be the one which is held up by the dietitians as their major claim to moral worth. This is evident, as we shall see, in some of the official attempts which organized dietetics have made to project their group rationale as well as in unofficial invidious comparisons made by dietitians among themselves.

In order to share in the preserving and prolonging of life with the doctors and the nurses, the dietitians have had to go about it in their own way. Like other occupational groups associated with and to some extent growing out of scientific medicine, they have had to carve out their own particular part of the field, being careful to keep out of the way of the doctors.

In the case of the dietitians the area held is: the provision of nutrition for "good" or "improved" health,

as far as that may be accomplished by means of oral feeding. In the medical situation this puts the members of this group into roles of technical specialists ancillary to doctors. Here they find themselves in a category with pharmacists, X-ray, and various other medical technicians.

It has been shown that not all dietitians choose service as technical hand maidens to doctors on the wards of hospitals. Like pharmacists, another occupation which in some respects is subservient to doctors in the medical context, dietetics attempts to bridge the gap between the medical and non-medical (in this case the business or commercial) worlds. It follows from this that the norms or the moral terms of reference which serve to specify the "how" and the "where" of practise, must differ significantly from those of the doctor and the nurse, two occupations with which the dietitians appear to align, if not identify in some cases.

For an actual definition covering the work norms or ideology of the dietitians we go to the Canadian Dietetic Association, which has made conscious attempts to bridge the gaps or barriers between its members in their many fields. The C.D.A. first attempted to pull

the group together in an ideological sense in 1954 by sponsoring a "Job Evaluation Survey."[56] A major purpose of this, apparently, was to sort out and classify the jobs in which qualified dietitians in Canada were working. A second basic purpose was to find out what sort of elements were common to all their work. The conclusion reached by the survey-taker was that the task and social purpose common to dietitians everywhere, whether they worked in medical or non-medical settings was:

> ...the dissemination of good nutrition, whether by means of theoretical principles or applied practice....

According to this official statement of ideology then, the goal of all dietitians in all their jobs is "...the dissemination of <u>good</u> nutrition". Good nutrition, of course, has an important role in the maintenance of human life; it may be instrumental in the treatment of people already sick, and it is often seen as useful in the prevention of illness. Whatever its immediate role, good nutrition is a fairly specific thing when judged according to the criteria of

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56 Canadian Dietetic Association, <u>Report on Job Evaluation Survey on Dietitians in Canada - 1954</u>, Toronto, 1954.

nutritional science. However, the means cited in the ideology, that is, "...the dissemination...whether by means of theoretical principles or applied practice..." is a non-specific imperative, and this relative broadness or vagueness of the dietetic ideology is clearly seen when we compare it with the moral commitments of nursing and medical practice.

While both the nurse and the doctor are committed during their socialization and by their oaths of initiation to the broad medical value concerning the maintenance of life, the manner of the practical application, or the definitions of the "how" and the "where" are significantly different in quality from that given the dietitians. The nurse and the medical doctor are quite specifically directed in their training and initiation towards achieving the major medical goal through ministering to the sick, and (with certain reservations) by alleviating pain. While it is true that preventive medicine is given some attention, it is submitted that this tends to be attention of a nominal sort. Most resources are channeled into the arts of treatment. This, of course, considerably narrows the sphere of activity for the nurse and doctor, and ascribes to them roles of mercy in what are for most

people emergency or crisis periods of life; when they as individuals are sick and become patients.

The dietitians, in the other hand, are not so limited to a specific area of practice. The "dissemination of good nutrition", whether it be by "theoretical principles" or whether it involves the practical techniques of food preparation and service, does not necessarily restrict the women in this occupation to the medical context and the treatment of the sick. Rather, the moral terms of reference of the dietitians permit and sanction their operation in both the realms of sickness or emergency, and in the area of what is commonly defined as the normal or the routine areas of people's lives. This is why it is said that the ideology of dietetics includes a vague definition of the ways or means for implementing the goal. Suggested reasons for such a loose definition of means follow in the next section.

There are some similarities, and some very significant differences between the case of the dietitians and that of the pharmacists when it comes to meeting the medical-commercial or professional-business dilemma. Each resolves the problem in differing ways and with different consequences. A more extended discussion of this will

come later. Meanwhile, let us consider some of the manifest and latent function of the dietetic ideology.

2. Some Functions of a Dietetic Ideology.

(a) The Moral Locus.

Dietetics is an occupational group which seeks to unite members who are incumbents of roles scattered by both a division of labour and a dispersal of outposts. This very division of tasks within one institutional setting and dispersal of others through various settings can perhaps be seen as a kind of social structure which would make necessary a somewhat loosely defined ideology in terms of means to the common end. It is submitted that a more restricting moral definition of the ways through which the goal of the occupation could be achieved might leave more of the tasks and roles in the wilderness of "deviance" than are definitely already there. This follows from the contention that the separation and segregation of roles within the group which is sanctioned by, and which perhaps follows from the ideology is not accompanied by a random distribution of equal "moral worth", in spite of the official assumption of organized dietetics.[57]

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57 For example, these words from a pamphlet designed to instruct dietitians in public relations techniques:
..Members of Canada's Dietetic Profession

Rather, the unofficial allocation of dietetic morality appears to involve first, the definition of it as being of one kind rather than another, and second, the asymetrical patterning of its distribution around a single moral locus.

The moral center of dietetics, which includes medical or quasi-medical values, emerges from the nature of dietetics and its traditional medical orientation, supported by continuing medical association. Such a patterning of values and structure about a normative center is to be demonstrated here with four kinds of evidence.

The evidence becomes apparent through

(1) Exploration of some of the social implications of health, sickness, and the role of the nutrition specialist or dietitian as an agent of healing.

(2) Examination of the historical tradition of dietetics.

(3) Examination of the job structure of dietetics and the socialization pattern.

(4) Examination of the various public images which organized dietetics will upon occasion project.

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arm-in-arm with medical authorities....must carry the banner of Good Nutrition and Good Health to a multitude of people in a multitude of ways every day...Canadian Dietetic Association, Your Stake in Public Relations, Toronto, 1954

First, a consideration of some of the social implications of the dietetic ideology takes us into the emergency culture and the hospital. The good nutrition ethos of the ideology, of course, is grounded on the medical ethic of maintaining human life. Good nutrition is desirable in this context because it assists in achieving such a goal. Some of the clearest demonstrations of attempts to maintain human life (where better or improved or stable nutrition is a determining factor) exist in those institutions specializing in the maintenance of lives which have been threatened by illness.

At the structural level, then, the roles which would be most vitally involved in these apparent and dramatic demonstrations of the part played by dietetics in maintaining life, would be the dietetic roles in the hospital. A study of the tasks assigned dietitians in the emergency culture of the hospital has shown the therapeutic dietitian, the research dietitian, and the out-patient dietitian -- the roles in contact with the sick-role -- as those with the most direct responsibility for patients and their health. It is suggested then, that these are the key-roles in terms of the dietetic ideology; the roles which, in effect, are most deeply involved in the "sacred" context of dietetic morality.

A review of the history of dietetics with the view to locating a moral center is a relatively simple task. As has been noted before, dietetics appears to be the product of two social movements: Nutrition and Home Economics. Of the two, the movement which seems to have left the heaviest moral stamp upon the occupation is the first. Even the authors of the text-book in institutional or frugality dietetics cited earlier (a book referred to by more than one dietitian as the "bible" of food production) lend credence to this.[58] Nowhere in the book does one find the nineteenth century mistress of the household or housewife referred to as the ancestor of the kitchen dietitian. Rather:

> Dietitians as well as nurses should honour and revere Florence Nightingale as the pioneer in their profession. Through her efforts a diet kitchen was set up in 1955 to provide clean, nourishing food for the ill and wounded soldiers in Scutari.

