DOCUMENT RESUME

ED 067 464 VT 016 554

TITLE	Accreditation of Health Educational Programs. Part 1: Staff Working Papers.
INSTITUTION	Study of Accreditation of Selected Health Educational Programs, Washington, D. C.
SPONS AGENCY	American Medical Association, Chicago, Ill. Council on Medical Education.; Association of Schools of Allied Health Professions, Washington, D. C.; National Commission on Accrediting, Washington, D.C.
PUB DATE	Oct 71
NOTE	128p.
AVAILABLE FROM	Study of Accreditation of Selected Health Educational Programs, One Dupont Circle, N.W., Suite 300, Washington, D.C. 20036 ($1.00 - limited supply)
EDRS PRICE	MF-$0.65 HC-$6.58
DESCRIPTORS	*Accreditation (Institutions); Educational Accountability; Educational Finance; *Educational Programs; Educational Research; *Health Occupations Education; Post Secondary Education

ABSTRACT

This publication contains the first set of working papers concerned with structure, financing, research, and expansion as they relate to the accreditation of health education programs conducted by professional agencies. Texts of these papers are included: (1) "Historical Introduction to Accreditation of Health Educational Programs" by W.K. Selden, (2) "Structure of Accreditation of Health Educational Programs" by J.W. Miller, (3) "Financing the Accreditation of Health Educational Programs" by K.L. Grimm, (4) "Research in Accreditation of Health Educational Programs" by W.K. Selden, (5) "Expansion in Accreditation of Health Educational Programs" by W.K. Selden, and (6) "Accreditation of Postsecondary Education: Problems in Organization" by H. Seidman. A second set of papers is available as VT 016 555 in this issue. (SB)

PART ONE: WORKING PAPERS

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Accreditation of Health Educational Programs

STUDY OF ACCREDITATION OF SELECTED HEALTH EDUCATIONAL PROGRAMS

The accompanying series of working papers was prepared by the staff of SASHEP to assist the members of the Study Commission as they consider the various issues related to the accreditation of health educational programs. Copies of these papers are being made available to the members of the Panel of Advisors, to representatives of each of the accrediting agencies in the health fields, and to officials of the three cosponsoring organizations. Copies are available to others, $1 a copy, as long as the limited supply lasts.

In preparing these papers, the members of the staff have relied on extensive interviews, correspondence, and questionnaires, which have involved numerous persons engaged in or knowledgeable about accreditation. In addition, the literature of accreditation and related subjects has been thoroughly reviewed.

This set of working papers in Part I is concerned with structure, financing, research, and expansion, as they relate to the accreditation of health educational programs. In addition, a paper prepared by a consultant to SASHEP is included and is concerned with alternate structures and responsibilities for a national body to supervise and coordinate all accreditation.

Part II of the working papers is scheduled to be completed and printed for public distribution in early 1972. These papers will be concerned with the relationship of accreditation to certification, licensure, and registration; with procedures of the accrediting agencies in the health fields; and with the accountability and social responsibility of accreditation. Part II will also include a commissioned paper related to the legal aspects of a professional society.

William K. Selden
Director

October 1971

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PART I: STAFF WORKING PAPERS
ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

October 1971 $1 a copy

Sponsored by: Council on Medical Education, American Medical Association
Association of Schools of Allied Health Professions • National Commission on Accrediting

Accreditation is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.

HISTORICAL INTRODUCTION TO ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

William K. Selden

This working paper and the others that follow are concerned with accreditation of health educational programs of study, conducted by what are known as professional agencies. Only incidentally are the papers concerned with accreditation conducted by the regional associations of colleges and schools.

Opinions differ as to which organization first employed accreditation as a means of exerting external control over educational standards. For this mark of distinction, there are supporters for the University of Michigan, the American Association of University Women, the University Senate of the Methodist Episcopal Church, the Illinois Board of Health, the Association of American Medical Colleges, and the Board of Regents of the University of the State of New York. Regardless of these claims, there can be little argument that the field of medicine has probably exerted more influence on the course of specialized accreditation, as it has been developed in the United States, than has any other single program of accreditation. This influence extends beyond the health fields, although it is most keenly felt in these areas.

The history of accreditation of medical schools must be understood if one is to appreciate the present factors that are involved in the accreditation of the other health educational programs. The name of Abraham Flexner immediately comes to mind, but he is only one element, albeit an important one, among the many factors that both influenced the program of accreditation in medical education and transformed our medical schools within a short time span from ones with generally low standards to ones whose accomplishments and contributions are respected around the world. As a result of this dramatic transformation in medical education in the United States, as well as for other reasons, the health professional organizations are striving in burgeoning numbers to emulate medicine, even when it may not be in the broad interests of society for them to do so in every respect.

The term *organized medicine*, which is so commonly employed today to refer to the American Medical Association, could not have been used prior to 1847, for that was the year in which the AMA was organized. The first invitation to the organizational meeting stated "that a national convention would be conducive to the elevation of the standard of medical education in the United States." Despite that statement of purpose, it was fifty-seven years before marked improvement in medical education was actually initiated on a national basis. Just as economic, political, and social factors today are bearing heavily on developments in the preparation of health personnel and in the delivery of health care, so in the nineteenth century similar forces were at work. As Henry

Sigerist has emphasized, medicine is only one aspect of a civilization, reflecting the general cultural conditions and the underlying national philosophy of a society.[1]

In the latter part of the nineteenth century, the United States enjoyed the benefits and also the handicaps of scientific and technological developments, the rapid accumulation of wealth and fortunes, the spirit of manifest destiny, and the heritage of Jacksonian democracy. It was still a pioneer country, heavily influenced by immigration and a westward migration and strongly committed to the economic philosophy of laissez faire and caveat emptor. Society was filled with entrepreneurs, not the least of whom were the physicians, including eclectics, homeopaths, osteopaths, and physiomedics. Licensure laws, once in vogue, then in abeyance, were not revived until the very end of the century and then only on an uneven basis among the various states.[2]

As with all occupations, entrance into the practice of medicine was relatively easy to attain. Although apprentice training continued to exist, didactic education in any one of numerous medical schools was the quickest way to a medical livelihood. In many cases, the operation of a school of medicine proved to be financially attractive, as witnessed by the number of proprietary institutions in existence at the turn of the century. Including all types, according to Morris Fishbein, there were at the end of the nineteenth century "about as many medical schools in the United States as there were in all the rest of the world."[3] In 1881 the number of medical schools totaled 96; by 1890 there were 120; and by 1900 the number had expanded to over 150, whose total enrollment comprised more than 24,000 students in a national population of 76 million, compared with some 40,000 students enrolled today in 103 medical schools in a population of over 200 million.

Despite the fact that since its founding in 1847 the American Medical Association has had a standing Committee on Medical Education, it was powerless throughout the last half of the nineteenth century to control the excessive proliferation of schools or their educational standards. The membership of the association comprised during its early years a smaller percentage of the practicing physicians, and many of those members objected to any type of critical action for fear of adversely reflecting on their own medical educations. Fishbein also claims that one of the reasons for the ineffectiveness of the AMA was the presence of medical college professors whose influence was so great as to prevent the association from "establishing a national standard for medical teaching and demanding that the colleges shall accept it or not be recognized."[4]

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1. Quoted by Jeanne Brand in "English and American Medicine and Society 1900-1914" in *Medicine and Culture*, ed. F. N. L. Poynter (London: Wellcome Institute of the History of Medicine, 1969), pp. 137-51.

2. Richard H. Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins Press, 1967).

3. *A History of the American Medical Association, 1847-1947* (Philadelphia: W. B. Saunders Co., 1947), p. 889.

4. *Ibid.*, p. 890.

Concurrent with this seemingly ungovernable expansion of medical education, there were forces which in time led to concerted attack on the problems and eventually to what is now strong control through accreditation, possibly for some too strong and too concentrated. During the latter part of the nineteenth century, there was notable progress in European medical and scientific education to which a small but able group of young Americans were attracted. On their return to teaching positions in American universities or to the practice of medicine, following their studies on the continent, they exerted a constructive influence on the development of graduate and improved medical education, which led in turn to further advance of the practice of medicine in their native land. Johns Hopkins University, established in 1876, was the cynosure of all who aspired to the best in university education; and its new medical school soon highlighted the contrast between it and the many shoddy institutions that claimed to be training future doctors of medicine.

Three other events, which were related to the establishment and enforcement of standards for medical education, should be noted. *First*, in 1887, the United States Congress authorized the establishment of the Interstate Commerce Commission to regulate interstate transportation and to control the excesses of the railroad industry. This was the first significant effort of the federal government to regulate economic affairs since the expiration of the charter of the second Bank of the United States in 1836, during the Jacksonian period.[5] The passage of this act presaged a departure from the philosophy of laissez faire, a change which became more evident in the Roosevelt and Wilson administrations when increasing attention was given to control of excessive economic self-serving. This same movement toward social control subsequently became manifest with respect to educational entrepreneurs.

Second, the American Medical Association was reorganized shortly after the turn of the century. As part of this reorganization, a Council on Medical Education was created, and the members, who were appointed, immediately assumed a position of constructive leadership. This led in 1905 to the first Congress on Medical Education, which published a classification of medical schools based solely on the percentage of licensure examination failures for each school. This classification was followed by another rating system based on ten categories and on inspections of each school, a process of accreditation that the AMA has supported with procedural variations for nearly two-thirds of a century. This second classification, completed in 1907, comprised 82 schools in Class A (approved), 46 in Class B (probation), and 32 in Class C (unapproved), for a total of 160 schools. The latter classification was not made public, although each school was advised of its individual standing. As a result, resentment of the council developed, and its work might have floundered had it not been for the concurrent interest of a recently created foundation.

5. Marver H. Bernstein, *Regulating Business by Independent Commission* (Princeton: Princeton University Press, 1955), p. 21.

Third, in 1905 Andrew Carnegie created and endowed the Carnegie Foundation for the Advancement of Teaching. Under the guidance of its president, Henry S. Pritchett, it gave immediate attention to the need for unity in education. It was sponsoring studies not only of the relationship between the secondary schools and the colleges but also of the colleges to the graduate and professional schools. When the Council on Medical Education found itself under attack for the excellent steps that it had initiated for the improvement in medical education, it turned to the Carnegie Foundation for assistance. There it found a ready and favorable response to its request for sponsorship of an independent study of medical education. Abraham Flexner was appointed to conduct the study, and he was assisted throughout by Dr. N. P. Colwell, secretary of the Council on Medical Education. Their report was completed and published in 1910 and provided substantial support for the steps already initiated by the council of the AMA.

The Flexner Report is commonly cited as the motivating force for the rectification of medical education in the United States and Canada. Although it was an outstandingly thorough and constructive contribution which gave public recognition to needed changes, it would not have been so dramatically influential if the Council on Medical Education had not already initiated the movement for improvement in medical schools and created the pattern for accrediting them. A graduate of Johns Hopkins University and enamored with the stress on academic and scientific education provided by the German universities, Flexner emphasized the vital steps that were needed to improve medical education: raise the requirement for admission to the schools, require of students a background in scientific subjects, replace didactic instruction with laboratory experience and clinical exposure, and improve the faculties and the facilities of the schools, which should be associated with and be integral parts of universities.

Flexner and Colwell personally visited each of the 155 schools in existence at the time of the study and divided them into three groups: (1) those that required two or more years of college work for entrance; (2) those that demanded actual graduation from a high school or oscillated around this requirement; and (3) those that stipulated few, if any, requirements for admission. The report contained the drastic proposal, never fully implemented, that the number of schools should be reduced by eliminating some 120 through mergers or closings. However, by 1915 the number of schools had been reduced to 95—a reduction of 40 percent—largely as a result of the impetus that Flexner gave to the movement initiated by the AMA. In that year, the council again classified the schools: 66 in Class A, 17 in Class B, and 12 in Class C. The others had closed or merged.

The great contribution of the Flexner Report, which many other directors of studies have endeavored to emulate, was its emphasis on scientific medicine as the direction of the future and on the need to require a higher quality of students and faculty in order to provide improved quality in medical practice. To help accomplish these goals, Flexner insisted that "the improvement of

medical education cannot therefore be resisted on the ground that it will destroy schools and restrict output: that is precisely what is needed."[6]

This goal of restriction on the production of physicians was strongly endorsed by the Carnegie Foundation, not only by its support of the Flexner study but also by the comments of Pritchett when he wrote in the foreward of the report, "It is evident that, in a society constituted as our modern states, the interests of the social order will be served best when the number of men entering a given profession reaches and does not exceed a certain ratio."[7] Pritchett placed much of the blame for an enormous overproduction of uneducated and ill-trained medical practitioners on the existence of a large number of commercial schools that flourished at a time when there were only the beginnings of governmental control over the excesses of the free economic market and when there were few checks of any kind on any educational enterprise at any level of instruction.

It was in this economic, political, and social atmosphere that accreditation took shape. It was needed as a means of some protection for society, and it proved to be a mechanism by which medicine could begin more adequately to protect itself.

The development of nongovernmental accreditation and the fact that its organizational structure involved and continues to involve primarily professional and institutional interests can be traced to the political philosophy and social and economic values of the United States.

> The non-existence of an accrediting program operated by the national government can be attributed to the principles enunciated in the United States Constitution and to the American conviction that our social welfare is dependent upon education as a local responsibility. The absence of adequate state accreditation springs from a tradition of laissez faire independence and sectarian rivalry, a fear of political interference, and a later acceptance of regional associations [of colleges and schools and of professional bodies] as the best instruments to perform what the states are legally empowered to do.[8]

Quite commonly in recent years, the AMA has been flailed for some of its past actions with respect to limitations on the number of medical schools and on the numbers entering the profession of medicine. Elton Rayack has added his voice to the chorus by stating, ". . . organized medicine has frequently used that power of restrictionist device, with socially undesirable results, in order to increase the incomes, power, and prestige of its members."[9]

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6. *Medical Education in the United States and Canada* (New York: Carnegie Foundation for the Advancement of Teaching, 1910), p. 16.
7. *Ibid.*, p. XIV.
8. William K. Selden, *Accreditation: A Struggle Over Standards in Higher Education* (New York: Harper and Brothers, 1960), p. 45.
9. *Professional Power and American Medicine: The Economics of the American Medical Association* (Cleveland, World Publishing Co., 1967), p. 210.

It is true that any professional society or group, no matter how socially oriented, will tend to develop barriers to protect itself. As in human anatomy, there is a group physiological reaction to create protective mechanisms. Among the contemporary protective mechanisms for the health professions are accreditation, certification, licensure, and registration. All four of these mechanisms medicine has employed with excellent results, if not always for the benefit of society, at least for the benefit of most members of the profession. And now many of the numerous other health professions wish to adopt, if they have not already done so, the same steps which medicine has fashioned to meet the needs of society and its own protection.

In the early part of this century when the health professionals were almost exclusively physicians and dentists, a less complex situation prevailed than presently exists. Now physicians comprise only about 12 percent of the health workers, with the others identified by some 250 different classifications of health occupations, entrance to many of which is dependent upon completion of formal educational requirements. Moreover, the number of health occupations will undoubtedly multiply, nourished by the expansion of knowledge, the increase in technology, and the specialization of society. Most of these health occupations will aspire to professional status, including the functions of accreditation of the educational programs preparing the future members of their respective professional occupations.

Between 1900 and 1930, in the order of their initiation, the following programs of accreditation of health educational programs of study were begun: medicine, osteopathy, dentistry, podiatry, nursing, occupational therapy and physical therapy, a total of seven fields. Between 1930 and 1960, as many as thirteen programs of accreditation were initiated in the following order: social work,[10] medical technology, occupational therapy assistant, pharmacy, optometry, medical record librarianship, practical nursing, x-ray (radiologic) technology, public health, veterinary medicine, psychology, nurse anesthesiology, and medical record technology.

Since 1960 accreditation has been established for fields of study leading to the following health occupations: audiologist, blood bank specialist, certified laboratory assistant, community health educator, cytotechnologist, dental assistant, dental hygienist, dental technologist, environmentalist, histologic technician, hospital administrator, inhalation therapist, medical assistant, operating room technician, optician, orthopedic physician's assistant, nuclear medicine technician, nuclear medicine technologist, physical therapy assistant, speech pathologist, and urologic assistant. For another occupation, accreditation was begun just prior to the 1960s: radiation therapy technologist.

Is there an end to this multiplicity of programs of accreditation? How should they be controlled? How can they be financed? How do they validate their operations?

10. Even though most social workers are not employed in health related settings, social work is included in this listing because much social work practice is health related.

These are only a few of the questions to be raised in the working papers prepared by the staff of SASHEP for the benefit of its Study Commission, Panel of Advisors, and representatives of the various accrediting agencies, collaborating organizations, and institutions that are concerned with the future of accreditation of health educational programs in the United States. Other issues will be identified in the following papers.

STRUCTURE OF ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

Jerry W. Miller

Accreditation is important to health care because it certifies the quality of educational programs preparing the health care professional. Thus, it is important to society that accreditation function effectively and in a manner calculated to enhance health care delivery.

Yet, accreditation's effectiveness in the health fields is being jeopardized by mounting tensions evident among the health professions. Due in part to a struggle for control of the accrediting process, these tensions have a potentially debilitating influence both on the effectiveness of the accrediting process and working relationships among the health professions. As their consequence, the quality of health care could be expected to suffer.

The effectiveness of accreditation and the spirit in which it is conducted are largely determined by the organizational structure under which accreditation functions. Who controls or participates, under what circumstances, and in what manner are important factors in assuring a socially useful mechanism. One of the central objectives of the Study of Accreditation of Selected Health Educational Programs is the framing of recommendations for accreditation that will eventually have a favorable impact on the quality of health care in the United States.

This paper analyzes the organizational structure of accreditation in the health care fields. Its central focus is on the structure utilized by the American Medical Association in providing accrediting services. Information on the organization of accreditation in general and on accreditation of other health-related educational programs in particular is provided for contextual considerations.

Background

Nongovernmental accreditation has come to be the principal means of assuring the academic integrity of postsecondary education in the United States. The nongovernmental agencies, often characterized as private and voluntary, are considered by the public as the most reliable determiners of quality in postsecondary education, even though many of the fifty states also have agencies that conduct accreditation, approval, or registry of institutions or curricula. In nearly all foreign countries, these functions are served by government ministries.

There are two types of accreditation practiced by nongovernmental agencies in the United States:

> *Institutional accreditation* is concerned with the quality of the total institution. The best known example of institutional accreditation is that conducted by the six regional associations of colleges, universities, and schools. Control and responsibility for this type of accreditation rests with associations of accredited institutions located in the six regions of the country.

Specialized accreditation is concerned with a particular field of study. It is conducted on a national basis in such fields as architecture, dentistry, engineering, medicine, optometry, and physical therapy. Control and responsibility for specialized accreditation are varied, but primarily involve professional associations and associations of professional schools. This type of accreditation, for example, is conducted for dental schools by the American Dental Association and for nursing by the National League for Nursing. By concentrating expertise on more narrow educational concerns, it has become identified with the protection of the health and safety of the public through more extensive evaluation of the educational process.

Institutions of higher education often hold accreditation by an institutional accrediting agency as well as by one or more specialized accrediting agencies. Educational programs offered in hospitals or laboratories and involving only a single field of study are accredited only by specialized accrediting agencies.

Accrediting agencies in the United States have legitimacy conferred upon them through recognition by the National Commission on Accrediting and/or the U.S. commissioner of education. Both the National Commission and the commissioner annually publish lists of recognized accrediting agencies. To be included on the lists, agencies must make application for recognition and be evaluated against a set of criteria. The criteria of the NCA and the commissioner are virtually identical, though the purposes of recognition are different.

Since 1952 the U.S. commissioner of education has been required by law to publish a list of accrediting agencies that he determines to be reliable authorities on the quality of education or training offered by educational institutions or programs. The statutory purpose of his role is directly related to the establishment of eligibility for federal funding.

The National Commission on Accrediting was organized in 1949 by representatives of institutions to serve a controlling and coordinating function for accreditation of higher education. The commission relies on the regional commissions of higher education for institution-wide accreditation and currently recognizes agencies to grant specialized accreditation in thirty-seven fields. The primary purpose of the National Commission's list is to serve as a guide to its member institutions.

The lists of both the National Commission and the U.S. commissioner of education have taken on significance beyond their stated purposes. These lists are widely used as guides to the ability and willingness of accrediting agencies to serve socially useful functions.

It is important to note that accrediting agencies can and do function without authorization from either the NCA or the commissioner of education. Furthermore, competing efforts arise, even among recognized agencies. Though the criteria of both the NCA and the U.S. commissioner discourage such competition, the commissioner has recognized two agencies to accredit practical nurse education, the National Association for Practical Nurse Education and Service and the National League for Nursing. Competitive efforts are most

apparent in the medical laboratory field, where some agencies operate without recognition by either the NCA or the commissioner.

Such terms as *nongovernmental, voluntary, peer review, professional responsibility, cooperation,* and *institutional and specialized* reflect the concepts and values that have characterized accreditation in the United States. It is within these parameters that accreditation in the health fields operates.

Organization of Accreditation in Health-Related Fields

There is no deft way to categorize precisely the organization of accreditation in the health fields. Small variances and an occasional significant exception confound any such attempt. However, there has been a tendency for the organization to develop common characteristics concerning type of control and role and position of the health care worker. In considering some of the issues facing SASHEP, the exceptions to these characteristics are of equal significance.

Control

The organization of accreditation in the health fields is mainly dominated and controlled by professional associations. The accrediting efforts exhibit three important variances in type of control.

1. *Professions that assume total or major responsibility for educational programs leading to entry into their respective professions*—Examples are clinical and counseling psychology, dentistry, dietetics, hospital administration, medicine, nursing, nurse anesthesia, nurse midwifery, optometry, osteopathy, pharmacy, podiatry, public health, social work, speech pathology and audiology, and veterinary medicine.

The organization of accreditation in these fields provides varying degrees of involvement of practitioners and educators who are members of the particular profession. Representatives of groups identified with state licensure are sometimes included in the membership of the accrediting body.

2. *Professions that assume responsibility for accreditation of educational programs preparing allied technologists, technicians, and others providing health care services*—Examples are dentistry (dental assisting, dental hygiene, and dental technology), medicine (certified laboratory assistant, cytotechnology, histologic technology, inhalation therapy technician, medical assisting, medical record librarian, medical record technician, medical technologist, nuclear medicine technician, nuclear medicine technologist, occupational therapist, orthopedic assistant, physical therapist, radiation therapy technologist and radiologic technologist), nursing (practical nursing), physical therapy (physical therapy assistants), and occupational therapy (occupational therapy assistants).

In these fields, the organizational structure provides for varying degrees of involvement from the health occupations whose educational programs are being accredited. The process is controlled by the profession that has assumed responsibility.

3. *Professions that assume primary fiscal support for the accrediting operation but organize the accrediting agency in a manner that does not assign*

control to the profession—The American Medical Technologists has organized its accrediting effort in such manner to prevent control by the profession or by accredited schools, and the Accrediting Commission of the International Society of Clinical Laboratory Technologists is named by delegates from the accredited schools. The organizational structure of both these groups is discussed later in this paper in the section entitled "Accreditation of Educational Programs in Medical Laboratory Sciences."

Role and Position of the Health Care Worker

Accreditation in the health fields has tended to be organized in a manner generally coinciding with the relative statuses and roles of the health care occupations.

Primary Health Care—Dentists, medical doctors, optometrists, osteopathic physicians, podiatrists, and doctors of veterinary medicine are often classified as primary providers of health care. These professions, characterized by the doctor's degree certifying professional competence, have formed accrediting operations with strict control by the professional association and generally with involvement of educators who are also members of the profession.

Allied Health Professions and Services—Nearly all the above professions either control or are developing plans to control the accreditation of educational programs for technologists, technicians, and others who work under a doctor's general supervision or on referral or who provide allied services and support. These include the fifteen health educational programs accredited by the Council on Medical Education of the American Medical Association and the dental auxiliary services accredited by the Council on Dental Education of the American Dental Association.

Nursing, nurse anesthesia, and nurse midwifery are significant exceptions. Although nurses practice under circumstances similar in most respects to other allied health occupations, organizations in professional nursing have gained sole responsibility for accreditation of nursing education and specialties.

For two reasons, these exceptions have significance for SASHEP.

1. Nursing's autonomy in accreditation is undoubtedly envied by other health professions. Its success in escaping the dominance of physicians has encouraged other professions to be restive about their relationships with medicine.
2. Some critics contend that the quality of health care has suffered because of nursing's isolation from medicine.

Segments of medical technology involving some 13,500 registrants of the American Medical Technologists and the International Society of Clinical Laboratory Technologists are also exceptions in that their accreditation is not controlled by medical associations. However, they do involve physicians in the accrediting structure.

Independent Health Professions—Other groups, often characterized as independent health professions, which do not embody in their practice the attributes associated with the primary delivery of health care, have also assumed the responsibilities for accreditation through their professional associations and/or with substantial involvement of educators who are also members

of the professions. These include clinical and counseling psychology, dietetics, hospital administration, pharmacy, public health, social work, and speech pathology and audiology.

The organizational components of accrediting agencies operating without collaborative arrangements with the American Medical Association are detailed in table 1.

The AMA's Collaborative Approach to Accreditation of Allied Health Education

The involvement of the American Medical Association in the accreditation of allied health education programs began in the mid 1930s with the development of minimal training essentials for medical technologists, occupational therapists, and physical therapists. In the intervening years, the AMA slowly broadened its concern with allied health education, reaching its present level of commitment during the late 60s.

The following statement from an official report of the AMA summarizes the philosophical basis for the association's participation in the accreditation of allied health education.

> The AMA recognizes that it has great responsibility and that it must be actively aware of, and related to, all the allied fields for one extremely important reason: that all of the allied health workers find their focus, indeed their reason for existence, in the care of the patient; and where the care of the patient is concerned, the physician ultimately has legal, moral, and ethical responsibility. As the major professional organization for physicians, the American Medical Association feels this responsibility keenly and believes that it must increasingly be involved in coordination, guidance, and direction of the multiple, increasingly fragmented components of the health-care team, through which the care of the patient is provided.[1]

For the AMA, involvement in the accreditation of educational programs for allied health came as a logical extension of many years of concern with educational standards for preparation of health care workers. One of the first acts of the organizational meeting of the American Medical Association, held in Philadelphia in 1847, was the appointment of a Committee on Medical Education.[2] The AMA, thus became one of the pioneers of voluntary accreditation.

Since the AMA's concern with allied health education became apparent in a tangible way in the mid 1930s, events have reinforced this interest. On June 16, 1960, the House of Delegates adopted the *Final Report of the Committee*

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1. "Medical Education in the United States, Section V, Educational Programs in Areas Allied to Medicine," *Journal of American Medical Association*, 1968, no. 9, p. 2,054.

2. *A History of the Council on Medical Education and Hospitals of the American Medical Association*, 1904-1959 (Chicago: American Medical Association, 1960), p. 1.

to Study the Relationships of Medicine with Allied Health Professions and Services. The committee, chaired by Raymond M. McKeown, M.D., was appointed "to consider how physician leadership can best be activated in relationships with professional and technical personnel closely related to medicine" and "to study the matter of liaison at the professional and technical level leading to the above objective."[3]

The report declared that the medical profession had a responsibility to act as a unifying force in assisting vitally important professional and technical groups in recruitment, education, and professional growth and urged effective liaison between the AMA and representatives of professional and technical groups whose activities related to the care of patients.

AMA interest and commitment to involvement in allied health education reached a new high in 1967. It was in that year that the Council on Medical Education decided to further its interest in allied health education with a request to the AMA Board of Trustees for funds to expand the Department of Allied Medical Professions and Services. The trustees approved, and currently the department is manned by a director, four assistant directors, an administrative research assistant, one administrative assistant, and eleven other clerical, secretarial, or administrative personnel.

The AMA House of Delegates now approves essentials or standards for fifteen educational programs in allied health. The fact that nine of the fifteen were approved during the decade of the 60s—six in the past three years—is an indication of both AMA's expanding interest and role and the growing importance of new health workers.

Five decision-making bodies and the Department of Allied Medical Professions and Services influence or perform functions having a bearing on the accreditation program in which the American Medical Association is involved.

