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THE PAST, PRESENT AND FUTURE OF ARMY DIETETICS

BY

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17 MARCH 1989

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USAWC MILITARY STUDIES PROGRAM PAPER

THE PAST, PRESENT AND FUTURE OF ARMY DIETETICS

An Individual Study Project

by

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PAST, PRESENT AND FUTURE OF ARMY DIETETICS

CHAPTER I

INTRODUCTION

This paper discusses the role of dietetics in the United States Army Medical Department. It provides historical background information, discusses present issues and roles of Army dietitians and finally, makes recommendations for the future of Army dietetics.

BACKGROUND

The Army Medical Department (AMEDD) has been part of the U.S. Army since 1775. Over the years it has developed into a highly structured and sophisticated organization composed of both broad and narrow based professional specialties with diverse training and skills. The military hospital organization basically mirrors similar civilian organizations. Designing the overall force structure for combat with the correct number of trained and skilled personnel having both the balance and flexibility needed for mission accomplishment while still maintaining the capability

of a high quality, affordable peacetime health care system has challenged senior leaders within and outside of the AMEDD. Medical care is ranked high on individual soldier and family priorities for staying in the Army. Thus the mission of providing peacetime care to soldiers, dependents and retirees has been the focus of the AMEDD's resources in the recent past rather than its combat or readiness role. The AMEDD recently has began to look more closely at the readiness issues of the AMEDD and its ability to meet its wartime mission. The competition of providing peacetime health care at the expense of readiness has been discussed in a previous U.S. Army War College Study Project. The study concluded that the constraints and demands on the entire AMEDD have caused impairments to readiness.[1] The AMEDD has recently become more articulate at defining and justifying its importance and value to the Army and others in terms of its wartime mission. In 1984 at the Academy of Health Sciences (AHS), Fort Sam Houston, Texas, the Vice Chief of Staff of the Army was told that the AMEDD could provide experienced replacements to commanders within a very short time period. By providing health care to soldiers wounded, having diseases or nonbattle injuries and returning them to duty as far forward as possible, the AMEDD could quickly provide the fighting units with experienced and "blooded" soldiers. The AMEDD's value has also been considered in determining a strategy for low intensity conflict (LIC) situations by providing medical, technical and organizational capabilities to foreign countries.[2] Commanders not understanding the value of the medical assets available to them or who fail

to see the AMEDD as a combat multiplier are at a considerable disadvantage and could suffer serious consequences when they conduct combat operations.

The AMEDD consists of six special branches that all work together in providing medical and health care to soldiers.[3] One of the smaller branches, and one which has gotten little recognition or publicity, is the Army Medical Specialist Corps (AMSC). This branch is composed of officers in three distinct professional specialties: dietitians, physical therapists (PT) and occupational therapists (OT). The focus of this paper is on the dietitians who compose 37 percent of the AMSC (181 officers). It will look briefly at dietetics and the role it has played in the Army since the Spanish American War. By looking at the past, and reviewing some of the outstanding contributions that have been made by Army dietitians it is hoped that a better understanding and appreciation of this group of professionals will occur. Present and future challenges and issues facing this group will also be identified concluding with a list of recommendations for future consideration.

ENDNOTES - CHAPTER I

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2. Jenkins, Elray., COL, Medical Civic Action Programs (MEDCAPS) and Medical Readiness Training Exercises (MEDRETES) as Instrument of Foreign Policy. Thesis. Carlisle Barracks: U.S. Army War College, May 1988.

3. U.S. Department of Army, Army Regulation 40-1: Composition, Mision, and Functions of the Army Medical Department. Washington: 1 July 1983.

The six special officer branches within the AMEDD and under the supervision and management of the Surgeon General are:

* Medical Corps (MC)
* Dental Corps (DC)
* Veterinary Corps (VC)
* Medical Service Corps (MSC)
* Army Nurse Corps (ANC)
* Army Medical Specialist Corps (AMSC)

Additionally, career management field (CMF) 91 enlisted soldiers and DA civilians employed in AMEDD activities and organizations are part of the AMEDD.

CHAPTER II

HISTORICAL INFORMATION

WORLD WAR I AND BEFORE

Dietetics in the military began in 1898 during the Spanish American War when specially trained nurses were hired by the U.S. government as "dietists" and placed in charge of the dietary management of wounded patients. They were only kept on the payroll for a few years after the war.[1] In 1899 at the Lake Placid Conference on Home Economics, the term "dietitian" was first defined as an individual who specialized in the knowledge of food and could meet the demands of the medical profession for diet therapy.[2] It wasn't until World War I that the need for dietitians to staff the military hospitals, both in the United States and with the expeditionary forces overseas, was identified again. In 1917 the National American Red Cross Dietitian Service was asked to provide the dietitians for the military since the professional organization of the American Dietetic Association (ADA) had yet to be formed. By the end of the war a total of 356 dietitians were employed as civilians by the government to serve in both the continental United States and overseas military hospitals.[3]

In 1918 one visionary woman, Lenna F. Cooper, on a leave of

absence from Battle Creek College in Battle Creek, Michigan, was the first dietitian appointed to the Surgeon General's Office (SGO) to supervise the activities of the dietetic service in the Army.[4] She is also credited with initiating a special conference in Cleveland, Ohio, which resulted in the creation of the American Dietetic Association (ADA) in 1917.[5]

As Superintendent of Dietitians, Cooper provided the leadership and vision to a group of civilian dietitians who would serve in the military hospitals and were the pioneers of the yet to be formed Dietitian Section in the Army Medical Specialist Corps. Miss Cooper made many contributions in the SGO. Before she left in 1919, she was asked to make recommendations on the future status of dietitians.[6] One of her recommendations was to create a separate corps, similar to the Army Nurse Corps, composed of dietitians with the same rank and privileges as the nurses. It took a period of over 20 years and another war to implement many of these objectives.

One of these civilian dietitians, Katharine E. Manchester felt that many have forgotten that Army dietetics began with the group of dietitians who served the Army in a civilian status in WWI. She was impressed with this group's contributions toward providing nutritional support to soldiers in Army hospitals under adverse conditions. The stories of inequities in privileges and the lack of status for these pioneer women during this period have been documented by her in an unofficial history organized and compiled by her and others from records being discarded from the repository in St. Louis when she was assigned to the SGO in

1943.[7] This history of Army dietitians during the period 1917-1947 is an enlightening account, much of which has been selectively incorporated into the official history of the AMSC.[8]

Because dietitians were not military officers, many problems were encountered which would continue to cause difficulties until relative rank was accorded them. As civilian employees of the War Department, they had no War Risk Insurance and no rights to compensation for death or disability. Duties, rights and privileges of dietitians were not defined by the military in the early years. Without military rank they lacked adequate authority to perform their necessary duties. It was only through their own initiative and individual personalities that they accomplished as much as they did. There was no standardization of the chain of command for dietitians thus their utilization was dependent on the individual commanders, mess officers, mess sergeants, and chief nurses. Dietitians also were not entitled to discharge bonuses, reduced railroad fares while on furlough or after discharge, nor award of the Victory Medal. Problems resulting from limited food and equipment and untrained personnel also were challenges these pioneer dietitians had to overcome.[9]

A Medical Department Mess Officer's Manual printed in 1919 identified the duties of dietitians during this early period. Their duties were outlined as follows:

> The Dietitian. - It is her duty to prepare menus for all patients in the hospital. She is to see that the food is properly prepared and served. She should see that the menus are served as written.
>
> She should be present in the kitchen during the preparation of meals. However, during the service she

should divide her time between the wards and mess hall in such a way that she may know whether the food is being properly served throughout the hospital. She or her assistant is responsible for the issuing of the food to the wards. She should also report to the Commanding Officer defects of service found in the wards, that these may be corrected through proper channels. Defects of preparation or service found in the mess hall or kitchen should be reported to the Mess Officer.

She is directly responsible for the preparation of special diets and for special items or modification of the three listed diets. She should, however, be supplied with sufficient help to relieve her from all the details of preparation of these items. It is her duty to advise with the heads of the services, ward surgeons or nurses as may be necessary to ensure the patients getting food that is adapted to their needs, while at the same time the kitchen may be relieved of preparing unnecessary specials.[10]

It was due to the contributions made during WWI concerning nutrition services provided to both the sick and duty personnel that the value of the dietitians as part of the Medical Department was recognized. Dietitians generally had the full recognition and support of the doctors, commanding officers and the Surgeon General after they had proved their value during World War I. According to Colonel Manchester, the doctors wanted good food for the patients and had a high regard for the dietitians. Because of this, during the peacetime years between the two world wars (1923-1940), dietitians continued to be employed. There are references in Congressional Hearings in 1927 of dietitians being recognized for their ability to provide a nutritional analysis of the Army garrison ration. This was at a time when the Army was seeking parity with the Navy for an equitable ration allowance.[11]

Also Manchester credits Lenna F. Cooper and Grace Fields with demonstrating to the Army that dietitians were needed in

Army hospitals after WWI. Because of their professionalism and selfless service they attended ADA meetings and conferences to keep updated and the dietetic internships approved - often at their own personal expense and on their own annual leave.