The historical evidence also points to the hospital and to the emergency culture as the moral reference point of the dietitian and her work.

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58 West and Wood, Food Service in Institutions, pp. 16-17

Third: the job structure of dietetics would seem to predispose both dietitians and outsiders to consider the occupation as bound up in the overall purposes of hospitals. By far the greatest number of dietitians in Canada spend a year as dietetic interns in hospitals. In addition to this more than sixty per cent (about seventy per cent in the Vancouver area) continue to work in hospitals. While not all of these take the kinds of jobs which have been described as being emergency oriented key-roles, still it would seem that the sheer numbers of dietitians in hospitals could contribute to the stablization of the moral center of dietetics in the place where the disseminator of good nutrition finds herself integrated with the other medical roles in restoring or preserving the returning health of people under medical treatment.

Finally, there is evidence that under certain kinds of pressure organized dietetics, which usually maintains publicly that all dietitians are equally concerned with the dissemination of good nutrition, will put aside this line for another. The decision to abandon this stand seems to depend upon the public it wishes to reach. Generally, organized dietetics -- in

this case the national organization: the C.D.A. -- will officially allude to the role its various members play in words like the following:[59]

> ...while the preparation of a day's menu for a hospital or hotel may sometimes seem a mundane task, it is in reality playing its part in building a strong, well-nourished Canada. If a community or a unit or group within a community is to prosper, somehow the people of that community need to know more about nutrition and its application to good health.

On other occasions, however, organized dietetics has seen fit to stress the medical connection. For example, compare the public image implied by the phrasing of a bill submitted to the Quebec Legislature in 1956. The bill, a "Dietitians' Act" giving dietetics the power to regulate itself, and monopolize its function and name, is one which in effect brings legal professional status for the occupation, something the members have been seeking for several years. This is the image of dietitians that the Quebec Dietetic Association (provincial affiliate of the Canadian Dietetic Association) officially

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59 Canadian Dietetic Association Your Stake in Public Relations, Toronto, 1954, p.8.

put before the Quebec legislature.[60]

> Whereas the aims of the profession is service to the community at large whether the requirements be special diets as prescribed by a medical doctor in the treatment of the sick, or in the promotion of good nutrition for all. Whereas work of the dietitian is closely allied with the medical and the nursing professions in this aim; in the same way as for the medical practise the University degree requires additional practical experience to the scientific back-ground, in order to achieve professional skill, etc.

Clearly the connection with medicine is emphasized in this representation of the occupation of dietetics.

To summarize, it can be seen that the ideology of dietetics, while formulated in such a way as to allow its application to many kinds of dietetic jobs, has none the less been subject to re-definition at both the official and the unofficial levels. With the moral locus of the ideology established in the emergency culture where dietitians deal with the sick, the essay now turns to the latent structure of conforming and deviating roles set up by the asymetrical distribution

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60 "An Act Respecting the Quebec Dietetic Association", Bill No. 232 (private), Legislative Assembly of Quebec, Fourth Session, Twenty-Fourth Legislature, 4, Elizabeth II, 1955-1956. As passed by the Legislature Assembly, February 1, 1956.

of moral worth which is a function of the establishment of such a point of reference.

(b) The Latent Structure of Conformity and Deviance.

It follows from the allocation of the greatest moral worth to one part of the dietetic job structure, that others are deprived accordingly. If it is true that the three emergency culture roles are the ideological standard bearers, this leaves the remaining dietetic roles with something less than complete ideological purity.

It could be suggested that a graded continuum of conformity and relative deviance is to be found, with the conformity pole set in the emergency culture and the deviance pole in the farthest commercial reaches of the medical value-free frugality culture.[61] Such a continuum might be exemplified at the level of social structure by using Merton's typology of modes of individual adaption[62] to characterize the various dietetic roles. For example, one could take the therapeutic, the research and the out-patient dietitians

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61 Talcott Parson, The Social System, Glencoe, Free Press, 1952. See Chapters 7 and 8 particularly.

62 R.K.Merton "Social Structure and Anomie", Social Theory and Social Structure, Glencoe, Free Press, 1949, especially p.133.

as "conformity-roles" using institutionalized means to accepted emergency culture goals. The dietitians who specialize in administrative matters could be seen as "innovation-roles" using novel means to accepted ends. The kitchen dietitians, and perhaps the residence dietitians would be "ritualist-roles" using institutionalized means to ends which are sometimes lost sight of in the struggle to stay within the budget. The younger, marriage-oriented dietitians who stand to give it all up could be seen in the roles of "retreatists", while finally the commercial restaurant dietitians and the public relations dietitians who scorn the goals and alter the means by rejecting nutrition oriented dietetics and creating profit-making food services would be the "rebels". Such a framework is mooted for a more complete analysis of the latent structure of dietetics, which it is suggested might be discernible upon closer sociological scrutiny. The evidence to be presented at this point, however, will merely attempt to delineate the two extremes or polar cases that might imply such a hidden constellation of roles.

Initial evidence of differentiation within the occupational group along the medical-commercial axis

comes in the socialization sequence. It will be recalled from Chapter Two that as early as the time when the dietetic trainees graduated from their Home Economics schools they were given the option of choosing a medical as against a commercial interning. While it was stressed that many inconveniences might beset the girl who chose the commercial internship, nevertheless some did, and those that did found themselves differentiated from their sisters who went on to the hospitals. This permanent differentiation followed from at least two reasons:

(1) girls who take the commercial internship are formally disqualified from working in the emergency culture jobs in the hospital, because they are not usually trained in diet-therapy and other medical matters, and

(2) girls who take the commercial course are socialized to a completely commercial world. They have not been associated with doctors and nurses and the passive sick. Their work-place interaction has been with businessmen and other white-collar staff, and the objects of their services are non-captive, mobile customers.

Of course, differentiation along the medical-

commercial axis does not necessarily take place during the training phase of socialization. Most Canadian dietitians are graduates of hospitals. However, hospital-trained dietitians who move into commercial jobs are then categorized as "commercials". Here is how the dietitians express the difference.

> ...there are two different kinds of work, in dietetics; two fields. You call the dietitians who work in hospitals the "hospital dietitians", and the others: "commercial people".

The differentiation is a reciprocal matter on the part of both groups. From the hospital side of the dividing line, the hospital dietitian will sharply differentiate herself from the girl in the public relations type of home economist position. Here is how one therapeutic dietitian explained how it was that some qualified dietitians were willing to authorize commercially produced food products:

> Well, that's their job. They're really in <u>advertising</u>.....

And another who had been herself attracted to the other camp:

> Well, actually, I wanted to get out of dietetics and get into

> home economics or demonstrating. I thought that when I went into the dairy maybe I could work the lab-technician's job up into that.

For their part, the girls on the commercial side of the occupation sometimes seem to want to put distance between themselves and the hospital dietitians. This follows from the fact that the association with medicine and the hospital, with its emphasis on good health, is not always good business in food services outside the hospital in the routine world.

While many dietitians reported difficulty finding people who knew anything concrete about dietitians (See Appendix B, Question No.19), most of those that did found themselves association with diets and with hospitals.

> People always mention diets when I tell them that I'm a dietitian. They say "Oh, you must know all about reducing diets!"
>
> Sometimes they don't know, but those that do usually think of the hospital. Some of them will say "I was in a hospital once and the food was lousy!" Of course, you always run into smart alecks like that!

It seems reasonable to assume that this type of public image of a dietitian would not necessarily be the best

one to promote business for a commercial feeding establishment. This would follow from the fact that the commercial dietitian, in food service, is after all stressing her economic virtues and appeal to the senses. She emphasizes, in short, her ability to keep a customer happy before keeping him healthy.

