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## Education Group Lecture

# Human nutrition in medical practice: the training of doctors

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Nutritional advice from doctors and other health workers is held in high regard by the general public. It is important, therefore, to ensure that the advice given is sound and safe. Historically, the training in nutrition for the health professions has been piecemeal and selective. As a first step in the development of national standards, a core curriculum on nutrition for health professionals was developed as part of the National Nutrition Task Force. Designed for undergraduates, the curriculum sought to provide a standard for training which would ensure safe practice. The curriculum, which has been accepted by all undergraduate medical schools, identifies eighteen bullet points covering: the principles of nutritional science; public health nutrition; clinical nutrition and nutritional support. Postgraduate training for doctors is the responsibility of the Royal Colleges, who have formed an Intercollegiate Group on nutrition. This group has developed an intercollegiate foundation course in nutrition which lasts for 1 week and is offered at different centres around the country. Using the Intercollegiate Course as a base, individual Colleges are exploring how they might best develop the next level of training by identifying the educational needs for nutrition in different sub-specialities. There is some discussion as to whether it is timely to develop a defined clinical speciality in human nutrition. Within these developments, nutritionists and dietitians are identified as a resource to be called upon by other health professionals, and therefore it is important that in their own training they are suitably equipped to take on this challenge.

### **Curriculum: Clinical speciality: Nutrition education: Undergraduate: Postgraduate**

#### **A basis of concern**

Doctors care for sick people, and from the earliest times the effective use of dietary interventions and nutritional advice have been an integral part of the art and science of effective clinical care. Indeed, many aspects of therapeutics can trace their roots to the ingenious use of medicinal plant derivatives. Thus, every branch of medicine has used nutrition, and over time has accessed nutritional information to some measure of benefit. The general public see doctors and other health professionals as the most reliable and trusted sources of information on diet and nutrition. Thus, it may appear surprising that traditionally very little attention has been given to the formal training provided to doctors in this area. Indeed, there has been a long-standing concern about the lack of an adequate level of knowledge of nutrition within the health professions. About 1980, the Black report

on inequalities in health identified that a large part of the burden of ill health in the UK could be linked either directly or indirectly to nutritional considerations (Townsend & Davison, 1992). A significant concern about the quality and standard of the training provided to undergraduate doctors justified more formal consideration in a report from a British Nutrition Foundation Task Force (British Nutrition Foundation, 1983). Most doctors being trained at that time readily acknowledged that they had little or no understanding and knowledge of nutrition, and few had received any training in the area. There was clearly a stark absence of any organised approach, and if any significant progress were to be made, training in nutrition would have to be identified as important and given some priority. A formal approach to the training of doctors would have to be developed.

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**Abbreviation:** SEG, Stratford Executive Group.

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### Combined activity across many fronts

Since that time a range of activities across a broad front have enabled progress, and the combined efforts of a number of groups have contributed to a changed climate. Perhaps of critical importance, a number of senior academic appointments, both clinical and scientific, have been made in human nutrition in undergraduate medical schools in the UK since 1985.

Increasingly, government departments have provided a stronger framework and the basic information which is absolutely necessary if there is to be a rational evidence-based approach to clinical care and public health. Notably, the Ministry of Agriculture, Fisheries and Food and the Department of Health with the Office of Population, Censuses and Surveys has supported a rolling programme of surveys on the dietary intake and nutritional status of nationally-representative groups within the population (Gregory *et al.* 1990, 1995, 2000; Finch *et al.* 1998). These surveys have provided information of a very high quality on the diet, nutritional and health status of the population. The 'grey book' series of scientific reviews produced by the Committee on Medical Aspects of Food and Nutritional Policy have provided considered and authoritative opinion on the available evidence linking diet and nutrition to health. Each of these activities has in turn identified a series of questions which need to be addressed, and thereby created a thought process within which priorities can be identified for the national research agenda. With time, as a firmer foundation of evidence has evolved, it has been possible to use this information as the basis of clear and unambiguous dietary advice for the general public. As an iterative process, the identification of gaps in knowledge and understanding has helped to structure the formulation of research policy of relevance to health care. The review of energy and nutrient requirements, reported as the dietary reference values (Department of Health, 1991), re-defined the conceptual framework within which nutrient requirements might be considered, and thereby the approach to be adopted in refining and consolidating the scientific base of nutrition. This process has clearly been of fundamental significance to the formulation of policy guidelines, and has also provided a critical link between public health nutrition and clinical care or dietetic practice.