In 1922 a training program was established at Walter Reed Hospital in Washington, D.C., which provided the majority of dietitians for the Army's hospitals. The educational and professional qualifications for entry into the program were established by the Surgeon General and consisted of a four year college degree in foods and nutrition in addition to an 8-12 month course in a recognized school for hospital dietitians.[12] By maintaining this pool of dietitians Army hospitals were able to rapidly expand as these dietitians assumed positions of responsibility and leadership during WWII. However, the lack of military status was still a problem that required legislation to change, although senior military leaders realized that if another war occurred dietitians would have to be militarized in order to avoid the problems encountered in WWI.

World War II

One retired dietitian who is considered both a pioneer in military nutritional care by the Army and in hospital food service by the civilian sector is Katharine E. Manchester, COL, USA, Ret. [13] She is credited with many innovations in Army hospital

food services and was hired as a civilian dietitian in 1940 before dietitians were militarized. Her career spanned a total of 31 years in the Army and culminated as she assumed the duties of President of the American Dietetic Association in 1971.[14] She was the first military dietitian to be elected to this office and after her tour, she served on the ADA Foundation Board of Directors. As President of the Board, she solicited corporate support for scholarships for dietetic students. Under her leadership, the board also completed projects for public nutrition education and established an endowment for operations, lectures and scholarships.[15] Through the foundation and the ADA, a National Center for Nutrition and Dietetics has been created to provide food and nutrition information to the public. This fulfilled a dream Colonel Manchester had since 1942 and for which she is most proud.[16]

Due to the close liaison of the military with the civilian profession, obtaining dietitians was easier during mobilization for WWII. The profession knew what the Army was doing and that the Army had good programs. Colonel Manchester remembers a meeting she attended in Philadelphia in the early 1940's to speak to a group of approximately 400 dietitians. She signed up 200 of them that evening for the Army's needs. She attributes this to the patriotism of the women who wanted to serve their country and who knew from friends or through their association near posts and stations that the Army was in need of their services.

The fact that military status was not a part of the employment contract was not a detractor. According to Manchester,

military status was attempted in 1937 by the Surgeon General and even ADA went on record supporting military status for the dietitians employed by the Army. Manchester noted, "If the Army dietitians had not been very skilled professionally and if they had not exerted themselves in the association and worked in the local professional organization, then we probably would never have gotten militarized."[17] However, the fight for militarization required Congressional approval and for reasons of spaces and money, the legislation was not passed prior to WWII. It was not until dietitians were deployed overseas that they were commissioned because of the problems they experienced after WWI with no military status. In 1942, dietitians and physical therapists were given relative rank in the Medical Department for the duration of the war and six months after.[18] Colonel Emma Vogel, first Chief of the AMSC and a physical therapist, and Lieutenant Colonel Helen Burns Gearin, the first Chief of the Dietitian Section, always said, "'that the fact that we are accorded military status is in recognition of the service of all the people who went before us.'"[19] Legislative efforts to formalize the group continued but it wasn't until 1947 that the Women's Medical Specialist Corps (WMSC) was officially created by Public Law 36.[20]

The contributions made by the dietitians in WWII were admirable, especially considering the working conditions -- lack of proper equipment, limited rations, and the problem of being women in a "man's" Army. They were patriotic and served overseas both in the European Theater of Operations and in the Pacific, and

even on hospital ships. In addition to the duties identified in the Medical Department's Mess Officer's Manual, the dietitians began to perform the following duties:

*instruction of patients with diabetes in measuring and weighing food

*supervision of mess personnel assigned to duty in the kitchens of some of the larger hospitals

*planning balanced menus within the ration value

*supervise preparation and service of all food to bed and ambulatory patients and inspect waste

*direct the employees in the preparation, service and storage of food and assist in ordering food supplies and procuring of kitchen equipment

*give patient instructions and demonstrate preparation of special diets to patients on such diets as ordered by the physicians.[21]

Three dietitians and one physical therapist were interred in the Philippine Islands by the Japanese as POWs.[22] *1LT Ruby* Motley, a dietitian interred in Bataan and later Santo Tomas Internment Camp, explained how difficult the conditions were and the problems with malnutrition of the POWs.[23] From a nucleus of dedicated women was built the foundation of the Dietitian Section in the Army Medical Specialist Corps. The peak strength would reach 1,633 dietitians in WWII.[24]

One of the advantages of militarization was the demise of the mess officer in the hospitals. Prior to 1942 the mess officers in the hospitals were usually doctors. Manchester spoke highly of these "old time" doctors who understood the importance of good food for the patients and who would come into the kitchens to check the quality of it. But during mobilization, Medical

Service Administrative Officers, called "90 Day Wonders," were placed in these roles to relieve the doctors of these duties. As civilians, dietitians could not sign requisitions, balance money from meals, or discipline enlisted personnel. However, abuses with spending money intended for food occurred creating an adversarial relationship between dietitians who were actually operating the hospital food services and the mess officers who seldom had food service backgrounds and would try and cut food costs to buy other things.[25]

POST WORLD WAR II AND KOREAN WAR

After WWII, a long and hard upward road continued to be pursued by the dietitians as they expanded their roles and responsibilities. Small but significant changes would occur in the organization of the hospital food services that would eliminate the mess officer and the dual responsibility for administrative functions in the area of food service by reorganizing the hospital food service operations into a Food Service Division headed by a dietitian who was responsible for all food service operations.[26]

During the Korean War, the first involuntary recall of dietitians was initiated and a civilian dietitian consultant, Miss Mabel M. MacLachlan, was appointed to the SGO to assist with the critical personnel shortages. Because industry, commercial

organizations, schools, colleges and hospitals were all utilizing dietitians there was an insufficient number of graduates to meet both the civilian and military needs. Once again, the liaison between the military and civilian professional groups was strengthened as they struggled to meet the needs of both groups.[27] At the outbreak of the Korean War, 11 dietitians were assigned to the Far East Command, but by the close of the war, the number assigned had doubled.[28] The peak strength of 245 dietitians was reached during the Korean War.[29]

According to one source, during the Korean War as the number of dietitian spaces increased, the role of the dietitian expanded. Physicians were more willing to let dietitians expand their involvement in areas of patient instruction, particularly in prenatal, pediatrics, and OB/GYN areas. Outpatient instructions increased and dietitians began to contribute in this area in addition to the inpatient instructions being given.[30]

POST KOREAN WAR

During the "Manchester Era" hospital food service matured and became more efficient and innovative. During this time Army hospitals had decentralized tray service for patient feeding and nurses were responsible for operating the ward kitchens. The majority of food was prepared in the main kitchen supervised by dietitians but was loaded in bulk food carts (i.e., food was

transported in sufficient amounts to serve the ward) and sent to the individual wards for final preparation, portioning and serving to the patients. This procedure was not looked upon as the most effective utilization of a nurse's time or skills. Manchester, as part of a management team, was assigned to the Medical Plans and Operations Division of the Army Surgeon General's Office with duty at Valley Forge General Hospital in Phoenixville, Pennsylvania. Her involvement in conducting management research in food service organization, developing new procedures and staffing, and delineating responsibilities for nursing and food service used in U.S. Army hospitals was significant. She initiated the transfer of the ward kitchens to the food service and conducted a study on centralized tray service at Brooke General Hospital. That study marked the closing of ward kitchens and the conversion to centralized tray service in the Army hospitals. According to Colonel Manchester she saw that in order to effectively manage manpower, money and control the patient's tray, dietitians would have to take over the ward kitchens. In that way dietitians were able not only to control the food service in the main kitchen, but the service of the trays to the patients.[31]

Besides the organizational changes in the hospital food service, a very significant change occurred in 1955 when male members where authorized to join and the WMSC's name was changed to the Army Medical Specialist Corps (AMSC).[32] According to Manchester, there was disagreement within the senior leadership of the WMSC concerning this decision. However,she felt males

added to the strength of the corps.[33]

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3. Anderson, pp. 16-18.

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5. American Dietetic Association, pp. 20-21.

6. Anderson, pp. 593-594.
Miss Cooper made seven recommendations in 1919 which were as follows:
* Make a permanent place for dietitians on the staff of the larger hospitals.
* Give the dietitian entire charge of the mess department, relieving the mess officer and mess sergeant of their duties.
* Increase the present salary of dietitians. The cost savings would be more than made up through proper management of the mess.
* Grant all technically trained female civilian employees of the Medical Department in the field receiving their appointment from the Secretary of War the same privileges that are granted to the members of the Army Nurse Corps.
* Create a separate corps for dietitians with a competent supervising dietitian at the head.
* All dietitians in the field should be responsible professionally to the commanding officer.
* Create a training school for Army dietitians at one of the larger hospitals (eg., Walter Reed General Hospital) which would prepare qualified dietitians for Army hospitals.
* The Supervising Dietitian in the Office of the Surgeon General be put on the regular list of inspectors of the Hospital Division and make mess inspections.

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17. Manchester, Personal Interview.

18. Anderson, pp. 101-102 (Public Law 828, 77th Congress, 2nd Session, 22 December 1942).

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25. Manchester, Personal Interview.