It is not surprising then, in the light of this reciprocal differentiation of tasks, that the commercial people attempt to broaden the gap between themselves and the hospital dietitians. For example, here is the way it is done by a senior dietitian, who manages a large commercial food production and service operation with half a dozen commercial dietitians working under her. Her words are particularly noteworthy, perhaps, because she has in the past been a teacher in Canadian Home Economics schools; her remarks came in the course of explaining to the interviewer what she thought people should know about dietitians. (See Appendix B, Question No. 19A.)

> Well, I have a feeling that maybe the name should be changed somewhat to signify those that are working with diets and who are in the hospitals, and those who are in food production. I think those in food production shouldn't be called dietitians --they should be called food managers.

Appropriately enough, the six dietitians working under her, while all accredited members of the C.D.A., were referred to as "unit-managers" or more generally as "food-managers."

The disassociation from the "diet" or "sickness and health" component in dietetics also became evident among the commercial dietitians of lower rank. Some of them were less reticent about stating their views on this score.

> I never tell the customers I'm a dietitian. They expect you to try to tell them how to eat. I tell them I went to college and took Food Administration.

> .....The hospitals are full of dietitians who couldn't ever hold down a commercial job. Their work is all cut out for them. They get a diet order and then make up what they need from the diet manual.

> They never have to use their imagination...some of the food production girls in the main kitchen would do alright in business though.....

> Some customers are really prejudiced against a dietitian. They seem to remember how awful the food tasted when they were sick in hospital. It isn't really fair, but I keep quiet about the time I spent in the hospital.....

With a gap of this nature in the occupation, it is not surprising perhaps that in the "change of name" noted above and in the case to follow, we see evidence of social control set in motion by the moral locus of dietetics, working to draw the line where the non-conformity of the commercial people becomes deviance of an intolerable kind. Also apparent is the countering pressure of the differing morality of the market with its own definitions of conformity and deviance. This conflict at a more advanced stage, perhaps, is to be found in what happens to dietitians who take jobs in public relations and commercial test-kitchens.

Perhaps the use of the term "home economist"[63] rather than dietitian already needs no further explanation.

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63 There is a complication here in that the dietitians apparently invade the field of a sister occupation, that of Home Economists, who have their own occupational organization with professional aspirations and which sometimes works with the C.D.A. on matters of joint interest. The explanation is that all dietitians qualify for the C.H.E.A. because all have bachelor's degrees in home economics or its equivalent. Home Economists, on the other hand, do not qualify for the C.D.A. unless they have taken one year of practical interning.

The fact that a qualified dietitian usually takes on the title of home economist when she is in a commercial test-kitchen or public relations job would certainly be open to the interpretation that the role of dietitian in the commercial setting is a conflict situation with what could be intolerable strains for the position's incumbent. Thus the firms that require qualified dietitians for some of the latter's specialized knowledge and training, as well as for the symbolic legitimization of their goods and services, often specify in advertisements that they want qualified dietitians to take posts as home economists in their organizations. Furthermore, as it has been demonstrated, dietitians in public relations work do not work as dietitians but as something else again. To repeat:

> Well, actually, I wanted to get out of dietetics and get into home economics or demonstrating...

Again, it is suggested that this case of change of job-title might be seen as another example of social control at work where conflicting institutional requirements come together in roles played by individuals.

The final case sees things carried even farther, that is, the use of an established psuedonym by the

dietitian. This is where the dietitian literally steps into a role and acts a part as an actress on a stage. It is an instance where the dietitian, while limiting the possibility of losing face or professional prestige in the eyes of colleagues who might retain a strict interpretation of the occupation's medical moral commitment is in danger of losing her identity as a dietitian and, perhaps, as the person who has become a dietitian.

A number of large firms retaining dietitians in the role of home economists have come to appreciate the important trade-mark functions of this legitimizing symbol once it is set up and operating. The home economist of the firm is recognized as something that stabilizes the worth of the firm's goods and services in the eyes of the public. The important thing then becomes the retention of the name and personality of the established legitimizing, stabilizing, scientifically-trained food expert, if not the retention of the actual individual. The matter is further simplified by creating the symbol in the first place, and then recruiting and replacing at will the specialists who perform the rituals in the test-kitchen or in the public relations office, wherever and whenever they are needed.

Thus we find the creation of "Brenda York" in the meat packing industry with a number of qualified dietitians playing that role at various points throughout the country, and the meaningful name of "Bea Wright" answered to by anyone of several young ladies -- usually members of the C.D.A. -- when a customer telephones a well-known department store in Vancouver.

This then, is given as an extreme example of what can happen when the values of the emergency culture and the frugality culture conflict. In this case the victory would seem to be clearly that of the institution of "business". This is demonstrated in the fact that business has obtained precisely what it wants and needs, and no more, from the activity of dietetics. Qualified dietitians are enlisted like parts of the machine, and used only for what is wanted of their trained skills. In short, what seems to have happened to the dietitian here is what happens to the workers the production dietitian seeks to incorporate into the machinery of her food production system. Just as the cooks in the dietitians' kitchens in effect have their roles written for them in the pre-planned menus and the standardized recipes, the dietitian who works for the food company behind the mask of the copyrighted home economist

personality, finds her name, her title, and her part written for her, as well as her role written into the overall rationalization of the bureaucratically organized industry for which she works. At no stage here is she an independent specialist in the sense that the hospital, the residence, the public health dietitian or even the commercial food manager or restaurant dietitian is. She is a specialized part in somebody else's machine.

The analysis to this point has dealt with differentiation of hospital from commercial roles following from socialization, differences in means and ends as seen from the two poles of the emergency and the frugality cultures, and finally the differentiation imposed by an out-group, in this case the organization of a rationalized industrial bureaucracy. Now the essay reaches the point of examining evidence of strains engendered by the moral dichotomy within the formal organization of the occupational group of dietetics itself. The focus shifts at this point to examine the compromises which have been necessary in the Canadian Dietetic Association in order to incorporate the overtly commercial dietitians into the organization which otherwise is set up, in fact tailored, in a sense, to the requirements of a medically-oriented group of professional-

type workers.

It will be remembered that organized dietetics can call upon only slightly more than a thousand women in Canada to make up a professional organization. Graduate nurses, on the other hand, number about thirty-four thousand, and other profession-type groups are similarly if not equally large in comparison. One of the major problems of dietetics then is that its practitioners number so few. This is further complicated by the fact that what dietitians there are, while concentrated in urban areas, are none the less scattered across four thousand miles of territory in a way which can be described only as typically Canadian. All of this makes it very difficult to both finance and maintain communications to the extent necessary to keep an occupational organization, or in this case, a professional association alive. Problems of annual conventions, publication of a journal, financing of committee work, payment of full-time office staff, etc., become extremely difficult when there is only a few thousa nd dollars a year available from members' dues to finance such things on a national scale.[65]

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65 C.D.A., Annual Report, 1954-55, pp 17-19.

It follows that when from thirty to forty per cent of the dietitians work outside hospitals, in jobs at various stages of marginality from the "good health through nutrition" ethic, and correspondingly at various stages of absorption into the frugality-commercial ethos, then an occupational organization would seem to have to recognize officially the fact that they belonged within its terms of reference. This is already done, it has been noted, in the official interpretation of the ideology, at least in most cases. Things are taken a step further, however, by the inclusion of a special stricture in the occupation's professional code of ethics; a rule which would appear to apply only to the commercial people, and to the public-relations and test-kitchen dietitian type of role in particular.

The "Code of Ethics" was formally adopted in 1956 during the continuing campaign of the C.D.A. to raise the occupation to "full professional status". With existing professional bodies as apparently their reference group the dietitians in their "ethics" spelled out their responsibilities as "professional people". Thus, a number of the rules of ethical procedure govern the dietitian's obligations to society:

A member of the Association

Will place service to society before personal gain. Will continue to advance her knowledge and understanding of new developments in her own and related fields.