During the same period, the Nutrition Society itself was embracing change in its own activities, which included the formation of special-interest groups. This change in structure enabled the integration into the mainstream of scientific nutrition of a group with a special interest in clinical nutrition and nutritional metabolism in serious illness (Clinical Metabolism and Nutrition Group). The consolidation of the Clinical Metabolism and Nutrition Group as an integral part of the Society has had far-reaching consequence for nutrition in medical practice. The Clinical Metabolism and Nutrition Group itself was instrumental in facilitating the development of the British Association of Parenteral and Enteral Nutrition. Following an independent appraisal of the special nutritional needs of patients in hospital by the King's Fund, the published report formally accepted the important part played by adequate nutrition as a fundamental aspect of all clinical care (Lennard-Jones,

1992). Further, it provided unequivocal support for the need for an adequate understanding of nutritional support to be an important feature of the clinical training of all doctors.

### Undergraduate training for doctors

Within this relatively sympathetic climate there were two further developments of major importance. First, the government adopted a strategic approach to the development of health care delivery; a policy which enjoyed cross-party support. *The Health of the Nation*, published as a white paper, identified specific health objectives to be achieved, and created a useful framework within which action might be developed (Department of Health, 1992). A Task Force on Nutrition was set up with a sense of considerable urgency to report on the actions and activities which would be needed to bring about measurable improvement (Nutrition Task Force, 1994a). The work of the Task Force was divided amongst four panels, one of which had special responsibility for looking at the training of health professionals in nutrition. About the same time the General Medical Council completed a review of the structure and content of the undergraduate medical curriculum: *Tomorrow's Doctors* (Education Committee of the General Medical Council, 1993). The necessity of developing a more integrated approach to training and education was at the heart of the changes recommended. The document identified the need for all doctors in training to be competent in core elements and able to deal with the fundamental elements of clinical practice, while special options could be offered to provide some flexibility. Further, explicit threads were to be identified which would enable students to develop vertical and horizontal integration of their understanding. A very clear statement was made about the importance of public health, i.e. the environmental and social factors which underlie much preventable disease. This review provided the opportunity for nutrition to be placed at the heart of the learning experience.

### What are we trying to achieve?

Within most populations across Europe, individuals obtain most of their information on nutrition from the media, but consider that their most trusted sources of advice are health professionals, most especially clinicians (de Almeida *et al.* 1997; Institute of European Food Studies, 1999). Thus, it has to be a matter of some concern how doctors are trained in nutrition. It would be nice to be assured that on graduation a clinician possesses a minimal level of understanding, which ensures that they are safe to practice and capable of providing advice which is sound. At the very least it would be prudent to ensure that they would not be obstructive in their advice, nor likely to give advice which was contrary to current dietary recommendations. We cannot at present be assured that this situation obtains. There are a number of reasons why in the past it has been difficult to make sustained headway in providing doctors with a sound training in nutrition, but one common difficulty has been that nutrition has been seen as being too broad and

diffuse. In situations where some training has been provided it has often been driven by the personal enthusiasm of an individual, with the danger that the exposure has often been unbalanced and inappropriately detailed. There does not seem to have been any serious concerted attempt to address the questions:

What is the minimum information and understanding required to make a doctor safe to practice?

What are the things that every doctor needs to know?

How best is that information and understanding communicated to doctors and medical students in a way which is manageable and accessible?

In part these problems represent a lack of clarity within the nutrition community itself. Thus, the obligation to find a way to communicate the discipline to those who wish to access it, without becoming experts, has been an important journey of reflection in its own right. For the clinician, the science of nutrition relates to an understanding of how much the body needs in terms of energy and nutrients, how that need is satisfied, how the need changes with age and different functional states, and what goes wrong in disease. One important consideration is that faulty diet might in itself cause or contribute to disease, but also disease processes lead to problems with nutrition. There is an important difference between those who use or access nutrition, and those for whom nutrition is a core skill. For most doctors and health professionals nutrition is not a core skill, but as the public credit doctors as the custodians of knowledge for understanding of all matters which relate to health, it is very important that their advice is based on a firm foundation of sound understanding.

