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Challenges Perceived by Hospital Dietitians in the Czech Republic

Doctoral thesis

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Annotation

This doctoral thesis explores the challenges faced by hospital dietitians in the Czech Republic, focusing on professional identity, interprofessional collaboration, and systemic barriers to effective nutritional care. Using qualitative methods, the study identifies key themes and proposes recommendations for improving the integration and recognition of dietitians in hospital settings.

Abstract

Introduction

Hospital malnutrition affects up to 65% of patients and is associated with increased morbidity and mortality. Despite international consensus on the importance of interprofessional collaboration in nutritional care, its implementation remains inconsistent. In the Czech Republic, the profession of dietitian was officially recognized in 2004, yet anecdotal evidence suggests persistent challenges in hospital settings. This study aims to explore the challenges in delivering nutrition care perceived by Czech hospital dietitians.

Methods

A qualitative methodology was employed using applied thematic analysis. Fifteen dietitians from various hospital types and educational backgrounds were recruited through purposive sampling. Semi-structured interviews were conducted via ZOOM, transcribed, and analyzed inductively. Thematic coding was performed using Atlas.ti, and themes were refined through collaborative discussions among researchers and practitioners.

Results

Three major themes emerged: (1) unclear professional role and identity, (2) marginalization of nutrition care, and (3) tension between professional aspirations and legal boundaries. Participants reported limited recognition from other healthcare professionals, fragmented professional identity, and systemic barriers such as low staffing and restricted scope of practice.

Conclusion

This study provides the first in-depth exploration of hospital dietitians' experiences in the Czech Republic. Findings highlight the need for systemic steps, including improved interprofessional and nutrition education, clearer professional standards, and enhanced organizational support. Addressing these issues may strengthen the role of dietitians in healthcare teams and improve patient outcomes through better nutritional care.

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Glossary

AHPs	–	allied health professionals
AND	–	Academy of Nutrition and Dietetics
BDA	–	British Dietetic Association
ČANT	–	Česká asociace nutričních terapeutů; Czech Association of Dietitians
ČAS	–	Česká asociace sester; Czech Association of Nurses
DN	–	dietary nurse
EFAD	–	European Federation of the Associations of Dietitians
ENHA	–	European Nutrition for Health Alliance
ESPEN	–	European Society for Clinical Nutrition and Metabolism
HCPs	–	healthcare professionals
HCPC	–	Health and Care Professions Council
IPC	–	interprofessional collaboration
IPE	–	interprofessional education
NCONZO	–	Národní centrum ošetřovatelství a nelékařských zdravotnických oborů; National Centre for Nursing and Allied Health Professions
SNT ČAS	–	Sekce nutričních terapeutů České asociace sester; Section of Dietitians of the Czech Association of Nurses
SVNP	–	Sekce výživy a nutriční péče; Section of Nutrition and Nutrition Care

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1 Introduction

Hospital malnutrition is one of the key factors influencing patient prognosis, affecting up to 65% of hospitalized individuals[1]. If left untreated, it can lead to impaired wound healing, increased risk of infections and complications, and overall higher morbidity and mortality rates[2]. In recent years, the European Society for Clinical Nutrition and Metabolism (ESPEN) issued the Vienna declaration[3], where they emphasize that high-quality, evidence-based, and therefore interprofessional nutritional care is a fundamental human right. This was followed by the Budapest Resolution[4] issued by the European Federation of the Associations of Dietitians (EFAD), which explicitly states that dietitians are essential members of such interprofessional teams.

Despite this international consensus, research shows that interprofessional collaboration in nutritional care faces numerous barriers at various levels[5–7]. Although multidisciplinary teams are considered indispensable for the treatment of malnutrition and nutrition-related diseases, their implementation remains inconsistent. Nutritional care and nutrition itself are often marginalized, which may ultimately result in poorer treatment outcomes for affected patients[8].

In the Czech Republic, the profession of the dietitian ('nutriční terapeut'; 'nutritional therapist' in verbatim) was officially recognized only in 2004. Although it is gradually being incorporated into national clinical guidelines issued by professional societies and the Ministry of Health, anecdotal evidence suggests that the organization of nutritional care remains problematic from the perspective of interprofessional collaboration. Indirect data indicate a similar pattern: some hospitals do not employ dietitians at all, or their contracts are so limited that they cannot fully engage in clinical work, let alone participate in interprofessional teams[9].

The aim of this study is to explore the challenges faced by Czech dietitians working in hospital settings. As no prior research has been conducted in this area in the Czech Republic, this exploratory study represents the first of its kind. Its findings will serve as a starting point for future research, including longitudinal and implementation studies aimed at improving the state of nutritional care in Czech hospitals.

2 Development of dietetics in the Czech Republic

This chapter is based on the following paper of the author of the thesis and expands parts of its text:

> *Krobot M, Hawk VH, Spáčilová V, Kapounová Z. A historical perspective and opportunities for dietetics education, practice and professional organizations in the Czech Republic. Profese online. 2021:14(1);9-18. doi:10.5507/pol.2021.001*

Although dietetics as a science is relatively young, efforts to modify diets according to a person's state of health can be traced back in history. In terms of the Czech spa tradition, the first records of what we might call dietetics date back to 1522. That year, the writings of the Czech physician Wenceslas Payer of Loket were published, in which he describes the care of visitors to the spa of Karlovy Vary and, among other things, the regulations for their lifestyle and nutrition.[10]

Regarding dietetics in terms of disease, however, we find the origins of dietary meals for the sick in the early modern history in monastic hospitals, where they noticed that patients with fever or anorexia thrived better on a lighter diet, which differed from the food intended for others. Further records come from the general hospital in Vienna, where as early as 1784 they served a 'strict' diet, which included only soups, albeit of various kinds, four times a day. The beginnings of a system of standardized diets are in the hospitals of Paris in 1867, where diets were introduced in a similar pattern to those we know today, e.g. standard, for recovery, dyspeptic, diabetic, etc. At the same time, along with the demands of the wealthier classes entering the hospitals, an individual choice of food is being introduced, depending on the overall health status of the patient.[11]

However, the first Czech publication dealing specifically with dietetics was not published until Otakar Kose's Handbook of Dietetics in 1928, which summarised the basic principles of dietetics. It is of particular interest to the history of dietitians because of its conclusion, in which Kose calls for dietary kitchens in hospitals, dietary restaurants, and *"intelligent nurses who know dietary cooking, as they already have abroad."*[12]

2.1 First half of 20th century: Origins of dietetic care

The first person to realize the importance and need for specialized dietetic workers was prof. Bohumil Prusík, who established the **Higher School for the Education of Dietary Workers** by the Internal Medicine Department IV of today's General University Hospital. The students were educated in Czech language, basic mathematics, and

medical and practical courses, where the diet order was given by the doctor, the particular changes were implemented by the teacher and the students carried out the orders. In 1936, an outpatient dietetic clinic was founded by the school for patients in a need of dietetic treatment. In 1937, the school was reformed into **Higher School of Practical Dietetics** with two-year curriculum, finished with graduation. Admission criteria were demanding for the time – 4 years of secondary education, 2 years of female vocational school, 1 year of college and experience in cooking.[13]

Although first graduates were admitted to hospitals in Bulovka or Krč in Prague, the profession of dietary worker was not well understood and only a mere third of graduates ended up employed in healthcare. Having a dietary worker in the hospital wasn't customary and they were often mistreated by other healthcare professionals who didn't understand their job and role, as witnessed by Gjuričová in her article describing feeling rather as a dietary cook.[13,14] However, as early as 1947, Klein emphasized in his book **Institutional catering of patients and fundamentals of Czechoslovak dietetics**[11] that maximum potential of dietetics could be reached via individualization, which could be achieved only with the help of dietary assistants, who could ensure that the food would be *"medicine, joy and pleasure"*. He also criticised downplaying of dietetics by healthcare professionals and stated the need of their education similar to other countries, where doctors are educated in nutrition and they understand the role of dietary assistants. He also compares the level of education of dietary workers from abroad, frequently already with university degrees, with Czechoslovak workers who are, according to him, treated as *"servants"*.

Contemporary literature[11,14] summarizes the tasks of dietary workers as follows:

- **in the kitchen**
  - work organization
  - creating menus
  - supervision of cooks, staff instructing
  - supervision of the food quality, food stocks, distribution of food
  - purchase of the right and suitable types of food with the cooperation of technical management
- **at the ward**
  - guiding patients in food choice limited by the doctor's order, respecting patients' wishes
  - keeping food records of the patients
  - coordination of doctors, cooks and management – pointing at the early conception of multidisciplinary care

The recommended number of dietary workers was 1 person per 100-150 beds, claiming benefits for the healthcare facilities despite the costs. They should be working independently but were not allowed to decide for any treatment aspects, since this was

considered to be the responsibility of the doctor by all the involved professionals, including dietary workers themselves.

Klein also criticised the system of standardized diets, calling them monotonous, ignoring the individuality of a patient and admitting their use only in case of staff shortage. He also complained about the lack of educated staff, leading to bad reputation of hospital meals, patients gathering supplies from home, and food waste. He proposed educating dietary assistants during 2 years of school, equipping them with knowledge about culinary techniques, and educating doctors and nurses in the new system of food provision and the role of dietary assistants. However, Gjuričová points out that kitchen staff consider dietary workers a threat and tries to get rid of them. She also finds individualized diets too costly for the hospital and rather academic than practical.[11,14]

2.2 Second half of 20th century: Institutionalization of dietetics

During the post-war period in 1948 the Ministry of Education standardized the curriculum of the schools that provided education for healthcare professions to four years.[15] All students received the same education during the first two years and discipline specific courses for years three and four.[16] Students were admitted starting at the age of 15 and the program emphasized strict hygiene along with the respectful and ethical treatment of patients.[13] The second school for practical dietetics was established in Brno[17], and by 1949, there were ten schools educating dietary workers in the whole Czechoslovakia. The Ministry of Health also guided the hospitals to employ dietary workers by an order from 1948.[13]

The 1950's brought significant changes for health professionals through new legislation that designated responsibility for their education to the Ministry of Health. More specifically, the graduates of these specialized colleges were recognized as mid-level healthcare professionals and dietary workers were given the title of dietary nurse (DN).[16,18] The association of dietetics with nursing was important not only because the nurses were identified as healthcare professionals, but they also had new educational standards and practice guidelines. These included an education program that followed a standardized curriculum, the requirement to pass a standardized examination at graduation, and job responsibilities based on a specific scope of practice.[18,19]

2.2.1 1950's to 1960's: Era of Přemysl Doberský

The first known opportunity to discuss and collaborate among DNs was the congress of dietetic staff organized by the Society for Rational Nutrition (nowadays Society for Nutrition) in 1951, which was then organized every year. Just in 1952, Dr Přemysl Doberský started voicing concerns about the medical nutrition therapy in Czechoslovakia[13], followed by Mašek's Brief Dietetics[20] in 1953, where he criticized large numbers of standardized diets and proposed an individualized system led by a professional

DN, who creates individual menus adequate to the restrictions ordered by the physician. This system was inspired by the system operating in the Soviet Union, however, Mašek admits that it needs lots of well-trained professionals. Larsenová extends this also to the management, who needs to be educated in order to support dietetics.[21] Finally, in 1953, a completely new diet system was demanded by the healthcare professionals.[13] Thus, by 1956, the New diet system[22] for hospitals by Přemysl Doberský had been introduced into Czechoslovak healthcare.[21]

In 1960, the Czechoslovak Ministry of Health issued a resolution claiming that dietetics are an inseparable part of healthcare.[23] In the same year, the Centre for Further Education of Mid-level Healthcare Professionals is established in Brno (later National Centre for Nursing and Allied Health Professions; Národní centrum ošetřovatelství a nelékařských zdravotnických oborů; NCONZO) with the focus on specialization courses for allied health professionals. In this context, Přemysl Doberský delivers a paper called "Perspective long-term development plan of dietetics in CSSR" at the national conference of dietetic staff. According to the discussion records in the abstract book[23], Doberský criticized several issues causing troubles in delivering proper nutrition care:

- food adjusted to dietary restrictions is prepared by people who don't understand them and lack adequate education
- cooks have low salaries and are leaving hospital kitchens, there is no system of their life-long learning, and the numbers of cooking graduates are concerning
- nurses should be knowledgeable about dietetics from the secondary school, but they often undervalue it
- physicians are introduced to dietetics only in voluntary activities
- there are no professional study texts for dietary nursing

According to Doberský, the qualitative change of dietetics cannot be driven only by raising the food budget and the number of DNs. He described the ideal system as follows: DNs are present in three different position – chief, charge and regular (clinical). Nutrition care is overseen by a dietologist (physician), to whom all the DNs are subordinate, who can be also in two different positions – regional and institutional. DNs create the menus (approved by the dietologist, including any changes), they inform the physician about the status of the patients, their comments, and the conditions of food preparation. In diabetology and gastroenterology outpatient clinics, they are creating menus for individual patients under the supervision of the physician. Finally, together with the dietologist, DNs participate in planning the staffing capacities and education of other healthcare professionals. The future was seen in merging technical and nursing competencies, allowing the DNs to work independently, attend rounds etc., however, this required a change in education concept.[23]

That should have been achieved by a new curriculum for DNs introduced in 1959, shifting the focus to medical courses. Since their range could not cover everything

needed, practical placements were emphasized; however, due to the lack of staff, frequently students were missing professional supervision.[23] In 1962, even the first university programme for DNs was proposed by Charles University. Unfortunately, it wasn't until 2008 when the first Bachelor level programme of Dietetics started at the 1st Faculty of Medicine, Charles University.[24]

In 1965, Doberský published a book Study of Nutrition and Dietetics[25], where he described the desired structure of dietary nursing. DNs should work as a connecting point between the food service, the physician, and the patient. The DN should be coming to rounds since she needs to know patient, the course of his diagnosis and the opinion of the physician. To be able to cover for all these duties, Doberský proposes minimum of 1 DN per 200–300 patients with internal and surgical departments having their own DN due to the complexity of care.[25]

2.2.2 1970's to 2004: Bittersweet symphony

Since 1970's, the development of dietetics rather slowed down, as evidenced also by scarce literature from this period. According to Starnovská, after the Research Institute for People's Nutrition, the workplace of Doberský, was merged with other institutes into the Institute of Clinical and Experimental Medicine (Institut klinické a experimentlní medicíny; IKEM), dietetics lost its support and DNs gradually fell to the food service level, losing their earned prestige and employment opportunities.[26] The only systemic change which happened during this period was the establishment of two specializations fields for DNs taught by NCONZO – Population Health Education in 1971[27], followed by Nutrition and Metabolic Disorders in 1981[28], both of which were valid until 2004.

However, there are still some references to dietetics in thematic journals, especially from 1980's. Wolfová[29] in 1982 describes the role of DN in social services, including organizational, hierarchical and remit issues, mentioning a week-long course focused on dietetics in social services organized by NCONCZO. In 1986, Hlaváčková[30] described the work of DN in an outpatient clinic, which was very close to the current remit of a dietitian – educating about diets, following new food and trends, staying updated with new guidelines, preparing education leaflets or writing medical reports. She was also calling for a specialized course for outpatient dietitians. Finally, Hainer[31] was describing DN as a member of interprofessional team in his article from 1988.

After the Velvet revolution, the healthcare education system underwent a reform introducing healthcare higher vocational schools (HVS) into the system. During 1990's, new HVSs started educating allied health professionals in various fields in three-year study programmes following secondary school, including dietary nursing.[16] Also, in 1990, the Czech Association of Nurses (Česká asociace sester; ČAS) was established, with the Section of Dietary Nurses founded in 1992 as the first professional

representation of dietary nurses in Czecho-Slovak Federative Republic (later known as Section of Dietitians, see chapter 3.5)[32].

In 2000, Pavlíčková[33] and Starnovská[34] were describing the contemporary situation of DNs in clinical and outpatient care. Both write about DNs being laid off – after the stabilization of post-revolution situation, the conditions were not in favour of DNs. Hospital management had limited awareness about what DNs were supposed to be doing, in food service they were being used for jobs not requiring any qualification, and private catering companies were taking over hospital kitchens, dismissing DNs; in outpatient clinics, the main focus was on profit, DNs were forced to earn enough money to cover their salaries, which together with wrong valuation of clinical procedures by the insurance companies led to progressive disappearance of DNs. In spite of this situation, Pavlíčková still describes DNs as essential healthcare professionals, who should be present on internal wards, surgery, nephrology, oncology, geriatric and pediatric ward, gynaecology, haematology, and burn ward. According to her, DN should be educating both inpatients and outpatients, work with the public, assist in transferring the patient from parenteral nutrition to enteral or food etc., claiming that the raising responsibilities should be outweighed by extended professional remit.

"Fresh air" was introduced to this situation by Kužela[35], who issued new Guidelines for the Admission of Nutritional Support and for the Nutrition in Hospitals. These guidelines moved the notion of DNs as the members of interprofessional team much further, claiming that:

- medical nutrition therapy should be provided by the Department of Medical Nutrition Therapy and Food Service (DMNT), enteral and parenteral nutrition should be consulted with DMNT
- DMNT is led by a chief DN, is subordinate to the head nurse, cooperates with the head of food service
- DNs are essential partners of the physician, ensuring the optimal individualized diet for all
- physicians consult optimal diet composition or indication of tube feeding with DN
- dietologist checks the quality of food service and educates other healthcare professionals together with DN
- staffing of DNs should reach:
  - 1 DN per 50 to 100 beds, but not less than 3 DNs per facility
  - 1 DN per 100 beds in basic care
  - 1 DN per 75 beds in specialized care
  - 1 DN per 50 beds in highly specialized care
- DNs are an essential part of outpatient care

However, even Kužela admits at the end of the guideline, that staffing of DNs in Czech Republic is alarming, comparing several countries, mostly with the ratio of 100

patients per DN, to Czech Republic with 1718 patients per DN, when accounted for the job description.

2.3 21st century: Recognition of dietitians

In 2004, a major transformation occurred in the organization of allied health professions in the Czech Republic. Act No. 96/2004 Coll., on Allied Health Professions, came into effect, introducing a new system and classification for all healthcare professions except physicians, dentists, and pharmacists[36]. This legislation marked a turning point for dietetics, aiming to elevate Czech nutritional care to a competitive European level, meet international standards, and improve the quality of care[37].

In response to changing needs in nutritional care, the profession of diet nurse was abolished and replaced by two new professions: dietitian and dietetic assistant. These roles were differentiated by education level, assigned competencies, and the ability to work independently, since dietetic assistants are required to work under the supervision of a dietitian. The law also introduced, for the first time, the possibility of obtaining dietitian qualification through a bachelor's degree program at a university, a goal pursued by experts since 1992[24], with first Bachelor programme opening at Charles University, First Faculty of Medicine in 2007[38], followed by Masaryk University, Faculty of Medicine in 2008[39].

At the same time, the option to qualify through secondary education was removed, remaining only for dietetic assistants. However, in accordance with §15 of the law, individuals who began their studies in the field of diet nurse at secondary or higher vocational schools no later than the 2004/2005 academic year were also granted dietitian qualification[36].

The competencies of dietitians and dietetic assistants moved significantly toward clinical care, aligning with international practice. The newly introduced Decree No. 424/2004 Coll., on Activities of Allied Health Professionals, defined the scope of practice for these professions in a way that remains nearly identical today. Dietitians were authorized to take nutritional histories, educate patients, recommend diet order changes, develop individualized nutrition plans, and recommend more complex nutritional support[40]. New specialization fields were also introduced, reflecting the growing recognition of dietitians as nutrition experts[41].

At the time of implementation, confusion arose among healthcare professionals and institutions. The original intention was to adjust the job descriptions of diet nurses to align with the new decree and reclassify them as dietitians. However, contemporary reports indicate that the diversity of professional roles od dietary nurses across the country created administrative challenges. Many hospitals, aiming to reduce costs, reclassified diet nurses as dietetic assistants, who could not work independently, or claimed that existing graduates did not qualify as dietitians[26,42]. In 2005, Forejt noted

that the era of diet nurses persisted in hospitals, with some institutions failing to adopt the new classification system and university graduates being relegated to mere menu planners[43].

The following years were marked by quiet grassroots efforts to integrate dietitians into interprofessional teams, with little institutional support from the state. A significant shift occurred in 2018, when the Czech Association of Dietitians was founded in response to the growing demand for stronger professional representation. As an independent organization outside the Czech Nurses Association, it joined EFAD in 2019, integrating Czech dietitians into international structures[44].

The most recent milestone in the development of the profession was the publication of the Guidelines for the Provision of Food and Nutritional Care in the Ministry of Health Bulletin in 2020[45]. Its goal was to update and standardize the framework for nutritional care in healthcare facilities, replacing the widely used system according to Doberský. The recommendation significantly strengthened the role of dietitians, stating that:

- dietitians are always part of the nutrition team,
- they are subordinate to the allied health division, not the technical-administrative division,
- their number must be sufficient to cover care for all patients at risk of malnutrition, those with special nutritional needs, and those requiring dietary education,
- and providing an extensive explanation of their competencies in food service management, inpatient care, and outpatient nutritional counseling.

Despite these advances, dietitians still lack autonomy, as they have no decision-making authority within the system and act solely as consultants. Final decisions regarding nutritional care remain the responsibility of the attending physician.