Others covered her obligations to her own professional group, and to other professional people.

A member of the Association

Will strive to merit respect of members of her own and other professional groups.
Will in no way attempt to gain advantage over other members or injure the reputation or status of another dietitian.
Will use all the resources at her command to further the objectives of the Association.
Will support and work for the growth of the Association.

Yet another dealt with the dietitian's responsibility to non-professional associates and subordinates.

A member of the Association

Will give courteous co-operation to associates and support subordinates.

And another covered the confidentiality ethic which seems to figure so basically in discussions of professional ethics.

A member of the Association

Will respect information and confidences relating to the affairs of others.

Because this is the type of profession which finds its members employed, rather than in private practice, another dimension in professional ethics had to be added: that of responsibility to an employer. The dietitians are of course not alone in finding themselves in this context, any more than are the nurses. Furthermore, it would appear that what is covered in these rules would apply equally to commercial or hospital dietitians. Accordingly, she is expected to be "ethical" in her dealings with an employer, whether a hospital administrator or a food manufacturer:

A member of the Association

Will give honest, loyal, whole-hearted service to her employers.
Will adhere to established regulations of the organization for which she works.
Will avoid unguarded statements that might cause trouble to her employer or the Association.

As the last rule suggests, not only the prospects of the individual dietitian but the future of organized dietetics could depend upon "ethical" relations between dietitians and employers.

Up to this point, it might be mentioned again, all of the rules of dietetic ethical procedure would appear to apply to all dietitians equally. All can be reminded of their responsibility to society, their organization and each other, and to other associates at the professional level. All can be expected to take seriously their responsibility to non-professional associates and workers, and to their employers. Finally, every kind of dietitian can be expected to find herself in the position where she might be called upon to respect the confidence of other people in a professional manner. However, the last rule in the code of ethics would appear to apply to only one kind of dietitian:

> A member of the Association
>
> Will under no circumstances publicly endorse goods or services of firms other than her own.

The commercial dietitian, and particularly the kind who works for a manufacturer might find herself in the position of being forced to choose: to help in the dissemination of "less than good nutrition" over "good nutrition". The possibility of this dilemma is suggested by the fact that this rule is included in the dietetic code of ethics.

It would appear then, that at the institutional level, organized dietetics acknowledges the potential conflict that can result from the inculcation of members with an ideology stressing health-giving nutritious food above all, and then the extension of membership to those whose basic task is to by-pass such values and throw themselves behind the use of food products as a means to the end of promoting a commercial undertaking.

However, an attempt has been made to resolve the moral problem by fiat, an act which seems to have had some measure of success. For example, again, here is how one hospital dietitian sized things up. She was asked what, in her opinion, would constitute an "unethical act" (See Appendix B, Question No. 11A):

> ...authorizing anything. Putting your name to a product for personal gain and not for the betterment of human nutrition...

This was what she began by saying, but within a few seconds she reported her "second thoughts":

> But something that's <u>not good</u> mind you! If it's a good product it's quite all right!

Thus verbalizing, to some extent the moral dilemma of dietetics.

The foregoing has been an attempt to illustrate with data gathered during research on dietitians in Vancouver, how an egalitarian ideology as formulated by the professional association of dietetics is such that its manifest intent to unify and stabilize the occupation is accompanied by certain negative latent functions as well. The contention has been that the Canadian Dietetic Association has established an ideology that, because of a number of important structural factors, lends itself to redefinition at both unofficial and official levels as basically medical in nature. The establishment of what has been called a "moral locus" in the ideology in this manner has in turn created a latent structure of conforming and deviant roles. It was suggested that further research might reveal a graduated continuum of conformity and deviance, although the evidence introduced here was intended merely to show that there is ideologically, a most medical "conforming" pole and a least medical, commercially-oriented "deviating" pole with a gap between, across which the medical and the commercial people tend to reject each other. Thus it is suggested that the ideology of dietetics could be

seen as performing the latent dysfunction[66] of dividing the occupation along a medical-commercial axis.

3. Pharmacy: A Different Way of Dealing with the Dilemma.

The dysfunction said to be latent in the dietetic ideology attaches itself to the unity of the occupational group. A built-in pressure for invidious evaluations of relative moral worth in what is held to be a profession, i.e., an association of colleagues of equal standing, is suggested to be a pressure towards breaking up the group.

It is important to keep in mind, however, that the dysfunctional quality of the ideology is not merely the fact that conflicting value-orientations come together. Rather, the disruptive effects of this medical-commercial polarization arises from the fact that the conflicting orientations combine with the unique job pattern of this occupation. The case of the pharmacist or druggist is now introduced to show how a medical-commercial dilemma can be contained within an occupational organization.

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66 R.K.Merton, "Manifest and Latent Functions", Social Theory and Social Structure, Glencoe, Free Press, 1949, pp. 21-81.

The pharmacist or druggist incorporates the medical and the commercial values into a single role.[67] Their conflict, when it occurs, then becomes a problem shared in common by all druggists. The professional organization can then serve the function of providing an institutionalized base, that is, a legitimizing and supporting framework, to project and maintain a single occupational image. Such an image illustrates the rights and obligations of the particular role played by all druggists, and demonstrates the ideal "balance" of contending means following from potentially conflicting ends.

Deviance and conformity to such relatively unambiguous role-ideals can be defined with relative ease, although the official and unofficial definitions of the two states might conceivably differ from time to time, and now and then even come into opposition.[68]

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67 I am much indebted here to the work of Thelma Herman McCormack. See T.H. McCormack, "The Druggists' Dilemma: Problems of a Marginal Occupation", American Journal of Sociology, Vol 61. No. 4 (January 1956), pp. 308-315.

68 For example: officially the druggist who maximized profit by selling "illicit" items such as tranquilizers or any other controversial goods without a medical prescription would be "deviant", although some of his fellow druggists might not

While the druggist plays a dual role of assistant to the doctor and businessman, he is never completely one or the other. Thus, while he is in the commercial phase of his activities a commercial man, he can change in a moment and perform his medical function and thus clearly demonstrate his connection with the emergency culture by assuming a key-role within its institutional structure. For the dietitian, such a schizoid change of "face" is not possible. This follows from the fact that a division of labour characterizes the job-structure of dietetics and this has left dietitians to make their way to a great extent completely within or completely outside of the medical or business settings. The medical-commercial axis, then, cuts right through the occupational group, encouraging dietitians to become one thing or another.

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define him so. On the other hand the pharmacist content to remain in a hospital dispensary for low remuneration might be an official hero and an unofficial deviant.

Chapter Ten.

THE SOCIAL ORGANIZATION OF DIETETICS: CONCLUSIONS AND THEORETICAL IMPLICATIONS.

> ...here is my simile. I believe that the most beautiful finished production of ballet, is composed of the same fundamental steps which every performer must learn to perfection. These are then built into varied routines, and the routines into the polished perfection which is the finished performance. Do you see the resemblance ? Every C.D.A. member's job fundamentally consists of the same basic duties which she must learn perfectly. These can then be combined with expanding responsibilities into various jobs along the way, until she too reaches polished perfection - or the top.
>
> Frances S. McOuat*

This essay for the most part has concerned itself with the social organization of an occupational group. In this final chapter there will be (1) an attempt to explain this organization in terms of a balance of contending pressures, and (2) an effort to locate in a sociological sense this particular kind of activity in the sphere of occupations and other activities in the Canadian segment of North American industrial society. In the first case,

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*Canadian Dietetic Association, Report on Job Evaluation Survey on Dietitians in Canada - 1954, Toronto, 1954. P.3.

dietetics will be examined to show how it resolves problems stemming from disruptive pressures common to many occupational activities (particularly those monopolized by women) as well as how it contains disruptive pressures peculiar to its own case. In the second place dietetics will be seen as a particular kind of work among other kinds, and one which shows potentialities and tendencies to develop along either of two lines, and an official inclination to develop along both.

