

A STUDY OF THE NEED FOR SPECIALIZATION
IN DIETETICS

By

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CHAPTER I

INTRODUCTION

Since 1917, the dietitian's preparational training focused on a thorough knowledge of the science of nutrition, the techniques of feeding people, and the art and science of applied nutrition (The Dietitian, JADA, 1945). By 1960, the dietitian had progressed from the cooking schools and the hospital diet kitchen--once the chief area of practice--to a branching in three major areas: teaching, therapeutics, and food service (Johnson, 1960; Gilson, 1947; Langholz, 1982). Each area consisted of smaller areas of practice representing the major ones. Presently, The American Dietetic Association (ADA) designates four general areas of practice: clinical dietetics, administrative dietetics, general dietetics, and community nutrition (Position Paper, 1971). As the knowledge of nutrition increases and skills improve, the need for dietitians to become less generalized and develop in-depth knowledge and skill in narrower areas of nutrition increases (Zallen, 1983).

Dietetics is a profession in which dietitians apply the knowledge of food, nutrition, and management to provide nutritional services and care to people. Dietetic practice integrates and applies scientific principles of food, nutrition, biochemistry, physiology, management, and behavioral and social sciences to achieve and maintain people's health

(Turcotte, Vaden, and Hoyt, 1983). To achieve competence in these areas, The Association stipulates that dietetic education meet specific requirements through a strong knowledge base in nutrition, food selection and planning, and food production systems (Parks and Kris-Etherton, 1982). The ADA currently specifies these particular areas of knowledge in the "Plan IV Minimum Academic Requirements" based on educational competencies. From the beginning, The ADA has been concerned with the amount and type of education that dietetic students receive. As a result, high standards have been set which must be met in order to practice in the dietetic profession.

The ADA set high educational standards early in the history of the profession that contributed immensely to the advance of the profession. As the profession grew, the educational standards increased with the Association building a sound foundation to produce quality dietitians (MacEachern, 1949). Traditionally, The Association stipulated educational standards aimed toward an equal background in all areas of practice, producing the generalist dietitian. Gradually, however, areas of emphasis, along with a set of basic course requirements, developed. For instance, the 1985 "Directory of Dietetic Programs" lists 97 percent of the "Plan IV" Academic Programs as offering a "general" emphasis, 36 percent, management emphasis, 32 percent with clinical emphasis, and 25 percent with community nutrition emphasis. Programs may offer more than one emphasis. As this suggests, ADA has not specialized the education of the entry level dietitian to any significant degree. Parks and Kris-Etherton (1982) hypothesized that the profession of dietetics needs both generalists and specialists at the entry level in order to meet expectations in employment positions. Most dietetic programs, therefore,

modify and adapt their education programs to meet the changing needs of the profession (Parks and Kris-Etherton, 1982).

Change in the educational curriculum is not only needed at the undergraduate level, but also at the graduate level if dietitians are to keep pace with the rapid expansion of knowledge. Many graduate students who seek a masters degree in dietetics use the degree as a route to ADA membership as well as attainment of expertise in a specific area of the profession. The American Dietetic Association does not specify curricula for graduate programs meeting either of these needs and this lack of unified standards for graduate education concerns educators. The 1972 and 1983 American Dietetic Association Task Force on Education committees recommended that the Association set standards and pursue specialization in advanced education. With the extensive advances in knowledge and technology negating the feasibility of the dietitian being proficient in all areas of dietetic practice, dietitians will need to acquire in-depth knowledge and skill in selected areas, thus creating specializations (Position Paper, 1971).

In order for the Association to establish specializations, it is important to determine the attitudes and beliefs of practitioners and educators concerning specialization. Because there are not set educational requirements for specialization, it will be necessary to assess current thinking regarding the educational preparation of the specialist. To assess current thinking in these areas, four groups of dietitians were surveyed in this study representing practitioners and educators at the undergraduate and graduate levels.

Purpose and Objectives

In this study, the perceptions and attitudes of dietetic practitioners and educators concerning specialization within the profession of dietetics were determined. The objectives include the following:

1. Determining perceptions and attitudes toward specialization in dietetics among:
 - a. Members of a dietetic practice group
 - b. Directors of internship programs
 - c. Directors of Coordinated Undergraduate Programs
 - d. Directors of advanced degree programs
2. Determining what each group regards as necessary for the educational preparation and/or experience of dietetic specialists.
3. Determining options as to specific areas within the dietetic profession in which specialization is needed.
4. Comparing the similarities and differences among the practitioners and educators and to make recommendations based on the findings.

Hypotheses

The null hypotheses for this study include the following:

1. There will be no significant differences between the perceptions of the four groups regarding the definitions, and specific need for specialization in dietetics.
2. There will be no significant difference between what all groups consider as options to specific areas within the dietetic profession that specialization is needed.

3. There will be no significant difference between what all groups regard as important for the educational preparation and/or experience of a specialist.

Assumptions

The assumptions made concerning this study include the following:

1. Respondents will answer the questionnaire objectively and without bias.
2. The sample is representative of the attitudes and perceptions of those dietitians within the practice group surveyed and the educators who are members of The American Dietetic Association.
3. The four groups surveyed are knowledgeable and have opinions and interest concerning specialization.

Limitations

The specific limitations of the study include the following:

1. That generalizations based on the findings for the research will be applicable only to the sample survey.
2. The list used to obtain the dietetic practice group was two years old and the membership survey may have changed to some extent.

Definition of Terms

The following definitions will pertain to the words and abbreviations used throughout the study.

1. Administrative Dietitian, (R.D.): A member of the management team who affects the nutritional care of groups through the management

of foodservice systems that provide optimal nutrition and quality food (ADA Reports, 1974).

2. Advanced level: The position within each practice level of the role (or generic position) requiring greater or different skills and/or knowledge than the entry-level position (Lanz, 1983).

3. Coordinated Undergraduate Program, (CUP): (established in 1962) The Coordinated Undergraduate Program is a formalized baccalaureate educational program in dietetics sponsored by an accredited college or university and accredited by The American Dietetic Association. The curriculum is designed to coordinate didactic and supervised clinical experiences to meet the qualifications for practice in the profession of dietetics (ADA Position Paper, p. 66, 1981).

4. Clinical Dietitian, (R.D.): A member of the health care team who affects the nutritional care of individuals and groups for health maintenance; assesses nutritional needs, develops and implements nutritional care plans, and evaluates and reports these results appropriately (ADA Reports, p. 661, 1974).

5. Community Dietitian, (R.D.): With specialized community dietetic preparation, functions as a member of the community health team in assessing nutritional needs of the individuals and groups (ADA Reports, p. 661, 1974).

6. Dietetic Intern: A person who has completed the academic requirements of professional education in dietetics and is enrolled in a dietetic internship approved by The American Dietetic Association to fulfill the didactic and supervised clinical educational standards to become a practicing dietitian (ADA Reports, p. 661, 1974).

7. Dietetic Internship: (established in 1927) The dietetic internship is a formalized, post-baccalaureate educational program in dietetics sponsored and conducted by an organization and accredited by The American Dietetic Association. The curriculum of the program is designed to meet the qualifications for practice in dietetics (ADA Position Paper, p. 66, 1981).

8. Dietetic Specialties: Practice in an advanced level requiring additional expertise (knowledge and skills) beyond that defined for entry level (Task Force on Education, 1983).

9. Entry-level Dietitian: One who has completed the minimum educational requirements set by The American Dietetic Association.

10. Generalist: A health care professional who is knowledgeable about and can practice in all areas of the profession; not focused in one area.

11. Professional Education: A prescribed program of study and experience to develop competence in the practice of a profession, social understanding, ethical behavior, and scholarly concern (ADA Reports, 1974).

12. Specialization (in dietetics): Practice in a specific area of the profession. In dietetics there are three basic branches of dietetic practice: Clinical, Management of Foodservice Systems, and Community Dietetics, each requiring defined competencies (ADA Position Paper, 1981; ADA Reports, 1974).

CHAPTER II

REVIEW OF LITERATURE

This study determines the perceived need for specialization in dietetics by dietetic practitioners and educators. In order to understand the importance of specialization, the literature review covers the educational development in dietetics, the reports of the two Study Commissions on Dietetics and the Task Force on Education, the Practice Groups, Registration and Continuing Education, and Specialty Board Certification.

Early History of Educational Requirements

Early dietitians were educated in cooking schools that met the need for improved feeding of the sick and laid the groundwork for the profession of dietetics. At the turn of the century, dietitians came out of the diet kitchen and advanced to a broader field that required "newer knowledge of nutrition," (Huddleson, 1947) thus changing the emphasis of dietetic practice. Dietitians who practiced prior to 1925 provided skill in food preparation, discernment in flavor, and the ability to gain results with simple equipment in their positions (Gilson, 1947; Huddleson, 1947). The requirement for dietitians to achieve and maintain high standards in education and practice began in 1917 when a handful of dietitians met and held the first "Dietitians

Conference," (Langholz, 1982). Out of which The ADA was established (Langholz, 1982). There was general agreement that it was important that the feeding of as many people as possible be placed in the hands of those trained in the best possible way (Huddleson, 1947). At this organizing meeting, The Association designated the following objective:

To bring about a closer cooperation between dietitians and those in allied health fields, in order that more effective work may be done in improving the conditions and raising the standards of dietary work and the training of dietitians (Smith, pg. 145, 1927).

Since its formation, ADA has adapted its educational requirements for knowledge and skill of each dietitian to meet existing needs of those whom they serve. This was a necessity in order to advance with the increase in knowledge in health and disease areas and advances in technology.

At the organizing meeting, The Association established four sections within The Association.- One section was concerned with "teaching" and now has advanced to The "Council on Educational Preparation." This group was concerned with defining the dietitian's role and educational needs as well as developing educational standards for the profession. They continue to build on these standards to further the growth of the profession (Chambers, 1978). In 1924, the Education Section Chairman presented minimum specifications for a course for student dietitians in addition to at least six months of hospital experience to include administrative, therapeutic, and social service work (Chambers, 1978). This became effective in 1926 when a motion was passed requiring ". . .a bachelor's degree with a major in foods and nutrition, from a recognized college or university." This was put into effect on October 1, 1926 (Chambers, 1978).

In 1927, The Association passed an "Outline for Standard Course for Student Dietitians in Hospitals" that required a bachelor's degree with a major in foods and nutrition from a college or university of recognized rank. It specified that the hospital where the course was conducted must be a member of The American Hospital Association, its nurses learning school accredited, and all dietitians on staff eligible for American Dietetic Association membership. Course content included administrative practice, "diet therapy," theory of teaching dietetics, optional duties, and study and conferences (Chambers, 1978).

For several years after this outline was incorporated, general concerns were expressed concerning upgrading and standardizing course curricula. Then in 1934, a committee was appointed to draw up "An Outline for Administrative Dietitians." This was to be used as a basis for approval of courses of this type by The Association. The purpose of the outline was to prepare professionally trained women in controlling food standards in commercial food establishments and in directing foodservice in nonhospital settings. In 1935, an outline for training in a food clinic or in community nutrition was accepted (Johnson, 1949). By 1935 there were three specific areas of training for dietitians.

In 1940, "Outline Number 1" was adapted and went into effect in 1944. This outline provided for specialties in dietetics. Certain individual courses were designated for administrative internships, for hospital and food clinic internships, and for public nutrition. Hence, since 1944 there have been three specialty groups allowed in the academic requirement background (Annual Report, 1956-57). Since this time, The American Dietetic Association has made revisions in the academic requirements. These are known as Plans I, II, III, and IV.

Plans I and II

In 1947, The American Dietetic Association changed the academic standards to indicate required courses for graduates entering approved hospitals, food clinics, or administrative internships. This became known as Plan I Academic Course Requirements in 1955 and was to remain until 1962. The Plan listed five subject groups, semester hours, courses required and recommended additional courses. In 1955, a revised Plan II that detailed academic requirements came into effect. Required courses were grouped into four subject areas. The range of semester credit hours required for each group was indicated with a minimum number designated for each group giving a total of 60 hours required from all groups (Chambers, 1978). Plan II was delineated in 1965.

Plan III Academic Requirements

In 1958, The American Dietetic Association again revised the academic curriculum. The new requirements became known as Plan III. The Plan was a set of guideline requirements for the student's education, experience, endorsement, supervision and membership to The Association. The Plan broadened and accepted the increasing specialties at the undergraduate level and extended the graduate, post-graduate experience, and education. This was done in hopes of obtaining greater completeness in the dietetic profession (Annual Reports & Proceedings, 1957-58). Plan III did not list course titles but instead listed specific subject areas of learning, each with required hours. The areas included "Core Subjects," "Emphasis" (foodservice management, education, and foods), and "Concentrations" (therapeutic and administrative, business administration, and science - foods and nutrition) (Chambers,

1978). All students were required to take the core subjects and then to choose one area of emphasis and one area of concentration. Choices were made according to interests and the type of internship desired.

Plan III aided the student who wished to specialize in one area of dietetics. Generally, the "generalist" chose concentration A because it emphasized personnel management and principles of learning as well as nutrition. This prepared the student with both administrative and therapeutic skills. Those desiring specialization in therapeutics chose concentration C and those desiring to specialize in foodservice administration chose concentration B. Other routes in Plan II aided membership, by providing emphasis for those who prepare for college teaching, extension, community nutrition and public health, research, and other areas related to nutrition and food service administration (Robinson, 1965). As stated previously, the concentrations were chosen with a specialized internship in mind as well as in subsequent practice.

When the Coordinated Undergraduate Programs were established beginning in the 1960's, the academic course requirements and clinical experiences were coordinated into the total degree program. Plan IV was incorporated into the plan of study but the unique aspect of this innovative type of program was the incorporation of clinical experiences simultaneously with the didactic portion of the program. From the time of the first program at Ohio State University, some 70 to 80 such accredited programs came into existence by the mid-1970's.

Plan IV Minimum Academic Requirements

In 1972, the current revision came into effect, officially titled, "Plan IV Minimum Academic Requirements" (Junkermier, 1982). This provides the student with a conceptual framework permitting freedom and flexibility among courses (Chambers, 1978). The program was designed to provide the student with an understanding in all areas of dietetics, including the physical sciences and the behavioral sciences (Robinson, 1965). As a result, the entry-level dietitian is assumed to be supplied with adequate knowledge and skills to practice effectively and competently.

The competencies used in Plan IV are grouped under four areas of emphasis: general, management, clinical, and community. In addition, a set of basic subject matter courses are required. Both the traditional and the Coordinated Undergraduate Programs must submit to The American Dietetic Association a curriculum outline which shows compliance to the "Plan IV Minimum Academic Requirements." The Association then gives approval to the institution's plan for compliance (Junkermier, 1982).

The 1972 Study Commission on Dietetics

Early in 1970, The Executive Boards of The American Dietetic Association and of The American Dietetic Association Foundation authorized the formation of the "Study Commission on Dietetics," published as "The Profession of Dietetics" (1972). Support was provided by the W. K. Kellogg Foundation. The Study Commission was to study every aspect of dietetic practice, education, and the professional organization, and to then report all findings and recommendations. Several recommendations were made as a result of the study. Each were reviewed by a special

committee for the purpose of making recommendations for implementation of the report. The findings and recommendations were ranked according to priority and importance to The Association (News Digest, 1972).

One significant finding was that the current system of education and training of dietitians was deficient in the following ways: inadequate learning in science and nutrition, the separation of theory and application in practice, inconsistencies in quality, and insufficient identification in higher education and in relation to other health services (Galbraith, 1980). A further finding pertained to the current forces producing change in the field of health services and belief that future dietetic practice would be altered in six distinct ways:

1. There will be increased differentiation in the roles and functions of dietitians.
2. Dietitians will become more specialized.
3. New and additional competencies will be required.
4. Dietitians will increasingly delegate some of their present tasks and roles to other less highly trained workers.
5. More dietitians will practice in association with other health professionals.
6. A greater proportion of dietitians will be self employed.

This finding was supported and agreed upon by members of The Association. Because of the increased amount of new knowledge and the change that comes with it, it became evident that dietitians would need to limit their scope of practice in order to stay proficient in the field (Position Paper, 1971).

At the heart of the report were six recommendations, three dealing with education, competency, and identification of the dietitian. The

first recommendation dealt with a design for the basic education of dietitians in a four-year curriculum resulting in a bachelor's degree and including didactic learning and introductory clinical experience that is necessary for entry-level. Secondly, they recommended that the undergraduate curriculum be built around the central theme of the human life cycle. The fourth recommendation pertained to the registration and certification of dietitians as a means of assurance of the competencies of professional dietitians. The third, fifth and sixth recommendations centered around the memberships, responsibilities and functions of The American Dietetic Association.

The 1984 Study Commission on Dietetics

In 1983, The American Dietetic Association Foundation, again with financial assistance from the W. K. Kellogg Foundation, established the 1984 Study Commission on Dietetics. The purpose was to determine the impact of the Report of the 1972 Study Commission on Dietetics and to explore the relationship of dietetics to a changing health care delivery system.

Completed in 1984, The Study Commission reported that there is a need for substantial change in order for the profession to fulfill its potential in the future. Further, they believe that dietitians are accepted as experts in the science of foods and nutrition, and that this expertise is needed today. Dietetics, as a profession, must become more dynamic and more assertive. To do this, dietitians must increase in-depth knowledge and expertise. This will require changes in the education of dietitians at undergraduate, graduate, and continuing education levels.

The Study Commission found that dietitians are not widely recognized as qualified by education and training to provide the necessary expertise in the field. They found a growth in the application of the science of foods and nutrition to problem diseases which has given rise to new special areas of interest. The scope of dietetics was found to be much broader than in the past and is expected to broaden further. The Commission stated that The Association must strengthen its depth of knowledge and expertise by changing the education at all levels. Suggested changes include a broader base, especially in the arts, humanities, and behavioral sciences; increased emphasis on management and business, communications and networking, new technology, especially computers, and more depth in the scientific knowledge of nutrition. In respect to this, The Commission believes that advanced education will be necessary for the specialist whether a generalist or a specialist with formal advanced education and field experience. The needs of the experienced and entry-level dietitians should be met by targeted, individualized programs of continuing education.

The 1984 Study Commission reviewed the current system of registration of dietitians and commended The American Dietetic Association for their established system. They found that licensure, another form of credentialing, is becoming more and more popular. However, they believe that it must be studied thoroughly and carefully to avoid the attendant problems associated with it. The advantage of licensure is the legal identification of those qualified by education and training to function as dietitians and it may help protect the public from unqualified persons. They recommended the development of a

realistic and practical model licensure act promptly to ensure consistency among individual states.

The Study Commission supported earlier recommendations made by the Task Force on Education concerning the need for specialization. However, they believe that before the proposed approach is put into effect there needs to be a clear identification of specialty areas and their underlying bodies of knowledge defined. They also believe that it is vital that specialty groups not split from The American Dietetic Association but that The Association take the responsibility for the recognition, coordination, and regulation of the specialties. In conjunction with the practice group, the Commission believes that they should have no implication for eventual specialty recognition, but rather should be supportive and assist in defining and delineating various areas that may meet established criteria for classification as a specialty.

The Study Commission recommended that before formal certification is instituted, The Association should identify specialty areas and delineate the body of knowledge and skills required to permit dietitians to function effectively in each area. Further, that The Association should coordinate developments and define clearly the purpose of each credential and thus make clear the relationship between ADA membership, registration, licensure, and specialty certification. They also recommended that certification be an option for dietitians who complete advanced professional education and/or have professional experience in responsible positions (Report of the Study Commission on Dietetics, 1985).

ADA Task Force on Education

In 1982, a Task Force on Education, appointed by The American Dietetic Association Board of Directors, made four recommendations concerning the education of dietitians. First they recommended that The American Dietetic Association prepare all entry-level dietitians with a common body of knowledge, skills, and values in order to provide a foundation for quality practice at all levels. The focus of the recommendation was to remove the concept of emphasis or specialization at the entry level in order to prevent premature narrowing of education and training opportunities and lead to specialization too early. The Task Force suggested the use of the previously completed role delineation studies to identify the common foundation of knowledge, skills, and values that would prepare an individual to assume an entry-level position. They also suggested incorporating needed knowledge, skills, and values into curriculum requirements through Standards of Education, identifying which components of the educational preparation were responsible for developing specific knowledge, skills, and values and to then test and evaluate the Standards of Education to facilitate the transition. Replacement of the minimum academic requirements for Plan IV programs and Coordinated Undergraduate Programs, internships, and dietetic technician programs with "Standards of Education" was suggested. The Task Force suggested strategies to provide direction and assistance to education programs and American Dietetic Association organization units in the transition from Plan IV to the new Standards of Education. Establishing a means to assure that knowledge, skills, and values are evaluated and updated constantly to maintain relevance to entry-level practice was also suggested. In the second recommendation a

system was to be established to recognize dietetic specialties. To do this they suggested the need to define the concept of specialty and to establish criteria for recognizing a dietetic specialty; to determine areas of practice that currently meet established criteria for a dietetic specialty; to establish education and practice or performance standards for each dietetic specialty; to develop guidelines and direction for assisting institutions and practitioners interested in meeting criteria for a dietetic specialty; and to establish a system to recognize individuals practicing in identified specialties who meet established standards for that specialty. This recommendation was based on the supposition the undergraduate cannot acquire a broad educational base, learn the basic principles of the sciences, management, sociology, psychology, technology, and political strategy inherent in health care and become an expert in one area of dietetics all in four years.

A further recommendation of The Task Force was that specialization occur at the post-baccalaureate level with defined academic preparation, experience, and demonstrated competencies. It was stated that most specialties in dietetics demand advanced training or experience as well as the possibility for "specialty examinations" in some practice areas.

The Task Force on Education identified a need to formally recognize and develop new and existing roles or specialties to assist planned growth of the profession and to avoid splintering. They found a definite need to continually update and identify the knowledge and skills needed for advanced level practice in specific areas in order to promote professional competencies. As expansion and changes occur in established and potential roles of dietetics, The Association needs to plan and direct the growth of specialization. The need to define and

acknowledge specialties and specialization in the profession lies in the observation that dietitians have strongly expressed the need for developing specialties with guidance and recognition from The Association.

Dietetic Practice Groups

In 1977, Dietetic Practice Groups were formed with ratification of new Bylaws in The Association (ADA Reports, 1979). The four previous practice sections of dietetics were eliminated and in their place a new organized unit, The Council on Practice, was established (Langholz, 1982). Under the Council on Practice five divisions were created: Division of Community Dietetics, Division of Clinical Dietetics and Research, Division of Consultation and Private Practice, Division of Management Practice, and Division of Educators. Two further committees were designated under the Council: The Quality Assurance Committee and The Continuing Education Committee. Under each division, dietetic practice groups were identified that have rules, officers, newsletters, goals, and budgets (Langholz, 1982). The practice groups provide a way for members with common interests to share ideas and improve their practice skills. Currently, 23 practice groups exist as follows:

- * Public Health Nutritionists
- * Gerontological Nutrition
- * Dietetics in Developmental and Psychiatric Disorders
- * Community Nutrition Research
- * Research Dietitians
- * Renal Dietitians
- * Dietitians in Pediatric Practice
- * Diabetes Care and Education
- * Dietitians in Critical Care
- * Dietitians in Physical Medicine and Rehabilitation
- * Sports and Cardiovascular Nutritionists
- * Dietitians in General Clinical Practice
- * Consulting Nutritionists - Private Practice
- * Consultant Dietitians in Health Care Facilities

- * Dietitians in Business and Industry
- * ADA Members with Management Responsibilities in Health Care Delivery Systems
- * School Food Service
- * College and University Food Service
- * Clinical Nutrition Management
- * Dietetic Educators of Practitioners
- * Nutritionists in Nursing Education
- * Nutrition Education
- * Dietitians in Medical and Dental Education

The wide range of areas represented by the groups depicts the broad scope of knowledge and skills necessary to be a competent practitioner. Since it is impossible to be all things to all people and know everything about every area, The Association has been considering whether to make the practice groups specialty areas. Each practice group may adopt Bylaws consistent with The Association's Bylaws (Annual Report, 1976). The question arises as to whether or not each practice group is indeed a specialty, since the groups were formed because the previous sections were no longer adequate to provide a structure for the diversity of practice areas and interests of dietitians in The Association.

Registration and Continuing Education

In 1969, The American Dietetic Association established a professional register for dietitians meeting certain stipulations and desiring to be identified by a "protected" title of "Registered Dietitians." The purpose of registration was to protect the health, safety, and welfare of the public by encouraging high standards of dietetic practice performance. The program was designed to upgrade professional competency through evidence of self-improvement and assurance that the practitioner was competent with a broad knowledge-base in dietetics (Lanz, 1983). Registration continues to be a

voluntary process and is independent of American Dietetic Association membership. Registration has established a minimum national standard for entry-level practice and offers assurance that the dietitian has completed required education and appropriate professional practice as shown through the ability to pass a national examination.

To acquire registered status, the individual must have a bachelor's degree from an accredited college or university, have completed specific academic and experiential components with appropriate endorsements for verification, pay a registration fee, and have a passing score on the national registration exam (Lanz, 1983). To maintain registration status one must pay yearly fees and accumulate 75 hours of approved continuing education throughout a five-year period. The American Dietetic Association recognizes continuing education as a life-long process. The objectives of continuing education are to enhance the knowledge of the individual member, thereby improving competency and enabling the individual member to contribute to the advancement of the profession (ADA Reports, 1974). It is through this continuous study and learning that a professional gives the best service possible (Ross, 1970). Continuous learning may come by attending professional meetings, workshops, conferences, experiential opportunities, lectures, seminars, exhibits, independent study, or formal academic classroom study. A continual accumulation of knowledge is essential for all professionals, in order to keep pace with the rapid growth of new knowledge and technology (Patterson, 1964).

"Advanced Study" as Preparation for Specializing

A study conducted in Pennsylvania showed that

increased specialization will need to be implemented concurrently at the graduate level to meet changing needs of the 1980's and early 1990's (Parks & Kris-Etherton, pg. 574, 1982).

This type of education is a key component in acquiring advanced knowledge in one area of dietetics as well as keeping abreast in other areas. Liveright contended that

Continuing education has to be planned, organized, and developed on a life long basis with the goals of improving professional competency and providing personal enrichment (Flourney, pg. 927, 1984).

The baccalaureate degree provides the student with a foundation to practice dietetics and with which to build upon and become specialized (Position Paper, 1971). Advancement to the specialty areas occurs through academic programs usually leading to advanced degrees. For the dietitian it means in-depth study in a given subject area. In 1971, The Association defined four areas of emphasis: 1) General practitioner of dietetics; 2) administrator of dietetic services; 3) clinical nutrition specialist; and 4) nutrition educator. Within each of these areas is refinement of expertise. The American Dietetic Association believes that in-depth study towards an advanced degree in a defined specialty area would

accommodate the profession of dietetics to the extensive advances in knowledge and technology; improve nutritional care; raise the performance standards of the profession; and make allowance for the needs of women who are beset with the limitation imposed by mobility of family units and needs of employers who struggle with the rigor of supply and demand (Position Paper, p. 372, 1971).

The generalist with a good understanding and perspective becomes a "specialist in breadth" (ADA Reports, 1979).

The bachelor's degree is adequate for the "generalist," but an advanced degree will be more essential for the future specialist (Ross, 1970). Advancement of a profession rests squarely on the increase in the education and experiences of its members (Todhunter, 1957). The majority of today's dietetic specialties came by the dietitian limiting her concentration of her function in a specific setting. Thus, expertise came through on-the-job training. They have evolved with growth in employment opportunities and new development in all nutritional care systems (ADA Reports, 1979).

When the 1972 Study Commission on Dietetics contended that the ideas the dietitians translate are those of nutrition science and that those ideas are many and diverse and part of many scientific disciplines and of several clinical arts and that these arts of translation are numerous and diverse, they predicted the occurrence of specialization and the need for it. At this time, dietitians were already working in specialized areas such as pediatric, renal, cardiac, and metabolic units (Johnson, 1974). How the dietitian carries out the responsibilities of the nutritional care of individuals and groups depends on the educational background and the areas chosen to specialize in (Ross, 1970).

Credentialing

Credentialing is a generic term used to identify a system or systems of determining the professional competency of an individual. It is a broad term referring to one of four specific types of programs: registration, accreditation, licensure and certification. It is a safeguard to assure the delivery of quality health care services (Lanz,

1983). The purpose of credentialing is to protect the public by ensuring that the professional meets high performance standards.

Registration, as described earlier, is the maintenance of a legal registry in which the professionals who meet specific requirements are registered and recognized as highly qualified individuals.

Accreditation is the warranting of an education institution to ensure that it has appropriate educational resources, presents an educational program conforming to a prescribed form and content, and meets a defined, minimum level of quality. The American Dietetic Association currently has both of these credentialing processes in use. Licensure is the process by which a state takes legal responsibility to determine and warrant the minimal qualifications of the individual practitioner. This requires a voluntary association to warrant the competence of an individual by certifying that he/she has met certain prescribed criteria of education and/or has passed an examination (Report of the Study Commission on Dietetics, 1972).

