FACTORS INFLUENCING FOOD ADMINISTRATION PRACTICES IN SMALL HOSPITALS IN A NON-URBANIZED AREA

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By

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A PROBLEM

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PREFACE

For three years the author of this study directed a small hospital dietary department. This report is a written description of objective and subjective observations of her experiences and the ideas and opinions of persons in similar positions. The possibility of biasing attitudes and prejudices because of personal involvement in existing circumstances was recognized. For this reason, the research design included information from others in like situations. Through interviews with them, the author was able to substantiate or negate her own impressions. She is grateful to them for relevant material supplementing the study.

The author expresses appreciation for the help which she received from her committee: Professors Katherine Hart and Grace Miller. Acknowledgment is also made to Miss Doris Downs and Dr. Lynn R. Peters.

INTRODUCTION

A phenomenon in the culture of American society is population mobility. One family out of five moves to another location every year, and dietitians have become part of this mobility. Many professionally trained dietitians are moving to rural areas and accepting positions as shared or consultant dietitians or as the only dietitian in a small hospital. State dietetic associations and public health atencies have contacted married dietitians to renew their interest in accepting positions in smaller hospitals. A nation-wide survey of hospital food services conducted by The American Dietetic Association in 1962 indicated that this recruitment program should be continued (5). Thirteen per cent of the smaller hospitals reported vacancies for full-time dietitians.

Early in their careers, dietitians are often hesitant to direct departments because of the responsibility associated with administration. The role of the dietitian in a small hospital appears formidable. They also view the position as precarious because of its public vulnerability.

A realistic perception of the way their educational background has prepared them for the responsibilities of the profession is essential. The dietitian is capable of adjusting to any hospital situation because she is equipped with required techniques and skills. Basic principles of nutrition, management, supervision and education taught in academic and internship programs are applicable to any institution. Although her previous experience may have been in larger hospitals, she encounters few difficulties transferring her knowledge to a smaller operation.

No other opportunity in dietetics provides a more realistic perception of the profession than a position in a small hospital. In performing diversified duties the dietitian realizes how each activity is directed toward the ultimate goal of improving the health and well-being of patients.

Problems exist in small hospitals as in large ones; some are similar, some dissimilar. The dietitian in the small hospital solves problems in a socio-economic environment quite different from urban surroundings. Decisions made in either area will reflect influences of the society in which they are made.

The job performance of the dietitian is judged by the quality and cost of the food served to the patients, hospital staff and guests. She performs her duties in a certain behavioral pattern because of the multi-dimensional factors in her environment. This study explores factors that are cognitively and unconsciously influential on the decisions of the dietitians or food service managers in small hospitals in non-urbanized areas.

THE DIETITIAN IN AMERICAN SOCIETY

In 1835, a brilliant young Frenchman, de Tocqueville commented:

> Providence has not created mankind entirely independent or free. It is true that around every man a fatal circle is traced beyond which he cannot pass, but within the wide range of that circle he is powerful and free.[1]

The dietitian in American society today exists within a complex social circle. Around her are divergent publics or social groups whose efforts are integrated with hers to meet objectives of society. She remains a "powerful and free" individual by her unique contribution to the social structure.

Dietitians are products of the scientific and socio-economic developments of the last century. The value of balanced diets became part of the treatment of soldiers injured during the Crimean War when Florence Nightingale planned the first diet kitchen. This idea of patient food service spread to general hospitals on the Continent, England and America. Prior to this time families of patients provided food for hospitalized relatives.

The group of professional persons known as dietitians has homogeneous and heterogeneous characteristics. Education and experience requirements are specified by The American Dietetic Association. Ages range between the new interns of twenty-one to the respected years

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[1]Alexis de Tocqueville, Democracy in America, trans. Henry Reeve (New York: Oxford University Press, 1946), p. 599.

of the charter members; dietitians belong to every ethnic group and all religious faiths. Marriage seldom ends their professional interest. Membership in The American Dietetic Association affords them a status they are reluctant to terminate.

Dietitians are employed in hospitals, universities, colleges, restaurants, food contract services, armed forces, research laboratories in food and nutrition and in independent positions. The occupational opportunities are limitless. The following descriptive titles indicate the types of positions they hold: therapeutic, executive, teaching, shared, consultant and research dietitian, nutritionist.

They live in every geographical location and find full or part-time employment. Through membership in local and state dietetic associations they are accessible to special professional and educational activities and continuing education.

The dietitian, besides being a professional person, is an individual with distinguishing characteristics. She has her own skills and physical and mental abilities. She possesses certain capabilities; is creative in some areas and adequately imaginative in others. Through education she has learned to apply and discipline her intelligence to all situations. From experience she has developed human relation skills, a sense of humor and self-discipline. She has special interests in her position that are compatible with her abilities and personality; visiting patients may seem a more valuable activity to one dietitian while another may prefer administrative duties.

Every individual has basic social and egoistic needs. Through her work, the dietitian may find satisfaction of such social needs as friendship, belonging to a group and helping others. A motivating factor in satisfying her ego needs may be seeking to attain self-actualization and creativity in her job performance. The success of the dietary department

is largely dependent upon the ability of its director. If the department is efficient and effective in its operation, the dietitian realizes a great amount of self-fulfillment.

In smaller communities where fewer professional dietitians are employed, the dietitian is viewed as an authority in many diverse areas. The public expects her to be a nutritionist, an expert at food preparation and a financial wizard in food and labor costs. The medical staff see her role as a therapeutic one devoted almost completely to patient care. Her employees expect her to be a problem-solver, a grievance preventer, an arbitrator, a master-mind in scheduling time, and often an amateur psychologist. The hospital administrator, from a different perspective, sees her role as a food cost expert, a master planner of menus and food preparation, a food complaint preventer, an organization planner and director, a layout and equipment design engineer, and an authority on human relations.

The dietitian has a perception of her position in the hospital and the community. She is also well aware of her abilities and motivations. All the different perceptions influence her actions, sometimes consciously and usually unconsciously. She may attempt to live up to the expectations. If she is able to fulfill the expected roles, she does establish herself as an authority. The administrator values her varied abilities and her employees attain greater satisfaction in their work through her acceptance of leadership. To the public she projects the true image of the modern dietitian: a professional person with managerial abilities and specialized knowledge of food and nutrition and dedicated to helping mankind through the application of her knowledge.

Americans have become more food and diet conscious, and dietitians have played a significant role in the increased public knowledge and understanding of nutrition. The hospital dietitian communicates directly with

the public through diet interviews and instructions. By serving nutritious and attractive meals she utilizes a means of changing negative attitudes or reinforcing positive ones about food in the American diet.

DIETARY ADMINISTRATION IN THE SMALL HOSPITAL

Hospital patient care requires the combined efforts of many departments regardless of hospital size. The person with the authority to direct the dietary department has a key position in the hospital organization. To administer the department effectively she must possess managerial abilities of planning, organizing, staffing, directing, coordinating and controlling (11). Her efforts extend beyond her own department, for she must also coordinate dietary functions with other hospital activities in an harmonious manner.

Role of the Dietitian

The director of dietetics in larger hospitals administers and directs the food service program. She has a professional staff to whom she delegates part of the duties. The therapeutic dietitian(s) formulates menus for diets prescribed by physicians. Teaching dietitians instruct classes in dietetics, nutrition and institution management. The administrative staff plan menus, supervise food preparation and service, and maintain sanitary and safety standards. A responsibility of the director is to coordinate these dietary services with activities of other departments (21).