1. Social Organization: Resolution of Common Problems of Women's Work Groups.

It will be recalled from the early chapters that the occupational group of dietitians is united by the fact that by far the greatest number of the practitioners are either of middle class origin or middle class orientation. This follows from the requirement that to qualify as a dietitian a woman must have trained first at a university or college.[69] The group is further unified by the fact that the specific qualification of a dietitian is technical

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69 Talcott Parsons, "Analytical Approach to Theory of Stratification", Essays in Sociological Theory, Glencoe, Free Press, 1954, pp. 69-88. Suggests a number of interesting "class indicators" including the "normal expectation of a college career" as a criterion for differentiating middle class orientation.

training in the theory and practice of nutrition and home economy up to, and including, one year of post-graduate interning.

It was noted further that the Canadian Census in 1951 showed that practically all dietitians found themselves in the position of working for someone else, and that only a handful out of the eleven hundred in the country were "entrepreneurs". It is suggested that these things in common, together with the fact that all dietitians appear to be somehow concerned with the feeding of people -- however indirectly -- could serve as a basis of common purpose upon which dietetic organization might be founded.

As the analysis noted, however, there is in dietetics the usual schism between the young and the old, reinforced as it is in the case of womens' career-occupations by the instability following from the reluctance of younger women to commit themselves to the occupation for life until the very last. It was suggested in the analysis of this situation that there exist two broad groupings in this womens' career occupation: those under thirty-five years of age, who were called "marriage-oriented", and those over that age who are "career-oriented". The existence of two groups of this nature was said to make for a continuing schism; however, it was noted that there is a possi-

bility that certain individuals could help bridge the gap by playing "mediating" roles.

Two possible types were suggested as incumbents for these mediating roles. However, further consideration seems to narrow the alternatives down to a single possibility.

One type suggested was the <u>older</u> dietitian who had made a marriage and yet managed to stay in, or get back into her career line. The other was the young girl who might conceivably dedicate herself to dietetics and turn her back on marriage.

It is suggested that the <u>older</u> dietitian who has returned to dietetics after a marriage is the most likely to serve as a successful mediator between the older career-oriented women, and the younger marriage-oriented girls. The contention is that the younger girl who chooses dietetics as a novitiate would be deviating too far from the values of her marriage-oriented age-mates. The older dietitian who has married has proved in the eyes of both groups that she can deal with the marriage-career dilemma. To the career-oriented older women she demonstrates also that while perhaps she was once "unfaithful" when she followed the "intruder" away, she never forgot her sisters and came back to them in the end. This in a sense can be taken as a proof of

her strong, if not stronger, attachment to the group.[70] In the case of the younger girl, however, the early career dedication is seemingly an absolute rejection of values fundamental to the marriage-oriented group. It is submitted then, that the age and marriage barrier in dietetics is bridged in part by the presence of older dietitians who have been married, and who play what are in fact "mediating roles". The whole question of mediating roles in occupational groups is put forward at this point as one worthy of additional study.

2. Social Organization: Resolution of Problems Peculair to Dietetics.

(a) Factors Contributing to Disruption of Occupational Cohesion.

The essay has pointed out that dietetics is an occupational activity characterized by the fact that it divides between two main sub-cultures, and that it operates through two differing institutional systems. The two sub-cultures were identified as the emergency culture and the frugality culture, and the respective "systems of means" to the ends implicit in these sub-cultures were the organization of treatment and nutritious feeding in the hospital and the organization of budget-

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70 The remarks here might be considered in context with the observations of Georg Simmel. See "Faithfulness and Gratitude", The Sociology of Georg Simmel, tr. Kurt Wolff, Glencoe, Free Press, 1954, pp.379-395.

balancing and profit-showing in the business, or the business-like enterprise. (Running through both these systems of means, of course, is the third value to which dietetics is oriented, that of palatability. However, perhaps as a result of the differential "captivity" of their respective publics, the dietitians in the emergency and frugality culture are not equally obliged to meet the demands of personal taste. In fact, a "locus of pleasure" appears to form within the frugality culture in the face of market pressures which the commercial dietitian must meet). The fact that there is segregation and differentiation between roles in these differing normative systems and institutional contexts is submitted as an important factor working against cohesion in the structure of the occupation of dietetics.

The essay submitted further, that the structural context of dietetics is such that it works against even the conscious attempts of the formal association to bring unity and stability to the occupational group. The formulation of an ideology to define a common cultural basis, is undermined by the unofficial, and sometimes even the official, definition of the medical roles in dietetics as those most conforming in nature. Thus, the latent dysfunction of the ideology (from the point of view of maintaining cohesion of the group) is to

further the split between the most medically-oriented side of the occupation and the most commercial or business-oriented. (It is interesting to note that the official ideology does not take into account the factor of palatability as a duty of dietitians).

While little attention was given it in the preceding text, there is another element in the structure of dietetics which potentially might prove to further the already established divisive influences in the occupation. This is the commercial internship. It will be remembered that there is only one commercial course available in Canada with places for only half a dozen interns. This compares with well over a hundred openings in hospital programs. While a few girls were said to have gone to the United States for accredited commercial internships, by far most dietitians, hospital and otherwise, had trained in hospitals. It will be recalled that commercially trained dietitians were not acceptable for jobs in hospitals; they could at most expect to work in the catering operations, such as the staff cafeteria. This is suggested to be the potential "seeding" of a permanent cleavage in the occupational activity of dietetics. Should the facilities for training commercial dietitians be expanded, then a substantial segment of the socialization pattern that most dietitians in Canada now have in common would be lost. With this gone, many of the links which still

connect hospital-trained commercial people with the medical ethic would be no longer in the picture. In addition, without hospital-trained dietitians occasionally moving from one side of the field to the other and playing another kind of mediating role, the gap between those in the hospital setting and those in commerce would likely become even more firmly structured than it is now.

All of this has been compiled to suggest that there are strong forces at work straining to break the cohesion that seems to hold the occupation of dietetics together. However, the fact is that dietetics has not been split apart by contending forces within. This is not to say that it might not in the future undergo a division. It is merely to raise the question: How is it that dietetics has managed to contain these disruptive influences thus far ? What is holding it together so that it is still recognizable as an occupational activity if not as involving only one occupational task or function ?

(b) Factors Contributing to Maintenance of Occupational Cohesion.

The common social class and level of education of dietitians are certainly important factors in maintaining the cohesion of this occupational group. Again, while the dietitians may not be too close in agreement on just what sort of thing a dietitian ought and ought not to do, one thing on which they would likely be in

firm agreement is the matter of who they are not. They know definitely that they are not to be categorized with the lower class cooks, bakers, dishwashers, serving maids and the like. They are not the kind of people to be included in the union.[71] They are not the kind of people who cannot read, or cannot speak English. They are not the kind of university graduates who took Arts and "ended up with nothing". They are, with one dubious exception, according to the Canadian Census of 1941, not men. All of these social points of reference, it is suggested, would likely combine to give the dietitians in Canada the initial sense of oneness of a group of like-thinkers, which the following additional factors might build on.

Further contributions to occupational group cohesiveness would be the shared socialization experiences. Successive sets of peers, which the socializing groups feed into the occupation, have the function of establishing within the latter a stepped series of "generations" and hence, a network of interpersonal relations involving women of like ages. This interpersonal grid incidently militates against the conflict between younger marriage-oriented and older career-oriented women mentioned earlier.

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71 Canadian Dietetic Association, Provincial Associations, Toronto, 1955, p. 3.