26. Anderson, pp. 511-539.

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28. U.S. Army Medical Department. The Army Medical Specialist Corps, 1917-1971, Washington: Government Printing Office, 1971. p. 13

29. Ibid.

30. Accountius, Patricia L. COL, USA, Ret. Personal Interview. San Antonio, TX., 25 January 1989.

31. Manchester, Personal Interview.

32. Anderson, p. 402 (Public Law 84-294, 84th Congress, 9 April 1955).

33. Manchester, Personal Interview.

CHAPTER III

Vietnam

When medical units were first sent to Vietnam, dietitians were not authorized as part of the field type hospitals. In January 1965, there were 110 AMEDD hospital beds in South Vietnam. However, by June 1969, there were more than 4,750 beds in 21 installations.[1] In April 1966, two dietitians and one physical therapist were sent to Vietnam.[2] There were no authorized spaces, but the need was felt and the Surgeon General approved their assignments which marked the first time that AMSC officers had been assigned to a combat zone.[3] It wasn't until 1967 that Lieutenant General Leonard D. Heaton, the Surgeon General, directed that dietitians be given new duties and responsibilities and were formally authorized to the personnel complement of field hospitals.[4]

There were many reasons for sending dietitians into Vietnam. Among them were:

* Problems caused by inexperienced and untrained food service personnel who were unfamiliar with hospital patient feeding requirements.

* Misuse of critically short nursing personnel to supervise the patient feeding in an attempt to partially solve the problems.

* Availability of a mixture of rations to include B rations (semi-perishable, canned and/or dehydrated food items) and A rations (canned, fresh and frozen food items)

* The necessity to prepare modified diets for patients.

* The permanent nature of the hospitals. All Army hospitals including the MUST (Medical Unit, Self-Contained, Transportable) units were on fixed installations and had area support missions.

* The 30-day evacuation policy.

* The approval and direction of the AMEDD senior leadership to assign dietitians there without authorized slots.[5]

The two dietitians sent to Vietnam were to provide staff and consultant support to the hospitals and Medical Groups. Major (later Colonel) Patricia L. Accountius was the first dietitian to arrive and was tasked to design a hospital food service system for the theater. Her position on the staff at the 3rd Field Hospital was initially under the Chief Nurse, but soon thereafter, she was to report directly to the hospital commander. The hospital commander soon realized that she needed to be assigned to the 68th Medical Group in order to take care of the problems surfacing at other hospitals within the medical group. After a short time at the 68th Medical Group, the commander, Colonel Pixley, recognized that the scope of her responsibilities and the calls from other medical groups concerning hospital food service problems would require her to be assigned to an even higher headquarters; subsequently she was assigned to the 44th Medical Brigade.[6]

Because the logistical supply system previously had been operated by the Navy, but was being turned over to the Army, confusion and disorganization was routine. B rations and combat rations were being sent in predetermined amounts based on troop strength without requisitioning from the theater. As a result, a build-up of certain commodities occurred, while unbalanced proportions of rations were shipped and issued, resulting in unbalanced diets and unpredictable menus. These problems caused the troop mess halls problems, but even more so for the hospitals trying to serve patients and prepare modified diets. A variety of diets were served in the hospitals to include liquid diets, diabetic diets, dental soft, bland, sodium restricted and others. It is doubtful with the food supply being so unpredictable and because of untrained food service personnel, if these diets were always correctly prepared and served.

Accountius convinced the command that a 4 week cycle menu using B rations and supplemented with fresh food was required to solve many of the subsistence problems they had. Once implemented, she could write house diets for the hospitals and establish a list of hospital unique subsistence items to be stocked by the 1st Logistics Command for issue to the hospitals.[7]

She also was involved with justifying supplementation of the Vietnamese Army's ration with B rations because it was nutritionally inadequate. She spent a week recording the intake of the Vietnamese soldiers in a dining hall and coordinated with the Metabolic Ward at Walter Reed General Hospital to analyze it. Her involvement with obtaining subsistence for the Koreans and

Australians was also important as was her work with the subsistence personnel in getting the ships reconfigured with a balance of subsistence items rather than one item which created the "feast or famine" situations. Finally, she was involved with malaria and diabetic patients in country.[8]

She spent a considerable amount of time meeting incoming planes looking for hospital-trained enlisted personnel. Even though the 94F MOS had been approved as a separate MOS by DA, the TOE slots and the personnel replacement system was not in place. This resulted in a mismatch of personnel being assigned to troop units and hospitals. When she found trained 94F personnel she was authorized to swap them for MOS 94B personnel and thus was able to get at least one or two 94F personnel in the hospitals.[9]

Besides food supply and personnel problems, equipment and facility problems were also a challenge. There was no standardization of facilities or equipment at the hospitals with each hospital usually having a mix of TOE field equipment and some limited garrison equipment. Various situations concerning the availability of running water, refrigeration and utilities were also experienced. Accordingly, there were considerable sanitation problems as well as operational problems. Preparing and serving food to nonambulatory patients on wards far removed from the kitchen as well as for ambulatory patients and staff of the hospitals was a daily challenge. According to Accountius, with so many problems and complications, priorities had to be established. Stabilization of rations and a realistic command menu

that could be supported by the logistical system, obtaining or improving equipment and utilities, obtaining hospital trained enlisted personnel who could help train the local hospital personnel to include the local nationals who spoke little English and who had a lower sanitation standard than Americans, and review of mess hall construction plans were all problems Major Accountius had to deal with when she arrived.

The overwhelming task of dealing with the problems of the hospitals in a consultant role was different than that in CONUS where each hospital had at least one dietitian assigned and a relatively stable ration supply system with familiar equipment and facilities. "Everybody except us, I feel, lost sight of the fact of how difficult it is to feed patients in the field - real large numbers of patients," one dietitian remarked.[10]

Inadequate preparation and training, personnel shortages and the overwhelming number of problems everyone was having probably accounted for many of the situations. One observation Colonel (then Major) Jesse Brewer, another dietitian assigned to Vietnam, related as she toured an orthopedic ward was about a patient in a body cast being served dinner. She related,

> The first time I went on the ward at the 95th Evac Hospital, there was a patient in a full body cast, one arm up and he had a paper plate on his stomach and one plate on his chest. He had a plastic fork and plastic spoon but he couldn't move his right arm. His meat was not cut and he was trying to balance that food and trying to eat it. And there was a whole ward full of patients like that. It was a perfect example of where a 94B (Food Service Specialist) was not used to dealing with the situation of feeding patients. They didn't have sufficient nurses to go around and feed these people so here was a guy that had hot and cold food right on his chest and yet couldn't eat it because they gave it to him on two paper plates. There were no

> trays, he had plastic silverware and his food was not cut up and he was supposed to eat it. That was when you needed 94Fs (Hospital Food Service Specialists). When 94Fs got to the hospitals, that made all the difference in the world.[11]

Because of the tenuousness of the dietitians' positions, getting things done was a real challenge. In their consultant roles they had to coordinate not only with medical units and personnel, but with engineers, logistical units, preventive medicine personnel, Quartermaster personnel, and the Headquarters of each of these units. The reception of the dietetic consultants varied from resistance by those who saw them as inspectors, to that of appreciation by others who saw them trying to assist in solving the feeding problems of the command and improving patient care. Despite all the problems, all of those interviewed commented on the improvements that were made.

Due to the efforts and outstanding achievements of the first dietitians, more would be assigned reaching a peak strength of 5 dietitians assigned to Vietnam in 1969.[12] The situation with hospitals being in close proximity to each other, readily available air transportation for the consultants, and the necessity of having to do with a limited number of dietitians worked during this war and provided both the troop and hospital feeding programs a solution to the multitude of problems besetting them in Vietnam. Although the Surgeon General's Office documented the lessons learned by interviewing returning personnel serving in Vietnam, these lessons are soon forgotten and the problems surface again for the next generation to solve. But from these first-hand experiences would come initiatives in

the 1980's requiring major modernization of the medical field feeding system by standardizing and procuring new food service equipment and reviewing staffing requirements for TOE medical units. Additionally, a field manual for medical feeding in a combat environment would be completed.

Although Vietnam took the priority of effort and resources, the dietetic internship programs improved during this period with the development of a uniform POI (Program of Instruction) and a more integrated learning program of both didactic and clinical instruction and emphasizing competencies. The Army's program was visited by numerous civilian internship staff members and was considered a model to emulate. Additionally, the implementation of computer support to hospital food service was done first at Walter Reed and would be proliferated to other medical centers.

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CHAPTER IV

POST VIETNAM

After the Vietnam era and into the 80's more changes took place, although on the surface not as significant as had occurred before. One interviewee used the term "stagnation" to describe this period since the strength of Army dietitians was drawn down from a peak of 269 during the Vietnam War to 181 in 1988. Another interviewee felt that Army dietetics "lost their momentum" and that dietitians were trying to maintain programs that had proliferated during the Vietnam buildup. This period saw the entire Army drawing down on personnel strength and everyone trying to maintain what they could.

In the area of fitness and nutrition, the civilian sector was becoming more involved and interested. Emphasis on outpatient treatment continued to be seen as the inpatient workload decreased. Weight control became a major focus of the Army and brought dietitians into the limelight emphasizing their role in providing diet instructions, educational classes and nutrition counseling. However, it wasn't until the Army weight control program contained regulatory guidance for eliminating personnel for failure to maintain satisfactory progress that the program had the "teeth" for enforcement.

Skin calipering for percent body fat was done for a period

of time until the regulation (AR 600-9) changed the screening procedure to a tape measurement done at the company level. This did much to relieve the already overburdened medical system of this workload congestion.

HEALTH PROMOTION

However, the Army Health Promotion Program with the Health Risk Appraisal (HRA) instrument soon followed in 1986 and was supported by the senior leadership of the Army. This proactive program on health and fitness evaluated a person's lifestyle behaviors. It heavily involved the dietitians in the education of the individual soldier and his family in good nutrition, lowering dietary cholesterol, fat and sodium, weight control, eating a more nutritious diet, and living a more healthful lifestyle.