The dietitian working full-time in the small hospital has all the administrative, therapeutic and educative duties and coordinates all activities (21). Since she is on duty approximately forty hours each week, many tasks are delegated to competent employees. The early cook assumes responsibility for breakfast service and the late cook supervises supper meal service. The dietitian must educate all the

employees on the standards of meal service, sanitation and safety, in such a way that even during her absence there is continuity of performance within these standards.

Some management theorists believe morale is higher among employees where the working situation provides a degree of autonomy. The dietitian in the small hospital realizes she can not be present in the department fourteen hours a day, seven days a week. To avoid chaos, she must structure a coordinated semi-autonomous organization that is capable of continuing performance without her actual presence.

The first month of employment is a critical time for the new dietitian. She must learn the existing policies and customs for menus, special diets, food purchasing, meal service and cleaning. Once these policies are determined, she must decide what changes should be made to modernize or perfect them. She must detect the communication system among the dietary employees and throughout the hospital; she must become a functional part of the hospital communications. During the first month, she makes immediate changes, decides on future modifications and lists all equipment necessary for long-term operation. This is the time for evaluating her department, deciding where it should go and tentatively planning ways of obtaining these goals.

Her organization chart is the simplest type in existence. It consists of two levels: the dietitian on one and the employees on the other. The distance between the two levels is a very short line. The close working situation is a unified effort and the dietitian performs many line duties in emergencies. She may find herself scraping dishes and loading the dishwasher some days and willingly helping with the manual dishwashing during the days between the removal of the old dishwasher and the installation of the new one.

In the last decade the employment of dietitians on a part-time basis has increased. The designated title describes the nature of their

duties and responsibilities. The part-time dietitian may perform all the duties of the director or she may delegate many of them to an assistant or a head cook. The shared dietitian has the responsibility of more than one hospital food service in a particular area by actually directing the activities in each hospital. Although a consultant dietitian delegates the actual direction of the dietary department to the food service supervisor or head cook, she does the organizing and planning duties for the hospital. She has an important educative role in training personnel.

Environments of the Dietitian

The dietitian makes a series of decisions during the performance of the duties of her position. In decision making she believes her judgments are based on cognitive factors, but attitudes and beliefs in her own experience background and in the environment subconsciously affect her decisions.

The Dietary Department

The physical facilities of the dietary department in a small hospital may be described as a cross between a miniature adaptation of institutional size kitchen and an oversize home kitchen. Some of the equipment is appropriate for either kitchen. The efficiency of food preparation depends on the type of planning achieved when the kitchen was built and the improvements made since its establishment. Many kitchens have inconveniences which can be removed or lived with. Often employees have worked around them for years and unconsciously have accepted them as non-removable. They also have worked for long periods of time without some types of equipment and have developed an attitude that they can cook or wash dishes without adequate facilities.

Employees have other beliefs and attitudes that have persisted through many years. Because most operations must be performed consistently by all personnel, the tasks become routinized. The structured way of abiding by the established patterns of performing part of the work seems to be imperative. Strict adherence to definite times for meal service reinforces this attitude.

The various types of work in the dietary department require multi-skilled employees. The head cook needs to be able to plan the cooking, carve meats and serve the patients' plates. The dish-machine operator may also set up trays, and the special diet cook may serve as the dietary communication center to other parts of the hospital.

The dietitian finds few chefs or trained cooks obtainable in the rural community. The type of experience of the cooks prior to coming to the hospital is usually food preparation and service in local church or civic organizations. People seek employment in the hospital for two reasons, service to others and status in the community. In a rural area few opportunities are available for women workers, and the hospital represents a clean and honorable place to be employed.

The Small Hospital and the Community

The small hospital is a small society with reference groups, many leaders and a communication system without parallel. All the efforts of different groups are directed toward the common goal of the best service to the patients and community. The efforts are not always coordinated, but there exists a reasonable amount of cooperativeness. Like any work situation with various and varied functional departments, some departments have different perceptions of their value to the organization from the way other departments perceive them.

In the rural areas, the hospital is considered a cornerstone of the community (2). Health has become a valued possession for the people

and the hospital is the community health center. With the trend of physicians making fewer and fewer house calls, the people seek more medical assistance at the hospital. Recently the policy of maintaining a physician on call for emergencies and necessary professional attention at the hospital has been formulated to satisfy the need for medical care. Many types of hospitalization insurance programs have increased the utilization of the community hospital. Financial costs of specific diagnostic and therapeutic services are paid by insurance compensations if performed in the hospital.

People in the community have always had a civic pride and interest in the hospital. They respect the purpose of the hospital and its service to the community. As potential patients, they are concerned with the quality of the medical, nursing and dietary functions.

The dietitian in a smaller and more integrated community is aware of the circle of social influences around her, perhaps more so than dietitians in cities. The customs and attitudes developed in the smaller community social structure are more firmly embedded in the public mind through more frequent and continued interaction of its people. The hospital dietitian learns the customs and attitudes and performs her duties within their influence.

Training for the Position

Dietary departments in small hospitals are directed by persons with diverse backgrounds. Education and experience are the distinguishing characteristics between the qualified dietitian and the food service manager who may be employed as administrative head of a small hospital dietary department.

The Professional Dietitian

Since the early 1930's, the American College of Surgeons has stipulated for hospital accreditation that the head of the dietary department possess the education and experience background required for membership in The American Dietetic Association (18). These requirements are:

1. A bachelor's or advanced degree from an accredited college or university which has included or been followed by required courses and credit hours as outlined.
2. A record of satisfactory completion of an internship in a hospital, administrative or food clinic approved by the Executive Board, or as alternative, three years of acceptable experience in the field of dietetics. (If the applicant has an advanced degree in a field related to dietetics, the experience requirement is modified.) (17)

The academic requirements for membership in The American Dietetic Association for a hospital dietitian are basic courses of human physiology, bacteriology, chemistry, food selection and preparation, meal planning and service, and specialized courses in theories of food service management and therapeutic and administrative dietetics.

During the administrative phase of the approved dietetic internship, the intern applies these theories to the operational process of the hospital. She gains experience in menu planning, food purchasing, food costing, supervision, employee training, organization, equipment design and layout, and food distribution and service. While on therapeutic duty she applied the theories of normal and therapeutic nutrition to patient care. In every phase, the intern acquires new techniques for training and educating employees, patients and student nurses.

After their years of college and internship, members of the Association often remain in the cities where they have trained or transfer to larger hospitals. Although the costs of living are higher in urban

areas, dietary department salaries are proportionately higher. The dietitian who has always lived in a city usually prefers that environment when selecting a position; one who has grown up in a rural area is attracted by the urban surroundings and salaries. Hospitals in the urban areas usually are not as seriously affected by the shortage of dietitians as are the hospitals outside munipalities.

The qualified dietitian employed in the smaller hospital is usually married and resides with her family in the area. Many American Dietetic Association members return to professional employment after their children are high school or college age and are more self-sufficient.

The Food Service Supervisor

In communities where the services of a qualified dietitian are not obtainable, a food service supervisor or cook-manager is employed as the food service manager in the smaller hospitals. The title, food service supervisor, is frequently given non-professional persons in charge of the dietary department. If the person in charge is also responsible for food preparation, the title designation is cook-manager rather than food service supervisor (5).