It is submitted further, that the social organization of the occupational activity known as dietetics is maintained by the fact that dietitians find themselves marginal in so many other institutional contexts. Dietitians in both the emergency culture and the frugality culture find themselves standing apart. For example:

> I interned at the ----- Hospital and I worked there for a year, and I never felt at home at any time. I had dietitian friends and I felt alright in the kitchen where I felt I belonged..... We were warned when we started our (Commercial) interning. We were reminded that it wouldn't be the same for us as it was for the dietitians in hospitals. They told us we'd probably be moving into fields where men had the monopoly and that we would meet with more opposition, and that we were going to have to prove ourselves.....

Thus, the fact that dietitians, both in the hospital setting, and in the sphere of commercial activity, find themselves playing roles which somehow exclude or bar their acceptance by others in the same context would appear to be a pressure for the individuals to turn to one another for support. Dietetic social organization is maintained for all its unique dualism then, to some extent, by the fact that initial similarities of status and common accomplishment, are reinforced by common marginality of status in the actual sphere of work. These factors then, it is submitted, have worked

to hold in check the disintegrative pressures that seem to be also at work within and upon the occupation. The reference here is to both the threat of absorption by the medical and the commercial cultures and their respective institutions, and the further internal strains encouraged by what appears to be literally a lop-sided ideology.

Finally, mention is made of a current development in dietetics in Canada which potentially could contribute to the cohesion of the occupation at the manifest level at least. This is the solidarity engendered by a formal campaign to obtain professional status. The Canadian Dietetic Association has been concentrating upon this for a number of years now, and the primary goal seems to involve the persuasion of provincial legislatures to pass statutes defining and regulating dietetics in the manner that medicine, nursing, and other established professions are established and regulated. To date, as was noted earlier, only the dietitians in the Province of Quebec have been successful in this regard; however, provincial dietetic associations are working under the guidance of the Canadian Dietetic Association towards the same end in the other provinces. The implications of the campaign for professionalization will be treated more fully in the sections to come; in the meantime it is noted merely as a development which potentially could contribute to

cohesion of the group on the structural level, but which exists for the time being as a factor promoting solidarity or loyalty among C.D.A. members.

The organization of the occupation of dietetics into a recognizable occupational group then is seen as the striking of a balance between contending factors, or functional and dysfunctional elements. Thus, in spite of the pull of contending values and segregated institutions, unity is brought through commonality of initial status, similarity of present status, and it appears, the prospect of ultimate achievement of a new status, as a legally established profession. Such an achievement could conceivably add to the occupation's organization the firmness sufficient to maintain even more efficiently (from the point of view of the persistence of the group) the cohesion of dietetics in the face of the built-in strains described here. At any rate, such is the hope of the dietitians. While the final section of the essay will not attempt to predict what will happen to dietetics in this respect, it might make prognosis possible by viewing dietetics, with its actions and aspirations, in the occupational sphere and Canadian society in general.

3. Dietetics and Change: What is Happening to Dietetics?

The essay has for the most part concerned itself with locating and identifying the occupational activity of dietetics using data on normative patterns and social

structure as co-ordinates or reference points. So far little attention has been given to changes involving dietetics relative to other occupational activity and the social system generally. No attempt has been made to fit dietetics into general patterns of social change which can be seen to be at work in the occupational sphere and the social system generally. Let us first consider the question of change and dietetics, and then generalize in order to consider its consequences for the sociology of occupations.

(a) Expansion of Function: Apparent Scope for Expansion of Dietetics.

It would seem clear from the nature of the social structure of hospitals, that dietitians are now fully in possession of all the roles that they will be able to take over there. This is certainly true in the job structure of the emergency culture, if not in the frugality areas of the hospital where there are some signs of further proliferation of technical specialities in administrative positions. In other words, the dietetic position in the hospital setting is one of a relatively static nature, with the dietitians rigidly hemmed in and held firmly in their allotted places by other roles with which they share the general goal of performing the activities involved in ministering to the sick.

Out in the everyday world of food production and service, however, where the values of the frugality

culture are uncontaminated by the sometimes uneconomical demands of illness, the dietitians find themselves in a different situation. Here, as has been suggested earlier, the dietitians are in the process of trying to take over systems already functioning to fill needs for food production and service. Here it would appear that dietitians have before them a relatively clear field for a successful invasion. They are, in this area, able to represent themselves as the appropriately trained specialists with the specific skills for carrying out the most economically efficient production of food, in a value zone where efficiency of this kind is a primary goal.

Thus, it is suggested that dietetics has scope for the expansion of its function, in the sense of taking on more and more existing jobs (as well perhaps as increasing the variety of tasks to be taken over) in the institutions strongly committed to the monetary goals of the frugality culture. Furthermore, dietitians, it will be remembered, are university-trained specialists and hence perhaps by definition, members of a class of people who lead, if not members of a class of leaders. If they can prove in the first place that they are more efficient, economically, this would seem to add to the argument for having them take over from the usually lower-class based, practically-trained chefs, cooks, stewards, and so on, among whom the field of commercial food production and

service is for the most part now distributed. It is suggested, then, that this is the area in which dietetics could expand its function, because here dietetic roles could safely supplant the key-roles of the functioning structures which exist without, in effect, destroying the system. Such a thing, of course, could hardly be conceivable in the case of our hospitals.

(b) Enhancement of Status: Professionalization as Collective Mobility.

The second tendency towards change in dietetics is different from the first in a number of important ways, but is none the less closely associated with it.

Whereas the expansion of function involves a demographic shift, a flow of recruits into commercial roles in the job structure, the enhancement of status or professionalization (literally, the taking on of attributes of certain "established" professions), is a kind of collective mobility upwards, in terms of the closely linked occupational and social class structures.

The movement of dietitians into commercial jobs on an expanded scale would seem to have the function of extending dietetic control and making "more dietetic" an area where dietitians already have a firm hold. It would be a kind of occupational "empire-building". On the other hand, the gaining of the trappings of professional

status (including, of course, a monopoly on the name if not the tasks involved in dietetics) must be seen as an important change in the basic character of the occupation.

As indicated at the beginning, the two tendencies to change are not separate trends. Most dietitians apparently see them as going on together. As a matter of fact, efforts to combine the two pressures seem to contribute to the increased solidarity of both hospital and commercial dietitians mentioned in the second section of this chapter. While it is not completely clear whether the hospital dietitians favour the further expansion of dietetics into the commercial field (though they might welcome additional opportunities to make invidious comparisons of professional "purity" or appreciate commercial dietetics as a potential place to escape to from the hospital !), the commercial girls for their part seem to share the general interest in what the C.D.A. calls "full professional standing".

At the same time, it is suggested that the professional aspirations of the two differing kinds of dietitians would necessarily involve the identification with two rather different images of the professional person, one for the hospital dietitian, and the other for the commercial dietitian. It seems likely that the hospital dietitian would incorporate the attributes of

the established professional roles of doctor and nurse into her picture of what the professional dietitian would be like. This would involve a medical picture of the dietitian committed to the humanitarian values involved in maintaining life through ministering to the sick, etc. The commercial dietitian, on the other hand, would appear to find herself at a loss for concrete examples of a professional role with a particular similarity to her own, and although she might be quite familiar with doctors and nurses, as a result of a hospital internship, it seems unlikely that she would identify with the medical professionals if she held one of those kind of jobs where the medical halo was bad business.

It is suggested then that the commercial dietitian would find it necessary to formulate a picture of what professionalism involves that differed from the medical stereotype. Some evidence of how this is done may be found when attention is turned on a formal attempt to define the attributes of the professional dietitian, included in the self-administered Job Evaluation Survey cited earlier.[72] Two things must be remembered in connection with this survey: first, the person who did it was a commercial administrative dietitian and, second, her formulation was like the dietetic ideology, an

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72 McOuat, Job Evaluation Survey, p. 3.

attempt to define the "average dietitian" in terms broad enough to include all dietitians wherever they work in both of the major sub-cultures. Here is what the survey-analyst said:

> The survey demonstrates clearly the trend to establish the dietitian as a professional person in an administrative or executive capacity, working in nearly every instance in an extremely practical field.....