The process of certification has also been described as the

. . . process by which a governmental agency or association sets standards for professional practice and grants recognition to individuals who offer these credentials for certification (Lanz, pg. 30, 1983).

This definition also describes The American Dietetic Association's registration program that is in fact synonymous with certification. The 1983 Task Force on Education went further and recommended that "a system be established to recognize dietetic specialties," which was supported by the Commission on Dietetic Registration and the 1984 Study Commission on Dietetics.

House of Delegates Special Committee
on Specialty Board Certification

In 1979, an Ad Hoc Committee on Specialty Board Certification in Dietetics, appointed by the Chairman of the House of Delegates, proposed requirements for establishing Specialty Board Certification. The Committee was formed to

study the feasibility of establishing Specialty Board Certification to identify registered dietitians who have achieved expertise in an area of specialization such as Administrative Dietetics, Clinical Dietetics, Renal Dietetics, etc. (ADA Reports, pg. 153, 1979).

The applicants were to give evidence of satisfactory moral and ethical standing in the dietetic profession. The professional qualifications included

- * R.D. (mandatory)
- * Currently employed professionally in practice, education, or research in area of specialization (mandatory)
- * Experience in practice (mandatory). A minimum three years experience in progressively responsible positions in the area of specialization, as documented by employers or professional colleges.
- * Passing score in written and oral examinations (mandatory).
- * Advance specialized education, for example; short courses/ workshops/planned study/observation in centers of excellence; graduate level courses; residency programs; and/ or master's/doctoral degree.
- * Developmental activities.
- * Publications in refereed professional journals.
- * Professional activities in dietetic and related organizations that demonstrate involvement and leadership (ADA Reports, pg. 154, 1979).

A competency examination could be given which would follow a similar format to the registration examination except that it would contain material related directly to criteria particular to a specific area of specialization. After considerable discussion for at least two years in the House of Delegates, the proposal was not accepted. Leaders at that time speculated that it was an idea "ahead of its time." The

Association was not ready to consider the concept of specialty practice at that time.

Summary of Activities

The concept of specialization in the profession of dietetics has gradually developed since the formation of The Association in 1917. The educational preparation of dietetics has been delineated through plans for education preparation, the current being the "Plan IV Minimum Academic Requirements." The experience components have been specified in standards for the dietetic internship, the Coordinated Undergraduate Programs, three years experience, or six months experience with an advanced degree.

In the 1960's, Registration was established as a means of legally recognizing professional preparation and competency and stipulating that continuous education should be a requirement for continued registration. In 1979, a House of Delegates Committee presented a way of recognizing specialty practice in the profession, but the plea was not accepted. Further support for specialization in practice has come through recommendation by both the 1972 and 1984 Studies of the Profession and by the Task Force on Education in 1982. The 1984 House of Delegates has appointed a committee to prepare a plan for specialization in the profession, signifying the willingness of The Association to take further steps toward such a program. Because of the interest evidenced from many sources, this study was designed to investigate the perceptions and attitudes of educators and practitioners toward specialization as a basis for further program development.

CHAPTER III

METHODS AND PROCEDURES

This research will examine the perceptions and attitudes of dietetic practitioners concerning specialization within the profession of dietetics. The five objectives of the study include determining perceptions and attitudes toward specialization in dietetics among a practice group and three groups of educators; determining what each regards as necessary for the educational preparation and/or experience of dietetic specialist; determining options as to specific areas within the dietetic profession in which specialization is needed; comparing the similarities and differences among the practitioners and educators and to make recommendations based on the findings. These objectives can be divided into the following two categories: first, the ideas about what is needed for specialization among educators and practitioners; second, comparison between the groups making the recommendations. Recommendations as to specialization are expected to result from the study insofar as what these professional groups regard as the process. It is anticipated that there may be differences in perceptions between educators and practitioners.

Research Design

The research design used was the descriptive status quo survey. Descriptive research involves describing, recording, analyzing, and

interpreting the existent conditions. It also involves comparing and relating existing non-manipulated variables (Best, 1981).

Population and Sample

The research surveyed four groups of dietitians who are members of The American Dietetic Association and who would be involved in and affected by specialization: a dietetic practice group, and directors of internships, Coordinated Undergraduate Programs, and advanced degree programs. A total of 615 dietitians were contacted for this study. A random sample of 200 of the total membership of the dietetic practice group, "Dietitians with Management Responsibilities in Health Care Facilities." All 104 dietetic internship directors; all 61 Coordinated Undergraduate directors; and all 151 advanced degree program directors were contacted using the ADA "1985 Directory of Dietetic Programs." Dietitians in the CUP or Internship Programs who were also listed under the Advanced Degree Programs were arbitrarily placed in the CUP or Internship group. Thirty-nine percent of those surveyed were practitioners, 31 percent were directors of the two types of undergraduate degree programs, and the remaining 30 percent were from the graduate level programs.

Data Collection

Instrumentation

The research tool was a self-administered questionnaire, designed to elicit the information indicated in the study's objectives. The recommendations made by the 1983 Task Force on Education became the

guidelines used in developing a set of questions that were expected to elicit the most pertinent information and give the greatest impact.

The questionnaire consisted of two sections. Section I asked for demographic information and Section II asked for the individual's specific opinions and perceptions concerning specialization. The instrument consisted of both open-ended and closed-ended questions. The open-ended questions provided further information and clarity to the responses of the closed-ended questions. Six faculty members of the Food, Nutrition and Institution Administration Department and two dietitians in the University Foodservice at Oklahoma State University reviewed the instrument for content validity, clarity and format as well as answering the questionnaire. The questionnaire was revised by making a few changes in the order of information and wording. The final draft of the complete research tool was then developed. An introductory letter explaining the purpose of the survey, the importance of prompt responses, current thinking on the subject, and confidentiality of information the questionnaire. A postage page return was pre-printed with instruction for refolding and stapling the form for return.

Survey Procedures

The introductory cover letter and questionnaire were mailed on February 19, 1985, to each randomly selected dietitian in the practice group and each director of an internship program, Coordinated Undergraduate Program, and advanced degree program. They were to return the completed questionnaire by March 6, 1985. The second mailing consisted of a reminder postcard sent to 195 randomly selected persons who had not responded to the questionnaire. In addition, new questionnaires were

sent to those who replied that they did not receive the first questionnaire and to 10 randomly selected members of the practice group to replace the 10 that were returned with no forwarding address. These ten were asked to respond by April 9, 1985 (Appendix A).

Data Analysis

In analyzing the data, the Chi square test was used. This test provides information concerning the number of responses, objects, and people that fall in two or more categories. The test reveals if significant differences exist between the practice groups and the three groups of educators relating to an observed number and an expected number of responses that fall in each category. Questionnaires were coded for computer analysis. All open-ended responses were recorded for further reference. Demographic, educational, personal and individual choices were translated into means, percentages, and frequencies.

CHAPTER IV

RESULTS AND DISCUSSION

The purpose of this study was to determine the perceptions and attitudes of dietetic practitioners and educators regarding specialization in the dietetic profession. A cover letter and four-page questionnaire pertaining to characteristics of the respondents, the need for specialization, areas of specialization, identification of a specialist, and minimal educational and experiential requirements was sent to dietetic practitioners and educators. The sample included dietetic practitioners who were members of the Practice Group, "ADA Members with Management Responsibilities in Health Care Delivery Systems," and directors of Internship Programs, Coordinated Undergraduate Programs (CUP), and Advanced Degree Programs listed in the "1985 American Dietetic Association's Directory of Dietetic Programs."

Response to Survey Questionnaires

From a total of 615 questionnaires mailed to prospective participants, 45% (N=231) were returned (Table I). A few returned questionnaires were unidentifiable and unable to be placed into one of the four groups. The total usable response was then 43% (N=222). One-fourth (24%) of the respondents were Advanced Degree Directors, one-sixth (17%) were CUP Directors, one-fourth (28%) were Internship Directors, and one-third (31%) were Practice Group Members. Within each

group, one-fourth (N=54) of the Advanced Degree Directors surveyed responded, two-thirds (N=38) of the CUP and Internship Directors (N=63) surveyed responded and about one-half (N=67) of the Practice Group Members surveyed responded.

TABLE I
RETURN OF QUESTIONNAIRE FOR ALL GROUPS

Group	Total Surveyed	Total Returned	% of Group Respondents in Each Group	% of Total Respondents
Advanced Degree	200	54	27.00	24.37
CUP	61	38	62.29	17.12
Internship	104	63	60.58	28.38
Practice Group	151	67	44.37	30.78
Total	516	222	43.02	100.00

Characteristics of Respondents in All Groups

Age and Sex

The ages of the respondents ranged from less than 35 to over 60 years. The majority of respondents were between 31 to 60 years (Figure 1). The Advanced Degree Directors' ages ranged between 31 and over 60 years. The CUP Directors had more between 36 and 50 years and 56 and 60

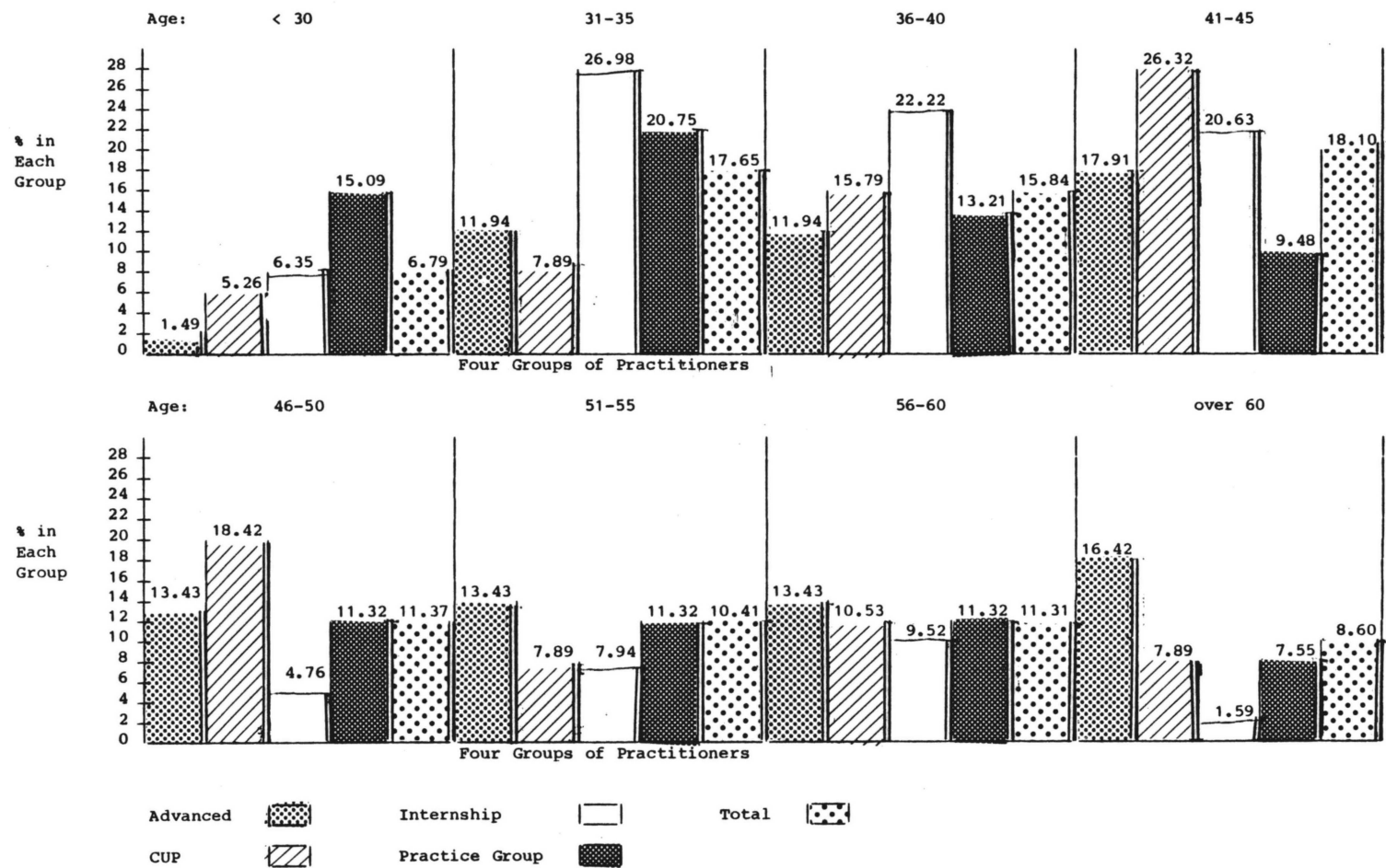


Figure 1. Age Range of Groups of Respondents

years. Most of the Internship Directors were between 31 and 45 years. Finally the ages of the Practice Group Members ranged from below 30 years to 45 years. They were the youngest with the Advanced Degree Directors having the older members. In regard to group characteristics by sex, only 7 were male and 181 were female among the 222 respondents.

Educational Level of Respondents

The highest educational level achieved in each group is illustrated in Figure 2. Among the Practice Group Members 63% had a Bachelors in Dietetics or Management as their highest degree obtained. Fifty-three percent of the Internship Directors had a Masters degree in Dietetics and 27% a masters in education as their highest degree obtained. Of the CUP Directors, 79% had a Masters degree in Dietetics and 67% a Ph.D. in Dietetics. The Advanced Degree Directors indicated the majority (69.2%) held a Ph.D. or Ed.D. in Dietetics.

Ninety-four percent of the respondents in all groups were Registered Dietitians (RD) and 95% were members of the American Dietetic Association (Table II). The lower percentage of RD members were those in the Advanced Degree Program and Practice Group Members; while the only group at less than 100% as ADA members were those in the group of Advanced Degree Directors.

Ninety-five percent (N=205) of the respondents were employed in full time positions. Only 88% (N=43) of the Practice Group Members, however, were employed in full time positions, with more in 75 percent time positions than in the other groups. Regarding annual income, 47.8% (N=99) earned between \$25,000 and \$34,999 annually (Table IV). Twenty-seven percent (N=13) of the Practice Group Members earned less than

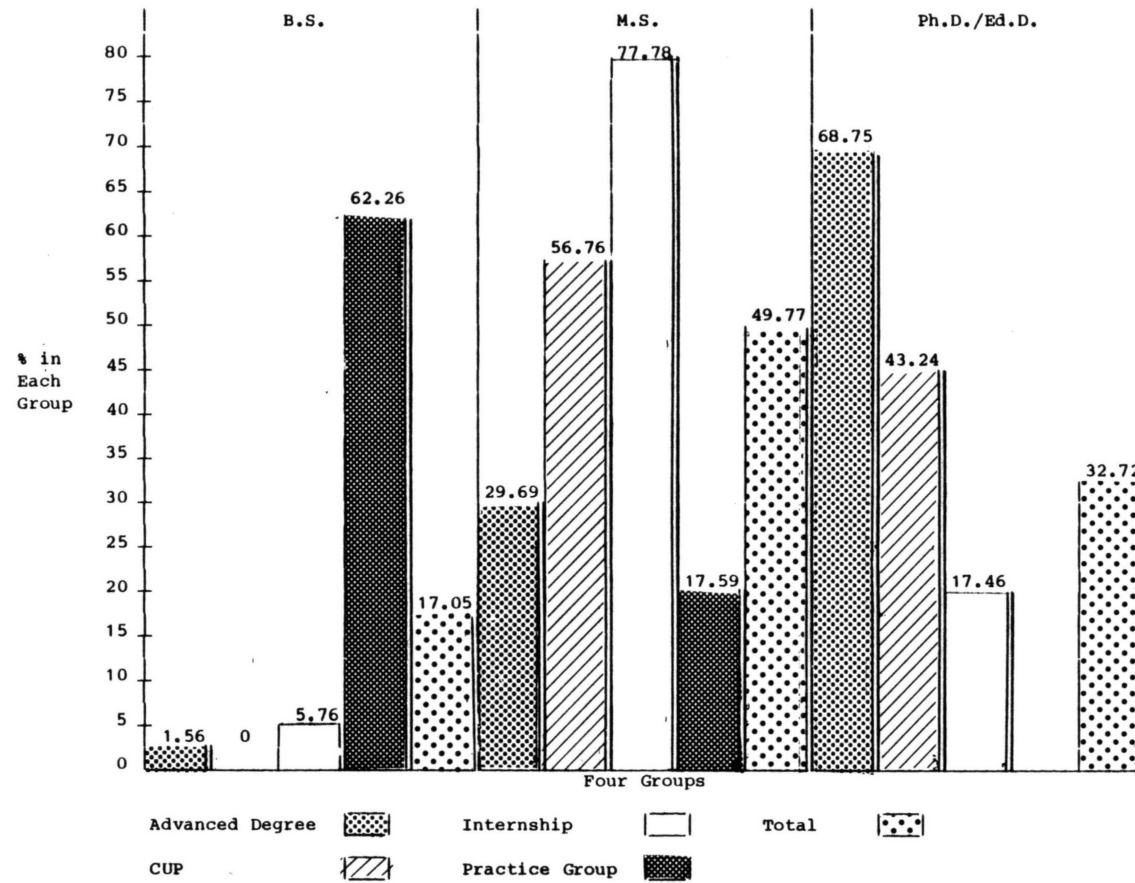


Figure 2. Level of Education Achieved by Each Respondent in Each Group

\$24,999 whereas the other groups averaged more. However, all groups except the Advanced Degree Directors had over 50% earning \$25,000 to \$34,999 and one-third ($N > 71$) earning \$35,000 to \$44,999. Of the Advanced Degree Directors, 21% ($N=13$) earned \$34,000-\$44,999 or over \$45,000.

TABLE II
REGISTRATION AND ADA MEMBERSHIP
STATUS OF RESPONDENTS

Group	R.D. %	A.D.A. Member %
Advanced Degree	80.60	85.48
CUP	100.00	100.00
Internship	100.00	100.00
Practice Group	98.15	100.00
Total	93.67	95.54

TABLE III
EMPLOYMENT STATUS OF RESPONDENTS

Group	Full Time		Part Time		0.75 FTE	
	F*	%	F*	%	F*	%
Advanced Degree (N=67)	63	94.03	3	4.48	1	1.49
CUP (N=38)	38	100.00	0		0	
Internship (N=62)	61	98.39	1	1.61	0	
Practice Group (N=49)	43	87.76	1	2.04	5	10.20
Total (N=216)	205	94.91	5	2.31	6	2.78

*F = frequency of yes responses

TABLE IV
ANNUAL INCOME OF RESPONDENTS

Group	<\$24,999		\$25,000-\$34,999		\$34,000-\$44,999		>\$45,000	
	F*	%	F*	%	F*	%	F*	%
Advanced Degree	11	17.46	23	36.51	16	25.40	13	20.63
CUP	5	13.51	20	54.05	11	29.73	1	2.70
Internship	9	15.25	32	54.24	14	33.73	2	3.39
Practice Group	13	27.08	24	50.00	9	18.75	0	-
Total	38	18.36	99	47.83	50	24.15	8	3.86

*F = frequency of yes responses

Previous positions held in the field of dietetics by the respondents showed that position titles varied considerably and were thus arbitrarily placed under the five divisions of The Council on Practice as mentioned earlier. Among the Advanced Degree Directors, 39% had held Management positions and 58.82% had held Educational positions (Table V). Among the CUP Directors, 36.11% had held Management positions and 75% had held Educational positions. Among the Internship Directors, 41.94% had held Management positions and 69.35% had held education positions, whereas among the Practice Group Members, 70.59% had held management positions and only 15.69% had held educational positions. It was expected that the three groups of educators would have a higher percentage of previous educational positions and the Practice Group (comprised of managers) would show a higher percentage in previous management positions. Of the 201 participants, 12.44%, 65.62% and 5.97% of 201 participants had held previous community, clinical or other positions, respectively.

Among the 52 Advanced Degree Directors, 19.23% had held community positions, 59.62% had held clinical positions, and 11.54% had held other positions (Table V). Among the 36 CUP Directors, 5.56% had held community positions, 66.67% had held clinical positions, and 5.56% had held other positions. Among the 62 Internship Directors, 14.52% had held community positions and 77.42% had held clinical positions. Among the 51 Practice Group Members, 7.84% had held community positions, 56.86% had had clinical experience, and 7.84% had held other positions. Only 19% (N=38) of the respondents had held a consultant position.

TABLE V

CATEGORIES OF PREVIOUS POSITIONS HELD BY RESPONDENTS

Group	Management Positions		Education Positions		Community Positions		Clinical Positions		Other Positions		Consultant Positions	
	F*	%	F*	%	F*	%	F*	%	F*	%	F*	%
Advanced Degree (N=52)	20	39.22	30	58.82	10	19.23	31	59.62	6	11.54	8	15.38
CUP (N=36)	13	36.11	27	75.00	2	5.56	24	66.67	2	5.56	8	22.22
Internship (N=62)	26	41.94	43	69.35	9	14.52	48	77.42	0	0.00	13	20.97
Practice Group (N=51)	36	76.59	8	15.69	4	7.84	29	56.86	4	7.84	9	17.65
Total (N=201)	95	47.50	108	54.00	5	12.44	132	65.67	12	5.97	38	18.91

*F = frequency of yes responses

Identification of the Need for Specialization

Hypothesis I stated that the four groups would differ significantly concerning the need for specialization and regarding the definitions for specialization. With the increase in awareness and interest in specialization, it has become necessary to ascertain if members of The Association feel that there is a need for specializations to be formed. Respondents were therefore asked to indicate their opinion as to the need for specialization within the dietetic profession. Ninety-two percent (N=197) of the respondents felt there is definitely a need for the profession to specialize (Table VI). There was no significant difference between any of the groups regarding this response, thus Hypothesis I was rejected.

TABLE VI
INDICATION OF THE NEED FOR SPECIALIZATION
IN THE PROFESSION

Group	F*	%
Advanced Degree (N=63)	59	93.65
CUP (N=38)	38	100.00
Internship (N=59)	53	89.83
Practice Group (N=54)	47	87.04
Total (N=214)	197	92.06
$\chi^2 = 6.432$ $df = 3$ $P = 0.3766$		

*F = frequency of yes responses

Respondents were asked their opinions concerning the significance specialization would have on the credibility and impact in the profession. The responses fell into eight categories:

- a. increase credibility;
- b. increase recognition (visibility and identification of the professional);
- c. increase knowledge;
- d. increase impact, enhance position and employment opportunities;
- e. increase quality of practice;
- f. limit, segregate or fragment the profession;
- g. no significant influence.

There was no significant difference between the groups in any of the categories and no one category was listed significantly more often than another. Hence, it was observed that there was no agreement as to the type of impact specialization will have in dietetics. However, the majority of responses consisted of various positive statements (see Appendix B).

Areas of Specialization Identified by the Four Groups

In 1978, the Special Committee on Specialty Board Certification recommended three major areas of specialization: administrative dietetics, clinical dietetics, and community dietetics. Of the total respondents, 57.14% (N=105) considered these areas acceptable since they covered the main areas of employment and dietetics. In addition, they indicated that these areas served as a good starting point but were too

broad and in need of subsequent further division, especially in the area of clinical dietetics. The educators and Practice Group Members varied in that the educators felt education should be added and the latter felt further division might cause fragmentation (see Appendix B).

The Chi square test indicated a difference between the groups at the .1 level ($P=.1166$). Difference occurred in that the Advanced Degree Directors and the Practice Groups Members tended to agree with the recommendation whereas the Internship Directors and the CUP Directors did not (Appendix C). Negative responses were made on the grounds that the specialties should follow those of the American Medical Association or be divided in another way (Appendix B). The broadness of the three areas and the lack of areas such as research, education, and/or business were the major complaints regarding the recommendation of administrative, clinical, and community dietetics being the main areas of specialization.

The respondents were asked to list the areas of dietetics they felt needed specialization. As expected, the areas of management, clinical dietetics, community nutrition, and education as well as subspecialties were listed more often. Fifty-six percent ($N=105$) of the respondents listed management including administrative or foodservice management. As expected, a higher percentage of the Practice Group Members listed management. The Internship Directors had the next highest percentage with the other two groups having a lesser number listing management. Consequently, there was no significant difference between the groups regarding management as an area needing to be specialized.

Fifty-four percent (N=83) of the respondents listed clinical dietetics as an area to be specialized. The Advanced Degree Directors had the highest percentage, the Practice Group Members were second with the other two groups having less than 40 percent listing clinical dietetics. Generally, each group was split between those considering clinical dietetics as an area to be specialized and those not.

Twenty-eight percent (N=53) of the respondents listed Community Nutrition or Public Health as an area of dietetics needing to be specialized. Two-thirds of the educators and 15% (N=7) of the Practice Group Members listed Community Nutrition as an area needing specialization. The Chi square test showed a significant difference between the groups at the .1 level concerning this area ($P=0.0690$).

Twenty-five percent (N=47) of the respondents listed clinical subspecialties as an area to be specialized. Clinical subspecialties was listed slightly more often by the CUP and Internship Directors than by the other two groups. Approximately 30% in the first two groups listed clinical subspecialties. There was no significant difference between the groups regarding this category. However, the Chi square test did show significant difference ($P=0.0185$) between the groups concerning specialization of education. Even though only 19% (N=35) of the respondents listed education, difference occurred in that 33% (N=17) of the Internship Directors and only a tenth in each of the other groups listed education. Hypothesis II stated that there would be a significant difference between the areas of dietetics that each group felt should be specialized. This was rejected since very few areas showed significant difference, and the majority felt the four main areas of dietetics as well as clinical subspecialties needed specialization.

To discover how members felt areas of specialization should be determined, they were asked their opinion as to what the relationship between the Dietetic Practice Groups (DPG's) and the areas of specialization should be. The majority (93.83%) of the respondents felt they should be related (Table VII). There was no significant difference between the groups since over 90 percent of each group agreed with this motion. They were of the opinion that the DPG's should support the areas of specialization but should not necessarily be the areas of specialization. This was based on the fact that the DPG's were set up purely as interest groups and not as specialty areas. They felt the DPG's could set up guidelines, definitions, and standards as well as assist the specialty areas in other ways (Appendix B).

TABLE VII
THE RELATIONSHIP BETWEEN PRACTICE GROUPS
AND AREAS OF SPECIALIZATION

Group	Related		Unrelated	
	F*	%	F*	%
Advanced Degree (N=42)	38	90.48	4	4.52
CUP (N=28)	27	96.43	1	3.57
Internship (N=49)	45	91.84	4	8.16
Practice Group (N=43)	42	97.67	1	2.33
Total (N=162)	152	93.83	10	6.17
$\chi^2 = 2.576$ df = 3 P = 0.4618				

*F = frequency of yes responses

Respondents were asked their opinion as to whether the areas of specialization should be based on position or practice. Eighty-two percent (N=157) of the respondents felt they should be based on practice, 15% (N=29) felt they should be based on both and a few (N=7) felt they should be based on position of neither, with more (N=5) listing neither (Table VIII). Over 80% of each group of educators and 72% of the Practice Group members listed practice as a basis for specialization. However, all groups were in general agreement that specialization should be based on practice and not on position.

TABLE VIII
RELATIONSHIP BETWEEN GROUPS CONCERNING SPECIALIZATION
BY POSITION OR PRACTICE

Group	Practice		Both		Position	
	F*	%	F*	%	F*	%
Advanced Degree (N=55)	46	83.64	8	14.55	0	0
CUP (N=33)	29	87.88	3	4.09	0	0
Internship (N=57)	48	84.21	8	14.04	0	0
Practice Group (N=47)	34	72.34	10	21.28	1	2.13
Total (N=192)	157	81.77	29	15.10	1	.52
$\chi^2 = 6.645$ $df = 9$ $P = 0.6740$						

*F = frequency of yes responses

In developing areas of specialization, there has been speculation as to whether a "generalist" dietitian is indeed in specialized practice. A generalist is one whose position encompasses all areas of dietetics, more specifically administration and clinical, and who must be knowledgeable in all areas. Forty-three percent (N=83) of the respondents felt that a "generalist" was in specialized practice (Table IX). However, the Chi square test showed a significant difference between the groups (P=0.0178). Twenty-eight percent (N=16) of the Advanced Degree Directors and 38% (N=13) of the CUP Directors concurred agreement. The Internship Directors were split, with less agreeing (N=24) than disagreeing. Sixty-one percent (N=30) of the Practice Group Members agreed.

TABLE IX
DIFFERENCES BETWEEN GROUPS CONSIDERING A
"GENERALIST" IN SPECIALIZED PRACTICE

Group	F*	%
Advanced Degree (N=57)	16	28.07
CUP (N=34)	13	38.24
Internship (N=52)	24	46.15
Practice Group (N=49)	30	61.22
Total (N=192)	83	43.23
$\chi^2 = 15.333 \quad df = 6 \quad P = 0.0178$		

*F = frequency of yes responses

Respondents who agreed reasoned that the generalist was analogous to the "Family Practitioner" in medicine. Other reasons included:

- a. because a generalist needs to know "something about everything" and must be competent in all areas, especially if employed in a small institution;
- b. because he/she needs a broad knowledge in several areas;
- c. because a generalist has a working knowledge in all areas and needs a variety of knowledge and skills;
- d. because he/she has a broader perspective of the profession as a whole.