AMA House of Delegates

The house is composed primarily of delegates from the federated state medical associations and includes representatives of the military service, U.S. Public Health Service, Veterans Administration, and sections of the AMA scientific assembly. The house, whose membership is held at approximately 250 delegates, must approve all new and revised essentials and other basic accreditation policy under which the AMA accrediting program for allied health education operates.

Council on Medical Education

The council, a standing committee of the AMA House of Delegates, is charged with the responsibility of studying and evaluating all phases of medical education and "education relating to the health professions and services important to medicine." Its activities are divided into five general areas: (1) undergraduate medical education, (2) graduate medical education, (3) continuing medical

3. *Report of the Committee* (Chicago: American Medical Association, 1960), p. 2.

education, (4) education for the allied health professions and services, and (5) international medicine.

Under a reorganization plan adopted in 1967, the council's function as an operating body was deemphasized and its role as a deliberative body emphasized. The intent of the reorganization was to make the council, "as the only agency in medicine that has continuously demonstrated active concern with all of education in medicine and in fields important to medicine," responsible for establishment of broad policies in all areas of medical education.[4]

The ten-member council is composed entirely of physicians, who must be members of the AMA. They are nominated by the Board of Trustees or from the floor of the House of Delegates and are elected by the latter body. The council retains final authority for the accreditation of allied health educational programs and for transmitting recommendations concerning policies governing accreditation to the House of Delegates or the Board of Trustees. As a matter of practice, only essentials and revisions thereof and very basic accreditation policy are forwarded to the House of Delegates.

Advisory Committee on Education for the Allied Health Professions and Services

As part of the 1967 reorganization, the Council on Medical Education, feeling the growing burden of exercising the functions assigned to it, asked the AMA Board of Trustees for permission to appoint four advisory committees in order that the council could earn and exert "the responsible central authority required for effective national leadership" in the entire span of medical education.

Permission was granted, and the council subsequently appointed a five-man advisory committee for allied health education. In September 1969, approval was obtained from the trustees to increase the membership of each of the advisory committees to ten members.

Members of each committee are appointed annually by the chairman of the Council on Medical Education with the advice and consent of the council. Each of the advisory committees is asked for nominations for its membership. Members are limited to a maximum tenure of ten years.

General requirements for membership on the Advisory Committee for allied health are--

> Members of the Committee should include persons having broad interest and competence in the fields of the allied medical professions and services, with special consideration given to persons such as:
>
> a. University vice presidents having jurisdiction over multiple health schools.
> b. University educators concerned with broad areas of health education.

4. *Reorganization of the Council on Medical Education* (Chicago: American Medical Association, 1967), p. 3.

c. Hospital administrators having jurisdiction over multiple allied medical programs and major interest in the manpower supply in the allied health fields.
d. Representatives of the allied medical professions and services.
e. Practicing physicians interested in the concept of the cooperative provision of health care through the use of the "health team," such as representatives of the American Association of Medical Clinics.
f. Representatives of the broad field of university education outside the field of medicine.
g. Representatives of the informed public.
h. Representatives of government in the field of health.[5]

The current composition of the Advisory Committee for allied health is five physicians and five nonphysicians with a physician-educator serving as chairman. Initially appointed by the council, the chairman of each advisory committee is now elected annually by his respective committee. The chairman attends and participates without vote in all regular meetings of the council.

The Advisory Committee on Education for the Allied Health Professions and Services is charged with the following responsibilities:

a. To study and evaluate manpower needs in the allied medical fields.
b. When new technical and professional areas have been identified, to develop for the Council's consideration, proposals for and outlines of training programs to prepare personnel for these areas and to give consideration to the methods available for financing the training programs. Proposals should be prepared in close collaboration with those medical specialty groups and technical groups most directly concerned with the respective areas.
c. For those identifiable technical and professional groups allied to medicine for which no minimal training essentials have been established by the American Medical Association, to establish liaison with the groups in order to make clear medicine's interests and concern.
d. To review continually existing minimal training essentials and accreditation programs and procedures now in effect under the Council's jurisdiction.
e. To bring to the Council information relating to the training programs for allied health personnel in other parts of the world as background information for the development of possible programs in the United States.
f. To keep abreast of licensure, certification and registration of allied personnel in the United States and how such regulation may affect availability and training of paramedical personnel.

5. *Ibid.*, p. 6.

g. To maintain liaison with the community college organizations, the schools of allied health professions now developing in medical centers and with the National Health Council and similar organizations relating to the recruitment and training of allied health personnel.
h. To establish an effective mechanism for maintaining active liaison with professional and technical societies related to medicine.
i. To suggest to the Council areas of research and development in the allied fields.
j. To carry out those assignments given it by the Council.
k. To execute effectively and judiciously the accreditation programs now in effect under the Council's jurisdiction, and such others as the Council may direct in the future.
l. To review and advise the Council on any significant health legislation which might influence education in the allied medical professions and services.[6]

The Advisory Committee, like the Council on Medical Education, feeling the pressures inherent in its sweeping charge, sought to broaden its expertise and to assure that it would communicate effectively with the varied interests in allied health education and services. To accomplish these objectives, the Advisory Committee asked each of the fourteen organizations collaborating in the accreditation effort to appoint members to a Panel of Consultants. This panel, along with other special consultants, usually meets twice a year with the Advisory Committee.

The committee acts as an intermediary between the Council on Medical Education and both the review bodies and collaborating organizations. It reviews recommendations on the accreditation status of individual programs, essentials, recommended changes in essentials, and policy matters. It forwards these with comments or recommendations to the council. The committee may return items to the review bodies or collaborating agencies for further consideration.

Department of Allied Medical Professions and Services

The Department of Allied Medical Professions and Services is part of the Division of Medical Education of the AMA; the director of the department reports to the secretary of the Council on Medical Education, who is responsible for the total operation of the division.

The director of the department serves as secretary to the Advisory Committee on allied health, and the four assistant directors are responsible for liaison with review bodies and collaborating organizations. These liaison activities in accreditation vary significantly but may include sitting with review bodies as nonvoting participants, participating in accreditation surveys, providing staff support for meetings of review bodies that have no full- or part-time staff, and serving as consultants in a variety of situations.

6. *Ibid.*, pp. 5-6.

All requests for applications for accreditation are forwarded to the department, and the completed forms are returned to the department for routine processing before being forwarded to the review bodies. Staff members of the department estimate that they spend approximately 25 percent of their time on activities directly related to accreditation.

The department also participates in or has direct responsibility for a host of other activities in allied health education and services. It is difficult to isolate the accreditation-related activities from the nonaccreditation, and it is impossible to measure how many of these responsibilities fall upon the department solely because of its involvement in accreditation.

The formal training and experiences of the current top-level staff of the department are varied:

> Experience as an educational administrator and association official and holder of a master's degree in public health.
>
> Experience as a practicing dentist, hospital administrator, and staff member of a professional association and holder of a doctor of dental surgery degree and M.B.A. in hospital administration.
>
> Experience as a professor and researcher in medical and dental schools and holder of Ph.D.'s in biomedical sciences and environmental health.
>
> Experience as an instructor and professor in a college of medicine and holder of a Ph.D. in physiology.
>
> Experience as a college teacher and college student personnel worker and holder of a Ph.D. in philosophy.
>
> Experience as a community college educator and licensed practical nurse, and holder of a master's degree in health education.

AMA Council on Health Manpower

The *Guidelines for Development of New Health Occupations* adopted by the AMA House of Delegates in December 1969 place the responsibility for the decision on whether to accredit educational programs for new health occupations on the AMA Council on Health Manpower. Thus, the Council on Health Manpower must establish the need for a new category of health worker before the Council on Medical Education can authorize the initiation of an accreditation program.

There is evidence that the council, composed of sixteen AMA physician members representing the medical specialties, will seek to exercise a growing influence on such matters related to new health occupations as: (1) definition of the scope of duties of the new occupation in collaboration with the emerging profession and the related medical specialty, (2) establishment of the need for the new occupation, (3) educational planning to assure continuity of the program, (4) assessment of employment opportunities, (5) assurance of procedures for professional certification, and (6) consideration of factors of career, education, and geographic mobility.[7]

7. *Guidelines for the Development of New Health Occupations* (Chicago: American Medical Association, 1969).

The philosophical basis for the AMA's activity in this area directly parallels the philosophical basis for its involvement in accreditation.

> The AMA strongly endorses the concept of innovation and experimentation in developing new categories of health manpower. This "accelerated evolution" in new types of assisting personnel will possibly enable the health manpower pool to expand at a faster rate than would be possible otherwise and thereby assist in increasing the supply of health services. Depending on the program, the acceleration may also of course pose such dangers as irrelevance to actual practice needs, lack of adequate physician supervision, or overlap with duties of existing personnel. Once established, however, new health occupations quickly and naturally tend to seek recognition through certification or licensure and in other ways become "institutionalized" within the health system. It seemed important, therefore, for the medical profession to assume an active role in influencing and guiding the development of such new occupations.[8]

The Collaborative Organizational Structure

Five organizations in the medical specialties and nine societies or associations of allied health professionals participate in activities of review bodies accrediting fifteen educational fields. Four of the groups—the American College of Radiology, the American Society of Clinical Pathologists, the American Society for Medical Technology, and the American Society of Radiologic Technologists—participate in two review bodies each.

These fourteen collaborating organizations in various configurations form nine review bodies, five of which have responsibility for two or more fields. (A detailed listing of the review bodies, their program responsibilities, and collaborating groups will be found in table 2.)

AMA plus single allied health association—In four of the nine review bodies, only one allied health professional association is involved—medical assisting, medical record librarianship and medical record technicians, occupational therapy, and physical therapy. In these cases, the education and/or accreditation committees of the associations assume responsibility for reviewing programs and drafting essentials.

AMA plus single medical specialty academy—In the emerging technology of the orthopedic physician's assistant, the Subcommittee on Orthopaedic Physician's Assistant of the American Academy of Orthopaedic Surgeons has assumed review responsibilities as well as responsibility for initiating essentials. No association of orthopedic physician's assistants exists to participate in the process.

AMA plus medical specialties and allied health professional groups with equal physician-technologist representation—Three joint review bodies conduct

8. Thomas C. Points, "Guidelines for Development of New Health Occupations," *Journal of the American Medical Association*, 1970, no. 7, p. 1,169.

accreditation activities with equal memberships from the physician and technology sectors. These include inhalation therapy, nuclear medicine technology, and radiologic technology and radiation therapy technology.

For inhalation therapy technician programs, two medical specialty groups appoint two members each, and the technical association appoints four.

In nuclear medicine technology, six groups—three physician medical specialties and three technological societies—each appoint two members to a twelve-member review committee. The Society of Nuclear Medicine Technologists, the only professional association with membership limited to nuclear medicine technologists, is one of the three technological societies. Other technology representation comes from the American Society for Medical Technology and the American Society of Radiologic Technologists, whose interests and memberships intersect with those of the field.

AMA plus medical specialty society and allied health professional society with majority physician representation—The Board of Schools of Medical Technology, which draws its membership from the American Society of Clinical Pathologists and the American Society for Medical Technology, is the only review body fitting this category. The Board of Schools is organized as a standing committee of ASCP with six of the eleven members, including the chairman, required to be clinical pathologists.

ASCP serves as the fiscal agent for the Board of Schools, and the board's budget requires approval by the ASCP Board of Directors. The board's recommendations on the accreditation of individual programs are referred directly to the AMA Advisory Committee without consideration by the Board of Directors of ASCP.

The board has sole responsibility for medical technology programs at the fourth collegiate year and postbaccalaureate levels and functions in a house-of-lords relationship with its committees on certified laboratory assistants, cytotechnology, and histologic technic programs. The board plans to add a committee for associate degree medical laboratory technical programs when essentials are approved by the AMA House of Delegates. In addition, there is current consideration being given to the Committee on Education of the American Association of Blood Banks functioning as a board committee for the accreditation of programs for blood bank technicians or technologists.

The existing committees function with de facto autonomy on decisions relating to the accreditation of individual programs but report their recommendations through the chairman of the Board of Schools to the AMA Advisory Committee. The fiscal affairs of the committees are included in the budget for the Board of Schools.

With regard to matters of policy and essentials, the board may review the recommendations of the committees and either forward them to the appropriate bodies for further action or return them for reconsideration. In the latter situation, the committee may elect to reconsider or to maintain its initial recommendation and the Board of Schools then forwards the committee's recommendations with positive or negative comments to the appropriate body.

The chairmen of the committees sit as members of the Board of Schools when matters from their respective groups are under consideration.

The Committee on Cytotechnology is appointed by ASCP, and its present membership of eleven includes three ASCP-registered cytotechnologists and eight clinical pathologists. Essentials initiated by the committee are forwarded to the ASCP Board of Directors and to the House of Delegates of the American Society for Medical Technology for approval before being transmitted to the AMA Advisory Committee.

The Committee on Certified Laboratory Assistants, which had functioned as a separate entity, was unilaterally reorganized by ASCP in 1970 as a committee of the Board of Schools. It is now a ten-member body, composed of five clinical pathologists and five medical technologists, reporting its recommendations to the AMA Advisory Committee through the chairman of the Board of Schools. The CLA essentials, written by the committee, are considered by the board before being forwarded for endorsement by the Board of Directors of ASCP and the House of Delegates of ASMT.

The Committee on Histologic Technic is appointed by the presidents of ASCP and ASMT. The six-member committee includes three pathologists and three ASCP-registered histologic technologists, with a pathologist member serving as chairman. The committee reports its recommendations to the AMA Advisory Committee through the chairman of the Board of Schools. Essentials are approved by both the ASCP Board of Directors and the ASMT House of Delegates.

The Collaborative Decision-Making Process

The collaborative decision-making process under which the AMA operates its accreditation program is designed to manifest the association's philosophical basis for its involvement in the education of allied health workers. The process provides opportunity for physician input at points along the route and vests ultimate control and final responsibility with the AMA, the physician organization.

Thus, collaboration, an AMA term, is an accommodative act. It is not collaboration in the sense that all parties cooperate with equal responsibilities and authority. The fourteen "collaborating" organizations have major responsibility for initiating and recommending but the AMA retains the responsibility for final decisions through actions of the Council on Medical Education and the House of Delegates.

The decision-making process on the accreditation of individual programs follows this sequence:

1. The appropriate review body evaluates the program on the basis of reports and/or site visits and forwards its recommendation for action to the Advisory Committee on Education for the Allied Health Professions and Services. The committees of the Board of Schools of Medical Technology report through the board chairman to the Advisory Committee.

2. The Advisory Committee studies the recommendations of the review body and forwards its own recommendations to the Council on Medical Education.
3. The Council on Medical Education takes final action.

The decision-making process for essentials and other basic accreditation policy takes a different but similar route:

1. The appropriate review body recommends a set of essentials or changes in essentials to the collaborating association(s) or society(ies).[9]
2. The collaborating association(s) or society(ies) endorse the essentials and forward them to the Advisory Committee on Education for the Allied Health Professions and Services.
3. The Advisory Committee forwards the essentials with recommendations to the Council on Medical Education.
4. The Council on Medical Education forwards the essentials with recommendations to the House of Delegates.
5. The essentials are assigned to a House of Delegates reference committee, which offers any interested party the opportunity of providing comment.
6. The House of Delegates takes final action.

Thus, the final decisions on the accreditation of individual programs are made by the Council on Medical Education, and the final decisions on essentials and other basic accreditation policy rendered by the House of Delegates. Any recommendation in which the Council on Medical Education does not concur can be returned through the Advisory Committee to the review bodies for further consideration. The Advisory Committee likewise can return to the review bodies items with which it is not satisfied.

Theoretically, the Advisory Committee, because of its advisory status, would be required to forward review body recommendations to the council should it and a review body adopt opposing positions. In practice, actions of the Advisory Committee on Education for the Allied Health Professions and Services, and subsequently the Council on Medical Education, have been pro forma with regard to the accreditation status of individual programs. The council would serve as an appeals body should an institution or program decide to appeal a recommendation of a review body.

The important policy matters relating to the accreditation of allied health education would also be forwarded to the House of Delegates for final consideration. For example, the *Statement of Basic Principles*, essentially an agreement of working relationships between the AMA and the collaborating organizations, which shall be referred to in more detail later, was scheduled for submission to the House of Delegates before being withdrawn from further

9. A joint committee of the American College of Radiology and the American Society of Radiologic Technologists perform this function for Radiologic Technology and Radiation Therapy Technology, with review and suggestions by the Joint Review Committee on Radiologic Technology.

consideration, for a second time, because of the Study of Accreditation of Selected Health Educational Programs.

AMA-Collaborating Organizations' Roles and Relationships

A description of the organizational structure and procedures of decision-making does not reflect accurately the roles and relationships among the AMA, the collaborating organizations, and the review bodies in the accreditation of allied health education. For this dimension, it is necessary to examine the intricacies and substantial variations in these roles and relationships and to assess their impact on past decisions.

In attempting such an evaluation, it is also necessary to keep in mind several factors concerning the AMA.

1. Before 1967, AMA involvement in the accreditation of allied health education was limited. Only four years have passed since the Council on Medical Education made a substantial commitment to allied health education by expanding the staff and operations of the Department of Allied Medical Professions and Services. During that period, the Department has concentrated a great deal of its efforts on formalizing relationships that existed previously and bringing a degree of coordination to bear on fledgling accrediting efforts, which were tending to head off in independent directions.
2. Burgeoning activity in allied health education reached new levels of intensity during the four years, further complicating the AMA role.
3. The Council on Medical Education, because of its mounting involvement in allied health education, also felt the pressures of growing tensions between allied health professionals and the physicians and medical specialties. The council, fearful of becoming involved in litigation between the American Society for Medical Technology and the American Society for Clinical Pathology, felt compelled to exercise extreme caution in dealing with such disputes.
4. The AMA, acting through its Council on Medical Education, has been hesitant to use its presumed power and substantial influence because of the general public image of the organization and for fear its actions will be grossly misinterpreted. Additionally, the AMA, whose membership also encompasses the medical specialties, is naturally hesitant to take action that might alienate a substantial proportion of its members. Also, the AMA influence on members of a particular specialty area is considerably less than the members' own specialty society.
5. It has been the personal style of key staff members of the Division of Medical Education to attempt to lead through persuasion, conciliation, and influence rather than by seeking policy directives from the Council on Medical Education.
6. Some of the older, well established accrediting operations, which had tended to operate in laissez faire tradition while

enjoying the status gained through the AMA relationship, viewed the AMA staff buildup with a wary eye, fearing tighter AMA rein and more explicit direction.

In addition to these factors, the Advisory Committee on Education for the Allied Health Professions and Services has been acutely aware of–and to a degree shackled by–the tensions among allied health professionals and physicians. The Advisory Committee has sought a statesmanship role of leadership rather than one of direction.

On the one hand, the Advisory Committee has sought to educate the membership of the Council on Medical Education to bring it to a philosophical position that medicine, to achieve its objectives in this area, need not be paternalistic or baronistic toward allied health professionals. On the other hand, it has sought to coalesce the allied professional groups by focusing on such common concerns, as formalizing and clarifying relationships between the AMA and the collaborating organizations and establishing task forces on general problems and issues in allied health.

In large measure, the Advisory Committee has achieved its statesmanship objective. The committee's leadership role in bringing the autonomous Commission for the Study of Accreditation of Selected Health Educational Programs to fruition is a prime example of its efforts to achieve credibility as an objective and well intentioned body.

With the creation of the Panel of Consultants and the launching of SASHEP, hostility has lessened, but the role of the Advisory Committee is still suspect by many. It is sometimes viewed as an unnecessary layer in a bureaucracy and as a buffer between the Council on Medical Education and the joint review bodies. Its membership is criticized by allied health representatives for giving prominence to allied health educators to the detriment of representation by officials of allied health organizations.

There is no formalized working agreement spelling out either the duties and responsibilities of the various collaborating organizations and review bodies or the role the staff of the Department of Allied Medical Professions and Services is to perform in servicing the Advisory Committee and the Council on Medical Education and in providing liaison with the collaborating groups.

The *Statement of Basic Principles for the Accreditation of Allied Health Education* was intended as the basic working agreement. Formally approved by eleven of the fourteen collaborating organizations (the July 1970 revision), the document will not be sent to the House of Delegates for endorsement pending the completion of SASHEP. It is, however, serving to guide the policy of the Council on Medical Education for accreditation of allied health education, and it contains many of the elements and principles of the informal agreements for the current collaboration process. The document–

Affirms the responsibility of the physician in allied health education, consonant with the previously expressed AMA philosophy in this regard.

States the role of the AMA and collaborating organizations:

a. The AMA "may" provide participants for survey teams, approves original essentials and proposed revisions, provides approval or

accreditation for schools and educational programs, serves as coordinating national approval agency.

b. The collaborating organization provides expertise in its specific area, participates in drafting essentials and revisions, provides representatives to meet as a review committee for programs of education, and recommends appropriate action to the Council on Medical Education.

Recognizes the right of collaborating organizations to designate their own representatives for review bodies.

Provides for equal representation between the profession and the related medical specialty groups in cases where there is more than one collaborating agency.

Provides for a Panel of Consultants to the Advisory Committee consisting of one representative from each of the collaborating bodies.

The document is an important step toward clarifying the roles and responsibilities of the collaborating groups, but it does not provide the details of how these roles and responsibilities are to be accomplished. Currently, confusion exists and irritations occur over the lack of basic understanding on these points. Particularly is this true in the area of functions, responsibilities, and prerogatives of the staff of the Department of Allied Medical Professions and Services. As a result, the staff has been left to establish these relationships on a personal basis.

As a consequence of these factors and of a growing militancy of some allied health professions, the current relationships among the AMA, the review bodies, and the collaborating organizations are grossly uneven. In evaluating these relationships, it is necessary to be concerned with the depth and extent of AMA staff liaison, AMA participation and nature of this participation in the accreditation process, and the influence and input that the accreditation organizational structure has on the decisions that are made.

Relationships among the participating groups range over a broad scale: cordial and substantial, tolerated, largely ignored, neglected, increasingly strained, and cautious. Using these broad and judgmental headings, these relationships could be categorized as follows.[10]

Cordial and Substantial–Three of the collaborating efforts fall into this category: the Curriculum Review Committee, American Association of Medical Assistants; Education and Registration Committee, American Medical Record Association; and the Subcommittee on Orthopaedic Physician's, American Academy of Orthopaedic Surgeons.

The AMA staff has provided substantial assistance for the developing accreditation program for medical assisting. A staff member sits with the AAMA Curriculum Review Committee as a nonvoting participant, and the AMA appoints a physician to participate in site survey visits. In addition, the

10. Such categorization requires considerable value judgment. The data for these judgments were gathered through extensive personal interviews and by written responses to SASHEP questionnaires.

AMA has provided grants to supplement the funding of the accreditation program. The depth and frequent involvement of the AMA staff and the presence of the physician adviser sitting with the Curriculum Review Committee have lessened the likelihood of need for input by the AMA Advisory Committee or Council on Medical Education.

Few if any conflicts on educational matters have ever existed between the AMA and the American Medical Record Association. An AMA staff member and representatives of the American College of Surgeons and American Hospital Association sit with the AMRA Education and Registration Committee as nonvoting participants. As a result of the formalized decision-making procedure, the Council on Medical Education has made suggestions that were incorporated into the essentials. AMA staff or AMA-appointed physicians participate in accreditation site visits.

The Subcommittee on Orthopaedic Physician's Assistant, whose accreditation activities are still in the developmental stage with only three approved programs as of August 1971, has looked to the AMA for staff support and participation in the site visits conducted so far. Since the concept of a formally trained orthopedic physician's assistant is relatively new, no association of such assistants exists to participate in the accrediting process.

Tolerated—The attitude of the American Occupational Therapy Association regarding the AMA collaborative effort is one of tolerance, lack of enthusiasm, and awareness that change could bring a deterioration in the AOTA position of influence on educational programs. The collaborative decision-making process has not resulted in any change in the recommendations of the AOTA Accreditation Committee in recent memory. AOTA-AMA staff relationships have been cordial but uneven over the years; the contributions of AMA-appointed physicians on the site visit teams are variously viewed as excellent to poor. The overall impact has not been meaningful, even though physicians on the site visit team are nominated by AOTA for selection by the AMA.

Suggestions that the AMA should be involved in the accreditation of educational programs for occupational therapy assistants were ignored by AOTA, which now accredits these offering outside the AMA collaborative process. However, AOTA has abided by the AMA process at the therapist level.

Largely Ignored—The American Physical Therapy Association, like AOTA, feels there is no substance to the current collaborative process. Physician participation on site visit teams has contributed very little to the process, in the opinion of APTA officials. Recent appointment of an AMA staff member who is a physical therapist is viewed as helpful because of his participation on site visits and his availability for consultation. The current relationship is assessed as a bureaucratic hindrance that results in very little meaningful physician input.

The last set of essentials approved by the AMA House of Delegates for physical therapists was in 1955. Since 1961 the APTA Basic Education Committee on Accreditation has been using (on an "informal basis") its own set of *Standards for Physical Therapy Education* as the criteria for making recommendations to the AMA on the accreditation of programs. The APTA, which is

beginning an accreditation program for physical therapy assistants, never seriously considered asking the AMA to collaborate in the process.

Neglected–The affairs of the Joint Review Committee for Inhalation Therapy have drifted into serious disarray despite substantial staff efforts by AMA. Applications for accreditation have been lost for extended periods of time; programs that were accredited for a one-year period in 1967-68 are still carried on the accredited lists without a site visit or followup since that time. Only one site survey was conducted during fiscal year 1971; forty-four such surveys are scheduled for fiscal year 1972.

At one time the committee's conduct of its work was so ineffective that one of the collaborating agencies, the American Association for Inhalation Therapy, considered withdrawing its support; the president of AAIT commissioned a special study of the committee's activities. The findings were derogatory.

Some physician members of the committee, who are appointed for indefinite terms by the American College of Chest Physicians and the American Society of Anesthesiologists, have been criticized for lack of interest and ineptness. The chairman of the committee with the help of a half-time secretary is responsible for the bulk of the administrative work load of the committee, a voluntary effort on his part. He is now receiving some staff support from the AMA, and plans are being made to add additional secretarial assistance.

The relationship of the AMA to the committee has shifted dramatically in recent months. An assistant director of the Department of Allied Medical Professions and Services is now in close contact with their activities. A previous committee chairman personally wrote the heads of programs to inform them whether they were accredited prior to the formal action being taken by the Council on Medical Education. Such official notification under the AMA collaborative approach is reserved for the council.

The AAIT reluctantly accepts the role of the AMA, the American College of Chest Physicians, and the American Society of Anesthesiologists, according to its officials. They also believe that the proper physician group to be involved in the accreditation of inhalation therapy education programs is the American Thoracic Society.

Increasingly Strained–Of all the review bodies, the Joint Review Committee on Radiologic Technology appears to be chafing most under the AMA collaborative approach. Both physician and technologist members of the committee question, and in some cases resent, the need to submit its decisions for review by the Advisory Committee on allied health and the Council on Medical Education. Layers in the decision-making process only confuse, delay, and serve no useful purpose, they contend. The committee complies with the process because the Council on Medical Education is the recognized accrediting agency.

In contrast to the situations with other review bodies, the AMA staff liaison attends the meetings of the Joint Review Committee on Radiologic Technology by invitation. In recent months these invitations have always been

issued, but with limitations; certain sessions of the committee's meetings are not open to the AMA staff.

There is some indication that the invitation had been interpreted more narrowly by AMA staff than by the committee. SASHEP questioning of these relationships has led to clarification during the last three months. However, confusion over the role of the AMA staff still exists between the Joint Review Committee and the AMA and is due mainly to a lack of a specific agreement on such points and to the committee's understanding of its independent status.

Currently, other issues are building to a level that could provoke open confrontation among the Joint Review Committee, its collaborating organizations, the AMA staff, the Advisory Committee, and the Council on Medical Education. At issue are two distinct but related matters.

The Review Committee has stuck rather rigidly, though it has made some exceptions, to a 2,400-hour clinical guideline for the training of radiologic technologists. This guideline is not part of the essentials approved by the AMA House of Delegates but was recommended by a committee of technologists and radiologists of the American College of Radiology and was accepted by the Joint Review Committee as part of a set of guidelines for radiologic technology programs. It is, however, often being interpreted as a requirement for accreditation.