And the kind of individual required to play this professional-executive role:

> ...This means that the dietitian must be a person of broad cultural background, with a thorough appreciation of business practices, of personnel principles, and of the required practical skills.

All in all, the kind of professional image which dietitians generally are being asked to identify with depicts not so much a particular profession or type of profession, as it does some of the middle class attributes that go with professional status. It also includes one quality, executive or administrative authority, which proves to be a problem in dealing with "near-professions" and "would-be" professions like this one, when we compare it with "traditional" or established professions.

The university education, combined with practical training and technical ability in a particular area, are all professional qualities. However, there is

a significant difference between the kind of authority which doctors, nurses, and other traditional professionals exercise, and the administrative authority of the frugality-oriented dietitian, which includes commercial and other types of production roles. In the case of the doctors and the nurses, and for that matter, the dietitians, who deal with sick people, the medical ethic requires the use of their specific technical authority whenever and wherever they find themselves in a position where their services are required, and another professional is not committed or able to bring his or her skills to bear. The executive or administrative authority, on the other hand, which is the kind the commercial and frugality-oriented dietitians generally use, once the food production system is set up and working, is a bureaucratic authority which attaches only to the particular office or kitchen where she has secured appointment.[73]

While the first quotation above indicates that organized dietetics differentiates in a relatively crude way between professional and executive, this is certainly not dwelt on. As a matter of fact, the Canadian Dietetic Association, while noting perhaps a duality in the character of the "common" dietetic role, does not appear to concern

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73. H. H. Gerth and C. Wright Mills, ed., From Max Weber: Essays in Sociology, New York, Oxford University Press, 1946, pp. 295 et seq.

itself with this as a dilemma, but as merely something to be juxtaposed and lived with. In other words, the dietetic organization does not seem to see sociological paradoxes as obstacles in their path. While they have had to struggle, they have at this point managed to obtain a Dietitians' Bill with what is in effect legal recognition of their professionalism in at least one province in Canada, and work is going ahead to bring about the same thing in others. In a sense, they seem to be like the bumble bee who it is said could be told by any aerodynamist that he is theoretically unable to fly -- but doesn't find out and so is not grounded by this knowledge.

In the terms of reference group theory[74] here is what the dietitians seem to have done to get around the difficulties involved in campaigning for professional status for an occupational group of such diverse types. It is suggested that the hospital dietitians, who are in relatively sustained contact with doctors and nurses, take these traditional medical professions as the kind of reference group professions which they see dietetics as coming to resemble. The frugality culture dietitians and especially the segregated commercial people, are

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74. R. K. Merton and Alice S. Rossi, "Contributions to the Theory of Reference Group Behaviour", Social Theory and Social Structure, 2nd ed., Glencoe, Free Press, 1957, p. 232.

certainly more removed from sustained contact with all kinds of professional workers. This isolation would certainly have some effect on any early identification with doctors and nurses picked up during the interning days, combining this with the difficulty inherent in trying to see commercial dietitians as <u>like</u> doctors and nurses, it seems very reasonable to expect that the reference group of the commercial girls has to be more generalized in nature and to take the broad category of <u>types of people</u> rather than <u>types of occupation.</u> In short, then, it can probably be said that the reference group of the commercial people, and of organized dietetics as a whole, is taken from the class structure rather than the occupational structure.

Moving now to the sociological level, it could be said that the manifest function of both kinds of reference group is to act as mechanisms promoting the differentiation[75] of dietitians from the general category of technically trained food workers and "lower class" stewards, chefs, and the like, and the assimilation of dietetics to the more specific category of "higher class" professions. There is also a reference group held up by the C.D.A. and adopted by the frugality and commercial dietitians. This latent function (which assumes consolidation on a wider scale of statutory position and relative

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75. F. G. Vallee, M. Schwartz and F. Darknell, "Ethic Assimilation and Differentiation in Canada", <u>Canadian Journal of Economics and Political Science, Vol. 13</u> (November, 1957), pp. 540-549, <u>passim</u>.

acceptance by the in-group of the established professions and the out-group of the public) would appear to involve a further broadening of the concept of profession in both sociological and layman's terms.

4. Change in Dietetics and Change in the Occupational Structure.

Noting with Talcott Parsons[76] the extent to which western industrial society depends on the functioning of professions, A. M. Carr-Saunders and P. A. Wilson[77] have provided a definition of professionals wherein the limiting factor is the structural context of the occupation under scrutiny.[78] They say

> We recognize a profession as a vocation founded upon prolonged and specialized intellectual training which enables a particular service to be rendered.....

and further[79]

> ...But this recognition may be hindered by dependence, which militates against group consciousness, since it is only

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76. Talcott Parsons, "The Professions and Social Structure", Essays in Sociological Theory, 2nd ed., Glencoe, Free Press, 1954, pp.34-49.

77. A.M. Carr-Saunders and P.A.Wilson, "Professions", Encyclopedia of the Social Sciences, 1950, vol. 11, pp. 476-480.

78. Ibid., p. 478.

79. Loc. cit.

> under the stimulus of the latter that the practitioners associate together and become a profession in the full sense of the word...

It is suggested that this case study of the social organization of dietetics as an occupational group has dealt with a particular case of the phenomenon defined by Carr-Saunders and Wilson. It is a profession or at least a "marginal profession" which appears to be a "vocation founded upon the prolonged and specialized intellectual training which enables a particular service to be rendered". It is dependent on outside structures organized around what are now and then conflicting value-systems, and hence is an interesting example of the "dependent vocation" for which recognition as a profession may be hindered in the sense of these two writers.

The case of the dietitians in Canada seems to exemplify also the emergence of new occupations in the occupational structure, which take on old forms and yet turn them into new <u>forms</u> of organization, all of which Carr-Saunders and Wilson see as part of the continuing rationalization of western science-oriented industrial society.[80]

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80. Carr-Saunders and Wilson, <u>op. cit.</u>, p. 480.

> ...there can be no doubt that with the progress of science and the increasing co mplexity of social organization, new intellectual techniques will evolve, around which new professions will grow up.....

Finally, dietetics appears to be an example of a tendency to consolidate middle class technical occupations into one kind of structure.

> ...In other words, there will be a considerable extension of professionalism outwards.....

Turning to the field of the sociology of occupations in a general sense, we can see organized dietetics as successfully containing the strains engendered by the fact that dietitians work as specialized roles in differing normative areas and discreet institutional settings. They are not able to deal with these sometimes opposite pressures each in the same way, each in a single role as the pharmacists are. Rather, they are forced to contain these pressures at the level of occupational structure. An attempt was made to explain how dietetics copes with its organizational problems, and one of the ways appeared to be by anticipating a new occupational and social class standing which all would share.

This interest of dietitians in professional status has important long-term implications for the sociology of occupations.

The implication follows first from Carr-Saunders' and Wilson's remarks on the "extension" of professions "outwards", and second, from the salutary way in which the dietitians have dealt with the internal differentiation of professional images and the taking of different kinds of reference groups, in a relatively successful campaign for legal recognition as a profession. By doing this, and, depending on the extent to which they are able to carry the differing values and differing conceptions of professional qualities into the professional areas, and to the extent that they are able to secure public, if not in-group acceptance, as a profession, the dietitians are not only changing themselves into professional workers, but they show signs of broadening the general definition of professions in the social structure as well.

A P P E N D I C E S

Appendix A

FACE SHEET - QUESTIONNAIRE FOR DIETITIANS

F. DARKNELL

Number of Informant .....