Reasons for negative responses included because:

- a. a generalist's practice and knowledge are too broad to be qualified as a specialist;
- b. lack of in-depth experience and knowledge;
- c. is an entry-level position and
- d. by definition of a generalist.

Identification of a Specialist

In 1978, the Committee on Specialty Board Certification suggested requirements for the classification of a specialist. Respondents were asked to select from nine of the categories suggested by the Committee. These included advanced education, a certifying examination, a specified type or level of experience, interest in a practice area, specialized area of practice, licensed dietitian status, RD status, specified position level or title.

The Chi square test showed a significant difference ($P=0.0002$) between the groups for the category advanced education as a requirement

for classification as a specialist (Figure 3). This difference was observed since over three-fourths in each group (>77%) of educators selected advanced education and only 48% (N=26) of the Practice Group Members selected advanced education. This difference can be compared to previous information concerning those in each group who held an advanced degree, with the majority of the educators holding or working on a Masters degree, Ph.D. or equivalent degree.

A certifying examination as a requirement for being classified as a specialist also showed significant difference ($P=0.0186$) between groups, (using the Chi square test). Fifty-six percent (N=122) of the respondents selected this category. Fifty-eight percent (N=39) of the Advanced Degree Directors, 70% (N=26) of the CUP Directors and 60% (N=36) of the Internship Directors, and only 39% (N=21) of the Practice Group Members selected a certifying examination as a requirement. Thus, the difference occurred between the educators as a whole and the Practice Group Members with only slight differences between the three groups of educators.

A specified type or level of experience as a requirement for classification as a specialist was selected by 61% (N=155) of the respondents. However, the Chi square test showed significant difference ($P=0.0157$) between the groups. Sixty-one percent (N=41) of the Advanced Degree Directors and 62% (N=34) of the Practice Group Members selected this category, whereas over three-fourths of the CUP Directors (79%) and Internship Directors (83%) selected this category.

The Chi Square test showed a significant difference ($P=0.0186$) between the groups, in regard to interest in a practice area as a requirement. However, it was an inverse relationship. That is, 31

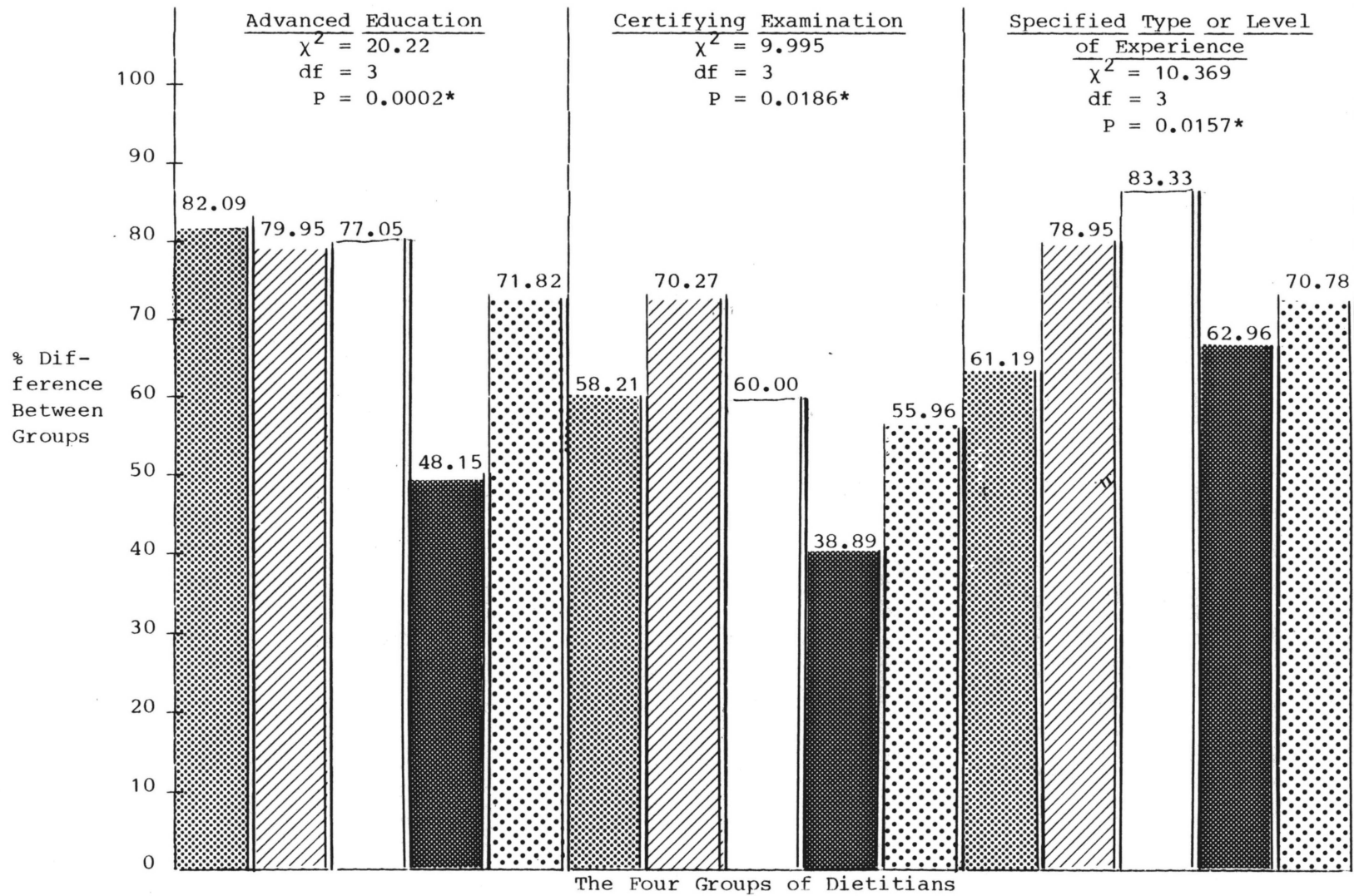


Figure 3. Routes for Classification of a Specialist

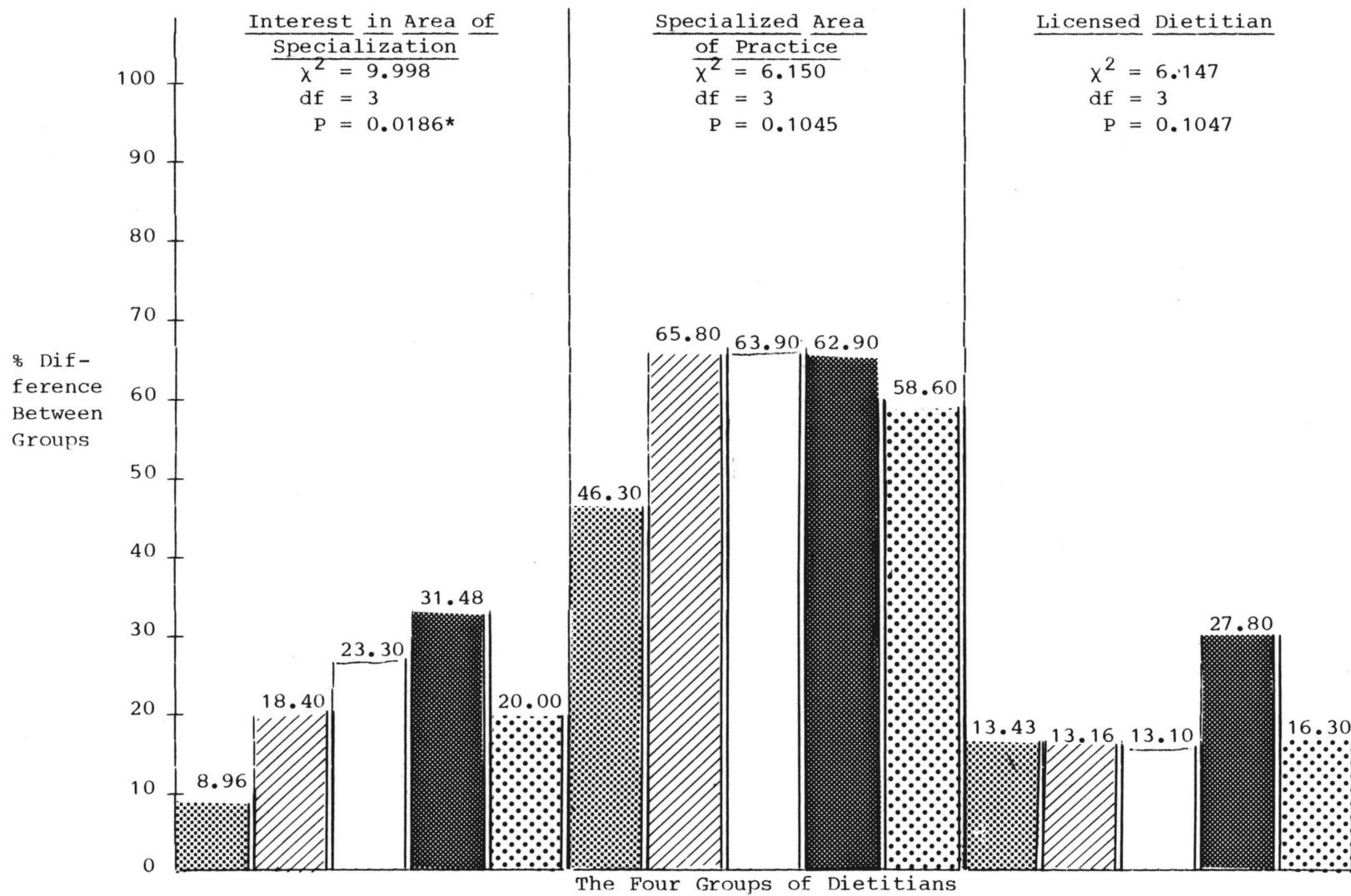


Figure 3 (Continued)

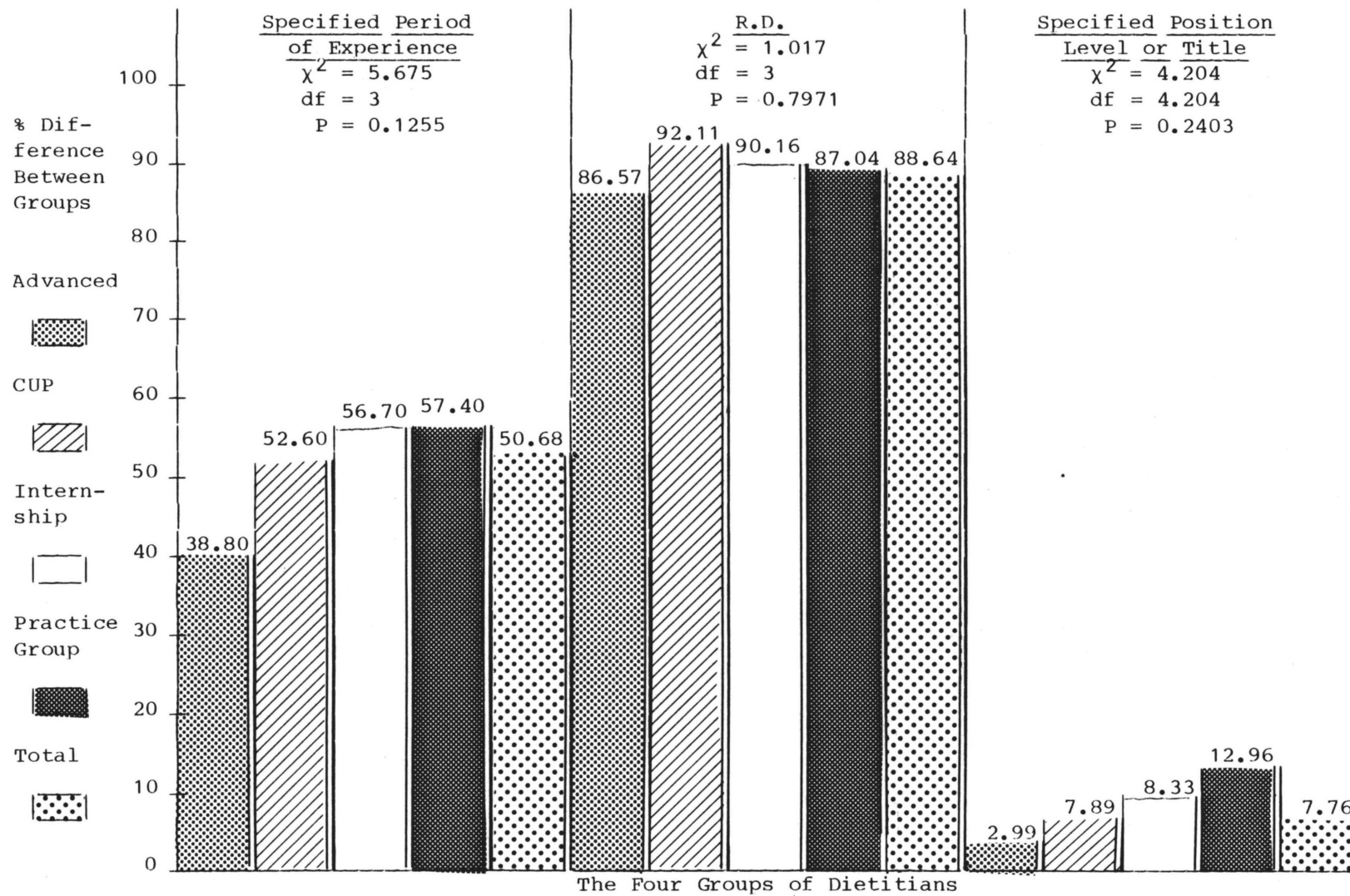


Figure 3 (Continued)

percent (N=17) of the Practice Group Members, 18% (N=7) of the CUP Directors and 23% (N=14) of the Internship Directors and 9% (N=6) of the Advanced Degree Directors selected this category. Since only 20% (N=44) of the respondents selected interest, it supports an earlier finding that areas of specialization should not be based on DPG's which are interest groups but should be supportive entities.

Sixty-five percent of the CUP Directors (N=25), 63% (N=39) of the Internship Directors and Practice Group Members, (N=34) selected a specialized area of practice as a requirement for classification as a specialist. In contrast, 46% (N=31) of the Advanced Degree Directors selected this category. The Chi square test showed a significant difference ($P=0.1045$) between the groups at the .1 level. Twenty-eight percent (N=15) of the Practice Group Members and 13% in each group of educators selected a licensed dietitian as a criterion for classification as a specialist. This created a significant difference ($P=0.1047$) between groups at the .1 level.

Eighty-seven percent (N=195) of the respondents selected the title RD as a criterion while 8% (N=17) of the respondents selected a specified position level or title as a criterion for classification as a specialist. In total, the criteria selected by the majority of all respondents included advanced education, specified type or level of practice, specialized area of practice and the title RD. Significant differences between the groups were observed in the categories of advanced education, certifying examination, specified type or level of practice, and interest in an area of specialization. A significant difference was observed in the categories of specialized area of practice, licensed dietitian, and specified period of experience.

Concerning appropriate identification of a dietetic specialist, respondents were asked to select from the following by title, by designated subject area, by appropriate initials, and/or by an appropriate advanced degree. Twenty-six percent (N=55) of the respondents selected by an appropriate advanced degree. Within the groups, one-fourth of the Advanced Degree Directors (22%) and CUP Directors (24%) selected this category, 40% (N=24) of the Internship Directors as well as 15% (N=8) of the Practice Group Members selected it. As a result of the difference between the groups, the Chi square test showed a significant difference ($P=0.0183$).

Sixty-two percent (N=132) of the respondents considered that a specialist should be identified by title, with no observed difference between the groups. Forty-five percent (N=96) of all respondents selected identification of a specialist by subject area and 25% (N=53) of the respondents selected identification of a specialist by appropriate initials. There was no significant difference between the groups in any of these categories (Table X). Overall identification of a specialist by title was selected more often with the other categories being split. A significant difference was observed in the category of advanced education.

Respondents were asked if they considered themselves a specialist and why. This was to verify their responses concerning qualifications and requirements of a specialist. Sixty-eight percent (N=203) of the respondents considered themselves to be a specialist (Table XI). Sixty-six percent (N=44) of the Internship Directors, 71% (N=37) of the Practice Group Members, 68% (N=24) of the CUP Directors, and 57% (N=33) of the Advanced Degree Directors considered themselves to be a

TABLE X
RELATIONSHIP BETWEEN GROUPS IN IDENTIFYING A SPECIALIST

Group	Advanced Degree		Title		Subject Area		Initials	
	F*	%	F*	%	F*	%	F*	%
Advanced Degree (N=63)	14	22.22	37	58.73	24	38.10	13	20.63
CUP (N=38)	9	23.68	25	65.79	18	47.37	10	26.32
Internship (N=60)	24	40.00	34	56.67	32	53.33	12	20.00
Practice Group (N=53)	8	15.09	36	67.92	22	41.51	18	33.96
Total (N=214)	55	25.70	13	61.68	96	44.85	53	24.77
$\chi^2 =$		10.027		2.016		3.244		3.763
df =		3		3		3		3
P =		0.0183		0.5691		0.3555		0.2882

*F = frequency of yes responses

specialist. There was no significant difference observed between the groups.

TABLE XI
RELATIONSHIP BETWEEN GROUPS OF THOSE WHO
CONSIDERED THEMSELVES TO BE A SPECIALIST

Group	F*	%
Advanced Degree (N=58)	33	56.90
CUP (N=35)	24	68.57
Internship (N=58)	44	75.86
Practice Group (N=52)	37	71.15
Total (N=203)	138	67.98
$\chi^2 = 8.380$ $df = 21$ $P = 0.2115$		

*F = frequency of yes responses

A difference in qualifications making the respondent a specialist was found between the four groups. The qualifications listed by the respondents were placed into four categories--education, advanced education, experience, and interest in that area. Thirty-nine percent (N=55) of the respondents listed education and 44% (N=63) of the respondents listed advanced education (Figure 4). A significant difference was found between the groups in both of these categories. Forty-two percent (N=15) of the Advanced Degree Directors, 44% (N=11) of

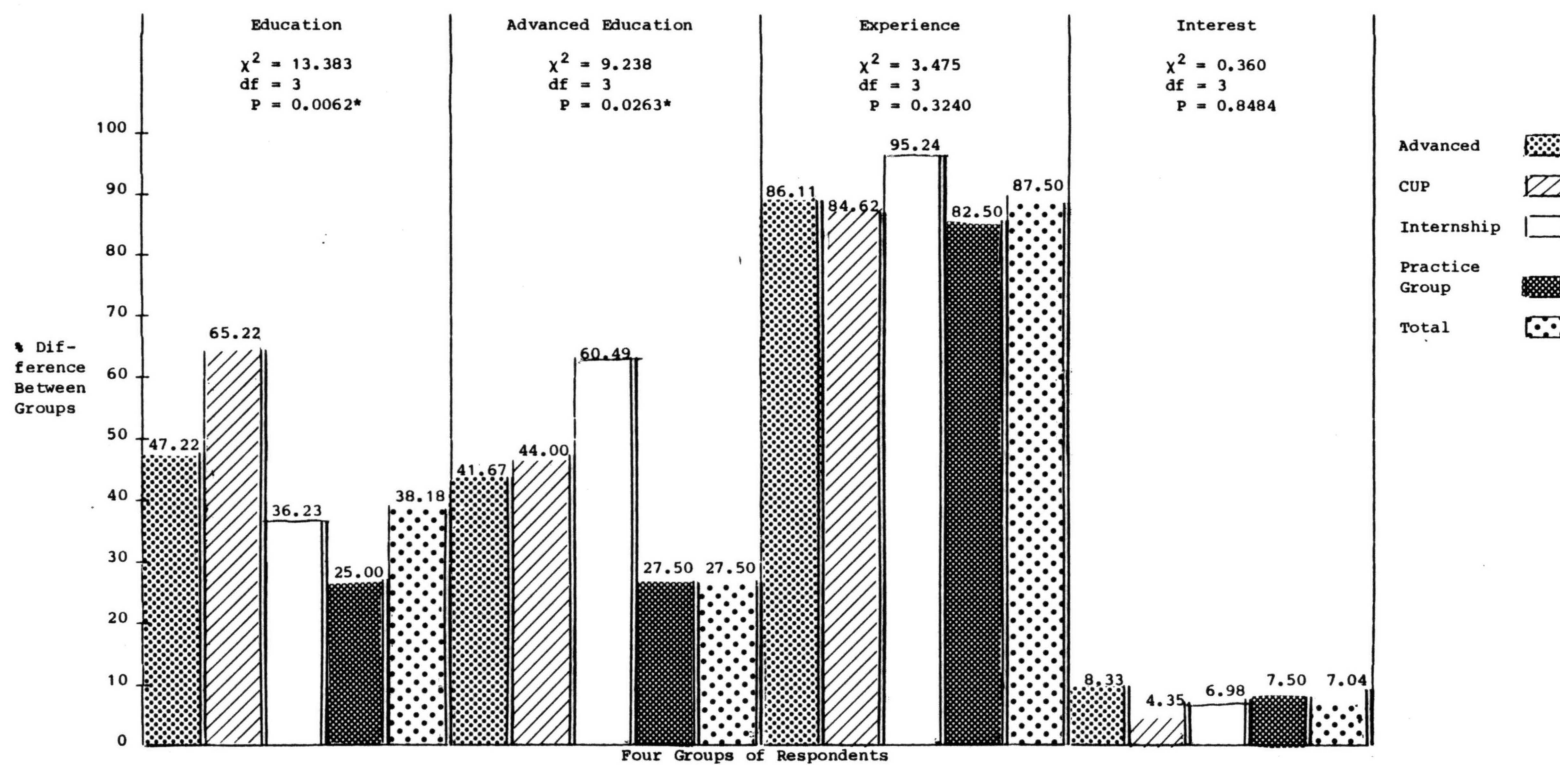


Figure 4. Routes that Qualified Respondents as a Specialist

the CUP Directors, 60% (N=26) of the Internship Directors, and 27% (N=11) of the Practice Group Members selected education as qualifying them as a specialist. The Chi square test showed a significant difference ($P=0.0062$) between the groups. Forty-seven percent (N=17) of the CUP Directors, 60% (N=26) of the Internship Directors, and 27% (N=11) of the Practice Group Members selected education as qualifying them as a specialist. The Chi square test showed a significant difference ($P=0.0062$) between the groups. Forty-seven percent (N=17) of the Advanced Degree Directors, 65% (N=15) of the CUP Directors, 30% (N=13) of the Internship Directors and 25% (N=10) of the Practice Group Members listed education as qualifying them as a specialist. This difference between the groups was observed using the Chi square test which showed significant difference ($P=0.0263$). The results in this category can be compared with earlier results that indicated a higher percentage selecting advanced education categories to be among the educators who hold that degree.

There was no significant difference between the groups in listing experience and interest as qualifying them as a specialist. Eighty-seven percent (N=126) of the respondents listed experience and seven percent (N=10) listed interest. In summary, a higher percentage was observed for the category of experience and the lowest for interest. A significant difference was observed between the groups in the categories of education and advanced education.

Respondents were asked if their current position was considered to be specialized. Fifty percent (N=88) responded that their position was considered a specialized area of practice (Table XII). However, the groups differed with 33% (N=17) each of the Advanced Degree Directors

and 37% (N=11) of the CUP Directors, and 64% (N=30) of the Internship Directors and Practice Group Members responding affirmatively. As a result, the Chi square test showed a probability of 0.0064, indicating significant difference between the groups. Reasons given why their position was considered specialized included:

- a. required knowledge and skill level;
- b. responsibilities; focus of the position;
- c. advanced preparation required;
- d. uniqueness of the job qualifications;
- e. advanced experience required; and
- f. is recognized as a specialist.

Negative responses were because of:

- a. the general requirements and responsibilities;
- b. the broadness of knowledge and skills required;
- c. not identified as a specialist; and
- d. not listed as part of the medical areas.

For a list of all responses please refer to Appendix B.

TABLE XII
REASONS RESPONDENTS FELT THEIR POSITION
WAS SPECIALIZED

Group	F*	%
Advanced Degree (N=51)	17	33.33
CUP (N=30)	11	36.67
Internship (N=47)	30	63.83
Practice Group (N=47)	30	63.83
Total (N=47)	88	50.29
$\chi^2 = 17.983 \quad df = 6 \quad P = 0.0064$		

*F = frequency of yes responses

Minimal Educational and Experiential Requirements to be a Specialist

Concerning specific educational and experiential requirements to be a specialist, respondents were asked to select the categories they perceived should be the minimum educational requirements. The categories included: a Bachelor of Science Degree, a Master of Science Degree, a Ph.D. or Ed.D., post graduate work (no degree), specialized courses, and/or specific training in a specialized area. The category that was selected most frequently was training in a specialized area (Table XIII). A master's degree was selected by 51% (N=114) of the respondents and a Bachelor's degree by 45% (N=94) of the respondents.

TABLE XIII
MINIMUM EDUCATIONAL REQUIREMENTS

Group	Bachelor's Degree		Master's Degree		Ph.D.		Post Graduate Work		Specialized Courses		Training in Specialized Area	
	F*	%	F*	%	F*	%	F*	%	F*	%	F*	%
Advanced Degree (N=66)	23	34.33	36	54.55	3	4.55	11	16.92	25	37.88	41	62.12
CUP (N=36)	14	37.84	25	67.57	1	2.70	7	18.92	17	45.95	23	63.89
Internship (N=63)	25	45.45	34	53.99	3	4.76	8	12.70	28	44.44	45	71.43
Practice Group (N=52)	32	62.75	19	35.19	0	0.00	6	11.11	23	42.59	37	71.15
Total (N=217)	94	44.76	114	51.82	7	3.18	32	14.61	93	42.27	146	67.28
$\chi^2 =$	10.348		9.973		2.711		1.544		0.851		1.833	
df =	3		3		3		3		3		3	
P =	0.0158		0.0188		0.4383		0.6722		0.8373		0.6073	

*F = frequency of yes responses

Thirty-four percent (N=23) of the Advanced Degree Directors, 37% (N=14) of the CUP Directors, 45% (N=25) of the Internship Directors and 63% (N=32) of the Practice Group Members selected a Bachelors degree as a minimum educational requirement. The Chi square test showed a significant difference ($P=0.0158$) between the groups. The opposite was true for the Master's degree. Fifty-four percent of the Advanced Degree Directors (N=36) and the Internship Directors (N=34), 35% (N=19) of the Practice Group Members and 68% (N=25) of the CUP Directors selected a masters degree as a minimum educational requirement. This difference created a probability of 0.0188 indicating significant difference using the Chi square test. This difference shows consistency in the Practice Group and educators' perceptions concerning the type and/or level of education needed to be classified or qualified as a specialist.

Concerning a minimum requirement of a Ph.D. or an Ed.D., only 3% (N=7) of the respondents considered it necessary (Table XIII). Of the total respondents, 15% (N=32) considered that post graduate work should be a minimal requirement, 42% (N=93) considered specialized courses in an area of specialization as necessary, and 67% (N=146) considered specific training in a specialized area as necessary. There was no significant difference observed between the groups in any of these categories. In summary, respondents felt that specific training in a specialized area should be a minimal requirement. The respondents were split concerning specialized courses in a specialized area, a master's degree and a bachelor's degree as minimal requirements. Significant difference between the groups was observed in the categories of a bachelor's degree and a master's degree.

Respondents were asked to select either three years or five years of experience in the area of specialization as minimal experience requirement to be a specialist. Eighty-four percent (N=165) of the respondents considered three years of experience in a specialized area adequate experience, whereas 16% (N=31) considered five years of experience necessary (Figure 5).

The Task Force on Education defined "dietetic specialties" as "practice at an advanced level requiring additional expertise (knowledge and skills) beyond that defined for entry level." Respondents were asked to give their opinion of this definition and to make any necessary recommendations. Eighty-three percent (N=150) of the respondents agreed with the definition (Table XIV). Over three-fourths of the respondents in each group agreed resulting in no significant difference between the groups. Respondents felt that the definition was a good starting point but should be expanded and more specific, defining all terms in their simplest form. Significant difference between the groups concerning the definition of specialization was not observed, thus that aspect of Hypothesis I was rejected.

Hypothesis III stated that a difference would occur between the groups regarding what they considered necessary to be a specialist, both educationally and experientially. Significant difference was observed in only two of the six categories of education and more in the area of experience. Consequently, Hypothesis III was rejected.