One issue deals with whether the Council on Medical Education wishes to be identified with the 2,400-hour requirement when it is being resisted by educators associated with the collegiate-level institutions. The other issue is whether the Council on Medical Education wishes to deny accredited status to a program on the basis of a document that neither it nor its Advisory Committee nor the House of Delegates has approved.

Technologist and physician members of the Joint Review Committee have worked harmoniously together since the committee was recast with equal physician-technologist representation. This arrangement, a spokesman for the technologists emphasized, was accepted by the American Society for Radiologic Technologists as the "best we could get" at the time. Officials of ASRT contend that the society has the maturity and should have the responsibility for policing its own educational programs. On the other hand, the American College of Radiology strongly supports the AMA role.

Cautious—The relationships between two review bodies, the Board of Schools of Medical Technology and the Joint Review Committee on Educational Programs in Nuclear Medicine Technology, and the AMA exhibit cautious leadership and slight pressures on the part of AMA.

Litigation between the American Society for Medical Technology and the American Society of Clinical Pathologists, initiated in 1969, has put a damper on AMA efforts to bring about change in the Board of Schools of Medical Technology. AMA leadership feared that action might result in the litigation's being broadened to include the association.

In addition, the litigation has in effect prohibited the American Society of Clinical Pathologists from making any changes along the lines sought in the American Society for Medical Technology's suit. Such changes, made while the

litigation is still a live matter, could be construed as an admission of ASCP guilt.

The litigation has resulted in some strained relationships between the leadership of the Board of Schools of Medical Technology and the AMA staff, and there is evidence that members of the board resent many of the activities of the AMA staff. Likewise, some AMA staff resent the Board of Schools' making exceptions to policy of the Council on Medical Education. These relationships appear to have shown substantial improvement since June 1971; however, there still is no general understanding, written or verbal, to guide these relationships, and they seem likely to fluctuate with the heat generated by the issues in the medical laboratory sciences.[11]

The Joint Review Committee on Educational Programs in Nuclear Medicine Technology embraces six organizations—three medical specialties and three technologies—in its collaborative process. As a consequence, it took more than ten years for the groups to agree and obtain approval of their organizations for the essentials that were submitted to the AMA House of Delegates in 1969. Furthermore, the Joint Review Committee is still engaged in considerable discussion about the interpretation of the essentials and is now attempting to obtain agreement among the six organizations on guidelines or interpretations of the essentials.

Careful and cautious handling and the effective and strong leadership of the chairman pro tem have resulted in the Joint Review Committee's movement into a period of relatively smooth operation. Relationships with the AMA staff have been extremely good. Nevertheless, it is reasonable to predict that problems will abound as nuclear medicine technology develops.

The development of nuclear medicine as a specialty had its roots both in the basic sciences and in pathology and radiology. Thus, pathology and radiology and their related technologies have logically been involved in its early stages.

As nuclear medicine has evolved, medical doctors, basic scientists, and technologists with a primary interest in nuclear medicine have formed their own organizations, the Society of Nuclear Medicine and the Society of Nuclear Medicine Technologists. This logical gravitation of interests will undoubtedly result ultimately in these two organizations' having more than a co-equal voice with the other four collaborating groups, whose interests are more diverse and less focused on the nuclear medicine field.

The balance of power is sure to shift, creating jurisdictional problems and competition among the groups and resulting in significant implications for the accreditation of educational programs in nuclear medicine technology.

11. See the section entitled "Accreditation of Educational Programs in Medical Laboratory Sciences."

Analysis and Commentary on Collaborators' Roles and Relationships

Recognition of the AMA Council on Medical Education for the accreditation of certain areas of allied health education involves three basic assumptions.

1. The AMA's stated philosophical basis for its involvement in the accreditation of allied health education is valid; the AMA, as the major organization of physicians, is the proper agency to assume responsibility for the accreditation of allied health education.
2. The collaborative process devised by the AMA implements this philosophical basis by providing substantial physician input and participation.
3. The AMA, as the recognized agency, can be effective in providing the leadership and control necessary to assure an evenness of quality and consistency among the accreditation efforts for which it is responsible.

An analysis of the collaborative accreditation process forces conclusions that contrast strikingly, and often seriously conflict, with the preceding assumptions.

1. In such areas as occupational and physical therapy, AMA and physician participation are not important factors in accreditation.
2. Physician influence as manifested in the actions of the Council on Medical Education and the House of Delegates of the AMA has not been significant when considered in relation to the total accreditation endeavor for allied health education.
3. The Advisory Committee on Education for the Allied Health Professions and Services has shown effective leadership under the circumstances but lacks real power and authority as currently organized.
4. The collaborative arrangement for decision-making is cumbersome, and in cases where varied and multiple interests are involved, it has the potential for producing an impasse in approving or revising essentials and basic accreditation policy.
5. The AMA has not been able to effect a solution to the dispute between the American Society for Medical Technology and the American Society of Clinical Pathologists; ASCP has been allowed to continue to hold majority representation on the Board of Schools of Medical Technology, a situation that violates a principle endorsed by the Council on Medical Education.
6. Part of the accreditation effort of the AMA, principally inhalation therapy, has been allowed to drift into disrepute.
7. The lack of a detailed working agreement between the AMA, the joint review bodies, and the collaborating organizations has led to confusion, particularly concerning AMA staff duties and responsibilities.
8. Administrative procedures followed in the handling of application forms and notification of accredited status are superficial and confusing to institutions in light of the pro forma decisions

of the Advisory Committee and the Council on Medical Education with regard to the status of individual programs.

9. The AMA has been neither willing nor able to maintain effective control of the accreditation process.

Basic fairness dictates that it be reemphasized that only since 1967 has the AMA been engaged in its current volume of activity in allied health education. A portion of that time was spent in gearing up the staff and organization to accomplish the task. Tensions and disputes in allied health have handicapped and complicated the AMA efforts.

It should be recognized that significant progress has been made in reaching more equitable distribution of responsibility between technologists and physicians in the accreditation of allied health education. And despite continuing litigation, tensions appear to have eased with the AMA support of a study of allied health accreditation.

Through its efforts at coordination and policy-making, the AMA has served to provide some guidance and coordination for the accreditation process. But, though this is a vitally needed function, the results are not consistent with the philosophical basis for AMA involvement.

Enhancement of coordination through physician input and influence has been minimal; indeed, due to the general questioning of the motives of the AMA by society and the allied health professions, it may have been a handicap.

Physician participation in site visits and on review bodies is often criticized by allied health professionals on several points.

1. The physician is too busy with other matters to take a primary interest in the educational programs for the technologies and services.
2. The physician, in some cases, lacks the expertise necessary to participate effectively in the accreditation program.
3. The physician is sometimes appointed to review bodies as a means of paying off a political debt rather than on the basis of competence in the field.
4. The physician is more inclined to come under the influence of the buddy system than is the technologist.
5. The physician's participation inhibits technologists and keeps them from participating as effectively as they would otherwise.

Despite the skepticism the AMA generates when taking stands on issues construed to be related to the economic interests of its members, it commands wide respect when it speaks out on matters related specifically to professional medicine. This status is readily recognized and admitted by its critics. Even the most critical among the allied health professionals and medical specialties want the AMA-approved or -accredited tag for their programs, but they want it with a minimum of influence and direction. And there is considerable evidence that the AMA, by declining or failing to exert influence and direction, has allowed these very groups to misuse its status-loaded approval.

Accreditation of Educational Programs in Medical Laboratory Sciences

Nowhere in the health fields are issues as numerous and hotly contested as in accreditation for educational programs in the medical laboratory sciences. The issues revolve around a wide spectrum of concerns—educational content, functions of the medical laboratory worker, economic and professional control, and proprietary versus nonprofit education—and are often related to the control of certification and registration.

The principal contestants are the American Society for Medical Technology, the American Society of Clinical Pathologists, the Accrediting Bureau for Medical Laboratory Schools, American Medical Technologists, and the International Society of Clinical Laboratory Technologists. Microbiologists and clinical chemists are also showing an intensified concern.

Accreditation in the medical laboratory sciences is currently conducted by the Accrediting Bureau for Medical Laboratory Schools, an autonomous agency with fiscal support from the American Medical Technologists; the Board of Schools of Medical Technology, accrediting under a collaborative arrangement with the Council on Medical Education; and the Accrediting Commission of the International Society of Clinical Laboratory Technologists. With the exceptions of the laboratory specialties of blood banking, cytotechnology, and histologic technic, these efforts are competitive and overlapping and reflect the historical differences and competition among the associated registries.

Litigation between the American Society for Medical Technology and the American Society of Clinical Pathologists, filed in 1969 but still unresolved, beclouds relationships within one of the accrediting bodies, the Board of Schools of Medical Technology.[12]

Recognition or lack of recognition afforded the accrediting bodies by the National Commission on Accrediting and the U.S. commissioner of education further confuses the situation. Both the NCA and the commissioner recognize the Board of Schools of Medical Technology, in collaboration with AMA, to accredit educational programs at the fourth collegiate year level. The commissioner of education but not the NCA recognizes the Accrediting Bureau for Medical Laboratory Schools to accredit two-year programs for the medical laboratory technician. In 1969, pending completion of the Study of Accreditation of Selected Health Educational Programs, the National Commission deferred action on requests from the American Medical Association for recognition of the Board of Schools of Medical Technology as the accrediting body for areas or levels of cytotechnology, histologic technic, and the laboratory assistant. The commissioner of education, who deferred similar action on the

12. The suit was dismissed by the U.S. District Court of Northern Illinois in the spring of 1971. ASMT is currently appealing that dismissal. The suit is also being amended to include a class action alleging that some medical technologists have been fired by their pathologist employers because of the roles they played in their professional association. Representatives of ASCP deny the allegation.

same basis in 1969, is now reviewing the AMA application. The Accrediting Commission of the International Society of Clinical Laboratory Technologists holds neither USOE nor NCA approval.

ASMT-ASCP Litigation

The central issue of the litigation between the American Society for Medical Technology and the American Society of Clinical Pathologists is the control of the profession of medical technology. The suit alleges that pathologists either own or control the vast majority of the clinical laboratories in the United States and as a consequence employ the vast majority of the medical technologists. The suit also alleges that pathologists further dominate the profession by controlling the Board of Registry of Medical Technology and the Board of Schools of Medical Technology. In the litigation, ASMT seeks to establish both the registry and the accrediting functions as autonomous operations.

As provided in the ASCP bylaws, the Registry and the Board of Schools of Medical Technology are now standing committees of ASCP. A minority of the members are appointed by ASMT, the majority by ASCP. The chairman of each body is a pathologist.

After the litigation was filed, the ASCP unilaterally abolished the Board of Certified Laboratory Assistants, which had been serving both registry and accrediting functions for that program. The board had been functioning as a separate body drawing equal memberships from ASMT and ASCP. It now functions as a committee of the Board of Schools.

ASCP, by approving the *Statement of Basic Principles of Accreditation*, has officially accepted the principle of equal technologist and physician memberships on the Board of Schools. It refuses to implement this position, however, awaiting conclusion of the litigation. ASCP fears that changes made while the litigation is an ongoing matter might be construed as an admission of guilt.

In private negotiations between ASCP and ASMT officials, differences in interpretation of the pertinent statement in the *Basic Principles* have arisen. The *Principles* say, "There should be equal representation between the profession under consideration and the medical specialty groups." The differences arose over the likelihood that future boards would include members other than those from the profession under review and the related medical specialties. ASMT holds that equal representation would apply only to the technologist and pathologist members; ASCP takes the position that equal representation means simply equal physician and nonphysician members.

Currently, ASCP favors broadening the base of the Board of Schools to make it more representative of laboratory medicine, is not opposed to equal physician and nonphysician membership, endorses the principle that the Board of Schools should be a freestanding autonomous body, and favors the concept of a rotating chairmanship.[13]

A change under consideration in the ASCP bylaws raises ASMT apprehensions about this position. The proposed revision, to be voted on in October

13. Telephone interview with Elmer Jennings, president, ASCP, August 1971.

1971, provides for the membership of the Board of Schools to be determined by the ASCP Board of Directors, "pending the development of more definite standards for accrediting agencies."[14] Here again an issue in the ASCP-ASMT litigation comes into play.

In the suit, ASMT charged that ASCP had established an "affiliate membership" for technologists to compete with ASMT. The suit alleged that, because they are generally the employees in the employee-employer relationship, technologists would be coerced into joining ASCP. ASMT representatives fear that if the changes in the bylaws are approved only ASCP-affiliated technologists will be appointed to the Board of Registry and the Board of Schools.[15] There are now approximately 12,000 affiliate members of ASCP[16] and approximately 20,000 members of ASMT.

Throughout the litigation and negotiation, ASCP representatives have consistently refused to consider any change in the Registry's status as a standing committee of ASCP. ASCP had agreed to equal physician-nonphysician membership on the Registry, but this agreement has been negated because the ASCP-ASMT negotiations have been terminated.

ASMT contends that the Board of Registry and the Board of Schools are related functions essential to the welfare of the profession of medical technology, and this is the peg on which the litigation continues to hang.

Accrediting Bureau for Medical Laboratory Schools

The Accrediting Bureau for Medical Laboratory Schools is an agency of the American Medical Technologists, a 10,000-member professional group which is also a registry. AMT was formed in 1939, and from its inception, the organization had a concern for educational standards related to the training of the laboratory worker.

The accrediting efforts of AMT enjoyed an uneven reputation before 1964. In that year, AMT reorganized the accrediting agency into the autonomous Accrediting Bureau for Medical Laboratory Schools. The bureau establishes its own standards and conducts the accrediting operation from its own office. AMT provides a large share of the bureau's operating budget.

Primarily identified with private and proprietary schools prior to 1969, the Accrediting Bureau has now broadened its scope of operation to include public vocational schools and private and public community colleges offering medical laboratory educational programs of two years or less. In 1969 its operations took on new vigor and status at its recognition by the U.S. commissioner of education as the accrediting agency for medical laboratory technician

14. Article VIII, section III, paragraph b in draft of bylaws changes for the American Society of Clinical Pathologists, dated November 22, 1970. In August 1971 Jennings stated that ASCP had no "current plans" to change the composition of the Board of Schools.

15. ASCP counsel has informed the ASMT counsel that ASCP does not intend to effect any immediate change in either the function or composition of the Board of Registry or Board of Schools. Letter dated August 19, 1971 from John D. Conner to John F. Sembower.

16. Figure cited by president of ASCP, August 1971.

education. At the encouragement of USOE officials, the bureau is now expanding its operation to include the accreditation of programs preparing medical assistants.

Organizationally, the Accrediting Bureau provides less opportunity for vested interest control than does any other recognized accrediting operation.

1. None of its operations or decisions are reviewable by any parent body.
2. At least five members of the nine-member Board of Commissioners must be from outside the medical technology field.
3. The commissioners from outside the medical technology field are to be diversified, insofar as possible, to include representatives from the medical profession, hospital administration, government, universities, public schools, adult and vocational education.
4. No national director or employee of AMT can act as a commissioner, and no member of AMT can serve as one of the five members from outside the medical technology field.
5. Three commissioners are selected by schools accredited by the bureau. One of these cannot be associated in any way with a school, though colleges and universities accredited by a regional association are exempted from this provision. None of the three can be medical technologists or technicians.
6. Three commissioners, one of whom cannot be an AMT registrant, are selected by AMT.
7. Three commissioners are selected by the Board of Commissioners of the bureau. None can be associated in any way with a school, though colleges and universities accredited by a regional association are also exempted from this provision. None can be medical technologists or technicians.

The current membership of the bureau comprises a medical school professor, a professor of chemistry, two pathologists, a hospital administrator, a school owner, a president and a dean of an accredited school, and a professor emeritus of medical technology.

The bureau's status as the only recognized accrediting agency for programs below the baccalaureate level has been under consistent attack by organized pathologists. Letters attacking the credibility of the bureau and the quality of the schools it accredits have been directed to congressmen and USOE officials. The bureau's status with the commissioner of education will be reviewed again in 1971.

Accrediting Commission of ISCLT

The Accrediting Commission of the International Society of Clinical Laboratory Technologists establishes standards, accredits educational programs, and sets criteria for individual membership in ISCLT. It is autonomous.

Under the society's bylaws, the educational membership, composed of one delegate from each accredited school, elects a five-member Accrediting Commission. Only two of the members can be from the society's educational class; the others are public members chosen from pathology or another branch

of medicine, hospital administration, public health, public licensing authority, medical laboratory technology, and education.

One position on the commission is now vacant; the last full membership comprised a school representative who is also an M.D., an M.D. pathologist, an osteopathic pathologist, a second school representative, and a microbiologist employed by a state health department.

Clinical Chemists and Medical Microbiologists

Even in modern times, the clinical or medical laboratory has not been the exclusive domain of the pathologist or the medical technologist. Recent and current developments are likely to make it even less so. It appears that other clinical laboratory scientists and technologists, principally the clinical chemists and technologists and medical microbiologists, will play larger roles and gain greater visibility in the field. Contributing to this likelihood are these factors:

1. Increasing demand for health care and the growing reliance of the clinician on laboratory tests for diagnostic purposes;
2. Increasing recognition of other laboratory workers in federal health legislation;
3. The consent decree issued by a U.S. District Court in July 1969 enjoining the College of American Pathologists from practicing restrictive measures in the laboratory field;
4. A change in the standards of the Joint Commission on the Accreditation of Hospitals permitting nonphysicians to direct laboratories under certain circumstances; and
5. Interests of clinical chemists and medical microbiologists in capitalizing on professional and economic opportunities in the laboratory field.

These developments are already having an impact on accreditation of educational programs for laboratory workers. Representatives of the American Association of Clinical Chemists and the American Society for Microbiology have been engaged in discussions about their organizations' becoming more involved in assuring the quality of education for the laboratory. Their interests intertwine beyond the preparation of clinical chemists and medical microbiologists to the question of the quality of training in chemistry and microbiology, which other technologists and higher level professionals take in preparation for laboratory practice.

Undergirding these interests are the registries for clinical chemists and medical microbiologists, all requiring education or experience for eligibility.

Clinical chemistry and microbiology bring to laboratory education a level of professional preparation that has the potential to alter the balance of influence on education for technicians and technologists. Clinical chemists and microbiologists are trained at Ph.D. and postdoctoral levels. The number of special programs to train directors of clinical laboratories at postdoctoral, Ph.D., and M.D. levels is growing and apt to influence education for the technologists and technicians.

Other Issues and Factors

Other issues and factors that are, or have the potential for becoming, entangled in the accreditation process abound in the medical laboratory education field. The major ones, nearly always related to the organizational structure of accreditation, are as follows.

Levels of Workers—There is no consensus on whether the medical laboratory needs three levels of technical workers. Yet, despite this present lack of agreement, training programs are being developed and accredited for three levels: laboratory assistant (one year of education), laboratory technician (two years), and technologist (four years to become an MT(ASCP) and two years of training plus three of clinical experience for the MT designation of the American Medical Technologists.) For the RMT designation, the International Association of Clinical Laboratory Technologists requires either a baccalaureate degree from an accredited institution with a major in chemical, physical, or biological sciences and a minimum of one year of laboratory experience or registration as an RLT (technician) with five years of experience and certain continuing education credits. Critics claim that the usefulness of the laboratory assistant and the technician will be about the same; the major difference in the education of the two is the technician's devotion of more time to general education. Proponents of the two classifications argue that the technician, because of his broader educational background, will adapt to change more readily and will more easily advance up the laboratory career ladder.

MLT Designation—MLT, Medical Laboratory Technician, has been copyrighted by American Medical Technologists as a designation to be associated exclusively with its registry. The Board of Schools of Medical Technology has current plans to use the designation to classify graduates of two-year associate degree programs in medical laboratory education. AMT has formally protested, asking the board to cease and desist from infringing upon the copyright.

AMT-ISCLT—Differences in the American Medical Technologists caused a group of AMT members and others to form the International Society of Clinical Laboratory Technologists and subsequently, in 1963, the ISCLT Accrediting Commission. ISCLT, which terms the accreditation of the Accrediting Bureau of Medical Laboratory Schools unacceptable, to date has accredited only private or proprietary schools. Other institutions are eligible.

Proprietary Schools—Only within the past few months has the AMA consented to the accreditation of proprietary schools, and the Council on Medical Education through the Board of Schools of Medical Technology has now accredited some such institutions.

The quality of training in the proprietary schools is constantly under attack by organized pathologists. Some pathologists are willing to accept these schools for training at the assistant level but not for the technician category. Proponents of the programs contend that the education offered is actually superior because the student receives instruction in an educational laboratory, whereas training in a clinical laboratory frequently provides the laboratory with cheap labor. Opponents contend that the clinical education offered is inferior because the student receives no exposure to clinical conditions and patients.

Summary Observations and Questions

Accreditation, as conducted by associations of health professions and professionals who are educators, is widely credited with being an important factor in the quality of health care in the United States. On the other hand, changing patterns of health care delivery and the widespread questioning of existing social institutions have raised significant issues regarding the organizational structure of accreditation for the health-related professions.

Observations

Accreditation, particularly when it is inexorably related to the quality of health care delivery, is clearly affected with the public interest. Official recognition of this fact is indicated by (1) the federal reliance on accrediting agencies to establish eligibility for federal funds, (2) the dependence of state licensure agencies on accrediting organizations for certification of the quality of educational programs for professional practitioners, and (3) the extensive legislative use of the professional registries as a means of assuring the quality of health care delivery. (These registries in turn often require graduation from an accredited program to establish eligibility to sit for their examinations.)

But only through the circuitous route of professional responsibility can it be argued that the organization of accreditation in the health fields gives more than token recognition to its public trust function. A few accrediting bodies do themselves select public or government representatives as members but this does little to add to the credibility of the particular organization.[17]

Accreditation is conducted by professional associations as a professional responsibility. But what is done in the name of professional responsibility is not always accepted as being in accord with the public interest, even by members of the profession.[18] An often repeated charge, one that is virtually impossible to refute or substantiate through documentation, holds that the American Medical Association has used accreditation of medical schools to limit the supply of physicians in the United States. Similar charges are laid at the doorsteps of other professions.

Whether such charges are true, partially true, or erroneous is important; but of overriding concern to a study of the organization of accreditation is the fact that the current organizational structure permits such charges to exist with a measure of credence. There is serious public distrust of organizations that purport to serve the public interest and at the same time are responsible for the professional and economic welfare of their members. This situation tends to erode the credibility of accreditation, yet accreditation's usefulness to society depends upon credibility.

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17. Harold Seidman, *Politics, Position, and Power* (New York: Oxford University Press, 1970) notes that who selects the representative is of critical importance. It is relatively easy to find a nominal Democrat whose views generally coincide with a Republican administration or vice versa, he points out.

18. Alex Gerber, *The Gerber Report* (New York: David McKay Company, 1971), pp. 48-49.

Proponents of the current reliance on professional groups to accredit educational programs in the health fields hang their argument on the concept of peer review. The essence of the concept is that only members of a given profession have the expertise necessary to make competent judgments about education for the profession, subprofessions, or related technologies.

There is a growing number of individuals who insist that this argument fails to make proper recognition of the interdependence of the health-related professions and of the complementary and supplementary knowledge and skills of all health care practitioners. For example, biochemists and microbiologists are intimately involved in and knowledgeable about the education of dentists, medical doctors, osteopathic physicians, podiatrists, and veterinarians. To a considerable degree, all of these professionals complement or supplement the care delivered by others. The technologist may be more expert in some areas of medical procedures than the physician or medical specialist. With this line of argument, no professional group today can claim exclusive knowledge in its particular field.

The peer review concept of accreditation is also being questioned in other fields. There is mounting pressure for all accreditation to be reorganized to reflect more concern with the public interest. It now appears likely that this pressure will result in some kind of action, and accreditation in the health fields will be forced to fit into evolving patterns based on current sociopolitical thought.

Questions have also been raised about another feature of the current organizational structure of accreditation; namely, the potential of one profession's exercising professional and economic control over related professions, subprofessions, and technologies. Such control, whether actual or perceived, seriously affects relationships among professionals and undoubtedly exerts an eventual deleterious effect on the quality of health care. The current dispute between medical technologists and pathologists is a prime example.[19]

Such potential conflicts of interest appear not to be confined to medicine and the medical specialties. Dentists control the accreditation of the dental auxiliary fields. Occupational therapists control the accreditation of programs preparing the occupational therapy assistant. Medical technologists are heavily involved in the accreditation of educational programs for related laboratory workers.

Some analysts have observed that perhaps the greatest potential for economic and professional control lies in the area of nursing services. If the current trends continue, the number of practical nurses could equal the number of registered nurses within a few years, and as the number of those providing nursing services grows, it is likely that the practical nurse will provide greatly

19. E. R. Jennings, president of the American Society of Clinical Pathologists, reporting to ASCP membership on negotiations between ASCP and the American Society for Medical Technology, wrote, "The strains and stresses that exist between the two societies resulting from litigation find their way down to the laboratory. I continue to hope that we can reach a settlement so that the effect of this stress will disappear." (Letter dated May 19, 1971)

increased economic and service competition for the registered nurse. Such a likelihood raises serious questions about the present structure of accreditation for practical nursing education programs conducted by the National League for Nursing. Compounding the situation is the fact that boards controlling licensure for practical nurses are dominated in forty-two states by registered nurses. Such boards frequently have power to prescribe educational requirements and in some cases are able to define the scope of nursing services that can be provided.

The AMA collaborative arrangement is also perceived by many professional groups as giving the physician some economic and professional control over the allied professions and services. This perception is a significant factor in the strained relationships between the AMA and some of the collaborating groups.

The primary responsibility of physicians for the delivery of health care has been the justification for their assuming the responsibility of determining the quality of education for the professions and services allied to medicine. The structure provides medicine with control of the process for at least fifteen allied health fields, even though until recently that control has generally been more illusory than real. However, even the potential for control appears to stimulate growing breeches in the relationships between physicians and their allied professions and services, a situation that is good for neither medicine nor the other health professions.

Historically, there has been competition and struggle for preeminence between such practitioners as the medical doctor and the osteopathic physician, the ophthalmologist and the optometrist, and the orthopedist and the podiatrist. Such struggles always involve polemics over the rigor and quality of education. As a result, control of or participation in the accrediting process, particularly if it has national recognition, is of critical importance in achieving or guarding vested interests. Professional associations are quick to insist on representation in the organizational structure as one means of protecting the interests of their members. For example, this was the case in the organizational arrangement to accredit programs in nuclear medicine technology, where six organizations are represented in the review body.

Such groups readily understand the importance of the organizational structure. Witness the situation in legal education, where change in the standards for accreditation has been blocked or thwarted by a group legitimately controlling the Section on Legal Education and Admissions to the Bar of the American Bar Association.[20]

One can predict with some confidence that current unrest and attitudes among the allied health professions and services and some medical specialties

20. The ABA structure permits the packing of the meetings of the Section on Legal Education and Admissions to the Bar. Situations have occurred where less than 250 ABA members, a major block of them being alumni of one law school, have defeated changes in standards for legal education, which have not been revised since 1950.

assure continuing controversy and confrontation over the control of educational standards. As a result of its coordinating and leadership role, the American Medical Association stands to be centrally involved in such issues, perhaps quite unwillingly.

The cost to the AMA of such participation goes far beyond the substantial funds it now spends on the allied health professions and services. The AMA is limited by its public image, which has the economic interests of physicians in a prime spot. What some people fear is that the AMA's objective in accreditation for the allied health professions and services will be increasingly interpreted as seeking to control the process for the advantage of physicians. Such interpretation, or misinterpretation, will further undermine the acceptance or image of the AMA and handicap it in achieving objectives more central to the welfare of medicine.