3 Current system of dietetics in the Czech Republic

This chapter is based on the following paper, written by the author of the thesis:

> *Krobot M, Hawk VH, Spáčilová V, Kapounová Z. A historical perspective and opportunities for dietetics education, practice and professional organizations in the Czech Republic. Profese online. 2021:14(1);9-18. doi:10.5507/pol.2021.001*

Chapters 3.1, 3.2 and 3.4 are expanded and rewritten. Chapter 3.5 is transcribed in verbatim with minimum amendments. Chapters 3.3 and 3.6 were added extra.

3.1 Professional qualifications

The basic framework for the education of dietitians in the Czech Republic is defined by Act No. 96/2004 Coll., on Allied Health Professions. This law recognizes dietitians as graduates of:

- a three-year bachelor's degree program,
- a three-year higher vocational education program,
- a three-year higher vocational education program in the field of "Diplomovaná dietní sestra" (Dietary Nurse with a Diploma) started no later than the academic year 2004/2005,
- a secondary school program in the field of "Dietní sestra" (Dietary Nurse) started no later than the academic year 2004/2005[36].

The content of dietitian education is regulated by Decree No. 39/2005 Coll., which sets the minimum requirements for study programs leading to professional competence in allied health professions. This decree outlines the theoretical education areas and, for dietitians, specifies a minimum of 1,800 hours of practical training. The theoretical curriculum must cover preclinical and selected clinical medical disciplines, food science, nutrition in public health and clinical care, as well as related fields such as pedagogy and economics[46].

A more detailed breakdown of the curriculum is provided by the Qualification Standard for the Dietitian Profession, which defines learning outcomes, acquired competencies, and specifies the minimum number of hours per subject. This document is used in the accreditation process of study programs[47].

Although EFAD defines a dietitian as a healthcare professional educated to at least bachelor level[48], in the Czech Republic, the qualification of a dietitian can currently be obtained through both university and higher vocational education. Both are classified at level 6 of the European Qualifications Framework[49], with higher vocational schools

awarding the graduates with a degree of Specialist with Diploma (diplomovaný specialista; DiS.), however, the higher vocational education is not recognized as a university education equal to bachelor's degree. As a result of this broad definition, dietitians in practice may have three different levels of education, yet they hold the same professional title and competencies. This situation was already criticized by the national strategy "Health 2020", which pointed out the inefficiency of public resource allocation when undergraduate education for healthcare professions is provided simultaneously by two types of institutions[50]. Nevertheless, this dual system remains unchanged to this day.

3.1.1 Specialization

In addition to the professional qualification in dietetics, it is currently possible to obtain a specialized qualification for any dietitian regardless of the level of formal dietetics education. This qualification not only expands the scope of practice[51] but also allows dietitians to report certain healthcare procedures for public health insurance reimbursement, that are restricted to those with specialization[52] (see below). Officially, specialization should also be linked to placement in a higher salary grade, as some tasks performed by dietitians are classified as "specialized" in the national job catalogue[53].

When the profession was established in 2004, Government Regulation No. 463/2004 Coll. defined three specialization fields: *Nutrition in Childhood*, *Nutrition in Critical Conditions*, and *Community Nutrition Care*[41]. In 2010, Government Regulation No. 31/2010 Coll. merged the latter two into a single field: *Adult Nutrition*[54]. In 2018, Government Regulation No. 164/2018 Coll. further consolidated all specializations into a single field: *Nutrition for Adults and Children*[55]. The content of this specialization is governed by the Educational Program for Specialized Training in Dietetics – Nutrition for Adults and Children, published in the Bulletin of the Ministry of Health[56].

Currently, there are two pathways to obtain this specialization (the educational pathways in dietetics are clearly illustrated in Figure 1):

1. The primary route is through NCONZO, which provides specialized education for allied health professionals (see chapter 2.2).
2. The second route is through master's degree programs at the Faculty of Medicine, Masaryk University or the First Faculty of Medicine, Charles University, whose curricula are aligned with the educational program of the specialization and guarantee the award of the specialized qualification.

Since the specialized education provided by NCONZO is open to all groups of dietitians regardless of their initial level of education, the professional field includes graduates of secondary school with specialization, graduates of higher vocational schools with specialization, bachelor's degree holders with specialization, and master's degree

holders who also possess the specialized qualification. All these groups of dietitians hold the same scope of specialized practice, in accordance with the relevant decree[51].

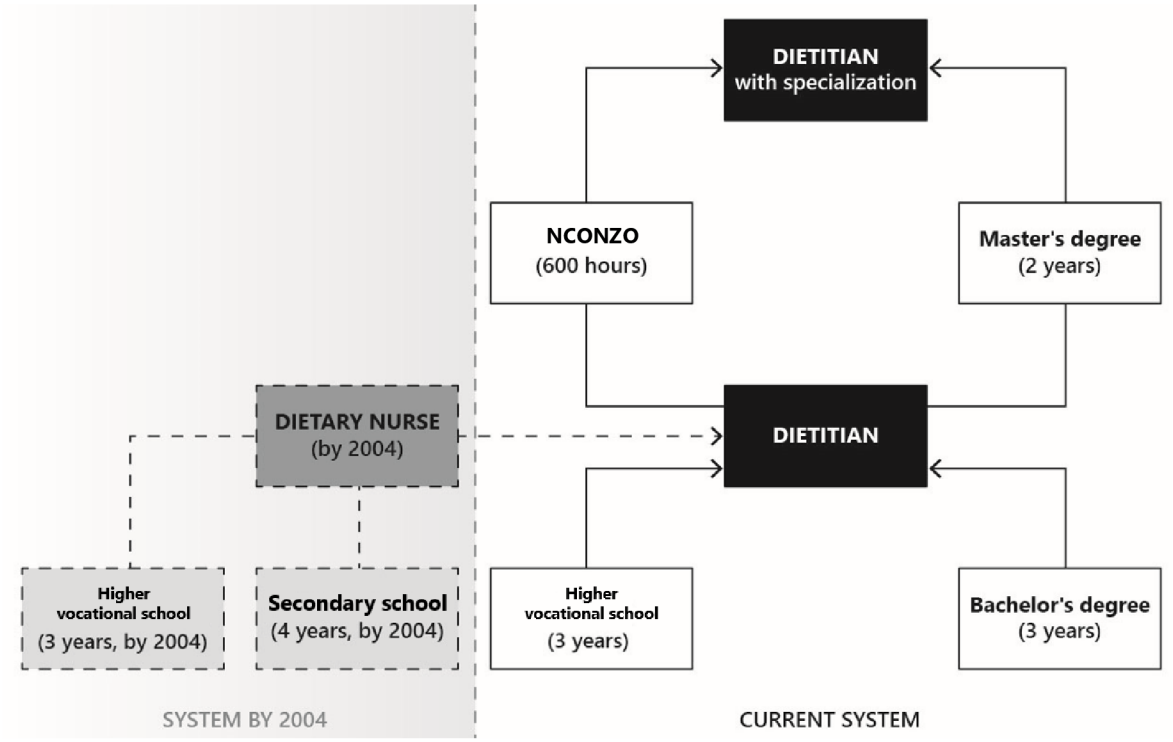

Figure 1 Education system of dietetics in the Czech Republic[9]

3.1.2 Life-long learning

Life-long learning in the field of dietetics was previously overseen by the NCONZO through the Register of Healthcare Professionals Qualified to Practice Without Supervision. This register recorded AHPs who met the requirements for lifelong learning. Upon graduation, any AHP could apply for registration, which was valid for ten years and allowed them to use the title "registered" (e.g., registered dietitian). To renew their registration after ten years, professionals were required to provide evidence of a specified number of continuing education credits and a minimum number of hours worked in healthcare. Alternatively, they could take an examination in lieu of these requirements. Failure to meet these conditions resulted in the loss of eligibility to practice independently.

However, in 2018, the register was abolished without replacement. All existing registrations became invalid, and eligibility to practice independently is now granted to any healthcare professional who has completed the education required by law. The responsibility for ensuring continuing professional development, as well as defining

its conditions, has since shifted to employers and is currently not regulated at the national level.[36]

3.2 Scope of practice

According to Decree No. 55/2011 Coll., dietitian scope of practice is officially divided into procedures that can be performed without a physician's referral and those that require a physician's indication. Under §15 of the decree, all dietitians are authorized to:

- assess and evaluate nutritional history, analyze dietary intake, and recommend changes to prescribed diets or ways of food intake,
- conduct examinations necessary to determine the nutritional status of patients,
- supervise, coordinate, and organize food preparation in healthcare facilities, and prepare meals for special diets when needed,
- develop meal plans for individual diets and for entire healthcare facilities, including calculations of biological and energy values,
- provide counseling and education to individuals, families, and groups on healthy and therapeutic nutrition, including recommendations for appropriate *dietary supplements*,
- **based on a physician's indication** – prepare individualized meal plans, including calculations of biological and energy values.

Dietitians with specialized qualifications have additional competencies defined in §110 (shared scope of practice) and §§111–114a (specialization-specific). Shared competencies include preparing educational materials, providing education on specialized diets, standardizing nutritional care within facilities, or conducting research. Specialization-specific competencies include calculating and recommending specialized forms of nutrition, assessing patients in critical condition, or working in public health settings. However, specialization still does not grant any autonomy for the dietitian[51].

The scope of practice of dietitians today is almost unchanged from that introduced in 2004. One of the key characteristic is the absence of direct decision-making authority. In most cases, dietitians act as consultants, recommending interventions to the attending physician. The prescription of diets, changes to dietary plans, and the prescription of ONS, enteral, or parenteral nutrition remain under the physician's authority. Some products are even restricted to physicians with a special license in clinical nutrition[57].

There is also terminological ambiguity in the definition of competencies. The decree uses various terms for what dietitians are expected to do or recommend, but unlike countries such as the United States, the Czech Republic lacks standardized definitions across healthcare and legislation. Terms such as *dietary supplements*, *nutritional supplements*, or *food supplements* are used interchangeably, moreover likely referring

to ONS, and phrases like *nutritional calculations* are mentioned without further specification. Furthermore, if applied strictly, dietitian with no specialization cannot prepare an educational brochure for a patient, although he/she has the authority to educate the patient. The scope of practice of dietetic assistants is written in completely different words, sometimes with statements overrunning the scope of practice of dietitians, although being subordinate to them. These inconsistencies can create challenges in practice when defining the role of dietitians within healthcare teams.

3.3 Reimbursement

In the Czech Republic, healthcare is financed through two main mechanisms: Diagnosis-Related Groups (DRG) for inpatient care (case-based payment), and fee-for-service reimbursement for most outpatient services[58,59]. The complete list of procedures eligible for reimbursement from public health insurance is published in the regularly updated Decree No. 134/1998 Coll., which also specifies which professional groups may report which procedures, in what settings, how frequently, and under what conditions reimbursement may be limited[52].

Dietitians work in both inpatient and outpatient settings. However, the reimbursement system for their services differs significantly between these two areas.

Outpatient care

In outpatient care, dietitians have access to six procedures that can be reported for reimbursement (see Table 1). To report a procedure, the hospital employing the dietitian must have a contract with the patient's health insurance company for the dietitian's specialty. Once this condition is met, the dietitian can report the procedure, and the insurance company reimburses the hospital. In this context, the dietitian's work becomes financially visible, as each procedure is reimbursed individually.

Table 1 Healthcare procedures reportable by dietitians[52]

Procedure	Settings restriction	Frequency restriction	Specialization required
Nutritional assessment by a dietitian	outpatient only	1/day	Yes
Creating a nutrition plan	outpatient only	3/trimester	Yes
Education by a dietitian	outpatient only	1/year	No
Reeducation by a dietitian	outpatient only	3/trimester	No
Calculation of nutrition intake	outpatient only	1/day	No
Indication of ONS by a dietitian	outpatient only	1/day	Yes

Notably, half of these procedures can only be reported by dietitians with specialized qualifications. Since these procedures are essential for providing comprehensive nutrition care, this restriction may complicate operations in hospitals that do not employ specialized dietitians.

Inpatient care

In the Czech healthcare system, nutritional care provided to hospitalized patients is typically included in the nursing day reimbursement model. This model represents a flat-rate payment for a day of nursing care, which covers a range of services provided by allied health professionals, increased for specific procedures reported by healthcare professionals, which can be aggregated to the payment for nursing day. Unlike outpatient care, where individual procedures are reported and reimbursed separately, inpatient nutritional interventions are not reimbursed as standalone procedures, but are considered part of the comprehensive nursing care package. This system can lead to limited visibility and recognition of the specific contributions of dietitians in hospital settings, as their work is not directly linked to itemized billing. However, dietitians currently do not have any available procedures which they would be able to report; therefore, they do not contribute to the nursing day payment anyhow[52].

3.4 Workforce and staffing

In 1951, DNs, along with other AHPs, were classified as mid-level health workers. Their presence in healthcare facilities began to grow steadily from 1957, with their numbers doubling by 1983 (from 3.67 to 7.44 DNs per 100,000 population). Despite some unexplained fluctuations in the following decades, the number of dietitians in the Czech Republic reached 7.74 per 100,000 population in 2025[60], which is comparable to other developed countries. While e.g. Portugal, Denmark, and Iceland, reporting highest figures in Europe, have 42.64, 31.66, and 28.15 dietitians per 100,000 population, other European countries such as Germany, France, and Italy reported lower numbers, with 4.05, 3.22, and 2.47 dietitians per 100,000 population[61].

As of 2025, there are 3,290 dietitians in the Czech Republic[60]. According to the latest data summary published by the Institute of Health Information and Statistics, a total of 864.71 full-time equivalent (FTE) positions for dietitians were recorded in healthcare facilities in 2023. Among hospitals (160 facilities), 13 did not employ any dietitians at all, and 31 hospitals reported a combined total of no more than one FTE dietitian[62]. Due to the absence of employment registries outside the healthcare and social services sectors, it is not possible to confirm the employment status of other dietitians. However, it is likely that many work in private practice or in various other sectors, such as the National Institute of Public Health, the Ministry of Health, educational institutions, school catering services, agriculture, the food and pharmaceutical

industries, and more. Unfortunately, there is no research currently published on the reasons why dietetic graduates do not enter the workforce. Overall, employment data for dietitians remains limited due to the lack of comprehensive registries and low participation in professional organizations within the Czech Republic.

The mandatory staffing levels for healthcare professionals relative to the number of beds are regulated by Decree No. 99/2012 Coll., on the requirements for minimum personnel provision in healthcare services. Until April 2025, the only obligation concerning dietetic care was stated in Annex 3, Part I, Item 16, which specified:

> *"In inpatient departments listed in Parts II.1, II.2, II.3, and II.4 of this Annex, the availability of a dietitian must be secured."*[63]

According to Item 23 of the same annex, *availability* was defined as *"the availability of advice and assistance via telephone or electronic means, with physical presence required upon request depending on the urgency of the procedure and the clinical condition of the patient."* Thus, no facility was explicitly required to employ a dietitian.[63] A recent amendment to the decree introduced a new obligation for healthcare facilities to staff inpatient departments with dietitians as follows:

> *"In inpatient departments, healthcare shall also be provided by a dietitian at a rate of 0.1 FTE per 30 beds; in the case of patients receiving acute inpatient care in the fields of intensive care, surgery, internal medicine, pediatrics, or psychiatry, healthcare shall be provided by a dietitian at a rate of 0.3 FTE per 30 beds."*[64]

This regulation came into effect in April 2025, with a transitional period lasting until December 2026, by which time healthcare facilities must comply and ensure adequate staffing.[64]

3.5 Professional representation

Currently there are two main professional organizations representing the dietitians in the Czech Republic, each differing in their genesis, membership, goals, and activities, and one organization stemming from its former activities under the umbrella of Czech Association of Nurses. The organisations are listed chronologically in the order they were established, with the membership of dietitians concentrated between two associations, the Section of Dietitians of the Czech Association of Nurses and the Czech Association of Dietitians.

Section of Dietitians of the Czech Association of Nurses
Historically the oldest professional organization of dietitians is the Section of Dietitians, as a part of the Czech Association of Nurses (Sekce nutričních terapeutů České asociace sester; SNT ČAS), which was established in 1992[32]. This section brings together dietitians and dietetic technicians working in health and social care facilities, education, and counselling services, as well as students and retired members. The 2024 Annual report documents 199 members in SNT ČAS[65]. Their goals include strengthening the role of dietitians in support of the current legislation, increasing the salary of dietitians, providing easy availability of professional information, and improving awareness of SNT ČAS activities[32].

Section of Nutrition and Nutrition Care
The Section of Nutrition and Nutrition Care (Sekce výživy a nutriční péče; SVNP) was established in 2016 after separating from the ČAS. It is a multi-professional organization that is open to nutrition experts including dietitians, specialists in other disciplines and students. The annual report was not available for review, and there was no information about the number of members. Its goals are broad and include information about increasing the expertise of members, educational programs about health and nutrition for the population. To fulfil these goals, SVNP reports organizing conferences, supporting cooperation with other organizations and publishing education materials[66].

Czech Association of Dietitians
Founded in 2018, the Czech Association of Dietitians (Česká asociace nutričních terapeutů; ČANT) is an independent organization with a membership that consists of dietitians and dietetic students (future dietitians) with 143 members according to the latest published annual report of 2020[67]. In 2019 ČANT became an associate member of EFAD. Through the affiliation with EFAD, ČANT brings Czech dietitians the opportunity for international collaboration with European dietitians. The aims of ČANT include improving nutritional care in the Czech Republic through greater involvement of its members, creating opportunities for the application of their skills and knowledge, constantly increasing the expertise of its members, cooperation with other professionals and involvement in European and global professional structures[44]. In 2020, the ČANT merged with the Association of Dietetic Students, creating a platform for the self-actualization of future dietitians[67].

3.6 International context

While workforce data provide important insights into the availability of dietitians across countries, they do not fully capture the structural and regulatory conditions that

shape dietetic practice. This chapter therefore focuses on comparing the legal and professional frameworks that define the scope, autonomy, and specialization of dietitians in the Czech Republic, and the United Kingdom and the United States as English-speaking countries due to the accessibility of normative documents and their reputation as progressive systems in the field of dietetics. In addition, it considers the European Federation of the Associations of Dietitians (EFAD) standards as a reference point for minimum professional competencies expected across Europe.

Professional qualifications

EFAD defines a dietitian as a professional holding at least a bachelor's degree. In the Czech Republic, this level of education has been available since 2004 and has been implemented in practice since 2007. However, it is still possible to obtain professional qualification through higher vocational schools, which, despite awarding a formal title, are not equivalent to a bachelor's degree and are more practice-oriented. In addition, some practicing professionals are graduates of secondary schools who began their training in the field of dietary nursing no later than 2004. Central regulation of continuing professional development and the associated registration of healthcare professionals was abolished in 2018 without replacement.

In the United Kingdom, university-level education for dietitians has been in place since the 1950s[68]. Currently, in accordance with the requirements of the Health and Care Professions Council (HCPC), a minimum of a 3–4 year bachelor's degree is required to obtain professional qualification. For those who have completed a related undergraduate program, qualification can be obtained more quickly through a master's program, provided that the bachelor's degree included general theoretical modules that are omitted from the master's curriculum. If the program concludes with a thesis, the graduate receives a master's degree; otherwise, a Postgraduate Diploma (PgDip) is awarded. All of these qualifications are considered equivalent[69]. Continuing professional development is monitored by HCPC, which conducts random audits of 2.5% of registered dietitians every two years[70].

In the United States, entry into the profession now requires a full master's degree, followed by a mandatory internship in accordance with the standards of the Accreditation Council for Education in Nutrition and Dietetics (ACEND), which accredits dietetics and related programs. Graduates must then pass a national examination administered by the Commission on Dietetic Registration, which operates independently of educational institutions. In some states, an additional local license is required before a dietitian is authorized to practice independently[71]. Registered dietitians are also required to document their continuing professional development every 5 years[72].

Scope of practice

The scope of practice of Czech dietitians is strictly defined by legislation, down to specific tasks and with explicit identification of (in)dependence on physician referral.

In the Czech Republic, dietitians currently do not hold any rights related to prescribing items covered by public health insurance, such as ONS, enteral or parenteral nutrition, blood tests, or medications. Dietitians are not permitted to manage or insert feeding tubes, nor to independently adjust treatment plans for patients with obesity or diabetes. In these matters, they are typically regarded as consultants, and if any such responsibilities are delegated to them, it occurs outside the scope of valid legislation and under the responsibility of the relevant healthcare professionals.

International comparisons might be complicated, as many countries do not define scope of practice in a fixed manner. Instead, they are relative to the practitioner's experience, additional training, and career development, such as in the United Kingdom. The Health and Care Professions Council (HCPC) defines competencies broadly, focusing on the skills and abilities required for registration. HCPC explicitly states that *"a registrant's scope of practice will change over time, and the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues."* Although competencies are not strictly enumerated, the system suggests that UK dietitians may attain higher levels of responsibility through practice and specialization. Based on selected formulations in HCPC standards and the *Model and Process for Nutrition and Dietetic Practice* issued by the BDA, it can be inferred that UK dietitians may independently decide on certain modalities of nutritional intervention, provided they adhere to HCPC standards, document their decisions appropriately, and respect the boundaries of their scope of practice[73]. This flexible definition allows for greater professional development, but may also lead to ambiguity in delineating roles within the team. The UK also allows dietitians to obtain the qualification of *supplementary prescriber*, which enables them, based on prior agreement with the patient and the attending physician, to assume responsibility for certain aspects of medication prescribing, including dosage adjustments[74].