Preventive medicine programs such as the Health Promotion Program require resource expenditures and a commitment to implement them Army-wide without impacting on the hospital system. Unhealthy lifestyle habits can impact on the occurrence or severity of certain disease conditions. If changes can be made early in the individual's career and lifestyle, the cost and personnel savings are believed to be offset in the longterm. This assumes that by changing unhealthy lifestyles, individuals will not require expensive inpatient treatment for cardiac and other conditions in later years. Cost-benefit studies are needed and recognized by the profession as necessary to firmly substantiate

the cost effectiveness of preventive health programs. Until these studies are performed preventive health programs will remain controversial and more vulnerable to budget cuts than curative health care programs.

As the public's interest in health promotion continues to grow the medical profession is being challenged to provide programs to fill this need. The dietitian's role in health promotion today is not new; rather it is the same as what used to be called nutrition education. The difference today is that there is a much larger audience and the demand for service is greater due to the awareness and changes in the social environment.[1] The real change has been that nutrition education has moved out of the hospitals and into the units, i.e., company, brigade, and division. Teaching soldiers to consume operational rations is also important and a concern since observations have indicated that insufficient fluid, calories and nutrients are being consumed. This has a direct impact on combat readiness and a training package will be developed out of the Surgeon General's Office (Dietitian Section) to correct this.[2] Families of soldiers, retirees and other beneficiaries are important as well, and demand the services of the dietitian. Preliminary data from hospitals that have implemented the Health Promotion Program indicate that it has increased the workload of the dietitian by 40-50 percent due to increased dietary counseling and troop education.[3]

The absorption of this increased workload is difficult and will require new ways to perform current jobs. Hiring civilian dietitians to perform some of the inpatient workload and placing

the military dietitian in the area of troop education is a suggested way to handle this workload. Better utilizing the MOS 94F personnel is also recommended.

Colonel Martha A. Cronin, Chief Dietitian, Office of the Surgeon General, has proposed placing a dietitian in each Active Army division for the purpose of providing this troop education and being available to advise the command about nutrition issues. These division nutritionists would be assigned to the Division Surgeon's Office and provide the needed support that cannot be provided by the hospital dietitian. There are currently two divisions testing this arrangement with excellent results. Colonel Cronin states that measuring the impact of health promotion and determining the value of placing a dietitian in the division won't be seen for a period of years because the troops are a young population and results are long term not short term. She confidently remarks that the Army's senior leadership is very positive about the division nutritionists, but it is still a spaces game and there are no requirements or authorizations as of yet.[4]

AMERICAN DIETETIC ASSOCIATION'S (ADA) CONCERNS

In dealing with current issues and challenges facing dietitians, the professional organization, the American Dietetic Association, is looked to for leadership and direction. Because the professional organization represents the membership's concerns and interests, by looking at the ADA's position and

guidance to the profession, directions for Army dietetics can be identified. As the numbers entering and practicing in the profession grows, the roles and images of the members continue to change and expand. Concern about image and direction for the future are major concerns of the ADA. A Study Commission was formed and tasked with the following in 1970:

> The Commission was charged to assess the resources and potential of the dietetics profession, to determine desireable areas for further growth and development, and to identify and recommend improved approaches, techniques, and methods of providing dietetic services. It was to look at the education and practice of dietetics at that time and determine the appropriate education for the dietitian of the future. It was asked further to evaluate the present role of the American Dietetic Association as the major professional organization of dietetics and to determine the future needs of its members.[5]

The report entitled, "The Profession of Dietetics (commonly referred to as the Millis Report)," was published and widely distributed in 1972.

The report contained three major findings:

1. The dietitian is a translator of the science of nutrition into the skill of furnishing optimal nourishment to people.

2. The current system of educating and training the dietitian was found deficient and needed to be made more effective. The Commission believed the following areas needed to be addressed:

a. The amount and quality of nutrition science learning needed to be increased.

b. The science and art of nutrition needed to be learned concurrently instead of separately.

c. There is great variation in the quality of instruction and learning opportunities.

d. Dietetic education lacks a clear identity within higher education and its institutions, thus recruiting potential may be impaired.

e. Dietetic education is not sufficiently related to other health sciences and to the education of other health professionals.

3. Dietetic practice in the future will be altered in the following ways:

a. Increased differentiation in the roles and functions of dietitians.

b. Increased specialization.

c. New and additional competencies will be required.

d. Increased delegation of present tasks and roles to other less highly trained workers.

e. Increase in the number of dietitians practicing in association with other health professionals.

f. Increased portion of dietitians who will be self employed.[6]

The Study Commission also made six recommendations:

1. The basic education of dietitians be designed as a four-year curriculum resulting in a bachelor's degree and including both the didactic learning and introductory clinical experience necessary for beginning practice as a dietitian.

2. The undergraduate curriculum should be built around the central theme of the human life cycle since nourishment and diet

play an important role throughout the human life span.

3. Membership in the ADA be as open and voluntary as possible.

4. ADA should assume responsibility for the warranty of the competence of professional dietitians by registry and by certification. Registry would occur for entry level positions upon examination and review of educational accomplishments. Certification would occur for dietitians who have advanced professional education and/or have had professional experience in responsible positions through examination and review of advanced education and professional experience.

5. At this time, ADA should not undertake any direct responsibility for accrediting educational institutions in dietetics per se.

6. ADA should operate through four councils to be known as:

a. The Council on Dietetic Practice

b. The Council on Dietetic Education

c. The Council on Dietetic Research

d. The Council on Communication[7]

In 1983 another Study Commission on Dietetics was formed at the direction of the ADA and ADA Foundation to begin following up on the above report, assessing the education and practice of dietetics in the present time and determining the status of the findings and recommendations issued in the 1972 report. In addition, the new study would look at the future directions of the profession and the relationship of the profession to the changing

health care delivery system. Again, it was to make recommendations on the role and functions of dietetics and the ADA since many changes had occurred since the Millis Report. Changes in the social environment had occurred such as increased emphasis on preventive care and concern of the public over diet and nutrition. Other changes in the health care delivery system such as documentation of dietetic services provided to individuals, third-party reimbursement for dietetic services and provision of more highly specialized dietetic services in a variety of new and different settings was a realty. Additionally, factors such as increased costs of health care and increased public awareness of risk factors and diseases had been less evident during the time of the Millis Report.[8]

The Study Commission finished its work in 1984. They concluded that at the time the 1972 report was disseminated it did not appear to have any major impact on the profession. There was concern about it being too narrowly focused and it was criticized by the Food Service Systems Management Education Council for not giving adequate acknowledgement to the management aspect of dietetics thereby unduly restricting the profession.[9] However, later surveys indicated that the report was widely read and used particularly in the educational community. According to the 1984 Study Commission, "Almost all of the findings and recommendations are in effect today or in the process of development."[10] The 1984 Study Commission concluded that the 1972 report was "an important landmark and that it had significant favorable impact upon the profession."[11]

The 1984 Report provided an extensive look at the profession and addressed many issues in depth. It is assumed that this report will have as significant an impact upon the profession as did the 1972 report. However, because of brevity only the following selected issues will be discussed in this paper:

1. Traditional and nontraditional roles of dietitians
2. Education of dietitians
3. Generalist versus specialist training
4. Licensure and certification
5. Support personnel
6. Manpower and recruiting
7. Leadership
8. Cost-benefit studies

TRADITIONAL VS. NONTRADITIONAL ROLES OF DIETITIANS

The first Army dietitians functioned in very traditional hospital-based roles with responsibility for sick patients in the area of nutritional care and feeding. In the beginning they had limited authority and responsibility for the management or administration of the hospital food service operation since by regulation the operation was controlled by a mess officer with the assistance of mess sergeants. As time went on the dietitians began to assume more operational responsibilities and obtained more control of the operation based on their initiative and because of the changing attitudes of women's roles in the military. The

militarization of dietitians also helped in this transition. However, in executing the above duties, it became apparent that in order to ensure patients were properly fed, control over the complete operation was necessary. Eventually, the dietitians assumed complete responsibility for the operation of the hospital food service and eliminated the need for mess officers as the head of the department. Because traditional hospital-based positions are now fully "institutionalized," dietitians have become fully accepted as members of the health care team with full authority and responsibility for the Nutrition Care Division.

Colonel Accountius credits Colonel Manchester with changing the role of the dietitian in the Army and says, "She did more to contribute to developing our roles as true professionals probably than any other dietitians have done."[12] Absorbing more administrative duties for the complete operation of the hospital food service, furthering the use of support personnel (both civilian, eg. Diet Aides, and military, i.e. MOS 94F), eliminating the nonprofessional duties of the dietitian and delegating them to trained support personnel, were just some of the efforts undertaken to change the traditional role of the dietitian.