Questions

The following are basic questions to be faced by SASHEP:

Hypothesis:	Accreditation is not now organized in a manner that reflects a primary concern for the public interest.
Question:	What changes should be effected in the organizational structure of accreditation in the health fields in order that the operation takes into greater account the broad welfare of society?
Hypothesis:	The current organization of accreditation embodies the potential for a profession to use the process for the professional and economic control of other professions, subprofessions, and technologies.
Question:	How can such potential for control be minimized or eliminated while retaining desirable participation in the accreditation process?
Hypothesis:	Medicine has theoretical control of the accreditation process for some allied health professions; in others it has no effective voice.
Question:	What is the proper balance of influence for medicine in the accreditation of educational programs preparing allied medical professions and services?
Hypothesis:	Currently, accreditation has the potential for becoming involved in competitive struggles among professional groups and professional levels.
Question:	How can accreditation be reorganized to diminish the possibility that it will become a weapon in competitive struggles?
Hypothesis:	Duplicative and competing accrediting efforts produce health workers with varying degrees of acceptability and are confusing to the public and to institutions offering educational programs.
Question:	Should accreditation in the health fields be organized to eliminate duplicative or competing accrediting programs?
Hypothesis:	The coordination and supervision functions for accreditation in allied health education are essential; the functions as now carried out by the AMA are not sufficiently effective.
Question:	Should the AMA role in coordination and supervision be strengthened? Or, should a new mechanism be created to serve the coordination and supervision functions? If so, what should be the mechanism?

TABLE 1

Accrediting Agencies Operating Independently of AMA In Health Fields

ACCREDITING AGENCY	FIELDS ACCREDITED	RECOGNITION	SIZE OF ACCREDITING BODY	AGENCIES SELECTING REPRESENTATIVES AND NUMBER APPOINTED	
Accrediting Bureau for Medical Laboratory Schools	Medical Laboratory Technician	USOE	9	Accredited Schools	(3)
				American Medical Technologists	(3)
	Medical Assistants	None		Selected by Accrediting Bureau	(3)
Accrediting Commission on Graduate Education for Hospital Administration	Graduate Programs in Hospital Administration	NCA USOE	7	American College of Hospital Administrators	(1)
				American Hospital Association	(1)
				American Public Health Association	(1)
				Association of University Programs in Hospital Administration	(4)
American Association of Nurse Anesthetists, Board of Trustees[1]	Nurse Anesthetists	USOE	9	American Association of Nurse Anesthetists	(9)
American Chemical Society, Committee on Professional Training	Chemistry	NCA USOE	9	American Chemical Society	(9)
American College of Nurse-Midwives, Approval Committee	Nurse Midwifery	None	5	American College of Nurse-Midwives	(5)
American Council on Pharmaceutical Education	Pharmacy	NCA USOE	10	American Association of Colleges of Pharmacy	(3)
				American Council on Education	(1)
				American Pharmaceutical Association	(3)
				National Association of Boards of Pharmacy	(3)
American Dental Association, Council on Dental Education[2]	Dentistry	NCA USOE	9	American Association of Dental Examiners	(3)
	Dental Assisting	NCA USOE		American Association of Dental Schools	(3)
	Dental Hygiene	NCA USOE		American Dental Association	(3)
	Dental Technology	NCA USOE			
American Dietetic Association, Dietetic Internship Board	Dietitian	None	10	American Dietetic Association	(10)
	Dietetic Supportive	None			
	Dietetic Assistant	None			
	Dietetic Technician	None			
American Occupational Therapy Association, Accreditation Committee	Occupational Therapy Assistant	None	12	American Occupational Therapy Association	(12)
American Osteopathic Association, Bureau of Professional Education[3]	Doctor of Osteopathy	NCA USOE	9	Accredited Colleges	(1)
				American Osteopathic Association	(8)

1. The Approval of Schools Committee recommends action on the accredited status of educational programs.
2. Committee C of ADA submits recommendations on matters of policy and accredited status for dental auxiliary programs; its membership includes representatives of the dental auxiliary fields and the Public Health Service.
3. Final action on standards, procedures, and accredited status is taken by the Board of Trustees of AOA.

ACCREDITING AGENCY	FIELDS ACCREDITED	RECOGNITION	SIZE OF ACCREDITING BODY	AGENCIES SELECTING REPRESENTATIVES AND NUMBER APPOINTED	
American Physical Therapy Association, Task Force on Approval of Physical Therapy Assistant Programs	Physical Therapy Assistant	None	6	American Physical Therapy Association	(6)
American Podiatry Association, Council on Podiatry Education	Doctor of Podiatric Medicine	NCA USOE	10	American Association of Colleges of Podiatric Medicine American Podiatry Association Federation of Podiatry Boards	(2) (7) (1)
American Psychological Association, Committee on Accreditation	Clinical and Counseling Psychology	NCA/USOE	8	American Psychological Association	(8)
American Public Health Association, Executive Board[4]	Graduate Programs in Public Health; Graduate Programs in Community Health Education	NCA/USOE	16	American Public Health Association	(16)
American Speech and Hearing Association, American Boards of Examiners in Speech Pathology and Audiology[5]	Speech Pathology and Audiology	NCA/USOE	9	Accredited Programs American Speech and Hearing Association	(6) (3)
American Veterinary Medical Association, Council on Education	Veterinary Medicine	NCA USOE	10	American Veterinary Medical Association[6]	(10)
Council on Social Work Education					
Commission on Accreditation[7]	Graduate Programs in Social Work	NCA USOE	17	Council on Social Work Education	(17)
Committee on Standards for Undergraduate Programs	Undergraduate Programs in Social Work	None	11	Council on Social Work Education	(11)
International Society of Clinical Laboratory Technologists, Accrediting Commission	Medical Technology	None	5	Accredited Schools	(5)
Liaison Committee on Medical Education	Medicine	NCA/USOE	14	Association of American Medical Colleges Council on Medical Education, American Medical Association Liaison Committee	(6) (6) (2)
National Association for Practical Nurse Education and Service, Accrediting Review Board[8]	Practical Nursing	USOE	7	National Association for Practical Nurse Education and Service	(7)

4. Routine matters are handled by the Council on Health Manpower without action by the Executive Board.

5. The Board of Examiners delegates routine accrediting procedures to the Education and Training Board.

6. AVMA bylaws require that the Council's membership include three faculty members from accredited schools, three practitioners, three employees of government agencies, and one from veterinary research.

7. The CSWE Board of Directors determines accreditation policy and standards; actions of the Committee on Accreditation relative to accredited status of programs are not reviewable by the Board of Directors. CSWE policy requires membership of graduate students on the Committee on Accreditation.

8. The NAPNES' Education Committee sets accrediting policy and delegates the administration of the process to the Accrediting Review Board, whose decisions on accredited status are nonreviewable.

ACCREDITING AGENCY	FIELDS ACCREDITED	RECOGNITION	SIZE OF ACCREDITING BODY	AGENCIES SELECTING REPRESENTATIVES AND NUMBER APPOINTED	
National League for Nursing[9]					
Council of Baccalaureate and Higher Degree Programs	Baccalaureate and Graduate Programs in Nursing	NCA/USOE	9	National League for Nursing	(9)
Council of Diploma Programs	Diploma Programs in Nursing	USOE	7	National League for Nursing	(7)
Council of Associate Degree Programs	Associate Degree Programs in Nursing	NCA USOE	7	National League for Nursing	(7)
Council of Practical Nursing Programs	Programs in Practical Nursing	USOE	7	National League for Nursing	(7)

9. The Board of Directors elected by the membership of NLN delegates responsibility for accreditation to the four councils. The councils are autonomous with respect to (1) establishing standards and accrediting procedures, and (2) the appointment of boards of review which have final authority for decisions related to the accredited status of programs.

TABLE 2

Agencies Collaborating With AMA In Accreditation In Health Fields

REVIEW BODY	FIELDS ACCREDITED	RECOGNITION	SIZE OF REVIEW BODY	AGENCIES SELECTING REPRESENTATIVES AND NUMBER APPOINTED	
Accreditation Committee, American Occupational Therapy Association	Occupational Therapist	NCA USOE	12	American Occupational Therapy Association	(12)
Board of Schools of Medical Technology*	Medical Technology	NCA USOE	11	American Society of Clinical Pathologists American Society for Medical Technology	(6) (5)
Committee on Certified Laboratory Assistants	Programs for Laboratory Assistants	None	10	American Society of Clinical Pathologists American Society for Medical Technology	(5) (5)
Committee on Cytotechnology	Programs for Cytotechnologists	None	11	American Society of Clinical Pathologists	(11)
Committee on Histologic Technic	Programs for Histologic Technicians	None	6	American Society for Clinical Pathologists American Society for Medical Technology	(3) (3)
Committee on Accreditation in Basic Education, American Physical Therapy Association	Physical Therapist	NCA USOE	6	American Physical Therapy Association	(6)
Committee on Education and Registration, American Medical Record Association	Medical Record Librarians Medical Record Technicians	NCA USOE USOE	9	American Medical Record Association	(9)
Curriculum Review Committee, American Association of Medical Assistants	Medical Assisting	None	6	American Association of Medical Assistants	(6)
Joint Review Committee for Inhalation Therapy	Inhalation Therapy Technician	None	8	American Association for Inhalation Therapy American College of Chest Physicians American Society of Anesthesiologists	(4) (2) (2)
Joint Review Committee on Education for Radiologic Technology	Radiologic Technologist Radiation Therapy Technologist	USOE None	6	American College of Radiology American Society of Radiologic Technologists	(3) (3)
Joint Review Committee on Educational Programs in Nuclear Medicine Technology	Nuclear Medicine Technologist Nuclear Medicine Technician	None None	12	American College of Radiology American Society of Clinical Pathologists American Society for Medical Technology American Society of Radiologic Technologists Society of Nuclear Medicine Society of Nuclear Medicine Technologists	(2) (2) (2) (2) (2) (2)
Subcommittee on Orthopaedic Physician's Assistant, American Academy of Orthopaedic Surgeons	Orthopaedic Physician's Assistant	None	8	American Academy of Orthopaedic Surgeons	(8)
Council on Medical Education, American Medical Association	Health Educational Programs listed above	Six by USOE, four by NCA.	10	American Medical Association	(10)

*The Board of Schools of Medical Technology functions in a house of lords relationship to the committees on laboratory assistants, cytotechnology, and histologic technic. The committees report their recommendations to the Council on Medical Education through the Chairman of the Board of Schools of Medical Technology.

FINANCING THE ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

Karen L. Grimm

Stepping into the vacuum created by government agencies either unable or unwilling to undertake health educational accreditation, the health professions themselves originally assumed the primary responsibility for conducting and financing accreditation in the health fields. Today, aided relatively little by the education community and even less by government funds, health professional organizations continue to be the financial mainstays of health program accreditation; and society, looking to the past, has come to depend upon these professional groups not only to conduct but also to finance this vital activity. However, the past is not the present, and it may be that patterns established in the past may be neither desirable for the present nor viable for the future.

The health accrediting scene has undergone dramatic change within the past fifty years. In 1920 there were no more than six health professional organizations engaged in accrediting health educational programs; today there are eighteen recognized national health accrediting agencies, and numerous others are in various stages of development. Although fifty years ago only a handful of health fields were subject to national accreditation, today approximately thirty different categories of health educational programs are accredited by recognized national accrediting agencies.

Not surprisingly, increased costs have accompanied the rapid growth and expansion in health educational accreditation. Many accrediting agencies, currently finding themselves beset by spiraling costs, petitioned by an increasing number of programs seeking accreditation, and overwhelmed by the proliferation of new and emerging health professions, are already casting about for new sources of income to finance their accrediting programs. What will the future hold? Will existing health professional organizations continue to be both able and willing to underwrite accrediting programs, increasingly expensive as they might be? Will newly emerging professional organizations, in their initial struggles for financial stability, be capable of donating a sizable chunk of their rather lean budgets to accrediting programs; and, more important, is it in fact desirable that they do so?

Attempting to lay the necessary factual groundwork for the future discussion and resolution of these and related questions, this working paper will (1) describe the past and current sources of support for health program accreditation, with special emphasis upon the role played by health professional organizations; (2) discuss the financial problems currently confronting the health accrediting sector; and (3) explore several means by which current financial distresses might be alleviated and future financing needs might be met.

Figures and tables referred to in the text will be found in the appendix following this paper.

The Role of Health Professional Organizations–Today

Accrediting programs for the health professions are typically sponsored, operated, and financed by health professional associations having professional stakes in maintaining such programs for their own or related professions. Though differing to a great extent in their financial resources and operating budgets, existing health accrediting agencies are supported under a surprisingly limited number of financial arrangements. These may be described in terms of the following models.

Model A

Paving the way for specialized accreditation in the health fields, the American Medical Association, through its Council on Medical Education, originally assumed the responsibility for both conducting and financing medical school accreditation as one of a large number of activities sponsored by the association. Functioning as an integral part of the association, the council was totally dependent upon its parent organization for financial sustenance. All accrediting costs were borne by the association; no charges were levied on schools seeking accreditation.

Today, the financing pattern established by the AMA continues to be one of the most prevalent and widely utilized in the health fields. The American Dental Association, operating through its Council on Dental Education, assumes complete financial responsibility for accrediting dental schools, as well as for accrediting programs in dental assisting, dental hygiene, and dental technology. In like fashion, the American Optometric Association underwrites the costs of accrediting schools of optometry, the American Osteopathic Association funds the accrediting program for schools of osteopathic medicine, the American Podiatry Association assumes the cost of accrediting schools of podiatry, and the American Veterinary Medical Association funds the accrediting program for schools of veterinary medicine. Likewise, the American Association of Nurse Anesthetists finances the accreditation of nurse anesthetist programs, and the American Dietetic Association underwrites the costs of accrediting dietitian internships. In all cases, accrediting expenses are borne entirely by the sponsoring organization; none of the agency's direct costs are shifted to participating educational institutions.

Representing a collection of established associations with comfortable operating budgets, it is not surprising that the Model A agencies rely to a large extent upon paid staff to administer their accrediting programs. In marked contrast to most newly emerging and less well established accrediting agencies that tend to rely heavily on volunteers to administer all phases of their accrediting programs, the Model A group shows substantial reliance on volunteers only for site visitations and the formulation of accrediting policies and decisions. Moreover, though the accrediting costs of all the agencies in the Model A group have increased in absolute terms over the past five years, the rates of increase are typically less than those registered by the more recently established accrediting groups (see table 1).

Model B

Like the Model A agencies, the Model B accrediting agencies also receive the bulk of their financial support from the parent associations to which they belong. However, unlike the Model A agencies, all accrediting agencies of the second group also rely for financial support upon participating educational institutions and programs of study.

Composed of the accrediting agencies sponsored by the American College of Nurse Midwives, the American Psychological Association, the American Public Health Association, the American Speech and Hearing Association, the Council on Social Work Education, the National Association for Practical Nurse Education and Service, and the National League for Nursing, the Model B group presents a less homogeneous picture than does the first model.

While all Model B agencies are somewhat dependent on educational institutions for financial support, the types of charges levied on the education community differ considerably from one agency to another (see table 8). Where one agency may require the payment of application fees, another may assess only initial accrediting fees to help defer actual site-visit costs. While one agency may charge annual sustaining fees, another may assess additional fees only in reevaluation years. Moreover, direct charges for accreditation are only one avenue by which educational institutions and programs are expected to help foot the bills for accrediting services provided by professional associations. For example, while direct charges levied by the National League for Nursing are limited to reimbursement of site-visit expenses, nursing schools, as members of the league, also provide support for the NLN accrediting program through the payment of annual association dues. A similar pattern is seen in the financing of social work accreditation, although the Council on Social Work Education, unlike the NLN, assesses sizable direct accrediting fees in addition to annual membership dues (see tables 4 and 8).

The Model B agencies also differ significantly in the extent to which they rely upon educational institutions to underwrite their accrediting costs. For example, while direct charges offset only 9.5 percent of the total 1970 accrediting costs incurred by the American Boards of Examiners in Speech Pathology and Audiology, the American Psychological Association was able to shift 93 percent of its accrediting costs to participating educational institutions. Whereas the American Public Health Association was able to pay for almost 20 percent of its 1970 accrediting costs with the income realized through accrediting fees, the Council on Social Work Education estimates that only 8 percent of its 1970 accrediting costs were offset by fee assessments (see table 6).

In addition to relying upon the education community as a source of revenue, most of the associations that sponsor Model B agencies rely to some extent upon government and foundation grants as additional sources of operating funds (see table 4). Though the federal government has only on rare occasions ventured into the direct financing of health program accreditation, the associations sponsoring Model B accrediting agencies rely to a considerable extent upon government aid for the implementation of other association projects and programs, thereby freeing additional association funds for accrediting and related activities. Moreover, despite the traditional hands-off policy of

the federal government toward accreditation, both the psychology and the speech and hearing accreditation programs owe their beginnings to federal government grants.

Differing in their reliance upon outside sources of revenue, the Model B agencies also show considerable diversity in the extent to which they rely upon volunteers to implement their accrediting programs. At one end of the spectrum lies the accrediting program sponsored by the American College of Nurse Midwives, which, by depending upon volunteers and support from the education community, is virtually self-sustaining.[1] At the other extreme lies the National League for Nursing, which relies heavily upon paid staff to administer almost all phases of its accrediting programs. Determined in large part by the amount of financial resources available, the extent to which organizations must depend upon volunteers differs significantly from one accrediting agency to another. However, even agencies that find it possible to transfer administrative tasks to a paid staff usually vest the primary responsibility for policy formulation, decision making, and site visitations in agency or association members serving on a voluntary basis.

Like the Model A agencies, most of the group B agencies experienced an absolute increase in accrediting costs between 1965 and 1970 (see table 1). Although most of the increases for the Model B group were relatively modest, the accrediting costs of the Council on Social Work Education more than tripled between 1965 and 1970. On the other hand, those of the National League for Nursing registered only a slight increase.[2] Relative to total incomes and expenses, the differences are even more striking (see tables 2 and 3).

Model C

Most programs of health educational accreditation are conducted by committees that operate as integral parts of their sponsoring organizations and look, in some measure, to their parent associations for financial support. However, four accrediting agencies, though relying upon professional groups for financing, operate on either a semi- or a completely autonomous basis.

One of the agencies included in this Model C group looks to only one organization for financial support. Heavily dependent upon the American Medical Technologists for financial sustenance, the Accrediting Bureau of Medical Laboratory Schools looks to the AMT for almost 75 percent of its operating budget. The other three agencies each rely upon two or more professional groups for their operating funds. The Accrediting Commission on Graduate Education for Hospital Administration is funded by direct contributions

1. The American College of Nurse Midwives reports that "members of the Committee are not compensated; their expenses are not reimbursed. Meeting space is donated by the Maternity Center Association. In general, the institution bears cost of approval by doing the bulk of the paper work, paying visitors' expenses and [paying] fee for visits which should cover incidental costs of committee."

2. Although the NLN registered a slight overall increase in accrediting costs, it experienced a decrease in its costs for accrediting baccalaureate and diploma programs and a sharp increase in the associate degree sector.

from the American College of Hospital Administrators, the American Hospital Association, the American Public Health Association, and the Association of University Programs in Hospital Administration. The American Council on Pharmaceutical Education looks to the American Pharmacy Association, the Association of American Colleges of Pharmacy, the Federation of State Pharmacy Boards, and the Foundation of Pharmaceutical Education for its support. The costs of the Liaison Committee on Medical Education are shared equally by the American Medical Association and the Association of American Medical Colleges.

All four Model C agencies rely to some extent upon institutions and educational programs to help defray their accrediting costs, though in the case of the American Council on Pharmaceutical Education this dependence appears to be more apparent than real.[3] In contrast to the council, both the Accrediting Commission on Graduate Education for Hospital Administration and the Accrediting Bureau of Medical Laboratory Schools rely upon direct accrediting charges to underwrite a significant portion of their total accrediting costs (see table 6). Likewise, the rather substantial dues and fees exacted of medical schools for membership in the Association of American Medical Colleges provide a substantial measure of support for the Liaison Committee's accrediting program (see table 4).

The Model C agencies rely heavily upon paid staff to administer their accrediting programs. However, in the case of the Accrediting Commission on Graduate Education for Hospital Administration, *paid staff* refers, not to the staff paid by the commission, but rather to staff paid by the Association of University Programs in Hospital Administration and donated to the semi-autonomous commission. In similar manner, the administration of medical school accreditation is primarily undertaken, not by staff charged to the Liaison Committee budget, but rather by staff paid by its sponsoring organizations and donated on an annual rotating basis.

Dependent for financial support on a combination of sponsors, joint accrediting agencies are currently less common than are those sponsored by one professional association. However, the patterns of support adopted by the most recent newcomers to the health accrediting scene suggest that the joint support pattern may be seen with increasing frequency in the years ahead.

Model D

Functioning under the aegis of the American Medical Association's Council on Medical Education, nine agencies presently assume the primary financial and operational responsibility for accrediting educational programs for fifteen categories of health personnel. Though differing somewhat in their reliance upon the AMA, all nine collaborating agencies rely to a degree upon the coordination and advisory services provided by the association through its Department of Allied Medical Professions and Services. Acting as a staff arm of the Council on Medical Education, the department counts accreditation as only one of its

3. Though the ACPE fee schedule calls for the assessment of application fees, no income has been realized from this source within the past five years.

many functions related to allied health, and judging from past trends, it seems likely that in the years ahead an ever decreasing portion of the department's total budget will be allocated to accreditation (see figure 1).

The types of expenses incurred by the department are indicative of the role it plays in the accreditation of allied health educational programs. Acting in an advisory capacity to the Council on Medical Education, the department's primary responsibility in accreditation is to provide the necessary liaison between the council and the nine agencies functioning under the AMA umbrella. Thus, the expenditures reported for staff salaries and travel costs are incurred not so much for the actual operation of accrediting programs as for the provision of advisory services to both the operational agencies and the council.[4]

In the light of this division of responsibility, it is hardly surprising that the accrediting costs incurred by the operational agencies have substantially outpaced those incurred by the Department of Allied Medical Professions and Services (see figure 2). Nor is it surprising that, in the former group, the problem of financing accreditation is becoming of ever increasing concern.

Single Collaborating Agencies–Like the accrediting agencies previously discussed, the nine operational agencies functioning under the Council on Medical Education are sponsored either by one professional association or by a number of associations contributing to the support of one joint agency. Of the nine agencies, five are sponsored by only one professional organization. These sponsoring associations include the American Association of Medical Assistants, the American Medical Record Association, the American Occupational Therapy Association, and the American Physical Therapy Association.[5] At the present time, all four associations support their accrediting programs primarily through the collection of individual membership dues; none impose charges for their accrediting services.[6]

However, this may soon change. Feeling the pressure of rising accrediting costs, the American Medical Record Association is currently considering the possibility of augmenting its income through the collection of accrediting fees. The American Association of Medical Assistants, which previously relied exclusively upon volunteers to perform site visits, will soon find it necessary to hire additional paid staff to cope with its expanding volume of accrediting business. The association's accrediting costs, already accounting for almost 8 percent of its total budget, grew by 63 percent between 1970 and 1971 and show no sign

4. The Department pays the travel expenses of its staff members who serve on site-visit teams. However, this cost represents a relatively minor item in the department's total accrediting budget.

5. The fifth organization that collaborates with the Council on Medical Education is the American Academy of Orthopedic Surgeons, which did not submit any financial data to the study.

6. The AOTA-sponsored accrediting program for occupational therapy assistants requires reimbursement for site-visit costs. However, this program is not administered under the aegis of the Council on Medical Education.

of leveling off. Though currently seeking additional grants to finance its accrediting program, the American Association of Medical Assistants reports that it will eventually have to turn to accrediting fees to help solve its financing problems.[7]

Though perhaps more severe in the case of newly established associations and accrediting operations such as the AAMA, all four single collaborating agencies are already feeling the impact of expanded accrediting responsibilities on their association budgets (see tables 2 and 3). Whether these organizations will continue to be both willing and able to raise membership dues to offset increasing accrediting costs appears highly questionable. On the other hand, whether any one of the other ad hoc cost-cutting and income-raising measures currently being considered will prove any better able to meet the long-term needs of the future, as well as the immediate demands of the present, appears even more unlikely.

Joint Agencies–Functioning as joint agencies in collaboration with the Council on Medical Education are the Board of Schools, sponsored by the American Society of Clinical Pathologists and the American Society for Medical Technology; the Joint Review Committee for Inhalation Therapy Education, sponsored by the American Association for Inhalation Therapy, the American Society of Anesthesiologists, and the American Society of Chest Physicians; the Joint Review Committee on Education in Radiologic Technology, sponsored by the American College of Radiology and the American Society of Radiologic Technologists; and the Joint Review Committee on Educational Programs in Nuclear Medicine Technology, sponsored by the American College of Radiology, the American Society of Clinical Pathologists, the American Society for Medical Technology, the American Society of Radiologic Technologists, the Society of Nuclear Medical Technologists, and the Society on Nuclear Medicine.

The Board of Schools, established in 1949 as a companion organization to the ASCP-sponsored and-controlled Registry, was originally financed by the American Society of Clinical Pathologists, and even as late as 1965 almost all operating funds were provided by the society. However, due to the increased income realized through transcript evaluations and annual accrediting fees, the board by 1971 had become virtually self-supporting (see tables 5 and 6). Benefiting from its healthy operating budget, the board now finds itself able to employ a staff that assumes the major responsibility for clerical duties. (However, the American Society of Clinical Pathologists continues to act as the fiscal agent for the board.) In addition, substantial sums can now be devoted to workshops and other activities intended to improve the accrediting process (see table 7).

The Committee on Certified Laboratory Assistants was originally financed by contributions from the American Society of Clinical Pathologists and the

7. In 1971 the American Medical Association awarded a $15,000 grant to the AAMA's Curriculum Review Committee. A portion of this grant is currently being utilized to operate the association's accrediting program.

American Society for Medical Technology; however, it now functions as a committee of the Board of Schools, through which it is funded. Clerical support for the committee program is provided by one paid secretary, but all visits are performed by members of the committee.[8]

In contrast to the Board of Schools and the Committee on Certified Laboratory Assistants, the Committee on Cytotechnology owes its existence to a federal grant, which, until last year, provided the only source of financial support for the committee's program (see table 5). Incorporated into the Board of School's budget in fiscal year 1971, the committee is now, in part, supported by accrediting fees collected from cytotechnology programs (see table 8). Committee members implement all phases of the cytotechnology accrediting program; assistance from the Board of School's staff is provided only on an ad hoc, infrequent basis.

Illustrating the same pattern of support evolved by the Board of Schools, the accrediting program now operated by the Joint Review Committee of Education in Radiologic Technology was, until 1970, largely underwritten by the American College of Radiology. Based as it was upon the voluntary efforts of college members, the accrediting program, by 1970, could no longer cope with the increasing deluge of educational programs seeking accreditation. Prompted by this crisis, the college, in cooperation with the American Society of Radiologic Technologists, established the self-supporting Joint Review Committee to assume responsibility for collaborating in the accreditation of all diagnostic and therapeutic radiologic technology programs. Today, the Joint Review Committee is totally dependent for its financial well-being on the annual dues collected from accredited radiologic technology programs. Neither sponsor provides any direct monetary contribution to the committee, and a sizable staff provides most of the necessary clerical support. (However, the American College of Radiology continues to act as the fiscal agent of the Joint Review Committee.) Nevertheless, though the accrediting costs of the Joint Review Committee almost tripled between fiscal years 1970 and 1971, the operating capital provided by accredited programs was more than adequate to keep pace with the agency's skyrocketing costs (see table 6).

Like the Board of Schools and the Joint Review Committee on Education in Radiologic Technology, the Joint Review Committee on Educational Programs in Nuclear Medicine Technology also depends to a large extent upon accrediting charges to finance its operation (see table 6). Though initiated in 1970 with $1,500 start-up grants from each of six sponsoring organizations, the Joint Review Committee decided at that time that the need for additional assistance from these organizations would be reviewed on an annual basis. Assessing its financial status in fiscal year 1971, the Joint Review Committee found it could rely upon a budgetary surplus from fiscal year 1970 coupled with accrediting fees to finance its accrediting operation; however, it is expected that the sponsoring associations will again be asked to come to the aid

8. Regular surveys of schools are not performed. Only schools in which problems exist are visited.

of the committee during the current fiscal year. To date, the volume of applications submitted to the Joint Review Committee has been relatively small. Committee volunteers and staff members of the Department of Allied Medical Professions and Services continue to administer the program; no paid staff are employed by the Joint Review Committee. However, what of the future? Will not the inevitable expansion of the program necessitate different staffing patterns and increased financial support? Will not the increased demands for site visits put additional strains on the committee's budget? In the future, from what sources will operational funds be sought and obtained?