In the last ten years, many state dietetic associations and educational institutions have organized special training courses and seminars for the continuing education of non-professionals presently employed as food service managers in small hospitals and institutions. The objectives of these training courses are to provide a standardized educational program for food service supervisors, which will qualify them to assume the supervisory responsibilities delegated to them by the dietitian or hospital administrator and prepare them to meet the performance level of today's concept of supervisory leadership (7). Four training courses offered in the United States in 1960 were: Jane Addams Vocational

School, Cleveland, Ohio; Pennsylvania State University Extension Service; Michigan State University Continuing Education Center; and the Irwin Vocational School in Pittsburgh, Pennsylvania. The American Dietetic Association in 1958 established a correspondence course supervised by area preceptors, which is available for training persons who prefer to remain in their present positions during the training period (22).

A group of trained food service supervisors organized the Hospital, Institution and Educational Food Service Society under the auspices of The American Dietetic Association in 1960. Membership in this H.I.E.F.S.S. association on July 1, 1964 was 537 (7).

The best qualified person available for food service manager in the small hospital is usually an untrained person. Occasionally an individual with a willingness to accept responsibility and learn new skills is hired for the position. These desirable traits are sometimes more qualifying than experience and education.

The first cook who develops into a cook-manager with a growing hospital learns many theories and practices through a rapid trial and error experience. She becomes adept at hiring and scheduling employees. The Golden Rule becomes her creed in handling her suborginates. She becomes a wise food and supply buyer, and she attempts to apply what diet therapy knowledge she can acquire to the special diets in her hospital. Every fragment of information from magazines, company flyers, and salesmen is stored, treasured and used when possible. Like a homemaker she tries new recipes and menu ideas. She transfers many practical homemaking ideas to the hospital situation. In many communities the qualifications and traits of the cook-manager meet the needs of the small hospital. Extensive theoretical knowledge is not a necessity for good job performance at this level of operation.

PURCHASING PRACTICES IN THE SMALL HOSPITAL

Food purchasing involves a two-way communicative process between the dietitian and the food suppliers in her environment. Marketing strategies of suppliers are affected by her food buying pattern, and she is affected by the tactics of the food companies. In studying how a dietitian makes her decisions about food purchasing, the reasons why she decides on a certain food or supplier are determined. These reasons provide a scope of the multitudinal influences or pressures felt not only in food purchasing but in the performance of other phases of her dietetic position.

Administrative activities in productive organizations include those related to the acquisition of raw materials for operative processes. In a dietary department the material resource is the summation of foods required for meal service. The food items required for the quantitative and qualitative needs of the institution are purchased from food merchandizers in the market area by a designated member of the staff. In large institutions, the purchasing process for all departments is centralized in one purchasing department. The person directing the dietary department of a small hospital is responsible for selecting and buying food, equipment and other supplies.

Between the time the need for a food item is felt and the time it is delivered to the institution, the food buyer makes a series of subjective and objective judgments. Involved in buying are item selection, quality and suitability determination, quantity calculation and choice of sources of supply (1). To make these decisions the food purchaser must possess knowledge about food varieties, the needs of her institution,

records of previous usage of the food item, the companies from whom she can secure the item, their policies and reliability. Her decisions are affected by the cultural setting in which they are made; in turn, the decisions affect the attitudes and ideas of her social surroundings.

The objective of the food buyer is to secure the most efficient and economical transaction for her institution. Kotschevar states that food purchasing decisions should be based on the rational economic and financial factors (12). This is logically possible when a product alone is bought. Few items, however, are selected on a price basis alone; a choice also includes the services accompanying the product. In deciding between two coffee suppliers, a food buyer compares prices, quality and services of the companies. A coffee distributor with salesmen who check the supply of coffee for outdated packages, service the mechanical performance of the coffee urn, and arrange for temporary replacement of the urn during a breakdown may be preferred to a company that only delivers the coffee supply, although the coffee price of the former may be higher. When services are added to merchandising the product, the buyer is faced with evaluating unequal alternatives.

In food buying, the dietitian is confronted by a complex situation. As she attempts to buy wisely and maintain low food costs she finds many factors affecting her buying decisions. Hospital size and geographical location from primary market areas limit her purchasing power and skill. Proximity to farming regions is not advantageous for securing lower priced foods. Products grown locally are transported to population centers and then redistributed to local secondary markets. These factors create an atmosphere in which the food buyer must use ingenuity to solve purchasing problems.

Food buyers are aware of another type of influence on their buying decision: the public interest or attitude that the buyer should

purchase all food items from local suppliers (3, 15, 16). A conflict in the mind of the buyer develops when she feels the social pressure to buy locally for loyalty reasons and the rational influence to purchase an item more economically from non-local purveyors. She must anticipate the resulting reactions whichever way she decides.

Purchasing was selected as a basic administrative procedure to study because the activities of buying involve the dietitian in internal thinking within the processes of external environments. The study of these activities in small hospitals should reveal a background profile of when, where and what is purchased and by whom. The reasons why specific items are preferred to others may provide insight concerning the internal and external factors which affect the thinking of the food buyer.

Investigation

This investigative study was developed to provide "accurate descriptions of the phenomena with which men work."[1] The research technique selected for the investigation of existing food purchasing practices was a survey by personal interviews with food buyers in selected small hospitals. Despite possible bias and non-skilled interviewing capabilities of the interviewer, the personal interview is the technique most suitable to an intensive research of actual conditions (10, 23). After the basic elements of research design were determined, chronological steps followed an accepted research pattern: the sample was selected, the interviewing instrument was developed and validated by pretesting, the investigation was executed and the data were summarized.

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[1]Deobold B. Van Dalen and William J. Meyer, Understanding Educational Research (New York: McGraw-Hill Book Company, Inc., 1962), p. 184.

Northwest Ohio was arbitrarily designated as the region for sample selection because of the concentrated number of hospitals within the range of the controlled variables and the fact that the investigator had previous experience as a food purchaser in this area.

The one pre-test hospital and five test hospitals were selected by two controlled variables, the number of patient beds and geographical location of the hospital. The hospitals range in size from 50 to 125 beds and are located in cities of 16,000 population or less. Each city is classified in the 1960 United States Bureau of Census as being outside an urbanized area and geographically beyond the distance encompassed by large municipalities (19). Specific information relevant to the pre-test and test hospitals follows: Pre-test hospital, 50 beds, 5,311 population; Hospital A, 50 beds, 7,361 population; Hospital B, 120 beds, 14,553 population; Hospital C, 75 beds, 2,204 population; Hospital D, 130 beds, 13,574 population; Hospital E, 75 beds, 11,323 population (8, 19).

The education and training background of the food purchasers was not disregarded as a variable in the selection of the hospitals. To secure a wider scope of the actual activities involved in food purchasing it was felt more extensive information could be obtained from a heterogeneous group with divergent backgrounds than from a group selected for similarity of experience and education.

The objective of the interviews was to secure the desired information about food purchasing and the food buyer; the reliability of the information depended upon the structure of the question. The original guide was a semi-structured questionnaire. Some structured questions were used as guides to gain desired specific information and to insure a degree of continuity to the interview. Unstructured questions were included to initiate new discussion areas and to encourage all the respondents to develop ideas.

The investigator designed the original interview guide from the formats of two previous surveys and constructed questions similar to those included in these surveys (3, 5). The original guide was pre-tested in a hospital selected by the same criteria as those of the proposed study. The interview was conducted a month prior to the beginning of the actual investigation.

Following the pre-test interview, the guide was modified to incorporate more relevant material (see Appendix). The revised guide provided for the collection of basic data on food purchasing, who does it, what is bought, when and how it is done. The supplemental information was related to the reasons why certain foods and purveyors were selected in preference to others. The answers to these "why" questions added depth to the interviews.