In the United States, competencies are defined more specifically by the Commission on Dietetic Registration (CDR), which provides a general framework that varies by state legislation. While many competencies resemble those defined in Czech law, the U.S. framework elaborates more extensively on the dietitian's role in shaping nutrition care within healthcare institutions. Several key differences are evident:

- Many competencies include the terms "order" or "initiate," indicating that dietitians may independently perform or prescribe certain actions (e.g., laboratory tests, indirect calorimetry, diet prescriptions, ONS).
- Dietitians are explicitly involved in the development and implementation of nutrition protocols within healthcare settings.
- If a pharmacological plan or specific medication prescription is part of an official nutrition protocol, dietitians may be authorized to prescribe these based on their clinical privileges.

Dietitians holding the title of *Advanced Practitioner* based on additional education may also be authorized to insert feeding tubes, adjust treatment regimens for diabetic patients (including glucose monitoring and insulin pump settings), use ultrasound to assess muscle mass loss, or perform wound care interventions when nutrition is a contributing factor[75].

In this context, the competencies of Czech dietitians appear relatively limited, primarily focused on nutritional assessment, patient education, and recommending interventions to the attending physician, without significant autonomy.

Professional representation

In the United Kingdom, the British Dietetic Association (BDA) serves as both the professional association and trade union for dietitians. Founded in 1936, it is the only body representing the entire dietetic workforce of UK. The BDA plays a central role in shaping national policy, developing clinical guidelines, advocating for professional rights, and supporting members through legal and employment services. It collaborates closely with the Health and Care Professions Council (HCPC), which regulates the profession, and is actively involved in campaigns for expanded prescribing rights and advanced practice roles[76].

The Academy of Nutrition and Dietetics (AND) in the United States is the world's largest organization of nutrition and dietetics professionals, with over 112,000 credentialed members. Established in 1917, the Academy is a powerful force in public health, education, and policy advocacy. It influences federal legislation, develops national nutrition standards, accredits educational programs, and publishes evidence-based guidelines. AND also maintains a strong presence in research and professional development, positioning registered dietitian nutritionists (RDNs) as key players in clinical care, public health, and food systems[77,78].

In contrast, professional representation in the Czech Republic remains fragmented and comparatively weak. Existing organizations, SNT ČAS established in 1992 and ČANT established in 2018, function primarily as voluntary associations with limited influence over legislation, education, or clinical standards. They lack formal regulatory authority and their capacity to advocate for the profession is constrained by limited resources, low membership engagement, and absence of institutional support. Compared to the BDA and AND, Czech dietetic organizations resemble informal interest groups rather than strategic professional bodies.

EFAD standards

There is no binding European legislation that uniformly regulates the profession of dietitians across member states. The body responsible for standardization in the field of dietetics is EFAD, which publishes a wide range of documents, from position papers and policy papers to professional standards, that member states, through their national associations, are expected to follow at minimum.

According to EFAD's definition, dietitians are expected to operate across three main domains:

- **clinical dietetics**, where the dietitian follows the nutrition care process to identify and treat nutrition-related problems in individual patients
- **food service dietetics**, where the dietitian is responsible for the production of adequate, safe, palatable, and sustainable meals tailored to the nutritional needs of specific individuals
- **public health or community dietetics**, where the dietitian works in the public sphere with individuals, groups, and populations to promote health and prevent disease[48]

These domains are reflected in EFAD's most recent revision of academic standards from 2018, which outline the core areas that dietitians should cover during their education. These include:

- Healthcare professionalism
- Knowledge base of dietetics
- Dietetic process and reasoning skills
- Evidence base in dietetics
- Autonomy, accountability, and quality in dietetic practice
- Communication, relationships, and partnership skills in dietetics[79]

Although Czech educational documents for dietitians partially incorporate many of EFAD's requirements, the scope of practice defined by national legislation do not fully align with EFAD's domain structure. Food service is rather marginalized, and scope of practice in public health is only formally recognized within the framework of specialization. Even then, they are defined in vague terms and fail to capture the role of the dietitian in public health as envisioned by EFAD[51].

Moreover, Czech legislation defines the competencies of healthcare professionals strictly within the context of healthcare facilities. This contrasts with EFAD and systems in countries like the UK and USA, which interpret the scope of practice more broadly. In this area, the voice of professional organizations should be more prominent, helping to better define the role of dietitians in the Czech Republic across all domains of practice. Doing so would support the continued professionalization and development of the field.

4 Interprofessional collaboration in dietetics

Interprofessional collaboration (IPC) is now considered a fundamental prerequisite for high-quality and effective healthcare. Given the process of delineation among health professions, each of which focuses narrowly on a specific aspect of patient health, it is essential that professions work together to maximize therapeutic outcomes while ensuring the most efficient use of resources[80].

In 2010, the WHO, in its *Framework for Interprofessional Education and Collaborative Practice*, defined IPC as the moment when multiple health professionals from different fields work with individuals, families, or communities to provide the best possible care. This approach allows the involvement of anyone whose skills contribute to achieving defined health goals[80]. Professional societies also emphasize IPC in their documents, e.g. ESPEN in its Vienna Declaration[3] and EFAD in its Budapest Resolution[4], both of which frame IPC as a necessary condition for providing care in line with current evidence. Beyond policy documents, IPC is increasingly integrated into clinical guidelines, which often presuppose collaboration across several health professions.

Existing research describes numerous benefits of (IPC) across multiple levels:

- **patients:** improved clinical outcomes, enhanced quality of life, greater adherence to treatment, increased self-confidence in self-care, reduced rehospitalization rates, and overall higher satisfaction[81,82],
- **health professionals:** greater job satisfaction, reduced stress, improved performance, lower error rates, more effective communication, strengthened team identity and sense of belonging, increased innovation, enhanced responsiveness to patient needs, better coordination, improved information sharing, conflict resolution capabilities, and greater team adaptability[82–85],
- **organizations:** more efficient use of healthcare resources, cost reduction, fewer rehospitalizations, decreased emergency department visits, improved processes, higher adherence to clinical protocols, and greater sustainability of implemented changes[81–83].

Despite the broad acceptance and consensus on the importance of IPC at the level of scientific literature and the international community, its implementation in practice remains challenging and faces numerous barriers. One of the most comprehensive studies addressing this issue is a systematic meta-review of systematic reviews by Wei et al., which categorized IPC facilitators and barriers across three levels: individual, team, and organizational[81]. This chapter summarizes the key factors influencing IPC in healthcare at these levels, as well as evidence of its benefits for patients, teams, and organizations.

4.1 Ways of collaborative practice

In relation to the simultaneous collaboration of multiple health professionals, the literature most often refers to four terms – *multidisciplinary, interdisciplinary, multi-professional, and interprofessional*. Although these terms may appear to describe the same phenomenon, each captures a different level of structure and group dynamics, which can ultimately influence health outcomes[86]. However, authors frequently use them interchangeably without further reference[87].

A **multidisciplinary team** refers to a team composed of members of different professions, with each profession working separately and with limited contact with others. Professionals work in parallel, approach the patient independently, and contribute their expertise to the overall treatment outcome; however, the process may lack complexity and cohesion.

An **interdisciplinary team** typically refers to a team in which members not only work independently but also share information, communicate about the case, and integrate their knowledge to create the best possible treatment plan. This approach emphasizes the complexity of healthcare through the use of diverse expertise and supports the coordination of care.

The term **multiprofessional team** is used less frequently and usually highlights the structural fact that a team is composed of members of different professions.

An **interprofessional team** represents the most integrated form of collaboration. In addition to coordinating activities and sharing expertise in treatment planning, it emphasizes mutual respect among professions, shared decision-making, shared responsibility, and reciprocal learning among team members. One of the prerequisites for achieving this level of collaboration is **interprofessional education** (IPE), which prepares future health professionals to acquire the competencies necessary for successful collaboration[86,88].

Since the latter model is most desirable in terms of both healthcare effectiveness and the individual well-being of team members, this designation will be used throughout the remainder of this thesis to denote the interprofessional aspects of dietitians' practice.

4.2 Individual level – personality and professional identity

Each health professional brings to the team their professional identity, understanding of their role, and previous experiences that shape them. Already at the individual level, there may therefore be factors that either positively or negatively influence the possibility of IPC. The collaborative practice does not stem from the system, but the ability of individuals to accept their role in a broader team.

For successful IPC, professionals need not only to have a clear understanding of the roles of other professions, but also to comprehend their own role within the team and to have a strongly internalized professional identity[81]. Health professionals may fear the loss of professional identity within the team, or the redefinition of roles that, from their perspective, may not be congruent with their expertise. Fear of losing one's autonomy can also be significant, which can be seen among general practitioners who perceive the participation of other professions as disrupting to their traditional role[85]. Conversely, an unclear identity may lead to role confusion and hinder collaboration[81].

Personality characteristics of team members also play a role. Teams whose members are empathetic toward the needs of others, respectful, and trusting of their colleagues' abilities tend to collaborate more successfully. They must be willing to share information with other team members and to cooperate with them[81,83,84]. On the other hand, tendencies toward egoism, fear of delegating tasks, or a lack of perceived psychological safety within the team may lead to failure[83,84]. At the moment of IPC implementation, it is also important whether professionals are personally inclined to accept change or not[85].

Finally, team members' views on IPC itself also matter. A positive attitude toward IPC and confidence in its benefits act as important facilitators, whereas negative attitudes toward IPC or doubts about the value of collaboration reduce its effectiveness. Related to this is the role of education, both in IPC itself and in the specific field where collaboration is required, along with the competencies that professionals must possess, which in turn enhance motivation. Previous experience with IPC also acts as a facilitator, as it may motivate team members and alleviate concerns, e.g. regarding continuity of care[81,83–85].

4.3 Team level – dynamics of collaboration

Within a team, interpersonal relationships play a crucial role in determining how effectively and efficiently collaboration will unfold. Many factors present at the individual level reappear at the team level; however, the perspective shifts from personal traits in individuals to the overall atmosphere within the team.

Trust, mutual respect, and recognition of each other's competencies are fundamental to effective teamwork. Teams that value the expertise of their members tend to exhibit greater cohesion, openness, and an enhanced ability to resolve conflicts[82,84,85]. Shared goals and a unified vision of care further support coordination and team effectiveness. When team members align in values and objectives, care delivery becomes more synchronized, contributing to improved patient satisfaction[82,83,85]. Informal interactions, such as spontaneous discussions and the exchange of experiences, also strengthen team relationships and facilitate prompt problem-solving[85]. Understanding the roles of others and enhancing team effectiveness is further supported by IPE[82,85].

Professional roles may also influence team dynamics. Ambiguities in the definition of competencies and responsibilities can lead to confusion and concerns about professional identity, potentially escalating into intra-team conflicts[82,85]. Unclear roles may result in overlapping responsibilities, disrupted continuity of care, misunderstandings, and reduced efficiency, all of which may contribute to frustration among team members[85]. Excessive hierarchy within the team, particularly when physicians dominate decision-making, can limit the autonomy of other professions and disrupt team dynamics[83–85]. In contrast, shared decision-making has been identified as a facilitator of interprofessional collaboration[81].

A frequently cited barrier is insufficient or ineffective communication among team members. Effective communication encompasses regular team meetings, constructive feedback, shared documentation, and clearly defined communication channels and protocols, all of which enhance transparency and coordination. The use of technology further facilitates information exchange[81,82,84]. Teams also benefit from formal structures such as standards, guidelines, and conflict resolution strategies[81]. A lack of regular meetings or unclear communication pathways may lead to fragmented care[83–85], with a key barrier being the absence of effective mechanisms for transferring or receiving patient information. Additionally, inappropriate or unprofessional behavior within communication may hinder collaboration[81].

4.4 Organizational level – conditions of the environment

Even a well-functioning team cannot succeed without support from the environment in which it operates. This environment encompasses both physical factors that the team depends on, as well as the leadership and institutional support provided by the healthcare facility.

Leadership plays a pivotal role in the implementation and sustained support of IPC. Support from management signals a culture of collaboration, enhances team motivation, enables alignment with broader organizational structures, and facilitates change processes[81,84]. Ideally, leadership should be participatory, promote shared goals, and foster a climate of trust[84].

Hospital leadership also holds tools that can ease the work of teams. Clearly defined team structures, work protocols, and shared tools (e.g., clinical guidelines, care planning instruments) serve as important facilitators of effective collaboration[82,85]. The availability of information and coordination of care are further improved when leadership supports telemedicine and digital technologies[82]. A particularly critical factor is team colocation, that is, the physical presence of team members in the same location. Colocation facilitates communication, encourages informal interactions, and helps mitigate hierarchical barriers. It is especially effective in primary care settings, where it enables rapid information sharing and consultation[81,85].

Repeatedly identified barriers include a lack of time, staffing, education, and technological resources. Health professionals often lack the capacity to engage in collaboration, even when they recognize its value[83,85]. From a staffing perspective, high turnover and team instability represent significant barriers, as they introduce uncertainty, reduce trust among team members, and hinder long-term planning. Stability is essential for sustaining innovation and effectively implementing change[83,84].

4.5 Current evidence on IPC in dietetics

Interprofessional collaboration forms the foundation of optimal nutritional care. The European Nutrition for Health Alliance (ENHA) emphasizes this principle in its flagship initiative Optimal Nutrition Care for All (ONCA), which is built on the establishment of national multidisciplinary teams aimed at implementing necessary measures to ensure optimal nutritional care for every individual. These teams should include physicians, dietitians, nurses, as well as patients and other stakeholders, each of whom can contribute to shaping the culture of nutritional care. However, ENHA itself encounters barriers even at the European level, where representatives of the EU and major European organizations often have limited awareness of the importance of nutritional care or of the risks, costs, and consequences associated with untreated malnutrition[8].

ESPEN has recently reinforced the interprofessional nature of nutritional care in the Vienna Declaration, which describes high-quality, evidence-based, and therefore interprofessional, nutritional care as a fundamental human right[3]. This was followed by EFAD's Budapest Resolution, which states that dietitians are essential members of such teams[4].

Despite ongoing efforts at both international and national levels, the current state of IPE in the area of nutrition and dietetics remains insufficient. Although education in IPC is a necessary prerequisite for effective team-based healthcare delivery, its integration into curricula is still suboptimal. As a result, the system fails to adequately prepare health professionals not only for delivering evidence-based care, but also for working in ways that have the potential to reduce medical errors and the prevalence of burnout[89].

In addition to IPE, education in nutrition itself is also insufficient. Without adequate knowledge and understanding of its importance, other health professionals cannot be expected to fully engage in nutritional care. Although students and recent graduates express a strong demand for nutrition education, current opportunities are limited[90]. Most students must rely on isolated lectures outside the formal curriculum or on self-directed study, driven solely by personal interest and squeezed into time outside of other academic obligations[91]. Beyond curricular gaps, a major issue is the shortage of academics capable of providing systematic education in this field, along with the

limited involvement of dietitians in training future generations of healthcare professionals. However, the more dietitians engage in nutrition education within universities that train healthcare workers, the more knowledge, appreciation, and understanding of nutrition and the role of dietitians in nutritional care will be cultivated among health professionals[90,92,93].

4.5.1 Perspective of dietitians

Dietitians are a key profession in the provision of nutritional care and indispensable members of interprofessional teams in this field. Nevertheless, studies exploring dietitians' perspectives on IPC remain relatively fragmented, often focusing either on collaboration with a specific profession or on narrow aspects of IPC. No secondary research in this area was identified during the literature review. The available studies employ a mix of quantitative and qualitative methods, with the quantitative ones typically offering only superficial assessments without deeper understanding. The findings of these studies will be summarized into thematic groups and subsequently presented using the framework proposed by Wei et al.[54]

Professional identity and mutual role recognition

Several studies suggest that dietitians perceive a lack of awareness among other healthcare professionals regarding their role and contributions to the team. This lack of understanding results in dietitians not being recognized as full members of the team, not being respected, and being consulted on minor issues while more critical matters are overlooked. This underutilization contributes to frustration and burnout[7,94,95]. Dietitians themselves emphasize the need to establish a strong culture of nutritional care, in which all team members understand their own roles and the role of the dietitian, the importance of nutrition, and how to collaborate effectively in this domain[7,96]. At the same time, dietitians acknowledge gaps in their own understanding of other professions and report uncertainty about when to refer patients to other specialists[97]. Exposure to other professions, ideally through shared workspaces, facilitates mutual understanding and helps clarify responsibilities[98], which, when unclear, can act as a barrier to IPC[96] and lead to conflicting advice given to patients[97].

Communication and teamwork

Dietitians view effective communication as fundamental to successful IPC. Processes must be well-organized, and communication, including digital communication, must function reliably, especially in terms of sharing patient information[7,96]. Under such conditions, IPC is perceived as enriching and beneficial[99]. Several studies highlight the importance of shared goals, perspectives, and a common understanding of IPC itself[96,98,99]. Barriers include insufficient communication[95], incomplete patient data[7], and limited experience and knowledge regarding IPC[96].

Autonomy and decision-making

One study explicitly addressed the imbalance of decision-making power, particularly in relation to physicians, who hold significantly more authority. This asymmetry becomes especially problematic when physicians make decisions about nutritional care without adequate understanding, leading to frustration and resignation among dietitians. Dietitians do not seek full autonomy but rather consensus-based decision-making within the team that considers the needs of all team members, including the patient. A key factor is the individual approach and willingness of team members to collaborate. Dietitians often experience frustration from having to repeatedly justify their recommendations and seek approval for interventions that fall within their expertise. Their level of autonomy depends on professional resilience, experience, and confidence. To effectively advocate for nutritional interventions, dietitians must build relationships, defend patient needs, and negotiate care plans. This process requires the ability to present evidence-based arguments and to time consultations appropriately[100].

In other studies, autonomy was a more peripheral theme. Perceived autonomy was identified as a facilitator of collaboration, while perceived interdependency was seen as a barrier[96]. Some healthcare professionals who are skeptical of IPC may perceive the concept itself as a threat to their autonomy[98]. Conversely, fostering a sense of accountability among professionals was viewed as a facilitator[7].

Organizational factors

One of the most frequently mentioned facilitators was the physical colocation of team members, ideally in shared workspaces, which enhances communication efficiency[7,95], enables spontaneous interactions and quick coordination[98], and supports referrals[99]. Organizations must ensure the availability of screening tools, adherence to protocols, and sufficient staffing to allow professionals to perform their expected duties and build interprofessional relationships[7,97]. Regarding food services, dietitians reported that outsourcing significantly hinders collaboration, while in-house services increase flexibility[7]. Dietitians working in clinical and food service settings should not operate in silos but ideally collaborate across domains[101]. In a study involving dietitians and physiotherapists, inadequate financial compensation was also identified as a barrier[96].

Systemic factors

Some studies also highlighted systemic factors beyond the control of individuals or organizations. IPC may be limited by what is covered by public health insurance, i.e., what patients can afford, which in turn affects the possibility of referrals to other professionals[98]. Dietitians also pointed to shortcomings in education, which did not adequately prepare them for IPC[97]. However, there may be a gradual shift, as a Canadian

study found that dietitians familiar with the concept of IPC had significantly less time in practice, suggesting recent improvements in education[95].

Table 2 Barriers (red) and facilitators (green) to IPC in nutrition according to dietitians[7,94–101]

Level	Barrier/facilitator
individual	lack of awareness about dietitians
	lack of awareness about other HCPs among dietitians
	limited experience and knowledge of IPC
	awareness about the importance of nutrition
team	disrespect and underutilization of dietitians
	unclear responsibilities
	member autonomy
	working in silos
	sense of accountability
	shared understanding of IPC
	shared goals and perspectives
	functioning communication
	role clarity
organizational	outsourced food service
	inadequate financial compensation
	strong culture of nutrition care
	exposure to other professions
	physical colocation
	availability of screening
	adherence to protocols
	sufficient staffing

4.5.2 Perspective of other HCPs

The existing evidence regarding the attitudes and experiences of other health professionals with IPC in the context of nutrition is rather fragmented, with very limited secondary research. Moreover, the available studies tend to focus on specific wards or isolated steps within the nutritional care process. Nevertheless, a broader picture can be drawn from individual, predominantly qualitative studies that address this issue. The findings of these studies will be summarized the same way as above.

A relatively recent systematic review from 2021 by Lyons et al.[5] explored perceptions of nutrition in intensive care settings. Although it does not focus specifically on IPC, it captures factors closely related to it that may influence collaboration, as previously outlined. According to the review, both physicians and nurses perceive nutrition

as important, though not more important than other activities associated with intensive care. Nurses often do not consider themselves responsible for delivering nutritional care. Nutrition is sometimes viewed as a complicating factor, delaying procedures, causing adverse effects, or placing additional burden on staff. A lack of personnel to fully integrate nutrition into care was also identified as a limiting factor. Clear guidelines and the formation of a supportive team were cited as facilitators or, conversely, as barriers when absent. Despite these results, healthcare professionals generally rated their knowledge of nutrition as relatively good; however, insufficient knowledge was still reported as a barrier.

An earlier systematic review from 2013 by Green et al.[6] assessed barriers and facilitators to nurses' involvement in nutritional screening, a critical prerequisite for effective nutritional care and a key source of information for dietitians. The findings reflect factors across all levels. Nurses reported that screening was not mandatory, not included in internal guidelines, too complex, and that they were lacking appropriate tools. As a result, they did not perceive it as a priority and often lacked time to perform it, especially for patients who did not appear at first glance to be at risk. Some nurses even considered their own clinical judgment to be more accurate than screening tools, indicating limited knowledge, which was also cited as a barrier. Role ambiguity also emerged, with some nurses viewing nutritional screening as the responsibility of the dietitian.