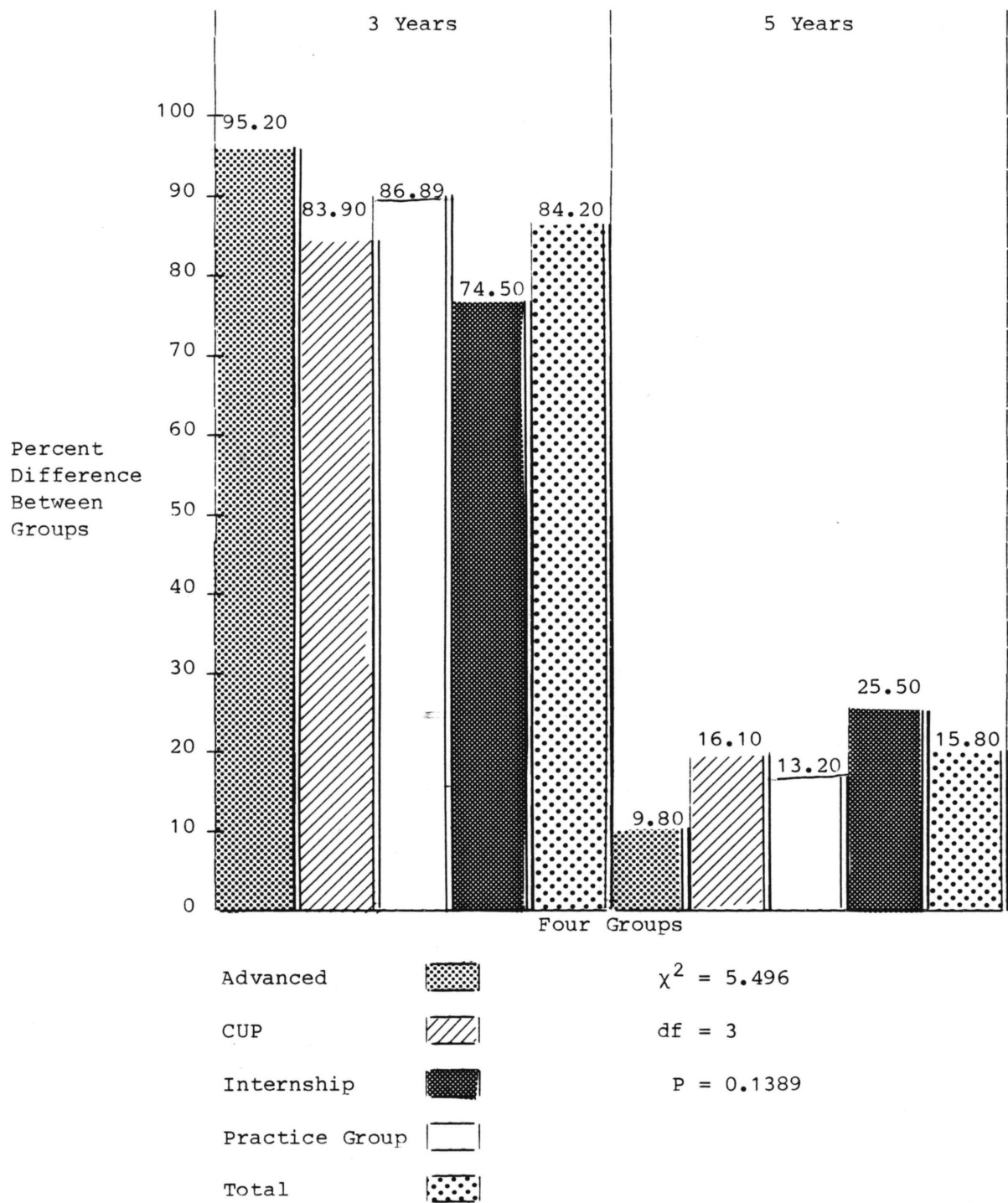


Figure 5. Minimum Required Experience Identified by Each Group

TABLE XIV
 AGREEMENT WITH TASK FORCE ON EDUCATION'S
 DEFINITION OF "DIETETIC SPECIALTIES"

Group	F*	%
Advanced Degree (N=57)	49	85.96
CUP (N=31)	24	77.42
Internship (N=43)	35	81.40
Practice Group (N=49)	42	85.71
Total (N=180)	150	83.33
$\chi^2 = 1.381 \quad df = 3 \quad P = 0.7100$		

*F = frequency of yes responses

Identification of Requirements for Certification of a Specialist

In 1977, the Special Committee on Specialty Board Certification suggested specific routes for certifying a specialist. Respondents were asked to identify the routes they felt were necessary among the following: RD exam; exam over Plan IV Minimum Academic Requirements; licensure exam; and/or an exam in the area of specialization. Seventy-six percent (N=165) of the respondents selected an RD exam as a mean of establishing certification (Figure 6). In each group, the Advanced Degree Directors had a significantly lower percentage selecting this category. Eight percent (N=18) of the respondents selected a licensure exam with the Practice Group Members having a slightly higher percentage

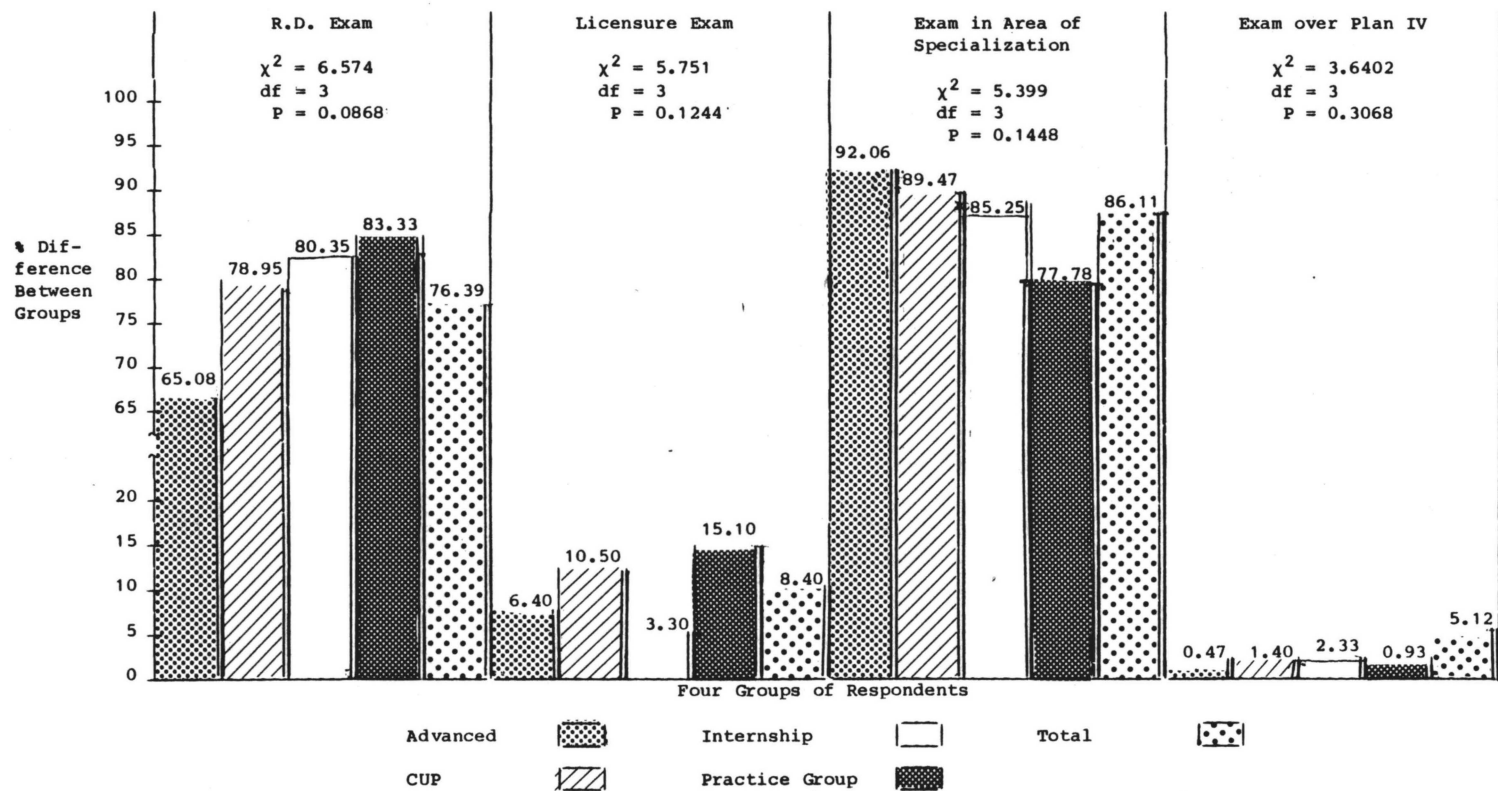


Figure 6. Minimum Requirements for Certification

(15%) selecting it. Eighty-six percent (N=186) of the respondents selected an exam in an area of specialization as a mean of certification. The Practice Group had a slightly lower percentage (77%) selecting this category than the other three groups. Only 5% (N=11) of the respondents considered an exam over Plan IV Minimum Requirements necessary for certification of a specialist. There was no significant difference observed between the groups in any of the categories. In summary, the respondents felt an RD examination and an examination in the area of specialization necessary for establishing certification of a specialist while a licensure examination and an examination over Plan IV Minimum Requirements were not considered necessary.

Concerning recertification of the specialist, respondents were asked to select from either a periodic re-examination; continuing education hours; developmental activities, such as courses/workshops/residencies, research; and/or publications in refereed journals. There was significant difference observed between the groups in selecting a periodic re-examination, continuing education hours, and research. Regarding a periodic re-examination, 30% (N=20) of the Advanced Degree Directors, 33% (N=15) of the Internship Directors, and 21% (N=11) of the Practice Group Members selected this category, whereas 51% (N=19) of the CUP Directors selected a periodic re-examination (Figure 7). The Chi Square test indicated significant difference ($P=0.0232$) between the groups. Continuing education hours was selected by 82% (N=174) of the respondents. Within the groups, 75% (N=48) of the Advanced Degree Directors and 70% (N=26) of the CUP Directors selected continuing education. In contrast, 90% in each of the other two groups selected continuing education hours creating a

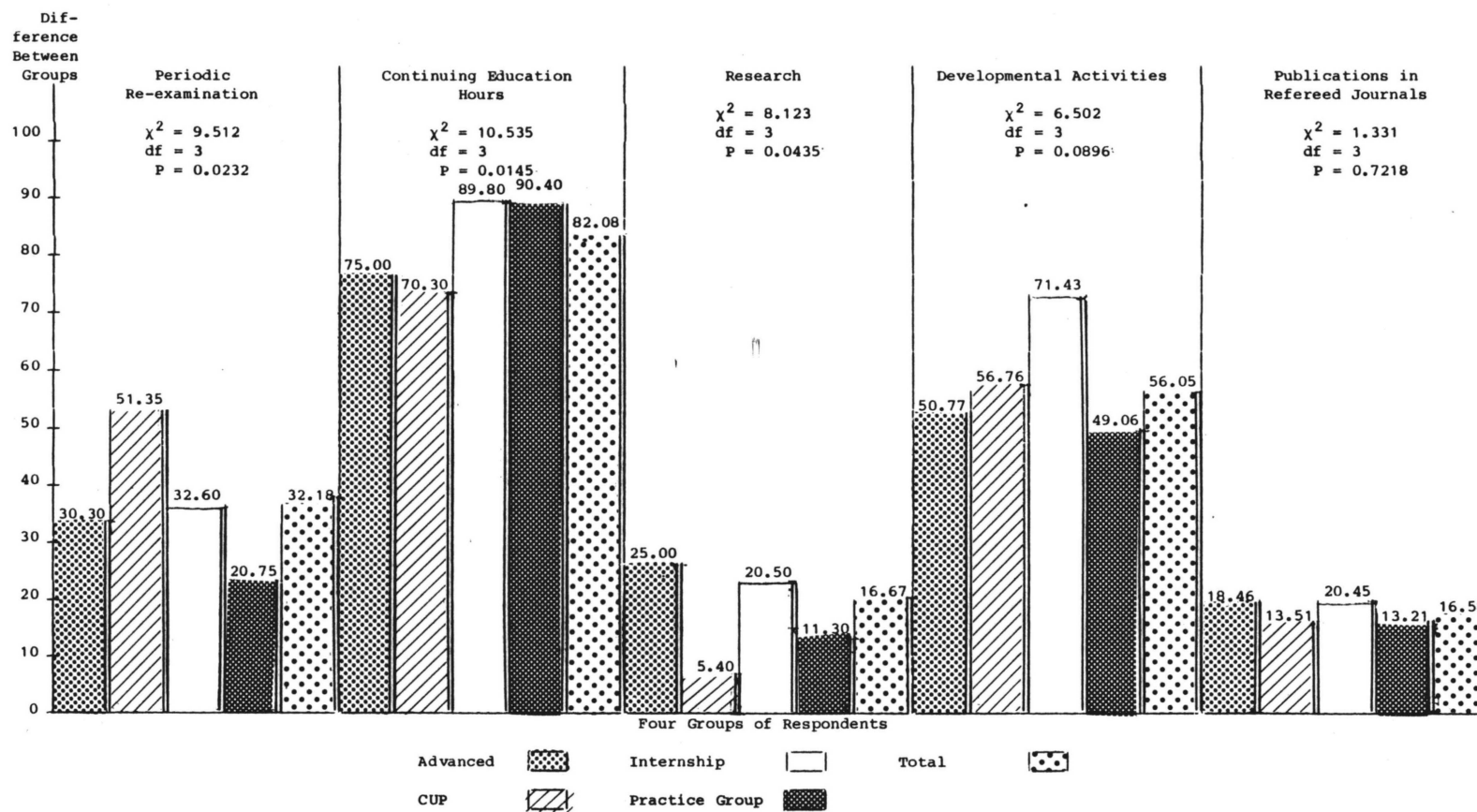


Figure 7. Minimum Requirements for Recertification

probability of 0.0145 as indicated by the Chi Square test. The category of research was selected by 17% (N=33) of the respondents. One-fourth (N=16) of the Advanced Degree Directors and 20% (N=9) of the Internship Directors felt research was necessary. In contrast, only 11% (N=6) of the Practice Group Members and only 5% (N=2) of the CUP Directors considered research necessary. Thus, the Chi square test indicated significant difference ($P=0.0435$) between the groups.

Concerning the necessity for developmental activities, 56% (N=115) of the respondents selected it. However, within the groups, the CUP Directors differed with three-fourths (N=35) selecting it and the other groups being split (50%) creating a slight difference and a probability of 0.0896 as indicated by the Chi square test. Only 17% (N=33) considered publications in a refereed journal necessary. In summary, significant difference was observed in the categories of periodic re-examination, continuing education hours, and research, and differences were observed in the category of developmental activities.

Discussion

This research revealed that of the 222 respondents 197 felt that specialization is indeed needed in the profession of dietetics. Further, the Dietetic Practice Groups (DPG's) can be instrumental in the development of the specialties and their implementation by setting guidelines, definitions, objectives and requirements for each specific area of specialization. It was also discovered that specialization should not be based on position but rather on practice.

The study revealed that the four major areas of dietetics, specifically, management, clinical, community nutrition and education,

are considered specialized areas with clinical subspecialties as a category among them. There was little agreement as to which subdivisions need to be specialized. It was, however, generally agreed upon that the four major areas of dietetics should be divided further.

From the results of this research it can be recommended that a specialist be identified by a title and possibly by subject area. Even though only one-fourth of the respondents felt a specialist should be identified by an advanced degree, at least half of the respondents considered themselves a specialist because of education or an advanced degree.

A minimum educational requirement deemed necessary by the respondents was specific training in a specialized area. The categories of specialized courses in the area of specialization, a B.S. and an M.S. were divided as to their importance as a requirement. Three years of experience in the area of specialization was considered necessary by the respondents.

Requirements for certification of a specialist were found to be a registration examination and an examination in the area of specialization. Continuing education hours and developmental activities were found to be considered necessary for recertification of the specialist.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

The purpose of this study was to ascertain the perceptions and attitudes of dietetic practitioners and educators concerning specialization of the dietetic practice. The review of literature revealed the progressive interest and need for specializing it revealed that, generally, the educational curriculum and the profession have been specialized or divided into three or four main areas since its foundation in 1917. These areas are management, clinical, and community. The area of education has been a recognized area of specialty on and off again. A need for specialization was formally recognized in 1972 by The Study Commission on Dietetics, in 1982 by The Task Force on Education and again in 1984 by The Second Study Commission on Dietetics. This study was conducted to get an understanding of whether dietetic professionals really felt that there was a need for specialization and what the areas of specialization and the requirements for them should be.

A survey questionnaire was sent to 200 members of the Practice Group--"Dietitians with Management Responsibilities in Health Care Facilities," and all Coordinated Undergraduate Program (CUP) Directors, Internship Directors, and Advanced Degree Directors who were listed in the 1985 American Dietetics Association Directory of Dietetic Programs.

Data were collected from a total of 54 Advanced Degree Directors, 38 CUP Directors, 63 Internship Directors, and 67 Practice Group Members.

Findings

The study revealed that all groups were of the opinion that specialization is needed within the profession of dietetics. There was, however, controversy as to how this should be achieved. All groups were of the opinion that specialization should be based on practice rather than position. They also felt that the Dietetic Practice Groups (DPG's) should be a major influence on the development of the areas of specialization. It was indicated that the areas of specialization and the DPG's should not be one and the same. As to the areas of dietetics that should be specialized, three very broad areas of specialization considered traditional areas of specialty practice, i.e., administrative dietetics, clinical dietetics, and community nutrition were considered valid categories. Respondents felt, however, that further divisions in these areas were necessary. A large majority of the respondents listed the above three areas as well as education and clinical subspecialties as the areas to be designated as specialties. The most common area of practice, general, was not listed often, however, there was a significant difference between the groups concerning whether or not a generalist was in specialized practice.

Another aspect of specialization centers around identification of the specialist. The study revealed that the majority of respondents felt a specialist should be identified by title. Respondents were divided concerning identification by subject area. One-fourth of all respondents felt a specialist should be identified by initials and

one-fourth by advanced degree, however, there was significant difference in the latter category in that the Internship Directors had a higher percentage selecting identification by advanced degree. Over half of the respondents considered themselves to be a specialist with half or more listing education or advanced education as the qualifying credential. Half of all respondents felt their present position was considered to be specialized.

The study also revealed that there is discrepancy concerning minimum education and experiential requirements for a specialist. Respondents were divided concerning specialized courses in a specialized area, a master's degree and a bachelor's degree as minimum educational requirements. There was, however, significant difference observed between the groups in the last two categories. Respondents were in agreement that specific training in a specialized area should be a minimum requirement. Respondents did agree that three years of experience in the area of specialization were sufficient.

A major step in the implementation of dietetic specialties is defining specialization and the areas of specialization. The research revealed that all groups were supportive of the definition of "dietetic specialty" suggested by the Task Force on Education, but they felt there was need for further revisions to be made later and that this was an initial step.

In the area of certification, the study revealed that respondents felt a registration examination and an examination in the area of specialization were necessary whereas they felt a licensure examination and an examination over the Plan IV Minimum Requirements was not necessary for establishing certification of a specialist. Necessary

requirements for certification of the specialist that were agreed upon by all groups were continuing education hours and developmental activities.

Recommendations

It is recommended that further study be completed among other areas in the profession and possibly among other allied health professionals regarding specialization. Other Dietetic Practice Groups within the Association could be surveyed to reveal any differences that might occur between the various areas of practice. From this study, it appears there is a need for the ADA to implement the 1984 Study Commission's recommendations concerning specialization. It is recommended that the Council on Practice and the Council on Education in the ADA be encouraged to include in their long range plans for the Association and begin the process of developing dietetic speciality areas. It is also recommended that a differentiated questionnaire, such as variation in color, be used to identify each group to ensure accurate placement of each respondent.

SELECTED REFERENCES

- A new look at the profession of dietetics - Final report of the 1984 Study Commission on Dietetics: Summary and Recommendations. J. Am. Dietet. Assoc. 84(9):1052, 1984.
- ADA Reports: Certification in dietetic specialities: Proposed guidelines for establishing the American Board of Dietetic Specialties. Am. Diet. Assoc., 74:153, 1979.
- ADA Reports: Titles, definitions, and responsibilities for the profession of dietetics - 1974. Report of the Committee to develop a glossary and terminology for the association and profession. J. Am. Diet. Assoc. 64:661, 1974.
- Annual Reports & Proceedings, 40th Annual Meeting, 1956-1957. Am. Diet. Assoc., 1957.
- Annual Reports & Proceedings, 6th Annual Meeting, 1976-77. The American Dietetic Association. Chicago, Illinois, 1976.
- Best, John W.: Research in Education. Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1981.
- Bogle, Margearet L.: Registration - the sine qua non of a competent dietitian. J. Am. Dietet. Assoc. 64:616, 1974.
- Chambers, Maj. Mildred J.: Professional dietetic education in the U.S. J. Am. Dietet. Assoc. 72:596, 1978.
- The dietitian - A specialist in feeding people. J. Am. Dietet. Assoc. 21:529, 1945.
- Flournory, Icilda C.: Planning for continuing education: Goal setting and self-assessment. J. Am. Dietet. Assoc. 84:926, 1984.
- Galbraith, Annie: Twenty-four-carat dietetic practice for the eighties. J. Am. Dietet. Assoc. 77:529, 1980.
- Galbraith, Annie L.: Excellence defined. J. Am. Dietet. Assoc. 67:211, 1975.
- Gilson, Helen Evangeline: Some historical notes on the development of diet therapy. J. Am. Dietet. Assoc. 23:761, 1947.
- Huddleson, Mary Pascoe: A new profession is born. J. Am. Dietet. Assoc. 23:573, 1947.

- Johnson, Doris: Changing role for the dietitian. J. Am. Dietet. Assoc. 36:593, 1960.
- Johnson, Doris: The dietitian - a translator of nutritional information. J. Am. Dietet. Assoc. 64:608, 1974.
- Junkermier, Polly, A., Wenberg, Burness G.: Implications of ADA Plan IV for active membership. J. Am. Dietet. Assoc. 80:338, 1982.
- Langholz, Edna P.: The president's page. J. Am. Dietet. Assoc. 80:584, 1982.
- Lanz, Sally J.: Introduction to the Profession of Dietetics. Lea & Febiger, Philadelphia, 1983.
- MacEachern, Malcom T.: Advances in dietetics from the hospital viewpoint. J. Am. Dietet. Assoc. 25:494, 1949.
- News Digest: Report of the Committee to Study, Evaluate, and Make Recommendations for Implementation of "The Profession of Dietetics: The Report of the Study Commission on Dietetics." J. Am. Dietet. Assoc. 61:430, 1972.
- Parks, Sara C., Kris-Etherton, P. M.: Practitioners view dietetic role for the 1980s. J. Am. Dietet. Assoc. 80:575, 1982.
- Patterson, Isabel: Dietetic education - some current issues. J. Am. Dietet. Assoc. 45:19, 1964.
- Position paper on education for the profession of dietetics. J. Am. Dietet. Assoc. 59:372, 1971.
- Position paper on recommended salaries and employment practices for members of The American Dietetic Association. J. Am. Dietet. Assoc. 78:66, 1981.
- Report of The Study Commission on Dietetics: The Profession of Dietetics. Am. Dietet. Assoc., Chicago, 1972.
- Report of the 1984 Study Commission on Dietetics: A New Look at the Profession of Dietetics. Am. Diet. Assoc., Chicago, 1985.
- Robinson, Wilma F.: Your role in the continuing development of dietetics. J. Am. Dietet. Assoc. 47:89, 1965.
- Ross, Margaret L.: The long view. J. Am. Dietet. Assoc. 65:295, 1970.
- Smith, Florence H.: Presidential Address. J. Am. Dietet. Assoc. 3:145, 1927.
- Task Force on Education. Am. Dietet. Assoc. Courier, 22:9, 1983.
- The American Dietetic Association Position paper on continuing education. J. Am. Dietet. Assoc. 64:289, 1974.

The American Dietetic Association. Am. Diet. Assoc., Chicago, 1985.

Todhunter, E. Neige: Our profession moves ahead. J. Am. Dietet. Assoc. 33:681, 1957.

Turcotte, Judith Marie, Vaden, Allene G., Hoyt, Donald P.:
Recommendations of the National Commission on Allied Health
Education: Priorities for the dietetic profession. J. Am. Dietet.
Assoc. 83:531, 1983.

Zallen, Zugenia M.: Linkages between administrative and clinical
dietitians. J. Am. Dietet. Assoc. 83:415, 1983.

APPENDIXES

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APPENDIX A
RESEARCH INSTRUMENT



Oklahoma State University

Department of Food, Nutrition and Institution Administration

425 HOME ECONOMICS WEST
STILLWATER, OKLAHOMA 74078
(405) 624-5039

February 14, 1985

Dear Colleague:

There has been considerable interest in the concept of specialization in dietetics for several years but there is no formally recognized identification of specialty areas at present. The Task Force on Education and the Commission on Dietetic Registration have recommended that "a system should be established to recognize dietetic specialties" and that a phased approach of several steps be used. Until a clear identification of specialty areas and a definition of their underlying bodies of knowledge is completed, however, the development of such a system may be premature.

In line with the need to determine present understandings, opinions, and beliefs of ADA members about specialties, I am surveying particular groups in the Association. These are the directors of internships and of Coordinated Undergraduate Programs, directors of advanced degree programs and a dietetic practice group. The data will be reported in my masters thesis and, perhaps, be made more broadly available to the appropriate House of Delegates and Council on Education groups. Individuals or programs will not be identified in the study and the forms are coded for analysis only. Your prompt return by March 6, 1985 will be very much appreciated and will prevent the necessity of reminder notices.

Thank you for your interest and participation. Your response will be extremely important to the outcome of the study.

Sincerely,

Elizabeth A. Olson
Graduate Student

Esther A. Winterfeldt, Ph.D.
Major Advisor



Oklahoma State University
Department of Food, Nutrition
and Institution Administration

I. General Information on background and present employment.

Directions: Please check or fill in the appropriate answers.

1. Age: ___(1) Under 26 ___(4) 36-40 ___(7) 51-55
 ___(2) 26-30 ___(5) 41-45 ___(8) 56-60
 ___(3) 31-35 ___(6) 46-50 ___(9) Over 60

2. Sex: ___(1) Male ___(2) Female

3. Highest level degree obtained and major(s)?

___(1) B.S. _____
___(2) M.S. _____
___(3) Ph.D. _____

4. Are you an R.D.: ___(1) YES ___(2) NO

ADA member: ___(1) YES ___(2) NO

5. Please list positions in dietetics that you have held: (other than present position)

Title of position

Length of employment

6. If not presently employed in dietetics, please indicate the most important reason, and proceed to section II.

___(1) Attend school ___(5) No job available in area
___(2) Raise family ___(6) Did not want to work for a while
___(3) Marriage ___(7) Am employed in a non-dietetic
___(4) Health reasons position

(Please indicate)

___(8) Other _____
(Please specify)

7. Currently employed in

___(1) Dietetic Practice ___(3) Other _____
___(2) Education (Please specify)

8. Place of employment: (i.e., industry, private business, hospital, management company, long term care facility, education)

9. Number of years in present position: _____

10. Present position title: _____

11. Please give a ONE SENTENCE description of your present position activities: _____

12. Employment Status:

____ (1) Full time (at least 35 hrs/wk)

____ (2) 3/4 time (20-34 hrs/wk)

____ (3) Part time (under 20 hrs/wk)

13. Annual Income:

____ (1) Under 14,999

____ (5) \$45,000 - \$54,999

____ (2) \$15,000 - \$24,999

____ (6) \$55,000 - \$59,999

____ (3) \$25,000 - \$34,999

____ (7) Over \$60,000

____ (4) \$34,000 - \$44,999

11. The Task Force on Education has recommended that "a system should be established to recognize dietetic specialties," and the Commission on Dietetic Registration has supported that recommendation. Identification of specialty areas and delineation of the body of knowledge and skills necessary to allow individuals to function effectively in each area is needed. Until there has been clear identification of specialty areas and a definition of the underlying bodies of knowledge, a system for recognition of specialties is not possible.

"A new look at the profession of dietetics - Final report of the 1984 Study Commission on Dietetics: Summary and Recommendations." J. Am. Dietet. Assoc. 84(9):1052, 1984.

Directions: In this section, please give your opinion about the concept of specialization in dietetics.

1. Do you believe that there is a need for specialization within the profession of dietetics?

____ (1) YES

____ (2) NO

2. What significance do you believe specialization will have on the credibility of and impact in the dietetic profession?