The investigator arranged for the interviews with the food purchasers by mail. The initial letter sent to the potential interviewees described the objectives of the study and stated the possibility of mutual interest in purchasing problems. A return addressed and stamped envelope was enclosed with each letter. A positive response was received from each interviewee. Interviews were conducted at the convenience of the interviewees in their offices or working areas.

Questions of the interview guide were pre-recorded on cards for reference during the interviews. Answers were recorded on the cards quickly and accurately. When an answer suggested a special interest, the investigator continued questioning on the subject to gain more information. Rapport was established easily by discussion of mutual interests and problems of small hospitals.

Although the structured interview guide was followed, many ideas were pursued during the interviews to clarify the understanding of the investigator. The interviewees responded with many of their own

perceptions of existing situations and all discussed other subjects of interest beyond food purchasing during the informal consersations.

Following the interviews, the recorded data was examined for similarities and differences among the group. The findings of the survey are presented below as a profile of food purchasing practices in small hospitals.

Profile of Purchasing

Factual information from the conversations with the dietitians and food service managers presents an overview of activities performed in procuring food for meal production in small hospitals. This profile is a verbal description of food purchasing, who does it, how, when and what food is bought. Specific information about the geographic and physical surroundings is included for definition and clarification of food purchasing environments.

Geographic Location

The cities situated in the agricultural region of northwest Ohio have numerous small industries and several large factory divisions of large corporations. Nationally known food corporations have production plants for canning and freezing foods grown locally. Tomatoes, other vegetables and milk are the main products processed.

Food services in the communities are restaurants, country clubs, schools, colleges and hospitals. The greater the number of food services, the wider the selection of foods and choice of suppliers.

Historically, the cities are one hundred to one hundred fifty years old. The industry and house building impetus after World War II has caused the communities to grow and spread out. Sociologically they are still classed as small, static, closely knit groups.

Large cities of 300,000 population or more are within fifty miles or one-hour car travel time. Large food market areas are located in these larger cities. Food purveyors are numerous, starting up overnight and undergoing many mergers with larger companies.

Small Hospital Organization

Small hospitals are privately or publicly owned and operated. The typical organization structure is the Board of Trustees at the highest level of command, and the hospital administrator next in line. The department heads are directly responsible to him and the line employees are in the next lower level of the hierarchy. The number of employees in a dietary department ranges between fifteen and twenty. Normally, no additional supervisory assistance is required or available, but during the absence of the manager a cook or responsible person is designated as the "person-in-charge." The organization structure and department head duties are determined by the abilities and capabilities of the persons making up the organizational group. Department heads may have both supervisory and managerial duties.

The authority and responsibility for all operational procedures are usually delegated to the manager by the administrator. In a simple organization it would seem logical to find the manager performing all the food buying procedures. Some hospitals, however, have purchasing agents.

Dietary Department

The physical layouts for the hospitals followed no specific pattern. Designed at the original building of the hospitals, the kitchens have not been enlarged when other facilities have been added.

Patients and employees were served by the dietary department. The patient food distribution was centralized-decentralized--carts with

hot and cold foods assembled on the floors. Cafeterias located near the main kitchens were available for employees and staff physicians. Meals were included as part of employee salaries. Guests of patients may secure guest trays in patient rooms since state laws require a special license when a food service charges for meals. The size of the cafeteria eliminated the serving of non-hospital clients, and thus precluded a public relations technique.

Employees were hired on full and part-time bases. Determining a schedule with a heavy employee load at meal times was difficult in all types of food services. Part-time employees solved some of the problems and created some of their own.

Food Purchasers

The groups of food buyers was heterogeneous: ages of the four women and one man ranged from twenty-five to fifty years; education varied from high school level to nursing school and completion of college dietetic programs. The previous experiences included dietetic internship, cooks and bakers school, restaurant and institution operation and nursing school food laboratories. The years of experience as food buyers ranged between four months and thirteen years.

These variations illustrate the diverse backgrounds of a group of food buyers. The heterogeneity dimension is multiplied by the differences in hospital organization, types of administration and personalities of people working in the organizations.

Markets

The food buyers purchased from local and non-local companies. It was not always possible and practical to buy all foods locally. The buyers had individual reasons for buying from suppliers in or out of

the community. Not all items were bought from wholesale firms. Retail type companies were able to sell to hospitals and other institutions at competitive prices. The number of firms in the market varied with the product and the size of the city. Where no local wholesale supplier for fresh produce was available, the buyers either purchased from local retail or non-local wholesale firms.

In smaller cities, it is not always possible to classify a firm as either wholesale or retail. Their markets for selling are in both categories. Customarily they give discounts for large volume purchases. In some localities approximately half the food bought for hospitals was obtained from retail firms and the other half from wholesalers. The buyers all purchased fresh fruits and vegetables from local truck farmers at seasonal times.

Food Buying Practices

Although the manager is responsible for a twenty-four hour operation, the average number of hours worked a day is eight. Special activities make it necessary for the manager to be at the hospital six days a week although he may be on a forty-hour week.

On days off, the food service managers delegated to designated employees the responsibility of calling in orders or talking with salesmen. The actual decision-making of what food to buy and from whom was retained by the food purchaser. Each had developed a series of buying habits. Specific food items were bought on the same day each week and usually from the same vendors. Through continued satisfaction with the products and services of reliable companies, the buyers chose the same vendors consistently.

The buyers were aware of the small amount of time they spend a day in food purchasing activities. The total time to determine needs

and talk with salesmen was about thirty to sixty minutes, depending on the day of the week. All believed better purchasing would be possible if other duties were less demanding.

The limited time also eliminated keeping accurate food cost records within the department. A centralized financial department in the hospital collects and authorizes payment of the bills. None of the buyers were on a strict budget limitation, but they tried to maintain a continuous control of spending by checking bills and weekly totals of costs.

Patient and employee cafeteria menus were written before ordering the food. Cycle menus were used by some. The master menu was modified for special diets, catered meals and employee menus. The pre-written menus are infallible as long as food items are available on the market. Menu changes are necessary when certain foods cannot be secured.

Certain types, varieties and forms of food were preferred by food buyers. Convenience foods such as cake, pudding and cookie mixes were widely used. Frozen vegetables were preferred but not always bought. The use of pre-cut or portioned meats, fish and poultry was a common practice. The buyers kept a supply of these items stored for occasions when it was necessary to adjust the menu or to satisfy patient desires.

The quality and suitability of a food item to the needs of the institution were determined within limitations and abilities of the physical storage facilities and employee skills. Specifications were used inconsistently and dictated by state laws: all hospitals required government inspected meats and specific grades when possible.

Inventory tasks of determining the quantity of food stored on the premises were usually delegated to the first cook, assistant to the dietitian or storeroom clerk.

Supplier Selection

Quotations from several vendors were not secured consistently. Satisfaction with the product and service becomes a determinant of companies considered in the buying decisions.

Canned fruits and vegetables were chosen by bid or brand names. The selection of fresh fruits and vegetables was based on market availability and quality. The objective of securing a variety of products was relinquished when items were not readily obtainable.

Dairy products were bought locally; each buyer had different reasons for buying from the suppliers. Some bought by bids, others divided their orders between two or more local dairies. This was also the prevalent pattern for obtaining bakery items.

Frozen fruits, vegetables, fish and poultry were secured consistently from the same companies weekly because of continued satisfaction in products. Fresh poultry was bought continually from the same firm.