Role and responsibility ambiguity

Several studies identify unclear role definitions as a barrier to effective IPC in nutrition care [102–104]. Ambiguity regarding who is responsible for specific tasks can lead to interpersonal conflict and mutual blame, stemming from assumptions that someone else should be accountable[103]. One frequently criticized issue is the tendency to work in silos, which complicates communication and makes it difficult to identify or reach the responsible person[105]. Among physicians, there can be also resistance to divert from the physician-led model of care[106].

Lack of knowledge

Healthcare professionals themselves cite insufficient knowledge and low awareness of malnutrition as major barriers to participating in nutritional care[103,104,107,108]. In addition to limited understanding of nutrition itself, they often lack clarity on whom to approach or what processes to follow[103]. There is a recurring call for improved education in nutrition and nutritional care across healthcare professions[103,105,107,109,110], with evidence suggesting that increased knowledge correlates with greater perceived importance of nutritional care[92].

Deprioritization of nutrition care

Several qualitative studies involving nurses indicate that, although they consider nutrition important, it is often deprioritized in favor of other tasks. Nurses tend to focus on activities they perceive as having a more immediate impact on preventing deterioration in the patient's condition[104,108]. In most studies, the lack of time and staffing is cited as the primary reason for this deprioritization, leading to nurse overload and reduced capacity to engage in nutritional care[102,103,107,108]. Some nurses also report that dietitians develop overly complex nutrition plans that are difficult to implement within the time constraints of routine care[107]. Another complicating factor is the perceived lack of interest in nutrition among physicians, which makes collaboration difficult and leaves nurses feeling solely responsible for nutritional care[107,108].

Communication and teamwork

Healthcare professionals often feel they are working concurrently rather than collaboratively[102]. In some studies, interprofessional communication is perceived as limited, with a lack of accessible information[103,109]. The presence of a dietitian on the ward was viewed positively, as it facilitated consultations[104], whereas the absence or centralization of dietitians was seen as a communication barrier[107,111]. Regular reminders and meetings were suggested as helpful tools to maintain awareness and coordination[104]. Among kitchen staff, the perceived superiority of dietitians and their limited availability for questions and consultations due to time constraints were viewed negatively[112].

Role of management

Only one study directly involved members of hospital management. According to this study, successful implementation of interprofessional nutritional care requires clear communication from management regarding what needs to be done and why, along with efforts to instill a sense of responsibility and importance among staff[111]. Managers themselves must be engaged in the change process, identify key staff members with an interest in nutrition, and foster an environment where appropriate resources are available. Other studies also emphasize the role of management in building a positive nutrition culture and communicating the benefits of change for both patients and the organization. They highlight the importance of making the process appear simple and worthwhile, and suggest that change should always be initiated by management[105,110]. However, some respondents perceive management as a potential source of harm to nutritional care through inappropriate decisions[113].

Organizational factors

Organizational challenges include both issues related to food services and broader operational conditions. Food services are often perceived as inflexible[109], lacking options for individualized diets[108], and constrained by rigid meal times and delivery

methods[107]. The unavailability of food outside designated mealtimes was also noted as problematic[103,109]. On the other hand, food service staff report operating at full capacity and indicate that greater flexibility would require additional personnel[112].

Beyond food services, staffing shortages are a major concern. They force nurses to prioritize tasks, often at the expense of nutritional care[103,110], and make activities such as feeding patients seem unrealistic[104,109]. High staff turnover further exacerbates communication issues and contributes to errors[104]. On the other hand, having evidence-based guidelines was seen as a facilitator promoting clarity and consistency[106].

Table 3 Barriers (red) and facilitators (green) to IPC in nutrition according to other HCPs[92,102–113]

Level	Barrier/facilitator
individual	focus on other tasks
	lack of interest in nutrition
	insufficient nutrition knowledge
	low awareness about malnutrition
	education about nutrition
team	nutrition plans perceived too complex
	team members not interested in nutrition
	unclear role definitions
	unclear responsibility
	working in silos
	unclear communication pathways
	lack of information sharing
	superiority in communication
	regular meetings and reminders
organizational	lack of time/personnel
	staff turnover
	work overload
	inappropriate management decisions
	inflexible food service
	food in between mealtimes not available
	lack of individualization options
	positive nutrition culture
	definitions of responsibility
	engaged managers
	providing sufficient resources
	champions interested in nutrition
	physical colocation
	evidence-based guidelines

5 Methods

This chapter is a minimally amended verbatim transcription of the Methods section of the following paper, written by the author of the thesis:

> *Krobot M, Jančeková K, Hawk VH, Zelenková V, Kapounová Z. Challenges in delivering nutrition care perceived by hospital dietitians in the Czech Republic: a qualitative study. BMJ Open. Accepted for publication 2025.*

5.1 Theoretical background

The aim of this study falls within the scope of applied research since its purpose is to answer questions focused on practical problems and bring hypotheses about possible solutions. In qualitative research methodologies, this is best reflected in the **applied thematic analysis** (ATA) outlined by Guest.[114]

The methodological framework of ATA uses thematic analysis in an environment combining components of grounded theory and phenomenology in positivist and interpretive manner. ATA is focused on a transparent and credible process; hence the positivist epistemological approach requiring all assertions being based on evidence. Interpretive approaches are also available to analyse the meanings, understanding and behaviour of participants. However, due to its focus on answering the research questions in an applied way, ATA may miss some nuanced data and also omit data not directly related to the research questions.[114]

The results will be examined through the lens of following frameworks. On the level of the profession of dietitians, the concept of professionalism by Evetts[115] will be used, which distinguishes between occupational and organizational professionalism, with the first one coming from within the community (e.g. trust, ethics, professional associations) and the latter from the outside (e.g. guidelines, regulation, managerialism). Furthermore, since dietitians as AHPs should be integrated into interprofessional teams, the systematic meta-review of Wei, et al.[81] will be employed, which proposed a three-level framework for the classification of barriers to interprofessional collaboration, which can help situate the experiences of dietitians within broader context.

This thesis adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ).[116]

5.2 Recruitment

Based on the previous experience of the researchers, we anticipated varying utterances from dietitians:

3. **with diverse levels of education** – in the Czech Republic, dietitians come into practice with different levels of education with focus on various aspects of dietetics which might influence their opinions and expectations
4. **working in diverse types of healthcare facilities** – larger facilities or facilities providing more specialized care might provide different conditions in terms of implementation of guidelines, allocating resources etc.

We used maximum variation purposive sampling[117] to recruit hospital dietitians from the Czech Republic based on the criteria above regarding their level of education in dietetics (secondary school, higher vocational school, BSc, MSc) and the type of hospital they worked in (regional, university, specialized; see Table 4). Participants for piloting the data collection were identified through professional contacts and invited for pilot interviews. Subsequently, the study was advertised via professional associations and social media. At the end of each interview, participants were asked whether they knew of other dietitians who might meet the predefined criteria, allowing for additional recruitment via chain referral[117]. No incentives were provided to motivate participation. While some participants were known to the interviewer, they responded to the advertisement of their own will and were not invited based on their relation to the interviewer except for the two initial pilot participants. Since the study aim was stated clearly in the advertisement, it is possible that the sample was skewed towards dietitians who were more dissatisfied or had experienced more challenges in their workplace. This potential self-selection bias was considered in the analysis and results interpretation.

Table 4 Recruitment matrix

Secondary school graduate working in *regional hospital*	**Secondary school graduate** working in *university hospital*	**Secondary school graduate** working in *specialized hospital*
HVS graduate working in *regional hospital*	**HVS graduate** working in *university hospital*	**HVS graduate** working in *specialized hospital*
Bachelor working in *regional hospital*	**Bachelor** working in *university hospital*	**Bachelor** working in *specialized hospital*
Master working in *regional hospital*	**Master** working in *university hospital*	**Master** working in *specialized hospital*

Informed consent was obtained from all participants before scheduling the interview. The entire research team signed confidentiality agreements to ensure data protection and prevent potential data breach, including the assistants hired for interview transcription. The research was approved by the Ethics Committee of the Faculty of Medicine, Masaryk University, No. 18/2021.

5.3 Data collection

We conducted online, in-depth, semi-structured interviews using conversational interviewing via the ZOOM platform to engage dietitians from across the country. The interview guide (Table 5; full version in appendix) consisting of open-ended questions was developed in consultation with a senior researcher and a nutrition practitioner expert, and then face-validated with three dietitians not involved in the study. The first two interviews were used to pilot the data collection process. Since there was no need for a change in the process, these interviews were included in the dataset.

All interviews were conducted between May 2021 and February 2022 in Czech by MK to ensure consistency. MK is a registered dietitian and an assistant professor at a university dietetics program. At the time of the study, he was also serving as the chair of the Czech Association of Dietitians. While this background provided valuable contextual understanding and rapport with participants, it may have also influenced the responses due to perceived professional authority or social desirability, which was reflected during the interviews and the subsequent analysis. Participants were informed about the researcher role before the interview, and efforts were made to create an open and non-judgmental atmosphere during the interviews to minimize the effect on participants' responses.

The interviews lasted between 21 to 71 minutes (median length 36 minutes). A notetaker (ZK or VZ) was present in each recorded part of the interview to record field notes in order for the interviewer to focus fully on the interview[118] and also as a method of triangulation[119]. We acknowledge that even an unseen observer may influence participants' comfort and willingness to share sensitive information. To minimize this potential impact, notetakers were introduced under pseudonyms, did not interact with participants, and remained off-camera throughout the interview. None of the participants expressed concerns about the presence of a second researcher before, during or after the interview.

To protect the participants' data, only the principal investigator knew their identity and characteristics. Each participant was assigned a code, which was used to pseudonymize all the materials related to that participant and under which they were joining the ZOOM call with their camera turned off, and the participants were also advised to avoid disclosing names of people or places during the interview. Demographic data

had been acquired before the recorded part of the interview and before the notetaker joined the call. No repeat interviews were carried out. The audio of each interview was recorded and transcribed by research assistants using oTranscribe. All transcriptions were compared with the recordings for accuracy and readability and de-identified by MK before analysis.

Table 5 Domains of the interview guide and example questions

Domain	Example question
Job satisfaction	What do you enjoy, find fulfilling about your work?
Perception by other healthcare professionals	How do you feel involved in the interdisciplinary team at your workplace and what is your role in it?
Perception of job description	To what extent does your job description match your expectations?
Perception of nutrition care	What are the barriers in your workplace that prevent you from providing care as you would like to?

5.4 Data analysis

Thematic analysis followed an inductive approach, grounded in the principles of applied thematic analysis described by Guest[114]. All interview transcripts were analysed alongside field notes. Two researchers (MK and KJ) independently conducted open coding of the transcripts to capture recurring patterns and concepts. An initial codebook was created and iteratively refined through team discussions, ensuring both consistency and flexibility during the coding process. Final coding was performed using Atlas.ti version 23 (ATLAS.ti Scientific Software Development GmbH Berlin, Germany).

Once coding was completed, codes were reviewed for conceptual similarities and grouped into preliminary categories. Through a series of collaborative meetings involving both academic researchers and practicing dietitians (MK, KJ, VZ, ZK, VH), these categories were further organized into candidate themes and subthemes. The process included constant comparison of coded segments across transcripts, identification of patterns and discussion of potential overlaps. Special attention was paid to maintaining internal coherence within each theme and ensuring distinct boundaries between themes.

The final thematic structure was agreed upon through consensus among all members of the research team. During the peer-review process, the structure was revisited in response to reviewer feedback, prompting regrouping and renaming of some

themes to better reflect the research aim and reflect the introduction of theoretical frameworks for interpretation. Throughout the analysis, we aimed to preserve participants' voices while situating their perspectives within a broader institutional and professional context.

Although the thematic analysis was conducted inductively, the interpretation of the findings was subsequently informed by two theoretical frameworks. On the level of the profession, the concept of professionalism by Evetts[115] distinguishes between occupational and organizational professionalism, with the first one coming from within the community (e.g. trust, ethics, professional associations) and the latter from the outside (e.g. guidelines, regulation, managerialism). Furthermore, since dietitians as AHPs should be integrated into interprofessional teams, the systematic meta-review of Wei et al.[81] proposes a three-level framework for the classification of barriers to interprofessional collaboration into individual, team, and organizational. These frameworks were used to interpret the themes and discuss their broader implications for the professionalization of dietitians in the Czech Republic and the delivery of nutrition care within hospitals.

6 Results

This chapter is an expanded version of the Results section of the following paper, written by the author of the thesis:

> *Krobot M, Jančeková K, Hawk VH, Zelenková V, Kapounová Z. Challenges in delivering nutrition care perceived by hospital dietitians in the Czech Republic: a qualitative study. BMJ Open. Accepted for publication 2025.*

6.1 Characteristics of participants

Several hundred dietitians were approached online, and 11 dietitians were approached in person via chain referrals with recommendations obtained at the end of each interview to maximize the coverage of the recruitment matrix. Out of these, 26 expressed an interest to participate, of which 15 completed informed consent and participated in the research.

Overall, the participants represented dietitians aged 24–63, mainly female, and working in a variety of settings, including outpatient clinics, and large and small hospitals at clinical or food service positions. Participants comprised dietitians with different levels of education and varied amounts of professional experience in several types of hospitals, thus offering multiple perspectives and expertise. Their characteristics are summarized below (see Table 6).

Table 6 Characteristics of participants

Parameter	Value	n	%
Sex[a]	Male	2	13%
	Female	13	87%
Age	24–30	6	40%
	31–50	7	47%
	51–63	2	13%
Years of practice	0.25–10	8	53%
	11–20	3	20%
	21–44	4	27%
Highest level of formal dietetics education	Secondary school	4	27%
	HVS	3	20%
	University (BSc)	4	27%
	University (MSc)	4	27%

Parameter	Value	n	%
Type of hospital	Specialized hospital	2	13%
	University hospital	6	40%
	Regional hospital	7	47%
Professional role[b]	Inpatient care	13	87%
	Outpatient care	10	67%
	Food service	8	53%
	Chief dietitian	2	13%

[a]The term "Sex" refers to biological sex as reported by participants during demographic data collection. In the original Czech version of the interview guide, the term "pohlaví" was used, which corresponds to sex assigned at birth. No data on gender identity were collected.
[b]Participants could report more than one professional role. Therefore, the percentages account for the share of all the participants claiming that role and do not sum to 100%.

Through thematic analysis, we identified three themes and four subthemes, which are further described below (see Table 7). Although the interviews and analysis were held in Czech, the quotes were translated for the purpose of reporting the research.

Table 7 Themes and subthemes

Theme	Subtheme
Unclear professional role and identity	Insufficient recognition of the dietitian's role
	Internal fragmentation of professional identity
Marginalization of nutrition care	Lack of strategic support for nutrition care
	Disregard of nutrition care by other HCPs
Tension between professional aspirations and legal boundaries	

6.2 Theme 1: Unclear professional role and identity

6.2.1 Subtheme 1.1: Insufficient recognition of the dietitian's role

Dietitians frequently reported a misalignment between how they perceived their role in healthcare and how it was understood by other healthcare professionals (HCPs). Many participants described a lack of respect for their expertise, interventions, or even

for themselves as professionals. They were often associated solely with food service, and some had experienced not being recognized as healthcare professionals at all. This led to inferior treatment compared to other clinical HCPs, including unprofessional behavior, exclusion from interprofessional collaboration, and the assignment of irrelevant tasks such as placing food orders or managing ONS stock. Efforts to justify their role and emphasize the importance of nutritional care were often perceived as futile. Dietitians attributed this situation primarily to a lack of awareness among other HCPs regarding the education and scope of practice of dietitians.

> *"My colleague's ward nurse actually claimed that she's not even a healthcare professional. So yeah... the awareness is really, really poor. (...) Before, there were just the 'dietaries' in the kitchen, so now they see us as just another 'dietary' who suddenly showed up on the ward. But no one really knows what I'm supposed to be doing or how it's supposed to work."*
> — D13, MSc, regional hospital[a]

In such contexts, dietitians were not consulted following positive nutrition screenings, and their suggested interventions were either modified or disregarded entirely; actions they believed compromised the quality of care and potentially harmed patients. Participants viewed this situation as the result of several interconnected issues. First, healthcare professionals were not adequately educated about IPC or the role of dietitians, either during their formal training or through continuing education. Dietitians also felt burdened by the legacy of dietary nursing and noted a general lack of understanding among other HCPs regarding the evolution of their profession. Additionally, physicians and nurses often exhibited a sense of superiority, positioning themselves as the primary decision-makers.

> *"Oh, absolutely, the attitude of some doctors is really discouraging. Sometimes it's just... I don't know, like that time on the surgical ward when a doctor started explaining a diet to me, and he wasn't even getting it right. That really pissed me off. He hadn't studied it, he clearly didn't even know what he was talking about, and yet there he was, lecturing me."*
> — D04, BSc, regional hospital[b]

[a] Mně se to konkrétně nestalo, ale kolegynina staniční dokonce, jak se řešily ty covid odměny a tak, tvrdila, že není ani zdravotnický pracovník. Povědomí je fakt, fakt mizerné. Asi tak. (...) Předtím byly jen dietky v stravováku, takže nás berou jako takovou dietku, která je najednou na oddělení. Ale nikdo neví ani, co bych měla dělat, jak by to mělo probíhat.

[b] No určitě, ten přístup od některých lékařů, to mě dost demotivuje. Občas, když je to takový, že... nevím, se mi stalo, že právě na té chirurgii, že mi ten lékař přímo vysvětloval nějakou dietu, přitom to ani neříkal dobře. A to mě strašně naštvalo, že on to nestudoval, že on prostě nevěděl moc ani, o co jde, mi přišlo. A úplně mě tam začal poučovat.

However, some participants described instances of respectful collaboration, where physicians or nurses actively engaged with dietitians, referred patients to them, and appreciated their skills and experience in nutrition. Key facilitators included previous positive experiences with dietitians, recognition of their expertise, the ability to articulate sound clinical reasoning, the gradual development of interpersonal relationships, and frequent contact. Physicians and nurses generally responded positively to supportive and respectful approaches, rather than directive ones, and some participants emphasized patience combined with persistence.

> *"And then at the other clinic, I'm seen as a proper colleague, they ask me straight up how to initiate parenteral or enteral nutrition, how to connect the bags and everything. When it comes to educating patients with various conditions, they openly say they don't really understand it and that's what I'm there for, and they're genuinely glad to have me. So in terms of being part of the healthcare team, the collaboration is really good there. They're very open, willing to take advice, and it's much easier to have a proper discussion with them."*
> — D07, BSc, university hospital[c]

> *"I feel like with surgical departments, you either have to match their temperament or consciously adjust to it. And when I think about how things could be improved, unfortunately, I have to bring up relationships again. Because if you don't have that relationship and approach them in a purely directive way, especially in surgery, you'll hit a wall. There, it's not just about pointing out a problem, you need to say, 'Look, here's how I can help you.'"*
> — D02, secondary school, university hospital[d]

Participants shared examples of both rejected and embraced collaboration, even within the same hospital. They highlighted the influence of respected figures leading the team (e.g., head physicians or charge nurses), whose attitudes could shape the behavior of entire departments, either positively or negatively. Some noted the significant impact of leadership figures who advocated for nutrition and dietitians,

[c] A zase na tý druhý klinice, tam jsem nutriční terapeut jako jejich kolega, na rovinu mi řeknou, jak zahájit parenterální výživu, jak enterální, co kam jak napojit, jaký vaky, edukace pacientů při nějakých jako různých jako onemocněních, a na rovinu řeknou, že tomu nerozumí, že jsem od toho tam já a že jsou za mě moc rádi, takže tam ta spolupráce ve smyslu týmu zdravotnickýho je na velice dobrý úrovni. A jsou velice vstřícní, nechají si poradit a dá se s nima více diskutovat.

[d] Ta chirurgická oddělení vnímám, že tam člověk musí buď mít jejich naturel, anebo se tam doopravdy nastavit a když přemýšlím, jak se to dá zlepšit, tam já zase bohužel musím zmínit ty vztahy. Protože ve chvíli, kdy tam nemáte ten vztah a jdete jenom direktivně, tak obzvlášť u chirurgií narazíte. Tam je potřeba nejenom ukázat na problém, ale spíš nabídnout: "Podívejte se, já vám tady mohu takto pomoci."

particularly when they were personally interested in the topic or understood its importance. Generational differences also appeared to play a role, with younger physicians described as more open to collaboration. Larger hospitals were perceived as more likely to foster professional recognition compared to smaller regional facilities.

> *"We had this hugely respected chief surgeon who openly claimed that dietitians had no place in a hospital, that they were completely useless. And over the course of thirty years, he basically manipulated the whole hospital into believing that. (...) The only place where I was actually used as a dietitian was a long-term care facility in another town. (...) The head nurse there used to work in gastroenterology and had come from outside. She knew that dietitians existed and that we could be really helpful. And once she found out I was there, with a university degree, she gave everyone a sort of crash course on who I was, what I do, how I work, it was absolutely great."*
> — D09, BSc, regional hospital[e]

Although participants identified many facilitators of interpersonal communication and, by extension, IPC, these strategies were not always effective. Many expressed frustration that, in some settings, professional recognition seemed unattainable despite their efforts, suggesting the presence of deeper systemic barriers to integration.