3. In what areas of the profession is specialization needed?

4. What should the relationship be between Practice Groups and areas of specialization?

5. Do you consider a generalist as being in specialized practice? Why or why not?

6. Which of the following, in your opinion, are necessary for a dietitian to be classified as a specialist? (Please check all that apply)

<input type="checkbox"/> (1) R.D. <input type="checkbox"/> (2) Advanced Education <input type="checkbox"/> (3) A certifying exam <input type="checkbox"/> (4) A specialized area of practice <input type="checkbox"/> (5) Licensed Dietitian	<input type="checkbox"/> (6) A specified type or level of experience <input type="checkbox"/> (7) A specified period of experience <input type="checkbox"/> (8) A specified position level or title <input type="checkbox"/> (9) Interest in a practice area
--	---

7. How should a specialist be identified? (Check more than one if it seems appropriate)

<input type="checkbox"/> (1) By title <input type="checkbox"/> (2) By designated subject area	<input type="checkbox"/> (3) By appropriate initials <input type="checkbox"/> (4) By appropriate advanced degree
--	---

8. What minimum educational requirements should a specialist have?

<input type="checkbox"/> (1) B.S. <input type="checkbox"/> (2) M.S.	<input type="checkbox"/> (3) Ph.D. or Ed.D. <input type="checkbox"/> (4) Post graduate work	<input type="checkbox"/> (5) Specialized courses <input type="checkbox"/> (6) Specific training in specialized area
--	--	--

9. Minimal required experience for a specialist: (Please check under both a and b)
- a. ☐ (1) 3 years in area of specialization
☐ (2) 5 years in area of specialization
- b. ☐ (1) Progressively responsible positions in area of specialization Years
☐ (2) Highest level of practice attainable in area of specialization Years
☐ (3) Research in area of specialization
☐ (4) Other _____
(Please specify)
10. Minimum for establishing certification of a specialist: (Check all that you believe apply)
- ☐ (1) R.D. exam ☐ (3) A licensure exam
☐ (2) An exam over Plan IV Academic Course Requirements ☐ (4) Exam in area of specialization
11. Minimum requirement for recertification: (Check all that you believe apply)
- ☐ (1) Periodic re-examination ☐ (4) Research
☐ (2) Continuing education hours ☐ (5) Publications in refereed journals
☐ (3) Developmental activities such as courses/workshops/residencies
12. Should the areas of specializations be based on position or practice?
13. The 1978 report from the Ad Hoc Committee on Specialty Board Certification in Dietetics recommended three major areas of specialization: administrative dietetics, clinical dietetics and community dietetics. Do you consider this a logical designation? Why or why not?
14. Do you consider yourself a specialist in your current area of practice?
- ☐ (1) YES ☐ (2) NO

15. If yes, what qualified you as a specialist and why?
16. In your opinion, is the position you are in considered to be a specialized area of dietetic practice? Please explain.
17. The definition of dietetic specialties used by The Task Force on Education is, "dietetic specialties mean practice at an advanced level requiring additional expertise (knowledge and skills) beyond that defined for entry level." Please comment on this definition, including any changes that you believe may more clearly define a specialist. Please indicate if you agree or disagree with this definition.

Please make sure that you have completed the front and back portions of each page. Thank you for your participation. Please fold the questionnaire in thirds and staple it closed. The return address should be visible after stapling. Return postage is provided. Thank you very much.

APPENDIX B
RESPONSES OF EACH GROUP TO
OPEN-ENDED QUESTION

Responses of Advanced Degree Directors
Concerning Significance Specialization
Will Have on the Profession

This will depend on the training (basic) as well as advanced (training) and the ability of the dietitian to be intelligently understood by other professionals. So far there has been a lot of wishy-washy impressions put out.

Authority and knowledgeable which will be really repeated.

Good if specialty come after general background at bachelors level, not before. All should take general RE exam first then specialty exams later.

Should enhance credibility of standards and requirements are sufficiently rigorous.

Recognition for expertise in specialized areas; natural expansion of DPG roles.

Very little.

Will depend on performance of the individual in the profession.

It will have more credibility. ←

Indepth knowledge and skill in a specialized area will lend credibility to dietitians.

Specialization should not come too early.

A) Ability to market expertise. B) Recognition that the term dietitian does not assume same level of competence in all areas.

Prepare members to adequately function.

Both negative and positive.

We can strive to be experts in a specific area rather than trying to live up to publics expectations of "knowing everything about nutrition."

May be helpful with proper education of dietitians, other professionals, and the public. Many in public are not yet aware of what an RD is and does.

Very little on the profession but could have an impact on peers.

This would identify people qualified to work in areas requiring special skills and knowledge, therefore helping employees.

Just as in medicine, dentistry, nursing, etc., specialization will improve the quality of patient care and will enhance the education of Dietitians.

It will increase employment capability.

There appears to be no alternative to encouragement of specialization. It will allow in depth study where needs are great.

Upgrade profession; Provide recognized certification for specialized areas.

Professional training can be planned and implemented at the necessary depth. Employers will have a means to evaluate the competence of an individual to do a specific job.

Improved knowledge and greater respect for dietitians.

Improve visibility, credentials, and enhance level of performance.

Not necessarily in the credibility, but on the impact in positions requiring specialized knowledge and skills - ie. renal dietetics, public health nutr.

Quality assurance for advanced levels of practice.

Improvement (however, I'm not well versed with the practice of dietetics).

General specialization makes it easier for identification and hence support.

May improve image from without, will demoralize from within maybe even splinter.

Same as for other health care groups but not necessarily increase income as noted by MD's.

Enhance credibility.

Increase in depth expertise and enhance credibility in specific areas of nutr./dietetic focus.

Increase knowledge in a specific area.

The same as it had in nursing.

Just that improve credibility. I am responsible for two separate areas of emphasis.

May further divide profession as a negative point. Help identify the profession as a positive point.

More highly trained and knowledgeable professional will improve credibility of the profession.

It is difficult to keep up with everything. It will make us more credible and professional.

Increase credibility; make it difficult for the generalist to have credibility - which may be a problem.

It would provide the impetus for developing specialty education programs which would improve competence of dietetics practitioner. It would provide recognition of these specialists by title or other means after appropriate certification.

Yes

FSSM should be used instead of Administrative Dietetics. Administration is a high level that can relate to any of the above.

Probably to begin with -- it's practical, each reflects broad areas.

NO - too general.

May not be broad enough to identify all types of specializations.

Yes

No because they overlap and many dietitians do two of the 3 -

Yes - delineates major areas of activity with broad enough population to support development of process/procedures

NO - Clinical dietetics too general

NO - not specific enough

Too broad - See II - 3 (NO)

Yes

Yes - see # 3

To start with - subdivisions under each of these is also probably desirable.

To start with in 1978 - now it needs further designation.

NO - too broad, particularly for clinical dietetics. I would prefer narrower categories such as pediatrics, gerontology, critical care.

Yes, but may need subspecialties in clinical dietetics. Leaves out educators of practitioners.

Not defined and refined sufficiently.

Les basis for specialization in community dietetics than in the first two in my opinion.

Yes, may also include in education.

NO - specialties in renal, diabetes, TPN, etc.

Yes, but clinical needs to be broken down into areas.

Yes - Admin. and Comm. clinical needs further breakdown.

Increase visibility	only if some degree of
Increase credibility	expertise required

Will increase recognition and standing along with credibility among other scientific professional societies and the public.

It will help define parts of dietetic practice and help the profession limit the subject matter basis of their practice.

Additional credentials in specialty areas.

More educated in employment area.

Will significantly increase credibility.

Considerable enhancement.

Promote advanced education; encourage indepth preparation; promote commitment to an area of dietetics and -- promotion of self.

Specialization would bring about indepth study, therefore, greater expertise in the art. The resulting impact would be the attraction of those in their professions, the profession of dietetics as well as support of the dietetic profession.

Important in clinical area.

Improve it.

Members could become more qualified and more knowledgeable in a specialization.

Specialization should be recognized as advanced preparation, requiring unique development of expertise. At the same time, generalists should be recognized equally for the integrativeness of their abilities.

Will force need for continuing education through credit and non-credit options.

I think we are seeing specialization occurring right now, in practice. Why not legitimize it.

Increase divisioness (fragmentation) of profession and increase problems of credibility/recognition to public.

Very significant that other health professional and clients recognize that every dietitian cannot assume specialized roles.

May not have that much until concept has been marketed.

The medical practitioners will find us more credible if we have specialties - esp. in the clinical setting.

Recognition of the high level of technical competency required to handle specialized areas of clinical care.

Expert resource persons.

Responses of CUP Directors Concerning Significance
Specialization Will Have on the Profession

Enable competence in a shorter time than previously achievable.

It would make specialists clearly identifiable and increase both their visibility and respect. However, the generalist dietitian would still be most common and in demand.

Increase both

Without specialization, we are not recognized as experts as are other health professionals with specialization. We also need it because our area is too broad to be experts in everything.

Specialties should increase credibility as increase quality of practice will accompany; Development of specialties will provide "ladder" for advancement in the field.

As individuals become more specialized, their knowledge base should have greater depth.

It would make it clear that certain members of the profession have invested the necessary personal and financial resources to be especially qualified in a particular area of practice, not unlike physicians who specialize or not in area of practice.

Much more impact due to greater and more in-depth knowledge (will hopeful application) of a particular field.

I believe specialty board certification will have a significant impact on the credibility of dietetic practitioners.

Provides impetus for additional competency developments as well as targeting market segments.

The dietitian should not be a jack of all trades. It is important to have specialized knowledge and skills in an area or areas.

Specialization should provide the educational background and hands-on skills which will better enable the practitioner to meet the needs of the market place. Wherever those needs are ie, foodservice operations, wellness & fitness centers, HMOS's, Metabolic support teams, etc. In my opinion, one reason we have lost ground in the employment arena is due to the fact we don't have enough specialized ed. Look at Hotel/rest. Mgmt. programs and what they provide. Their grads are replacing R.D.'s in foodservice operations right & left. In Community health programs, health educators & R.N.'s perform tasks which R.D.'s are prepared to do. We have failed to give our students the skills they need to compete. Twenty years ago a generalist could have functioned quite well.

Increase credibility.

Quality of care should improve and therefore credibility increase in some areas, however, what becomes of the generalist dietitian who is equally qualified and may lose credibility.

Aid in making us more credible. People will recognize us as "experts."

It will be significant for recognition of advanced expertise for individuals.

Positive.

Profound if specialists are adequately prepared.

Practitioners will know that they can do well and employers will know what to expect from practitioners. Dietitians should be better fit to jobs they hold - this should sooner or later improve credibility of dietitians.

Impact - R.D.'s with greater knowledge of a small topic. Credibility - increased.

Built on a firm generalist base will increase credibility and prestige as a practitioner.

Increase credibility, especially with other health professionals. Help ensure competent practitioners are available.

Improved practice through expertise.

Specialization should improve the image of the dietitian and increase the credibility of the professional. This assumes that the specialist is "very good" at what he/she does.

Greater respect and visibility. If someone is specialized, they will be more knowledgeable, and opinions will carry more weight.

Should substantially enhance credibility.

Recognition.

May increase recognition in some instances.

Not sure. Designation of specialization, in itself, will not enhance credibility. Increased skill and results of research would result in advancement to positions of greater power and influence, increased salaries, etc. (if accompanied by leadership and interpersonal skills).

Professional training can be planned and implemented at the necessary depth. Employers will have a means to evaluate the competence of an individual to do a specific job.

Unrealistic to expect dietitians to function effectively as a generalist good training but not the way most work effectively. Given the level of care being demanded to justify 3rd party reimbursement you don't have to

"know" diets you need strong pharmacy, counseling and medical skills to understand and contribute to overall patient care plan.

Responses of Internship Directors Concerning Significance
Specialization Will Have on the Profession

Important to employees who can hire for specific specialty and be assured of request knowledge to do the job. Credits practitioner for expertise.

May help weed out those RD's who attempt to work in areas they are not adequately trained for. In this respect I think it will help with our credibility.

Increase credibility by increasing level of practice.

It will put us out of jobs, because we are not effective or defined in any category as a profession. We still can not manage, there are few "pure" educators and good clinicians are hard to find.

Increase our credibility.

Increase credibility, impact on visibility. For those individuals who received specialization status, they will feel greater accountability for their performance.

Education and practice.

Increase credibility.

Positive effect.

Increase credibility and revitalize the profession.

Increases credibility and upgrades the profession.

Food service manager will have greater expertise and greater success in large scale foodservice - also more competitive salaries with men. Clinical dietitian will have greater expertise and greater respect from other medical specialists.

I believe it is impossible for one person to be totally knowledgeable in all areas of dietetics. Specialties would identify a body of knowledge one would be expected to be expert in.

Increase credibility within given areas of practice (i.e. nutr. support, pediatrics, ed.)

I'm not completely sure but I think would add credit to professional as well as make individual dietitians better at what they do.

N/A - based on

Prepare the professional before assuming a specialty position

Could impact, particularly in Acute-care setting closely involved in DRG's funding.

Tremendous

Clearer definition of specialties to follow professionals, other health professionals, and public. Better capacity to set professional goals.

Limit ability to change direction, ie. move from clinical to administrative.

Little impact. It will have a splintering effect. The association is not large enough to have specialty groups, ie, pediatric nutrition, also, majority of jobs require a person with a generalist background with a clinical or Management emphasis.

Just as physicians have specialties and are able to develop in expertise in an area. I believe dietitians should be able to. In this way the "specialty R.D." can become more efficient and effective in his/her area.

Focus on more indepth knowledge and skills for each area.

Enable us to function in areas where we are best prepared assuming that hiring practices are geared toward same.

There are too many generalists who know in little bit about everything. With specialization, expertise would improve in specific areas - more experts to call upon.

Great significance - must be experts in an area to be credible - as generalists, we're spread too thin.

Credibility - should help public and employers be able to identify exactly the area of expertise.

Impact on profession - will need much organization and require significant change for all concerned. I can see many people being threatened by this so there is more than just identifying "specialists." Also - does this foretell the ending of the "generalist" R.D.?

Should improve.

Certify competence of practitioners.

Believe credibility will be impacted upon favorably.

Quality assurance for advanced levels of practice.

Better skilled dietitian.

Depends on how we do this.

It will be harder to switch between one area and another. It may slightly help credibility if assure RD's in a certain area have minimum qualifications.

Give credentials to people who want to specialize.

Limiting job opportunities but having better practitioners when hired.

Significant, only in large medical centers.

Recognized credentials impacts greatly on 3rd party reimbursement and consultation.

Because specialists will be prepared with advanced education and practice, they will be knowledgeable and able to contribute significantly to the team with which they are working.

Improve recognition and status of practitioners.

Increase credibility in areas requiring more intensive care or therapy.

It will help improve image; areas allow people to be more knowledgeable in specific areas.

Specialization with proper credential should increase the profile of the individual. It should signify that additional study, testing etc. has been obtained.

I think it will enhance the credibility as it has in the medical profession.

If certification of specialization is undertaken credibility will be realized by other professionals.

Improved.

Lessen impact as become more fragmented but certain groups may have more impact.

If those who are specialists

Can only improve credibility among other health professions. However, specialization may not be appropriate for professionals working in rural areas where generalists are in the most demand.

More opportunity for productivity and funding.

None really - I'm not sure anyone outside the field will care.

Increase credibility.

1) Legislation; 2) Recognition; 3) Knowledge base. (Everyone cannot be a generalist and a specialist "By experience.")

As specialization most appropriately goes hand-in-hand with licensure. I think it will have a positive effect on quality of practice; if done right it should enhance awareness of RD as the nutrition expert to public audience.

Responses of Practice Group Members Concerning Significance
Specialization Will Have on the Profession

I believe specialization could enhance credibility with team members in the health care profession. The trend in health care is toward specialization and I believe R.D.'s better relate to other professions (I do think that specialization should happen only at the MS level.)

Specialization will confine the dietitian in seeking employment. It would enhance the credibility of the specialized dietitian, but the decision for what specialty to enter would need to be made before really knowing whether he/she will enjoy it.

Significant impact.

The current DRG's may not support specialization - depends on the type of hospital, I believe.

More recognition for the profession - (badly needed).

Should enhance certain fields and aid employers in selection process for competitive positions.

Will make the dietitian more credible in their particular area. I.e. Management dietitian vs Foodservice Manager. It will segregate dietitians.

Specialization will allow individuals to concentrate on specific areas of dietetics & Employers will more easily be able to identify individuals with expertise in specific areas of nutrition care.

Recognition of specialists in given areas similar to that of Doctors.

It will allow the dietitian to become more knowledgeable in certain fields rather than a general knowledge in many fields.

Clinical - possibly none; Management - More credibility among peers.

Little - except in Critical Care.

Could increase salaries of very technical areas (Renal, TPN, etc.). Would not help my area as we must remain active in several roles (Manager, clinician, administrator, etc.) Companies in long-term care are getting individual and hospitals and home health, which increase area need to keep up with aspects of community dietetics as well.

Key to credibility is specialization.

It will increase credibility as only individuals with true expertise will be identified as certified specialists while others may work in specialization areas without being considered the "expert" when they may be in first time position.

You could keep up with the wealth of knowledge - I'm not sure there are enough positions to support the specialization.

Any further definitions will have impact.

Increase prestige for the profession.

Higher utilization of the talents and training of dietitians who are now actually capable of and in many instances implementing very specialized nutritional care.

It will also open up a channel for people now as in the near future who would like the challenge of a specialty.

It will allow one to exemplify an expert body of knowledge in a specified area of dietetics.

More specialized areas particularly in clinical field, should result better services, knowledge.

I don't know.

As with the nursing profession it would identify the expertise and concentration of knowledge toward a specific area of health care. The public physicians and other professions would acknowledge that expertise more readily.

It will provide documentation of specialized areas of expertise.

Increased competencies of dietitians.

Very significant - important in educational circles, research, to be a part of medical team in a specialty area - in larger medical centers.

I think that you need dietitians that are "generalists," but also ones who are specialized and handle large numbers of people needing help on a certain nutrition topic (ie. in large metropolitan areas). Specialization helps keep you current in one particular area.

It would place more demands on the profession and perhaps more recognition.

It would lend considerable credibility to third party reimbursement.

It will allow dietitians to become proficient in specific areas rather than all - a misconception that we know all aspects of foodservice - management and clinically.

Improved.

Planned studies to obtain specialization is recognized by other professions, and I feel it would help our profession.

Will allow dietitians to become "experts" in a particular area which should increase credibility and visibility and decrease chances of advancement by other professions.

I feel that specialization will benefit the individual who chooses to specialize - but this fact alone will not change the image of profession. Those people listed on pg 1053 3rd P from Bottom exert a major force in their doing "nothing." Other professional groups of "predominately female" don't accept secondary roles, ie. Educators, nurses, growing numbers of women in business, media ie TV.

It will increase the knowledge of one area rather than just knowing a little about all area.

Positive impact - So much new information is available that one person cannot retain it all. It will aid in our being recognized as a profession by other medical areas and help in 3rd party payment.

Quality of care will be improved.

Dietitians will be more confident of their skills.

Specialization will identify those "experts" in various clinical fields to be resources for other health care professionals (ex. Urologist use a renal dietitian).

I feel "specialization" will limit job opportunities for dietitians. I believe that most dietitians are so well educated that they can move to different specializations by study on their own. A resume of experience should be as good as a "specialization" credential to an employer.

Survival.

Credibility will depend more on the individuals recognizing their own worth and ability to contribute to society. I believe that focus on the image (self & collective) is more important than specialization at this time.

I feel it will greatly improve the credibility of dietitians if not taken to an extreme. Other health professionals can truly consider dietitians experts in certain areas.

There could be more specialized training resulting in greater expertise. However, specialization should be optional.

Should enhance credibility.

Each area could get specific information and have concepts discussed with their own peers instead of having a mish-mash of things offered.

Those of us in business and industry are so far removed from the tunnel vision of dietitians in therapeutics and certainly not really recognized when it comes to planning continuing education hours. We are treated as step-children. Believe me there is more to life than diabetes education.

Malse lack until stronger.

Responses of Advanced Degree Directors Concerning
the Areas of Specialization Recommended by The Ad
Hod Committee on Specialty Board Certification

Community dietetics - No

Yes

Reasonable as a start; more specific specialties are likely to emerge;
e.g. pediatric nutrition, renal nutrition, etc.

Yes - a good first step - unless more specific areas can be identified
early, eg. renal, nutrition support, etc.

No. Too broad.

Not sure.

Yes - it seems to be the three major thrusts.

Yes

This seems to be a logical designation some might see it as clinical and
admin.

It's not bad for start. I can image subspecialties being re-defined in
the future.

NO - does not relate to life cycle or people.

Yes I do.

except include specialists in dietetic education in the initial groups--
perhaps initially (& perhaps long term as excessive specialization can
fragment the profession w/out serving a useful purpose. Perhaps further
specialization should be considered later).

I am not sure. I am confused.

Under each of these headings further specialization is required such as
renal, oncology, etc.

Yes, the majority of Dietitians are employed in one of those 3 areas.

Yes

This seems reasonable as it would allow one to specialize within each
area.

Yes

Too Broad - specialty areas should be more specific i.e. renal or
diabetes or oncology.

Yes. This is essentially my response to item # 3.

NO - Role delineations can serve as a guide but there is little difference between clin. and Comm. For example, where does nursing home nutr. care fit? Suggest Primary care vs Acute or critical care and Administration as the areas of specialization. Get some people certified in prevention & rehabilitation.

What will be done with administrators of clinical and community programs?

Yes, but these could have divisions within each area.

Yes

Yes, these are main areas for specialization.

Yes; for a beginning. Growth may lead to subspecialties.

Yes

I think renal dietetic represents a viable sub-specialty.

The Why Not -- Education of professional is not included. Also the 3 listed categories are an antiquated categorization of the dietetic profession.

No. Clinical dietetics has much too broad a scope. At the minimum we should recognize pediatric vs adult and specialized clinical support.

May wish to have more -- looking at Dietetics only from hospital-nutrition aspect.

Yes, although the categories are broad, ie. does not include educators.

Yes, but clinical could be further specialized.

Yes.

Yes

Responses of CUP Directors Concerning the Areas of
Specialization Recommended by the Ad Hoc
Committee on Specialty Board
Certification

see 3

Logical, but need to go further - still too broad.

No - these are too broad, particularly in clinic.

No - Too general - and they overlap.

There needs to be a generalist specialist in these 3 areas but it is not possible to be a specialist in all of clinical or administrative dietetics. The knowledge base is overwhelming broad.

Not specific enough; especially within clinical there are several potential specialty areas.

Areas of practice can be categorized under these headings. Yes

This is a logical beginning - I think there is a need for some subspecialties in clinical dietetics.

I would add 2 more - consulting in each of these areas and generalist.

Am not sure. Would need to investigate less broad classifications as a possibility.

Yes, it's at least a place to start and is based on current definitions.

Yes, with some finer lines drawn in the clinical area.

Yes. Basically, these three areas cover the gamut of employment opportunities for R.D.'s as they exist today.

Yes, with breakdown of clinical, and adding education. I think #3 is pertinent.

Yes because few positions encompass each area - may have some combined clin/admin positions.

No. Need to be more specific.

Yes - all areas of dietetics would fall in one of these three.

Clinical and community should be broken down into specific categories.

Yes, even though I will be glad when we can progress to even more specific areas such as renal, TPN.

NO - too broad

No - not specific enough.

No. Other health professional (when they ask what a clinical dietitian is), for example, consider a clinical dietitian to be a generalist. To be a specialist, the clinical dtn. or comm. dietitian must specialize in a more narrow area of health care.

No specialties within clinical are even more defined: renal, pediatrics, oncology (maybe could be subspecialties).

NO. - all are too broad for specialization.

Yes, although education of practitioners doesn't necessarily fit into the structure. Designation generally fits the different job types.

Seems appropriate though I definitely see subspecialties in clinical.

OK but somewhat broad. It doesn't differ, with the exception that the generalist is not mentioned, from what we have had for many years.

These are acceptable but I can identify sub-special group under clinical.

These are very broad. When I think of specialization I think of them within Clinical, Administration and Community.

No, too broad.

Yes, but need further specialization in clinical dietetics.

Yes. - Main areas of emphases for educational programs. If too divided; too hard to coordinate.

Not sure. Trends in health care suggest less of a division between clinical and community. Is it, perhaps, critical care, and care of the chronically ill/near-well (with more emphasis on biochemistry/physiology/medicine in critical care and emphasis on major public health problems/prevention and communication in the second case)?

There should also be public health, nutrition educator (dietetic education)?

No. - see Advance she

Good start - but not enough.

Responses of Internship Directors Concerning the Areas of
Specialization Recommended by the Ad Hoc Committee on
Specialty Board Certification

Education? Practice areas in clinical.

No, it should be divided further, as some of the specialty require expertise in the field.

Need only magt and clinical.

No - they require a knowledge of food and you should be able to manage in all capacities.

Yes - it is what most people are comfortable with.

No. The major area excluded is education. The problem of dividing community and clinical dietetics is that the two areas are merging together with changes in current health care delivery systems and only the location of practice is likely to be the distinguishing difference between the two.

No. In some areas, dietitians practice on administrative clinical and community. Specialty educator belong to nowhere.

Yes to start with.

NO -- too general. "Specialty" by its very definition implies specificity.

Yes with sub-specialties as an option, ie clinical with cardiac sub-specialties.

NO. Add nutrition education for wellness. Under each heading, specialists are needed. A specialist in diabetes might not qualify as a renal dietitian.

Yes

No - There should be more specific areas with respect to administration and clinical dietetics.

NO - Too broad and non-specific.

We need general one and education one -- but also need subspecialties for clinical.

Yes, but it omits "educator," and "basic research."

No see # 3

I think research also needs to be included.

No argument, see answer before. Feel educators need own classif. because they overlap and may have higher requirements to practice.

Yes, Clinical dietetics more specific -- pediatrics, renal, acute care, etc. Areas need to be defined.

No -- where does this place the consulting dietitian who does both management and clinical.

Yes

Yes, however I feel they need to be broken down further within each group.

Yes. The areas correlated with employment possibilities. Similar knowledge and practice. Suggest add education as a fourth specialty.

Clinical dietetics is too broad. No. Also what about those persons teaching dietetics?

Seems too broad.

Yes, but each should be subdivided further to identify more specifically the areas.

No -- these are the three main areas of practice -- Specialization occurs within these areas of practice. Community may be the one area of exception due to its unique make-up.

No -- I think this is an entry-level division of practice that should exist but it doesn't relate to what "specialization" should be.

Yes

NO -- Too general

Yes -- this is exactly what our program is.

I suppose but there are other areas.

Yes but possibly need clinical subspecialties.

Yes

Yes

Yes

Yes -- at this time.

As a beginning point - yes. Further delineation will be required or other organizations and professions will take over the recognition and power for us. This is happening already.

I feel that dietetic education should also be included.

No -- These are areas of practice, not specialties.

Leaves out those involved in education as well as being too broad in clinical.

I think research should be added as well as education.

I feel this is too broad.

Yes, with subspecialties under clinical. See Question #3.

No. Clinical dietetics needs to be further specialized, i.e., renal, cardiac, sports, etc. Also education considering it is the basis for all professional endeavors.

No. Where does the educator fit?

Yes. I believe this is a start.

Yes, overspecialization would limit employment opportunities.

NO -- The generalist should be considered as an area also as well as education.

Think these are too broad -- need to further subdivide.

See question #3

No -- what happens to educators?

A good start.

Yes -- for a start. I think a start would be an advanced degree or three years experience in one of these areas. We must begin somewhere.

I think something like "generalist" is needed. Also clinical/research seems more appropriate.

No. Should include education & be delineated according to Dietetic Practice Groups (DGP's) eg. Dietitians in Medicine & Dental Education, EDP, etc.

Yes/no - clinical needs to have sub-groups.

Responses of Practice Group Members Concerning the Areas of
Specialization Recommended by the Ad Hoc Committee on
Specialty Board Certification

No, again believe they should be more defined to include Board Specialties recognized by AMA.

Yes, if it is broken down any further, it will be much too confining.

Yes. Generally, these areas cover dietetics.

I think administrative and clinical are sufficient. There could be sub-specialist under one of these.

No - outside of a hospital setting, there is too much overlap of duties. The dietitian usually is the single professional on staff and, therefore, must function in all areas of dietetics.

No - I feel it should follow practice groups to cover all areas more thoroughly.

I prefer the terms I used on 3. Each area should have more clearly defined subspecialties.

To begin with but they may need to be broken down further in the future.

I think this is excellent - there have been too many different specializations.

Yes - General enough to accommodate most. I am not in favor of narrow categories.

One can be all 3 in certain situations - you are "boxing in" the dietitian! Warning - not M.D. difficulties today!

For a start on - this is best. I feel it is more appropriate for hospital acute setting, where dietitians are totally in a technical area (Renal, burns, etc.)

Long-term care is a mix of administrative/clinical and should be added as 4th area of specialization.

Yes - these encompass the major areas of study within the profession. To break into smaller areas would fragment the profession.

It is logical - may need to add research.

Yes. The decision is already there. Why change?

Yes - all areas of the profession fall under one of these designations.

No, I feel in this age that these categories are too broad. There should be more highly defined areas.

No, there are broad categories within those specialties.

Yes.

Yes although more specialization in clinical fields are and should continue.

A R.D. in general practice cannot separate these three areas. As a single R.D. (only one) in this corporation it is necessary to have knowledge in all areas - we will soon be including Home Health Care which will include Nutrition services - time and hours don't extend that far!

Limited too much to practice in med/surg hospitals only. Needs to inc. L.T.C. facilities, ambulatory care, specialize hospital and facilities.

Yes but feel that there is specialization in clinical dietetics that can be further defined.

Broad Yes - but I think there is room for specialty within each grouping.

Yes. There are major areas. However, specialization, I feel, could be achieved in a subgroup of these 3 areas (i.e. renal dietetics).

Yes, however, there could be more categories within each major area.

No - clinical Dietetics needs to be more defined. See #3.

No. In my current position I am involved in both admin. and clinical responsibilities.

Yes, for status.

Yes - it could include research specialist and business. However, I feel the areas need to be broad and not too specialized.

Yes. These categories accurately describe current areas of practice. I don't see these categories changing in the foreseeable future.

Yes.

Yes.

Yes.