Using this position as its point of departure the Nutrition Task Force (1994b) sought to develop a core curriculum. If this curriculum were to be useful and accepted it would have to bring together information and understanding which was diverse, and somehow fit this core curriculum into a curriculum which was already seen as crowded, without adding to either the amount or the complexity of the information which students were expected to acquire and assimilate. From the examples available at the time it was important to be clear that the objective was not to try to produce an expert in human nutrition; rather, a more relevant, and hopefully more achievable, objective was to determine the minimum required to make a doctor safe to practice, and how that might be communicated best. The core curriculum identifies specific learning outcomes (Table 1). Further, a relatively simple approach was adopted which identified that understanding was required in three broad areas: the principles of nutritional science; public health nutrition; clinical nutrition and nutritional support. In each of these areas six bullet points were identified, making a total of eighteen bullet points (Table 2). The same eighteen points were considered to be appropriate for all health professionals. How the points might be covered and the material delivered was left to each profession or school to determine for itself. Given the level of training being provided at that time, it seemed likely that simply reading through the eighteen bullet points would substantially increase exposure, and would thereby represent considerable progress on the current situation.

**Table 1.** Learning outcomes in the core curriculum for nutrition in the education of health professionals (Nutrition Task Force, 1994b)

1. Appreciate the importance and relevance of nutrition to the promotion of good health, the prevention and treatment of disease
2. Describe the basic scientific principles of human nutrition
3. Identify nutrition-related problems in individuals and in the community
4. Give consistent and sound dietary advice to people in an appropriate manner, and know when and how to refer to a State Registered Dietitian for more specific advice
5. Know and be able to promote and explain current dietary recommendations and the advantages of breast-feeding
6. Provide appropriate and safe clinical nutritional support, and know when and how to refer to a State Registered Dietitian or another specialist in clinical nutrition
7. Understand the relative costs and benefits of nutritional compared with other approaches to preventive and therapeutic care
8. Assess the validity of nutritional literature and nutritional reports in the media

**Table 2.** The eighteen bullet points: content of education and training (Nutrition Task Force, 1994a)

#### Principles of nutritional science

1. Diets, foods and nutrients (substrates and cofactors)
2. Metabolic demand, digestion and absorption, balance and turnover, physical activity, metabolic effects of excess, obesity
3. Requirements, essentiality, bioavailability, limiting nutrients, effects of nutritional status on biochemical and organ function
4. Adaptation to low nutrient intakes, body composition (form and function)
5. Assessment of diet and nutritional status
6. Physiological mechanisms that determine appetite, sociological, psychological, economic and behavioural aspects of food choice

#### Public health nutrition

1. The average British diet, including subgroup differences (e.g. region, gender, ethnic origin), lifestyle, risk factors and epidemiology (socio-economic factors, smoking and activity)
2. Pre-conception, pregnancy, breast-feeding, infant nutrition, growth and development, ageing
3. Dietary reference values, dietary recommendations and guidelines, diet and CHD and stroke, the health targets
4. Nutritional surveillance and identification of markers of nutritional status
5. Achieving change, education and motivation (education resources, theory and skills)
6. Food supply, monitoring, cost-benefit of nutritional interventions, legislation, food labelling and policy which affects food consumption

#### Clinical nutrition and nutritional support

1. Assessment of clinical and functional metabolic state, effect of functional state on nutritional intake and status, effect of status on clinical outcomes
2. Anorexia and starvation, response to injury, infection and stress
3. Altered nutritional requirements in relevant disease states, unusual requirements
4. General principles of nutritional support, routes of support
5. Basis of nutrition-related diseases, therapeutic diets (diabetic, renal), weight reduction
6. Drug-nutrient interactions

In that document it was stated explicitly that the sources of professional advice for training were dietitians and nutritionists (Nutrition Task Force, 1994b). Thus, it was presumed that dietitians and nutritionists were suitably skilled to provide the necessary support. This presumption clearly has important implications for training within nutrition. It seems a reasonable expectation that any individual claiming to be adequately trained in human nutrition has, as an absolute minimum, the knowledge and understanding expected of other health professionals.