When asked about the nonhospital-based jobs of dietitians, Manchester responded by relating stories of dietitians with unique skills who were tasked by their commanding officers to perform jobs outside of the traditional Army role. Some of these jobs were operating a mass feeding operation in an old airplane factory at Willow Run in London, being part of research teams for hepatitis and burns, writing the history of the dietitians and

the AMSC, and being staff officers at the SGO. During the end of Colonel Manchester's career she was tasked as the Surgeon General's consultant to a Subsistence Operations Review Board (SORB) created by General William Westmoreland and headed by Lieutenant General John D. McLaughlin. As such, she was tasked to visit troop dining facilities throughout the world to evaluate troop feeding. Army dietitians have also been tasked to assist in humanitarian efforts in Peru (1958), Jordan (1962), Venezuela (1963), Columbia (1964), Guatemala (1975) and El Salvador (1986).[13] Taskings such as these where the expertise of the dietitian is required are still occurring as evident by the recent selection of Colonel Martha A. Cronin, Chief, Dietitian Section, AMSC, as Team Leader for the Research and Development Team of Army Task Force 2000. The purpose of the Task Force is to look at feeding the Army in the field through the year 2000. As part of the review, current and future operational ration and packaging systems that have applications to Army feeding were investigated and will be briefed to the Chief of Staff of the Army.[14]

During the 80's a proliferation of new nontraditional roles and nonhospital-based positions of Army dietitians came about. These opportunities outside the hospital were carved out of bonafide concerns for the profession by the senior leaders in the AMSC. An added benefit was that such positions better prepared the future senior leaders for these jobs by giving them staff officer experience at a junior level. This allowed them to become familiar with broader aspects of the military and was an

alternative to traditional hospital jobs.

The nontraditional roles presently being performed by dietitians are:

1. FORSCOM Surgeon's Office - duties include working with the PROFIS dietitians, FORSCOM hospitals as well as Reserve Component hospitals working with both the dietitians and MOS 94F personnel assigned.

2. Division Nutritionist - Currently at Fort Polk, Louisiana and Fort Carson, Colorado, assigned to the Division Surgeon's Office. They provide nutrition education to soldiers, commanders, food service sergeants and family members. They ensure that nutrition initiatives are in place and enforced.

3. 44th Medical Brigade - Works with MOS 94F personnel and their training, rotation, Medical Proficiency Training (MPT) at the TDA hospital, interfaces with reserve units training at Fort Bragg and has gone to the National Training Center (NTC) in a support role.

4. United States Army Institute of Environmental Medicine (USARIEM) - Two dietitians assigned in the Military Nutrition Division at Natick Labs where they conduct nutrition studies on rations, impact on soldiers, nutrition initiatives, electrolyte beverages for personnel in MOPP and have done some garrison and field feeding studies.

5. Deployable Medical Systems (DEPMEDS), Office of the Surgeon General (OTSG) - works with equipping new DEPMEDS hospital food service as well as coordinate physical and occupational therapy equipment sets.

6. Combat Developments, AHS - working on Medical Force 2000 and AMSC integration into that force.

7. Health Promotion, OTSG - Nutrition policy for soldiers, assists in the Army Nutrition Planning Committee which has membership from all food service related activities (i.e., Quartermaster School, TISA, West Point, Soldiers Physical Fitness Center, Academy of Health Sciences, TRADOC, AAFES, Commissary and the Club System).

8. Recruiting - Officers recruit AMSC and Veterinary Officers.

9. Army and Air Force Exchange Service - this is a rotating position with the Air Force; works with the DOD school system particularly in OCONUS and with all AAFES units.

10. Defense Medical Systems Support Facilities - works with the automated data processing (ADP) applications for the DOD hospitals. Implementing a hospital food service computer system, (TRIFOOD) at present in CONUS hospitals and will follow on with OCONUS hospitals.

11. Academy of Health Sciences (AHS) - Training MOS 94F personnel, conduct short courses for both officer and enlisted, teach in AHS courses, write doctrine.

12. Field Exercises - dietitians are routinely going on field exercises either in a TDY status or at their local installation when they are the PROFIS for the field medical unit on the installation. Recent taskings include support to operations in El Salvador, Honduras, Egypt, NTC, etc.

13. Administrative Assistant, AMSC Office - Works as a staff officer in the Office of the Chief, AMSC.

14. Quartermaster School - One dietitian and one Hospital Food Service Specialist are assigned to instruct on nutrition and other related subjects in the Quartermaster's food service training programs.

15. Cadet Mess, West Point, New York - Provides nutrition guidance and education to U.S. Military Academy.

16. Exceptional Family Member Program (EFMP), Europe - Provides nutrition guidance and dietary counseling to personnel in the EFMP.

The majority of the above positions initially were filled at the expense of valid requirements and authorizations. Many were filled based on a verbal agreement with the gaining command that a valid requirement would follow. There was a risk involved in doing this and in order to understand why an effort was made to establish these nonhospital-based positions, two retired Chief Dietitians were asked to elaborate on this.

Colonel Jesse Brewer stated that the risks involved were great but the risk of not being represented or involved at the concepts stage was even greater still. She felt the importance of being in the concepts stage of developing doctrine was the reason for placing an AMSC in the Combat Developments Directorate at the Academy of Health Sciences (AHS). She continued,

> As the Army looks toward the future with decreased resources, if you're not needed in wartime you will be eliminated. If you are not in the concepts stage, the figures and arguments get finalized without

> your input and it becomes even more difficult at higher levels to change these figures and arguments. It became evident from the very beginning that someone needed to be at the ground level or our AMSC would have been wiped out and we would not have had the numbers to support our specialties.
>
> We know from experience in every war we've ever been in, we've had our three specialties (OTs, PTs and dietitians). I mean that's the way our profession in the United States got started based on the fact that it was needed for wartime rehabilitation. Nutrition support does make an impact on the patient after surgery; it impacts on the return to duty and recovery time. But how do you prove it?
>
> I convinced the Medical R&D Commander that nutrition research needed to be reintroduced into the Army's program. I placed a dietitian in USARIEM to conduct nutrition related research. There are both short and long term implications with the health of troops of getting misinformation on nutrition. As the fitness and health initiatives in the civilian sector increased, there were commanders and others giving out misinformation on nutrition and impacting their ideas on the soldiers they commanded.
>
> No spaces were given up to fill these nontraditional roles but the reason I felt it was important to do that even though it was hurting our hospitals, and it was hurting the other areas that needed people was the fact that if we didn't have somebody in there doing the job then someone else was going to do it that wasn't qualified and trained in the science of doing it. So we put someone in the Health and Fitness/Preventive Medicine area to develop policy for the troops to combat the fads and the misinformation. Some sacrifices were made even though no spaces were given up by anybody.[15]

She further explained that she had two reasons for taking the risks:

1. Sometimes you have to prove yourself before you get the requirements.

2. If you're not willing to take a risk you'll never get a requirement. If they have you and see the impact, they won't want to give you up and will work to get the space.

Colonel Frances Iacoboni was Chief Dietitian when Colonel Brewer was appointed as Chief, Army Medical Specialist Corps. Iacoboni said that Colonel Brewer supported her completely when opportunities arose for dietitians. She expressed her rationale for taking the risks in this way.

> Because nutrition had become one of the preeminent interests in the Army, I felt that in the long run the gamble would pay off by gaining us not only good recognition, but in the very long run additional spaces. At the worst case we would be cut less than we would maybe in the ordinary course of events. The Army dietitians understood what I was doing. They supported me and were anxious to see this kind of involvement occur because it gave them additional oppportunities besides clinical dietetics, and/or production and service or administration. In addition many of these jobs were targets of opportunity and by placing dietitians in these jobs we were able to compensate for some of the shortcomings in our system. So I not only tried to maintain or build up the Dietitian Section but we had to have input into the new regulations and systems that would affect us.[16]

The 1984 Study Commission Report expressed concern over the roles of dietitians in nontraditional jobs. Because of the newer positions open to dietitians, the role of the dietitian in these settings has not been well defined and is probably as diverse as the personalities in these roles. According to the Survey Commission, the profession will have to identify and clarify how dietitians will function in these roles to ensure the best interests of society are met and for the benefit of the patients or clients served.[17]

There are other health care professionals entering into the domain of dietetics and some members within the profession feel that the overlapping or competition needs to be addressed. The Study Commission takes a positive and offensive approach rather

than a negative and defensive one by stating: "The emphasis of dietetics should be on moving ahead with more dynamic and expanded roles based on scientific expertise, rather than on attempts to protect present functions so that others may not engage in them. Attempts at 'turf protection,' even if successful, are almost always self-defeating in the long run."[18] It concludes by saying, "If the profession is to keep pace with the changing scene, dietetics must become more dynamic, more assertive, more progressive, and more expansive in its education and practice and in its relations with the public."[19]

Despite the inroads and the proliferation of individuals with dietetics education, the image of dietetics is not all positive, especially among the younger members of the profession. Because the profession is predominately female and has been a supporting profession rather than a leading one, acceptance of this status seems to be common. Those in the profession are generally satisfied with their jobs, but rank their career secondary to that of their families. Due to the expanding opportunities opened to women since the 1970's, the profession may have a harder time attracting qualified and dedicated members especially with this perceived negative image. It should be noted however, that this perception is more widely held by the dietitians themselves rather than those they interface with such as hospital administrators, physicians, nurses, etc.[20] The 1984 Study Commission made the following recommendation concerning the status of the profession:

> The profession of dietetics should grow to encompass new areas, through more intensive education and

> training, so that the services of dietitians are recognized as crucial components in the care and treatment of patients with special problems. Dietitians should also look for new ways to apply their expertise for the good of society. The profession should not try to delimit its boundaries, nor to erect barriers to prevent others from entering, but should expand its activities into new areas where knowledge of foods and nutrition is valuable.[21]

Combat Role of Dietitians

Probably the most important role of the Army dietitian is their combat role in field type hospitals (TOE). Since dietitians had been accepted in fixed type hospitals (TDA), it was only a matter of time before this change would be reflected in field type hospitals. This change occurred during the Vietnam era when the Food Service Warrant Officer positions that had been authorized in field type hospitals were eliminated and converted to dietitians. However, even though the TOE documents have been changed, there continues to be resistance by individuals who question the need for dietitians as the Academy of Health Sciences looked at the changing structure of the TOE hospitals in the Theater of Operations in order to comply with the new Army doctrine. This controversy appears to have been one of a lack of representation at the concepts stage of the process and a lack of appreciation and knowledge of the contributions of the dietitians, as well as politics. This situation may partially be the fault of the current PROFIS (Professional Filler System) since TOE hospitals in the active component do not see the dietitian in a professional wartime role on a routine basis.