Community dietetics should be under clinical dietetics.

Yes, because these are the major areas of employment.

Yes, with possible specializations within clinical. Why? Because these seem to be the logical delineations within dietetics.

I don't believe in specialization.

Yes - place to start.

No. Clinical and community dietetics, I think are moving closer and closer as time goes on. "Research" or "Teaching" (advanced level) may be a better 3rd category.

Yes, if done at the undergraduate level. Further more limited specialization should come at the graduate level.

Yes

Yes

This is still too broad to me, I think it needs a little more specific names but not carried to extremes.

No. See last page.

Again...where is the room to grow for DIBI - surely not administrative dietetics. Again...tunnel vision. Just remember, those of us who are the "step children" of this profession work shorter hours, make more money so that helps soften the blow of being shunted aside.

Clinical and Community
Administration and Community

I think education should also be provided with

Responses of Advanced Degree Directors Concerning the
Relationship Between Dietetic Practice Groups and
Areas of Specialization

Clinical - the communication between the clinical dietitian and the medical profession should be on an equal give and take basis. The dietitian should not feel inadequately trained to the physicians.

PGs responsible for helping set criteria for specialty.

Not sure.

DPG's should take the leadership role in their development with some guidance and coordination from CUP and the HOD.

Integrate

PGs should challenge specialization but should not be limiting on membership.

End PG

There needs to be a common base of some sort.

To start with yes.

None

Related.

DPG's should be involved in establishing and reviewing standards for specialties.

Specialization needs to be defined for proper answer to this question.

PG's should represent the areas of specialization and help with the continuing education.

PGs could function as the sub-groups of the 3 major areas of specialization.

They should be closely related.

It appears that PGs could provide sound information about expectations. Educators must form a part of the board that delineates criteria.

PG should participate in developing criteria and meeting educational needs of specialists but should not be a directly correlated unit. For example a specialty could exist without a PG.

There should be PGs for specialization.

None. Perhaps advisory or consultant relationship.

The former have groups like Topsy, the ones in existence can be used to suggest areas of specialization, but not to determine them. I think that justification of some of DPG's will be needed soon.

I think once specialization is defined and the specialties identified, there may be some reorganization of PGs.

Difficult to answer.

unsure.

Equal partners.

As component of ADA set standards.

PGs could define specialty areas and help set standards.

Sources of information related to specialization.

Legislative.

I don't really know.

PGs should exist for each specialization.

PGs are broad interest groups - specialization implies a credentialing process, thus one could join any PG and not be a specialist.

No ideas.

PGs need to be related to specialty. Specialty could be in several PGs.

Specialists may come from out of PGs if they meet identified, qualifying criteria, but should be no blanket, direct relationship but, DPG & Spec., involves the EOG in the future bases membership on meeting specified criteria.

Be content support groups to areas of specialization and a way to disseminate information.

Consistent groupings.

Advise members of current findings or innovations.

PGs should be "interest groups" one should not have to be a specialist in that area to be a member of one.

None

That PGs serve as the liaison for areas of specialization.

Support groups.

PGs should be subgroups for three majors areas.

PGs could serve as the administrative framework or structure for special areas.

Direct relationship.

Coordination, communication and perhaps ID to the criterion. But at present there are way too many PGs compared to the number of specializations I would anticipate.

I would presume the former would evolve into the latter.

Should have similar basic background structure.

Areas of specialization should be closely governed by the ADA.

Yes

Responses of CUP Directors Concerning the Relationship
Between Dietetic Practice Groups and Areas of
Specialization

Close partnership if not identical

I see areas of specialization as more encompassing and that there might be a number of practice groups within an area of specialization.

Should be close. PG should provide direction in defining and monitoring the specialty, but should be open to non-specialist as well as specialist.

I can visualize some practice groups for areas that are not a unique specialty. PGs could be similar to an "interest group" but should not have to be certified or licensed in that area.

Not sure.

PGs have developed to meet the needs of specialists and they should continue to do this. They are therefore permanently interrelated.

PGs could be source of standards for individual specialties.

PGs should be identified under specific areas of specialization.

Areas of specialization could encompass several PGs. A given practitioner (with one or more specialties) might be a member of more than one PG.

PGs should assist in setting and maintaining the standard of practice for a specialization and provide educational programs to keep specialists updated in recent trends, issues and practices. A supportive mechanism.

None

Serve as networks which include meetings and publications to share knowledge.

Coincide with the areas of specialization.

PGs should assume responsibility for identifying the common (or unique) knowledge base and skills which one germane to their area of practice or work.

PGs are not to fragmented to be completely responsible for each specialty area. They should act in advisory capacity for the Council of Practice Divisions.

PG should help identify specialties needed and set standards and perhaps competencies for education.

Not sure

None, they would be serving two different purposes.

PGs should be designated for each area of specialization.

Supportive - not directive.

I don't know.

PGs can be vital organization base for each specialization.

? ? not sure what you want

I don't know. I can't believe like people should always congregate with other like people.

Initially could help identify needed skills & knowledge for specialization and design or identify training. Later, specialists could/should join groups. Provide continuing education.

PGs may provide a forum as a support group for those engaged in a specialty.

They should be closely related. The PG might include several areas of specialization. Ex: A PG called Dietitians in metabolic diseases might include diabetes and renal specialists.

If a PG is made up of specialists, they could be one and same but not necessarily true.

PGs should help establish qualifications and credentialing of specialists.

In many instances could be the same, although there are more PGs than needed specialties.

Assist in development of criteria and competency statements.

Sub-sections of specialty areas.

PGs should generate the education standards, competencies, role delineation, & routes to specialization.

PGs should help to identify possible areas of specialization & criteria for obtaining specialization in those areas. We do not need as many areas of specialization as we have PGs.

Gatekeeper of specialty credentials or have major impact on credentially body.

Responses of Internship Directors Concerning the Relationship
Between Dietetic Practice Groups and Areas
of Specialization

PGs should be used to ID areas of specialization needed - give input into criteria to be used, etc.

None

The same - we should work on our quality of practice and not allow people to come into a field that were not BS MS and Internship graduates.

Very close relationship - they should have a lot of input into defining and governing specialization

Areas of specializations should be very closely aligned with practice groups - not that the practice groups have to exist as they now do.

PGs and areas of specialization should be the same.

Dietitians in specialized areas may choose to be members of certain PG but should not be required to.

Voluntary membership only.

I see the two as evolving as one and the same.

Not sure.

I believe PGs could help to establish the standards for the specialized areas.

The practice group should be the support of those in that specialty.

Close - PGs could develop appropriate standards of care for group; qualifications, etc.

Should work together towards common goal.

The same at least for active members.

As it is now - a common interest bond or association.

None

PGs should be involved in setting Standards of Practice and continuing education programs.

In the future, PGs would set credentialing standards for subspecialties.

Similar to that between National Kidney Foundation's Council on Renal Nutrition and renal dietitians.

PGs are the support and communication mechanisms between professionals practicing in similar areas.

None - We have too many PGs

I believe they should be intimately related. This would help strengthen the abilities of the different areas of the country to strive for common goals and share research.

PGs should be formed for each area of "acceptable" specialization.

Not sure.

Should be a PG for each area of specialization. A practice group should consist of those persons working in same specialty area.

PGs would have specialists as its members.

One does not necessarily lead to the other (both directions). I don't have a feeling for what should be at this point since specialization has not been thoroughly defined.

PGs support - present systems seems adequate.

They should be closely related - The PG should be involved in devising standards and certifying specialist.

Concomitant: first specialization then restructure DPG's

? Do not know how to answer.

PGs can help supply information in specific area hopefully increasing knowledge - specialization is the knowledge and application that comes from actual experience. One can aid the other but the actual doing is what is the most effective.

People who consider themselves in a specialization should join PGs to help further that area.

PG's set standards.

PG's should take the initiative in delineating guidelines.

PG's should establish the criteria approved knowledge base or core experiences, and certification process guidelines.

It would seem that there should be a very close relationship between these two.

DPG's help identify competencies and standards of practice.

Provide support thru keeping specialized dietitians up to date, educational opportunities, job listing.

PGs should be limited in number to meet specialties. There are too many PGs with too much duplication.

Ideally I feel to belong to a PG an individual be credentialed in that area of specialization.

PGs should relate to the area of specialization; i.e., Dietetic Educators of Practitioners should relate to educators. I feel specialists should be a member of that PG representing that specialization.

Strong relationship.

PGs should regulate their specific area of expertise.

Close relationship with appropriate groups.

PGs should determine the standards of practices and Quality Assurance standards for the area of specialization.

PG should have major vote in determining criteria for stds of practice for specialty area and have major impact on qualifying exam.

No formal relationship -- any interested person (R.D.) should be allowed to join a PG.

Specialists might choose to belong to a PG.

Assist in defining education requirements, criteria for specialty.

None. At this point I strongly oppose the PG concept for educators.

PG's should be the major provider of input to specialization/

The DPG's accurately summarize areas of specialization.

DPG should be used to identify areas of specialization needed - give input into criteria to be used etc.

Responses of Practice Group Members Concerning the
Relationship Between Dietetic Practice Groups
and Areas of Specialization

Don't think practice groups are that successful but could coordinate areas and people within.

Teach each other, learn from each other. Do more than teach diet therapy in continuing education.

Should be the same.

They should be one in the same.

Close relationship.

The practice groups could become like the colleges of the American Medical Association and regulate standards.

Practice groups should be available in the various areas of formal specialization for continuing education/communication purposes.

Coordinate information to keep individuals current in their area. I would also like to see communication and cooperation between practice groups to share information.

Parallel.

Direct, hopefully the specialist will be a member of that group.

Obviously already in existence with the specialists developing a unified goal.

The practice group should be the specialization's professional organization for continued education, etc.

Should be in close contact; similar goals.

They could be the same.

Provide continuing education. Provide resource information center for specialty.

I feel if you claim to be specialized you should belong to that Practice Group. I do not feel that to be in a P.G. you must be specialized. The generalist could use the P.G. as a resource.

No opinion.

These could compliment one another. The practice groups could become specialty units with members as fellows in that specialty.

Practice group should support special areas; be main liaison with ADA.

Congruent.

Direct relationship.

Supportive - training and up-dating info.

Specialist groups should support the practice group of their specific area.

As determined by individual members, some individuals will always be interested in other areas of the profession.

Practice groups should be basis for specialization.

Should help identify standards of practice, provide current state of the art information and provide communication link to "coordinating cabinet".

Practice groups would be a source of specified information to all interested or qualified persons. In essence the practice group could provide standards of care and "hands-on" information and serve as resource center-direct to member.

A group to assist in reference, put available materials together, a source of information to contact or contribute.

They should interface.

They should be aligned to meet the needs of the specialization. It seems obvious to me that the dietitians presently in the practice groups are doing a limited amount of specialization already.

Practice groups would operate under the overall area of specialization. Ex. Renal, Enteral, Diabetes etc. under Clinical Dietetics.

I do not know.

They should establish criteria for the areas of specialization and identify the academic, continuing education and/or experience components of the ladder to becoming a specialist.

Practice groups should reinforce area of specialization.

Perhaps these groups should do the credentialing of the special areas.

Required association for exchange of information.

More general than it is now.

Practice groups could pull together area of spec. which work together or might overlap.

Practice groups should help to establish guidelines and criteria for specialization.

If they were the same areas they would act as guides and educators to those in that specialization.

Working - Specialists should belong to practice group.

??? I think practice groups dilute the organization.

I can't believe that a practice group could be anything but an area of specialization.

Direct.

Practice groups could be the policy making group for the specialty.

No opinion.

Responses of Advanced Degree Directors Concerning
Whether or Not a "Generalist" is in
Specialized Practice

I think so!?

Unsure.

A generalist needs to be able to function some in all areas but doesn't have to specialize.

Yes, to an extent. Dietitians who must function as a generalist are in a specialized situation.

Uncertain.

No

Very difficult to define. But very possible (like Family Practice M.D.)

No - the areas of specialization have become too sophisticated.

No, but dietetics is a specialized profession in itself.

Not really - but it is a good place for an entry level person to start, with direction.

No

No

No at entry level, but a competent experienced generalist could be analogous to physicians in family practice, which is considered a specialty.

No. I believe in a generalist emphasis at the undergraduate level with specialist designation by subsequent education and experience.

In small hospitals generalists are still needed and the other areas of specialization aren't required. However, they need to keep up with what's happening in the field to do an effective, efficient job.

Yes, especially those in small hospitals or nursing homes.

Generally no.

Many area. I hope those who lead in specialized practice have received additional education.

Yes - interest and experience can bring specialization, completing plan IV program for clinical, community, or administration.

Too broad responsibilities to be specialist in any one.

NO

No, too broad with too many duties and a broad range.

Not at entry level. High level administration could be general specialist practice.

NO - unless and until one can define particular skills as for the M.D. who is a specialist in family practice.

NO - entry level.

NO - shoulve have basic knowledge - the specialist would build on basic knowledge.

NO - they may start as generalist but the on-the-job experiences and usually self selected continuing education go toward developing a specialty.

NO - a generalist is jack of all trades, master of nones.

Better find another name. Is as important re criteria of advancement and ability.

No - covers entire area.

NO, generalist by definition needs to know a little about many areas, no depth.

No -

No, not yet, timing wrong.

NO

Yes - needs to be kept up to date in all areas.

No because generalist does not necessarily have advanced learning in any area of dietetics.

Question is unclear.

NO - but I think a generalist needs education and experience beyond the entry level preparation.

Not sure. it seems important that dietitians practicing in small hospitals where they do everything should have the opportunity to have their skills through advanced study.

Could be if for ex. a generalist in nutrition handled all modified diets. But not only dietitian in hospital.

No. Definition of a generalist is a non-specialist. Could a person function this way also.

Yes.

NO - includes all areas. Too broad-based.

No, a generalist has no specialized training.

No

Yes - if the generalist is qualified sufficiently to practice in the specialized area; however, the reverse is not true generally (i.e. a specialist is not necessarily qualified to practice as a generalist).

NO - all dietitians are generalists - as it should be at the entry-level B.S. education.

In special interest, not in specialized practice.

Yes, as in medicine the patient often is best served by a generalist.

Yes - must have broad range of knowledge; usually specialized knowledge due to size of operation.

No, a generalist would be useful until a specialization was chosen.

Yes! Too many institutions in non-metropolitan areas need the generalist.

No - too broad to function effectively. I do feel it should be the basis for all practitioner education - you need the "Big Picture" and vocabulary.

No. A generalist cannot be informed, knowledgeable and trained in ALL facets of the profession.

Yes - needs breadth which in itself is a demanding specialty area.

Yes, there is a need for the Generalist, too, esp. in education - teaching.

ABSOLUTELY YES! The one or two dietitian hospital could not exist without the generalist.

NO. I believe entry level is still generalist, and advanced experience and knowledge lead to specialty.

Could be recognized just as a general practitioner in medicine is.

Yes. Maybe the name is the problem; the generalist educator is actually the most highly specialized of all--has to know (in order to teach) something about all other areas.

Yes, same as a General Practitioner medical doctor. Most small hospitals will need generalists.

Yes, a generalist must be competent in all areas of clinical nutrition and FSM; certainly a difficult task.

No

No. This is a practical area. . .very much needed.

Responses of CUP Directors Concerning Whether or Not
a "Generalist" is in Specialized Practice

No. Generalists use several specialty techniques concurrently which generally do not allow for depth in understanding and practice.

Yes, just as a family practice physician is needed in some areas, a general and clinical dietitian is needed.

NO - unless we developed something like family practice in medicine or possibly dietetics management (not just food services).

No

Not if working in general area, or if position entails tasks in more than a special area.

Yes - (see Family Practice concepts) Small organizations needs generalists and educators in small schools often need to be generalists, at least generalists in clinical or food service administration.

Yes - requires maintenance of competence in variety of areas, but not some specialties . . . someone who can handle a variety of "common" problems.

Yes

Yes & No. A doctor who is a general practitioner is not a specialist, yet he is in family medicine - A generalist is a special "breed" who needs to work with specialists and has unique qualifications of her/his own.

Yes - due to fact that the generalist may be the only dietitian in a particular facility. This specialization should consist of basic graduate courses in the other specializations.

No - A specialized practice implies in-depth knowledge and practice in one specific area.

No, it's an obvious contradiction in terms.

Possibly, such as a small hospital setting or nursing home.

No.

Yes - she has a broad knowledge of several areas - such as in medicine with a specialty of "Family Practice."

No because they do not have in-depth experience in working with many patients - disease states.

No. Does not have in-depth training and experience.

Yes -

No, this is good for undergraduate but the knowledge base required is too large for specialization.

NO - Term itself indicates lack of specialization.

NO. The generalist is a title used in dietetics differently than in other health professions. In other hospitals, a generalist deals with care for patients in varied states of health. The specialist cares for patients in more specific area (neuro, etc.).

NO - if one has broad training he/she begins as a generalist; thus it is the foundation for specialties.

No - The generalist contains the broad base to function across the practice in the majority of areas which require a dietitian.

Yes - Like Family Practice MD's; but I have mixed feelings.

No - by definition.

Yes - There is an area of dietetics that will "fall through the cracks" if we have no generalists.

No because a generalist knows a little about all areas.

We have so many hospitals with less than 75 beds which needs a generalist - but I don't consider the practice specialized.

No. Although generalists are needed very much they cannot have the depth of knowledge that specialists should have.

Yes - Requires skills from all areas. Probably the most difficult if good.

Depends on how one defines "generalist." To me, the generalist is the dietitian who provides care for the chronically ill and near-well, with greater emphasis on patient/client-practitioner interaction than on food service.

No - not enough depth in any one area.

No. A true generalist has a broad background - a little knowledge about more things. There are rules that are called "generalist" that require advanced knowledge and skills. These probably need to be renamed.

No - too broad to function effectively. I do feel it should be the basis for all practitioner education - they need the "Big Picture" and vocabulary.

Responses of Internship Directors Concerning Whether
or Not a "Generalist" is in Specialized Practice

Yes, in some rural area, generalist can serve the purpose to meet the community need.

NO - Have not developed increased level of knowledge in special area.

Yes - at least they know food which is nutrition and something about managing.

No - they just usually meet entry level knowledge and should not be specialists.

If a generalist is one who is not a beginner with a broad base of educational preparation, but rather one who has achieved in-depth competencies in practice in several specialized areas. No, if this is a description of a dietitian who has an undergraduate level academic preparation which is broadly based and who has not achieved higher than entry level roles in both food service management and clinical dietetics.

Unsure.

Depends on the generalist's background - work experience and education.

NO

In a broad sense, yes. Similar to a "family practitioner" in medicine.

Yes, the generalist in dietetics is similar to the family practitioner in medicine. A specialized course of study with standards of practice can be planned as easily as any other area.

Yes, a generalist can become specialized if that is one's preference.

No. Not at this point because of the broad knowledge base and ability to move into different specialty areas with added practice.

Yes & No - A generalist may have a practice which requires a specialist's expertise in general areas i.e. - generalist clinical R.D. with renal patients and nutrition support duties.

Yes - I suppose if a person preferred work in an area that included several of the terms mentioned in #3, a generalist could be the specialty area.

If there's specialization - why not a generalist?

There is a place for the generalist and needs to be given the credit.

Usually, yes. To me, generalist refers to training, specialization to practice and advanced education.

NO

Yes, a generalist has to have a working knowledge of many areas.

No

No. A generalist is not specialized. They fall into two categories: entry-level, 2) top, top positions (chiefs, etc. or Education Department Chairs) and specialty can be selected from those listed previous page)

No, a specialist would have advanced education in a given area, develop expertise (not possible with gen.).

No. They have to be competent in management and clinical.

No. It's very difficult to keep abreast of all the current information in the field of dietetics and to specialize in all of them.

No, knowledge and experiences are too broad.

Yes, these persons will have developed advanced skills that no other group will have yet able to perform in either area but at a specific level.

No. No one is a specialist in everything.

Yes/no - could compare to family practice of M.D. need for generalist in small facilities - become expert at both Food Service Systems Management and clinical.

? definition of generalist -- The crux of the problem. If clinical is a specialization on the Master's level Generalists would be specialists on the Ph.D. level - Requires high integrative capability and subject areas are simply too vast and varied.

No

NO

No -- It's for entry level practice.

Yes, because they need a wide variety of skills and knowledge.

Yes One certainly gains more understanding and ability if one continues to practice in this area and has a broader perspective of the profession as a whole.

A generalist often must (should) know the basics of all specialties.

Yes

No - for the reason the name describes.

Yes, the profession of Dietetics prepares you enough plus inservice trainings and self-study will help keep you up to date.

Not at this time.

Could be. I would suggest using nursing or other allied health prof. as models. Nursing has def. levels of R.N. certification along with board certified specialties.

A well prepared generalist is, indeed a specialist. Just as the medical profession now recognizes family practice as a specialized residency, so we need to look upon the generalist dietitian as one who has specialized knowledge and experience.

No - How can a generalist be a specialist?? Look up the definitions --

No--dietetics is becoming such a broad field it's impossible to be a generalist and specialist at same time.

A generalist will probably require additional training to be a specialist. This can be on job training or formal education.

NO, all specialists should have the generalist background.

No - by title it implies a practitioner with a generalized knowledge and not a "subject matter expert."

Yes, just like General Practitioner or Family Practitioner in medicine.

No. One can not be an expert in all things.

Yes, needs knowledge in several areas - like medical family practice.

Yes, the generalist cannot know all there is to know in all areas however key standards can be identified.

Generalist should not be considered a specialized practice. This is the beginning point for entry level dietitians and/or persons in rural areas who have met core standards of education.

No

No

Yes - similar to "family practice" in medical field.

No. A generalist cannot be informed, knowledgeable and trained in all facets of the profession.

Yes. Maybe the name is the problem; the generalist educator is actually the most highly specialized of all--has to know (in order to teach) something about all other areas.

Yes if the generalist had achieved specialization in an area of practice--e.g. a generalist could be specialized in Diabetes, . . . , Pediatrics depending on patients assigned.

No, I think all RD's are "generalists." RD test is a "generalist" test. CE's should be required for all areas to maintain RD status.

Responses of Practice Group Members Concerning
Whether or Not a "Generalist" is in
Specialized Practice

Yes

I consider generalist to be a Clinical Dietitian.

No. A generalist should be knowledgeable in all areas, but certain areas like Renal often require an in-depth knowledge that most generalists are not comfortable with, this is particularly true in small settings where

Yes. Because they do two or more jobs at once and there are special problems with this that can be discussed.

No. Because one does not have an in-depth knowledge of any one area.

Yes! like a family practitioner (M.D.) in small hospitals or industries, a generalist is essential. I would choose this specialty myself.

No. A generalist is expected to be an expert in all areas of dietetics - both Clinical Nutrition and Food Service Administration. This is something I feel is impossible to do well because both areas have become too large/complicated.

I think it depends on the requirements of the particular job, I would have to say yes because being able to "shift gears" and function effectively in more than one area requires special talent.

Yes but becoming obsolete.

No, they assume the specialization of where they are employed.

Yes, the generalist needs to know a little about a lot of various topics and is constantly updating their knowledge base, so if they are willing to put the time and effort, as well as meet the minimum requirement.

Yes - the generalist must be familiar and confident in Administrative as well as clinical applications in order to be successful.

Yes. Generalist is the analogous to Family Practice in medicine.

Yes - generalist can be used to do basic diet set-ups or float between hospital dietetic depts.

No.

Yes. Through necessity we have followed the trend of specialization - particularly in the healthcare field. But there is still a need for the generalist. Particularly in nonurban areas, I feel.

Yes. Many persons are in "small" companies or hospitals which cannot afford a person from each "specialty". The generalist must know enough to get started searching in case of unusual needs.

Yes. Considerable judgment must be exercised in knowledge areas in order to maintain generalist competency/ i.e. what to disregard and what to study.

Yes. The generalist would need working knowledge of all areas but would not be expected to have in-depth knowledge in each specialty.

Yes, many small institutions need only a generalist.

The terms are contradictory. No.

No - It means they see all types of patients therefore not specialized.

Yes, if with additional years of experiences or additional training.

Yes. Because we must keep up-to-date with all current aspects of nutrition, administrative and clinical.

Yes - there is a real need for a generalist requires special characteristics.

Yes - generalist has different competencies.

Yes. Some facilities census limit the number of dietitians it can effectively use. In such a case a generalist is necessary. Size limitation should not limit.

Yes, I think the need will continue as our country is so vast and diverse we will continue to have smaller area medical centers rather than urban to serve. More people use facilities at home with physicians with expertise available.

Yes in reference to field of Dietetics - human nutrition.

No.

No, a generalist is that would practice many areas of dietetics and not just one.

No. Too broad an area. However, this is definitely a category of practice. I don't consider it specialization.

No - a generalist operates in all areas of the profession. Ex. R.D. responsible for administration, education, clinical in hospital settings.

I do not think so.

Yes It takes a great deal of expertise to manage the different areas.

No - although a generalist requires knowledge in many areas, by the time a generalist has reached a point of being an expert their interests and expertise is probably in a particular area of dietetics practice.

No.

Yes, that is what I am. Too narrowly defined oneself will keep the public seeing R.D.'s as technicians. Need to see the whole business picture, if R.D.'s are to be accepted in industry.

Yes - depending on background and experience.

No but this category needs to exist for beginning members and small institutions.

Yes, because in a small facility, this is greatly needed.

It could be considered one except as profession grows it will be hard for a generalist to keep up in all areas.

Yes. The generalist needs to have a good working knowledge of all areas of Clinical Practice.

Yes - one area should be generalist dietitian, covering clinical and management as in nursing homes and small hospitals. Other areas of specialization would come after graduate work.

Yes - medical profession recognizes general practice as a specialty practice now.

NO - because your practice involves so many areas that you cannot concentrate on anyone. Your time is spread very thin.

In Aristotle's logic, one can agree from general to the specific, therefore a generalist is capable in all specific areas.

No. Cannot be specialized with a general degree. Too much to know in specialization.

A generalist is not specialized - but is a necessary area, all hospitals and nursing homes cannot afford more than one dietitian.

No, the concept is to know something about every area but not an in-depth knowledge.

Responses of Advanced Degree Directors Concerning
What Qualified Them as a Specialist

Ph.D. degree and experience.

Had actually worked with inborn errors of metabolism for 13 years but haven't had actual patient contact since moving to the university four years ago.

Specialize training and practice in community nutrition.

Dietetic Educator, because of years of experience workshop, course work and application.

MPH & Ed.D.

My work experience as an administrative dietitian was the beginning. I have taught and researched this area for 18 years.

Education, experience, readings in the area, interest.

Research and practice.

I am a research nutritionist with 15 years experience in teaching and research. I am qualified to teach courses in nutrition.

Combination of advanced degrees and experiences. I did not get my Ph.D. until 1980, as I didn't consider it necessary. However, combined with experience, it has helped me become a much more effective professional.

Education and experience.

Education plus continuing education.

Bachelor of Science in foods and nutrition; internship (general) years in clinical work; M.S. and CAS in nutrition; 34 years in nutrition education with 20 of those years in college teaching where major area of research was community nutrition.

Met Plan IV for clinical - practice clinical dietetics, teach in that area.

Ph.D. in nutrition and experience and research.

Advanced education and practice.

Training - experience.

Graduate training, extensive experience, research and publication.

Education level, research.

Yes, level in a different way. Dietetic Educator falls under the "tenure" model.

Years of experience; advanced degree, research.

Advanced degree and experience.

When I was in public health, my education (M.S. or Ph.D.) + one year training program and constant inservice, and practice.

Education in subject matter, practitioner experience, constant updating by various means.

RD, PhD - research - experience.

A specialized area of practice (education) with advanced preparation (education/continuing education experience).

Experience and academic work.

PhD degree, national reputation, publications, 20 years of practice, RD numerous awards/honors, tradition of service, regular advancement in rank.

N/A

N/A

Education and experience.

Years of experience, education, and interest in area.

I'm qualified by education, but I teach practice experience.

Extensive experience through consulting and research, formal work for advanced degrees.

The nature of my job demands.

Position followed by 13 years of practice and continuing education in area of specialization.

R.D., training - graduate work; 20 year practice in this area; continuing education.

Position and experience and workshop/course work.

Education and experiences.

Responses of CUP Directors Concerning What
Qualified Them as a Specialist

Experience, education, and opinion of others.

Experience, advanced education, participation in research.

Formal and informal study and experience.

If education is a specialty, - 9 years of experience would be qualifying.

I've had years of experience and an academic background in education but am a generalist practitioner with greater knowledge in clinical.

Ph.D. and some clinical training.

Education and practice.

Master's degree in area plus experience (2 years) plus teaching courses in or related to field (8+ years).

Long years of study, practice and experience with continual consultant to updating and interfacing between actual dietetic practice and education.

Years of experience and graduate work.

I teach a variety of courses, but I have a certificate in Gerontology (30 hours coursework plus an exam).

In my current area of practice, I do not function as a specialist (i.e., educational administrator). However, I do feel qualified as a specialist in community or public health nutrition based on both education and experience.

Advanced degree, post-graduate work, increasing responsibility continuing education.

I may be considered a specialist in the sense of computer in dietetics.

