expectations and the emphasis on thinness in women.[7] Regardless of the reasons, it is quite apparent that these symptoms are much more prevalent than originally suspected.

It would behoove medical professionals to screen carefully for bulimia nervosa in their young female patients. Once these individuals are identified, treatment should be attempted. Limited evidence suggests that bulimia nervosa patients may respond favorably to behavioral psychological approaches.[8] Although the successfully treated cases justify guarded optimism, further controlled research is needed prior to the complete advocacy of these or other treatment approaches.

In conclusion, bulimia nervosa appears to be a prevalent disorder, and further research is needed at the levels of assessment, diagnosis, and treatment. It is hoped that physicians will appreciate the implications of the present study, and that it will aid them in identifying and assisting patients with the symptoms of bulimia nervosa.

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The Clinical Dietitian in Family Practice Residency Programs

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There is increasing emphasis on nutrition education throughout medical education. The American Academy of Family Physicians recently added education in nutrition to its revised special requirements for family practice residency training, which were effective July 1, 1983.[1] How programs will meet this requirement has not been examined. Physicians with a strong background in nutrition may be suitable to teach nutrition, but their scarcity may have been a compelling force behind this new requirement. The clinical dietitian may appropriately assume this role; however, as yet the scope of the dietitian's involvement has not been established.

The purpose of this study was to define the current role of dietitians in family practice residencies. Specifically, their numbers, educational degrees, and functions were investigated to identify their participation in resident nutrition education.

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Methods

In November 1982 a written questionnaire was mailed to the 385 program directors listed in *The*

Table 1. Dietitian Functions in Family Practice Residency Programs

Function	Percentage
Counsels referred patients	94
Prepares patient education materials	81
Lectures on nutrition	77
Reviews resident charts	40
Participates on rounds	35
Evaluates residents	18

1982 Directory of Family Practice Residency Programs.[2] At three-week intervals the nonrespondents were sent duplicate surveys and then reminder postcards.

The questionnaires were coded to identify the classification of the administrative structure of the responding program as follows: (1) community hospital, unaffiliated, (2) community hospital, university affiliated, (3) community hospital, university administered, (4) university hospital, and (5) military hospital. Completed questionnaires were returned by 89 percent of the programs. When divided into the five different program structures, the proportions of the respondents were similar when analyzed by chi-square.

On the questionnaire those directors having a dietitian on staff were instructed to state the total number of dietitians, their educational degrees, and functions with the number of hours spent in each function. They were further questioned as to whether their program had written behavioral objectives in nutrition. These questions were analyzed for differences among the responding program structure categories using chi-square, with responses ranging from "not beneficial" to "very beneficial," determined by whether they felt the dietitian was a benefit to their program. Using the same scale, those directors without a dietitian were asked whether they felt a dietitian would be beneficial to their program. The answers to these last two questions were compared by program structure category using two-way analysis of variance and Duncan's multiple range test. Military programs were not included in this analysis because of the small sample size.

Results

Of the responding programs, 40 percent had a dietitian on staff, and 35 percent of these programs had instituted written behavioral objectives in nutrition, both consistent findings among the differing program structure categories. The highest academic degrees obtained by the dietitians or nutritionists were bachelor's, 52 percent; master's, 43 percent; and doctorate, 5 percent.

Dietitians were found to have a variety of functions in the residency setting (Table 1). Patient service accounted for the top two kinds of work performed, and duties related to resident education made up the remaining four. Counseling of

Table 2. Perceived Benefit of Dietitians to Family Practice Residencies by Program Directors With or Without Dietitians on Staff

Program Structure Category	Mean Perceived Benefit*		
	With Dietitian	Without Dietitian	Row Mean
Community	4.94	3.40	4.17
University affiliated	5.25	4.01	4.63
University administered	5.29	4.05	4.67
University	5.81	4.61	5.21**
Column mean	5.32***	4.02	

*Responses ranked on a scale from 1 to 7, where 1 = not beneficial, 7 = very beneficial
**Significant at .01 level, two-way ANOVA, Duncan's multiple range test
***Significant at .01 level, two-way ANOVA

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referred patients and preparing patient education materials ranked as the two most frequent patient services of dietitians. Of the direct resident education functions, the leading activity was lecturing, performed by 77 percent of dietitians. If 40 percent of programs have a dietitian and 77 percent of these lecture, then at least 31 percent of the responding programs utilize a dietitian for resident education. This calculation does not include possible lectures to residents by dietitians not on staff and other educational functions performed such as chart review, attending rounds, and evaluating residents.

Program directors expressed significant differences regarding their perceived benefit of a dietitian to their programs depending on whether they already had a dietitian (Table 2). Those program directors with dietitians perceived a greater benefit than those directors without. Furthermore, university program directors indicated a greater benefit regardless of their employment of a dietitian.

Comment

Dietitians are contributing to the nutrition education of family practice residents. Their predominant role, however, is still centered on patient service. Written nutritional behavioral objectives are used in teaching residents in only slightly more than one third of programs having dietitians on staff, suggesting that despite the participation of a dietitian, nutrition education may remain unorganized in many residencies.

The most interesting aspect of this study is the more positive feeling toward the benefit of a dietitian by directors who already have a dietitian on staff. This response suggests that programs may not have a dietitian for reasons that are not entirely financial or due to the lack of a suitable candidate, but in part attitudinal.

These study findings were generated prior to the initiation of the new special requirements. What impact these requirements or the continuing evolution of nutrition education will have remains to be seen.

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