The food buyers secured information about products and prices from salesmen. For some products bought locally, they found it more convenient to use the telephone as the means of communication. Many non-local suppliers communicated by mailed flyers which reminded the buyer of the arrival time of the salesmen and announced food items at reduced prices.

A common practice that has become part of the pattern of buying is allowing delivery men to determine the size of the order. Companies supplying this service when the food buyer permits are those selling coffee, bakery and dairy products. Early morning delivery necessitates this practice for bakery and dairy orders. As part of the coffee delivery service, salesmen replace or move older packages of coffee forward on the shelves and determine the quantity needed.

The number of deliveries received each week for food items was comparable: meat, one to four times; bread and dairy products, five to seven times; eggs, once or more often if needed; fresh produce, twice; poultry, fish, canned fruits and vegetables and other staple items, once. The frequency of placing orders was determined by the menu and inventory requirements.

The interaction of the food buyer and the market environment in food purchasing does not proceed without problems. In an analysis of problems of food purchasing it is difficult to differentiate between the cause and effects of problems. They often are part of a chain reaction beginning with the basic essentials of food buying: food items, the institution food service, the markets and the food buyer who coordinates these resources. In the process of combining these facets, the food buyer encounters difficulties. She often is required by abnormal conditions in the environment to make adjustments in the normal routine of food buying. The conditions are not limited to external ones. The causes of problems may lie in the activities or beliefs of the food buyer. The analysis of purchasing problems continues in the next section with an enumeration and discussion of the factors influencing food purchasing decisions.

THE DIETITIAN AND THE CIRCLE OF INFLUENCES

Exhibit 1 is an abstract model portraying the scope of influences that visibly and invisibly surround the dietitian as she performs the activities of purchasing food for institutional use (14). The model shows the resources she possesses for performing her duties. The resources are not latent objects which she can manipulate at will. They exert positive and negative pressures on her thinking. She knows she is able or unable to purchase a certain food item from a specific firm because influential conditions exist in her purchasing environment. They may sway her thinking on many decisions or they may restrict the number of possible alternatives for decision making.

The dietitian is the focal point of the circle. The surrounding factors possess centripetal force but she possesses a centrifugal force of equal or greater strength. The two forces are continually pulling in opposite directions. By use of her mental resources she is capable of maintaining command of the forces and creating an equilibrium between them. Certain criteria exist for obtaining this equilibrium. The dietitian must be aware of the problems, she must be able to analyze the situation to determine their causes and she must know ways of adjusting the factors to solve the problems. Most importantly she must take the necessary action for resolving them.

No instrument is available to measure how or if the influences shown in Exhibit 1 affect the practices of a food buyer. It is also impossible to rank the factors according to importance. The factors are so inter-related they can not be segmented and identified as the sole cause of problems. However, it is possible to study and discuss the nature of each factor separately.

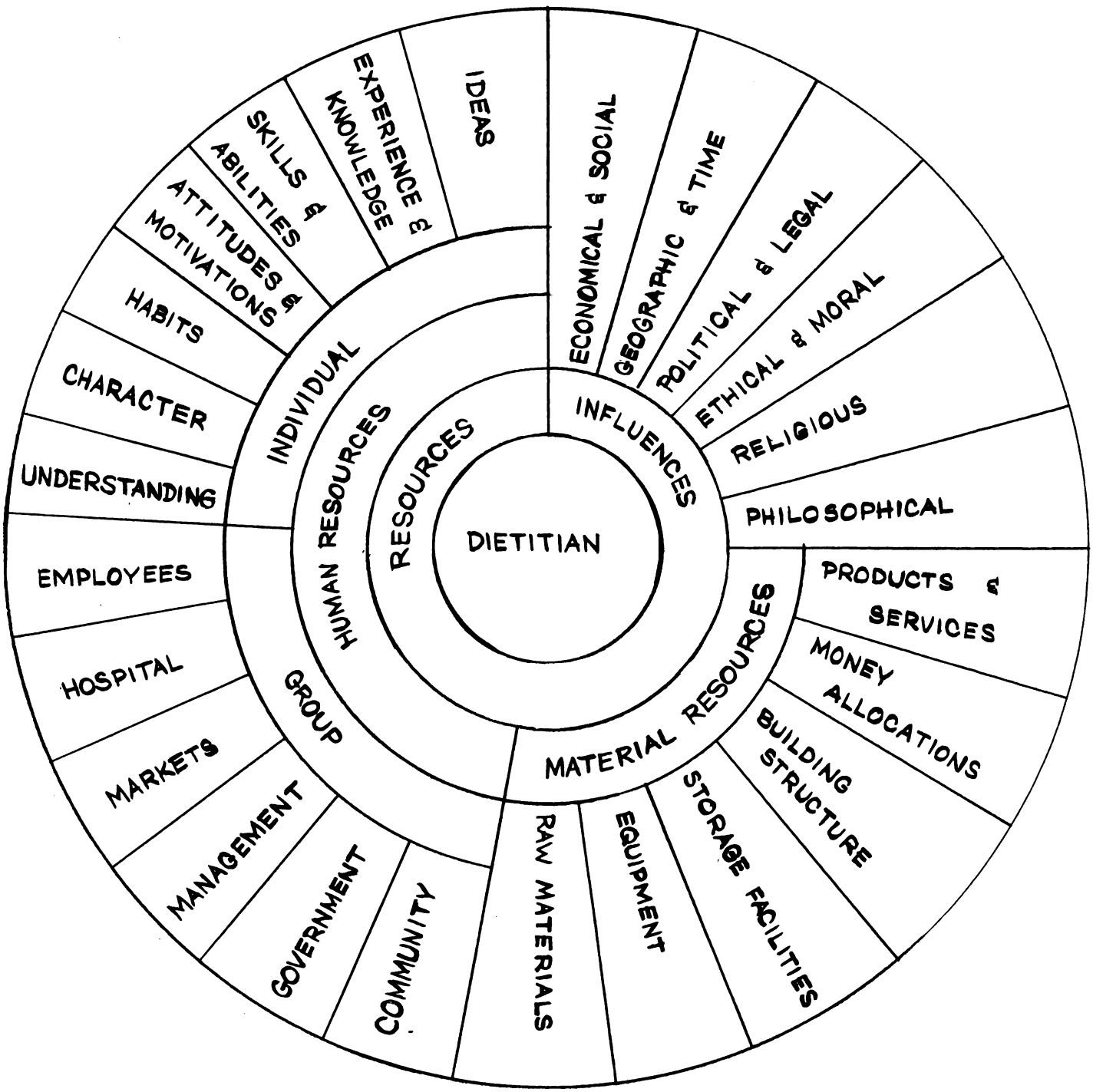

Exhibit 1. The Circle of Influences

This discussion includes a definition of each factor, its relation to the dietary department and its potential effect on the decisions of the dietitian. The starting point is the top of the circle and the discussion proceeds clockwise ending with the individual resources of the dietitian.

Influences

The word, influence, implies the power of persons or things to affect others either unconsciously or overtly. The result of an influential power may be a certain action, a change of behavior, or a definite decision. Not only do people or things but conditions of the psychological or sociological environment have power to exert an effect on a person. The circle of influences is composed of examples of concrete and abstract sources of power in the surroundings of the dietitian. The section of the circle defined as pure "Influence" is the most general and abstract; it affects the dietitian less consciously than concrete examples; the effects are as significant as more evident factors.