By its nature nutrition is pervasive, and although as a scientific discipline it has identifiable roots in physiology and biochemistry, it also embraces the broader considerations of economics and social interactions which revolve around the primary drive to access sufficient food for individuals and populations. Reductive science has played a very important role in establishing the base of knowledge within nutritional science, but if the point of reference for nutrition is the whole organism there is a clear need for basic information to be integrated. Further, in addition to a reductive approach which provides understanding of how energy and nutrients are made available to each cell within a tissue, there is an outward-looking dimension which asks how an individual is able to access food from the environment in adequate amounts on a regular basis. This unique perspective, from which nutritional science can stand astride the biological and sociological sciences, has a core of knowledge and skills operating within a conceptual framework which is particular to the discipline. This is the range of understanding which might be expected by the health professions from exponents of nutritional science.

### Core curriculum for health professionals

The core curriculum for health professionals was launched by the Department of Health in 1993, and adopted by the Chief Medical Officer, Chief Nursing Officer, Chief Pharmacist and Chief Dentist. Thus, for the first time we had a clear statement of what health professionals should know and understand, and the special responsibilities of nutritionists and dietitians in ensuring the training opportunities and the quality of that training. However, having an authoritative document with which to work provides a useful starting point, but does not of itself solve the problem. The revision of the undergraduate curriculum, as outlined in *Tomorrow's Doctors* (Education Committee of the General Medical Council, 1993), was the single biggest revision of medical undergraduate training for over 100 years. A major aspect of the recommended changes was a substantial reduction in the number of contact hours which the students would experience and the amount of information they were expected to assimilate. In that climate, all disciplines were busily protecting their own specialist interest. However, as explicit mention was made of the need for more extensive education in public health and the environmental determinants of well-being, such as diet and lifestyle, there was the need to explore how human nutrition could be incorporated effectively into the undergraduate learning experience. However, it was far from clear how it would be possible to add nutrition at a time when the system appeared to be under so much strain. The best way to

deal with that problem was not immediately clear, but there was certainly the need for a group to accept responsibility for carrying the process forward.

The Nutrition Society, with others, contributed to the formation of an *ad hoc* group, the Stratford Executive Group (SEG), charged with the responsibility of ensuring that medical schools did not lose sight of the need to develop undergraduate training in human nutrition. Whereas the core curriculum provided a simple list of core cognitive concepts and information which health professionals need to possess and understand, the SEG had a rather different objective. Central to the concerns of SEG was that nutrition should not simply be an addition to the present concerns which the professions have for health; rather, there was the need to create a focus which would enable nutrition to be seen as, and come to be, an embedded aspect of all clinical practice (assessment, diagnosis and the structuring and implementation of clinical care). There was the need to develop within the clinician a new range of attitudes and values through which human nutrition would be seen as a central and fundamental aspect of the practice of health care.

The SEG worked towards having a workshop at which representatives from all medical schools could come together. One objective was to develop a network of interested individuals from the different medical schools who might work together. Thus, after reporting on progress which had been made in adopting the core curriculum within the new undergraduate structure, the workshop was used to identify problems, share experience, develop shared materials (such as a bank of clinical cases), identify examples of good practice and plan for the future. An invitation was sent to the Dean of each medical school in the UK with a request to send two representatives, one of which had responsibility for curriculum development within their school, and the other being an individual who functioned as a technical resource with some responsibility for ensuring the delivery of nutrition training. In recognition of the importance of the need to ensure that the educational approach being adopted was the most appropriate, experienced educationists were involved in the activities of SEG from the very beginning. This involvement of educationists proved to be of special value in the workshop, particularly in helping to take best advantage of interactions with those with direct responsibility for the development of the curriculum in individual medical schools, many of whom came from a professional background in education. Most medical schools participated, twenty-seven in all. The workshop was structured to comprise five working groups, and for each group an identified leader prepared a background document before the workshop for discussion at the workshop. The five groups covered: learning materials; curriculum structure; nutrition teaching skills and structures; assessment and examinations; the scope of the undergraduate exposure, postgraduate training and continuing education. The proceedings of the workshop were published as a document within the series on Health of the Nation (Stratford Executive Group, 1996), and a summarised version appeared in *Proceedings of the Nutrition Society* (Jackson, 1996). The workshop was very useful in bringing a sense of national cooperation, and defining the way forward. All participants agreed that there was a need to

keep progress under regular review, and the exchange of experience was of special value.