The PROFIS dietitian in peacetime has primary responsibility to the fixed TDA hospital and may train with a TOE hospital only a few times a year and then only for short periods of time. Realistic training with real patients seldom occurs in these training exercises which may give the commanders the impression or misperception that dietitians are not needed. The lack of involvement by dietitians is as much a problem of the limited number of dietitians as with an unfamiliarity with their field role and how to make the most of the time they spend with the TOE unit. The latter problem is quickly being changed due to the initiation of a Field Nutrition Short Course that has been conducted three times at the AHS since 1985. This course is conducted for the PROFIS dietitians, reserve component dietitians and others so they become familiar with their wartime field roles, understand the type of equipment and systems they have to work with, and other related issues. Additionally, dietetic officers attending basic training at the AHS attend a three day orientation on dietetic specifics. A medical field feeding manual will also be distributed in 1989 identifying doctrine, roles, and responsibilities of dietitians and 94F personnel in field medical units.

Few remaining active duty dietitians have first hand knowledge or experience with field type hospitals in combat situations. The vast majority of dietitians to include senior dietitians, have served their entire career in fixed hospitals. Therefore, there are some who might have difficulty translating their peacetime role to a wartime role in TOE hospitals. This

basic but unfamiliar role is one which junior officers are filling through the PROFIS program, but one where limited guidance is furnished and little supervision from senior officers may be available.

The demands of the peacetime Army do impact adversely on this readiness role. Fortunately, the experience dietitians get in TDA hospitals does contribute to their overall preparation for the wartime role and should not be thought of as simply a competing priority. However, a better integration of time and training with the field hospitals needs to be accomplished while at the same time not neglecting the requirements of the TDA hospitals. Realistically, this will continue to be a problem as long as manpower resources remain constant.

EDUCATION

If the profession is to fulfull its potential in the future the 1984 Study Commission recommends substantial change as follows:

> The 1984 Study Commission recommends major changes be made to revitalize the profession and enable it to make its maximum contribution to society. The profession must become more dynamic and more assertive, but to do so, it must increase its depth of knowledge and expertise. This will require changes in the education of dietitians at undergraduate, graduate, and continuing education levels. It will also require changes in the patterns of dietetic practice and in the activities of the American Dietetic Association (ADA).[22]

Because of the rapid growth in the knowledge of foods and nutrition, the awareness and greater understanding of foods and nutrition by the public and their impact on a healthy life, there

has been a proliferation of "experts" expounding on all aspects of nutrition. These experts range on a continuum from food faddists or cultists providing misinformation, to other highly qualified health care professionals such as physicians, nurses and pharmacists getting involved in the domain of dietetics. Unfortunately, conflicting advice and often potentially harmful information is given to the public. Although dietitians are highly qualified nutrition experts and are increasingly being sought out as a source of guidance, the public has been slow in recognizing this.[23]

Although the largest number of dietitians are employed as clinical dietitians in health care institutions (39%), significant numbers of dietitians work in the areas of food service management (26%), and community dietetics (10%).[24] The scope of dietetics continues to broaden as more dietitians enter private practice, act as consultants for health care facilities, and even supervise personal nutrition programs for athletes, entertainers, and corporate executives. Dietitians are also involved in managing industrial cafeterias, test kitchens and other institutional food service programs. Computer skills, journalism, advertising and public relations training is also being combined with dietetics as they branch out into other areas. They are also being hired for administrative and management positions in industry, business and health care.[25]

In an attempt to revitalize the profession, the education of dietitians at all levels must change and increase its depth of knowledge and expertise. The Study Commission suggested that the

education of dietitians should be strengthened in one or more of the following ways:

> * a broader base, particularly in the arts, humanities and behavioral sciences
> * greater emphasis on management and business
> * greater emphasis on communications and networking
> * greater emphasis on new technology, especially the use of computers
> * greater depth in scientific knowledge of nutrition.[26]

The Study also recommended that role delineation studies be used to determine the common foundation required. In conjunction with this recommendation, in February 1989 a role delineation survey was sent out to more than 11,000 registered dietitians and dietetic technicians. Information supplied as a result of this survey will form the basis for defining dietetic education standards and dietetic practice in future years. Additionally, the survey will provide information on what dietetic practitioners do as a daily routine, how much time is spent on these activities and the importance of each activity to the overall quality of services rendered to clients.[27] The results should be used to evaluate Army's standard of practice and determine future directions and goals to be accomplished.

GENERALIST versus SPECIALIST TRAINING

The report also indicates that advanced education will be necessary for every dietitian, whether the individual is a specialist or a generalist. The promotion system in the Army has impacted on this since advanced degrees are indicators of

excellence and are perceived as discriminators on the promotion boards. The argument of specialist versus generalist training and utilization in the Army has been discussed for some time. There was unanimous feeling among all the dietitians interviewed that the present and future needs of the Army would require generalists because of the nature of the Army's health care system and force structure. However, comments were also routinely emphasized that there was a role for specialization but not until after the generalist training period and a few follow-on assignments. Discussion on this controversy should not cause polarization in favor of one or the other, but one of acceptance on the need and role of both specialists and generalists in Army dietetics.

The report stresses that the role of the generalist should not be regarded as any less important than that of the specialist. As the profession expands in knowledge and sees the need for more specialization, there may be a tendency to move away from the generalist. However, past experience with the general practitioner in medicine has demonstrated that there is a role for both generalists and specialists. The Study Commission's position on this issue states: "As the division of practice increases, the need for coordination and supervision also increases. The generalist with good understanding and perspective becomes a 'specialist in breadth.' There will be many instances where individual dietitians will have to handle many of the aspects of specialized practice because of the shortage of personnel and resources or because of the location

and setting of the practice."[28]

Cronin states, "We are preparing that officer to be multi-functional. The registration exam is still a generalist exam and so we must prepare them to pass it. Specialization usually occurs after 2-3 years in practice. But they can never lose the capability to be multi-functional against Army requirements."[29]

The younger officers are more adept and familiar with the new scope of practice than are some of the older officers. According to Cronin we must reassess our old way of doing things and determine if there isn't a better way.[30]

The Army has always supported the generalist dietitian both in their training programs and in their utilization. The discussion always arises on the need for specialization however, the small number of dietitians makes this a costly decision in terms of manpower utilization and flexibility. As the science of nutrition becomes more complex there is a need for more skilled, knowledgeable individuals in specific areas of specilization. Determining the number of specialists needed will be easier than determining how to afford them in terms of manpower spaces.

One such area of specialization is the application of computers or automated data processing (ADP) to the hospital food service operation. Colonel Manchester was again at the forefront of this application with her work with Major Jane Sager. Her belief in computer support application to the hospital food service was innovative at the time and led the civilian profession. However, the momentum was lost when the Army was directed to combine with the other military services in a DOD effort for

ADP support and the civilians outstripped the military services.[31] The increased efficiency and productivity in both the production and clinical aspects of dietetics is expected to be far reaching with the implementation of a tri-service automated data processing system for hospital food services (TRIFOOD). The ability to better manage money, resources, cost accounting, and inventory is possible with TRIFOOD as well as performing the calculations of a patient's nutritional assessment. Implementation of the TRIFOOD system in the hospital's Nutrition Care Divisions (formerly Food Service Divisions until 1983 when the Surgeon General changed the title to better reflect the importance of nutrition) in the Army hospitals is currently underway and the project manager hopes to have all CONUS Army Hospitals on the system by the end of next year.

LICENSURE AND CERTIFICATION

One of the current issues in the Association is the issue of licensure and certification of dietitians. Although the profession has required a registration exam since 1970 and continuing education requirements (75 continuing education credit hours are required every 5 years), several states have enacted legislation requiring licensure with the intent to provide the public a means of legal identification of individuals who are qualified by education and training to serve as dietitians and prevent those not qualified from misleading the public. Because the military move throughout the United States and overseas, and as more

states move to pass licensure bills, this issue will impact more and more on the Army. The Study Commission recommended that the ADA develop a realistic and practical licensure model so individual state laws are similar and deal with problems of reciprocity.[32] The Army should be particularly interested in this action so that potential problems associated with moving dietitians throughout its hospital system are avoided.

SUPPORT PERSONNEL

In addressing the issue of supportive personnel, the report indicates that dietitians were using support personnel during WWII when dietitians were in short supply.[33] It indicates that even in the civilian community such personnel have not been utilized well, nor has their full potential been tapped. Appropriate responsibilities based on their level of education and delegating duties besides clerical tasks are appropriate. The use of support personnel in the Army has always been done with the gradual delegation of duties to the civilian diet aid position in Clinical Dietetics Branches and the Hospital Food Service Specialists. However, Army dietitians could benefit from relooking at this problem within their own local hospitals and improving on this. The training programs for MOS 94F personnel, especially at the E-5 through E-7 level, teach appropriate level tasks but require on the job experience for application of this training and a willingness of the dietitians to support and

expect this level of performance from their NCOs. This issue has been one of routine discussion among dietitians and impacts on the very viability of the MOS. If these personnel are not being used for the tasks for which they are being trained, or they do not have the ability to perform these tasks, then appropriate action must be initiated by the dietitians.