Education and experience.

Education and experience.

I am a specialist in dietetic education - educational training and work experience.

5 years of experience in the area and interest.

Clinical nutrition by virtue of practice and continuing education based upon my graduate education.

Education - By degree (Ph.D.) and practice (approximately 20 years in education, 14 of those in dietetic education).

Education.

M.S. and 15 years of progressively responsible positions.

Education and years of experience.

Community/education.

Continuing education and experience. The "why": Awareness of needs in order to achieve and advance in my career required broadening of skills and "learning by doing."

Yes, all my education and practice has been in clinical dietetics. No, because there are areas of clinical dietetics that I have practiced, i.e., nutrition support team.

Ph.D. and experience.

Responses of Internship Directors Concerning
What Qualified Them as a Specialist

Master work and years of experience.

I have had over 7 years experience in Dietetic Education and have obtained training in the subject area.

Advanced degree. 15 years in increasing responsible positions in area. Peer review.

BS & MA, Consultant training, Internship, and 8+ years in the same area.

What - Experience, continuing education, increasing levels of responsibility. Why - My expertise is beyond entry level and its development occurred as a result of formal/informal continuing education efforts + experience and is applicable to the role of program director/consultant in dietetic education.

Work experience and education.

Experience and education.

Education and experience.

Experience and title - But believe an M.S. in education would have been better than MS in Food and Nutrition.

Food service management courses for BS & MS. Experience in hospital and school food service management.

Years of practice. Course work, Continuing education in the area of Dietetic Education.

Education qualification and practice.

To be an educator of dietetic practitioners one must be a generalist.

Education, practice. Not position.

Degree and years of practice.

Advanced education. M.S. Continuing education. Work experience.

But I do have good on the job training and Do consider myself a specialist in another area--clinical nutrition research.

Interest, earned teaching credential, earned Master's degree, ability, RD, experience.

Acute care - interest, reading/studying, selection of educational activities such as ASPEN, CRN, recognition by medical staff.

NO - I have to be competent in management, clinical and education.

Work in area and Ph.D.

Yes, I have had varied general experiences in addition to specializing in nutrition support and clinical management prior to my present position.

Yes, position requires that one possess knowledge and skill in planning and coordinating programs.

Educator, - both academic degree and experience.

Years of experience as educator and internship coordinator and Masters in education - active leader in education practice group. Site visits for ADA.

Advanced academic degree. Minimum of 5 years experience in the area of education.

Degree in Education plus many years in teaching but? specialist.

M.S. and experience.

Education and experience.

Learned the hard way - on my own.

Years on the job and being able to evaluate the effectiveness of what I do.

Ph.D. in food service management.

Experience, training and motivation to be "the best"

Experience.

Course work (advanced degree). Specific workshops, continuing education in specialty area. Membership to local, state and national association for networking.

Advanced education and experience in area of practice.

Master's in Education with experience in teaching dietetic interns and CUP students (9 years total).

On job training post doctoral degree.

Undergraduate education degree plus M.S. in nutrition, plus year experience.

Advanced degree and experience.

Advanced degree--practice.

Interest, Education, Years of experience.

N/A

Experience and advanced education.

Years of experience in the position--additional course work in the area.

Experience.

M.A. in education - 5 years experience in education.

Experience, advanced degree.

M.A. in education; R.D.; 3 years as clinical RD in hospital setting; 5 years experience in program planning; administration in business.

Responses of Practice Group Members Concerning
What Qualified Them as a Specialist

Experience.

Interest, ability to communicate, extensive reading, ability to manage change, maturity.

M.S. in Foodservice Management and working in positions from pantry aide to supervisor, to dietetic assistant, to dietitian, to administrative dietitian.

Education and experience. Experience in particular has provided me with sound management tools.

Work experience and advanced degree.

I think this is excellent - there have been too many different specializations.

Years of experience. Progressive, responsibility. Practice is limited to administration.

General consultation in all areas except Intensive Care.

1) M.S. degree with management courses, 2) Progressive increase in responsibility with officers of company and increase in number of people reporting to me as company grows.

5 years experience as administrative R.D. is adequate for consultant to long-term care.

Education and experience.

Position and Practice.

Experience qualifies one as a specialist now. No, I do not have opportunities to work with others doing this work, or advanced courses available.

Work experience and additional graduate course work.

Years of experience and interest.

Practice in a specialized area for a number of years, development of standards of care for the area.

CUP - Foodsystems Management and M.S. in Management Dietetics.

NA

Continual reading of ADA journal and dietetic practice group literature, attending dietetic meetings in our area has kept me updated in the generalist area.

Training, continuing education and experiences.

Experience - personal interest in increasing quality of life.

Education and experience - MBA; several years experience.

Additional management course on graduate level - workshops, seminars in administrative dietetics - work experience.

Because I am the only person in my organization with this area and knowledge.

I have MBA but deal just a little with business - major responsibility is with patient care, clinical, and production in the managing of people to do these jobs.

Experience and continuing education.

Advanced course work years of practice.

Most of my professional experience has been in the area of administration.

Years of experience in clinical dietetics.

8 years of successful work experience applying management principles.

MBA and four years as administrator of hospital food service with eleven years of progressive food service administrative resp.

R.D.; 22 years experience and continuing education.

Experience over long term.

NA

Experience, continuing education, post graduate work in specialized area.

My background, my experience, my further education in that area and other means of learning - seminars, organizations, etc.

I was already an experienced generalist, so I received specific training for my current position as a writer.

You wouldn't understand and it can't be described in this brief space. You people in academic are hung up on degrees and sick people. I welcome you and challenge you to survive in the real world.

Administrative - many hours of work and study on my own. .

Varied experience, long years of experience and success in the experience.

Responses of Advanced Degree Directors Concerning
Whether or Not Their Position is Considered to
be a Specialized Area of Practice

No

No

Yes, education - foodservice system management.

Probably not; university faculty position has broader responsibilities than training dietetic practitioners.

No -- (except for "research", in specialized areas), educators probably should have specialized areas from past experiences to bring to their teaching and research.

Yes. Requires specific skills and knowledge.

Yes - because of the courses I teach.

No

I believe so. The other faculty on our staff teach in the clinical subject matter area.

Yes - I teach Food Service Systems Management.

Not now.

No. This is a temporary part time position which we hope to develop a program to meet the above.

Probably not by many. At the graduate level it is specialized.

Yes. I am responsible for the educational program in Foodservice Management.

It requires constant training to keep up with research and changes in the field.

No, because we educate graduate students in both clinical and community dietetics and in international nutrition.

No - academic, general nutrition.

The person who replaces me will likely not be a specialist (although he/she will have PhD in Nutrition) until he/she has practiced at least 5 years as a director of field experiences in community nutrition.

Yes - I am expected to perform clinical role in consulting. Upon hiring I was asked if I was clinical dietitian. I market myself as a clinical RD.

Not sure - since I teach and don't "practice" I'm not sure I would qualify to be a specialist.

No

No - it's academic but the position should be specialized - either qualified in foods nutrition or Food Service Management.

No. My specialization is administration. I am a generalist in dietetics.

Yes

Yes

Is an education position.

No

Only if education dietitians is a specialty.

NA

Yes -

Yes. Focuses specifically on one specialized area of dietetics.

No

Many think it is because we get together--I think it is not nor should be.

NO - education not regarded as area of specialization.

Yes -

Yes - education.

No. As an educator, in an M.S. program for advanced study in dietetics, I have to take a broad approach. However, our program does have faculty who are specialists.

NO

Really education and research applies to practice.

Yes; has always required preparation beyond entry-level although debatable whether, education has been or is considered an area of practice in Dietetics.

Yes, if you consider education a specialty and a form of practice.

Renal dietetics - concentrated area of practice.

Well, educators are considered to be a special population, but not "specialists".

NO - education is not really dietetic practice.

Not necessarily. Education is not the practice of dietetics.

No - I'm an educator.

No

N/A

Not according to #13, but recognized as education (DEP).

No - academic administration.

No, I teach across several areas.

Not by the three terms given in #13.

No - I don't consider my position as department chair my specialty - my research and teaching in community dietetics is my specialty.

No - college professor.

Dietetic Educator.

No. I perceive a need for educators to be more generalist. I think it would be difficult to teach from the background of specialist since education is generalist.

Do not feel that many feel that way; I personally feel that a teaching dietitian in a non-hospital situation has a tremendous bearing on future dietitians and general population.

No I educate practitioners in all areas of general dietetics.

Perhaps - college faculty.

No

Responses of CUP Directors Concerning Whether or
No Their Position is Considered to be a
Specialized Area of Dietetics

I consider myself in the area of management, a broad classification.
Further sub-divisions are possible but not necessary.

No, University requirements are probably adequate for assuming
competency in dietetic education.

Higher education or dietetic education is specialized in that the
requirements and expectations are quite different from other areas of
dietetics.

No - most clinicians do not consider educators to be specialists, unless
they have a published research area.

NO - education is too general - requires broad background and
performance.

No - to teach in dietetics only requires knowledge of dietetics and
experience, no educational background.

NO

Yes. Administration of CUP with clinical emphasis.

No - I teach about administrative dietetics.

Many would not consider me a practitioner, since I am an educator. I
consider education a specialized area of my specialty (Food Systems
Admin.)

In the broad sense as defined in the 1974 paper by ADA and terminology
and specialization.

Yes - Teaching administrative dietetics is definitely a specialized
area.

A dietetic educator is not a practitioner as an academic administrator.

Certainly education in dietetics is a specialty.

No see number 15.

No - because everyone says "all dietitians are teachers" and some don't
even consider education as dietitians.

No. I keep up with everything.

No - I don't feel I have specialized in one area enough at this point.
I have knowledge in Food Service Management but have not practiced in
this area for 15 years.

No

Clinical in that I direct a clinical specialty CUP.

Yes

No, not at present time - I am teaching a variety of courses.

It is a Practice Group.

NO - Education has not been studied or classed as a specialty.

Yes. Job qualifications and duties are significantly different from other types of jobs in dietetics.

My position would probably be considered as an education specialty, if it was considered a specialty.

Yes - The position is characterized by advanced education and practice.

I do not see the need for a specialty in Education. I see the need in other areas.

Education is not a specialized area.

Yes, because it requires a M.S., R.D., and administrative education and experience.

Not the position but the clinical courses I teach.

Education is a DPG - should be a specialized area.

Not as defined in #13. But, yes, in terms of my position, experience, and expertise.

No - Program Director is not specialty area. Dietetic Education is not specialty area.

Yes - Education of Dietetic Practitioners.

Responses of Internship Directors Concerning Whether
or Not Their Position is Considered to be a
Specialized Area of Dietetics

I am the Dietetic Internship Director, I belong to the Dietetic Educator of Practitioner Practice Group.

No -- I don't believe my institution recognized specialties.

NO, because I am a pure administrator and educator.

NO - Because I am in charge of a generalist internship. Have to know a little about a lot of things.

Yes. The education of dietetic students requires advanced knowledge of education, dietetic practice, and health care practices and delivery systems.

NO. I am responsible for general type of internship program, which limits my opportunity to be specialized in any area.

Yes -

Yes.

Yes -- in my opinion -- education is a specialty area.

Yes, because there are certain parameters that are critical to doing the job. In used as resource by other dietitians.

Yes. As far as I know, there is no specialized training for being an internship director. ADA doesn't help much. ADA evaluates but does not help the new director.

Again to a certain degree. The ADA requirements and/or standards for an Internship Director imply that some special experience and/or knowledge is needed.

To be an educator of dietetic practitioners one must be a generalist.

Do not understand question unless you are referring back to #13 and if so, I am not in a specialized area.

I don't know.

No

Maybe -- But few dietetic educators (internships) have advanced training in Education.

No

Education is a specialized area but probably won't be defined as such.

Yes, see above.

TPN, Alternate feedings - opportunity practice and to educate (R.D., M.D., interns, Health professionals).

NO -- I have to be competent in Management, clinical and education.

NO - as an educator I must be knowledgeable in all areas of dietetics, especially as Director of a generalist Dietetic Internship. Primary Teaching emphasis in Food Service Management.

Yes. I have had varied general experiences in addition to specializing in nutrition support and clinical management prior to my present position.

Yes. Position requires that one possess knowledge and skill in planning and coordinating programs.

No, not really, we have a practice group, but in reality, all dietitians consider themselves educators.

Community.

Yes. --obvious in addition to education skills, management skill necessary to direct program.

Yes. Directing an internship program requires advanced academic training, and experience in education as well as experience in both clinical and administrative dietetics.

Could be - Education of practitioners is somewhat unique - specialized practice.

Should be, yes -- Education.

Yes. Specialized knowledge required.

Yes

Yes -- Dietetic Internship director, specialized, requires M.S. - have had Administrative experience.

Yes. Specialization in how to teach and develop practitioners.

Yes. Education of Dietetic interns and Masters Student field work.

Yes

Yes -- by non-dietitians as well as RD's - because of the internship.

I don't know.

I believe that education is a specialized area and all dietetic educators should have appropriate qualifications in education as well as dietetics.

My specialty areas are diabetes education as well as professional education. Both have specific identified knowledge base and skills required for practice.

It is considered as a specialty within the department in which I work.

No.

Yes - requires expertise in educational methods plus experience. In my case also clinical expertise as I supervise interns in experiences with an R.D. present.

Yes. Administrative aspects of clinical dietetics is quite specialized.

Yes -- Internship Director -- I feel this is considered specialized -- education.

I am a dietetic internship director, and most, I guess would consider the position a specialist in education. I'm more of a management specialist, however.

My area is education and it should be specialized as specific knowledge areas are required to successfully complete various undertakings (i.e. defining curriculum) that would not be necessary in other practice areas.

I believe an internship director needs expertise in all areas (Administration, Clinical and Community) if it is a general internship.

Yes it is a specialty of dietetic education.

NO, dietetic education.

Yes. The Council on Practice has recognized the Educators of Practitioners.

NO -

Yes.

Probably not.

No; see #13 - it's not even identified there.

Yes based upon ADA requirements for Internship Directors. But the DEP is not a group of specialists (in my opinion).

Yes.

Yes - you need more education than Plan IV to be an internship director.

Responses of Practice Group Members Concerning
Whether or Not Their Position is Considered
to be a Specialized Area of Dietetics

No

Yes, not everyone makes a good manager.

No. Management R.D. in Dietetics and Institution Management is enough.
No. M.S. required where I manage specialized R.D.'s/Units.

Consulting is specialized.

No. I think of specialist as someone who concentrates on one particular area of practice.

Not by fellow dietitians in general practice. The dietetic consultant, surveyor is recognized as the resource person and the final authority in the state by the State of Louisiana regarding regulations. Fellow dietitians in Louisiana regard the surveyor in a similar light but not really as a specialist.

No food service managers with experience and track record also currently fit into this area. Some with no college education.

Yes. In order for one to operate as a manager in dietetics specialized skills are required. The average generalist does not possess these skills nor does dietetic education adequately prepare one.

No

No I do Administrative, but not all areas.

Yes. No clinical responsibilities.

Yes - consulting.

Yes - working with DD and geriatric clients by managing the dietary operations in all facilities. But, still consider my area generalist on administrative.

Yes. Follows definition given in #17 below.

I am chairman of a food service department and consider the position requires someone with expertise in administrative dietetics.

It takes a great deal of skill and expertise to be able to manage a department and do clinical work.

I feel I have additional experience as defined by Task Force.

Few R.D.'s have worked with architects to plan foodservice facilities.

No. In my position I am expected to manage, teach, assess nutritional status and in a nutshell "run the whole show" to me that is not specialized practice.

No.

Yes

No, tends to be generalists, although more administration.

No, I need to know a varied amount of skills and information in both administrative and clinical areas.

Due to actual clinical practice being the primary involvement in my work it is considered a practice group but too much consulting and administrative time is required which takes away from the clinical time.

No. Because it is not a part of the med/surg practice area. Even though a large percent of patient population served in this specialty area, R.D.'s are not trained in this area (mental health/D.D.)

Yes - Director of Dietetics.

NA

No, as we must keep abreast of all areas of nutrition - administrative and clinical.

Administrative dietetics.

Administrative management.

No - I feel like I cover my areas - clinically, administrative, floor plans etc.

No. "Industry" is outside of the range of normal practice.

Yes - as director of the department, I am in an administrative position in the hospital organization and am considered to be a specialist.

No - generalist.

Yes. I don't think some one "straight" out of school (unless advanced management) can effectively manage a large department and motivate the variety of skill levels in the usual dietetic dept.

Yes. Is primarily administrative.

Yes, requires extra education and experience.

Yes! It would be difficult for one person in full time practice to be able to cover all areas of dietetics. (Clinical, Administration, Community). I've found that since most of my work has been in one field

I've lost some of my ability to quickly recall information in other areas - (natural occurrence I believe).

Yes - I am an HMO nutrition counselor.

Yes. Administrative dietetics is an area of specialization by the nature of the scopes of practice, it is definitely not for an entry level graduate who has not had an opportunity to apply theory with practice.

Yes, administrative! Because I am a department head of a medium size hospital with total financial and supervisory responsibility of that department.

Yes administrative.

According to the statement in #13, yes.

NA

Unsure

Yes, administrative dietetics.

Yes because I'm doing a specific type of business, through advancement of myself and someone who is in the first year or two of full-time work experience in their career could not do it.

No. My present position is unique to the Air Force. My duties in civilian facilities would be the responsibility of the Chief of Dietary Department.

Yes - administrative - because I manage a large department effectively and have unitization of near \$2,000,000 yearly.

Yes - because so few dietitians are employed in it or want to be employed in it (administration).

Responses of Advanced Degree Directors Concerning the
Definition of "Dietetic Specialties" Suggested by
The Task Force on Education

Agree.

Agree. Much beyond the entry level.

Good definition - agree.

Agree.

Reasonable working definition.

Agreed - your earlier questions covered this.

Disagree, see above.

Agree.

Agree.

Agree.

I agree.

I have a hard time doing either at this point. I have reviewed the three role delineation studies and although they claim to the entry level, it appears that a dietitian could take a long time to achieve entry level in any of the areas.

I agree with definition.

Good starting point, but must define terms; how "advanced"? How much "additional expertise" and how determined?

I agree with this basic definition.

The type of expertise such as passing an examination should be included. Therefore, unqualified people could not be hired as specialists reflecting unfavorably on the profession.

I agree with the statement.

Agree.

Agree.

What is additional expertise? Suggestions - additional 9 credit hours in area, 5 years in that practice area.

Agree - It's a broad definition. Will need to be more specific when designate each specialty.

Agree to a limit - it should be more specific is advanced degree.

Agree as amended. Added and maintenance.

OK as a working definition.

Agree.

Agree.

Agree.

One needs practice but as important in education is the field - needed are both.

Agree.

Agree, acceptable.

Agree.

....that defined as a general practitioner (not generalist in ADA's sense of the word).

Disagree - needs to be more defined - include more than practice - advanced degree, training.

I agree with definition as it is at this point in time.

I agree with it especially the part requiring knowledge and skills.

Agree.

OK definition.

Agree. Definitely beyond entry level definitely specific skills and expertise.

Agree.

Agree.

Good definition.

I like the definition.

Not sure. This model seems to copy that of the physician who first becomes a generalist and then becomes a specialist via advanced study and practice. I'm not certain that the same model is necessary or suggested.

Agree with definition but definition should spell out the specialized areas and state what the requirements are.

Agree.

Agree.

Agree - could include more academic preparation.

Seems adequate.

Agree.

Agree.

Agree because it should happen beyond the entry or bachelor's level. We can't graduate B.S. specialists.

Agree.

... and practitioner experience. Agree as amended.

I agree with definition.

Basically a good working definition; will not satisfy all but one has to start somewhere.

Agree - good definition and broad enough to be flexible.

Good definition.

Agree.

Responses of CUP Directors Concerning the Definition of
"Dietetic Specialties" Suggested by The Task Force
on Education

I agree with the statement, but criteria are required for specific identification.

Specialist has completed advanced education designed to develop in-depth knowledge in a specialized area and has passed a specialization exam. The specialist would have completed at least two years of experience in dietetics prior to initiating specialization.

Agree. I believe the specialty requirements should differ depending on the area. Therefore a broad definition is acceptable.

Unsatisfactory - could apply to a general position and practice.

A major problem will occur in that people trying to become specialized will not be able to "try-out" or work into a position as they have been able to do in the past. People will have to commit time and resource to developing specialization perhaps before they really know what the area is all about. Yet, if we are to take our place in AH as specialists, we'll have to do just that.

OK

In general, I agree. I do not believe that time should be a criterion.

There should be some way of ascertaining that a person has adequate knowledge. What is defined as "advanced"? The definition is fine as far as it goes, but all terms need to be defined - I agree with the concept. Implementation is the question.

I agree in principle, but advanced level and additional expertise in terms of skills and knowledge need to be defined. No two people reading this would agree on the meaning in terms of specifics for this statement.

Definition is vague - "beyond that defined for entry level" How far beyond? Also think you need to delimit the scope of practice.

Agree, it seems coherent.

Agree, but not necessarily meaning an advanced degree even though that would be desirable at some point.

I agree with this concept. However, I still have not been able to resolve the question many dietetic educators have, i.e. "what educational preparation should the entry level person have?" If dietetics programs (B.S. level) have developed resources to offer programs which provide a strong emphasis in food service (e.g., U. of Missouri) or community (Viterrobo, Chicago State U.) are we now asking them to move from that orientation to a more general one. It can be

argued that at the undergraduate level, many students are unsure of the area of practice they are most interested in. However, many do know their career plans and have actively chosen those institutions because of their specialized programs. I also believe grads (B.S.) of some of those programs which provide clinical or hands-on experience could be considered "specialists". For e.g. I feel a graduate of a food service CUP is just as much a specialist in foodservice management as is the graduate of a hospitality industry program graduate. I really believe the practice groups should be the bodies which establish criteria including knowledge and skills for themselves. In some instances, it is conceivable their expertise could be obtained in programs preparing entry level persons.

I agree with this definition if the knowledge is considered to be formal education, not just what has been learned in the job.

I think we already have the three major areas of dietetics. Feel specialties really does mean a specialist within one of these major areas.

No. See marks.

Agree with the definition - but the criteria for each specialization is the important part of the definition of what a specialist is in each area.

I agree.

This definition is one that I feel is adequate.

I agree with definition but it needs further refinement - indication that specialists will have demonstrated ability to pass a specialty exam.

The specialist must also have specific, understandable area of practice - which can be described to consumers (patients or clients), other professionals. For example, a client will understand that the dietitian who specializes in cardiovascular care can provide professional services for clients with cardiovascular problems. The client will not understand that a dietitian is a specialist because he/she has "an advanced level of expertise".

This would be an appropriate definition if the entry level were generalist. These 4 specialty areas are defined at the baccalaureate level when the R.D. exam is a generalist exam.

Need something in the definition about the complexity of the area designated as specialty.

Agree - sounds good.

Agree.

I agree with the definition.

Agree.

Using that definition everyone would be a specialist after being employed for one year. Needs to be much more defined.

Agree, but statement needs to be more concise to be measurable.

Agree.

I agree with the definition.

Good definition - agree.

I agree with this statement. I may have problems, however, with the Task Force definition of entry level (skills and knowledge).

Agree with statement.

Responses of Internship Directors Concerning
the Definition of "Dietetic Specialties"
Suggested by The Task Force on Education

It's OK.

Yes, I agree.

Good.

Agree.

Agree essentially - but don't feel like you have to be practicing in the area to be certified as a specialist.

Agree.

Yes, I agree with this definition.

Agree with definition.

Yes.

Yes, I have no objections to it.

Agree.

Disagree. Most dietitians cover a broad area. I see a specialty as needing greater expertise in a more narrow area -- a specialized area. Also a specialist needs to know far more than is needed for entry level -- not just "additional expertise beyond that for entry level".

I believe it should be narrowed to a defined body of knowledge.

Agree.

I agree somewhat with the definition - but it's rather vague and allows for misinterpretation. What is advanced level (fellowship, education practicum??), who defines expertise (exam, experience, etc.)

Define knowledge and skills -- and what is an advanced level.

Very broad.

I agree with this definition -- as it is defined as "practice", not specific certification, training or recertification.

If that definition is correct, then I would definitely be considered a specialist.

I agree but the "advanced level" also needs to be defined.

Agree. No problem with this definition.

Agree.

Disagree. Then all dietitians with experience are specialists -- which isn't true.

I agree with this statement.

Agree. I think it needs to remain general because stating specifics (for example number of years advanced training) may eliminate people who are qualified based on clinical practice and abilities and attendance and participation in seminars and research.

Agree. Our Internship Program is a good example. We have a Coordinated Internship Masters level Program (clinical emphasis) and I feel that our students are trained beyond the entry level. This is not because of the advanced degree, but because of the emphasis in the clinical component. We place a lot of emphasis on developing managerial skills, programs planning and team support. I don't feel the students are greatly rewarded for employment because of the "Internship" association by employers.

Agree.

Agree - however maybe want to define what additional expertise beyond entry level is required.

Add "both academically and experience."

Definition is too broad - open to several interpretations specialist "one who has a special knowledge of some particular subject." Major areas of practice is stretching this definition a bit far. What I have discussed this with groups, their definitions have been more along the lines of TPN dietetics. Caution must be exercised that students graduating with a bachelor's degree have a marketable degree which is competitive in the job market. We are already losing good students to engineering, etc. for this reason. Making the Master's Degree required where currently entry level is meeting job needs would only have negative effects on the profession.

I agree - see comment above since entry-level includes Clinical, Community, Administration -- specialties must go beyond this.

Yes.

Agree.

Yes - agree, good definition.

Agree. Key portion is what I underlined. (Practice at an advanced level)

Anyone who has advanced in responsibility above that of entry level could fit under this definition if increased knowledge and skills are required to perform additional job responsibilities.

Agree.

I agree because of the experience component.

Yes.

I agree with above definition.

I agree with this.

Agree.

Agree.

I agree with the definition.

Agree.

It's very general, but I'm not sure how you would clarify the statement.
"Requiring additional expertise (meaning M.S., Experience, practice)?

Basically agree.

I agree.

Agree if this expertise is assessed and consists of more than years of
experience in the same position.

I agree with the definition, however I do not feel an advanced degree is
necessary to be a specialist and/or recognized as a specialist.

Disagree; is a beginning definition.

Include productivity and evaluation.

Agree.

Agree.

Agree.

Agree.

Agree.

I would prefer to include "requiring" an advanced degree in the area of
specialization. I personally believe entry level dietitians should be
required to have an M.S. degree. Other professions do. Until dietetics
makes this a requirement, we are not considered "equal" to other
professions, i.e., social work, speech pathology, pharmacy.

Responses of Practice Group Members Concerning the
Definition of "Dietetic Specialties" Suggested
by The Task Force on Education

"Requirements including an M.S. in the specialty area, successful completion of a specialty examination, and three years experience in this specialty area".

I agree but do not feel that a graduate degree in the specialty is required.

Agree. Advanced education necessary.

The problem with the definition is that I fear the young will be kept from gaining additional knowledge and skills. These young people sometimes pose a threat to the older, established R.D. Then we will lose this young person to another work force. One R.D. works for a railway company at twice the salary at age 28 years.

Disagree - at present entry level must have education generally covering all phases of Dietetics. I do not believe one must first become entry level then specialize. I think programs should be available to begin specialization during undergraduate program and while doing internship or residencies.

Agree. (Comment) - I don't fully agree with specialization unless generalist is a category, attainable by R.D. exam only. All dietitians should not be required to specialize - nor is there a need for all dietitians to do so. ADA must work national, legal recognition of the R.D. as the expert - not nurses, doctors, and people off the street.

I agree if this means an advanced and therefore disagree with the areas of specialization named in #3 - I would consider clinical and community dietetics as generalist areas.

Agree with definition. What knowledge and skills are necessary may need to be spelled out.

I think additional education should be added to the definition.

Agree.

There are too many R.D.'s out there who have a severe lack of knowledge in the administrative or generalist area. This hurts all of us. We need to increase our visibility by being sure that a successful R.D. in that area is supervising or evaluating the work of the R.D. Many R.D.'s report to non-medical people who take it for granted that the R.D. is knowledgeable.

(Note) Our profession should be like a person with an MBA. They work in narrowly defined or very general areas depending on where they are employed (Accounting, Marketing, Personnel, etc.) This type of person has much more to offer a company.

Agree.

Agree.

Agree.

Agree.

Excellent definition; agree.

That is pretty clear except for the lack of addressing what type of practice at the advanced level. As stated, it could cover any dietitian who has practiced for several years and has obtained additional knowledge and skills during this time.

Agree.

Agree.

Agree with definition, would like to see degree of advanced level of knowledge and skills stated.

Yes, I agree.

There are facilities which require specialized areas of expertise - these have and will continue to exist. Do not forget there are many R.D.'s who work without others to offer rapport and support. Therefore ADA should always keep avenues open for us to gain expertise and knowledge to serve those we care for at the best level of care, we continue to scramble for the best qualified information.

Definition OK.

Agree.

Agree.

Yes, I agree with the definition. Also, I believe that a specialist should be deemed proficient in a particular area based on standards set by the ADA for each area.