Economic and Social

Human beings live as members of society--at no time are they completely isolated. Society is stratified into different groups, each being distinguished by definite customs, beliefs, attitudes, values and levels of income. The social group of which a person is a member influences the behavior of the individual. He thinks like others of the group; he acts and reacts according to group expectations of him.

Wealth has meanings beyond the socio-economic concept. The idea that economy is the general state of the distribution of wealth is a truer definition. An economic state of abundancy affects individual thinking in a different manner than a depression time.

When the dietitian performs duties, she acts and thinks in accord with social group expectations. Her financial decisions reflect the economic state of her surroundings. In depression times, she attempts to keep her food costs at a minimum. In more prosperous times she is less cost-conscious and more client-conscious. She buys for cost in recessive times and for flavor and color qualities in prosperous times.

Geographic and Time

Geographic locations are the physical surroundings of a specific object. Of the numerous categories of geographic environments available, the one most relevant to this study is population density. Population in the United States is categorized into three areas: urban, suburban and rural. Urban areas are the densely populated cities with smaller communities called suburbs located within a thirty-mile radius of the city. Rural areas are those lying outside this distance. In contrast to more densely populated areas, rural regions have fewer people, less buying power, fewer wholesale markets, less food available. The amount of food available is also affected by the time of the year. Seasonal foods are abundant at the time of their maturity. The buyer consciously selects foods in season at the lowest price period.

In this age of modern transportation and agriculture, nearly all foods are available in all geographical locations. Food buyers in rural areas encounter a few difficulties because their buying environment is outside the concentrated market areas. However, within twenty-four hours or less they can secure any needed food from the larger market. Each year the geographical factor becomes less influential. Tomatoes are now available every day as a result of research in growing, packaging and transporting perishable commodities.

Political and Legal

Legal influences are the limits ascribed to activities by federal, state and local laws. The drafting of the bills to become laws may be influenced by political or party interest. Political, in another sense, infers loyalty gained through acts or gifts of favoritism. This definition cannot be ignored. The dietitian faces situations when her objectivity is tested. Favoritism should not be a deciding factor in food buying.

Laws to restrict activities and to insure uniform standards have given the dietition legal advantages. The Food and Drug Acts are legal measures to prevent the marketing of harmful and mislabeled products. Although not completely effective in the prevention of harmless but scientifically and economically unsound food products, the federal laws are influential.

The specifications available for buying food are based on government research. They have been developed to provide standards of quality and are tools for the dietitian to purchase food effectively.

Ethical and Moral

Every profession has a code of behavior which decrees the use of honesty and integrity in the performance of duties. Each dietitian has her own moral code within which she judges whether an act is right, wrong, fair or unfair. Her professional code of ethics is part of this moral code.

An unwritten code of ethics for food buyers states that all purchasing must be based on rational principles (12). Buying is not a separate entity from selling. Sellers price their products on competitive, psychological, economic and sociological reasons. The buyer can not be expected to buy on economic reasons when this situation exists. A more realistic code is based on the principle that the food buyer know all about products and buy objectively without bias and prejudice.

Religious

Beliefs and adherence to beliefs in a divine super-human power determine the conduct of people. Laws and customs of a religious faith may decree the clothing their followers should wear or the food they should eat. Some religious diets include no meats, another excludes milk products being eaten at meals when meat is served, and another restricts the eating of meat on certain days and during specified periods of time.

The dietitian is mindful of the different religious laws affecting food habits when she plans menus. Allowances for these religious beliefs are usually observed by food service people. Market orders include some form of fish to be delivered for serving persons of the Catholic faith on Fridays.

Philosophical

The Webster definition of philosophy is a particular system of principles determining the conduct of life. Education in schools and colleges exposes people to different philosophies of life. Through associations, teachers pass on basic life principles and attitudes to students which ultimately affect their adult behavior. Individuals are also influenced by parents, their church leaders, and adults in professions of their interest. By adulthood systems of principles emerge which govern their behavior.

In their colleges and internships, dietetic students assimilate patterns of working, supervising and organizing from professors and dietitians. While learning basic principles of food buying, they acquire skills in evaluating foods objectively and communicating with others.

Resources: Material Resources

Moving clockwise on the circle of Exhibit 1 the next segment is Material Resources. These are the raw products and physical equipment needed to produce a finished product. In a food service, material resources are cuts of meat, fresh produce, staple foods and all other types of food needed for preparation and service of food to clients. The finished product requires special equipment for storage, preparation, steaming, broiling, baking and serving before it is changed to the form ultimately served to users. Possession of material resources is only a basic criterion for food production. The raw goods must be appropriate for their intended use, and physical equipment and facilities must meet the needs of the institution.

The food buyer is affected by the existing material resources of her department. Of all her resources she is most conscious of these tangible factors. They may represent obstacles to her when she is deciding what type of food to purchase. Some equipment may be outdated or the need for which it was purchased may no longer exist. Availability of storage space for particular items is a determinant of the quantity that can be purchased. Another factor directly related to this is the judgment of the adequacy of the storage space by the dietitian. If she thinks it is small for her needs, it will be insufficient, and becomes the scapegoat for her problems. Conversely, if she believes it is adequate for the needs of the hospital, the storage problem will not be a forceful influence on her decisions. She resolves the problem by changing her attitude towards the situation.

Materials and equipment do cause problems for the food buyer which can not be solved by ignoring them. The buyer must know when and what action to take when a situation requires it.

Products and Services

Products are the end results of creative forces, and services are the helpful action accompanying the products, which enhance the products by presenting them in an attractive way. If the dietitian is concerned only with providing her clients with nutritionally adequate meals, she may serve simple meals. If she is more concerned that her clients will consume the meals, she will attempt to present the food attractively. She conscientiously visualizes and writes menus that are harmonious in color and appetizing in texture and flavor; she arranges the food for service in an attractive manner and she strives to serve foods at temperatures most appealing to the consumer. In selection of foods for service of attractive meals, the food purchaser buys the quality of food that is most appealing in appearance and flavor. She buys special items to use as colorful additives to the meals; e.g., pomegranates, mint, blueberries, endive and dash of paprika are simple garnishes added to enhance a food or a meal.

Before food is bought and prepared, the buyer must set goals for the type of food to be served. The desired quality of the finished product determines the foods to be purchased.

Money Allocations

The budget of a department is the financial resource available to secure the material items necessary for production. Budgets are estimates of the amount of money needed to buy the raw materials and to prepare and serve the meals. They function as a control for evaluating the ability of the buyer to select raw products within the budget limitations. This factor exerts great pressure upon food decisions by creating a conflict between two goals of the department. It is not always possible to serve economic and attractive food simultaneously.

One goal may be sacrificed in obtaining the other. Because the pressure to buy within a budget is always present in her thoughts, the food buyer continually seeks methods of reducing food costs and serving quality food at the same time.

Building Structure

The building structure is the physical shell of the production area of an institution. In hospitals, the dietary department includes the layout of all the receiving, production and serving areas. Relevant factors to the department are the amount of work and travel space, the location of the department in relation to other departments, and the general design of the kitchen equipment. An efficiently planned production area centrally located in the hospital presents few problems to the food buyer. Insufficient work space for preparation limits possible selection of varieties of food. To resolve problems created by inefficient floor plans the food buyer purchases foods which require little preparation before service to clients.

Storage Facilities

Storage facilities refer to the areas of an institution reserved for stocking supplies needed, for production or for storing finished products before their use. A dietary department requires three main types of storage areas: refrigerator, freezer, and dry storage. Foods must be stored immediately after delivery. After the change to their serving form they must again be stored until served. Storage facilities raise numerous problems. They limit the buying power of the purchaser and restrict the purchase of wide varieties of available items. More deliveries of smaller quantities are necessary. Companies may refuse to deliver small orders or charge for extra deliveries. Menu items may be limited to delivery days of the week because of small storage space.