[e] My jsme tam měli veleuznávanýho pana primáře na chirurgii, kterej prostě prohlašoval, že nutriční nemá co v nemocnici dělat, že je to člověk, kterej je naprosto neschopnej. A takhle zmanipuloval celou nemocnici, manipuloval jima 30 let, těma všema lidma. (...) Jedinej, kdo mě používal jako nutričního terapeuta, bylo pracoviště LDN, které bylo v jiném městě. (...) Protože tam byla vrchní sestřička bývalá sestřička z gastroenterologie, která přišla z venku, a věděla, že prostě nějakej ten nutriční existuje a že je to hrozně fajn. Tak pak, když zjistila, že tam jsem já, vysokoškolsky vzdělaná, tak tam všem dala takovou osvětu základní, k čemu vlastně jsem, jak funguju, nefunguju, to bylo úplně super.

> *"I started out on the surgical ward, and I just couldn't handle it mentally with them. So I asked [to be transferred]. I was really interested in it, the patients, the fact that nutrition plays a huge role there, especially with surgical patients and obviously in GI cases, but it just wasn't doable. The communication there was really bad."*
> — D01, MSc, university hospital[f]

Some participants emphasized the value of collaboration with physicians specialized in clinical nutrition. In wards where such specialists were present, IPC was more readily facilitated and supported. Dietitians viewed clinical nutrition physicians as champions who advocated for their profession and educated other physicians about nutritional care.

> *"I believe the role of a dietologist, or a specialist physician in clinical nutrition, is really important, someone who should oversee the nutrition care. And if that kind of person isn't there, which unfortunately is my case, I don't have a partner like that, then it's really hard to push for proper nutrition care on your own."*
> — D10, secondary school, university hospital[g]

Interestingly, participants noted that physiotherapists and some other allied health professionals appeared to have a more established position. Their roles and contributions were believed to be better understood by other HCPs, and their legal professional status was perceived as more clearly defined and respected.

> *"I guess it mostly comes down to this: we have physiotherapists, we have occupational therapists, which is still a relatively new field, but everyone knows what an OT is, everyone knows what a speech therapist does, everyone knows what a physiotherapist does. Nobody's calling them rehab nurses anymore, at least not often. But when I show up? I'm still just the kitchen lady, most of the time."*
> — D01, MSc, university hospital[h]

[f] Já jsem začínala na chirurgii a já jsem to tam prostě nezvládla psychicky s něma. Takže já jsem si požádala *[o přeložení]*. Mě to hrozně zajímalo, ti pacienti, tam ta nutrice má opravdu velmi velký význam, skoro u každého chirurgického pacienta, na GITu, samozřejmě, ale to tam nešlo prostě. Tam byla opravdu velice špatná domluva.

[g] Myslím si, že je důležitá pozice dietolog, nebo jako nutriční lékař specialista, který by měl zaštiťovat tu nutriční péči, a pokud není tady takový, což bohužel nemám takového parťáka, tak je to hodně náročné prosazovat samostatně tu nutriční péči.

[h] Jde asi hodně o to, že máme fyzioterapeuty, máme ergoterapeuty, což je relativně novej obor, ale všichni ví, co je ergoterapeut, všichni ví, co dělá logoped, všichni ví, co dělá fyzioterapeut, už se to nenazývá rehabilitační sestra, málokdy. Ale já přijdu a jsem prostě paní z kuchyně kolikrát.

6.2.2 Subtheme 1.2: Internal fragmentation of professional identity

In addition to reporting a lack of awareness among other HCPs, participants expressed diverse and sometimes conflicting views regarding their own professional role and identity. Their understanding of the dietitian's job description varied considerably, and perceptions of the appropriate level of education required for the profession were inconsistent.

These differences were most evident in how participants described the clinical and operational dimensions of their work. Some viewed the integration of clinical care and food service as ideal and beneficial. Dietitians with experience in both areas emphasized that understanding the capabilities and limitations of food service enabled them to provide more individualized nutritional care. They commented on potential frustration of their solely clinical colleagues when clinical recommendations could not be implemented due to food service constraints. These participants appreciated the variety in their work and found satisfaction in food service tasks, especially when their clinical role was limited. They advocated for combining responsibilities, either by incorporating food service into their routine or through rotating shifts. While acknowledging that having dedicated clinical dietitians for each department could be advantageous, they argued that lacking insight into food service operations would hinder the delivery of optimal nutritional care.

> *"After school, I said I would never go to food service in my life and that I wanted to work only at the clinic. (...) –in a hospital in a particular region they were looking for a dietitian. When I saw it was a combination of food service and clinic, I must admit I didn't really feel like going there. But there was a motivation that they have relatively higher salaries, so I thought to myself that when there are no other positions available, I'll try it, and now after these three, four months I must say that I'm really glad, because I'd say that this should be the case of every hospital, everyone should go through the food service at least during the probation period, because as we rotate the food service and the clinic after a month, we know perfectly well what our options are."*
> — D15, BSc, regional hospital[i]

[i] Tak samozřejmě po škole jsem si řekla, že do stravováku v životě nepůjdu a že chci čistě na oddělení. (...) –v nemocnici v určité lokalitě sháněli nutriční terapeutku. Když jsem viděla, že tam je kombinace jak stravováku, tak oddělení, tak se mi tam úplně nechtělo, to se přiznám rovnou. Ale zase tam byla motivace v tom, že tam mají poměrně vyšší platy, tak jsem si řekla, že když jiný místa nejsou, tak to zkusím, a teď po těch třech, čtyřech měsících musím říct, že jsem strašně ráda, protože bych řekla, že takhle by to asi mělo být v každý nemocnici, minimálně by si tou kuchyní měli projít všichni aspoň ve zkušební době, protože díky tomu, že my se střídáme po měsíci stravovací provoz a oddělení, tak perfektně víme, jaký máme možnosti.

> *"When I had various practice placements during school, I got a feeling in Prague, that it's no good when clinical and food service parts are separated, because it seemed that the dietitians are rather fighting. So, I chose our hospital for the practice placement, which we had in hospitals, because I knew I could start [working] here and it seemed to me really great that I am going to the clinic, I discuss everything with the patient, but then I'm not sending the information blindly to someone else hoping they would follow it."*
> — D14, HVS, regional hospital[j]

Conversely, other participants, regardless of their level of education, perceived food service as an area that dietitians should not be primarily involved in. They felt that association with food service diminished the professional image of dietitians and believed their role should focus exclusively on clinical nutrition. Some considered food service tasks inappropriate given their education and suggested that such responsibilities should be delegated to other staff. A few respondents, based on prior experience, expressed a strong reluctance to return to food service and supported the idea of separating clinical and operational roles.

> *"I always say, even though I've mostly managed to work in places where the clinical and food service parts are connected, I've always told myself that the day I become just a clinical dietitian, I'll finally have it good. Because then I'll be doing what I actually studied for, what I enjoy. That food service part, I honestly don't think a dietitian is 100% necessary there. (...) Sure, I learn cooking at school, but only marginally, and I'm really not going to be the one cooking those diets. From my point of view, a dietitian in food services is a supervisory role. That means they do the work, and I check it randomly, not that I stand over them with a whip, no. They cook it, they're responsible. (...) Here, it's really just the basics, so I don't see any reason why a dietitian should be substituting for a cook, or a cook with a diploma."*
> — D06, MSc, specialized hospital[k]

[j] Já, když jsem chodila během školy na různý praxe, tak jsem získala v Praze pocit, že nedělá dobrotu, když je klinická a stravovací část oddělená, protože mi přišlo, že ty nutričky mezi sebou docela bojovaly. Takže já jsem už na praxe potom, co jsme měli v nemocnicích, tak jsem si naši nemocnici vybrala, protože jsem věděla i, že bych mohla nastoupit a přišlo mi to právě hrozně super, že jdu si na tu kliniku, s tím pacientem si to všechno řeknu, ale potom neposílám nějak slepě informace někomu dalšímu a budu doufat, že to dodrží.

[k] Já tvrdím, i když se mně podařilo teda celý život vždycky vyjít, nebo většinou vyjít ze zařízení, kde je ta klinická část spojená s tou provozní, tak jsem si vždycky říkala, že až jednou budu opravdu jenom ta klinická sestra, tak se budu mít dobře, protože budu dělat to, co jsem vlastně studovala, nebo to, co mě baví, protože ta provozní část, tam si nemyslím, že ta nutriční terapeutka je až tak 100% nutná. (...) A já dobře, vařit se učím na škole, ale tak jako okrajově, ale já jim opravdu ty diety vařit nebudu. Já, když z mého pohledu nutriční terapeut pro stravovací provoz je kontrolní orgán, to znamená, že oni něco dělaj, a já je namátkou chodím kontrolovat, ne že za nima budu stát

> *"I graduated in 2001, the field was called dietary nursing back then, and you only worked in food service, and there weren't even sip feeds. (...) I have that experience, I worked in the food service, and I would never want to go back."*
> — D08, HVS, university hospital[l]

Perceptions of what constitutes clinical practice also varied. For some, clinical dietetics was understood as pragmatic, food-based care, while others emphasized the importance of specialized nutrition interventions, including the use of ONS. These perspectives reflected differences in education, training, and personal experience, and revealed the absence of a shared understanding of the profession's core focus and role within healthcare.

> *"I'd really rather focus on clinical nutrition, values, individual nutrition types and so on, but they frequently call me to change the bread for the bun, so that's the job of the... dietary nurse? Or they call themselves dietitians... I think there should probably be some kind of distinction. Because when the dietitian from the kitchen picks up [the phone], she introduces herself as a dietitian, and I also introduce myself as a dietitian, and then I can imagine that some doctor here really has no idea who's who."*
> — D01, MSc, university hospital[m]

> *"It's nice to be up on the ward, discussing things with people in a lofty way and doing all sorts of calculations. But if I can't actually deliver that into the food service, then it's, not that it's useless, but it's just work that's been done without any real effect."*
> — D14, HVS, regional hospital[n]

s bičem, ne. Oni to uvaří, jsou zodpovědní. (...) Tady opravdu je jenom ten základ, takže tady nevidím důvod, proč by ten nutriční terapeut měl suplovat práci kuchařky, případně kuchařky s maturitou.

[l] Já tím, že jsem končila v roce 2001, tak ten obor se tehdy jmenoval dietní sestra a pracovalo se jenom ve stravováku, a ani nebyl sipping, nebyl prostě. (...) Já mám tu zkušenost, já jsem ve stravovacím provoze pracovala, a nikdy bych se tam už nechtěla vrátit.

[m] Já bych se ráda opravdu spíš věnovala té klinické výživě, hodnotám, těm jednotlivým výživám a tak dále, ale dost často mě volají, aby změnili chleba na rohlík, tak tohle je kompetence té... dietní sestry? Oni si teda říkají nutriční terapeuti... To si myslím, že by se možná mělo nějak rozlišit, protože když vezme [telefon] v kuchyni ta nutriční terapeutka, tak se taky představí nutriční terapeutka a já se taky představím nutriční terapeutka a pak věřím, že prostě nějakej lékař tady nemůže rozeznat, kdo je kdo.

[n] Je sice krásný bejt někde na oddělení a s lidma někde vznosně něco řešit a strašně počítat. Ale když potom to nedokážu dodat do toho stravovacího provozu, tak je to ne k ničemu, ale prostě je to jenom odvedená práce, která potom neměla žádnej efekt.

These conflicting viewpoints are not only limited to the simple description of a dietitian's role but also subvert the unity of the profession. Participants often viewed their own interpretation of the dietitian's role as the correct one and were critical of differing views.

University-educated dietitians expressed frustration about sharing the same scope of practice with colleagues who had only secondary or vocational education, arguing that insufficient clinical training among the latter could harm the profession's reputation. On the other hand, some dietitians with vocational or secondary education criticized university graduates for lacking practical experience and understanding of food service operations.

> *"I think that the university is far more difficult, but then we have it, the scope of practice, the same, or the things we can do let's say with bachelor's degree compared to them with their HVS degree."*
> — D04, BSc, regional hospital[o]

> *"And then I see limits in the university education (...) and that's cooking. To be able to think about the composition of a diet, replacements, creating new recipes, food plan adjustments (...) that's what I almost can't find in university educated dietitians, bachelor or master, who didn't graduate from dietetic secondary school before."*
> — D02, secondary school, university hospital[p]

Mostly university-trained participants perceived a steady evolution of the profession toward higher education and more complex clinical care. They expressed interest in developing more detailed specialization tracks (e.g., oncology, diabetes), citing information overload when expected to manage patients with diverse diagnoses. In contrast, some participants emphasized the need for dietitians to be broadly knowledgeable across all areas of nutrition care.

> *"...I always say that if a dietitian is to do their job 100% properly, they can't just run from one thing to another. (...) If I've spent my whole career working with oncology patients, why should I suddenly switch to treating kids and pregnant women, that would mean learning everything from scratch. (...) As far as I know, we have here just [specializations for] adults and children, and I think that's not enough, as in*

[o] No, protože si myslím, že ta vysoká je daleko těžší, ale my to potom vlastně máme, tu náplň práce, stejnou, nebo to, co můžeme dělat třeba s bakalářem, a oni s tím DiS.

[p] A pak celkově vidím limity stran vysokoškolského vzdělávání (...) což je vaření. Dokázat potom uvažovat nad složením stravy, záměnou stravy, vytváření novejch receptur, možnosti upravení jídelníčku (...) a to jako uvidím, že málokdy jsem to našla u vysokoškolsky vzdělaného nutričního terapeuta nebo specialisty, který předtím neměl střední nutriční.

> *adults, I would add at least two, three groups, such as the oncology, diabetes also works, but it would simply need something more."*
> — D06, BSc, specialized hospital[q]

> *"...we had rounds, where we went through all the departments and the food service. Then a dietitian based like this could manage all the departments and could manage also the food service. I think this should be essential, because dietitian should be a professional in all respects."*
> — D11, secondary school, regional hospital[r]

Two respondents offered contrasting reflections on the value of university education. One master's graduate described academic credentials as a gateway to professional opportunities, while a secondary school graduate expressed feeling marginalized due to the absence of a formal degree, despite believing they were well-qualified for their role.

> *"I have never expected that the moment you put a degree in front of your name, the door opens. I didn't believe it. And no matter how dumb I am, the door opens. However, then I have to be responsible [for my actions], then if you make a fool out of yourself, the degree won't save you. But it opens the primary door, that's nice."*
> — D06, MSc, specialized hospital[s]

> *"I think I am educated enough to do my job very well, but I am sometimes confronted with the fact that I don't have the degree. And that's something that still bothers me."*
> — D02, secondary school, university hospital[t]

[q] Já vždycky tvrdím, že nutriční terapeut, kterej má svou práci dělat 100% dobře, nemůže opravdu zabíhat zleva doprava. (...) Když celej život třeba dělám s onkologickejma pacientama, proč já najednou z onkologie půjdu dělat děti a těhotný, to se začnu učit všechno úplně od znova. (...) Pokud vím, tak my u nás máme pouze děti a dospělý, což si myslím, že je málo, protože u dospělých bych ještě aspoň dala dvě, tři krabičky nebo škatulky, jako rozdělit, jako je ta onkologie, diabetici taky celkem fungujou, ale chtělo by to ještě trošku víc tohleto.

[r] ... protože jsme měli kolečka, kdy jsme procházeli veškerá oddělení, procházeli jsme i stravovací provoz. Takže nutriční terapeut v této podobě, dokázal zastat funkci veškerých oddělení a dokázal zastat funkci i provozu. Což si myslím, že by měl být ten základ, protože nutriční terapeut by měl být odborník po všech stránkách.

[s] V životě jsem nepočítala s tím, že v momentě, kdy si dáte před jméno titul, se vám otevřou dveře. Nevěřila jsem tomu. A můžu být sebehloupější, dveře se otevřou, ale potom už si to musím zodpovědět, potom když ze sebe uděláte, s prominutím, blbce, tak ani ten titul vás nezachrání. Ale ty prvotní dveře vám to otevře, to je pěkný.

[t] Myslím si, že jsem dostatečně vzdělaná na to, abych svoji práci odváděla velmi dobře, ale bývá mi občas předkládáno, že nemám ten titul. A to mě mrzí.

Despite these internal divisions, participants across all educational backgrounds agreed that professional representation was insufficient. They viewed the existence of multiple professional organizations as a barrier to advancing the profession and called for greater unity. This tension between internal divergence and external expectations underscores the unsettled nature of dietitians' professional identity in the Czech Republic.

> *"I don't know if it's good that we have SNT ČAS [Section of Dietitians, Czech Association of Nurses] and ČANT [Czech Association of Dietitians] as two organizations. Both are doing similar things. But maybe if we were, as one organization, coordinated, united, we would have better position in negotiations. (...) That's the main message, since I think that many times the projects are similar in both organizations and sometimes we are just working in silos."*
> — D05, HVS, regional hospital[u]

6.3 Theme 2: Marginalization of nutrition care

6.3.1 Subtheme 2.1: Lack of strategic support for nutrition care

Many participants described a persistent marginalization of nutrition care by hospital management. Proposals related to resource allocation, equipment upgrades, systemic improvements, or the creation of new dietitian positions were often dismissed or deprioritized. This lack of support resulted in suboptimal working conditions, including poorly located offices, inadequate equipment, low food quality, and insufficient salaries for kitchen staff.

> *"But when I get someone with obesity, someone I actually need to weigh, I had to borrow a scale from the nurses who happened to have one they weren't really using. Because we're apparently not able to get our own scale for the outpatient clinic. Such a basic thing."*
> — D02, secondary school, university hospital[v]

[u] Nevím úplně, jestli je dobře, že máme SNT ČAS a ČANT jako dvě organizace. Obě organizace děláme podobný věci. Ale třeba možná kdybychom byli, jakožto jedna organizace, koordinovaná, sloučená, že bychom měli lepší pozici při vyjednávání. (...) Což je ta hlavní zpráva, protože si myslím, že kolikrát ty projekty jsou podobný v obou organizacích a že někdy prostě zbytečně tříštíme síly.

[v] Ale když by mi přicházela obezita, prostě někdo, koho potřebuju zvážit, tak jsem si musela od kolegyň, které momentálně měly váhu jednu ne úplně využívanou, tak jsem si musela půjčit váhu, protože nejsme schopní dostat do tý ambulance samostatnou váhu, takovou základní věc.

> *"Well, [the outpatient clinic] isn't even marked, I'm not listed in the public directory, nothing. (...) Apparently, there's no need to fix that! When I brought it up, my manager just said that if my patients need to find me, they can figure it out themselves. There aren't even any signs pointing to my office. Nothing."*
> — D03, secondary school, specialized hospital[w]

> *"I've been in this one nursing home, where the management was straight up against giving the grannies and grandpas proper nutrition if they were on blended diets. I had such terrible fights there... They just weren't open to the idea that blended meals should be on the same level as regular diets, like nutritionally complete and with the same energy value. And they'd serve them blended bread or a bun with water. That was their whole day's food."*
> — D11, secondary school, regional hospital[x]

Although economic arguments were frequently cited by management, nutrition care was rarely considered a strategic priority. It was often viewed as peripheral and financially unviable. Dietitians saw this as a fundamental contradiction, noting that effective nutrition interventions could improve patient outcomes and reduce hospital costs. They interpreted the persistent deprioritization as a reflection of limited understanding of both the clinical and economic value of nutrition care.

> *"Management should definitely be aware of the pros and cons of having a dietitian. How much money it could save if patients were properly nourished, if there was real attention paid to that. But they don't have that data, so to them it just seems like wasted money. They just decide it's unnecessary."*
> — D13, MSc, regional hospital[y]

This misunderstanding had a direct impact on dietitians' ability to deliver evidence-based care. Most participants reported being understaffed, which led to reduced time with patients, missed ward rounds, and prioritization of only the most urgent nutrition issues. Many described working overtime, investing personal time into

[w] No, [ta ambulance] je neoznačená, nejsem na telefonním seznamu veřejným, nic. (...) Ne, není to potřeba! Když mi vedoucí řekla, že když mí pacienti potřebujou, tak ať si tam dojdou. Nejsou tam ani šipky, nic, ke mně.

[x] Já jsem zažila, v tom posledním domově důchodců, co jsem byla, že vyloženě tam bylo i vedení proti tomu, aby se těm babičkám a dědečkům dávala plnohodnotná výživa, když byli na mixované stravě. Měla jsem tam vůbec prostě hrozný boje... jako nebyli schůdný pro to, aby se mixovaná strava dostala na úroveň mixované stravy, kde by byla plnohodnotná strava energeticky odpovídající stravovací jednotce normální diety. A dávali jim tam mixovanej chleba nebo rohlík s vodou. To bylo jejich celodenní jídlo.

[y] Určitě by to vedení mělo vědět ty plusy a mínusy, proč tam toho nutričního terapeuta mít. Kolik peněz, například, by to mohlo ušetřit, kdyby pacienti byli správně živení. Kdyby se na to dbalo. Takže tyto data nemají, takže jim to přijde jako vyhozené peníze. Ale prostě si to tak řeknou, že to ani není potřebné.

professional development, and experiencing symptoms of burnout. The staffing shortage also prevented specialization, as dietitians were required to cover multiple areas of care. Furthermore, participants believed that insufficient staffing contributed to low awareness of their role among other healthcare professionals, as they lacked visibility and opportunities to demonstrate their expertise.

> *"Sometimes even five clients were too much, if it was beyond thirty minutes, I just couldn't give them the time they needed. And I really hated having to say, 'I'm sorry, I have to leave, I don't have more time for you.'"*
> — D11, secondary school, regional hospital[z]

> *"If the dietitian has time to go on ward rounds, to actually calculate patients' needs, to really be seen and be part of the team, then everything's doable and it's not a problem. But if there are too few dietitians and they're responsible for twelve wards, including multiple ICUs, then they simply have no chance to do more. So doctors often don't even know that we're able to calculate nutritional intake — they just don't realize it's something they could ask us to do. But all of that takes time."*
> — D10, secondary school, university hospital[aa]

> *"Of course we try to manage somehow, but you simply can't manage everything. I'm doing, what I can, but..."*
> — D01, MSc, university hospital[bb]

Technological infrastructure was also described as outdated and insufficient. Participants reported reliance on paper documentation, lack of access to electronic health records, and minimal integration of nutrition care into hospital systems. Even basic software functionalities were often missing, complicating routine tasks. Attempts to advocate for improvements were frequently unsuccessful, and participants described these conditions as demotivating and disempowering.

[z] Kolikrát i těch pět klientů, když mi přesáhl rozsah půl hodiny, tak jsem prostě nemohla se tomu klientovi víc věnovat a bylo mi to strašně nepříjemný mu třeba říct: „Nezlobte se, já už musím jít, já na vás nemám víc času."

[aa] Pokud ten nutriční terapeut má čas chodit na vizity, prostě propočítávat pacienty, opravdu aby ho tam viděli, byl součástí toho týmu, tak to se všechno dá a pak to není problém. Ale pokud je těch nutričních terapeutů málo a mají na starosti 12 oddělení, prostě x JIPů, tak absolutně nemají šanci se věnovat víc. Takže oni to lékaři spíš nevědí, že třeba umíme propočítávat příjem výživy, že vlastně nevědí, že něco takového by mohli po nás chtít, ale je to všechno časově náročné.

[bb] Snažíme se to samozřejmě stíhat, ale všechno prostě stihnout nelze. Takže dělám, co můžu, no, ale...

> *"We don't have any patient records, no files for the patients who go through our outpatient clinic, it's basically just on trust. We don't even have the option to create their folders on the computer, nothing."*
> — D14, HVS, regional hospital[cc]

> *"The current system is pretty bureaucratic and outdated... It's a lot of paperwork, a lot of running back and forth between wards, so one patient ends up taking more time than would really be necessary. (...) We do have some access to the system, but there's no dedicated section for nutrition care. And when a ward requests a nutrition consultation, the report is written on paper and physically delivered to their files. Even though we have some electronic records, it still always starts on the ward, at the nurses' station, where they hand you a stack of papers, admission notes, discharge notes... It's a lot of paperwork."*
> — D05, HVS, regional hospital[dd]

Participants also noted that food service was often excluded from strategic planning and not considered part of essential healthcare. Decisions were made without consulting dietitians, which further undermined their role and led to poor food quality.

> *"In the reconstruction [of the food service facilities] somebody plans it from the technical department, and then when you say [what you really need and why], they say, 'We didn't think of that at all.' Because they think, 'We all cook at home, what's the big deal?'"*
> — D05, HVS, regional hospital[ee]

> *"[The chief dietitian] himself is desperate because of the 55 CZK [for food per day; cca 2,20 EUR], he applied for an increase in the food budget, since apparently it hasn't been updated since 1992. And he was told it definitely wouldn't be increased for at least another three years, because they have other priorities."*
> — D14, HVS, regional hospital[ff]

[cc] Nemáme žádnou kartotéku, žádnou složku pacientů, který nám tou ambulancí projdou, je to v podstatě na dobrý slovo. Ani v počítači k tomu nemáme možnost udělat si nějaký složky, nic.

[dd] Ten současný je poměrně byrokratický, zastaralý... Je to spousta papírů, spousta chození na oddělení a zpátky, takže jeden pacient zabere víc času, než by nutně musel. (...) Do systému máme nějaký náhled, není tam vyloženě záložka nutriční péče a když se zakládá nebo když si z oddělení vyžádají nutriční konzilium, tak se napíše papírová zpráva a odnese se jim do kartotéky. A byť máme nějakej elektronickej záznam, tak zase začínáte na oddělení, na sesterně, kde vám dají štos papírů, přijímací zprávy, propouštěcí zprávy... Je to hodně o papírech.

[ee] Což je vidět třeba i na tý rekonstrukci, že to někdo naplánuje z technickýho oddělení, a pak když tam člověk přijde a řekne [co a proč potřebuje], tak je tam spousta věcí, kdy pak třeba i oni si řeknou: „To nás vůbec nenapadlo, nad tím jsme vůbec nepřemejšleli." Že si řeknou: „Dyť vaříme všichni doma, co je na tom."

[ff] Ten [vedoucí nutriční terapeut] sám je zoufalej z těch 55 Kč, takže zažádal o zvýšení stravovací jednotky, protože ta tam prej je už do roku 92, a bylo mu řečeno, že další 3 roky určitě se zvyšovat nebude, protože mají jiný priority.

When dietitians attempted to address these issues, they often encountered resistance to change. Participants expressed frustration with the slow pace of reform and skepticism about whether meaningful improvements would ever be implemented. They believed this rigidity undermined the effectiveness of their work and the overall quality of nutrition care. Despite participants raising these concerns with management or responsible parties, resistance to change persisted.

> *"Things just don't work there, and when someone actually wants to improve or change something, it takes forever. It takes three years, three and a half years. Changes happen incredibly slowly. The whole system basically froze some fifty or sixty years ago and refuses to change. It's completely rigid. And I think that's probably the saddest part of it all."*
> — D13, MSc, regional hospital[gg]

Only one participant described a supportive management environment, noting interest in nutrition care and openness to modernizing food service, particularly in relation to staff meals.

> *"There is interest from the management. The director has shown willingness to refresh the menu and modernize the recipes, though they're mostly focused on staff meals. But I'm lucky to have an excellent supervisor, the deputy for nursing care (...) She processes all the feedback and suggestions, because there's also demand from the wards for more modern culinary techniques and for a much more varied approach to texture-modified meals."*
> — D05, HVS, regional hospital[hh]

6.3.2 Subtheme 2.2: Disregard of nutrition care by other healthcare professionals

Another dimension of marginalization described by participants was the perceived lack of nutrition knowledge among other HCPs. This deficit was considered a key factor shaping the current state of nutrition care and influencing interprofessional

[gg] Že to tam nefunguje a když se chce něco zlepšovat nebo měnit, tak to trvá. Trvá to tři roky, tři a půl roku. Hrozně pomalu tam dochází k změnám. Ten systém celkově zaspal před nějakými těmi padesáti, šedesáti lety a nechce se změnit. Je úplně rigidní. Takže to je na tom asi takové nejsmutnější.

[hh] Zájem vedení je. Ze strany paní ředitelky jsem zaznamenal zájem na tom refreshovat jídelní lístek a modernizovat receptury, ale tam je cítit spíš zájem na zaměstnanecké stravování. Nicméně mám výbornou nadřízenou, náměstkyni ošetřovatelské péče (...), a ta zpracovává všechny podněty, protože je zájem i ze strany oddělení na modernější přípravu, na daleko pestřejší úpravu mechanicky upravené stravy.

relationships. Participants reported that insufficient understanding of nutrition led to a lack of interest, with nutrition often being dismissed as irrelevant or deprioritized.

As a result, physicians frequently overlooked patients' nutritional status and needs, nurses failed to administer ONS or conduct nutrition screening, and food service staff disregarded guidance on food quality and preparation techniques, instead relying on personal cooking experience and cost-saving measures. Participants viewed this lack of knowledge as a root cause of many challenges they encountered in their daily practice.

> *"...there's simply no one there, no one with the specialization [in clinical nutrition], or even just with an interest in nutrition. Honestly, sometimes there's just no one to be found who cares [about nutrition]."*
> — D01, MSc, university hospital[ii]

> *"Surgery didn't want to hear anything about some dietitian or some low-residue nutrition. A patient had just gotten a fresh colostomy, and boom, they gave them the standard diet, they get cabbage, lentils, and apparently everything was just fine, because surgery, their own little world."*
> — D09, BSc, regional hospital[jj]

One participant specifically highlighted the misperception of the importance of various interventions provided by allied health professionals. Even within nutrition care, seemingly minor actions were often undervalued, despite their clinical relevance.

> *"When a patient needs to be thoroughly educated about a dialysis diet, about phosphate, potassium, and so on, the doctor really appreciates and respects that. Much more than, say, when a post-heart-attack patient is being educated on some kind of rational healthy eating. That just doesn't seem to carry the same weight. It's a stark contrast. (...) For example, during COVID, when it came to setting up enteral or parenteral nutrition, our work was very much appreciated. (...) And in those situations, our work was much more visible than, say, when a patient isn't being served the appropriate diet. Like, a doctor might not even notice that the patient has no teeth and keeps getting tough meat every day. It's also part of our job to change the diet, but*

[ii] ... tam vlastně nikdo takovej není, s tou licencí. Nebo se zájmem o výživu aspoň. Opravdu, tam nejde občas najít člověk, kterýho by to zajímalo.

[jj] Chirurgie vůbec nechtěla slyšel, že nějakej nutriční, že jsou i nějaký bezezbytkový výživy, pacient dostal stomii čerstvou na tlustý střevo, pink, dáme mu trojku, přijde mu zelí, čočka, a všechno je vlastně v pořádku, protože prostě chíra, vlastní svět.

> *things like that aren't really acknowledged. Even though they're necessary, they're just not seen as something important with immediate results."*
> — D07, BSc, university hospital[kk]

Nearly half of the participants reported issues with nutrition screening. Nurses were said to estimate responses rather than properly assess patients, or to skip screening altogether. Participants attributed this to a lack of understanding of the importance of identifying malnutrition risk.

> *"In some places, they don't do any screening at all. They won't call the dietitian even for a patient who's thin, has lost weight, isn't eating, they just don't call the dietitian, they don't deal with [nutrition]."*
> — D08, HVS, university hospital[ll]

Despite these challenges, a few participants described positive examples of collaboration, where physicians and nurses were aware of the importance of nutrition and actively supported proper care. These instances, however, were cited by a minority.

> *"They do the screening properly, but when someone slips through the cracks, the nurses notice and tell me, 'This gentleman isn't eating, this one has lost weight, that one is an oncology patient and their nutritional status doesn't look too good, go check on them.' So it works like this, the nurses are aware of the issue of malnutrition or poor nutritional status, and they let me know."*
> — D08, HVS, university hospital[mm]

> *"I have to say it's probably mainly due not only to the current department head, but also to one or two of his predecessors, who, probably because the department deals with inherited metabolic disorders that*

[kk] Když se má pacient opravdu dlouhosáhle edukovat o dialyzační dietě, fosfátech, draslíku a takhle, tak ten lékař si toho velice váží a respektuje to, než když prostě pacient po infarktu se bude edukovat o nějaký racionální zdravý stravě. Že se jim zdá, že to nemá takovou váhu, že prostě... Je to takhle diametrálně odlišný. (...) Já si myslím, že řekněme třeba při covidu, při nastavení enterálních, parenterálních výživ, tak to bylo oceňované hodně. (...) A tam ta práce byla asi vidět víc, než když pacient třeba nedostává správnou dietu, co by měl dostávat. Příklad, lékař si někdy nevšimne, že pacient prostě nemá zuby a nemůže rozkousat tuhý maso, který mu chodí každý den. Takže i role nutričního je, aby vůbec tu dietu změnil, ale tohleto úplně nikdo moc neocení, popřípadě jsou tam takový věci, který jsou potřeba, ale nejsou tak zohledněný jako něco opravdu důležitýho, co je hned vidět, že má nějaký výsledek.

[ll] Někde prostě vůbec nedělají screening, tu sestřičku nezavolají ani k pacientovi, který je hubený, zhubnul, nejí, prostě nezavolají tu nutriční, neřeší [tu výživu].

[mm] No, poctivě vyplňují screening, a když třeba náhodou někdo vypadne, tak to ty sestry vnímají a řeknou mně: "Tady tenhle pán nejí, tenhle pán zhubl, tenhle je onkologický a není to tam úplně dobrý s výživou, {jméno}, stav se za ním." Prostě, funguje to tímhle stylem, že ty sestřičky to vnímají, ten problém té podvýživy nebo toho stavu výživy toho pacienta, a upozorní mě na to.

are partially treatable mainly through nutrition, really place high demands on nutritional care. With every child, they actually ask directly about their diet."
— D12, MSc, university hospital[nn]

6.4 Theme 3: Tension between professional aspirations and legal boundaries

Some challenges described by participants were not rooted in interpersonal or organizational dynamics, but rather stemmed from systemic and legislative constraints. The current legal framework defining the profession of dietitian in the Czech Republic was perceived as misaligned with the expectations and aspirations of practicing dietitians. This misalignment led to frustration and concerns about the ability to deliver high-quality nutritional care. Participants most frequently mentioned issues related to compensation, staffing, and scope of practice.

Compensation and staffing

Several dietitians reported that salaries in public hospitals were insufficient, prompting some to seek additional employment or rely on grants and scholarships. They expressed concern about the sustainability of their work and its impact on both professional performance and personal well-being. Low salaries were also seen as a deterrent for new graduates considering hospital positions. Participants attributed this situation partly to rigid national pay scales and partly to hospital management's reluctance to increase wages, which the dietitians linked to the absence of reimbursement for inpatient dietetic services, making them look unprofitable.

"I'm being saved by the student scholarship, plus some grants I'm working on, so overall I'm happy, but if I had just the salary, I don't think [it would be enough]."
— D12, MSc, university hospital[oo]

"I feel like the management doesn't see it, so they don't really try to improve the situation. They mostly treat it as a burden, because

[nn] Musím říct, že je asi daný hlavně nejenom teda aktuálním přednostou, ale i jedním nebo dvěma přednosty před nimi, kteří jsou opravdu, asi i vzhledem k tomu, že tam jsou ty dědičný poruchy metabolismu, který jsou částečně léčitelný především výživou, tak oni opravdu na tu výživu maj veliký nároky. U každýho dítěte se opravdu ptaj i přímo na ten jídelníček.

[oo] Mě zachraňuje stipendium studijní a plus ještě nějaký granty, na kterých spolupracuju, takže celkově spokojená jsem, ale kdyby to mělo být jenom z toho platu, tak asi ne.

> *basically, they get nothing out of us being on the ward, we can't report any billable procedures there, so it's just a strain on the hospital."*
> — D13, MSc, regional hospital[pp]

However, other participants expressed satisfaction with their salaries, especially following recent nationwide increases. Some noted that regional differences in living costs influenced their perception of adequacy.

> *"I must say that after it raised several times recently, I think it's bearable, somehow (laughs). Well, I'm currently half-time (...) but if I was full-time, I think it would be probably enough. But of course it could be even better."*
> — D04, BSc, regional hospital[qq]

> *"I am satisfied, when I consider usual salary in this location, I think it's adequate. (...) Maybe I'd say something different if I should maintain living in Brno, Prague, a bigger city. This region is quite favourable in this respect. Of course it can be always better, but I can't complain."*
> — D05, HVS, regional hospital[rr]

Scope of practice

A major source of frustration was the limited autonomy dietitians had in clinical decision-making. Participants described being unable to make even routine adjustments to patients' diets, such as modifying texture or portion sizes, without physician approval. This dependency was perceived as undermining their professional competence and contributing to a lack of recognition, reflecting on the conflict between dietitians feeling educated enough to intervene and physicians holding the power to approve everything despite their limited awareness and knowledge.

> *"And constantly knocking on [the doctor's] door to ask if I can get two extra kefirs for some lady from who-knows-where, I honestly feel completely ridiculous. Like some kitchen worker begging a doctor for permission to send two extra kefirs. The doctor often doesn't even know what types of diets exist, and I'm the one who has to beg just to get*

[pp] Mně přijde, že to vedení to nevidí, takže proto to ani nějak nezlepšuje, celkově tu situaci. Spíš to bere jako nějakou zátěž, protože víceméně nic z nás nemá, když jsme na oddělení, prostě žádné výkony nemůžeme na tom oddělení vykazovat, takže je to jen zátěž pro ten špitál.

[qq] Musím říct, že po tom, jak se nám to teďka zvedlo několikrát po sobě, tak si myslím, že už se to dá *(smích)*, tak nějak. S tím, že já jsem teda na půl úvazku (...) ale kdybych byla na celým úvazku, tak si říkám, že by mi to asi i stačilo. Ale samozřejmě mohlo by to být i lepší

[rr] Spokojený jsem, když to vztáhnu na plat obvyklý v místě, tak si myslím, že je to adekvátní. (...) Možná bych mluvil jinak, kdybych si za tenhle plat měl zařizovat zázemí v Brně, v Praze, ve větším městě. *{Ten kraj}* si myslím, že v tomhle ohledu je poměrně přívětivý. Samozřejmě vždycky to může být lepší, ale nemůžu si stěžovat.

> *a kefir prescription. On [wards] where they already know me, I'm usually allowed to make these changes myself. But officially, that's not part of my job description, I'm supposed to get [the doctor's] approval for everything."*
> — D01, MSc, university hospital[ss]

Many participants advocated for an expanded scope of practice, including the ability to prescribe oral nutritional supplements (ONS), adjust diet orders, and in some cases, mostly among university-educated participants, prescribe enteral or parenteral nutrition. They argued that dietitians were often better equipped than physicians to make these decisions due to their specialized training.

> *"Ideally, I'd like to be able to prescribe oral nutritional supplements based on what we consider appropriate. Meaning I'd prescribe the specific products I personally find suitable for that particular patient."*
> — D15, BSc, regional hospital[tt]

> *"Definitely prescribing sip feeds, because doctors, honestly, it's unbelievable. (laughs) Like, giving five Nutridrinks a day to a 95-year-old patient and then wondering why they're constantly in soaked diapers, I mean, come on! (...) Then I'd definitely push for dietitians in hospitals to actually have the authority to decide on diets. Because sometimes, the decisions made are just nonsense. You've got a patient after acute pancreatitis who should be slowly reintroduced to food with special pancreatic diets and boom, the doctor prescribes a gallbladder diet right away. The patient has been on parenteral nutrition for three weeks, and we suddenly throw them onto a full oral diet, just like that. That kind of thing really needs to stop."*
> — D09, BSc, regional hospital[uu]

[ss] A klepat jim furt na dveře, že bych chtěla napsat dva kefíry tady pro paní z Horní Dolní, tak já se cítím jako úplně, úplně blbá. Jak ta žena z kuchyně, že tam musím klepat na dveře doktora, abych mohla poslat o dva kefíry víc. Ten doktor neví ani, co existuje za diety, a já se musím doprošovat, aby mi napsal kefír. Na těch *[odděleních]*, na kterých mě už znají, tak už si tyhle věci můžu měnit sama, ale vlastně v náplni práce to nemám, já to vždycky musím mít odsouhlasené.

[tt] Ideální by pro mě bylo mít možnost předepisovat sipping podle toho, co my uznáme za vhodný, s tím, že by se předepisovaly výrobky, který bych já sama uznala za vhodný pro toho pacienta.

[uu] Určitě předepisování sippingů, protože ti lékaři, to je neskutečný *(smích)*, jako nacpat pacientovi, kterému je 95 let, pět nutridrinků za den, a pak se divit, že má plný plíny, to je docela jako... *(...)* Pak bych určitě udělala to, že když už je ten nutriční pro kliniku, tak určitě jako rozhodovat o těch dietách, protože občas tam byly nesmysly, vemte si, máte pacienta po akutní pankreatitidě, pacient se má rozjídat SP dietama a PEG, a doktor mu dá 4, prostě žlučníkovou, hned. Byl tři týdny na parenterální výživě, a tak mu rovnou dáme plnou dávku. Prostě tohleto, vůbec tomu zamezit.

The contrast of prevalent desire for broader scope of practice and absence of autonomy reflected the broader misalignment between the profession's aspirations and the structural limitations of the system in which dietitians operate. Participants viewed greater autonomy not only as a way to improve care quality, but also as a path toward increased professional respect and accountability.

> *"Once our professional remit improves a bit, I think someone might finally come to their senses and maybe we'll start being taken a bit more seriously."*
> — D09, BSc, regional hospital[vv]

> *"And that's what bothers me. We don't have any real responsibility, because we have no authority. No professional remit, and then no accountability either."*
> — D01, MSc, university hospital[ww]

However, a few participants expressed reservations about taking on greater responsibility, citing concerns about liability and the burden of decision-making.

> *"Dietitians may want greater professional authority, but that also means greater responsibility, and I wouldn't want to be in the doctor's position regarding responsibility."*
> — D02, secondary school, university hospital[xx]

Staffing

Participants emphasized that expanding the scope of practice would require adequate staffing. They understood staffing issues as a complex interplay of an insufficient recognition among HCPs, lack of management support and limited knowledge about nutrition. However, they missed also systemic support, calling for national guidelines setting minimal staffing limits.

[vv] Až se trošku zlepšej ty kompetence, tak si myslím, že se někdo chytne za nos a třeba budeme trošku jako vážený.
[ww] To mně teda vadí, že vlastně nemáme žádnou zodpovědnost potom, dá se říct. Žádné kompetence a pak ani žádnou zodpovědnost.
[xx] Nutriční terapeuté by chtěli mít větší kompetence, ale ona s tím jde zodpovědnost a já nezávidím lékařům jejich zodpovědnost.

> *"I think it would definitely be a good idea to create some kind of plan or guideline for the future that shows how it should look in hospitals. Including a clear summary of all the benefits of having a dietitian, and how many dietitians should be employed in a given hospital. I really think that's necessary. Because if there's no guideline, then hospitals just won't hire dietitians."*
> — D13, MSc, regional hospital[yy]

> *"In a facility with, say, 250 people, a single dietitian simply isn't capable of handling it all. Especially when they're responsible for both the clinical and food service sides. I'd really like someone to think about this. (...) There should honestly be a regulation stating that one dietitian is assigned to every 50 patients, and in food services, the staffing should be based on capacity."*
> — D11, secondary school, regional hospital[zz]

6.5 Systemic cycle of marginalization

The previous chapters have illustrated how Czech hospital dietitians face challenges related to unclear professional identity, marginalization of nutrition care, and systemic constraints. These issues are not isolated but appear to be interconnected in a self-reinforcing pattern. Based on participants' accounts, this pattern can be conceptualized as a **systemic cycle of marginalization**, in which several interdependent factors perpetuate the undervaluation and underutilization of dietitians within healthcare teams.

1. **Limited awareness about nutrition**

Participants reported that other healthcare professionals, especially physicians and nurses, often lacked awareness of the clinical relevance of nutrition care. This led to its deprioritization in daily practice and contributed to a perception of nutrition as a peripheral concern. Since hospital management is typically recruited from the same professional pool, this lack of awareness also influenced strategic decisions and resource allocation.

[yy] Určitě by bylo možná dobré do budoucna vybudovat nějaký plán nebo nějaký guideline, jak by to v nemocnici mělo vypadat a například i sepsat všechny ty benefity, proč by ten nutriční terapeut měl být a kolik nutričních terapeutů by mělo být na danou nemocnici. Prostě to si myslím, že je potřeba. Protože pokud nějaký guideline není, tak ty nemocnice ty nutriční tam fakt nezaměstnají.

[zz] V tý kapacitě, kdy to zařízení má třeba 250 lidí, tak ten nutriční terapeut není vůbec schopný tohle pojmout. Kor když má na starosti jak klinickou, tak stravovací část. Tohle opravdu bych byla ráda, kdyby se nad tím někdo zamyslel. (...) Opravdu by se mělo někde uzákonit, že jeden nutriční terapeut je na těch 50 lidí a v tom stravovacím provozu zase podle kapacity.

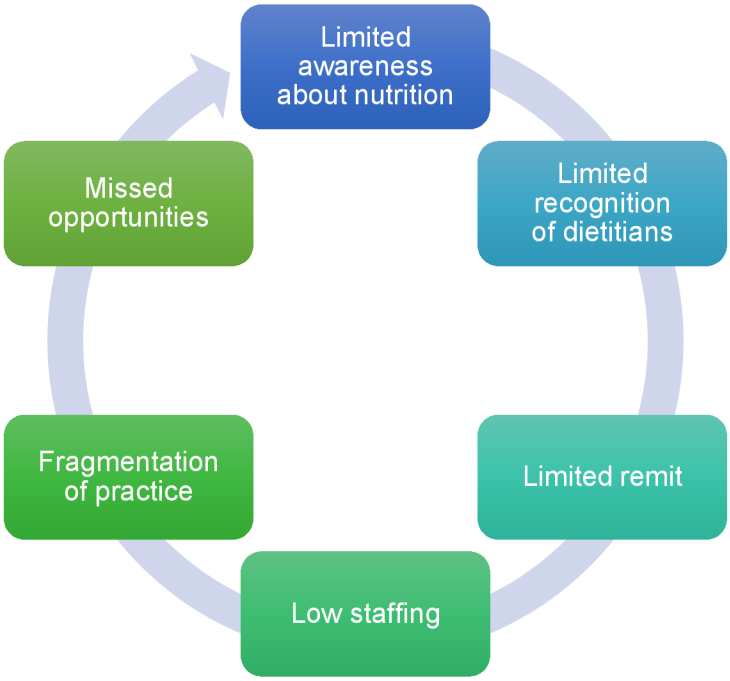

Figure 2 Systemic cycle of marginalization

2. **Limited professional recognition of dietitians**

The lack of awareness about nutrition was closely linked to limited recognition of dietitians as healthcare professionals. Participants described being perceived as food service staff rather than clinical experts, a perception rooted in the legacy of dietary nursing and reinforced by insufficient nutrition education among other HCPs. As a result, dietitians were often excluded from interprofessional collaboration and their contributions undervalued.

3. **Limited remit**

Participants described frustration with their restricted scope of practice, both legally and in daily operations, where they frequently do not have the opportunity to perform all the procedures they should be doing on a daily basis according to their job description. Apart from the excessive limitation of the scope of practice given by the law, dietitians frequently do not have the opportunity to perform all the activities they should be doing on a daily basis according to their job description. Participants describe situations like this emerging from the low professional recognition since other healthcare professionals either consider them incapable of doing so, or these activities are customarily assigned to physicians (e.g. calculations of enteral or parenteral nutrition), or due to the notion of pointlessness of nutrition interventions.

4. **Low staffing**

Since dietitians are not being allowed to perform nutrition care in its whole complexity, and since other healthcare professionals including management do not understand the benefits of the opposite, there is a limited willingness to open new positions for dietitians. Although many participants consider the amount of dietitians in their facility low, they are facing refusal to raise their numbers especially from the management, who believes that dietitians are mostly producing financial loss, with no support from the community of other healthcare professionals.

5. **Limited capacities for proper nutrition care**

Due to low numbers of dietitians, many participants describe being overwhelmed with work and not being able to give proper nutrition care to everyone who needs it in a suitable range. If the dietitians are not feeling overwhelmed, it is often due to the nutrition care being undermined by organizational issues, mostly resulting from the lack of nutrition awareness.

6. **Missed opportunities and perceived irrelevance**

Among the factors facilitating the cooperation between dietitians and other healthcare professionals, one of those cited multiple times is the frequency of contact. The more time dietitians spend on a particular ward, the more they can build the relationships with physicians and nurses and show the impact of proper nutrition care. With low amounts of staff, it is impossible for dietitians to cover both for food service and clinical care, visit wards every day, participate in rounds, or spend adequate time with the patients, maintaining the situation where the importance of nutrition is blurred by the absence of obvious effects on patient health outcomes.

Several participants proposed interventions to disrupt this cycle, including:

- improved education for healthcare professionals,
- clearer professional standards and role definitions,
- expanded scope of practice,
- national guidelines for minimum staffing levels.

While the feasibility of these suggestions varies, they reflect the perspectives of dietitians working within the system and offer insights into what would make their work more effective, meaningful, and professionally sustainable.

7 Discussion

This chapter is a minimally amended verbatim transcription of the Discussion section of the following paper, written by the author of the thesis:

> *Krobot M, Jančeková K, Hawk VH, Zelenková V, Kapounová Z. Challenges in delivering nutrition care perceived by hospital dietitians in the Czech Republic: a qualitative study. BMJ Open. Accepted for publication 2025.*

To our knowledge, this is the first qualitative study of Czech dietitians in hospital settings exploring the experiences and challenges they face. The three main themes identified were Unclear professional role and identity, Marginalization of nutrition care and Tension between professional aspirations and legal boundaries. Overall, the challenges described by participants reflect a complex interplay between underdeveloped organizational professionalism and multilevel barriers to interprofessional collaboration, as conceptualized by Evetts[115] and Wei[81].

7.1 Professional role and identity: who is a dietitian?

The professional identity of Czech dietitians appears to be shaped mainly by occupational professionalism[115], including the establishment of university-level education or professional organizations. However, these efforts are undermined by insufficient development of organizational professionalism, including limited autonomy, lack of organizational support or missing national professional guidelines. The existence of multiple professional bodies, divergent educational backgrounds, and inconsistent perceptions of the dietitian's role then may lead to internal fragmentation and hinder the development of a unified professional identity needed to foster the development of the profession, similar to conclusions of Feerick's study of paramedics[120].

Clarity of the roles of all the team members is one of the crucial factors of interprofessional collaboration on both the individual and team level[81]. However, there is still a lack of understanding of the dietitians' role among HCPs. While some participants acknowledged positive attitudes towards their presence in interprofessional care teams, many reported being disrespected, underutilized and viewed as food service workers. In a Canadian research study, dietitians claimed that the professional acknowledgment from other HCPs is critical for effective nutrition care[7]. The lack of professional recognition may raise the risk of frustration, as was described also by our participants, and potentially lead to burnout[94]. Although the importance of interprofessional education and competencies related to working in healthcare teams have been emphasized for quite some time[80], it seems that the education system is still not

equipping HCPs sufficiently with interprofessional competencies[89], as shown also in Czech context, where graduating medical students had limited awareness of dietitians' role or scope of practice[121].

The internal differences in the understanding of dietitians' role were noticeable particularly in the areas of education and job description, especially regarding the relevance of food service employment. Some dietitians viewed the combination of clinical and foodservice responsibilities as beneficial, emphasizing the importance of integrating both areas rather than working in isolated silos. This view is similar to the opinion of dietitians in other studies[101,122]. Others, however, perceived involvement in foodservice operations as less prestigious or unrelated to their professional role, and preferred to focus solely on clinical care. This was documented by other researchers especially in dietetic students, who felt they would not be able to demonstrate their competence in full[123,124]. In the Czech context, this divide may partly reflect the legacy of the former system of dietetic nurses, whose competencies were strictly tied to foodservice operations. The shift towards a modern concept of allied health professions may thus include a desire to distance the profession from this area similar to what happened e.g. in UK in 1960s, where clinical dietetics overshadowed food service role of dietitians[125]. Educational institutions appear to reinforce this trend by emphasizing clinical placements and competencies[122,123]. This divergence reflects the need to redefine the role of dietitians in modern Czech healthcare for both education and practice and the need for further investigation of the professionalization of dietitians in the Czech historical context and attitudes and practices of Czech education institutions regarding food service area.

7.2 Missing culture of nutrition care

Despite the inclusion of medical nutrition therapy in the clinical guidelines of numerous health conditions[126,127] and evidence supporting the benefits of nutrition care and dietitian involvement for optimal patient outcomes[128–131], many participants reported a lack of other staff interest in nutrition care. This resulted in insufficient resources, improper nutrition practice and poor recognition of dietitians. Our participants often considered these to be key reasons for suboptimal nutrition care, as did the participants of several other studies, who highlighted nutrition culture of the whole organization as one of the essential conditions for functioning nutrition care[7,105].

Current nutrition education for HCPs is not optimal. Students' demand for nutrition knowledge is often confronted with lack of academics educated in this area and rather isolated lectures outside the curriculum, leaving them dependent only on their interest in the topic and self-study of the literature[90,91]. A recent assessment in Czechia[132] found that nutrition education hours in medical school were below the recommended minimum by ESPEN[133], medical students felt unprepared to offer nutrition

care, and their awareness of the role of nutrition in clinical practice was limited[121]. This aligns also with findings of a systematic review on medical nutrition education, which identified that nutrition is not emphasized in medical curriculum, medical students feel insufficiently prepared, and they rarely interact with dietitians[134].

Participants described the deprioritization of nutrition care by nurses, reporting perceptions that they did not consider nutrition interventions important, lacked time for their administration, or intentionally skipped nutrition screening or fabricated its results. Available research shows that nurses in general do not consider nutrition unimportant, but cope with other barriers, such as high workload, working in silos, unclear roles and low staffing, leading them to prioritize other activities[104,105,107,108]. With the nutrition screening specifically, lack of guidelines and proper equipment, and the complexity of some screening tools can further decrease the motivation[6]. However, nurses themselves call for more education in this area, attaching greater importance to nutrition care with deeper knowledge[6,92,103,108].

Regarding hospital management, the last group mentioned in our interviews, participants described the reluctance to open new positions for dietitians, restrictions of their professional responsibilities, and a lack of access to necessary equipment or medical records, all of which represent organizational barriers according to Wei, with the ability to impede interprofessional collaboration and quality nutrition care[7,81]. Hospital management plays a key role in establishing the nutrition culture by providing sufficient resources, communicating the values and providing a sense of importance to the team members[111]. However, their improper decisions can hamper the provision of nutrition care[113], as interprofessional collaboration can flourish only in an environment of institutional support, positive work culture, and a suitable physical environment[80]. Implementation-oriented activities focused on the support of both undergraduate education and continuous professional development are needed together with the evaluation of their impact. Further investigation of the management decision-making process could also help tailor other interventions to support the development of nutrition culture in the whole organization.

7.3 When the system holds the profession back

Participants expressed aspirations which currently do not fit into Czech legal framework of the profession. While many participants advocated for greater autonomy in terms of ONS prescription or diet order adjustment, current legislation restricts these activities to physicians only, despite the evidence of effectiveness of the dietitians' professional scope expansion[135,136]. This lack of autonomy, which might reflect the underdevelopment of organizational professionalism[115], where lack of autonomy can hinder the consolidation of a strong professional identity, was described to lead not only to limited effectiveness of nutrition care, but also to feelings of professional inferiority.

However, it remains debatable whether granting full autonomy in selected clinical tasks alone would resolve the issue. Since clinical decision-making suffers from the lack of effective interprofessional collaboration and communication[100], granting higher autonomy would have to go hand in hand with the support of teamwork in the hospitals. A broader discussion about legislative reform and clearer professional standards to align the system with the evolving role of dietitians in clinical care is needed to address these issues appropriately.

Together with other systemic issues such as low salaries, insufficient staffing, and the absence of national guidelines for minimum dietetic coverage, all these issues might collectively hinder the development of organizational professionalism[115], preventing the profession from further growth. Furthermore, low staffing can negatively impact teamwork, productivity, and staff turnover[81,137], which can in turn hinder the nutrition care offered and negatively impact patient outcomes. For example, according to Eglseer[138], dietetic understaffing can be a major factor responsible for up to two-thirds of malnourished patients not receiving proper nutrition care. Setting a minimum level of dietetic staffing might benefit the entire nutrition care system in the Czech Republic.

7.4 Limitations

This study provides valuable insight into the challenges faced by hospital dietitians in the Czech Republic; however, several limitations should be considered. The exclusive focus on dietitians' perspectives may have resulted in a one-sided view of interprofessional collaboration, as the voices of other healthcare professionals were not included. The recruitment strategy, relying on professional bodies and social media, may have favoured more engaged or dissatisfied individuals, introducing potential selection bias. The principal investigator's professional role and visibility within the field could have influenced participants' responses due to perceived authority. Additionally, while efforts were made to include diverse hospital types, some settings may have been underrepresented. Finally, the findings are context-specific and may not be generalizable to countries with different healthcare system or professional structures.

8 Conclusion

According to hospital dietitians participating in this study, there is limited awareness among other healthcare professionals about dietitians' role, leading to insufficient utilization of nutrition to support clinical care. Moreover, dietitians themselves struggle to find a shared professional identity, which might hinder the further evolution of the profession. Lack of support from hospital management, limited resources, restricted autonomy and understaffing were perceived as contributing to frustration among dietitians and may complicate efforts to provide optimal nutrition care to patients. However, there are hospitals, where dietitians reported successful integration into interdisciplinary teams. The findings indicate that improvements in legislation, education, and hospital governance could support the evolving role of dietitians in Czech healthcare. Clarification of the professional role of dietitians, both in clinical and food-service contexts, may help its further development together with reflecting this in undergraduate training and continuous professional development. Future research could explore the impact of these interventions and decision-making processes within hospital management to foster a stronger culture of nutrition care. This research should include longitudinal studies to capture the evolving role of dietitians and the long-term effects of systemic interventions.

Summary of publications and research activities

Publications related to the thesis

Journal articles J_{imp}

1. Krobot M, Jančeková K, Hawk VH et al. Challenges perceived by hospital dietitians in the Czech Republic: a qualitative study. *BMJ Open*. Accepted for publication 2025.

Journal articles J_{rec}

2. Hawk VH, Kapounová Z, Krobot M et al. Student and faculty perceptions of nutrition education in medical school. *Clinical Nutrition ESPEN*. 2022;2022(47):351-357. doi: 10.1016/j.clnesp.2021.11.011
3. Krobot M, Hawk VH, Spáčilová V et al. A historical perspective and opportunities for dietetics education, practice and professional organizations in the Czech Republic. *Profese online*. 2021:14(1);9-18. doi:10.5507/pol.2021.001

Invited conference abstracts

4. Krobot M. Minimální požadavky na úvazky nutričních terapeutů a jejich nový legislativní návrh. In: Novák F, Těšínský P. *Sborník prezentací. XXXVIII. mezinárodní kongres SKVIMP*. EUROVERLAG s.r.o.; 2022:16.
5. Kapounová Z, Hawk VH, Krobot M et al. Hodnocení výuky výživy na Lékařské fakultě MU v kontextu doporučení ESPEN. In: Novák F, Těšínský P. *XXXVII. mezinárodní kongres SKVIMP*. EUROVERLAG s.r.o.; 2021:53-54.
6. Krobot M, Jančeková K, Kapounová Z et al. Problémy nutriční péče očima nutričních terapeutů: předběžné výsledky kvalitativního výzkumu. In: Novák F, Těšínský P. *XXXVII. mezinárodní kongres SKVIMP*. EUROVERLAG s.r.o.; 2021:58-59.
7. Krobot M. Personální pokrytí nutriční péče v ČR a ve světě. In: Novák F, Těšínský P. *XXXVI. mezinárodní kongres SKVIMP*. EUROVERLAG s.r.o.; 2020:48-49.

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8. Krobot M, Jančeková K, Kapounová Z et al. Acceptance of Dietitians and Their Job Satisfaction in Acute Care Settings in Czech Republic: Preliminary Results. In: 13th European Congress of Dietetics, 26-30 October 2021. *Ann Nutr Metab*. 2021;77(6):350-376. doi:10.1159/000519655

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Invited lectures

10. Krobot M. Interprofessional collaboration in nutrition care. Lecture presented at: Wroclaw Medical University; April 9, 2025; Wrocław, Poland.

Guidelines

11. Těšínský P, Novák F, Pražanová I et al. Metodické doporučení pro zajištění stravy a nutriční péče. *Věstník MZ ČR*. 2020;2020(10):2-45. Available at: https://mzd.gov.cz/wp-content/uploads/2020/09/Věstník-MZ-10-20.pdf

Other activities related to the thesis

Bachelor thesis supervision

12. Olajcová Ľ. Postoje českých nutričných terapeutov k zvyšovaniu kompetencií. Bachelor thesis. Masaryk University; 2025.
13. Kulhánek M. Struktura vzdělání nutričních terapeutů v českých nemocnicích. Bachelor thesis. Masaryk University; 2023.

Other publications and research activities

Journal articles J_{imp}

14. Riad A, Drobov A, Krobot M et al. Mental health burden of the Russian-Ukrainian War 2022 (RUW-22): Anxiety and depression levels among young adults in Central Europe. *Int J Environ Res Public Health.* 2022;19(14):1-14. doi:10.3390/ijerph19148418
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Journal articles J_{rec}

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20. Krobot M. School meals from a global health perspective. In: *International Students' Conference "Synergy of Dietetics and Pharmacy – a Holistic Approach to Human Health."* 2025.
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22. Krobot M. Role nutričního terapeuta v managementu potravinové alergie. In: *10. kongres Medicíny pro praxi v Ostravě.* 2024. ISBN 978-80-7471-481-8.

Conference abstracts

23. Holbová D, Hornáčková T, Lukianova A, Tanti Desjardins S, Krobot M. What can students buy at school? School food vending machines regulations across Europe. In: *International Students' Conference "Synergy of Dietetics and Pharmacy – a Holistic Approach to Human Health."* 2025.
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35. Krobot M. Rizikové živiny při potravinových alergiích – je vždy potřeba suplementace? In: *XXV. Beskydské alergologické dny.* 2024.
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Appendix A Interview guide

Tab. 1: Interview guide

Domain	Questions
Demographic data	Gender, age, level of education in dietetics (incl. year of graduation), specialized education (incl. year of graduation), hospital name, years of practice, length of current employment, workload level (hrs/week), professional role
Job satisfaction	Please describe your job to me. What kind of work do you do, what are your duties? What activity do you spend most of your working hours doing? Please rate your overall job satisfaction. What do you enjoy, find fulfilling about your work? What demotivates you, what bothers you? Please describe your working environment - your office, its location, technology, etc. How satisfied are you with it? How satisfied are you with your salary? Describe how you find the salary relevant to your job, its demands and its workload.
Perception by other health professionals	How do you think your work is valued and accepted by other health professionals in your workplace? Do you think there is a difference in the experiences of you and your colleagues? What healthcare professionals or other staff do you interact with while caring for a particular patient? Please describe how the interdisciplinary team works in your practice. How do you feel involved in the interdisciplinary team at your workplace and what is your role in it? Please name the barriers to the dietitian's full involvement in the team and ways you think they could be removed.
Perception of job description	To what extent does your job description match your expectations? If it does not match, what should ideally be different? To what extent does your job description match your position? How does your job description match your training in dietetics? Please think about your workload and how you do or do not manage your tasks within your work hours. How do you perceive the staffing situation in providing nutrition care at your workplace?