Similar to the Joint Review Committee on Educational Programs in Nuclear Medicine Technology, the Joint Review Committee for Inhalation Therapy Education was initiated by start-up grants of $300 collected from each of its three sponsoring organizations. By 1970, each sponsor was contributing $2,500 to the committee's program; however, apparently even this additional revenue proved to be insufficient, for the committee reports that it is now in the process of collecting an annual fee of $100 from approved schools and will, in the future, charge $250 for initial site visits and processing. Though some assistance is provided by DAMPS staff, much of the Joint Review Committee's accrediting operation is still handled by committee members serving on a voluntary basis. Employing only a half-time secretary and facing an ever increasing number of programs to be surveyed, the committee recognizes the need for additional staff but, due to insufficient financial resources, finds itself unable to hire the necessary personnel. Operating on a shoestring budget, dependent upon volunteers for continued operation, and faced with an ever expanding work load, it appears that the Joint Review Committee for Inhalation Therapy Education is functioning on shaky financial ground. The implementation of its new fee schedule may be expected to alleviate the committee's current financial distresses, but what of the future?

Though differing in financial stability, the joint agencies currently collaborating with the Council on Medical Education also have much in common. Nurtured under the protective wing of one or more professional associations, all four agencies still rely upon their founders for either direct contributions or indirect assistance, or both. However, pressed by increasing work loads, all four joint agencies have turned to the education community for additional financial assistance, and the AMA, though traditionally opposed to the practice of charging institutions for accrediting services, has thus far seen fit to approve the fee schedules proposed by the joint accrediting agencies operating under its jurisdiction. This approval, however, is viewed only as a temporary measure pending a more comprehensive long-term resolution of the entire problem of financing health program accreditation. Stopgap responses to rising costs may suffice for the present, but how tenable will they prove for the future?

The Role of Health Professional Organizations–Tomorrow

Though increasing costs appear to be an unpleasant fact of life for all health accrediting agencies, the means by which these agencies choose to cope with their expanded accrediting responsibilities differ significantly from one agency

to another. While some agencies find it necessary to effect only minor, operational cost-cutting measures, other agencies, enjoying less financial stability, see increased levies on educational programs as the only way out. Still others report that they will continue raising membership dues to offset any increases in accrediting costs.

However, whatever the exact means employed, it appears that the cost-ridden accrediting agency has in effect only two options–it must either cut its costs or increase its income. Used either singly or in combination, both options are obviously subject to severe constraints. For example, some agencies, already operating at a minimal level, may find cost-cutting virtually impossible, in which case increased income may be the only life-saving alternative to reduction in quality. Moreover, even associations currently able to trim some fat from their accrediting budgets may well be forced to turn to other more drastic measures as expenses continue to climb. In addition, it would appear that few additional sources of income are currently available to aid hard-pressed accrediting agencies. At the present time, individual membership dues, diversion of funds from other association programs, and direct accrediting charges apparently represent the only readily available sources of additional operating funds for accrediting purposes. However, of the three, the first cannot be tapped without inviting criticism from the members of the profession, the second cannot be implemented without compromising other association programs, and the third cannot be realized without the acquiescence of the education community. In the light of these constraints, where are accrediting agencies to turn for financial support?

It should also be borne in mind that, although all health accrediting agencies are finding themselves beset by increasing costs, the resultant financial pressures are likely to be felt more acutely by some agencies than by others. Many of the longer established accrediting groups, operating with sizable budget allocations and charged with maintaining relatively stable accrediting programs, may in fact experience little discomfort from rising accrediting expenditures. However, for many newly emerging accrediting agencies, especially those responsible for accrediting various allied health programs, the situation is becoming increasingly serious and the future promises no reprieve.

That the costs of accrediting allied health programs will continue to rise by leaps and bounds appears not only likely but virtually assured. If the patterns of the past offer any clues to the future, new categories of health personnel will continue to call forth new professional associations which, in turn, will endeavor to implement new programs of accreditation. Growing numbers of health educational programs will petition both new and existing accrediting agencies for recognition, thereby forcing the agencies to allocate additional dollars to the training of site-visit teams and site-visit travel. Expansion will render continued dependence upon volunteers infeasible; paid staff will become a necessity. All factors point to skyrocketing costs for allied health accreditation. Who, in the future, will be financially able and willing to assume the responsibility for funding this activity?

In the past, professional societies have proved themselves willing to provide start-up grants for the establishment of new allied health accrediting programs, and society members have shown themselves willing to undertake the administration of the newly developed programs on a voluntary basis. However, when program loads have become too overwhelming for volunteer efforts and additional funds have been needed, the societies which view their primary responsibilities as lying elsewhere, have tended to back off from providing open-ended support to these accrediting programs. At this juncture, the educational programs themselves have been asked to pick up the gauntlet dropped by the professional associations, and, judging from the precedents established by the AMA joint agencies, such reliance upon the education community as a source of operating funds will probably become even greater in the years ahead. However, is such reliance upon educational programs well founded? Can the education community be expected to continue providing financial support for specialized health accreditation? How, in fact, is such specialized accreditation regarded by college presidents and health education program directors?

The Role of Educational Institutions—Today

From the point of view of most health accrediting agencies, educational institutions provide relatively little direct financial support to the accrediting process (see table 6). Nor from an objective viewpoint do the fees levied by accrediting agencies appear unreasonable or onerous (see table 8). Nevertheless, charges that may appear entirely reasonable to an accrediting agency or outside observer may not be so regarded by the educational institutions upon which they are levied.

It was with this consideration in mind that a questionnaire requesting selected data on accrediting costs was sent to approximately 125 institutions representing a cross section of universities, state colleges, junior colleges, vocational-technical schools, proprietary schools, and hospitals offering one or more health educational programs. A companion questionnaire intended to solicit the opinions of administrative officials on the present conduct and financing of specialized health accreditation was sent to the same sampling of institutions.[9] The collective responses to the two questionnaires yielded little hard financial data; however, when analyzed en masse, they did point to several conclusions that will have to be taken into consideration in the future planning of health program accreditation.

1. *Most educational institutions are able to provide relatively accurate reports of the* direct *costs they incur as a result of accreditation; however, they are apparently unable to provide meaningful estimates of the* indirect *costs they incur as a result of accrediting activities.*[10]

9. Copies of the questionnaires and lists of respondents are available from the Study of Accreditation of Selected Health Educational Programs, Suite 300, One Dupont Circle, Washington, D.C. 20036.

10. Direct costs include application fees, initial membership fees, reevaluation fees, annual fees, and site-visit team expenses when charged to the institution. Indirect costs include salary costs, consulting fees, operational expenditures, and nonreimbursed staff travel related to accrediting activities; also included is the staff time spent on serving on site-visit teams.

Commenting on his inability to provide useful indirect cost data, one dean candidly remarked that "there is no appropriate way to estimate the financial costs incurred by the school as a result of accreditation processes . . . but I believe they are excessive." A university-sponsored study noted that "records on costs of accreditation are virtually non-existent except for the annual dues."[11]

In the light of these observations, it is hardly surprising that many of the surveyed institutions chose to reflect only direct costs in their cost estimates. Nor is it remarkable that the estimates provided should reflect personal impressions rather than hard budget data. As one respondent warned, "All figures approximate from memory, not records."

In addition to such verbal warnings, other evidence suggests that even those indirect cost estimates that were provided must be approached with extreme caution. For example, the wide disparities between the indirect costs reported by similar institutions for the same accrediting program might appear to bring the cost estimates themselves into question. How can one possibly account for indirect reevaluation costs totaling $250 at one university and $10,850 at another for the same program (pharmacy) at approximately the same point in time? Or $500 indirect expenditures for a dental school evaluation at one university and $21,000 at another? Or $1,500 for a medical school evaluation at one location and $20,500 at another?

All signals point in the same direction—accurate data on indirect costs incurred as a result of accreditation simply are not available at the present time. This in turn might help to explain why so few institutions were apparently able to provide estimates of their total accrediting costs. While the accrediting costs borne by educational institutions may in fact be substantial, the study strongly suggests that remarkably few institutions are able to quantify the costs they actually do incur as a result of either institutional or specialized accreditation.

2. Indirect *accrediting expenses appear to be of greater concern to the education community than do* direct *accrediting costs.*

Despite the apparent inability of educational institutions to document their indirect accrediting expenditures, institutional and program administrators alike appear to realize that indirect costs typically account for a substantially bigger chunk of their accrediting expenditures than do the direct fees levied by accrediting agencies. This conclusion, strongly suggested by the financial data received, is corroborated by the opinions of administrative officials expressed in the evaluation questionnaire.

Analyzed en masse, the collective responses to the two questionnaires suggest that school administrators' complaints of high accrediting costs are directed not so much toward the direct charges levied by accrediting agencies as toward the hidden indirect costs, which are incurred by the educational institution as a result of preparation for site visits, the writing of interim reports, and

11. "Accreditation Costs at Michigan State University" (unpublished study, Michigan State University Office of Institutional Research, May 1970), p. 2.

other operations attendant to attaining or maintaining accredited status. For example, of the ninety-three individuals who responded to the evaluation questionnaire only five respondents even addressed themselves to the subject of direct fees and, of the five, only one specifically asked for a reduction in accrediting charges. Furthermore, only two respondents stated that the financial burden of accrediting health educational programs should continue to be borne by the sponsoring professional organizations. Rather, it was frequently suggested that the institutions themselves should provide increased financial support to the accrediting process. Cogently summing up this point of view, one proprietary school president noted that "the accrediting agency needs financial support and it appears that such financing must be shared by the accredited institution and the organization sponsoring the accrediting agency." Expressing much the same sentiment, an occupational therapy program director predicted that "the time may well come when the cost of the accrediting process will need to be equally shared by the institution which benefits therefrom."

It is quite likely that direct fees may be perceived somewhat differently by the president of a multiuniversity than by the administrator of any given health educational program. However, judging from the survey responses, there is little indication that educational officials at any administrative level consider direct accrediting costs a serious problem; on the contrary, many actually appear to regard increased institutional support to accreditation as a somewhat inevitable, if not a pleasant, fact of life.

In marked contrast to the prevailing attitude toward direct accrediting charges, it would appear that any further escalation of indirect costs will be met with increasing resistance from every segment of the education community. A large number of respondents, apparently irritated by disruptive site visits, duplicative paperwork, and the increasing diversion of staff time to accrediting activities, pleaded for increased consolidation and improved coordination among currently operating accrediting agencies as one means of reducing costs.

The mechanisms proposed to accomplish these goals vary. Some administrators appear to favor the incorporation of all health accreditation into an institutional accrediting structure. Expressing this view, one junior college president notes that "accreditation costs are high in some cases and . . . the impact on the institutions could be somewhat lessened if these costs could be lumped into one master accreditation visitation." Expanding on this idea, the Michigan State University study wishfully suggests that

> if somehow, all voluntary accrediting could be merged into a simple total institutional agency, some economies might result and institutions would not be besieged as they now are by demands from many agencies operating on very different bases, requiring different types of evidence, and yet inevitably overlapping in some degree. Since accreditation of any single unit in an institution cannot proceed without some attention to the character of the institution in which

that unit exists, some coordination or unification of accrediting might alleviate both costs and attendant stresses.[12]

Other educators suggest that all health accreditation might be consolidated under one or several umbrella agencies with a concomitant reduction in costs. Developing this idea. the dean of a school of allied health and natural sciences proposes that

> the matter of developing a reasonable series of accrediting activities could be based upon a series of umbrellas for schools or colleges who have a series of health educational programs. . . . Institutions such as a junior college with a single program might pay a simple fee for the accreditation of one program. The multilevel type of institution with many programs could pay a single fee of a higher order, not necessarily predicated upon the simple addition of the individual fees . . . but a cut rate as a substitute.

Another dean, suggesting a variant of this approach, states that

> the current pattern of accreditation must not be permitted to continue. Individual national and state organizations must be convinced or by federal edict . . . must agree to combining forces. . . . There is no logic in having national associations for physical therapy, occupational therapy, and recreational therapy—they could all be represented in a single office under the heading of Rehabilitation Therapy. This single board . . . could accredit health education institutions and individual programs as well as work with state licensing boards to eliminate duplication.

While some observers suggest incorporation into the institutional accrediting system to reduce costs and others propose the restructuring of health accreditation to achieve the same end, a few less ambitious observers restrict their pleas to more limited objectives. "Coordinate the visits at the very minimum," asks one junior college president. Expressing much the same sentiment, the director of a health sciences program pleads

> At least consolidate the operation of the AMA so that each institution would be visited once instead of five times. If one visit were made by a team with representatives from each of the specialty areas, the cost could be reduced considerably.

Incorporation, consolidation, and coordination represent three proposed methods by which accrediting costs might possibly be reduced. Certainly there are others. However, whatever the mode, the message emanating from the education community is clear: Operations must be simplified and indirect costs reduced.

3. *The total accrediting costs incurred by any given educational institution are a function of both the number and types of programs accredited.*

12. *Ibid.*, p. 5.

While it is obvious that the total accrediting costs incurred by any educational institution will depend partially on the absolute number of programs accredited, it would also appear that these costs are influenced by the actual mixture of accrediting agencies with which the school is associated.

As has been noted, the direct fees and service charges exacted by health accrediting agencies differ considerably from one agency to another. However, the indirect costs necessitated by the review procedures of these agencies also suggest considerable variance. For example, whereas medical, dental, nursing, and social work evaluations appear to demand substantial investments of faculty time and institutional funds, some allied health accrediting programs apparently entail little, if any, additional effort or financial outlay on the part of surveyed institutions. At the state level, most nurse licensing boards conduct extensive accrediting programs, which usually require substantial institutional participation; however, most other state licensing boards, by relying upon the decisions of national accrediting bodies, require little or no additional effort on the part of institutions seeking state approval. From all indications, it would appear that an institution's total accrediting bill is determined not only by the number but also by the types of programs for which accreditation is sought and obtained.

The Role of Educational Institutions—Tomorrow

Though admittedly inconclusive, the collective responses to the financing questionnaire suggest that accrediting costs account for only a minute portion of most institutional operating budgets. Nevertheless, the concern over accrediting costs expressed by the education community appears to be both real and substantive. In part, this concern might be due to the following factors.

1. *Although accrediting costs may represent a relatively small proportion of total institutional budgets, in terms of absolute dollars they may be substantial.*

Especially within educational institutions offering a large number of health educational programs, the cost of obtaining specialized accreditation, while not prohibitive, may still be significant. For example, one major state university, which offers sixteen nationally accredited health education programs, estimates that, of $34,267 expended on all accrediting activities in fiscal year 1970, $33,617 (98.1 percent) was spent for specialized health accreditation. Another large university, subject to accreditation by fourteen specialized agencies in addition to the North Central Association of Colleges and Secondary Schools, estimates that its yearly average accrediting bill runs at least $20,000, approximately $17,000 of which is due to specialized accreditation. Moreover, annual dues account for only approximately one-third of these total accrediting expenditures; the remainder represents various indirect costs incurred by the university as a result of reporting and other requirements imposed by accrediting agencies.[13]

13. *Ibid.*, p. 4.

For some institutions, current accrediting costs are already substantial; however, it appears that future payments for accrediting services are expected to be even higher. The Michigan State University study reports that

> annual dues in 1960-61 amounted to only $3,480 against $7,255 in 1969-70. Costs will continue to rise. The North Central Association dues will be approximately doubled for the next year. . . . Annual dues to the AAMC will probably rise to $2,500 within a year and eventually reach $5,000 to $10,000. The costs of the review visits have also been increasing. Because of the irregular intervals involved, the increases are harder to determine, but roughly the costs have doubled in the past ten years.[14]

In addition to other factors forcing accrediting costs skyward, the report suggests that the increasing controversiality of accreditation itself may have a significant impact on institutional accrediting costs. Noting that "the 1970's may become the decade of courts and attorneys in accreditation,"[15] the study predicts that

> as accrediting bodies find that they may be brought into court, they are forced into more elaborate procedures and the maintenance of more detailed records. Dues and accreditation visit costs will reflect this.[16]

Current sizable allocations to accreditation coupled with the expectation of future increases in accrediting costs may well be one factor contributing to the education community's concern over the future of specialized health accreditation. However, it would appear that several other factors must also be taken into consideration.

2. *Even institutions that do not expend substantial sums on specialized health accreditation may believe their accrediting costs to be excessive in terms of benefits received.*

The survey responses suggest that most educators seek specialized health accreditation not so much for its potential value to the institution as for its presumed indispensability to the student in securing postgraduation employment. Yet, enrollments in many health educational programs are astonishingly low.[17] Might not administrative officials sometimes find it difficult to justify seeking accreditation for programs enrolling as few as two full-time students? Especially in times of constricted budgets, might not institutions question the advisability of putting scarce resources into the accreditation of such programs?

Expressing one viewpoint on this question, the vice provost for curriculum at a major state university observed that "sometimes accreditation results in rigidity of curricula and the definition of academic directions and expenditures

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14. *Ibid.*
15. *Ibid.*, p. 1.
16. *Ibid.*, p. 4.
17. *Directory of Approved Allied Medical Educational Programs* (Chicago: American Medical Association, 1971).

which become a problem in periods of economic austerity." According to another observer, "the cost spent each year [for accreditation] could be put into those programs for better teaching."

Forced by strained financial conditions to provide increased justification for all expenditures, educational administrators realize that giving to one program may entail taking from another. In such times, optimal utilization of limited funds is of prime importance; wasteful and unnecessary expenditures become of increasing concern. Is it any wonder that accreditation, seemingly administered with a minimum of coordination and a maximum of inefficiency, should be subjected to ever closer scrutiny by the education community? How long will educational institutions continue to underwrite accrediting costs they consider either unnecessary or unjustified? The education community has entered a strong plea for improved coordination and administration as one means of cutting accrediting costs, and it would appear that the accrediting sector, itself beset by rising costs, might do well to heed their collective advice.

The Role of Government Agencies—Today and Tomorrow

The Role of the Federal Government

Compared to the financial resources provided by health professional associations and the education community, contributions to specialized health accreditation from the federal government have been, and continue to be, remarkably small. Confining its role in accreditation to the recognition of agencies, rather than to the approval of educational programs, the federal government has by and large been more than willing to permit health professional associations and educational institutions to underwrite accrediting costs while devoting its own resources to the recognition program administered by the Office of Education's Accreditation and Institutional Eligibility Staff.[18]

To date, only three health educational accrediting agencies are known to have received direct financial support from the federal government. The first to receive such assistance was the American Psychological Association, which, in the immediate postwar years, received substantial encouragement from the Veterans' Administration and the National Institute of Mental Health to establish an accrediting program for the fast-growing clinical psychology field.[19] Originally initiated in 1946 with a training grant awarded by the National Institute of Mental Health, the APA program until as late as 1969 was subsidized by federal grants. The Committee on Cytotechnology was first developed by the American Society of Clinical Pathologists, which, after laying the initial groundwork for the committee's accrediting program, sought and received federal funds for the actual implementation of the program. Though

18. In fiscal year 1971, the direct costs of the AIES staff were approximately $174,000. (Estimate provided by John R. Proffitt, Director, Accreditation and Institutional Eligibility Staff, Office of Education, Department of Health, Education, and Welfare.)

19. In 1952 the APA accrediting program was expanded to include doctoral programs in counseling psychology.

now funded through the Board of Schools, the Committee on Cytotechnology was until 1970 totally dependent upon a federal grant for its operational funds.

Unlike the psychology and cytotechnology accrediting programs, the accrediting program of the American Boards of Examiners in Speech Pathology and Audiology is still subsidized by the federal government. Originally established with the aid of a Social and Rehabilitation Service grant, the board was heavily dependent upon the federal government in its earlier, formative years; however, the financial commitment of the federal government to the board's accrediting program has shown a steady decrease over the past five years, and by 1975 no government support is expected to be available to the board's accrediting program (see table 4).

Usually geared to specific health research and service grant programs, the few excursions taken by the federal government into the direct financing of health accrediting programs have apparently all been intimately tied to the perceived need for expanded training opportunities in certain narrowly defined occupational categories. Moreover, even when government grants have been made available to health professional associations to establish accrediting programs, the programs were established, not with the expectation of open-ended government support, but rather in the hope that the professional associations themselves would in time assume ongoing responsibility for the programs. By all available measures, it would appear that the financial contribution of the federal government to specialized health accreditation has been and continues to be minimal when compared to the substantial commitments of time, effort, and money on the part of concerned health professional associations and participating educational institutions and programs of study.

That the federal government is heavily dependent upon the services provided by voluntary accreditation is well known and widely acknowledged; that it has in the past been able to purchase these services at a bargain price appears to be equally obvious. However, what of the future? Will professional accrediting agencies continue to be both able and willing to provide accrediting services on an essentially cost-free basis to one of their primary beneficiaries? If there were no voluntary accreditation, upon what basis would eligibility for federal grants be determined? In the absence of voluntary accreditation, would the federal government be both willing and able to assume responsibility for performing the accrediting function, and is it in fact desirable that it do so?

The Role of State Governments

Unlike the federal government, most states do sponsor and conduct some health educational approval programs, usually as an adjunct to licensing board responsibilities. However, with the exception of the approval programs conducted by nurse licensing boards, most state approval programs appear to be neither well developed nor well financed. Though many licensure statutes confer on their boards the authority to approve intrastate health training programs, the boards, in practice, usually choose to rely upon the decisions of national health accrediting agencies, thus obviating the need for well-developed accrediting programs on the state level. Other boards, unwilling to relinquish all responsibility for approving in-state training programs for potential licensees, seek to

assure at least minimal board participation in the accrediting decision-making process by appointing one state board member to accompany national site-visit teams on visits to state educational institutions and programs of study. In neither case is the role played by the state likely to be either decisive or costly.

Not only do state boards depend upon national professional accrediting agencies to approve in-state programs of study, but, more important, they also rely upon the national accrediting sector to identify educational programs of minimum quality located outside their state borders. Even New York State, which in the past conducted an extensive health educational approval program both within and outside its state boundaries, now depends upon national professional accrediting agencies to conduct both in-state and out-of-state accreditation for selected categories of health personnel.[20] With the implementation of the New York decision in 1968, it would appear that all states, though relying to different degrees upon the national accrediting agencies to approve in-state training programs, rely heavily upon these agencies to identify out-of-state programs. Nor is it surprising that they have chosen to do so for, as the New York policy statement so rightly observes, besides the consideration of "finite resources," "only chaos would result if all fifty states were to devote a major effort to country-wide accreditation activities."[21]

Translated into dollar terms, the reliance of state governments upon the voluntary health accreditation system is substantial. The registration program conducted by New York State provides one example.

Despite the recent curtailment in its scope of responsibility, the New York registration program continues to represent one of the few relatively extensive and well-developed approval programs for health educational institutions and programs of study currently in operation. Administered primarily by the Division of Professional Education of the State Department of Education and the

20. As of October 1968, a new policy was put into effect whereby the State Department of Education announced its intention to discontinue registering programs outside New York State but "instead to accept the accreditation granted by the appropriate professional agency as indication of fulfillment of standards equivalent to those required for [state] registration. . . ." In-state programs would continue to be formally registered, but "except for sufficient cause," accreditation by agencies recognized by the National Commission on Accrediting would be recognized as fulfilling the standards for registration. Registration was made contingent upon the inclusion of a state representative on national site-visit teams. The policy statement stated further that "in the case of professional programs for which evaluations by professional accrediting agencies are either unavailable or not acceptable or only partially applicable, it will be the policy of the Division to continue to accept applications for registration from institutions wherever located in the United States or its territories." ("Policy in Regard to Registration for Professional Curricula" [policy statement of The University of the State of New York, The State Education Department, Division of Professional Education, 1968], pp. 3-5.)

21. *Ibid.*, p. 1.

State Department of Health,[22] it has been estimated that the cost of this registration program was almost $300,000 in fiscal year 1971.[23] Moreover, the New York program now relies substantially upon the national health accrediting sector. In the absence of the voluntary accreditation underwritten by national health professional associations, what would it cost state governments to undertake this necessary function? In the absence of the specialized accreditation provided by health professional accrediting agencies, upon what criteria would state licensing boards base their approval of training programs located outside their respective states? In such circumstances, would each state feel itself obligated to undertake its own national as well as state accrediting program?

Both state governments and the federal bureaucracy are heavily dependent upon the services provided by the voluntary health accrediting system; however, whether government agencies can reasonably expect to continue receiving these valuable services on an essentially cost-free basis might be open to serious question.

The Role of Private Contributors—Today and Tomorrow

If the financial commitment of government agencies to the accrediting process has been small, that of private foundations has been infinitesmal. Though foundation-funded studies have proved to be effective catalysts in the establishment of several health accrediting programs, foundation grants have not in the past been made available for the support of on going accrediting programs.

At the present time, only the American Council on Pharmaceutical Education relies upon foundation funds to help finance its accrediting program, and the foundation here relied upon is the American Foundation for Pharmaceutical Education, a fund established by pharmaceutical and drug trade associations for the express purposes of improving colleges of pharmacy and promoting pharmaceutical education (see table 5). Although foundation grants are currently available for specific, well-defined projects and studies having both direct and indirect relevance to accreditation, they are not available for the direct support of existing accrediting operations. Nor does it appear likely that the future will witness any substantial departure from this policy. In the years ahead, foundations may see fit to make available additional funds for research and development purposes; however, for operational funds, accrediting agencies will probably have to look elsewhere.

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22. It is the responsibility of the Department of Education to approve programs in dental hygiene, dentistry, chiropractic and massage, medicine, nursing, ophthalmic dispensing, optometry, physical therapy, pharmacy, psychology, social work, and veterinary medicine. Completion of a registered program indicates fulfillment of the educational requirements for admission to the state examination for licensure and certification. The Department of Health has responsibility for approving "programs organized by the Department to meet specific well-defined needs, comply with the [state] Hospital Code and meet federal requirements."

23. Expenditures of the Division of Professional Education were about $198,000; those of the State Health Department were approximately $75,000.

Financing Health Program Accreditation—Possible Future Directions

In the past, health professional organizations have assumed the major responsibility for underwriting the costs of accrediting health educational programs. However, there is increasing evidence to suggest that these organizations may be neither able nor willing to continue assuming the primary financial burden for this increasingly expensive activity. What options are, in fact, open to financially troubled accrediting agencies, and to what extent might they prove effective in meeting future financial needs as well as current operational demands?

Cutting Costs

One obvious method of coping with increased costs is to cut operational expenditures, the trick, of course, being to do so without compromising the quality of the accrediting program. The cost-cutting option, usually the initial response of accrediting agencies to tightened accrediting budgets, has already been explored by many agencies, some with apparent temporary success. One agency, by transferring administrative tasks from professional to clerical staff and site visits from professional staff to a pool of volunteer inspectors, found it was not only able to reduce its own administrative costs but also able to pass on its savings to educational programs as reduced fee assessments.[24] Several accrediting agencies, focusing on site-visit expenses, are currently experimenting with shortened site visits, the extension of time intervals between visits, and simultaneous visits to nearby programs as possible methods of reducing accrediting costs. Other agencies, hoping to reduce the need for site visits, look to increased emphasis on the self-evaluation process and institutionally prepared reports as a possible future development. Another agency proposes that measurements of student performance might, in time, be utilized in lieu of the site-visit system to identify programs of adequate quality.