Dietary departments planned before the increase in frozen food availability often have minimum freezer facilities. Although food buyers prefer frozen items, it may be necessary that they buy canned products.

Equipment

Equipment of an institution is the array of instruments, tools and mechanical devices needed for producing and serving the final product. In a dietary department, the mixers, cooking pots and pans, serving utensils, stoves, baking ovens, dishwashers and work tables comprise the equipment list. The food buyer selects foods which can be prepared with the equipment available. Presliced meats are a wise purchase when the department has no meat mechanical slicer. If a meat slicer is available they may be unwise financially. Small food services require some equipment a short period of time each day or week. It may be more economical to buy a more expensive convenience food than to acquire the equipment needed for its preparation. The food buyer must evaluate the alternatives for solving problems objectively before making her decisions.

Raw Materials

Raw products are those used to produce the end result. They are purchased in several states of preparedness. Foods bought may be secured in the original but unusable form or they may be bought ready for serving. The form best suited for use in the operation is determined, in part, by the prevailing conditions of the institution.

The food buyer must have knowledge of the various forms, grades, purposes and varieties of foods available for use as raw materials. This material resource is an independent variable for solving the problems created by the other factors.

Resources: Human Group Resources

Automation has eliminated the need for the human element in certain types of mechanical production. Some phases of food production and service have become automated by convenience foods and vending machines, but people are still essential for planning, organizing and coordinating the material, economic and human resources. As long as people require food in hospitals and other organizations, a need will exist for professional, semi-professional, and skilled workers in food services. Many positions in the food industry can not be classified as obsolete.

Human resources are persons to whom one can turn for aid in time of need. The dietitian needs sources of information, materials, and efforts from the groups of people around her. She should be resourceful in knowing how they are best able to help her.

A group is a number of persons gathered closely together and forming a recognizable unit. Banded together by a common goal or interest, the group is most effective when individual efforts are directed and coordinated toward obtaining the goal or pursuing the interest. A dietary department has objectives similar to other groups in the hospital and community: improvement of individual health and welfare of mankind. If the efforts of all groups are coordinated into a team, a more mutually satisfying relationship results.

Community

In the immediate civic surroundings of a hospital are various health organizations, commercial enterprises, religious, civic and service groups. They search for more ways of serving more people by offering their time and energies to philanthropic endeavors.

Humanitarian organizations with service objectives are perceived by the public with respect and admiration. Certain groups satisfy their own needs to help others by offering their services to hospitals and nursing homes in the community. Volunteer groups perform simple, non-skilled tasks or make supplies and special items for the patients. Few holidays are observed without a supply of hand-made favors for decorating patient trays contributed by Girl Scout or Boy Scout troops.

People in the community are authorities on specific subjects and interests. They are a source of information for answering problems or for teaching employees. The dietitian seeks the assistance of home economists employed by the local gas or electricity company for more informative materials concerning the selection and preparation of foods. These professional women are keenly interested in sharing knowledge about food.

The hospital patient, the major consumers of the products and services of the dietary department, are usually permanent residents of the community. All human efforts are directed toward accommodating and satisfying this group. The food buyer is aware of the local food customs and the individual patient desires and needs in planning menus and diets and ordering the food for their meals.

Government

The United States government maintains local agencies throughout the country for improving the general welfare of its people. The Public Health Departments of counties and cities are an example of a local government resource. These agencies provide gratis services to individuals and groups by teaching and talking with them about sanitation and preventive health measures. Their services also include inspection

of areas where food is stored and prepared in the community. All food merchandisers must meet standards of cleanliness and of food handling.

These standards are advantageous to the food buyer. She is assured the food has been stored correctly before its delivery to her institution. She should understand and utilize this source of authoritative information in the community to improve the environment of her operation through their knowledge.

Management

Persons with the responsibilities of administering an organization comprise the management resource. During the establishment period of an organization, policies are adopted which state its goals and the procedures for pursuing them. Policies are determinants of management decision-making and action-taking. Persons responsible for buying materials for the organization should clearly understand the policies related to procurement procedures.

Unwritten policies which exist in an organization also affect decision-making. Customs become firm parts of a cultural pattern by their continued use. The customs and policies make up the basic value system of the organization. Dietitians find different value systems in every hospital or institution where they are employed. They may be free to buy and serve any food without policy limitation but may be restricted by unwritten laws. If a food buyer decides to change the custom of serving chicken every Sunday, she must be prepared for the effects of the disruption in the normal pattern of hospital life.

Markets

Food marketing is the total process of transporting, preserving, packaging, selling and delivering food to the ultimate user. Institutional purchasers buy their food needs in many markets: local, non-local,

wholesale and retail. They are affected most by market availability and seasonal conditions.

To be effective in food buying, the purchaser must be familiar with the opportunities and limitations of the markets, the companies in the market, their policies, their goods and services, their product quality, their prices and their reliability. She should know from whom she is able to buy every food item. This basic knowledge is an essential part of the technique of purchasing.

Every merchandiser seeks every potential customer. In smaller communities, companies believe local buyers should be their customers through loyalty to local interests. The food buyer must anticipate and evaluate the circumstances of buying from companies outside her community.

Hospital

The hospital group is composed of many sub-groups with different functions. Interrelated by working toward the same objectives, every department needs the others in different ways and in varying degrees. The dietary department receives physician diet orders through the nursing department; special food requests from patients to nursing personnel are obtained from the dietary department.

A secondary function of the department is to provide meals for employees of the organization. Buyers attempt to satisfy all types of clients by choosing foods according to their likes. Local food patterns also influence the choice of food. Foods which are seldom served in local homes and restaurants are not likely to be appreciated in the hospital food service. Food prejudices are more common in smaller communities where people are more closely associated.

Employees

Employees are the greatest potential source for increasing the amount and quality of productivity. Theorists of management are now more concerned with psychological perceptions of work than with work methods. They believe the starting point for improving productivity is changing the negative attitudes about work that managers and employees have to positive ones. Managers possess valuable assets in the human employee resource. By training them and providing a favorable mental environment the manager increases their job satisfaction and their work output.

The food buyer may believe she is limited to buying food which can be prepared within the skills of the employees. By using training methods to improve their skills, she can help them develop their talents. Often when individuals are unaware of their skills, they will resist special training. They may believe their duties will be increased if they learn new operations. The dietitian may find it is necessary to include experiences in a training program which will encourage changes in employee attitudes.

Resources: Human Individual Resources

Influences are not all external. Of equal importance in individual thinking are internal mental factors. Decisions are the results of the past experiences, ideas, beliefs and perceptions of an individual at a certain moment of time.

Each person should continually seek to develop his own potential to a maximum. By being inquisitive, he spreads his interests in working and living to others around him. He creates an atmosphere for active rather than passive thinking. Others are motivated by his example.

Enthusiasm is a contagious quality. The dietitian who enlists employee assistance in her search for more knowledge kindles their enthusiasm. Like any tool, the mental tools she possesses must be active to be productive.

Understanding

Understanding is the state of comprehension of a situation, problem or subject by an individual. The greater his understanding of a situation, the more reliable are his judgments about it. The individual also has greater confidence that his judgments are correct ones when his understanding is more complete.