### Doctors in practice

One of the very big difficulties in moving forward with undergraduate training is that doctors still acquire their skills and abilities within a framework which is broadly based on an apprenticeship approach. Hence, they rapidly acquire the perceptions and approaches used by their senior colleagues. If those senior colleagues have little awareness of the critical issues in nutrition, and are not well skilled in providing the necessary ethos, then the theoretical lessons learned during earlier training are not put into practice, and rapidly disappear. Thus, to consolidate the learning experience it is necessary that more senior doctors be equipped and skilled in providing a suitable environment within which undergraduate training is, as a matter of course, reinforced and consolidated by desirable clinical practice and approaches to health promotion and public health awareness. In other words, there was the need to develop appropriate postgraduate training, a seemingly simple task which presents its own special problems.

The General Medical Council has statutory responsibilities and duties in relation to the undergraduate medical curriculum. At the postgraduate level formal statutory responsibility for training and accreditation falls within the gift of a number of Royal Colleges, each of which manages a different aspect of higher specialist training. Thus, it is within the powers of the Royal Colleges, individually and collectively, to recognise the need for professional competence in nutrition, and to see that an appropriate level of competence is assessed in a suitable way. However, the Colleges are characterised by diversity, and take pride in their individuality, and hence differences. Fortunately, the President of the Royal College of Pathologists saw that training in nutrition represented an important need, and invited the Presidents of other Colleges to send suitable representation to consider the possible ways in which progress might be secured. This action led to the formation of an Inter-Collegiate Group, and the formulation of a report to the Colleges on a possible way forward. As a consequence, the first step has been to plan, organise and deliver a 1-week common foundation course (Shenkin, 2000). This course identifies its point of departure as the first postgraduate exposure to formal nutrition training, and assumes an awareness of the undergraduate core curriculum (Nutrition Task Force, 1994*b*). It is a single course for all specialities, is evidence based, and seeks to characterise what is fundamental, and hence of general relevance and common to all doctors, regardless of speciality. Professional oversight of the course is through the Inter-Collegiate Group, but management and delivery of the course itself is the responsibility of a Management Group. Importantly, a key member of the Management Group is a senior educationalist with special experience in postgraduate medical education. This input has been critical in establishing and maintaining the quality, content and overall development of the course. The presence of a senior member of the Management Group with a sound understanding of the educational objectives has ensured that there has been an independent

formal assessment of the course, that the standard has been defined and maintained, and that objectives and outcomes have been clearly identified. Different approaches have been used to ensure the overall quality, but of very considerable value has been the thoughtful comments from the participants themselves. The establishment of this course represents a very important development, and its consolidation over the next years should make a considerable difference to the climate within which good nutrition is practised. To date the course has been run on six occasions, with over 100 participants. Many of the participants have been very senior clinicians with considerable responsibility for the education and training of doctors at all levels. Tasks for later stages will be to develop training experiences which are suitably tailored and of particular relevance for individual specialities and sub-specialities. The expectation is that with time the climate will be appropriate, and a demand will emerge, for structured training and career opportunities for a group of doctors who would wish to have nutrition as their primary speciality interest.

The foundation course of the Inter-Collegiate Group was developed by the group itself; the result of shared clinical experience in the management of patients with nutritionally-related problems in hospital and in the community. The experience was drawn from specialities as diverse as surgical intensive care, psychiatry and public health medicine. This distillation of experience has created, therefore, a new perspective on clinical nutrition. The unique attribute of this approach has been a focus on how to think about nutritional management, rather than detailed instruction on the care of individual patients with specific conditions. The course is designed to provide a perspective which underlies an effective philosophy of care of general applicability across the board. To date, the feedback which has been received from participants indicates that to a considerable extent this objective has been achieved. The first difficult part of the learning curve in course development seems to have been negotiated effectively, and we can look to the future with a degree of optimism.

### Inter-Collegiate nutrition: elements of the foundation course

The Inter-Collegiate course evolved in a unique way, and out of this experience a special approach has emerged. As this approach has found wide acceptance among the participants, it is likely to play an important part in the development of medical education in nutrition in the future. Perhaps of most importance in the overall structure of the course is the acknowledgement that from a nutritional perspective any individual may exist in one of three states: undernourished; adequately-nourished; overnourished. Each of these states is the consequence of the interaction amongst a range of factors, but by and large they can be grouped as falling within the broad domains of either the biological, psychological or sociological. For any individual, the opportunity exists for very complex interactions, but it is possible to explore the complexities in terms of underlying general principles.