Many agencies, looking beyond their own immediate operations, advocate increased coordination with other accrediting groups as a means of reducing accrediting costs. Currently enjoying widespread, although not unanimous, support and popularity, the combined team site visit is apparently looked upon with favor by a large number of accrediting agencies, as well as by the education community. A sizable number of those agencies currently operating under the AMA umbrella have already endorsed the concept of health team visits and look forward to its implementation to reduce their rapidly rising accrediting costs. Several other health accrediting agencies, which have already established cooperative arrangements with the regional associations, have stated their intentions of seeking even closer relations with these groups in the future. Others, though not presently coordinating site visits with the regionals, are seriously

24. As a consequence of these procedures, the 1970-71 accreditation fee for psychology programs was reduced to $350 for each internship training program and $200 a year for each university program, plus an additional $500 for visit costs in the year of an on-site visit. The 1969 fee for both internship agencies and universities has been set at $400 a year.

exploring the feasibility of this proposal for possible implementation. For example, one accrediting agency representative suggests that "while on-site visits for initial accreditation should be made by the professional specialty involved, after full accreditation has been attained it might simplify the continuing process of accreditation for the institutions concerned if resurvey visits were coordinated with regional accrediting bodies." Another respondent, envisioning an even greater role for the regionals in health program accreditation proposes that

> . . . regional accrediting associations expand their jurisdictions to include educational programs at noncollegiate institutions: hospitals, vocational-technical institutions, proprietary schools, military installations, etc.; and then make program accreditation a component of accreditation by regional associations.

However, if some health accrediting agencies are enthusiastic about the possibilities of increased collaboration with regional associations and other health accrediting agencies, others are apparently less sanguine about the net effect of such measures on accrediting costs. One council chairman, having experimented with the combined regional site visit, observes that

> limited experience in cooperating with the regional accrediting agencies prompts us to believe that cooperating with any other organization will both increase our costs and make the process of accrediting more complex with little net gain to either the public or the profession.

Another board chairman, while lending his support to the concept of combined health team visits, is hardly optimistic about the anticipated impact of this procedure on accrediting costs. He states:

> I think it likely that we can simplify the process of accreditation by having site visits by a team. However, this will not reduce the cost because the main cost is processing which would remain the same and the site visit which we would hope would continue to be provided on a voluntary basis. The only benefit would be to the institution being inspected.

Though there is little question that combined team site visits would render the accrediting process less burdensome to surveyed institutions, there does appear to be some doubt that improved coordination would, in fact, result in substantial cost reductions to the accrediting sector. Other ways of dealing with rising accrediting costs will probably also be explored.

Increasing Income

Should cost-cutting measures and in-house resources prove inadequate to respond to expanded accrediting demands, accrediting agencies may be expected to look for increased support from outside sources. This process already seems to be well under way.

Educational Institutions and Programs of Study—Educational programs are increasingly being asked to provide the necessary operational funds for accreditation. Newly formed accrediting agencies are charging for their services and longer established agencies are charging more (see table 8). Apparently agreeing with one program director who believes that "the university benefits from peer review and should therefore assume the cost as part of its investment in the training activity," the accrediting sector to date has shown little hesitation in calling upon participating institutions for financial assistance. However, whether this source of support, itself beset by financial problems, will continue to respond ad infinitum to such pleas for financial aid is questionable.

Not at all happy with the present state of health program accreditation, education officials are pleading for a reformed, rationalized system that would not only lessen their own financial burdens but would supposedly benefit the accrediting sector as well. Also requested is a voice in the establishment of fee schedules and the formulation of accrediting policy. One program director, expressing his "uneasiness about [the] accreditation processes presently employed by national associations," states:

> We do not wish to imply that all the standards established by these associations and other national health associations are not worthy of consideration. What we do insist upon is a voice in the establishment of standards and a defense of the program logic.

Expressing a similar sentiment, a community college vice president pleads:

> The public is going to pay the costs so the most effective process would be to continue to let individual institutions pay. But they should be given a voice in the process and amount.

Obviously, all is not well in the relationship between health accrediting agencies and the institutions that seek their services. In the absence of their requested reforms, will institutions offering health educational programs continue to provide a ready source of funds to the accrediting sector?

The Federal Government—A second source of possible funds recognized by both health accrediting agencies and educational institutions is the federal government. To some observers, federal funding seems not only a desirable but also a logical source of financial assistance. As one program director observed:

> The financing of accreditation should be considered a federal expenditure related to the utilization of schools of the health professions as natural resources and maintaining the on going quality of professional education and practices.

Emphasizing the federal government's reliance upon the services provided by the voluntary accrediting sector, the Michigan State University study noted that "if voluntary accreditation were to disappear, some existing or new federal agency would take over the task, for some assurance of quality is a prerequisite to the distribution of federal funds."[25]

25. "Accreditation Costs," p. 5.

That the federal government is heavily dependent upon voluntary accreditation is clear; that its financial support to the accrediting process is incommensurate with the services it receives is equally obvious. However, do these considerations necessarily lend support to those who argue that the federal government should reverse its traditional hands-off policy toward accreditation and become more directly involved in this activity?

Though there are individuals who would welcome increased government participation in the accrediting process, the basis upon which the government should become involved is apparently open to some question and speculation. One dental school dean proposed that "assistance in financing . . . be made by direct grants from national and state governmental agencies as an entitlement to maintain standards." Apparently f d that government funds might bring government control, one hospital pro m director suggested that tax funds be allocated to private agencies to conduct accrediting programs but stipulated that ". . . if bureaucratic funds are made available, bureaucratic control must never accompany medical education and practice." A proprietary school president, proposed that public funds be used to finance health program accreditation but added that "it should be operated on a contract basis, not by a government agency."

Perhaps the reservations expressed by these observers are not unfounded. Like the education community, the federal government might expect some quid pro quo for providing any increased financial support to the health accrediting sector and, while control might not be the price exacted for such support, some accountability to the public almost assuredly would be.

Concluding Observations

This working paper has shown that the financing for health program accreditation has been, and continues to be, provided primarily by health professional organizations; that the demands for increased accrediting funds have been growing at a rapid rate; and that many health accrediting agencies are finding themselves increasingly hard pressed to keep pace with their expanded accrediting responsibilities. In the light of these developments, can the financing patterns adopted in the past and followed in the present possibly prove viable for the future? Will professional associations continue to be able to assume primary responsibility for conducting and financing health program accreditation? Will educational institutions continue to be willing to lend even a modicum of support to the accrediting process? Will government agencies continue to be both able and willing to rely upon professionally controlled accrediting groups to perform an essentially quasi-governmental function?

The future viability of health educational accreditation is of immediate concern not only to the accrediting sector but to educational institutions, government agencies, and the general public as well. The responsibility for resolving the problem of financing health program accreditation devolves not upon one segment of society but upon society as a whole. Unilateral response to the problem will not suffice; only through multilateral cooperation and consensus will a viable, long-term solution be found.

FIGURE 1

Accrediting Costs Incurred by the Department of Allied Medical Professions and Services Compared to Total Department Expenses Fiscal Years 1965, 1970 and 1971
(In Thousands of Dollars)

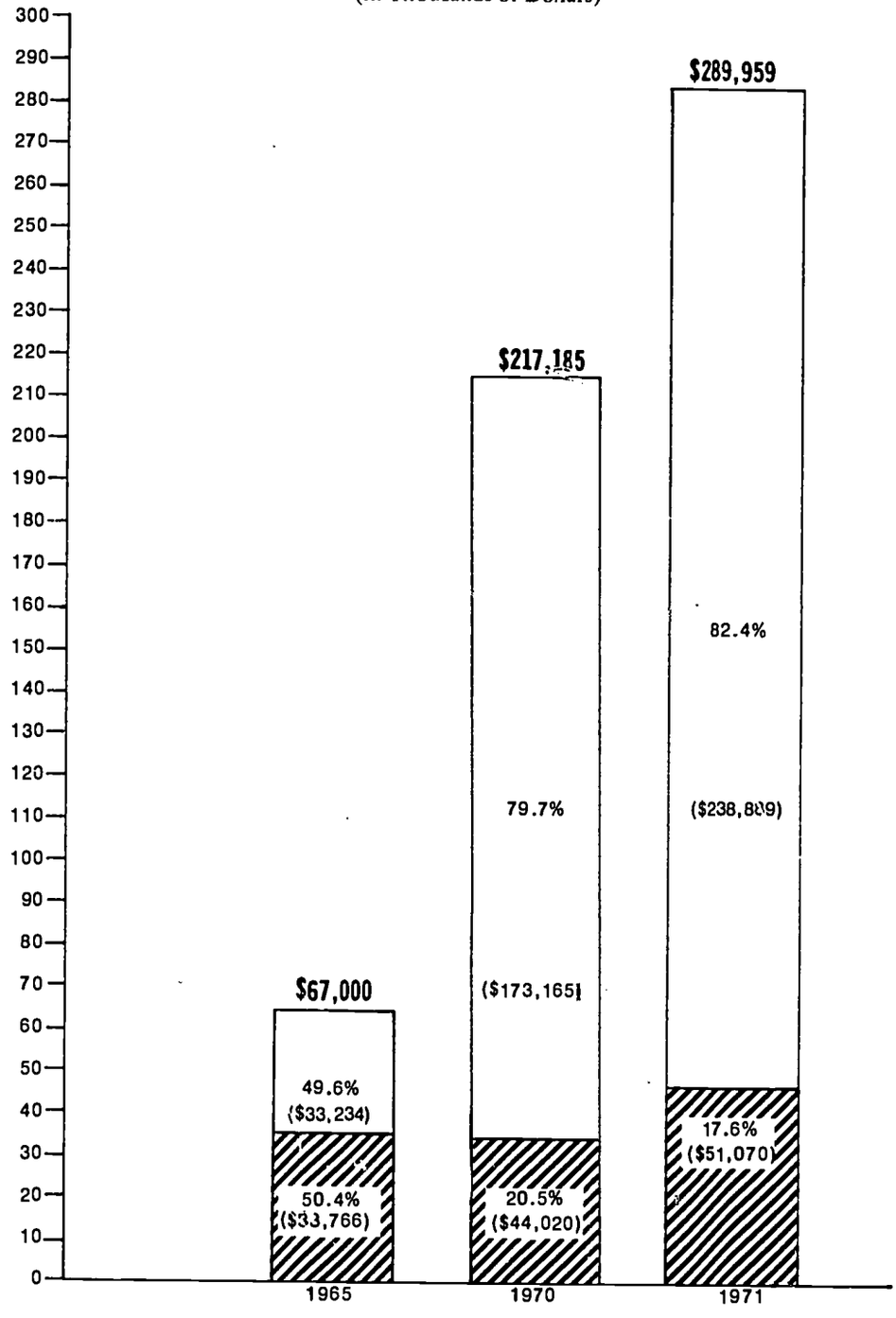

FIGURE 2

Growth in Expenditures for Allied Health Accreditation: Fiscal Years 1965, 1970, and 1971
(In Thousands of Dollars)

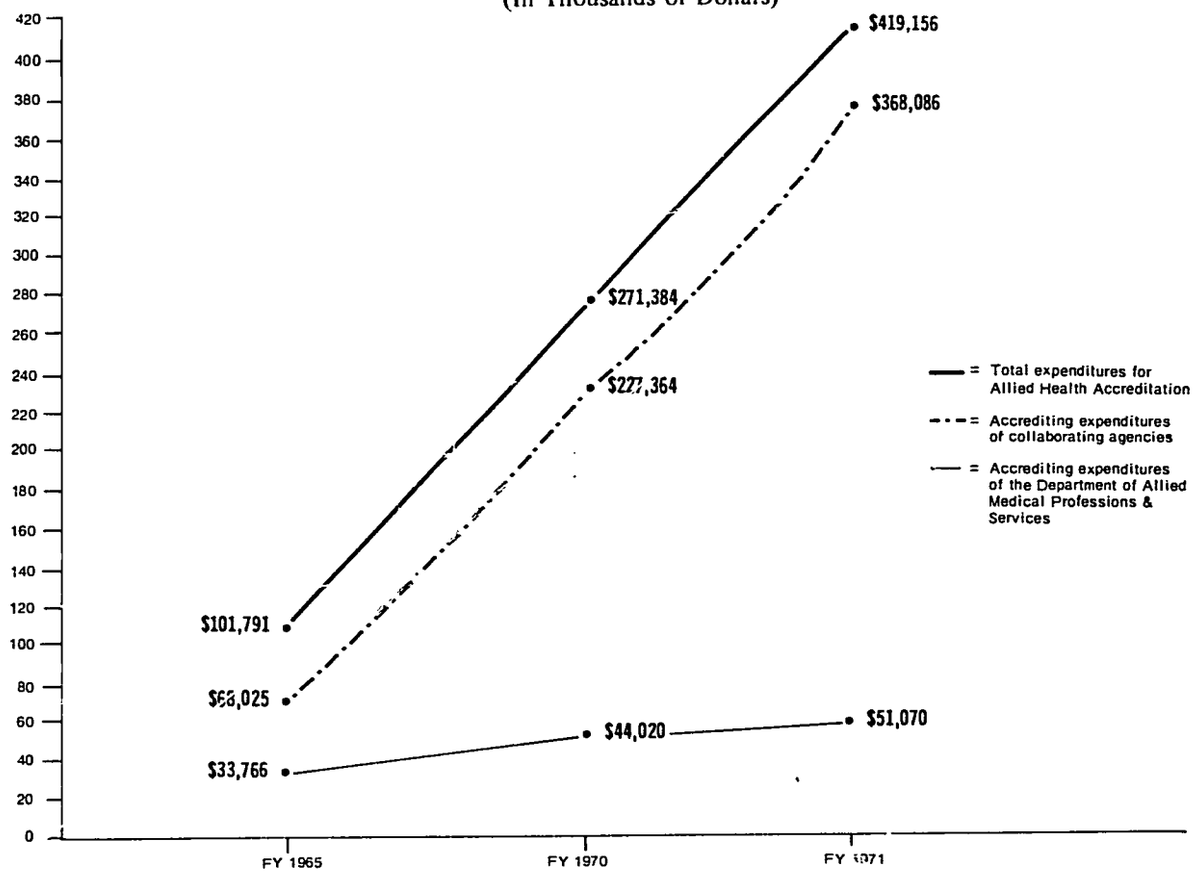

TABLE 1

The Costs of Accrediting Health Educational Programs
Fiscal Years 1965, 1970, and 1971
By Agency

	Total Accrediting Expenses (in Dollars)			Percentage Increase in Accrediting Expenses	
	F. Y. 1965	F. Y. 1970	F. Y. 1971	F. Y. 1965 to F. Y. 1970	F. Y. 1970 to F. Y. 1971
Model A					
American Association of Nurse Anesthetists	45,683	76,759[1]	83,000	68.0%	8.0%
American Dental Association	156,144[2]	311,600[2]	360,950[2]	99.6%	15.8%
American Dietetic Association	37,400	53,576	58,000	43.3%	8.3%
American Optometric Association	15,100	27,500	27,800	82.1%	1.1%
American Osteopathic Association	32,157	45,117	45,789	40.3%	1.5%
American Podiatry Association	12,110	25,017	39,300	106.6%	57.1%
American Veterinary Medical Association	14,848	21,496	25,650	44.8%	19.3%
Model B					
American College of Nurse Midwives	60[3]	10[3]	170[3]	-83.3%	1600.0%
American Psychological Association	4[4]	86,990	95,590	-	11.2%
American Public Health Association	12,861	23,191	25,510	67.3%	10.0%
American Speech and Hearing Association					
American Boards of Examiners in Speech Pathology and Audiology	9,700[5]	14,800[5]	16,000[5]	52.6%	8.1%
Council on Social Work Education	21,275	79,426	87,850	273.3%	10.6%
National Association for Practical Nurse Education and Service	32,413	37,080	49,500	14.4%	33.5%
National League for Nursing	259,324[5]	290,475[5]	298,995[5]	12.0%	2.9%
Baccalaureate and Higher Degree Programs	(112,555)	(105,302)	(105,290)	-9.5%	-.01%
Diploma Programs	(135,032)	(91,375)	(95,065)	-32.3%	4.0%
Associate Degree Programs	(11,737)	(72,821)	(76,925)	520.4%	5.6%
Practical Nursing Programs	0[6]	(20,981)	(21,715)		3.5%
Model C					
Accrediting Bureau of Medical Laboratory Schools	8,103[7]	53,676[7]	55,000[7]	562.4%	2.5%
Accrediting Commission on Graduate Education for Hospital Administration	8[8]	12,713	13,983		10.0%
American Council on Pharmaceutical Education	41,453	57,526	61,530	38.8%	6.9%
Liaison Committee on Medical Education	55,996[9]	66,132[9]	76,100[9]	21.5%	14.8%
Model D					
American Medical Association Department of Allied Medical Professions and Services	33,766	44,020	57,070	30.4%	16.0%
Single					
American Academy of Orthopaedic Surgeons[10]					
American Association of Medical Assistants	11[11]	11,475	18,715	-	63.0%
American Medical Record Association	8,170	18,250	24,200	123.4%	32.6%
American Occupational Therapy Association	12,129[12]	27,357[12]	29,928[12]	125.6%	9.4%
American Physical Therapy Association	14,299[13]	37,204[13]	49,863[13]	160.2%	34.0%
Joint					
Board of Schools	30,900	62,000	126,000	468.8%	103.2%
Committee on Certified Laboratory Assistants	15,667	29,602	24,080	88.9%	-18.6%
Committee on Cytotechnology	5,160	4,300	14[14]	-27.9%	-
Joint Review Committee for Inhalation Therapy Education	900	3,496	7,500	280.0%	114.5%
Joint Review Committee on Education in Radiologic Technology	15[15]	29,792	81,000	-	171.9%
Joint Review Committee on Educational Programs in Nuclear Medicine Technology	16[16]	3,888	6,800		74.9%

NOTES
1) Includes additional 10 year accreditation review expenses
2) Includes accrediting expenses for dental schools and dental hygiene dental assisting and dental technology programs
3) See page C9 for explanation.
4) Data not available
5) Figures are estimates not purported to be actual expenditures.
6) Accrediting program begun in 1966
7) Figures do not include the expenses of AMT as they relate to printing vocational guidance material, training guide, and accrediting manual nor does it include the staff time AMT members spent on accrediting projects.
8) Established in 1968
9) Does not include staff time donated by the AMA and the AAMC
10) No data provided
11) Accrediting program begun in 1969
12) Includes expenses for accrediting occupational therapy assistant programs.
13) Includes expenses for accrediting physical therapy assistant programs.
14) Incorporated into Board of Schools budget July, 1970.
15) Data not available.
16) Accrediting program begun in 1970

TABLE 2

Accrediting Expenses Compared To Total Organization Incomes: Fiscal Years 1965, 1970 and 1971
By Sponsoring Organization
(In Dollars)

	F. Y. 1965			F. Y. 1970			F. Y. 1971		
	Income	Accrediting Expenses	Percent	Income	Accrediting Expenses	Percent	Income	Accrediting Expenses	Percent
Model A									
American Association of Nurse Anesthetists	235,903	45,683	19.4%	291,696	76,759	26.3%	390,000	83,000	21.3%
American Dental Association	4,898,054	156,144	3.2%	8,508,929	311,600	3.7%	9,000,000	360,950	4.0%
American Dietetic Association	630,872	37,400	5.9%	1,310,544	53,576	4.1%	1,144,394	58,000	5.1%
American Optometric Association	575,000	15,100	2.6%	1,080,000	27,500	2.5%	1,090,000	27,800	2.6%
American Osteopathic Association	1,955,567	32,157	1.6%	2,958,727	45,117	1.5%	2,979,250	45,769	1.5%
American Podiatry Association	326,896	12,110	3.7%	476,205	25,017	5.3%	600,000	39,300	6.6%
American Veterinary Medical Association	1,011,556	14,848	1.5%	1,585,735	21,496	1.4%	1,523,215	25,650	1.7%
Model B									
American College of Nurse-Midwives	6,789	60	9%	23,339	10	.04%	43,345	170	.4%
American Psychological Association	1)	1)	-	5,044,000	86,000	1.7%	5,367,650	95,590	1.8%
American Public Health Association	2,485,771	13,861	.6%	3,219,835	23,191	.7%	2,695,000	25,510	.9%
American Speech and Hearing Association	366,000	9,700	2.7%	713,000	14,800	2.1%	886,000	16,000	1.8%
Council on Social Work Education	578,868	21,275	3.7%	1,363,288	79,426	5.8%	1,552,400	87,850	5.7%
National Association for Practical Nurse Education and Service	455,406	32,413	7.1%	662,672	37,086	5.6%	633,500	49,500	7.8%
National League for Nursing	2,720,549	259,324	9.5%	3,413,258	290,479	8.5%	3,543,680	298,995	8.4%
Model C									
American Medical Association	27,773,000	27,998[2)]	.1%	30,504,000	34,025[2)]	1%	37,295,000	39,050[2)]	1%
Association of American Medical Colleges	1,276,713	27,998	2.2%	2,844,066	34,026	1.2%	3,675,438	39,050	1.1%
Model D									
American Association of Medical Assistants	79,391	-	-	200,321	11,475	5.7%	237,050	18,715	7.8%
American Medical Record Association	3)			3)			3)		
American Occupational Therapy Association	441,544	12,129	2.7%	892,027	27,357	3.1%	735,587	29,928	4.1%
American Physical Therapy Association	358,540[4)]	14,299	4.0%	714,767[4)]	37,204	5.2%	825,970[4)]	49,863	6.0%

NOTES

1) Data not available

2) Includes only the expenses for medical school accreditation.

3) Data not provided

4) Does not include government grants which are not considered part of general income.

TABLE 3

Accrediting Costs Compared To Total Organization Expenses: Fiscal Years 1965, 1970, and 1971 By Sponsoring Organization (In Dollars)

	F. Y. 1965			F. Y. 1970			F. Y. 1971		
	Total Expenses	Accrediting Costs	Percent	Total Expenses	Accrediting Costs	Percent	Total Expenses	Accrediting Costs	Percent
Model A									
American Association of Nurse Anesthetists	237,499	45,683	19.2%	350,212	76,759	21.9%	390,000	83,000	21.3%
American Dental Association	4,236,947	156,144	3.7%	8,085,000	311,600	3.9%	8,827,900	360,959	4.1%
American Dietetic Association	575,598	37,400	6.5%	1,216,180	53,576	4.4%	1,196,679	58,000	4.8%
American Optometric Association	577,230	15,100	2.6%	1,095,300	27,500	2.5%	1,332,500	27,800	2.9%
American Osteopathic Association	1,959,575	32,157	1.6%	2,798,535	45,117	1.6%	3,105,420	45,789	1.5%
American Podiatry Association	334,738	12,110	3.6%	492,931	25,017	5.1%	600,000	39,300	6.6%
American Veterinary Medical Association	952,365	14,848	1.6%	1,533,931	21,496	1.4%	1,521,750	25,650	1.7%
Model B									
American College of Nurse Midwives	9,706	60	.6%	19,222	10	.04%	25,000	170	.7%
American Psychological Association	1)			5,041,000	86,000	1.7%	5,406,000	95,590	1.8%
American Public Health Association	2,457,531	13,861	6%	3,178,096	23,191	.7%	2,795,000	25,510	.9%
American Speech and Hearing Association	464,514	9,700	2.1%	837,941	14,800	1.8%	935,000	16,000	1.7%
Council on Social Work Education	578,509	21,275	3.7%	1,276,484	79,426	6.2%	1,552,400	87,850	5.7%
National Association for Practical Nurse Education and Service	452,717	32,413	7.2%	611,678	37,086	6.1%	658,000	49,500	7.5%
National League for Nursing	2,861,488	259,324	9.1%	3,351,132	290,479	8.7%	3,628,480	298,995	8.2%
Model C									
American Medical Association	27,964,000	27,998[2]	.1%	33,226,000	34,026[2]	.1%	35,762,754	39,050[2]	.1%
Association of American Medical Colleges	1,288,734	27,998	2.2%	2,796,985	34,026	1.2%	3,535,500	39,050	1.1%
Model D									
American Medical Association									
Department of Allied Medical Professions and Services	67,000	33,766	50.4%	217,185	44,020	20.3%	289,959	51,070	17.6%
American Association of Medical Assistants	87,029	– 0 –[3]	–	205,903	11,475	5.6%	237,975	18,715	7.9%
American Medical Record Association	4)			4)			4)		
American Occupational Therapy Association	431,855	12,129	2.8%	783,971	27,357	3.5%	735,860	29,926	4.1%
American Physical Therapy Association	347,794	14,299	4.1%	706,146	37,204	5.3%	838,240	49,863	5.9%

NOTES

1) Data not available.

2) Includes only the expenses for medical school accreditation

3) Accrediting program begun in 1969.

4) Data not provided.

TABLE 4

Sources of Income of Organizations Sponsoring Health Educational Accrediting Programs
Fiscal Years 1965, 1970, and 1971
By Sponsoring Organizations
(In Dollars)

	Fiscal Year 1965					Fiscal Year 1970					Fiscal Year 1971				
	Total Income	Dues from Educational Institutions	Accrediting Charges	Grants	Other[1]	Total Income	Dues from Educational Institutions	Accrediting Charges	Grants	Other[1]	Total Income	Dues from Educational Institutions	Accrediting Charges	Grants	Other[1]
Model A															
American Association of Nurse Anesthetists	235,303				235,970	291,695				2[illegible]2,496	390,006				390,000
American Dental Association	3,296,449				3,296,449	4,440,000				4,440,000	6,000,000				6,000,000
American Dietetic Association	630,672				630,672	1,317,544				1,215,544	1,144,294				1,144,294
American Optometric Association	575,000				575,000	1,090,000				1,082,000	1,090,000				1,090,000
American Osteopathic Association	1,955,557				1,955,557	2,356,727				2,356,727	2,573,250				2,573,250
American Podiatry Association	246,235				246,235	474,705				446,205	600,000				676,500
American Veterinary Medical Association	1,011,554				1,011,556	1,565,735				1,565,735	1,523,215				1,523,215
Model B															
American College of Nurse-Midwives	6,759		100	2	6,569	23,535		100	2	23,239	45,545		600	2	42,945
American Psychological Association	3					5,644,000		82,000	967,995 G	3,582,000	5,367,656		75,650	1,200,006 G	4,092,006
American Public Health Association	2,485,772		956	1,223,604[4]	1,261,212	2,219,835		4,500	1,029,944[5]	2,185,399	2,646,340		7,500	966,009	1,771,537
American Speech and Hearing Association	366,075				366,075	713,000				714,000	984,557				984,755
American Boards of Examiners in Speech Pathology and Audiology	410,770		400	10,500 G	300[7]	411,730		1,400	6,300 G	4,300	6,420		1,405	3,000 G	2,200
Council on Social Work Education	579,563	30,646		349,721 G	196,296	1,363,256	127,595	4,230	812,593[8]	414,630	1,552,470	124,000	6,500	969,650[9]	452,751
National Association for Practical Nurse Education and Service	455,476	601	5,335	127,155[10]	327,065	662,572	324	2,155	129,717 NG	530,476	633,505		2,072	115,096 NG	516,410
National League for Nursing	2,720,549	572,770	4,475	216,993[11]	1,927,391	3,413,256	544,105		197,173[12]	2,621,963	3,543,640	616,150		180,000[13]	2,767,537
Model C															
American Medical Association	27,273,000				27,273,000	30,554,000				30,554,000	37,295,000				37,735,000
Association of American Medical Colleges	1,276,713	140,125		671,842[14]	464,746	2,654,746	19,881		1,274,967[15]	1,369,923	3,675,435	755,774		1,366,095[16]	1,553,464
Model D															
American Association of Medical Assistants	79,391			5,000 NG	74,391	273,321			32,655 NG	167,654	237,750			40,000 NG	197,050
American Medical Record Association[17]															
American Occupational Therapy Association	441,544		450[18]	143,965 G	277,049	892,827		1,925[18]	253,641 G	637,166	775,567		1,850[18]	184,635 G	589,152
American Physical Therapy Association	359,540			167,910 G[19]	356,596	714,777			155,900 G[19]	714,767	825,913			179,339 G[19]	825,913

NOTES
G — Government Grants.
NG — Grants from non-government sources.
1. Includes individual membership dues, membership dues from organizations other than educational institutions, publications, convention proceeds, and other miscellaneous income.
2. Office space and phone donated by the Maternity Center Association.
3. Data Not Available.
4. Includes 1,101,[illegible] in government grants and 122,[illegible] from non-government sources.
5. Includes 8[illegible] in government grants and 222,[illegible] from non-government sources.
6. Includes [illegible] in government grants and [illegible] from non-government sources.
7. Registration fees and interim standards fees from speech and hearing centers and clinics.
8. Includes [illegible] in government grants and 1[illegible] from non-government sources.
9. Includes [illegible] in government grants and 152,[illegible] from non-government sources.
10. Includes 2[illegible] in government grants and [illegible] from non-government sources.
11. Includes [illegible] in government grants and [illegible] from non-government sources.
12. Includes 12[illegible] in government grants and 72,[illegible] from non-government sources.
13. Includes 80,000 in government grants and [illegible] from non-government sources.
14. Includes 19[illegible] in government grants and contracts and [illegible] from non-government sources.
15. Includes [illegible] in government grants and contracts and 5[illegible] from non-government sources.
16. Includes 1,[illegible] in government grants and contracts and 126,[illegible] from non-government sources.
17. Data not provided.
18. Accrediting charges are levied only on occupational therapy assistant programs.
19. Grants not considered as part of general income.