Additional expertise needs to be more specific. Example: M.D.'s with specialization have to attend school specific number of years, internship, etc.

Agree.

I dislike the last part of the definition beyond that...level - very vague - also definition of advanced level - would like a more concrete definition.

Agree.

I agree with the definition.

I am in agreement with the statement.

Agree.

Agree.

Agree.

Agree.

Agree - I feel years of experience is more important than advanced degree.

I agree.

A concise statement which I believe says it well. I also agree with the above definition.

Disagree, by being employed how can you not achieve expertise and skills just by experience. As an entry level dietitian, I had the background, but all practical learning was done by experience. It seems you can define "specialty" by years of experience.

Suitable.

I agree.

I disagree with the definition indicating that specialization means practice at an advanced level, and beyond that defined for entry level.

Agree.

Definition needs to be more specific as to what knowledge and skills need to be acquired, and how this will be measured.

I agree.

Agree.

Yes - agree - I do need much more expertise than entry level. I have been in the same hospital as assistant director and director for 12 years and it's still a challenge - I'm still studying and learning.

Agree - definition is accurate.

APPENDIX C

CHI SQUARE DETERMINATIONS
OF ALL CATEGORIES OF SPECIALIZATION
BETWEEN THE FOUR GROUPS

TABLE OF GROUP BY I11					
GROUP	I11				
FREQUENCY ROW PCT		1	2	3	TOTAL
A	4	59 93 65	4 6 35	0 0 00	63
C	0	38 100 00	0 0 00	0 0 00	38
I	4	53 89 83	5 8 47	1 1 69	59
M	0	47 87 04	6 11 11	1 1 85	54
TOTAL		197	15	2	214

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6 432 DF= 6 PROB=0 3766

TABLE OF GROUP BY I12_1					
GROUP	I12_1				
FREQUENCY ROW PCT		0	1		TOTAL
A	6	43 70 49	18 29 51		61
C	5	20 60 61	13 39 39		33
I	9	30 55 56	24 44 44		54
M	7	34 72 34	13 27 66		47
TOTAL		127	68		195

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 325 DF= 3 PROB=0 2284

TABLE OF GROUP BY I12_2					
GROUP	I12_2				
FREQUENCY ROW PCT		0	1		TOTAL
A	5	48 77 42	14 22 58		62
C	5	25 75 76	8 24 24		33
I	9	48 88 89	6 11 11		54
M	7	40 85 11	7 14 89		47
TOTAL		161	35		196

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 817 DF= 3 PROB=0 2819

TABLE OF GROUP BY I12_3					
GROUP	I12_3				
FREQUENCY ROW PCT		0	1		TOTAL
A	5	58 93 55	4 6 45		62
C	5	28 84 85	5 15 15		33
I	9	51 94 44	3 5 56		54
M	7	42 89 36	5 10 64		47
TOTAL		179	17		196

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 026 DF= 3 PROB=0 3876

TABLE OF GROUP BY I12_4

GROUP	I12_4				
FREQUENCY ROW PCT		0	1	TOTAL	
A	5	57 91 94	5 8 06	62	
C	5	26 78 79	7 21 21	33	
I	9	48 88 89	6 11 11	54	
M	7	43 91 49	4 8 51	47	
TOTAL		174	22	196	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 273 DF= 3 PROB=0 2335

TABLE OF GROUP BY I12_5

GROUP	I12_5				
FREQUENCY ROW PCT		0	1	TOTAL	
A	5	62 100 00	0 0 00	62	
C	5	33 100 00	0 0 00	33	
I	9	54 100 00	0 0 00	54	
M	7	46 97 87	1 2 13	47	
TOTAL		195	1	196	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 186 DF= 3 PROB=0 3638

TABLE OF GROUP BY AREA1

GROUP	AREA1				
FREQUENCY ROW PCT		0	1	TOTAL	
A	12	28 50 91	27 49 09	55	
C	2	18 50 00	18 50 00	36	
I	12	21 41 18	30 58 82	51	
M	7	17 36 17	30 63 83	47	
TOTAL		84	105	189	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2 905 DF= 3 PROB=0 4066

TABLE OF GROUP BY AREA2

GROUP	AREA2				
FREQUENCY ROW PCT		0	1	TOTAL	
A	12	25 45 45	30 54 55	55	
C	2	22 61 11	14 38 89	36	
I	11	33 63 46	19 36 54	52	
M	8	26 56 52	20 43 48	46	
TOTAL		106	83	189	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 045 DF= 3 PROB=0 2566

TABLE OF GROUP BY AREA3

GROUP	AREA3			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	37 67 27	18 32 73	55
C	2	24 66 67	12 33 33	36
I	11	36 69 23	16 30 77	52
M	8	39 84 78	7 15 22	46
TOTAL		136	53	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 5.039 DF= 3 PROB=0.1690

TABLE OF GROUP BY AREA4

GROUP	AREA4			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	51 92 73	4 7 27	55
C	2	27 75 00	9 25 00	36
I	11	43 82 69	9 17 31	52
M	8	36 78 26	10 21 74	46
TOTAL		157	32	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6.076 DF= 3 PROB=0.1080

TABLE OF GROUP BY AREA5

GROUP	AREA5			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	54 98 18	1 1 82	55
C	2	31 86 11	5 13 89	36
I	11	49 94 23	3 5 77	52
M	8	39 84 78	7 15 22	46
TOTAL		173	16	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 7.697 DF= 3 PROB=0.0527

TABLE OF GROUP BY AREA6

GROUP	AREA6			TOTAL
FREQUENCY ROW PCT		0	1	
A	13	51 94 44	3 5 56	54
C	2	33 91 67	3 8 33	36
I	11	46 88 46	6 11 54	52
M	8	40 86 96	6 13 04	46
TOTAL		170	18	188

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1.943 DF= 3 PROB=0.5844

TABLE OF GROUP BY AREA7

GROUP	AREA7			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	55 100 00	0 0 00	55
C	2	28 77 78	8 22 22	36
I	11	48 92 31	4 7 69	52
M	8	40 86 96	6 13 04	46
TOTAL		171	18	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 13 390 DF= 3 PROB=0 0039

TABLE OF GROUP BY AREA8

GROUP	AREA8			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	55 100 00	0 0 00	55
C	2	36 100 00	0 0 00	36
I	11	51 98 08	1 1 92	52
M	8	41 89 13	5 10 87	46
TOTAL		183	6	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 12 110 DF= 3 PROB=0 0070

TABLE OF GROUP BY AREA9

GROUP	AREA9			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	36 100 00	0 0 00	36
I	11	52 100 00	0 0 00	52
M	8	44 95 65	2 4 35	46
TOTAL		186	3	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 682 DF= 3 PROB=0 2979

TABLE OF GROUP BY AREA10

GROUP	AREA10			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	51 92 73	4 7 27	55
C	2	34 94 44	2 5 56	36
I	11	47 90 38	5 9 62	52
M	8	42 91 30	4 8 70	46
TOTAL		174	15	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 0 549 DF= 3 PROB=0 9079

TABLE OF GROUP BY AREA11

GROUP	AREA11			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	48 87 27	7 12 73	55
C	2	30 83 33	6 16 67	36
I	11	35 67 31	17 32 69	52
M	8	41 89 13	5 10 87	46
TOTAL		154	35	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10 011 DF= 3 PROB=0 0185

TABLE OF GROUP BY AREA12

GROUP	AREA12			
FREQUENCY ROW PCT		0		TOTAL
A	12	55 100 00		55
C	2	36 100 00		36
I	11	52 100 00		52
M	8	46 100 00		46
TOTAL		189		189

TABLE OF GROUP BY AREA13

GROUP	AREA13			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	52 94 55	3 5 45	55
C	2	35 97 22	1 2 78	36
I	11	52 100 00	0 0 00	52
M	8	42 91 30	4 8 70	46
TOTAL		181	8	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 949 DF= 3 PROB=0 1756

TABLE OF GROUP BY AREA14

GROUP	AREA14			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	48 87 27	7 12 73	55
C	2	30 83 33	6 16 67	36
I	11	47 90 38	5 9 62	52
M	8	43 93 48	3 6 52	46
TOTAL		168	21	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2 369 DF= 3 PROB=0 4994

TABLE OF GROUP BY AREA15				
GROUP	AREA15			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	34 94 44	2 5 56	36
I	11	50 96 15	2 3 85	52
M	8	45 97 83	1 2 17	46
TOTAL		183	6	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 219 DF= 3 PROB=0 7484

TABLE OF GROUP BY AREA16				
GROUP	AREA16			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	35 97 22	1 2 78	36
I	11	47 90 38	5 9 62	52
M	8	44 95 65	2 4 35	46
TOTAL		180	9	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4.082 DF= 3 PROB=0.2528

TABLE OF GROUP BY AREA17				
GROUP	AREA17			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	53 96 36	2 3 64	55
C	2	35 97 22	1 2 78	36
I	11	48 92 31	4 7 69	52
M	8	45 97 83	1 2 17	46
TOTAL		181	8	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2 253 DF= 3 PROB=0 5217

TABLE OF GROUP BY AREA18				
GROUP	AREA18			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	32 88 89	4 11 11	36
I	11	50 96 15	2 3 85	52
M	8	44 95 65	2 4 35	46
TOTAL		180	9	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 364 DF= 3 PROB=0 2247

TABLE OF GROUP BY AREA19

GROUP	AREA19			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	34 94 44	2 5 56	36
I	12	49 96 08	2 3 92	51
M	8	45 97 83	1 2 17	46
TOTAL		182	6	188

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 229 DF= 3 PROB=0 7460

TABLE OF GROUP BY AREA20

GROUP	AREA20			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	33 91 67	3 8 33	36
I	11	48 92 31	4 7 69	52
M	8	46 100 00	0 0 00	46
TOTAL		181	8	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 5 853 DF= 3 PROB=0 1190

TABLE OF GROUP BY AREA21

GROUP	AREA21			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	42 76 36	13 23 64	55
C	2	26 72 22	10 27 78	36
I	11	36 69 23	16 30 77	52
M	8	38 82 61	8 17 39	46
TOTAL		142	47	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2 553 DF= 3 PROB=0 4657

TABLE OF GROUP BY AREA22

GROUP	AREA22			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	52 94 55	3 5 45	55
C	2	35 97 22	1 2 78	36
I	11	52 100 00	0 0 00	52
M	8	45 97 83	1 2 17	46
TOTAL		184	5	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 140 DF= 3 PROB=0 3705

TABLE OF GROUP BY AREA23

GROUP	AREA23			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	53 96 36	2 3 64	55
C	2	36 100 00	0 0 00	36
I	11	51 98 08	1 1 92	52
M	8	45 97 83	1 2 17	46
TOTAL		185	4	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 402 DF= 3 PROB=0 7051

TABLE OF GROUP BY AREA24

GROUP	AREA24			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	36 100 00	0 0 00	36
I	11	52 100 00	0 0 00	52
M	8	45 97 83	1 2 17	46
TOTAL		187	2	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 791 DF= 3 PROB=0 6168

TABLE OF GROUP BY AREA25

GROUP	AREA25			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	55 100 00	0 0 00	55
C	2	35 97 22	1 2 78	36
I	11	52 100 00	0 0 00	52
M	8	44 95 65	2 4 35	46
TOTAL		186	3	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4 296 DF= 3 PROB=0 2312

TABLE OF GROUP BY AREA26

GROUP	AREA26			
FREQUENCY ROW PCT		0	1	TOTAL
A	12	54 98 18	1 1 82	55
C	2	35 97 22	1 2 78	36
I	11	50 96 15	2 3 85	52
M	8	46 100 00	0 0 00	46
TOTAL		185	4	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 845 DF= 3 PROB=0 6051

TABLE OF GROUP BY AREA27

GROUP	AREA27			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	53 96 36	2 3 64	55
C	2	36 100 00	0 0 00	36
I	11	49 94 23	3 5 77	52
M	8	46 100 00	0 0 00	46
TOTAL		184	5	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE

4.408 DF= 3 PROB=0 2206

TABLE OF GROUP BY AREA28

GROUP	AREA28			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	55 100 00	0 0 00	55
C	2	36 100 00	0 0 00	36
I	11	51 98 08	1 1 92	52
M	8	45 97 83	1 2 17	46
TOTAL		187	2	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE

1 892 DF= 3 PROB=0 5952

TABLE OF GROUP BY AREA29

GROUP	AREA29			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	55 100 00	0 0 00	55
C	2	36 100 00	0 0 00	36
I	11	52 100 00	0 0 00	52
M	8	43 93 48	3 6 52	46
TOTAL		186	3	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE

9.477 DF= 3 PROB=0 0236

TABLE OF GROUP BY AREA30

GROUP	AREA30			TOTAL
FREQUENCY ROW PCT		0	1	
A	12	55 100 00	0 0 00	55
C	2	36 100 00	0 0 00	36
I	11	52 100 00	0 0 00	52
M	8	45 97 83	1 2 17	46
TOTAL		188	1	189

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE

3 125 DF= 3 PROB=0 3727

TABLE OF GROUP BY I14

GROUP		I14			TOTAL
FREQUENCY	ROW PCT	1	2		
A	25	38 90 48	4 9 52		42
C	10	27 96 43	1 3 57		28
I	14	45 91 84	4 8 16		49
M	11	42 97 67	1 2 33		43
TOTAL		152	10		162

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2.576 DF= 3 PROB=0.4618

TABLE OF GROUP BY I15

GROUP		I15				TOTAL
FREQUENCY	ROW PCT	1	2	3		
A	10	16 28 07	38 66 67	3 5 26		57
C	4	13 38 24	21 61 76	0 0 00		34
I	11	24 46 15	26 50 00	2 3 85		52
M	5	30 61 22	19 38 78	0 0 00		49
TOTAL		83	104	5		192

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 15.333 DF= 6 PROB=0.0178

TABLE OF GROUP BY I112

GROUP		I112					TOTAL
FREQUENCY	ROW PCT	1	2	3	4		
A	12	0 0 00	46 83 64	8 14 55	1 1 82		55
C	5	0 0 00	29 87 88	3 9 09	1 3 03		33
I	6	0 0 00	48 84 21	8 14 04	1 1 75		57
M	7	1 2 13	34 72 34	10 21 28	2 4 26		47
TOTAL		1	157	29	5		192

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6.645 DF= 9 PROB=0.6740

TABLE OF GROUP BY I113

GROUP		I113				TOTAL
FREQUENCY	ROW PCT	1	2	3		
A	13	36 66 67	16 29 63	2 3 70		54
C	4	15 44 12	19 55 88	0 0 00		34
I	7	26 46 43	29 51 79	1 1 79		56
M	5	28 57 14	21 42 86	0 0 00		49
TOTAL		105	85	3		193

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10.198 DF= 6 PROB=0.1166

TABLE OF GROUP BY CS1

GROUP	CS1			
FREQUENCY ROW PCT		0	1	TOTAL
A	0	9 13 43	58 86 57	67
C	0	3 7 89	35 92 11	38
I	2	6 9 84	55 90 16	61
M	0	7 12 96	47 87 04	54
TOTAL		25	195	220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 017 DF= 3 PROB=0 7971

TABLE OF GROUP BY CS2

GROUP	CS2			
FREQUENCY ROW PCT		0	1	TOTAL
A	0	12 17 91	55 82 09	67
C	0	8 21 05	30 78 95	38
I	2	14 22 95	47 77 05	61
M	0	28 51 85	26 48 15	54
TOTAL		62	158	220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 20 220 DF= 3 PROB=0 0002

TABLE OF GROUP BY CS3

GROUP	CS3			
FREQUENCY ROW PCT		0	1	TOTAL
A	0	28 41 79	39 58 21	67
C	1	11 29 73	26 70 27	37
I	3	24 40 00	36 60 00	60
M	0	33 61 11	21 38 89	54
TOTAL		96	122	218

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9 995 DF= 3 PROB=0 0186

TABLE OF GROUP BY CS4

GROUP	CS4			
FREQUENCY ROW PCT		0	1	TOTAL
A	0	36 53 73	31 46 27	67
C	0	13 34 21	25 65 79	38
I	2	22 36 07	39 63 93	61
M	0	20 37 04	34 62 96	54
TOTAL		91	129	220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6 150 DF= 3 PROB=0 1045

TABLE OF GROUP BY CS5

GROUP	CS5		0	1	TOTAL
FREQUENCY ROW PCT					
A	0	58	9	67	
		86 57	13 43		
C	0	33	5	38	
		86 84	13 16		
I	2	53	8	61	
		86 89	13 11		
M	0	39	15	54	
		72 22	27 78		
TOTAL		183	37	220	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6.147 DF= 3 PROB=0.1047

TABLE OF GROUP BY CS6

GROUP	CS6		0	1	TOTAL
FREQUENCY ROW PCT					
A	0	26	41	67	
		38 81	61 19		
C	0	8	30	38	
		21 05	78 95		
I	3	10	50	60	
		16 67	83 33		
M	0	20	34	54	
		37 04	62 96		
TOTAL		64	155	219	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10.369 DF= 3 PROB=0.0157

TABLE OF GROUP BY CS7

GROUP	CS7		0	1	TOTAL
FREQUENCY ROW PCT					
A	0	41	26	67	
		61 19	38 81		
C	0	18	20	38	
		47 37	52 63		
I	3	26	34	60	
		43 33	56 67		
M	0	23	31	54	
		42 59	57 41		
TOTAL		108	111	219	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 5.675 DF= 3 PROB=0.1285

TABLE OF GROUP BY CS8

GROUP	CS8		0	1	TOTAL
FREQUENCY ROW PCT					
A	0	65	2	67	
		97 01	2 99		
C	0	35	3	38	
		92 11	7 89		
I	3	55	5	60	
		91 67	8 33		
M	0	47	7	54	
		87 04	12 96		
TOTAL		202	17	219	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 4.204 DF= 3 PROB=0.2403

TABLE OF GROUP BY CS9

GROUP	CS9		TOTAL	
FREQUENCY ROW PCT	0	1		
A	0 61 91 04	6 8 96	67	
C	0 31 81 58	7 18 42	38	
I	3 46 76 67	14 23 33	60	
M	0 37 68 52	17 31 48	54	
TOTAL	175	44	219	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9.998 DF= 3 PROB=0.0186

TABLE OF GROUP BY IDS1

GROUP	IDS1		TOTAL	
FREQUENCY ROW PCT	0	1		
A	4 26 41 27	37 58 73	63	
C	0 13 34 21	25 65 79	38	
I	3 26 43 33	34 56 67	60	
M	1 17 32 08	36 67 92	53	
TOTAL	82	132	214	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2.016 DF= 3 PROB=0.5691

TABLE OF GROUP BY IDS2

GROUP	IDS2		TOTAL	
FREQUENCY ROW PCT	0	1		
A	4 39 61 90	24 38 10	63	
C	0 20 52 63	18 47 37	38	
I	3 28 46 67	32 53 33	60	
M	1 31 58 49	22 41 51	53	
TOTAL	118	96	214	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3.244 DF= 3 PROB=0.3555

TABLE OF GROUP BY IDS3

GROUP	IDS3		TOTAL	
FREQUENCY ROW PCT	0	1		
A	4 50 79 37	13 20 63	63	
C	0 28 73 68	10 26 32	38	
I	3 48 80 00	12 20 00	60	
M	1 35 66 04	18 33 86	53	
TOTAL	161	53	214	

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3.763 DF= 3 PROB=0.2882

TABLE OF GROUP BY IDS4

GROUP	IDS4			
FREQUENCY ROW PCT		0	1	TOTAL
A	4	49 77 78	14 22 22	63
C	0	29 76 32	9 23 68	38
I	3	36 60 00	24 40 00	60
M	1	45 84 91	8 15 09	53
TOTAL		159	55	214

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10 027 DF= 3 PROB=0 0183

TABLE OF GROUP BY QUAL1

GROUP	QUAL1			
FREQUENCY ROW PCT		0	1	TOTAL
A	31	19 52 78	17 47 22	36
C	15	8 34 78	15 65 22	23
I	20	30 69 77	13 30 23	43
M	14	30 75 00	10 25 00	40
TOTAL		87	55	142

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 12 380 DF= 3 PROB=0 0062

TABLE OF GROUP BY QUAL2

GROUP	QUAL2			
FREQUENCY ROW PCT		0	1	TOTAL
A	31	5 13 89	31 86 11	36
C	12	4 15 38	22 84 62	26
I	21	2 4 76	40 95 24	42
M	14	7 17 50	33 82 50	40
TOTAL		18	126	144

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 475 DF= 3 PROB=0 3240

TABLE OF GROUP BY QUAL3

GROUP	QUAL3			
FREQUENCY ROW PCT		0	1	TOTAL
A	31	33 91 67	3 8 33	36
C	15	22 95 65	1 4 35	23
I	20	40 93 02	3 6 98	43
M	14	37 92 50	3 7 50	40
TOTAL		132	10	142

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 0 360 DF= 3 PROB=0 9484

TABLE OF GROUP BY QUAL4

GROUP	QUAL4				
FREQUENCY ROW PCT		0	1		TOTAL
A	31	21 58.33	15 41.67		36
C	13	14 56.00	11 44.00		25
I	20	17 39.53	26 60.47		43
M	14	29 72.50	11 27.50		40
TOTAL		81	63		144

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9.238 DF= 3 PROB=0.0263

TABLE OF GROUP BY I116

GROUP	I116				
FREQUENCY ROW PCT					TOTAL
A	16	17 33.33	33 64.71	1 1.96	51
C	8	11 36.67	19 63.33	0 0.0	30
I	16	30 63.83	15 31.91	2 4.26	47
M	7	30 63.83	16 43.04	1 2.13	47
TOTAL		88 50.29	83 47.43	4 2.29	175

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 17.933 DF = 6 PROB=0.0064

TABLE OF GROUP BY SPEC

GROUP	SPEC				
FREQUENCY ROW PCT		1	2	3	TOTAL
A	9	33 56.90	25 43.10	0 0.00	58
C	3	24 68.57	11 31.43	0 0.00	35
I	5	44 75.86	14 24.14	0 0.00	58
M	2	37 71.15	14 26.92	1 1.92	52
TOTAL		138 67.98	64 31.53	1 0.49	203

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 8.380 DF= 6 PROB=0.2115

TABLE OF GROUP BY MER1

GROUP	MER1				
FREQUENCY ROW PCT		0	1		TOTAL
A	0	44 65.67	23 34.33		67
C	1	23 62.16	14 37.84		37
I	8	30 54.55	25 45.45		55
M	3	19 37.25	32 62.75		51
TOTAL		116	94		210

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10.348 DF= 3 PROB=0.0158

TABLE OF GROUP BY MER2

GROUP	MER2				
FREQUENCY ROW PCT		0	1		TOTAL
A	1	30 45 45	36 54 55		66
C	1	12 32 43	25 67 57		37
I	0	29 46 03	34 53 97		63
M	0	35 64 81	19 35 19		54
TOTAL		106	114		220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9 973 DF= 3 PROB=0 0188

TABLE OF GROUP BY MER3

GROUP	MER3				
FREQUENCY ROW PCT		0	1		TOTAL
A	1	63 95 45	3 4 55		66
C	1	36 97 30	1 2 70		37
I	0	60 95 24	3 4 76		63
M	0	54 100 00	0 0 00		54
TOTAL		213	7		220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 2 711 DF= 3 PROB=0 4383

TABLE OF GROUP BY MER4

GROUP	MER4				
FREQUENCY ROW PCT		0	1		TOTAL
A	2	54 83 08	11 16 92		65
C	1	30 81 08	7 18 92		37
I	0	55 87 30	8 12 70		63
M	0	48 88 89	6 11 11		54
TOTAL		187	32		219

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 544 DF= 3 PROB=0 6722

TABLE OF GROUP BY MER5

GROUP	MER5				
FREQUENCY ROW PCT		0	1		TOTAL
A	1	41 62 12	25 37 88		66
C	1	20 54 05	17 45 95		37
I	0	35 55 56	28 44 44		63
M	0	31 57 41	23 42 59		54
TOTAL		127	93		220

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 0 851 DF= 3 PROB=0 8373

TABLE OF GROUP BY MERG

GROUP	MERG			
FREQUENCY ROW PCT		0	1	TOTAL
A	1	25 37 88	41 62 12	66
C	2	13 36 11	23 63 89	36
I	0	18 28 57	45 71 43	63
M	2	15 28 85	37 71 15	52
TOTAL		71	146	217

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 833 DF= 3 PROB=0 6078

TABLE OF GROUP BY MREA

GROUP	MREA			
FREQUENCY ROW PCT		1	2	TOTAL
A	6	55 90 16	6 9 84	61
C	7	26 83 87	5 16 13	31
I	10	46 86 79	7 13 21	53
M	3	38 74 51	13 25 49	51
TOTAL		165	31	196

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 5 496 DF= 3 PROB=0 1389

TABLE OF GROUP BY MREB

GROUP	MREB					
FREQUENCY ROW PCT		1	2	3	5	TOTAL
A	13	31 57 41	3 5 56	14 25 93	6 11 11	54
C	10	20 71 43	1 3 57	6 21 43	1 3 57	28
I	19	25 56 82	4 9 09	12 27 27	3 6 82	44
M	9	33 73 33	2 4 44	4 8 89	6 13 33	45
TOTAL		109	10	36	16	171

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9 604 DF= 9 PROB=0 3835

TABLE OF GROUP BY II17

GROUP	II17			
FREQUENCY ROW PCT		1	2	TOTAL
A	10	49 85 96	8 14 04	57
C	7	24 77 42	7 22 58	31
I	20	35 81 40	8 18 60	43
M	5	42 85 71	7 14 29	49
TOTAL		150	30	180

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1.381 DF= 3 PROB=0 7100

TABLE OF GROUP BY MECS1

GROUP	MECS1			
FREQUENCY ROW PCT		0	1	TOTAL
A	4	22 34 92	41 65 08	63
C	0	8 21 05	30 78 95	38
I	2	12 19 67	49 80 33	61
M	0	9 16 67	45 83 33	54
TOTAL		51	165	216

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6 574 DF= 3 PROB=0 0868

TABLE OF GROUP BY MECS2

GROUP	MECS2			
FREQUENCY ROW PCT		0	1	TOTAL
A	4	62 98 41	1 1 59	63
C	0	35 92 11	3 7 89	38
I	2	56 91 80	5 8 20	61
M	1	51 96 23	2 3 77	53
TOTAL		204	11	215

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 3 610 DF= 3 PROB=0 3068

TABLE OF GROUP BY MECS3

GROUP	MECS3			
FREQUENCY ROW PCT		0	1	TOTAL
A	4	59 93 65	4 6 35	63
C	0	34 89 47	4 10 53	38
I	2	59 96 72	2 3 28	61
M	1	45 84 91	8 15 09	53
TOTAL		197	18	215

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 5 751 DF= 3 PROB=0 1244

TABLE OF GROUP BY MECS4

GROUP	MECS4			
FREQUENCY ROW PCT		0	1	TOTAL
A	4	5 7 94	58 92 06	63
C	0	4 10 53	34 89 47	38
I	2	9 14 75	52 85 25	61
M	0	12 22 22	42 77 78	54
TOTAL		30	186	216

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6 399 DF= 3 PROB=0 1448

TABLE OF GROUP BY MRR1

GROUP	MRR1				
FREQUENCY ROW PCT		0	1		TOTAL
A	1	46 69 70	20 30 30		66
C	1	18 48 65	19 51 35		37
I	17	31 67 39	15 32 61		46
M	1	42 79 25	11 20 75		53
TOTAL		137	65		202

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 9 512 DF= 3 PROB=0 0232

TABLE OF GROUP BY MRR2

GROUP	MRR2				
FREQUENCY ROW PCT		0	1		TOTAL
A	3	16 25 00	48 75 00		64
C	1	11 29 73	26 70 27		37
I	4	6 10 17	53 89 83		59
M	2	5 9 62	47 90 38		52
TOTAL		38	174		212

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 10 535 DF= 3 PROB=0 0145

TABLE OF GROUP BY MRR3

GROUP	MRR3				
FREQUENCY ROW PCT		0	1		TOTAL
A	2	32 49 23	33 50 77		65
C	1	16 43 24	21 56 76		37
I	14	14 28 57	35 71 43		49
M	1	27 50 94	26 49 06		53
TOTAL		89	115		204

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 6 502 DF= 3 PROB=0 0896

TABLE OF GROUP BY MRR4

GROUP	MRR4				
FREQUENCY ROW PCT		0	1		TOTAL
A	3	48 75 00	16 25 00		64
C	1	35 94 59	2 5 41		37
I	19	35 79 55	9 20 45		44
M	1	47 88 68	6 11 32		53
TOTAL		165	33		198

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 8 123 DF= 3 PROB=0 0435

TABLE OF GROUP BY MRR5

GROUP		MRR5			
FREQUENCY	ROW PCT		0	1	TOTAL
A		2	53 81 54	12 18 46	65
C		1	32 86 49	5 13 51	37
I		19	35 79 55	9 20 45	44
M		1	46 86 79	7 13 21	53
TOTAL			166	33	199

STATISTICS FOR 2-WAY TABLES

CHI-SQUARE 1 331 DF= 3 PROB=0 7218

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