Essential criteria in food purchasing is the basic understanding of objectives to be accomplished and the methods of accomplishing them. The buyer must be able to interpret and apply purchasing principles and knowledge to the situation. Her purchasing practices often reflect her degree of comprehension of food buying.

Character

The character of an individual is his personality, but has connotations of role playing. Individuals often act as they believe persons with their personalities should act. They often imitate the actions of people with distinctive traits as a means of becoming more like them. If they perceive themselves as conservative, they will act in a conservative manner.

Persons buying food disclose their personalities in their practices. Buying conservatively, over-ordering for preparedness and buying every bargain are examples of actions associated with personality traits of an individual.

Habits

Habits are tendencies of people to perform certain activities in certain ways automatically. People develop habits of thinking to conserve time. Once acquired, the thinking habits of an individual are difficult to break.

As stated in a previous section, food buyers develop patterns of food buying. They buy the same foods consistently from the same companies rather than spend time comparing prices of several other firms. The buyer should recognize when the habits are no longer suitable to the requirements of the situation.

Attitudes and Motivations

An attitude is the manner of thinking that reflects an opinion or belief of the person. He thinks in a certain way because of his opinions and inner drives or motives. These motives are drives to satisfy a basic, social or ego need. They impel the person to act in a certain manner or to make decisions that will satisfy the need.

A food buyer may be influenced by a social need to act as other people do. People often buy a product because some acquaintance or rival has bought it. Special food items may be selected because another food service uses them.

The buyer may also set goals for himself which restrict his buying to essential items only. He will not buy non-essentials because of this inner drive.

Skills and Abilities

Individuals are born with innate talents and proficiencies for doing things with their hands, such as arts and crafts. They also have mental abilities to be developed.

The mental skill a food buyer should possess is the ability to evaluate objectively the needs of the institution, its food requirements, the products and services of the purveyors and the food procured.

Experience and Knowledge

Experience and knowledge are fundamentals upon which individuals learn more. Knowledge is an organized body of facts about life and experience is actually living through an event of life. Educational institutions prepare students for events of life by supplying them with the facts and the ways of applying the knowledge to life.

Principles of food purchasing are of little value to an individual unless he is able to use them effectively in life. The amount of knowledge and experience a food buyer has should influence his buying performance. Education alone does not insure a better ability to buy. People sometimes obtain more knowledge through actual experience than through formal education.

Ideas

Ideas are the mental images of a situation. Individuals have mental images of themselves, other people, problems and environmental conditions. If their mental images are near to reality, they will encounter fewer conflicts and misunderstandings between people. Individuals are more successful in solving problems if their perception of the problem is near reality.

Within the influences and resources discussed the dietitian develops her own ideas of food buying. Her responsibility is to make the wisest purchasing decision of which she is capable. Her perception of the total picture of the circle of influences around her determines the quality of the decision.

SUMMARY

In small cities in non-urbanized areas the dietitian performs administrative functions to meet the expectations of the social groups in her department, the hospital and the community. Because she is closely associated with all her immediate social environments, her decisions reflect the force of the influences around her. She is continually conscious of the problems created by physical facilities and employee abilities of her own department and the social custom of being loyal to local interests which is constantly present in her thinking. These local customs may be in conflict with the code of behavior and objective thinking developed in her previous education and experience. The dietitian is faced with the difficulty of solving problems by socially approved methods or by her own convictions. If she equips herself with sound rational bases for her decisions, she may act in accordance with her own ideas. However, she is more likely to act within the social expectations of her environment.

The conflict between the forces of self and society can be resolved by a compromise: changing her beliefs and behavior to meet social attitudes and altering social beliefs by her discerning actions. Over a period of time a change of attitudes occurs and an equilibrium of mutual acceptance develops. The dietitian adopts society limits but devises methods of performing her duties to her own standards. She becomes the charisma authority by her own wisdom and actions, and the factors and influences of the circle truly become her resources for performing administrative practices intelligently.

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APPENDIX

REVISED INTERVIEW GUIDE

I. The variables controlled by selection of the sample are size of city, size of hospital and geographic location of the city in relation to an urbanized area.

The 1960 census of the city:

The number of hospital beds:

The distance of the city from an urbanized area:

II. The food service manager may be responsible for food purchasing or, she may delegate all or part of the responsibility to another person in her department. It is necessary to determine the organization, authority and responsibility relationship within the food service in each hospital (5).

The position title of person in charge of the food service department:

The person to whom that person is responsible:

Daily purchasing responsibilities delegated and to whom:

Others in hospital organization responsible for food purchasing:

Person responsible for determining food and equipment specification:

Person responsible for final decisions regarding staples, meat, fish, poultry, fresh and frozen products, dairy and bakery products, expendable equipment, major equipment:

The number and specialized training of food service supervisors:

The duties of food services supervisors:

III. Problems are difficulties felt by a person or persons. Food purchasers in similar situations may encounter different problems from each other because various factors affect purchasing procedures. One of the most influential factors is the difference in educational and experience backgrounds of persons responsible for food purchasing (5).

Number of years experience of food purchaser in present situation:

Types of previous employment experiences:

Educational background of food buyer:

IV. Differences in variety and quantity of food purchased because of the type of meal service and menus used in the food service.

Type of meal service transportation to patients:

The method of serving and charging employees:

The method of serving and charging guests:

The number of patients on selective, non-selective and special diets:

Cycle menus, the frequency of use and the number of weeks per cycle:

The person responsible for menu writing:

V. The amount and type of storage space for food in each hospital may be a limiting factor on the purchasing power of the food buyer.

The type of refrigerator space for dairy products, meat items and fish, produce:

The type and adequacy of frozen food storage:

The type and adequacy of storage space for staple items:

VI. If the hospital has a policy concerning a dietary budget, the procedures of the food buyer may be different from less budget-conscious hospitals (3).

The type of budget limitation for the dietary department:

If no budget limitation is employed, what is the guide to spending?

VII. In the New York Extension Survey, Miss Colburn used two factors for the evaluation of purchasing procedures of the food purchasers: using specifications in purchasing food and obtaining prices from several good purveyors before placing an order. From the survey findings she concluded that insignificant differences in purchasing practices exist among food buyers due to variances in educational backgrounds (3).

Specifications used for which products:

The method of securing prices:

The number of vendors consulted regarding prices:

Although the information about size of hospital was determined by authoritative sources, other factors may be pertinent to food purchasing.

The number of employees served daily:

The number of patients served daily:

The number of guests served daily:

The average daily patient admission:

The deviations of number of patient admissions:

The frequency of large number of admissions:

The age of the hospital structure:

The number of hospital remodelings:

The number of kitchen remodelings:

VIII. The food purchaser has a choice of several variaties of a product, i.e., frozen, canned or fresh fruits and vegetables. She will select one variety in preference to the other varieties. The reasons for her selections may be related to problem areas in her department.

Convenience foods and prefabricated meats are widely used. Why?

Frozen foods are selected in preference to fresh items. Why?

Standing orders for bakery and dairy products are seldom changed. Why?

IX. If the food service manager does the food purchasing, her varied duties may curtail the amount of time available for food purchasing.

The amount of time spent each day for food purchasing:

The adequacy of that amount of time:

The amount of time spent with salesmen each day:

Other duties that take precedence over food purchasing:

X. Food vendors may not be available in the local markets of the smallest cities where these hospitals are located.

The number of local vendors available for meat, fish, poultry, dairy products, eggs, cheese, bakery products, frozen fruits and vegetables, fresh fruits and vegetables, canned fruits and vegetables: