Dietotherapy

DIETARY NOMENCLATURE

A UNIVERSAL, or at least widely accepted, system of dietary nomenclature is fundamental for the correct interpretation of the physician's orders, the unification of dietary regimens, the evaluation of new diets, and the comparison of results. The name of a diet should immediately convey to the physician, nurse, and dietitian a similar, if not always identical, description. The terminology should be commonly understood and accepted by the physician in a hospital in New York City, the nutritionist in the public health department of a city in Texas, or the dietitian in a food clinic in Los Angeles. Even the patient's acceptance of the diet may be conditioned by the name which is given to the diet.

Exact Nomenclature Determines Dietary Effectiveness

A primary requirement of good dietary nomenclature is exactness in describing the level of nutrients, when such quantitation is important to the final result. It would be unthinkable for a physician to prescribe a medication without indicating the amount to be used. Yet, the use of inexact terms such as "high" and "low" in describing diets is commonplace, and usually results in a great deal of confusion. As a rule, modifying terms are related to a standard for normal intake such as the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council.[1] For example, when a "high protein" diet is ordered it is customary in most hospitals to provide approximately 100 to 125 Gm. protein daily. This protein level is high when referred to the 70 Gm. protein allowance for a man in health. It is likewise a liberal diet for many ill persons. However, it would be the normal or expected protein intake for pregnant or lactating women, or it might be too low for satisfactory nutrition in certain surgical situations or in diseases of the liver. Thus, in many situations it would be necessary to specify more exactly the level of protein desired.

Similarly, a "low calorie" diet may succeed or fail depending upon the extent to which calories are restricted. The 800, 1200, and 1500 calorie diets are all "low calorie" when referred to normal requirements of the adult. If a physician fails to specify the caloric level which is desired for the patient, the dietitian or nurse will usually select a moderate level of restriction such as the 1200 calorie diet. Although such a diet can be planned to provide all of the nutritive essentials, it may entirely fail to produce the expected weight loss, or, on the other hand, may occasionally be too severe a program.

Exact Nomenclature Aids Dietary Evaluation

Progress in diet therapy is dependent upon a continual evaluation of the results obtained by various investigators. Such comparative studies are unquestionably facilitated by exactness in describing the level of a nutrient or of nutrients. At the present time considerable confusion still exists concerning the efficacy of diets restricted in sodium. Diets described as "low sodium," "low salt," and even "salt free" are known to vary from less than 200 mg. to more than 1000 mg., depending on individual planning. Thus, a description in general terms may mean that one investigator is basing his conclusions on the use of diets providing extremely limited amounts of sodium, while another investigator is basing his find-

ings on the use of much more liberal diets. Obviously, comparison of diets at such widely varying levels of intake is unreliable. Duplication of studies and considerable misinterpretation can be avoided when the physician, nurse, and dietitian are concerned with dietary planning at specified nutrient levels.

Nomenclature Depends on Knowledge of Food Values

Suitable dietary nomenclature is dependent on a knowledge of food values and on the behavior of foods in the body. To cite the currently popular low sodium diet again, the knowledge that almost all foods contain some naturally occurring sodium will emphasize the fact that no diet is, in a correct sense, "salt free." The term "low salt" is also insufficiently exact when sodium restriction is required, since many foods may be prepared without salt but may nevertheless contain important amounts of naturally occurring sodium or of added sodium products other than sodium chloride—such as baking powder, baking soda, and numerous others used in food processing.[2] The interchangeable use of the words "salt" and "sodium" in describing sodium restricted diets cannot be condoned. Indeed, one who uses terms such as "salt free" and "low salt" admits that he understands the diet poorly, or is careless in his use of terminology.

Adequate information on food values will eliminate certain nomenclature as well as lists of diets from daily usage, since it will be realized that some dietary modifications are impossible, or at least highly impractical. The so-called "high vitamin" or "high iron" diets do not in any sense provide therapeutically effective levels of most of the vitamins or of iron, respectively. Diets so described have no place in diet manuals and in textbooks.

Problems of Dietary Nomenclature

No group of diets suffers as much from undesirable practices in nomenclature and subsequent misinterpretation of orders as do the regimens for diseases of the gastrointestinal tract. Unfortunately, there is little information on the behavior of certain foods in the gastrointestinal tract. This is especially true with reference to so-called "low residue" diets. There appears to be little discrimination between the use of the words "fiber" and residue." It has been noted that some sources reduce the amount of fiber only, thus permitting pureed cooked fruits, vegetables, ground or tender meats, milk, fine cereals, bread, etc. Other regimens omit milk, fruit, and vegetables. Until reliable information is available, one cannot hope to achieve unanimity in the description of such diets; obviously, the term "low residue" will continue to mean widely divergent diets to different people.

Nomenclature Should Avoid Disease Names

All too frequently diets are named for disease conditions. For example, a patient is told that he requires an "initial ulcer diet," an "ambulatory ulcer diet," or an "ulcer discharge diet," and is given an instruction sheet so headed. Why should the patient need to be reminded of the fact that he has ulcers every time he consults his diet sheet? What is the meaning to the patient of the words "initial," "ambulatory," and "discharge"? Isn't this merely an example of carelessly adopted jargon by the professional person? Surely one could find a more appropriate name for the diet, such as "bland diet," "high protein bland diet with six meals," etc. Many diet manuals now designate the progressive dietary program used for peptic ulcers as Bland Diet I, II, III, etc.

Numerous examples of diets named for symptoms of diseases could be mentioned: "gastrointestinal section diet" (bland diet); "gallbladder diet" (moderate or low fat diet); "anticonstipation diet" (high fiber diet); "cardiac diet" (soft 500 mg. sodium diet); "colitis diet" (bland high protein diet); "nephrosis diet" (high protein 800 mg. sodium diet); yes, even "antivomiting diet" (dry diet)! Not only is the psychologic connotation of such nomenclature unfortunate, but the use of a disease name suggests that a diet is limited to that condition alone. Thus arises an unnecessary multiplicity of diets, usually varied in the slightest of details.

Nomenclature Should Avoid the Names of People

The use of a person's name for a diet is not desirable. True, some named diets such as the Sippy and Meulengracht diets have become so well known as to convey a definite description to anyone at all versed in dietary procedure. Even so, the "modified Sippy diet" means to some a liberal program graduated over a period of one week, and to others a severely limited, nutritionally inadequate progression over a three to four week period. More frequently, a dietitian, nurse, or physician has no knowledge of a diet by a person's name and may be at a total loss to duplicate a regimen.

Characteristics of Good Dietary Nomenclature

The Diet Therapy Section of the American Dietetic Association has recognized the need for a clarification of the terms used in dietetics and in describing diets. The newly revised *Handbook of Diet Therapy*[3] includes a glossary prepared by this Section, as well as descriptions of the diets named in this glossary.

From the foregoing discussion it is apparent that the nomenclature for most diets can meet these requirements:

1. Terminology should be related to the modifications of the normal diet; that is, it should be stated as an increase or decrease in one or more nutrients, change in consistency, flavor, etc.

2. Dietary nomenclature should specify nutrient levels whenever quantitation is essential to the success of the diet. Thus, just as the amount of protein, fat, and carbohydrate is specified for the diabetic patient, so the sodium level will be stated for restricted sodium diets, the calorie level for low calorie diets, etc.

3. Reference to diseases or symptoms should be avoided in describing a diet.

4. Names of persons should not be used to designate a diet since underlying principles are usually not clear.—CORINNE H. ROBINSON

REFERENCES

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3. TURNER, D. F.: *Handbook of Diet Therapy*. University of Chicago Press, Chicago, 1952.