AGE..... YEARS WORKED AS DIETITIAN .....

MARRIED OR SINGLE .....

IF APPLICABLE HOW MANY YEARS IN DIETETICS SINCE MARRIAGE?....

HISTORY OF TRAINING: COLLEGE .....
DATES .....

INTERNSHIP AT .....DATES .....

HOSPITAL OR COMMERCIAL .....
CDA.....BCDA .....ADA .....

TYPE OF DIETETICS DONE NOW .....
STATUS: Junior, Intermediate or Senior. (Circle)

EXPERIENCE IN OTHER FIELDS OF DIETETICS OTHER THAN DURING INTERNSHIP:

OTHER KINDS OF FULL TIME WORK DONE BEFORE OR SINCE BECOMING A DIETITIAN? BRIEF DETAILS:

OCCUPATION OF OTHER MEMBERS OF FAMILY (CLOSE RELATIVES).

FATHER ..... MOTHER..... HUSBAND .....

BROTHERS.....SISTERS .....

UNCLES, AUNTS AND COUSINS IF IN FAIRLY CLOSE CONTACT WITH THEM:

NOTICE: The above information is for my personal perusal and would be helpful in enabling me to interpret and generalize from my other material on dietitians. ALL INFORMATION WILL BE KEPT FULLY CONFIDENTIAL: At no time will anyone have access to the names of the people who fill out these individual sheets. No one but myself and Dr. K.D. Naegel of the Department of Anthropology and Sociology will see this sheet, and the typed-up transcripts from the tape-recordings of the interviews made. When my thesis is written no one will be in any way identified or presented in such a way that others would be able to identify her.

Frank Darknell.

Appendix B

STANDARDIZED QUESTIONNAIRE FOR DIETITIANS.

July 8,1956.

1. Could we have you start out by having you describe a day at your work? Tell me who you work with? Who you work under? What you do when? And so on.....

2. Is your work governed by strict rules at all times, or are you sometimes called on to improvise to get things done?

3. Do you see yourself as a specialist like a pharmacist or are your responsibilities broader?

4. What kinds of work in dietetics appeals to you most?

5. What kind of work in dietetics appeals to you least?

6. What would be an ideal kitchen maid? Counter girl? Waitress?

7. Describe an ideal cook.

8. In hospitals, have you found that the different professional people like doctors and nurses and dietitians always get along alright? Is there always as much cooperation as there could be?

9. What would be an ideal nurse from a dietitian's point of view?

10. What would be an ideal doctor?

11. What sorts of mistakes do you have to guard against on your job?

11a. What would be an unethical act for a dietitian?

12. Who can a dietitian go to when she has problems?

13. Does she usually have to keep some work problems to herself?

14. How did you happen to get into this kind of work?

15. What are the things you've found most enjoyable about your job?

16. Are there any things about your work that aren't always pleasant?

17. What are some of the advantages that might result from the hiring of dietitians to look after large restaurants?

18. If you were hired to run a restaurant, what qualities would you hope to find in the owner or the manager over you?

19. What do people usually say when they find out you're a dietitian? Do they usually know what it is all about?

19a. What sorts of things do you feel people should know more about?

20. What do you think are the important things about being a professional person?

21. Do most dietitians think of themselves as professional people with professional responsibilities? Do any seem to forget? Why?

22. Is there a union for the staff where you work? What does the staff seem to think of it? Do they take their troubles to it?

23. Do you find that staff people ask you to share their personal problems?

24. Do dietitians get enough of the right kinds of training? What would you add or leave out of their course?

25. What kind of person makes the best senior dietitian -- what is the best kind to have in authority over you?

26. What kind of person is a good junior? What qualities would you personally like in a dietitian working under you?

27. Are you able to take an active part in the C.D.A. and the B.C.D.A.? Who are the people generally most active?

28. How do dietitians generally seem to regard the C.D.A. and the B.C.D.A.? What is the general opinion? Do you agree with it?

29. By the way, how did dietetics come into existence?

30. What sort of advice would you give to a girl planning to go in for dietetics?

31. Think about this for a moment -- what would we all lose if dietitians and dietetics were eliminated?

32. Are there any questions you think that I should ask dietitians that I haven't asked? Anything you'd like to add to what you've already said?

33. What do you and the other dietitians think about being studied by a sociologist?

Appendix C

T A B L E 11 (excerpt)

"Labour force, 14 years of age and over, by occupation and sex, showing age group, marital status, years of schooling and class of workers, for Canada and the provinces, 1951."*

	Age Group					
	Total	14-15	16-17	18-19	20-24	25-34
Dietitians	1,100	-	1	6	2,311	356
Nurses	34,270	-	-	31	7,543	11,256
Nurses in Training	15,581	-	87	5,052	9,238	1,024

	Age Group Cont'd					
	35-44	45-54	55-59	60-64	65-69	70+
Dietitians	287	140	43	23	9	4
Nurses	7,532	4,719	1,491	944	492	262
Nurses in Training	165	14	-	-	-	-

* Census of Canada 1951, vol.4, pp. 11-1 to 11-170.

/cont'd.....

Appendix C

T A B L E 11 (excerpt)
(Cont'd.)

"Labour force, 14 years of age and over, by occupation and sex, showing age group, marital status, years of schooling and class of workers for Canada and the Provinces,1951."

	Marital Status			
	S.	M.	W.	D.
Dietitians	826	201	59	14
Nurses	2,364	8,685	1,663	321
Nurses in Training	15,405	129	41	6

	Years of Schooling			
	0-4	5-8	9-12	13+
Dietitians	1	13	78	1,008
Nurses	1	206	17,233	16,830
Nurses in Training	-	47	9,625	5,909

	Class of Worker			
	E	OA	W	ND
Dietitians	-	5	1,091	4
Nurses	-	8	3,424	1
Nurses in Training	-	-	15,501	-

T A B L E 14 (excerpt)

"Labour force (female) 14 years of age and over by occupation and sex, showing age, group, marital status and the number of wage earners for the census-metropolitan areas of cities of 10,000 population and over, 1951."*

Census Metropolitan area.	Total	Age Group						Marital Status		
		14-19	20-24	25-34	35-44	45-64	65+	S.	M.	W. or D.
Montreal	167	2	46	59	35	24	1	131	28	8
Toronto	264	1	29	73	85	69	7	176	61	27
Vancouver	84	-	23	38	15	8	-	63	21	-
Winnipeg	51	-	18	22	9	2	-	45	5	1
Edmonton	34	-	6	20	6	2	-	24	9	1
Hamilton	32	-	7	11	8	6	-	26	3	3
Ottawa	34	-	6	8	11	9	-	28	3	3
Quebec	19	-	6	6	5	2	-	18	1	-
Calgary	18	-	5	7	4	2	-	15	3	-
Windsor	8	-	2	2	1	3	-	6	2	-
Totals: -	711	3	148	246	179	127	8	532	136	43

* Census of Canada 1951, vol.4, pp.14-1 to 14-86.

T A B L E 4, (excerpt)

"Labour force, 14 years of age and over by occupation and sex, for Canada and the provinces, 1951." *

Dietitians.			B.C.	Que.	Ont.	Man.	N.S.	N.B.	NFD.	PEI.	Alta.	Sask.
Total	Male	Female										
1,001	1	1,100	118	210	514	56	42	40	8	5	71 (all female)	46
Nurses.												
Total 35,138	868	34,220	4,250	7,224	13,578	1,681	1,503	1,148	410	214 (all female)	2,225	2,037
Nurses in Training.												
Total 15,623	42	15,581	1,774	3,420	5,034	897	817	811	289	150 (all female)	1,253	1,136
Cooks.												
Total 35,176	19,513	15,663	-	-	-	-	-	-	-	-	-	-

* Census of Canada 1951, vol.4, pp.4-1 to 4-10.

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