TABLE 5

Sources of Direct Income of Health Educational Accrediting Agencies: Fiscal Years 1965, 1970, and 1971
By Agency
(In Dollars)

	F Y 1965				F Y 1970				F Y 1971			
	Total	Grants	Accrediting Fees and Dues	Other	Total	Grants	Accrediting Fees and Dues	Other	Total	Grants	Accrediting Fees and Dues	Other
Model C												
Accrediting Bureau of Medical Laboratory Schools					52,762	44,907[1]	7,455[2]	400	55,000	40,000[1]	14,000[3]	1,000
Accrediting Commission on Graduate Education for Hospital Administration					9,381	7,000[4]	2,200	181	11,000	7,000[4]	3,700	300
American Council on Pharmaceutical Education	41,000	41,000[5]			57,500	57,500[6]			60,000	60,000[7]		
Liaison Committee on Medical Education	8)				8)				8)			
Model D												
Board of Schools	10,000	10,000[9]			95,100	37,600[10]	57,500		150,000	1,000[11]	75,000	74,000[12]
Committee on Certified Laboratory Assistants	15,667	15,667[13]			29,600	29,600[13]			24,080	24,080[13]		
Committee on Cytotechnology	7,000	7,000[14]			4,300	4,300[14]			15)			
Joint Review Committee for Inhalation Therapy Education	900	900[16]			7,500	7,500[16]			7,500	7,500[16]		
Joint Review Committee on Education in Radiologic Technology					88,730		88,730		96,000		96,000	
Joint Review Committee on Educational Programs in Nuclear Medicine Technology					11,100	9,000[17]	2,100		2,500		2,500	

NOTES

1) Donation from American Medical Technologists

2) $4,500 from annual dues, $2,955 from application and initial accreditation fees

3) $9,000 from annual dues, $5,000 from application and initial accreditation fees

4) Grants from sponsoring organizations. In addition, the Association of University Programs in Hospital Administration contributes staff time and space to the Accrediting Commission

5) $2,000 from each sponsoring organization, $35,000 from the Foundation for Pharmaceutical Education

6) $5,000 from each sponsoring organization, $42,500 from the Foundation for Pharmaceutical Education

7) $5,000 from each sponsoring organization, $45,000 from the Foundation for Pharmaceutical Education

8) The expenses incurred by the Liaison Committee are shared equally by the American Medical Association and the Association of American Medical Colleges

9) $9,000 from the American Society of Clinical Pathologists, $1,000 from the American Society for Medical Technology

10) $36,600 from the American Society of Clinical Pathologists, $1,000 from the American Society for Medical Technology.

11) Donation from the American Society for Medical Technology

12) Income from transcript evaluations

13) Funds provided by the American Society of Clinical Pathologists

14) Federal government grant

15) Incorporated into Board of Schools budget, July 1970

16) Equal contributions from three sponsoring organizations

17) Equal contributions from six sponsoring organizations

TABLE 6

Proportion of Agency's Accrediting Expenses Paid by Educational Institutions and Programs of Study
Fiscal Years 1965, 1970, and 1971
By Agency
(In Dollars)

	F. Y. 1965			F. Y. 1970			F. Y. 1971		
	Income from Accrediting Charges	Total Accrediting Expenses	Percent	Income from Accrediting Charges	Total Accrediting Expenses	Percent	Income from Accrediting Charges	Total Accrediting Expenses	Percent
Model B									
American College of Nurse-Midwives	100	60[1]	–	100	10[1]	–	170	600[1]	–
American Psychological Association	2)			80,000	86,000	93.0%	75,650	95,590	79.1%
American Public Health Association	956	13,861	6.9%	4,500	23,191	19 4%	7,500	25,510	29.4%
American Speech and Hearing Association									
American Boards of Examiners in Speech Pathology and Audiology	400	9,700	4.1%	1,400	14,800	9.5%	1,400	16,000	8.7%
Council on Social Work Education	0[3]	21,275	–	6,500[3]	79,426	8 2%	6,500[3]	87,850	7.4%
National Association for Practical Nurse Education and Service	5,395[3]	32,413	16.6%	2 [illegible][3]	37,086	5.8%	2,900	49,500	5.9%
National League for Nursing	3,475[3]	259,324	1.3%	0[3]	–	–	0[3]	–	–
Model C									
Accrediting Bureau of Medical Laboratory Schools	4)	8,103	–	7,455	53,676	13.9%	14,000	55,000	25.5%
Accrediting Commission on Graduate Education for Hospital Administration	–	–	–	2,200	12,713	17.3%	3,700	13,983	26.5%
Model D									
American Occupational Therapy Association	430[5]	12,129	3.5%	1,020[5]	27,357	3 7%	1,800[5]	29,928	6.0%
Board of Schools	0	10,900	–	57,500	62,000	92 7%	75,000	126,000	59.5%
Joint Review Committee on Education in Radiologic Technology	– 6)	–	–	88,730	27,792	7)	96,000	81,000	8)
Joint Review Committee on Educational Programs in Nuclear Medical Technology	–	–	–	2,100	3,888	54 0%	2,500	6,808	36.7%

NOTES.

1) See explanation on page C9

2) Data not available.

3) Does not include annual membership dues paid by educational institutions and programs of study

4) Data not provided

5) Charges are levied only on occupational therapy assistant programs

6) Data not available.

7) Surplus of $58,938.

8) Surplus of $15,000.

TABLE 7

Distribution of Direct Accrediting Costs Incurred by Health Educational Accrediting Agencies Fiscal Year 1970 By Type of Expenditure

	Dollars								Percentage Distribution							
	Total Costs	Salaries and Staff Benefits	Office	Staff Travel	Accrediting Committee Travel	Non reimbursed Site Visit Travel	Honorariums	Other	Total	Salaries and Staff Benefits	Office	Staff Travel	Accrediting Committee Travel	Non reimbursed Site Visit Travel	Honorariums	Other
Model A																
American Association of Nurse Anesthetists	76 759	25 757	16 245	24 041	839	4,627	5,250		100	33.6	21.2	31.3	1.1	6.0	6.8	
American Dental Association	[illegible]	[illegible]	[illegible]	-	12,350	26 250		-	100	66.2	5.3		[illegible]	24.5		
American Dietetic Association	53 576	[illegible]	6 202	7 592	-	7 592		4 366[1]	100	51.9	11.6	14.2	-	14.2	*	8.1
American Optometric Association	27 500	9 000	3 900	1 100	7 500	6 000	-		100	32.7	14.2	4.0	27.3	21.8		
American Osteopathic Association	[illegible]	20 000	4 041	2 307	9 232	6 443	1 550	1 484	100	44.3	[illegible]	5.1	20.6	14.3	3.4	3.3
American Podiatry Association	[illegible]	19 922	1 191			3 916			100	79.6	4.7			15.7	-	
American Veterinary Medical Association	[illegible]	[illegible]	[illegible]	750	5 300	3 186			100	41.2	[illegible]	3.4	23.5	[illegible]		
Model B																
American College of Nurse Midwives	10[2]		10						100		100					
American Psychological Association	[illegible]	32 000	5 000	[illegible]	[illegible]	[illegible]		-	100	43.0	[illegible]	[illegible]	[illegible]	[illegible]		
American Public Health Association	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	100	[illegible]	5.3	[illegible]	[illegible]	-		
American Speech and Hearing Association																
American Boards of Examiners in Speech Pathology and Audiology	[illegible]	[illegible]	3 100	[illegible]	4 000	2 800			100	[illegible]	20.9		[illegible]	[illegible]		
Council on Social Work Education	[illegible]	39 245	15 402	3 195	6 535	-		[illegible][4]	100	50.0	[illegible]	4.0	[illegible]			[illegible]
National Association for Practical Nurse Education and Service	[illegible]	22 525	[illegible]	473[5]		4 531[5]	-	[illegible]	100	[illegible]	20.0	[illegible]	-	12.2		[illegible]
National League for Nursing	[illegible]	[illegible]	[illegible]	[illegible]	32,071	5 483	-	7 595	100	[illegible]	12.3	*	11.0	[illegible]		[illegible]
Baccalaureate and Higher Degree Programs	[illegible]	[illegible]	12 451	245	10 063	3 555		2 342[6]	100	[illegible]	[illegible]	*	[illegible]	3.4		[illegible]
Diploma Programs	[illegible]	[illegible]	12 257	210	17 644	966	-	[illegible][6]	100	69.4	[illegible]	*	[illegible]	1.1		[illegible]
Associate Degree Programs	[illegible]	[illegible]	[illegible]	300	[illegible]	1 304	-	[illegible][6]	100	[illegible]	[illegible]	*	[illegible]	1.8	*	[illegible]
Practical Nursing Programs	[illegible]	[illegible]	2 953	[illegible]	[illegible]	353			100	[illegible]	[illegible]	*	[illegible]	*		-
Model C																
Accrediting Bureau of Medical Laboratory Schools	[illegible]			1 362	2 955		5 012	44 312[7]	100			[illegible]	[illegible]	-	[illegible]	[illegible]
Accrediting Commission on Graduate Education for Hospital Administration	[illegible]	4 500[8]	2 250[8]	4 750[9]	-			873	100	37.5	[illegible]	[illegible]				[illegible]
American Council on Pharmaceutical Education	[illegible]	[illegible]	[illegible]	4 443		[illegible][10]		-	100	[illegible]	[illegible]	[illegible]		[illegible]		
Liaison Committee on Medical Education	[illegible]	5 212	[illegible]	[illegible][11]		-	[illegible]	[illegible]	100	[illegible]	[illegible]	[illegible]		-	[illegible]	[illegible]
Model D																
American Medical Association Department of Allied Medical Professions and Services	[illegible]	[illegible]	[illegible]	[illegible][12]	6 000[13]	[illegible][14]			100	63.2	5.9	[illegible]	[illegible]	[illegible]		
Single																
American Association of Medical Assistants	[illegible]	[illegible]	[illegible]	300	[illegible]	-		[illegible]	100	[illegible]	[illegible]	[illegible]	15.4			[illegible]
American Medical Record Association	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	100	[illegible]	9.9	11.5	[illegible]	-		
American Occupational Therapy Association	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible][15]		[illegible]	100	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
American Physical Therapy Association	[illegible]	[illegible]	[illegible]	1 812	[illegible]	6 071	750		100	[illegible]	1.5	[illegible]	[illegible]	[illegible]	[illegible]	-
Joint																
Board of Schools	[illegible]	[illegible]	[illegible]		15 365	[illegible]		[illegible][16]	100	[illegible]	[illegible]		[illegible]	[illegible]		[illegible]
Committee on Certified Laboratory Assistants	[illegible]	[illegible]	[illegible]		[illegible]	500	-		100	[illegible]	[illegible]		[illegible]	[illegible]		
Committee on Cytotechnology	[illegible]		500			[illegible]		-	100		[illegible]			[illegible]		
Joint Review Committee for Inhalation Therapy Education	[illegible]	1 350	[illegible]			200	-	-	100	[illegible]	[illegible]			[illegible]		
Joint Review Committee on Education in Radiologic Technology	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]		-	100	[illegible]	24.8		[illegible]	[illegible]		
Joint Review Committee on Educational Programs in Nuclear Medicine Technology	[illegible]		[illegible]		[illegible]	[illegible]	-	-	100		[illegible]		[illegible]	[illegible]		

NOTES

* Less than 1%

1) $[illegible] for internship board, $[illegible] for miscellaneous costs

2) See explanation on page C9

3) Included in Accrediting Committee Travel

4) Special Study

5) As the result of a 1969 policy change which extended the period of accreditation from [illegible] years, only programs applying for initial accreditation were visited in 1970

6) Training of site visitors

7) $[illegible] for legal fees, $[illegible] for contract for administration

8) Includes prorata share of AUPHA staff time and rent [illegible]

9) Includes site visit and accrediting commission travel

10) Includes accrediting commission travel

11) Includes all travel expenses

12) Staff expenses for surveys and review committee meetings

13) Advisory commission travel

14) Expenses of non staff survey teams

15) Professional evaluators

16) Workshops

TABLE 8

Accrediting Fees Charged by Health Educational Accrediting Agencies
Calendar Years 1965 and 1970
By Accrediting Agency

	1965					1970				
	Application Fees	Initial Accrediting Fees	Reaccreditation Fees	Annual Dues or Fees	Other	Application Fees	Initial Accrediting Fees	Reaccreditation Fees	Annual Dues or Fees	Other
Model J										
American College of Nurse-Midwives		$100					$100 day x number of days visited			
American Psychological Association					Advisory visits $300 1 day $400 2 days			$500 (Universities)	$200 (Universities) $350 (Internships)	Advisory visits $300 1 day $400 2 days
American Public Health Association	$15			$15		$20	$500		$20	
American Speech and Hearing Association										
American Boards of Examiners in Speech Pathology and Audiology		$50		$10	Actual site visit expenses up to $300		$50		$10	Actual site visit expenses up to $300
Council on Social Work Education							$500	$500	$1000–2000[1]	Candidacy fee of $1,000 1 year prior to initial accreditation
National Association for Practical Nurse Education and Service	$25	$200	$200		$35[2]	$25	$200	$200		$35[2]
National League for Nursing Baccalaureate and Higher Degree Programs	$20[6]			$500–$700[3] $100[4]	$1,050[5]				$575[3]	$1,500[5] Site visit travel costs $65 day per visitor[6]
National League for Nursing Diploma Programs	$50[6]			$500–$600[3] $100[4]	$1,050[5]				$575[3]	$1,500[5] Site visit travel costs $65 day per visitor[6]
National League for Nursing Associate Degree Programs				$285[3]	$1,500[5]				$385[3]	$1,500[5] Site visit travel costs $65 day per visitor[6]
National League for Nursing Practical Nursing Programs									$200[3]	$1,500[5] Site visit travel costs $65 day per visitor[6]
Model C										
Accrediting Bureau of Medical Laboratory Schools						$50	$150		$225–$300[7]	Site visit expenses
Accrediting Commission on Graduate Education for Hospital Administration						$500			$100	Travel costs for initial accreditation
American Council on Pharmaceutical Education	$500				Travel costs for consultations	$500				Travel costs for consultations
Model D										
American Occupational Therapy Association	$10[8]	$25 day per visitor[8]				$10[8]	$25 day per visitor[8]			
Board of Schools									$100 for first program $50 for each additional program[9]	
Joint Review Committee on Education in Radiologic Technology									$75 per school	
Joint Review Committee on Educational Programs in Nuclear Medicine Technology						$100			$100	

NOTES

1: Annual membership dues based on student enrollment. 149 or less, $1,000; 150–300, $1,500; over 300, $2,000.
2: For review of annual program report and recommendations to faculty reporting progress of program.
3: Annual membership dues paid by NLN members. Except for site visit costs, accreditation service is included in the payment of membership dues.
4: Fee paid by non-NLN members.
5: Lump sum fee paid by non-NLN members at the time of site visit. However, virtually all programs seeking accreditation are League members.
6: Fee paid by NLN members.
7: Annual membership dues based on student enrollment: 1–25, $225; 26–50, $450; 51–75, $675; over 75, $900.
8: Charge applies only to occupational therapy assistant programs.
9: Prior to incorporation into the Board of Schools budget, neither the Committee on Certified Laboratory Assistants nor the Committee on Cytotechnology exacted fees of educational programs; now all medical technology, laboratory assistant, and Cytotechnology programs accredited by the Board are assessed annual fees in accord with the schedule noted above.

RESEARCH IN ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

William K. Selden

Research has been defined as "careful, systematic, patient study and investigation in some field of knowledge, undertaken to establish facts and principles." Fortunately, this definition is sufficiently broad to permit one to state that in the fields of the health educational programs research immediately related to accreditation has been and is being conducted. However, in the definition the adjectives—careful and systematic—must be interpreted very broadly to classify as research all but a few of the approaches employed in relation to accreditation. Comments and responses received from various accrediting agencies, collaborating organizations, research centers, and numerous individuals attest to this conclusion.

Development and Validation of Criteria or Standards

The criteria of most of the accrediting agencies in the health fields have been adopted largely on the basis of "lots of value judgments." Questionnaires and surveys, conferences and meetings, advice from educational consultants, discussions and public hearings are the primary methods that have been employed by various accrediting boards or committees to develop and validate their accrediting requirements. These bodies have recognized the importance of their mission, but the methods employed in developing and validating criteria have been far from scientific. These methods amply justify one description of accreditation as "a fallible method of evaluating quality in education through reliance on gross measurements."

Recently, the chairman of a subcommittee on standards responded to a question posed by another member of a committee on accreditation about the basis for a proposed requirement. The answer epitomizes the method by which criteria for accreditation are usually developed. The subcommittee chairman replied, "The figure was just taken out of thin air. I did not know what else to insert and employed this figure as the best guess that I could make." At that meeting, no one challenged either the proposed specific figure or the method of arriving at it.

The development and validation of criteria in accreditation have truly constituted a process of trial and error. Even reliance on studies of performance on national board examinations and state licensing examinations for purposes of establishing and validating criteria leaves some basic unanswered questions:

Because of the delicate relationships prevailing among some of the organizations in the health fields and because responses to the SASHEP questionnaires on research were solicited on a confidential basis, the quotations in this working paper have not been attributed with identification of the authors in order to maintain their anonymity.

Do the examinations indicate actual competence in the performance of professional practice? Do the examinations have a high correlation with what is taught, or what should be taught, in health educational programs? Do the examinations give equal opportunity to each candidate to demonstrate his competence regardless of economic or social background and regardless of varying ability to respond to written tests?

At the time accreditation was first established in the United States, there were no better methods available for the adoption of criteria than the consensus of individual judgments. Even though techniques for evaluation have since been fashioned for many other purposes, these have generally not been adopted by the accrediting agencies.

One forthright chairman of a beleagured accrediting agency has written about the fields of study for which he has considerable responsibility.

> There has been virtually no research into the educational programs, other than statistical analysis of the variations and of the different ways in which the programs are put together. Nor has there been any research that I know of into the relative values of the different types of approach.

Even workshops convened for the purpose of developing criteria have been criticized by the president of a professional society, which sponsors them, on the basis that they are attended by the educators more to solve problems facing their own programs than to assume responsibility for the improvement of accreditation.

On the other hand, serious attempts are being made by a few of the accrediting agencies in the health fields, or by their sponsoring organizations, to develop and validate criteria. As an example:

> A group of . . . educators and practitioners developed the criteria used for the evaluation of educational programs in a two-fold process. First, the level of clinical performance, the level of mastery of didactic material, and the kinds of acquired attitudes expected in the graduates of the programs were identified. Then the curriculum content, facilities, and the procedures deemed appropriate for helping students acquire these characteristics were identified.

In varying degrees, most accrediting agencies do subject their criteria and procedures to continuous or periodic review. They do take into consideration the comments and suggestions made by members of the pertinent and related professions, representatives of hospitals, clinical facilities and government agencies, as well as officials of other organizations involved in the process of evaluation and accreditation. Despite all these good endeavors, the development and validation of criteria for accreditation continues to be very subjective, and an official of one accrediting agency confesses that for this reason alone his agency "tries to keep them general." In fact, he implies that the agency must do so because it cannot prove the validity of its standards.

Institutional Evaluations of Accreditation

It is likely that few institutions—colleges, universities, hospitals, or technical-vocational schools—would seek accreditation if there were not indirect inducements and potential tangible rewards for their doing so. Although there are few legal requirements that an institution or program of study must be accredited by a "voluntary" accrediting agency, nevertheless it is the unusual institution that can afford not to seek such accreditation in order to facilitate faculty recruitment, student admissions and transfers, and graduate employment; to attain eligibility for grants; and to maintain status with the public and within the professions.

In view of the fact that accreditation is seldom sought by an institution for the intrinsic benefits which accrue, but rather for more tangible purposes, it is to be expected that the subjective evaluations of the accrediting process made by the representatives of the institutions being subjected to accreditation would tend to be adversely critical. They frequently are.

As in the past, the agencies are being criticized simultaneously for being too specific and demanding in their requirements and at the same time for being "too diffuse, subjective, and irrelevant." While one educator writes that there is "the tendency for national professional accrediting agencies to support uniformity in professional standards, rather than supporting diverse innovative programs," another states that his institution needs "more concrete recommendations from the accrediting agency, such as, lists of reference books and publications for the library, and recommendations concerning curriculum content." By one institution the claim is made that "Our own internal academic check mechanisms are more responsible for maintenance of academic quality of the health educational programs." At the same time an official at an institution in a nearby state claims, "We find that there is some upgrading of teaching because of tighter and better planning in preparation for the accrediting surveys."

The criticisms from the institutions also involve comments related to costs, both in time of personnel and in actual outlay of funds; to the number of separate visits, especially when a college or university may have as many as twenty or even thirty different health-related programs subject to accreditation or some other form of external review; and to the competence of the visiting evaluators. Because of the nature of the process, individual judgment does and must inevitably play a significant part in accreditation. Therefore, it is vulnerable to such comments as, "The current review system is rather inadequate and is frequently made by people with little knowledge of a specialized field" and "Accrediting groups consisting only of peer types often become very rigid in their thinking, in that they see value only through their own images," and further "Physicians, who generally know nothing about teaching and learning processes, are frequently in charge. They do not have the time to do a good job, and in most instances are not truly qualified, but they exert all-powerful control."

Of all the comments and observations made about accreditation by representatives of hospitals and educational institutions, the ones to which the accrediting agencies should be addressing themselves most assiduously are represented by the following statements. "The older myth that specialized accreditation assures safety and high quality programs is not valid. There is no proof that this is the way to assure quality in educational programs." In fact, "there is no evidence to indicate a correlation between accreditation and quality." If accreditation is continued, there should be "less emphasis on judging the mechanics of the program and more on the quality of the product; for example, the physician."

Actual Research in Accreditation

A survey of the literature and correspondence with some fifty individuals engaged in educational and related research indicate that little research with immediate relationship to accreditation has been or is being conducted.

The only really extensive study of the techniques of accreditation was conducted by the North Central Association of Colleges and Secondary Schools in the early 1930s—forty years ago—in response to criticisms and allegations that the standards then being applied were constricting and stultifying. The old standards, appropriate for one era, were based upon specific minimum requirements for such factors as endowment, size of library, number of academic departments, size of classes, and credit hours required for graduation. As a result of the study, the North Central Association not only abolished the old standards but also evolved a new approach, which was considered radical at that time, by initiating an additional purpose for accreditation, that of providing external stimulation to institutions for their continual growth and improvement.

The North Central Association study was financed by a foundation grant of large size for those days of financial deflation. Since then, no comparable approach has been funded. In the past ten years, such foundations as Avalon, Carnegie, Commonwealth, Ford, Grant, Houston, Kellogg, and Twentieth Century have made grants to support studies of various professional education programs, curriculum reviews, revisions in the standards for hospitals, development of new health programs, improved uses of testing in the measurement of proficiency and equivalency, and aid to institutions to undertake self-evaluation for purposes of attaining or maintaining accreditation. On the other hand, no significant funding had been provided by foundations to make fundamental studies related to accreditation until the Commonwealth Fund made a grant to support SASHEP, and SASHEP is *not* a study of standards or the validation of criteria employed in the accreditation of the health educational programs.

The Ford Foundation has made a grant to the Western Interstate Commission for Higher Education so that its Planning and Management Systems Division can undertake explorations of methods of measuring the outputs of educational programs and activities. "WICHE is making a start toward development of an inventory aimed at identifying the benefits of higher education and

suggesting possible methodologies for measuring specific variables identified with the inventory."[1] If this project results in any success it should have important implications for accreditation.

In recent years, various departments and agencies of the federal government have been providing some support for a few studies directly related to vocational-technical and occupational education and to the problems of accreditation related to these fields of education. In addition, government funds have assisted in studies that do have some relevance to accreditation in the health fields. These include the following: training allied health workers, an analysis of functions, content, costs, and facilities; a functional analysis of paramedical occupations as a foundation for curriculum development; an objective method for evaluating training programs in counseling psychology; accreditation in dental hygiene; criteria for the evaluation of nursing, problems and issues in accreditation by specialized agencies for vocational-technical curriculums.

Of potential significance is a study, at the present time still in the planning stage, which was originally proposed by the National Commission on Accrediting and is now being considered for sponsorship by the United States Office of Education. Although its dimensions and specifications have not yet been settled, it appears that if the study is launched it will probably be directed primarily at issues related to the purposes, functions, and uses of accreditation, as well as at issues related to the structure and financing of the type of accreditation that is now being conducted largely by the six regional associations of colleges and schools. The fundamental questions of the validity of accreditation and the correlation between accreditation and quality may be included in the study, but it is doubtful that in the year to eighteen months projected for the study these issues can be given the attention which they require.

It is appropriate to note that some of the accrediting agencies concerned with the health educational programs report that they themselves are allocating funds each year for research. However, after analyzing the type of research that they include in their budgets, one is forced to conclude that what they term as research should be classified instead as either conferences, workshops, meetings of committees to review criteria or annual surveys of the performance of graduates on examinations for state licensure or board certification. In one case, the sizable appropriation for the research department of an accrediting agency, which prepares national qualifying examinations, was included under research for accreditation when this department apparently undertook no analysis of issues directly related to accreditation.

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1. Western Interstate Commission for Higher Education, *Inventory of Educational Outcomes and Activities* (Boulder: WICHE, 1971), p. iii. *See also* Rodney T. Hartnett, *Accountability in Higher Education: A Consideration of Some of the Problems of Assessing College Impacts* (New York: College Entrance Examination Board, 1971) for a short but excellent descriptive analysis of the issues and difficulties in assessing postsecondary educational programs and institutions.

Why So Little Research in Accreditation?

There are several reasons that may account for the fact that there has been very little actual research in accreditation.

Financing–Funding has not been available. The accrediting agencies, which generally operate on restricted budgets, have not had the extra money to allocate to an activity that is generally considered by accrediting officials not to be immediately relevant, especially in comparison with pressing operational financial demands. Although foundations, especially the Carnegie Foundation for the Advancement of Teaching and the Carnegie Corporation, have in earlier years made funds available for studies that have led to the establishment of accreditation in more than a dozen fields, they have in more recent times considered issues of accreditation to be of no more than tertiary importance in their order of priorities. With possibly no more than a single exception, it is only in the latter part of the past decade that the federal government has had funding available and has been relatively unrestricted by legal and political considerations in demonstrating a positive interest in and a concern about accreditation.

Structure–On March 16, 1971, the *New York Times* reported a study sponsored by the Mental Health Research Institute at the University of Michigan which concluded that "of this century's great advances in social science . . . the most important social research in the last four decades has tended to emerge from large teams of scholars working in major intellectual centers. Such centers . . . provide a certain critical mass in terms of intellectual power and resources–ready access to mathematics, computers, laboratories, specialists in other fields and complex urban cultures."

There is no critical mass in accreditation. In contrast to what one would expect on the basis of this study, which was conducted by Karl W. Deutsch, John R. Platt, and Dieter Senghaas, accreditation is conducted in a most fragmented manner, with each sponsoring organization jealously protecting its own interests and the interests of its members. Not only does this fragmentation frequently exert an adverse influence on the institutions being subjected to accreditation, but it also discourages any funding organization that might be considering a means to finance a broad study of the validity of accreditation. There is at present no organization that has the necessary critical mass and on which accrediting agencies can rely for objective analyses of their criteria and procedures. A funding agency could not now have much assurance that a grant for the validation of accreditation would lead to implementation of the recommendations of such a study.