Domain	Questions
Perception of nutrition care	What are the barriers in your workplace that prevent you from providing care as you would like to? Please describe them. What would need to change to improve the situation? How do you see nutrition care in the Czech Republic? Describe what are the weak or strong points in your opinion and experience.

Appendix B Ethics committee application (CZ)

Žádost o posouzení výzkumného projektu

Vyplňte prosím všechna relevantní pole

Název výzkumného projektu: Vnímání systému nutriční péče a své role na pracovišti nutričními terapeuty pracujícími v zařízeních lůžkové péče – kvalitativní výzkum

Hlavní řešitel: Krobot Martin, Mgr.

Pracoviště hlavního řešitele: Ústav ochrany a podpory zdraví, Lékařská fakulta, Masarykova univerzita

Spoluřešitel/é: Hawk Victoria Hazelette, PhD, MPH, RD; Kapounová Zlata, Mgr., Ph.D.; Spáčilová Veronika, Bc.

Pracoviště spoluřešitelů: Ústav ochrany a podpory zdraví, Lékařská fakulta, Masarykova univerzita

Typ projektu *(zaškrtněte odpovídající, případně specifikujte)*:

☐ standardní výzkumný	☐ pilotní	☐ mezinárodní
☒ doktorský	☐ interně-instituční	☐ jiný Klikněte sem a zadejte text.
☐ magisterský	☐ národní	

Poskytovatel *(zaškrtněte odpovídající, případně specifikujte)*:

☐ AZV MZ ČR	☐ MU	☐ jiný Klikněte sem a zadejte text.
☐ GA ČR	☐ MŠMT	
☐ GA MU	☐ ERC	

Doba trvání výzkumného projektu:

od: 01.05.2021 **do:** 30.09.2021

Stručná anotace projektu

Objektivní hodnocení systému nutriční péče v České republice na základě centrálních statistických dat, např. ve srovnání s ostatními státy, poskytuje mnoho informací o tom, jakým směrem by se mohla dále vyvíjet, nepostihuje však názory a motivaci samotných nutričních terapeutů, kteří v tomto systému pracují, a nereflektuje odlišnost reality od legislativně nastaveného rámce. Cílem tohoto výzkumného projektu je pomocí metody zakotvené teorie zmapovat názory, postoje a motivace nutričních terapeutů pracujících v zařízeních akutní lůžkové péče a prostřednictvím jejich výpovědí identifikovat silná a slabá místa systému nutriční péče v České republice.

Podrobný popis projektu

Výzkum, který by v České republice srovnatelně se zahraničím poskytoval informace o tom, jak reálně vypadá praxe nutričních terapeutů, a snažil se ji nějak systematicky popsat, dosud neproběhl. Bez validních dat je však rozhodování o systému nutriční péče odkázáno na předpoklady a domněnky. Cílem tohoto výzkumného projektu je prostřednictvím výpovědí nutričních terapeutů identifikovat silná a slabá místa systému nutriční péče v České republice. Metodika je z velké části inspirována výzkumem Kapounové a Hawk, souhlas EK č. 3/2019.

Jádrem tohoto kvalitativního výzkumu budou semistrukturované rozhovory s účastníky, kteří budou souhlasit se zapojením do výzkumu. Subjekty budou získány primárně oslovením profesních organizací, v případě nedostatku pak metodou sněhové koule a/nebo účelovým výběrem na základě kritérií (více v sekci „Lidský subjekt“). Pseudonymizované rozhovory budou následně analyzovány metodou zakotvené teorie do momentu teoretického nasycení – bodu, kdy další rozhovory nebudou přinášet nová témata.

Průběh rozhovoru: Respondentovi bude před domluvením termínu rozhovoru zaslán informovaný souhlas, bez jehož vyplnění nebude respondent k rozhovoru přizván. Rozhovory budou s ohledem na epidemiologickou situaci, na možnost získat respondenty z celé České republiky a na potřebné technické možnosti, které nenabízí platformy společnosti Microsoft, probíhat online na platformě Zoom. Ke každému rozhovoru bude přizván jeden notetaker pro záznam okolností rozhovoru (zvýšení validity výzkumu). Rozhovor bude pod kódem účastníka zaznamenáván výhradně jako zvukový záznam, čímž dojde k eliminaci záchytu obličeje a jména respondenta. Záznam rozhovoru následně bude nahrán na zaheslované úložiště, kam bude mít přístup výhradně hlavní řešitel a osoba pořizující transkripty nahrávek (více v sekci „Osobní údaje“).

Pseudonymizace: K pseudonymizaci bylo namísto plné anonymizace přistoupeno za účelem možnosti nabídnout účastníkům stažení informovaného souhlasu a výmaz dat z jimi poskytnutých rozhovorů. Kódy spojující informovaný souhlas s konkrétními záznamy budou uchovávány na zaheslovaném úložišti a budou přístupné výhradně hlavnímu řešiteli.

Zpracování transkriptů a publikace: Po transkripci nahrávek a výmazu citlivých údajů potenciálně vedoucích k identifikaci (jména, místní názvy apod.) budou transkripty

postoupeny kódování a tématické analýze. Kódování a tématickou analýzu bude provádět zejména hlavní řešitel, nicméně za účelem zvýšení validity pomocí triangulace budou vybrané transkripty zpracovány i druhým řešitelem s následnou komparací analýz. Tématická analýza pak bude provedena v software Atlas.ti. Pro účely publikace budou pro doplnění autorského textu citovány krátké úseky výpovědí tak, aby vybrané citace neumožňovaly identifikace ani na základě situační podobnosti. Zjištění, která by mohla v případě přímé citace vést k identifikace, budou zobecněna slovy autora publikace.

Další využití výstupů: Výstupem tohoto výzkumu bude publikace v mezinárodním impaktovaném periodiku. Kromě toho budou výsledky bez přímých citací využity jako podklad pro další výzkum (zejm. kvantitativní vystavěný na závěrech kvalitativního) a také pro jednání se zainteresovanými subjekty ze strany státní správy a zdravotnictví za účelem zlepšení postavení nutričních terapeutů a systému nutriční péče.

Lidský biologický materiál

V průběhu výzkumu nebude od participantů získáván biologický materiál.

Lidský subjekt

Účast lidských subjektů je nezbytná s ohledem na získávání dat pomocí rozhovorů. Účastníky budou nutriční terapeuti pracující v lůžkových zdravotnických zařízení, přičemž vzorkování bude probíhat účelově na základě dosaženého vzdělání a velikosti zařízení, ve kterém účastník pracuje, udané počtem lůžek. Velikost výzkumného souboru není přesně stanovena, jelikož nábor bude ukončen po dosažení teoretické saturace.

Očekávané kategorie vzdělání: střední škola, vyšší odborná škola, bakalářské studium, magisterské studium

Očekávané kategorie zařízení: malé oblastní nemocnice, okresní nemocnice a nemocnice bez specializované péče, velké krajské a fakultní nemocnice, specializovaná centra

Nábor bude zahájen oslovením členů České asociace nutričních terapeutů a Sekce nutričních terapeutů České asociace sester. K rozhovoru budou pozváni nutriční terapeuti, kteří na výzvu zareagují, a dále bude pro nábor respondentů použita metoda sněhové koule. Budou-li z určitých kategorií vzdělání či velikosti zařízení scházet respondenti, budou kontaktovány účelově konkrétní osoby.

Účastníkovi bude nejdříve elektronickou formou zaslán informovaný souhlas a bude vyžadován ještě před domluvením data rozhovoru. Deklarace souhlasu bude pro eliminaci osobního kontaktu a zátěže účastníků přijímána rovněž elektronicky. Účastník se následně bez uvedení svého jména a bez zapnuté webkamery (skrz přítomnost notetakera) ve smluvený čas připojí do hovoru v aplikaci Zoom, na který mu bude zaslán odkaz. Zátěž účastníků tedy spatřujeme v nutnosti odbavit informovaný souhlas vlastními prostředky elektronicky a v časové zátěži způsobené rozhovorem, který bude trvat přibližně 45–60 minut.

Riziko

S ohledem na charakter výzkumu nejsou předpokládána žádná rizika plynoucí z účasti subjektu na sběru dat.

Nahodilé nálezy

S ohledem na metodiku a cíle výzkumu nejsou předpokládány nahodilé nálezy se vztahem ke zdravotnímu stavu účastníka výzkumu.

Účast osob neschopných plného souhlasu

Výzkum nezahrnuje osoby neschopné plného souhlasu.

Osobní údaje

Osobními údaji, které budou na začátku spolupráce s respondentem sbírány, budou:

- **jméno, e-mailový kontakt** – za účelem domluvy rozhovoru a možnosti zpětného kontaktu a stažení souhlasu se zařazením rozhovoru do výzkumného vzorku
- **nejvyšší dosažené vzdělání v nutriční terapii** – za účelem stratifikace respondentů a účelového vzorkování
- **zdravotnické zařízení, ve kterém nutriční terapeut pracuje** – za účelem stratifikace respondentů a účelového vzorkování

Tyto osobní údaje budou v rámci pseudonymizace označeny kódem, přičemž dokument s přiřazenými kódy bude uložen na pracovním úložišti OneDrive hlavního řešitele (bude tedy chráněn heslem). S výjimkou informovaného souhlasu pak budou na dokumentech používány výhradně tyto kódy a žádný ze spoluřešitelů s osobními údaji účastníků nepřijde do kontaktu. V průběhu rozhovoru bude účastníkovi namísto jména vyplněn rovněž kód a teprve poté bude přizván notetaker.

Audionahrávky rozhovorů budou uloženy tamtéž, přičemž jejich sdílení s osobou pořizující transkript proběhne za využití odkazu chráněného heslem, které bude známé výhradně hlavnímu řešiteli a osobě pořizující transkript, a to s časovou platností omezenou na 14 dnů. Informované souhlasy budou uloženy tamtéž, přičemž nebudou zpřístupněny nikomu kromě hlavního řešitele.

Audionahrávky a dokument párující kódy s konkrétními osobami budou uchovány po dobu 5 let od ukončení sběru dat, následně budou nenávratně smazány. Transkripty očištěné od citlivých údajů potenciálně vedoucích k identifikaci účastníka budou uchovány na dobu neurčitou.

V průběhu celého výzkumu budou všichni členové řešitelského týmu písemně vázáni mlčenlivostí a nebudou smět vyzrazovat skutečnosti, které se z rozhovorů dozvěděli.

Další využití získaných dat a biologického materiálu

Osobní údaje získané během náboru účastníků budou uchovány po dobu 5 let výhradně za účelem možnosti stáhnout souhlas se zařazením do výzkumného souboru a následně budou nenávratně smazány. Sekundární využití není plánováno.

Kompenzace výzkumných subjektů

Subjektům účastnícím se rozhovorů bude nabídnuto zaslání souhrnu výsledků výzkumu (po přijetí celé publikace cílovým periodikem).

Pojištění rizik

Charakter výzkumu nepředpokládá vznik škody účastnícím se subjektům.

Spolupracující instituce

V rámci tohoto výzkumu nedochází k zapojení dalších institucí.

Vyjádření (jiné) etické komise

Výzkumný projekt neprojednávala jiná etická komise.

Přílohy:

Text **informovaného souhlasu** pro daný výzkumný projekt zohledňující všechny etické i právní aspekty plánovaného výzkumu.

Písemný souhlas vedoucího pracoviště řešitele (není třeba u projektů, kde projekt prochází standardním schvalovacím řízením na LF – např. AZV, GAČR, GAMU, Horizon 2020).

Všechny podklady Etické komisi LF MU se podávají v elektronické formě.

Appendix C Ethics committee approval (CZ)

MUNI MED

EK LF MU

Etická komise Lékařské fakulty Masarykovy univerzity

Navrhovatel:

Mgr. Martin Krobot

Ústav ochrany a podpory zdraví, LF MU

Název projektu:

Vnímání systému nutriční péče a své role na pracovišti nutričními terapeuty pracujícími v zařízeních lůžkové péče – kvalitativní výzkum

Žádost byla projednána pod pořadovým číslem 18/2021, dne 12. 4. 2021

Stanovisko: Etická komise Lékařské fakulty Masarykovy univerzity uvedenou žádost výzkumného projektu schválila.

Etická komise
Lékařská fakulta MU
625 00 Brno, Kamenice 5

doc. Mgr. Josef Kuře, Dr.Phil.

Předseda Etické komise LF MU

Etická komise
Lékařská fakulta MU
A19/109
Kamenice 5, Brno 625 00
Tel: +420 549 494 913
Fax: +420 549 497 935
Email: jkure@med.muni.cz

Appendix D Informed consent (CZ)

INFORMOVANÝ SOUHLAS S ÚČASTÍ VE VÝZKUMU

Informace pro účastníky výzkumu

Název výzkumu

Vnímání aktuálního nastavení systému nutriční péče a své pozice na pracovišti nemocničními nutričními terapeuty

Cíl výzkumu

Cílem kvalitativního výzkumu je posoudit vnímání aktuálního nastavení systému nutriční péče nutričními terapeuty pracujícími v zařízeních lůžkové péče, a to včetně vnímání jejich vlastní role v tomto systému a v jejich konkrétním zařízení.

Cílovou skupinou tohoto výzkumu jsou nutriční terapeuti pracující v lůžkových zdravotnických zařízeních.

Výsledky tohoto výzkumu budou primárně využity v akademických publikacích a na konferencích. Očekávaný přínos pro společnost spočívá v identifikaci problematických míst v systému nutriční péče v České republice, pročež mohou být data z výzkumu použita také jako informační základna pro jednání se státní správou a dalšími partnery. Budou-li v jakémkoli případě uváděny konkrétní citace účastníků výzkumu, budou striktně anonymizovány a budou z nich odstraněny jakékoli údaje, které by mohly vést k identifikaci osob, míst či pracovišť.

Výzkumný tým

Výzkum je prováděn na Ústavu ochrany a podpory zdraví na Lékařské fakultě MU. Výzkum provádí následující pracovníci:

- Martin Krobot – hlavní řešitel výzkumu
  - *krobot@med.muni.cz*, Ústav veřejného zdraví LF MU
- Kamila Jančeková, Ústav veřejného zdraví LF MU
- Zlata Kapounová, Ústav veřejného zdraví LF MU
- Victoria Hazelette Hawk, Ústav veřejného zdraví LF MU
- Veronika Spáčilová, Ústav veřejného zdraví LF MU

Financování a doba trvání výzkumného projetu

Tento výzkum je podpořen grantem **MUNI/A/1608/2020** (*Prohlubování znalostí v oblasti zdravotních rizik a benefitů výživy, prostředí a životního stylu III)* zprostředkovaným Masarykovou univerzitou probíhajícím od 1. ledna do 31. prosince 2021.

Sběr a zpracování informací

Informace od účastníků budou získány prostřednictvím jednorázového rozhovoru trvajícího přibližně 45–60 minut. Každý rozhovor bude veden přes online platformu Zoom, kde bude zachycena zvuková stopa, a následně bude přepisován pro další hodnocení. Před analýzou budou přepisy rozhovorů pseudonymizovány, tj. opatřeny unikátním kódem, pod kterým budou dále zpracovávány, a deidentifikovány, tj. všechny osobní údaje a místní názvy budou odstraněny.

Získaná data budou uchovávána na zabezpečeném úložišti přístupném výhradně hlavnímu řešiteli výzkumu. Pro účely zpracování transkriptů budou odkazy na nahrávky zabezpečeně sdíleny konkrétní osobě, přičemž všechny osoby, které přijdou s nahrávkou do styku, budou písemně vázány mlčenlivostí. Záznam rozhovoru bude uložen po dobu pěti let od ukončení studie, stejně jako osobní údaje, které budou uloženy na zmíněném heslem opatřeném úložišti dat. Po pěti letech od ukončení projektu budou osobní údaje i nahrávka rozhovoru smazány. Přepisy budou uchovány na dobu neurčitou, pokud není v zaznamenaném souhlasu stanoveno jinak.

Závěry z výzkumu budou publikovány zásadně v podobě souhrnných informací a formou anonymních citací, které vylučují jakoukoliv identifikaci jednotlivce.

Dobrovolnost

Vaše účast ve výzkumu je zcela dobrovolná. Během rozhovoru můžete odmítnout odpovědět na jakoukoli z kladených otázek, přerušit nebo ukončit rozhovor, případně klást doplňující otázky týkající se výzkumu. Z účasti ve výzkumu pro Vás neplynou žádné výhody či nevýhody. Jako poděkování za účast ve studii Vám bude poskytnuto shrnutí výsledků výzkumu.

Pokud se rozhodnete z výzkumu odstoupit, můžete tak učinit kdykoliv bez udání důvodů a bez jakéhokoli postihu. Stejně tak máte právo požádat výzkumného pracovníka o zpětné upravení nebo výmaz informací kdykoli v průběhu konání studie. V těchto případech se můžete obrátit na vedoucího výzkumného pracovníka, **Martina Krobota**: *krobot@med.muni.cz*

Kontakt na pověřence pro ochranu osobních údajů Masarykovy univerzity

V případě jakéhokoliv problému či jakýchkoli otázek týkajících se zpracování osobních údajů můžete kontaktovat osobu odpovědnou za ochranu osobních údajů na Masarykově univerzitě na kontaktním e-mailu *poverenec@muni.cz*.

SOUHLAS S ÚČASTÍ VE VÝZKUMU

Název výzkumu: Vnímání aktuálního nastavení systému nutriční péče a své pozice na pracovišti nemocničními nutričními terapeuty

Vedoucí výzkumný pracovník: Martin Krobot

Tento výzkum je podpořen grantem **MUNI/A/1608/2020**.

		Souhlasím s tvrzením
1	Potvrzuji, že jsem si přečetl/a dokument „Informace pro účastníky výzkumu" (str. 1–2) pro výše zmíněnou studii a porozuměl/a jsem mu. Měl/a jsem příležitost prostudovat informace, položit otázky a dostal/a jsem uspokojující odpovědi.	☐
2	Rozumím tomu, že má účast na výzkumu je dobrovolná, že můžu kdykoliv odstoupit ze studie bez udání důvodu a že odstoupení ze studie pro mě nebude mít žádné nepříznivé důsledky.	☐
3	Rozumím tomu, že výzkumné údaje shromážděné během výzkumu mohou být sdíleny osobami z Masarykovy univerzity pro účely tohoto výzkumu. Uděluji souhlas těmto osobám, aby měly přístup k informacím a výzkumným údajům týkajících se mé osoby.	☐
5	Rozumím tomu, že tento projekt byl přezkoumán a schválen Etickou komisí Masarykovy univerzity.	☐
6	Rozumím tomu, kdo bude mít přístup k získaným datům, jak budou data uchovávána a jak bude s daty naloženo po skončení výzkumu.	☐
7	Rozumím tomu, jak budou data k tomu výzkumu zpracovávána a publikována.	☐
8	Jsem si vědom/a toho, že mohu kdykoli klást otázky, vyjádřit obavy nebo podat stížnost.	☐
9	Souhlasím s nahráváním rozhovoru.	☐
10	Rozumím tomu, jak bude nakládáno se zvukovými nahrávkami a jak budou sloužit v analýze získaných dat.	☐
11	Rozumím tomu a souhlasím s tím, že výsledky výzkumu mohou být použity ve výuce, publikacích a během prezentací na vědeckých konferencích.	☐
12	Souhlasím s účastí na výzkumu.	☐
13	Byl/a jsem informován/a to tom, že obdržím elektronickou kopii tohoto informovaného souhlasu včetně písemně poskytnutých informací.	☐

Na základě přečtení dokumentu „Informace pro účastníky výzkumu" prohlašuji, že jsem porozuměl/a jeho smyslu a souhlasím se svou účastí ve výzkumu.

Byl/a jsem informován/a, že:

1. mám právo požadovat přístup k osobním údajům týkajícím se mé osoby, jejich **opravu** nebo **výmaz**, popřípadě omezení zpracování,
2. mám právo **vznést námitku** proti zpracování osobních údajů týkajících se mé osoby,
3. mám právo **podat stížnost** dozorovému orgánu (Úřad na ochranu osobních údajů) v případě, že se domnívám, že zpracování mých osobních údajů probíhá v rozporu s právními předpisy,
4. získaná pseudonymizovaná data mohou být předána **dalším subjektům** (spolupracujícím odborníkům a institucím), výhradně však za účelem vědeckého výzkumu,
5. mám právo tento souhlas se zpracováním osobních údajů **kdykoliv odvolat**, aniž by mi za to hrozila jakákoliv sankce či znevýhodnění, a to **e-mailem na adresu** *krobot@med.muni.cz*, případně oznámením na kontaktní údaje pro zpracování osobních údajů. Zákonnost zpracování údajů před odvoláním souhlasu tím není dotčena.

Na základě výše uvedených informací uděluji tímto Masarykově univerzitě (jako správci a zpracovateli osobních údajů) souhlas se zpracováním osobních údajů za účelem vědeckého výzkumu, a to na dobu 5 let po ukončení studie.

.....	.....
Jméno a příjmení účastníka výzkumu	Datum
.....	
Podpis účastníka výzkumu	
.....	.....
Jméno a příjmení osoby za výzkumný tým (nebo osoby pověřené, která poskytla informace)	Datum
.....	
Podpis osoby za výzkumný tým (nebo osoby pověřené, která poskytla informace)	