The second important development was to appreciate that, although much of nutritional science has benefited in

its development from the strict application of the reductive approach, this approach may not always be helpful for many situations. Thus, although in classical nutrition the model of a single specific deficiency being associated with a clearly-defined clinical outcome has been of value, this situation is seldom seen in practice. Hence, the approach which leads to an attitude where a single causative diagnostic problem is sought, with a single corrective intervention, along the model of pharmacotherapy, is the exception rather than the rule. In reality, it is appreciated increasingly that health and disease are the outcome of much more complex interactions. It may be that over the next decades we will be better able to quantify more directly the relative contribution of genes, nutrient exposure and lifestyle to individual problems, in a model which fits more comfortably with current diagnostic approaches. Nevertheless, in the meantime, approaches to care have to be based on the application of underlying principles, rather than simple recipes. This approach requires some understanding of the features and consequences of more complex interactions between a range of exposures for those in different states. What has emerged in practice is a course which is run over 5 d. On the first day, principles of nutrition are covered, as well as appreciation of the nature of evidence in nutritional studies. On the second day, nutrition throughout the life cycle is covered, with a consideration of normal growth and development, pregnancy and the ageing process. The basic principles are introduced in the context of practical care to establish that the lessons from one discipline, e.g. paediatrics, carry a relevance to adult care, and lessons might be readily drawn which are of direct relevance to the care of older individuals. The third day deals with issues related to under-nutrition and approaches to clinical support. Surgeons with an interest in intensive care have more in common with psychiatrists dealing with severe anorexia nervosa than they might have first appreciated. The fourth day deals with over-nutrition, a vehicle for introducing issues of relevance to public health nutrition, and provides the opportunity to consider the prevention of chronic disease, such as heart disease and diabetes in the public health context. Wider social issues, such as ethical considerations, or the psychological aspects of nutrition are used at all stages as illustrative materials to reinforce the underlying principles. The fifth day is used to draw the main threads of the previous 4d together and to summarise the overall experience.

Originally there may have been the expectation that it would be possible to create a course based on a series of topics to be covered by individuals with a suitable background. In practice it is clear that the course has evolved in a particular way, and to ensure that the breadth of material is covered effectively within the time available requires extensive cross-referencing, and reinforcement of earlier exposure as newer ideas are developed throughout the course. One of the first ambitions, therefore, has been to establish a group of trainers, from the different Colleges, who are recognised by their respective College. This activity of explicitly training the trainers has been invaluable in clarifying and consolidating the core principles. The expectation is that any individual who teaches on the course will themselves have previously been a participant. A

general awareness has developed that this course is suitable for all doctors, and there would be considerable benefit if it were available to all, across the country. We shall see how close we are able to come to this laudable ambition with time.

### The next steps

Training is not cheap, and high-quality training carries a cost, in terms of time, effort and hard cash. We have been fortunate during the development phase to have had generous support from a range of sponsors, most notably the Rank Prize Funds. Once established the course will be self financing, and we have now reached the stage where we are reasonably confident of its success, and have started to think of the next stages. Importantly, individual Colleges are considering more carefully how best nutrition fits within their own individual speciality, and how much further they need to go than the foundation course. Participants themselves have identified a need for further formal training, that the exposure is of value, but there is the need for more if they are to become competent practitioners offering suitable advice and care.

In addition to the medical Colleges, the Inter-Collegiate Group has formal representation from dietetics, pharmacy and nursing. The course itself has been structured and designed for the needs of clinicians, but it is equally applicable to other health professions, and potentially provides a very valuable opportunity for multi-professional training.

It may be that we have now completed the first round of an iterative process, which involves the contribution which nutritionists might make to the processes through which doctors are trained at the undergraduate and postgraduate levels. Recently, the Nutrition Society used a questionnaire to canvass opinion from medical schools on where the emphasis for future activities might lie. It is clear that a lot of work remains to be done, and that considerable effort is still required if the gains to date are to be protected and developed. If nutritionists in general, and the Nutrition Society in particular, wish to participate in this ongoing process of reflection and development, there will be the need to create suitable structures through which formal interaction can take place. It is clear that progress to date has been dependent absolutely on collaborative action and the effective interaction between those bodies which in law carry major responsibility for the training of doctors and other health professionals. Perhaps the most important challenge for the future is for the Nutrition Society to clearly define their relationship with these bodies and processes, where their respective responsibilities lie, and how best they might be discharged.

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