Support personnel for dietitians have always been important, although the training of these personnel for hospital feeding has not been easy. Initially, all food service enlisted personnel were trained by the Quartermaster School with additional training being provided in the hospitals for those personnel being assigned to medical treatment facilities. The medical feeding training was not standardized and it was inefficient for each hospital to continually provide such additional training without any assurance that those they trained would remain in the hospital system. In 1966 the Hospital Food Service Specialist (MOS 94F) was approved as a separate MOS (military occupational specialty). However, the training was not centralized and conducted at the Academy of Health Sciences, Fort Sam Houston, Texas, until the 1970's. In 1984 the proponency for the 94F MOS was transferred to the Surgeon General from the Quartermaster. The 94F MOS is now considered in the CMF 91 (Career Management Field) along with the other medical MOS's. Despite this evolving change, controversy and misunderstanding continues to revolve around the need for two distinct food service related MOS's (MOS 94B and 94F) even within the AMEDD. According to Cronin, in 1984 when the proponency changed, drastic changes needed to be done to

the 94F MOS to "bring 94Fs into the standards of practice of today and into the 1990s. One of our goals is to improve the 94F quality."[34] AR 611-201 will be changed to more accurately reflect the duties of the Hospital Food Service Specialist. Additionally, the alpha-numeric code will be changed from 94F to 91M to reemphasize the medical aspect of the MOS. This is another step in the evolution of hospital food service to change the long held attitudes expressed by many that "a cook is a cook."

MANPOWER AND RECRUITING

The issue of manpower and recruiting is a problem for both the profession and the Army. Because the factors that determine the demand for dietitians are constantly changing, determining the adequacy of the supply is difficult to predict in the long term. As of May 1984, the ADA had 51,202 members, 40,928 of which were registered dietitians.[35] The Study Commission had difficulty determining the adequacy of the numbers of dietitians but stated that it appeared the present supply of dietitians met or very nearly met the demand.[36] However, discussions with those trying to recruit potential candidates for the Army Dietetic Internships suggest differently. The number of candidates applying has sharply dropped in past years (from over 100 applicants in the past down to 37 last year for 14 positions), with the quality of the academic standing decreasing when compared with applicants from previous years.[37] This would suggest a potential problem for the future if the numbers

continue to dwindle and the quality becomes lower than desired.

Both the Army and the profession are aware of the recruiting problems and need to take an assertive and proactive position on attracting more high quality youth into dietetic careers. A related sub-issue is the need to attract more minority members to include men. In 1981, only 2.7 percent of ADA's members were male.[38] The diversity of having minorities in the profession is needed since the overwhelmingly white female profession has not changed significantly from the inception of the ADA. In the same 1981 census 97 percent of ADA's members were female and of that, 87 percent were white.[39]

Attracting more minority groups and dynamic and progressive youth to assume leadership positions is a goal that should be embraced by both the Army and the profession. The Army compares favorably with 25 percent male dietitians, although many of these men were recruited during the Vietnam era. Whether the percentage will continue to remain that high after they reach retirement age is yet to be seen.

The Study Commission's recommendation addresses this issue by stating, "ADA should provide the youth of America with accurate, up-to-date information about careers in dietetics and should work actively to recruit minority and male students to the profession. Dynamic and progressive students of all kind should be recruited for leadership roles in the revitalized profession envisioned for the future."[40]

An Association publication, the ADA Courier, has recently published a column on military dietetics which will not only help

recruiting and educate the profession on military dietetics, but will continue to forge closer relations with the military and the civilian professionals.[41]

According to Cronin, officers are leaving at their 5th and 6th year, which is leaving a gap in the middle experience level of dietitians. The promotion system is affecting this attrition since the last major's board had a selection rate of 30 percent. The junior officers are looking at this and getting frustrated and discouraged and getting out. As a result of the attrition, the section is having to take in more direct assessions to keep the numbers up. Such additions often are older applicants who have less flexibility because of families. Currently, 67 percent of the dietitians are married.[42]

Based on WWII figures, the ratio of dietitians per 1,000 troops varied from 0.184 in June 1939 to 0.320 in June 1946. The ratio went as low as 0.180 and peaked at 0.350 with an average over the 6 year period of 0.243.[43] In comparison, the ratio today is 0.232 (181 dietitians to a total active Army strength of 781,000) which seems insignificant (difference of 9 dietitians) except that the system was different during WWII when dietitians performed in more limited, traditional roles. The level of professional practice today is considerably higher and the overall role and responsibilities of the dietitian is greater. Looking at the ratios it can be seen that little progress has been made in staffing of dietitians since WWII even though the practice of dietetics has expanded. There is a crisis in the making if the numbers of dietitians continue to decrease.

LEADERSHIP

The importance of leadership is not unique to the military, and is a concern of the dietetic profession. As the profession changes and advances into new areas, new ideas and approaches must be implemented and brought quickly into the mainstream. The Study Commission's recommendation is valid for not only the profession but particularly the military where rank, promotion and the inherent bureaucratic system have a tendency to impede the integration of new ideas. However, the recommendation bears review and should be considered by the Army. It states, "ADA should make greater effort to identify and recruit potential leaders within the Association. Such persons should not only be involved in developing new proposals, but also should be given opportunity to follow through on their implementation, working in cooperation with established leadership."[44]

Since leadership is critical if the profession is to continue to advance, working and interfacing with other professions, groups and individuals is vital. One major obstacle to achieving this is to be perceived as an expert in your profession, but in the military achieving comparable rank is as important for credibility and to get your "foot in the door." Dietitians are perceived as nutrition experts, and have always sought to acquire advanced civilian education. But only recently has military education become equally available to the AMSC officers as to the rest of the Army. Only since 1984 has one

resident slot for the U.S. Army War College been made available every other year to the AMSC. This was a significant advancement since the lack of senior service school was an obstacle preventing further advancement of AMSC officers. The need for military schooling and its value to the dietitian and to the AMSC was discussed with past and present senior leaders. Those who had not been to formal military schooling felt they were missing something and had to work harder to understand the Army system and achieve credibility. Those who had attended felt it gave the officers a better understanding of the profession as a military officer, provided a broad perspective and helped them better interpret and apply their professional contributions to the Army and DOD.

The senior leadership of the AMSC still see the lack of a general officer as the Corps Chief as an obstacle with significant impact within the AMEDD. To achieve parity with the other AMEDD officer branches and to provide the AMSC officers equal opportunity to compete for general officer slots, a change in the current situation is required. It is highly unlikely that this change will come easily since someone will have to "pay the price" of a general officer space. Legislation appears to be the only solution for correcting this inequitability.

COST-BENEFIT STUDIES

"The Study Commission commends the efforts to develop reliable cost-benefit studies showing the relationship between good

nutrition and good health. It is rational to believe good nutrition not only improves the quality of life, but also will be effective in preventing disease, curing illness, and shortening the length of stay in health care institutions, thereby substantially reducing the costs of health care to the public. Research showing the positive benefits of the activities of dietitians will have great impact in the long run on the professional stature of dietitians and on their compensation."[45]

The Army is as interested in the above as is the profession as a whole and the need to demonstrate the relationship between good nutrition and good health and the cost benefits of such will do much to improve the standing and importance of dietitians in the future. Hard scientific studies are needed, especially during times when cost restraints in health care and in the military are rising in importance. Those who can prove their value and the benefits to the public at a reasonable cost will survive the budget cuts. Those who can't will be at the mercy of the system and will be eliminated. In 1989, the Journal of the American Dietetic Association will review the literature from 1966-88 on the costs and benefits of nutrition services.[46] All health care professionals should study this comprehensive review and determine what follow-on action is required. Additionally, the public and particularly the AMEDD should be made aware of this review. By sharing and communicating this information, visibility will be achieved and informed decisions can be made based on scientific data on the cost-benefits of nutrition services.

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CHAPTER V

THE FUTURE

What does the future hold for Army dietetics? In the previous chapter, selected issues of the 1984 Study Commission Report on Dietetics were reviewed as well as some of the impacts on Army dietetics. These issues are expected to influence the future for some time to come. Other issues that are of concern presently and will shape the direction of Army dietetics are:

1. Contracting out dietetic services in the Army hospitals to civilian contractors. According to the Health Services Command (HSC) Dietetic Staff Officer, due to a required cut in total Army manpower spaces, HSC facilities must identify their share of the cut. Nineteen out of thirty eight facilities have identified the Nutrition Care Divisions for review.[1] There is concern that if the Army contracts out these facilities there will be an overall negative impact on the readiness of the AMEDD. A training base for TOE hospital personnel and reserves is required as well as a rotational base for overseas personnel. Additionally, there has been a continual erosion of production and service spaces for both dietitians and enlisted personnel. Without authorized spaces, officer and enlisted personnel cannot gain the experience in operating hospital food services. This experience is critical for their go-to-war mission and seriously impacts on

dietitians being able to function as generalists.

One compromise that has been implemented at Fitzsimons Army Medical Center is contracting out only the Production and Service Branch and leaving the Clinical Dietetics Branch military operated. The Chief, Nutrition Care Division, is the Contracting Officer Representative (COR). There are mixed opinions on how well this arrangement works and how cost effective it has proved to be.[2] Concerns over quality food, variety in the menu, sanitation, flexibility, meeting patient's desires and needs, and appropriate staffing have all surfaced in the past with regard to this contractual arrangement. However, the fact that by contracting out the Nutrition Care Divisions the go-to-war mission is adversely affected has not gained sufficient notice. Rather, emphasis has been given to reducing manpower spaces and showing decreases in total operational expenses. There is a valid wartime mission for dietitians and enlisted personnel in TOE hospitals. The TDA hospitals provide those personnel the opportunity to practice their wartime mission in an acceptable manner within the constraints of a peacetime environment. There remain serious reservations over the implications of contracting out the Nutrition Care Divisions and efforts continue to be made to convince the senior leaders about the hazards and implications of such contracting.

2. Implementing the Health Promotion Program and capturing the workload for appropriate resource distribution. Colonel Karen Fridlund, Dietetic Staff Officer for Health Services Command, states there is a program for obtaining personnel

resources (eg., community health nurses and dietitians) by "buying" the service with funds allocated for this program.[3] Because of the increased workload the wellness programs have had on dietitians, this would help in providing the counseling to the beneficiaries.

3. Implementing the TRIFOOD automated data processing system into the Nutrition Care Divisions. This tri-service effort will assist in managing and operating the Nutrition Care Divisions but implementation requires an initial outlay of considerable time and resources. It is hoped that by the end of next year, all CONUS facilities will have the TRIFOOD system and then it will be implemented overseas.[4] This system is necessary before the Ala Carte System, discussed below, can be implemented. How well this is implemented and how well it provides the support promised will determine future directions for ADP in hospital Nutrition Care Divisions.

4. Implementing the Ala Carte System in the hospitals. This system converts the present "one fixed price" for a meal used in all troop and hospital dining facilities to a system of paying for only the items selected by the patron. It had been tested in one Army hospital and is presently being implemented in three additional facilities according to Fridlund.[5] It is a complex system but hospital commanders have desired to offer this system in lieu of the more traditional one presently used by most facilities. As with the TRIFOOD system it is too soon to determine how well this new system will be accepted. But it has the potential to impact on the hospitals in a way similar to what the

conversion of the decentralized kitchens and tray system had during the "Manchester Era."

5. Increasing use of medical resources to combat LIC situations. According to Cronin, she sees an increased role for dietitians in feeding Third World Countries. This could be part of the Foreign Military Sales Programs. Malnutrition and feeding problems will be topics of discussion at the next Nutrition Symposium conducted at Walter Reed Army Medical Center in early 1989.[6]

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CHAPTER VI

SUMMARY AND RECOMMENDATIONS

In summary, the profession of dietetics in the Army began prior to WWI and has served the Army in all past wars. Dietitians had difficulty being accepted by the military staff prior to their militarization, but they have routinely demonstrated their value and contributions to the military, have had to work under unclear lines of authority and responsibility, have had to overcome adverse working conditions, shortages of supplies, equipment and trained support personnel but have continued to expand the practice of dietetics. Improvements were made and the nutritional welfare of the patients has always been foremost. Their ability to organize and manage resources for feeding patients and staff has always served the Army well in past wars and will continue to do so.

The following is a list of recommendations based on the past, present and projected future of Army dietetics:

1. Maintain continued close relationships with the ADA. The role delineation survey results should be evaluated against the Army's standard of practice to determine what impact or future directions and goals need to be accomplished. The Army dietitians need to associate with the civilian profession and reenforce participation in local and national dietetic association

meetings. They need to assume both supportive and leadership roles to guide the profession in the future. Much is to be gained by both the civilian community and the Army.

2. There is a need for "political clout" to maintain and advance the role of dietetics in the climate of reduced resources. In an attempt to obtain parity with the other Army Medical Department branches, efforts should be made to obtain a general officer requirement and authorization. A general officer position is key to gaining equitability with the rest of the AMEDD and remain competetive with the rest of the Army. The Defense Advisory Council on Women in the Service (DACOWITS), Congressional support and ADA involvement as well as coalitions with other AMEDD branches should be pursued to this end.

3. A potential crisis exists on recruiting quality personnel. New approaches to recruiting may need to be examined and a return to past programs and techniques initiated again to recruit and maintain high qualilty officers. Minority groups and men need to be particularly targeted for the diversity and contributions they can make to the profession.

4. Continue to emphasize advanced degrees, particularly Ph.D.'s, to perform and interpret scientific studies supporting the effects of nutrition on both the ill and well soldier. Qualified credible spokespersons must articulate the benefits using these studies. Generalists who are "specialists in breadth" are needed primarily, but advanced specialist training needs to be supported.

5. Need to continue to place personnel in key positions where

new concepts or changes in doctrine, structure or mission are being planned and formulated. However, the risk of losing unfilled authorizations must be considered, so a specific time line needs to be established for obtaining formal requirements.

6. Wartime needs require dietitians as past history has consistently proved. The systems, to include adequate equipment to prepare and deliver food and nourishment to patients, and personnel to support the nutritional welfare of the patients also needs to be in place both in peacetime and wartime. War is chaotic and unpredictable requiring qualified personnel who understand the Army system and the priorities and can work within the system to provide the needed requirements and complete the mission. Army health care institutions and systems have evolved over long periods of time and have adapted to meet the needs of the patient. The lessons learned in past wars and exercises need to be continually updated to present situations. Leaders need to be educated and reminded of the past lessons learned and that nutrition and readiness are inseparable.

7. Support personnel are needed to perform duties previously performed by dietitians since the numbers of dietitians will probably not increase measureably in the near term. There is a need for high quality support personnel (MOS 94F) to perform appropriate level tasks commensurate with the civilian profession allowing dietitians to devote their time to professional duties. Since the ratio of dietitians to the total force structure has always been low, adequate support personnel trained in the provision of health care are even more critical to carry out the

mission of the Nutrition Care Divisions.

8. Dietitians have an expanding role in health prevention, wellness programs and other programs directed at the "healthy" soldier and his family. Although difficult to quantify the value and cost benefits, the literature and profession will begin to undertake this challenge. Army dietitians need to assume leadership roles in this area.

9. Visibility and marketing is the key to success. Because dietetics has been a supporting profession and has been an accepted institutionalized team member of health care systems in the United States since WWI, attempting to elevate the importance and value especially within the AMEDD will be a challenge. However, liaison with the ADA's program and continued persistence will be required to gain the support needed and begin to make the needed changes.

10. A concerted effort needs to be made to devote efforts to obtain a civilian historian to continue to write the history of the AMSC and analyze the lessons learned so that senior leaders can benefit from other's experiences based on factual data. This information should be widely disseminated and incorporated in courses and training. The lessons learned need to be continually applied to new systems or changes in the practice of dietetics to ensure that the same mistakes or situations are not created again.

11. Military schooling is required since it provides dietitians with a knowledge base identical to those that they interface with particularly at the senior staff level. It allows the dietitians

to more accurately understand the needs and problems of the Army and apply their professional expertise of dietetics to better serve this end. Their increased contributions and improved credibility has provided increasing opportunities to expand the profession of practice and influence of nutrition on the policies of the Army.

12. The strategy of the Dietitian Section needs to be tied with the ADA strategy and applied in the military environment. This strategy must be understood and supported by all members of the section with involvement and participation by all in achieving the goals and objectives identified in the plan.

13. Dietetic internship training programs need to continually change to meet the needs of the profession and the military. Dietitians in middle or senior level positions need to be renewed both educationally and philosophically, to meet the changing demands and utilize the trained young dietitians in areas they never have performed in before or have not performed at the expanding higher level of performance.

14. Identifiable standards must be quantified and maintained. The production and administrative areas of the hospital food services cannot be abandoned to civilian or contractor operated programs. Clinical dietetics is only as good as the control of the kitchen and food supply and the experience that the production and administrative positions give to Army dietitians prepares them for their wartime role. The rotational base these CONUS facilities provide for returning overseas personnel and the training base provided to enlisted, reserve and TOE personnel is

critical. Convincing the senior leadership within the AMEDD is key to changing this situation and hinges on the dietitian's ability to articulate the importance and value of this to them first, and then to DA, DOD, and Congress. The dietitian's wartime role is jeopardized and the ability of the Army to respond quickly to war or emergency situations is directly related to the operation of the entire hospital nutrition care operation, not just the clinical dietetics portion. A re-education is critical immediately to turn around this serious erosion of the AMEDD capability and flexibility.

15. Dietitians need to continue to branch out as the civilian profession does, but the hospital based dietitian needs to remain as the foundation and core of the Dietitian Section. As a noted visionary in Army dietetics stated, "I do believe that we have to realize that we are basically hospital dietitians. Our past, present and our future depends upon how well we do that. It depended on the past on how well we did it and the future depends on how well we continue to do it. If we don't do it well and we branch out too much, then we may lose everything."[1]

As Army dietetics strives for increased visibility, improving the image of the professional dietitian, marketing out the dietitian's expertise and expanding into nontraditional roles we must not forget our past. If this vision of the future is to be realized it must be done without sacrificing the hospital based dietitian who needs to continue to provide the high level of professional service to the soldier and his family that has characterized the history of Army dietetics.

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