Attitudes–The structure of accreditation is also related to and considerably dependent on the attitudes of the members both of the committees responsible for accreditation in the various health educational fields and of the members of the organizations that sponsor the accrediting functions. Several quotations from the report of a conference convened in 1959 by the National Commission on Accrediting have a bearing on this relationship. This conference was financed by the Ford Foundation and was intended to identify ways in

which the relevance and validity of accreditation could be improved. The following quotations are from the report edited by Dewey B. Stuit:

> Of the several problems in accreditation, the one which continually receives the most attention involves the issue of control. . . . An accrediting agency, while it may have fulfilled an important need when originally established, may, as it becomes more mature, develop a primary interest in its own perpetuation and in protection of the status quo. In other words, accrediting bodies may become citadels of conservatism standing in the way of those colleges and universities, or of educational programs within institutions, which wish to break with present practices and launch bold new programs of educational service.
>
> In view of the negative and possibly disastrous effects of non-accreditation, it becomes even more urgent that accrediting bodies "leave no stone unturned" in making sure that their philosophy, policies and procedures are not only defensible but consonant with the high ideal of improving education.
>
> Most accrediting agencies contend that protection of the public interest is one of their major purposes. But who defines the public interest? Is it not possible, or even likely, that accrediting agencies, both associations of colleges and universities and professional associations, may function primarily in the interest, not of the public, but of their own membership or the professions with which they are identified?

A question, which must be raised, is whether the attitudes of most of the individuals who are responsible for the conduct of accreditation, for the establishment of criteria, and for the validity of standards are supportive of the proposition that no stone should be left unturned in making sure that the philosophy, policies, and procedures of their agencies are not only defensible but consonant with the high ideal of improving education. Does the establishment of criteria--by taking them out of thin air--meet the test of what is best for the public interest?

There is little evidence that studies, which have been made in evaluation and testing, have been given much consideration by those directly responsible for the policies and operations of the numerous accrediting bodies. In any case, those studies appear to have been permitted to exert no more than marginal influence on the expanding process of accreditation.

Issues in Accreditation Subject to Research

Assuming that financing, structure, and attitudes are all favorable to the sponsorship of research in accreditation, there remains the fundamental question of the difficulties involved in developing precise educational measurements. The respondent to the SASHEP questionnaires for medicine emphasized this point.

> The SASHEP questionnaire on research is based on the implicit assumption that research related to accreditation standards is a feasible, appropriate, and desirable activity as an enterprise distinct from—even if related to—research bearing on professional education programs. It is with that assumption that we take issue, for it in turn assumes that accreditation standards are of such a nature as to be highly specific and objectively validated.
>
> Our perception is that such standards can be valid, and enforceable, only if they amount to little more than some specification of the meaning of the general principle upon which accreditation is based; i.e., "A program must have sufficient resources, in terms of both quality and quantity, organized in such a fashion as to enable it to meet its stated objectives."
>
> Thus, accreditation is not a process whereby a program or institution is measured against a single predetermined yardstick, but rather the judgment of expert individuals critically reviewed by a designated panel of authorities as to the adequacy of resources and their organization to meet program objectives.

In contrast, an official of the American Psychological Association insists:

> Research on the effectiveness of accreditation to improve the quality of education is most needed. Ideally, this would involve a design using experimental and control groups in which selected elements of accreditation would be varied systematically. The effects of such manipulations would be measured with objective scales describing the quality of the programs. Such research would then have to be carried out by accrediting agencies, or by independent researchers with the agencies' cooperation.

Educators and health professionals, who have been concerned with the learning process, the accomplishments of students and students' potential professional competencies, responded to the SASHEP inquiries with repeated emphasis on the need to develop more relevant criteria for purposes of evaluation, and in turn for accreditation. It was generally recognized that accreditation has been primarily an assessment of the process of education and less an evaluation of the learning and accomplishments of those who are or who have been subjected to the process. The implication is that, if accreditation continues with this same emphasis on process, it will prove ineffective, or even inappropriate, in view of the potential emergence of the free university, credit by examination, external degrees, independent study, and other alternatives to conventional programs.

In addition to research on criteria, both their initial development and their validation, it is obvious that analyses should be made of the characteristics of the persons who serve on visiting teams and on review committees or boards. Is the development of the criteria influenced by the characteristics of the indi-

viduals serving in these various capacities? Do the decisions on accreditation show any variations depending on the composition of the committees?

Could the accrediting process be improved by changes in the lengths of time spent on site visits, in longer or shorter intervals between the visits, or by methods other than actual visits?

Can the benefits of accreditation be improved by greater coordination among and cooperation on the part of the various accrediting agencies, each of which collects information from the institutions visited on its own schedule? What actual effects do result in the institutions and in their programs of study as a consequence of their gaining accreditation, being provisionally accredited, or not attaining accreditation?

The foregoing are examples of some of the issues that need to be studied and subjected to research analysis conducted by competent researchers, assisted by persons in the pertinent professions and in the various health educational programs. Increased reliance on tests for individual measurements may be a partial answer. The president of a national testing organization believes that tests are more than a partial answer when he writes:

> The development of innovative teaching methods, the increased recognition of non-traditional extra-mural ways of learning, the rapid acceleration of the birth-rate of new knowledge, the increased need and demand for health services with corollary requirements for increasing the efficiency, the quality and the quantity of health manpower—all serve to change the role of testing.
>
> Testing is the major tool available to sharpen the definition of the goals toward which educators, administrators, and practitioners are moving.

Whether the solution to the dilemmas confronting all accrediting agencies will be found totally or even partially in testing, or in a combination of several new or revised methods and techniques, answers must be found for the basic questions propounded by the executive officer of the American Board of Examiners in Speech Pathology and Audiology:

> Does accreditation necessarily result in the promulgation of training standards that insure a high quality of professional services delivered; and, are the procedures and standards utilized for accreditation of training programs pertinent to this goal?

Without some form of research, the answers will not be found. Without the answers, one is hard pressed to justify the costs—in effort, time and money—incurred each year for accreditation.

EXPANSION IN ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

William K. Selden

Medicine has exerted and continues to exert an all-pervasive influence on each of the health occupations and the emerging health professions. Not only do some members of these other occupations seek to wear the symbolic white coats, but they create organizations to represent their collective interests; and they consciously and unconsciously endeavor to fashion these bodies to the model of the American Medical Association with its local and state medical societies, its House of Delegates and Board of Trustees, and its active interest in the education and training of its future members, as well as their certification and licensure.

The situation could remind one of the musical composition of Camille Saint-Saëns *L'apprenti Sorcier*. This tone poem, based on Goethe's ballad, portrays the apprentice who employs his master's incantations to direct a broom and bucket to perform the boy's chore of cleaning the floor. Succeeding in making these objects perform for him, he becomes impatient with the slowness of the operation. Striking the broom to accelerate its sweeping, he breaks the handle, which in turn multiplies into numerous smaller brooms all sweeping madly in unison to the musical deluge of rushing water. Having lost control of the situation, the lad is saved by the return of the sorcerer, who is able to utter the magic words in time to reverse the process and restore order to a chaotic scene dramatically presented in sonorous tones.

As one surveys the scene with the rapidly growing number of health occupations, it becomes apparent that each profession is endeavoring to provide a necessary service in the delivery of health care--and at the same time seeking status for its members among the myriad variety of professions--and each is endeavoring to exert some control over the education and training of its future members. As this scene unfolds, one may wonder, What hath medicine wrought!

The exploding picture is startling and dramatic. This fact is demonstrated by presenting some statistics that help to explain the pressures for expansion in accreditation of health educational programs.

Increasing Demands for Health Services

Population

Various factors are contributing to the proliferation of health professions, but basic to all these is the growth in the population of the United States. As the figures in table 1 attest, our national population has almost doubled in the recent half century.

Although projections of the future growth in population vary widely, there is little disagreement that the number of inhabitants of this country by the end of the twentieth century will be some 300 million and that the size and growth in population has exerted and will continue to exert a pronounced influence on all socially related issues, one of which is health care. Furthermore, the patterns of demand for and the specialization of health care are affected by the urbanization of the nation and by the fact that approximately 10 percent of the total population is under five years of age and an equal percentage over sixty-five. For one example, the administration of health care delivery in a heavily urbanized area is exceedingly more difficult than in a city of medium size and is complicated further by numbers of older persons living longer and requiring special kinds of treatment.

Increasing Expectations

Not only is the population multiplying but the expectation for health care on the part of each individual is increasing. As the *Report to the President and the Congress on the Allied Health Professions Personnel Training Act of 1966, as Amended,* (dated April 29, 1969) states, "Our citizens have grown accustomed to the premise of public responsibility for welfare and social security systems and to prepayment and insurance systems to ease the burden of medical expense."

When it appears that someone else will pay the bills, one is more readily inclined to seek medical advice and health treatment, and partially for this reason the demand grows. As of 1970, three-fifths of personal health care expenditures were met by third-party payers—insurance, government, philanthropy, and industry, with government responsible for 58 percent of such payments.[1] And Congress will soon be engaged in extensive debates over the many bills proposing alternate methods to provide more health care and extend third-party payments even further.

A few more statistics will demonstrate this growth in demand. "Annual visits to physicians per person increased 80 percent from 1930 to 1964 and hospital admissions rose 160 percent."[2] The Joint Commission on Accreditation of Hospitals reports that the discharges from hospitals, both accredited and nonaccredited but excluding long-term care and specialized facilities, totaled 28,811,925 in 1965 and 30,755,500 in 1970. In its response to the SASHEP questionnaires, the JCAH added the prediction that by 1975 the total number of hospital discharges will be over 33 million a year.

Increasing Costs

The dimensions of the national health costs may be better understood from table 2, based on figures prepared by the Department of Commerce and the Social Security Administration.

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1. *Reference Data on Socioeconomic Issues of Health 1971* (Chicago: American Medical Association, 1971), p. 56.
2. Harry I. Greenfield, "Making Better Use of Health Personnel," *Manpower,* April 1969, pp. 3-6.

Between 1950 and 1969, the total expenditures for health care rose by $48.2 billion, of which $9.1 billion, or 19 percent, was attributed to growth in population; $14.7 billion, or 31 percent, to increased use of services; and $24.4 billion, or 50 percent, to inflation.[3]

One socioeconomic analyst, Leonard A. Lecht, has projected that by 1975, out of a GNP of over 1 trillion dollars, approximately $90 billion will be devoted to health costs.[4] A recently announced government analysis predicts that expenditures for health care will exceed $105 billion by 1974 regardless of what measures Congress enacts to extend health care benefits to the total population.

Arguments and contentions about the total future health bill and the best methods to meet the growing costs will soon swirl in Congress and in journals and newspapers throughout the country. Sufficient for this working paper is the conclusion that costs will increase, that demands for health care will grow, and that one of the responses to these conditions will undoubtedly be a larger number of persons providing health care, classified into an expanding number of health professions and health-related occupations.

Supply of Health Personnel

In response to the demand, the number of trained health personnel has shown a marked growth, as table 3 illustrates. Between 1900 and 1950, the total active health manpower increased 480 percent, and between 1950 and 1970, only twenty years, the increase was over 230 percent. The prediction for 1980 calls for one and a half times as many as in 1970 to be actively engaged in health care, a total of 5,491,000.

Expressed another way, between 1950 and 1960 nonagricultural employment rose by 20 percent while health employment rose 46.7 percent, or 2.3 times as fast. For the period 1950 to 1965, the ratios were a 33.6 percent increase for nonagricultural employment and 86.7 percent increase for health-related employment.[5]

Even with this growth, there are analysts who insist that the demand will continue to exceed the supply, while others insist that the supply will be sufficient but that the distribution and use of trained health personnel will likely continue to be the major causes of health manpower problems.

Figures 1 and 2 graphically show the relatively more rapid increase in the numbers of persons engaged in the delivery of health care in occupations other than medicine. Stated more explicitly, "Physicians active in medicine and osteopathy numbered about 305,500 in 1967. Between 1900 and 1967 they increased numerically 2½ times. However, as a proportion of the aggregate health manpower supply they declined from 35 to 9 percent of the total. Thus,

3. *Reference Data*, p. 54.

4. *Manpower Needs for National Goals in the 1970s* (New York: Praeger, 1969), p. 23.

5. Harry I. Greenfield, *Allied Health Manpower: Trends and Prospects* (New York: Columbia University Press, 1969), p. 32.

figure 1 shows the sharp changes in the composition of the health manpower supply, moving from a time when one health worker in three was a physician to a situation of only one in ten."[6]

It has also been pointed out that "from 1955 to 1965, while the population increased 17 percent and the number of active physicians increased 22 percent, professional nurses in practice increased 44 percent, registered x-ray technologists increased 56 percent, and clinical laboratory personnel increased 70 percent."[7]

Table 4 encourages the further assumption that in the coming years the disparity in the ratio of physicians to the total number gainfully employed in the health occupations will become even more pronounced. This change in ratio implies further alterations in the patterns of the delivery of health care; it also implies the possible need for changes in the patterns of control exerted over educational programs preparing individuals for employment in various health professions. (See appendix A for the estimated number of persons employed in selected occupations within each health field in 1969.)

The Proliferation of Health Professions

When the uninitiated first encounters the lists of occupations related to the delivery of health care, he is immediately appalled at the total number and the apparently unlimited expansion in the number of health occupations that is taking place. Examples of recently developing health occupations are biomedical technologists, kidney dialysis technicians, drug abuse experts, health facility surveyors, histotechnologists in electron microscopy, radiobiologists, and radiologic administrators. Assistants, technologists, technicians, aides, and others are burgeoning in all fields. In addition, established health occupations are frequently seeking more advanced education as a requirement for acceptance of future practitioners into their professions.

To provide a foretaste of some of these occupational fields that are currently being developed or are predicted for the near future, the selected list that forms table 5 has been gleaned largely from the responses to the SASHEP questionnaires completed by the currently active accrediting agencies.

Factors Causing Proliferation of Health Professions

There are two types of forces causing proliferation of health professions: those forces that are general in nature and apply to all vocations and those that are relevant to the health fields. With respect to the former, one must accept the fact that the wide growth in knowledge during the twentieth century has led inevitably to specialization. No one person is capable of encompassing all

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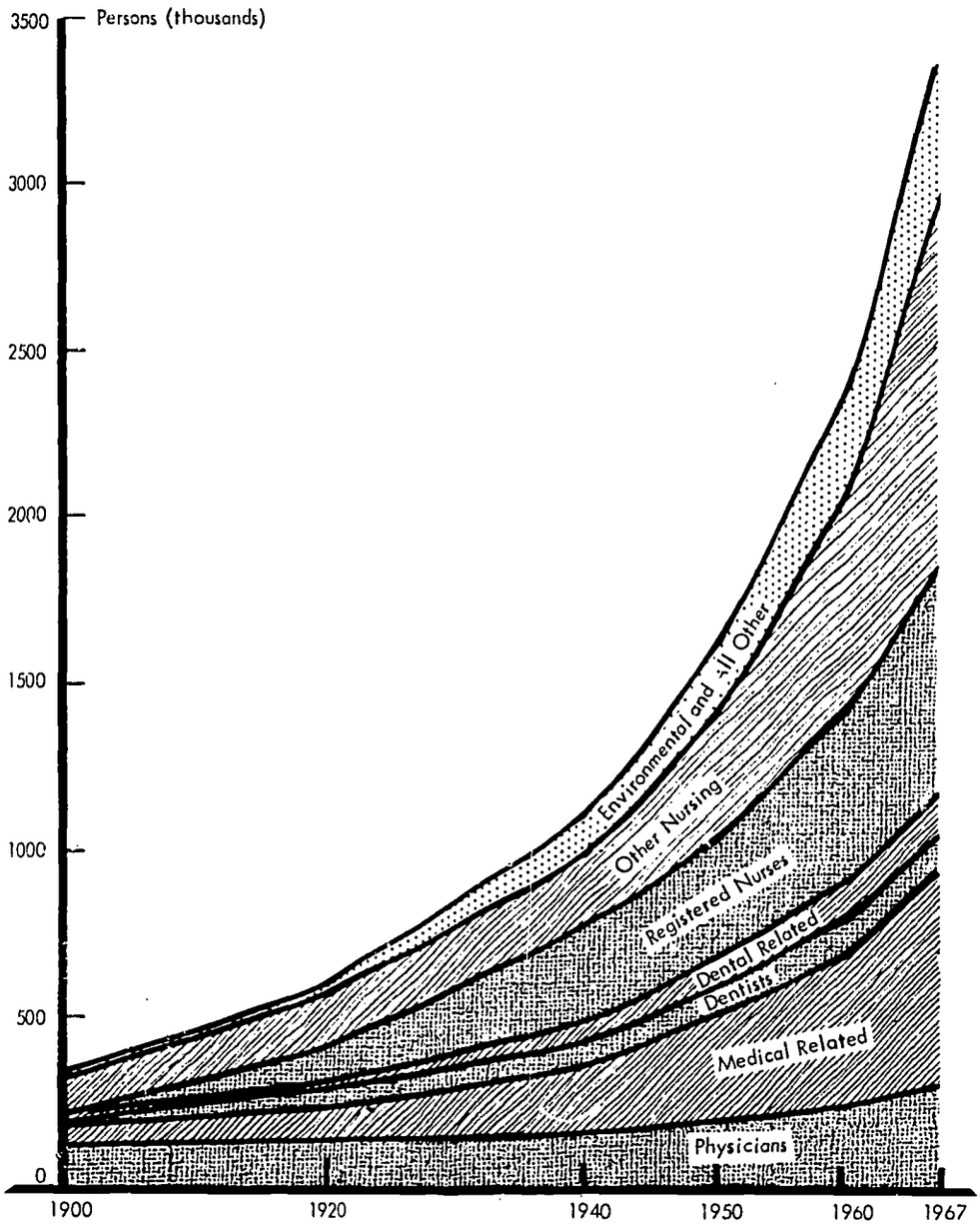
6. M. Y. Pennell and D. B. Hoover, *Allied Health Manpower, 1950-80.* Health Manpower Source Book 21. Public Health Service pub. no. 263, section 21. (Washington: U.S. Government Printing Office, 1970), p. 1.

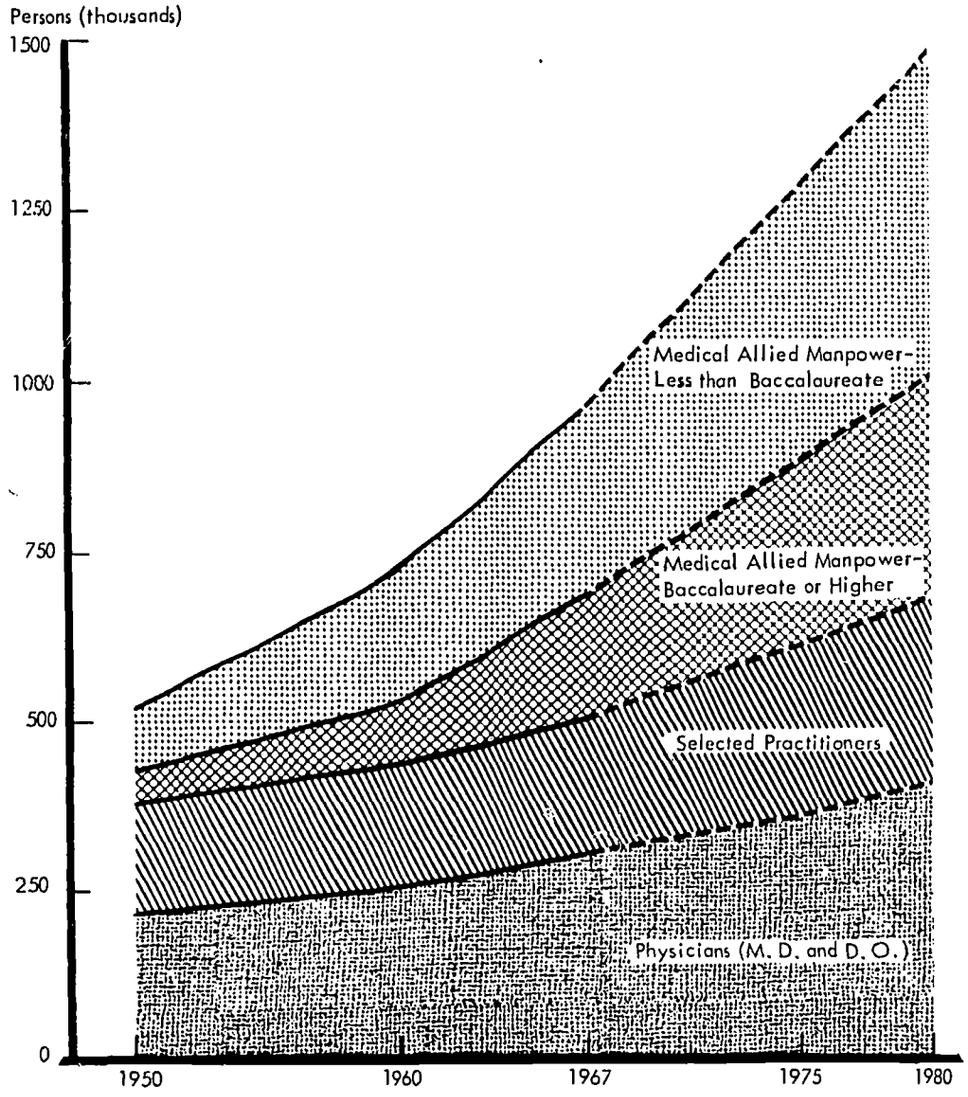
7. *Report of the National Advisory Commission on Health Manpower,* vol. 1 (Washington: U.S. Government Printing Office, 1967), p. 7.

FIGURE 1. Employment in Health Occupations: 1900–1967



Reprinted from *Health Manpower Source Book 21: Allied Health Manpower Supply and Requirements, 1950-1980* (Washington: U.S. Government Printing Office, 1970), p. 2.

FIGURE 2. Medicine and Allied Services: Employment 1950–1980



Reprinted from *Health Manpower Source Book 21: Allied Health Manpower Supply and Requirements, 1950-1980* (Washington: U.S. Government Printing Office, 1970), p. 8.

that needs to be known in order to perform the complicated tasks in governing and operating the complexities of our contemporary civilization. Our technological society requires a broad variety of technicians who are specialists in their respective fields of competence. Furthermore, and this point is frequently overlooked, the economic, political, and social concepts on which our society rests, coupled with the rapid growth in population, encourage individuals to seek personal identity and protection through membership in some defined and organized segment of society, such as labor unions or professional societies.

In the case of the health-related vocations, there are at least two other specific factors that apply. In the first place, all of the health vocations endeavor to emulate medicine, and medicine itself has become a very specialized profession. At present there are some sixty medical specialties largely identified by the medical specialty boards and conjoint boards in such fields as anesthesiology, colon and rectal surgery, dermatology, family practice, internal medicine, neurological surgery, obstetrics and gynecology, opthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preventive medicine, psychiatry and neurology, radiology, surgery, thoracic surgery, and urology.

Bernhard J. Stern has identified several of the reasons for the growth in medical specialization.[8] Not only is it impossible for a physician to encompass all of the current medical knowledge, but the actual administration of health care further requires the participation of individuals with different special competencies to serve in such situations as cardiac and intensive care units. Specialization also facilitates the advance of the scientific frontiers of medicine, and specialization has been further stimulated by the growth of large centers of population where the specialist can thrive economically. The economic attraction of specialization for the individual practitioner is a significant inducement, as is the subtle desire for professional and public recognition that generally accompanies specialization. These factors are not overlooked by the members of the growing number of other health professions.

There is direct federal economic stimulation to devise and develop new careers in the health fields for the purpose, among others, of increasing and improving the delivery of health care to larger numbers of persons. The Department of Health, Education, and Welfare established the Office of New Careers in 1969 to support the new-careers concept; and the Bureau of Health Manpower Education of the National Institutes of Health and the National Center for Health Services Research and Development of the Health Services and Mental Health Administration have each been and are continuing to provide funding for various projects, many of which will encourage the development of new health occupations. Among such projects identified in the *Report on Licensure and Related Health Personnel Credentialing,* the June 1971 report from the secretary of HEW to Congress, are the following: development of new anesthesiology personnel, development and evaluation of educational programs in

8. *American Medical Practice in the Perspective of a Century* (New York: The Commonwealth Fund, 1945), p. 53.

biomedical equipment technology, dental restorative technician, urologic assistant, orthopedic assistant training and certification program, nuclear medical technology development, speech and hearing technologists, pilot physical therapy assistant program, specialists in radio-pharmaceuticals, hospital pharmacy technicians, model therapist delivery of dental care to indigents, family nurse practitioners (PRIMEX).

In addition to the factors just mentioned, the health professions and their individual members are endeavoring to develop ways by which they can improve and expand the delivery of their health services. The result is almost a plethora of new vocational terms that imply both an overlapping of services and conflicts among old and new professions as new professions concurrently struggle to be born.

Health Educational Programs

The future members of these newly developing health occupations will undoubtedly be prepared in educational programs. As a result, we must anticipate a marked increase in the number and types of such programs.

An accurate total of the number of health educational programs offered in vocational-technical schools, junior colleges, four-year colleges, universities, hospitals, and other institutions is not available. The numbers are constantly changing and generally expanding.

An indication of this fact can be observed by referring to appendix B, which shows the estimated growth in accreditation of selected health educational programs between 1965 and 1975. These figures were obtained from the questionnaires completed by representatives of most, but not all, of the accrediting agencies in the health fields.

For the fields reported, the total number of accredited programs in 1965 was 2,855. By 1970, the number had increased 28.4 percent to 3,666. The prediction by the representatives of the agencies for 1975 is 4,974, a further growth of 35.7 percent. These figures do not include radiologic technology since a figure for this field was provided for only one year. To include it, in view of the size of the number, would have created a distortion.

Parenthetically, the comparable figures from the Joint Commission on Accreditation of Hospitals, which voluntarily provided this information to SASHEP, shows that in 1965 there were 4,401 accredited hospitals and 1,765 separate accrediting visits. With the addition of long-term care and rehabilitation facilities to their operations, the total number of JCAH accredited institutions rose to 6,743 in 1970, with 2,441 separate accrediting visits in that one year. It is estimated that by 1975 the total number of accredited institutions, including facilities for the mentally retarded and psychiatric facilities, will be 13,350 and the number of accrediting visits necessitated by this expansion will be over 7,000 a year.

Another indication of growth in the number of health educational programs is a study reported by the American Association of Junior Colleges. As of November 30, 1970, there were 2,132 allied health and related programs in

junior colleges; 616 were less than degree level, 128 were community service programs, and 1,388 were at the associate degree level. The report further indicated that 916 additional programs were being planned for operation within the following three years. A similar study of allied health programs in senior colleges and universities is now being conducted by the Association of Schools of Allied Health Professions under contract to the Public Health Service, U.S. Department of Health, Education, and Welfare. Results of the study will be published in directory form by spring 1972.

An additional dimension to the potential growth in accreditation involves the military services, which conduct health-related occupational specialty training programs. Although a few of these programs are, by their titles, obviously entirely service related–for example, aeromedical evacuation technician and medical deep sea diving technician–most are preparing service men and women to perform health-related functions similar to those in civilian capacities. In FY 1970, the Air Force offered 54 basic and advanced courses to 6,104 graduates; the Army operated 27 programs with 27,590 completions; and the Navy conducted 28 courses for 8,954 graduates. Furthermore, the Veterans' Administration is presently participating in the training of more than 40,000 health personnel, including dentists, nurses, physicians and allied professionals, technicians, and aides. By 1975, the VA is expecting the total to exceed 90,000.

The sorcerer's apprentice appears to have extended his activities into the health fields!

Health Educational Accrediting Agencies

As identified in the working paper on structure, there are two sources of formal recognition of accrediting agencies. These are the National Commission on Accrediting and the U.S. Commissioner of Education. Collectively, they have granted recognition to date to agencies that accredit the following health educational programs of study:

clinical pastoral education
community health education
dental assisting
dental hygiene
dental laboratory technology
dentistry
engineering (environmental)
hospital administration
medical record librarianship
medical record technician
medical laboratory technology
medicine
nurse anesthesia
nursing
  professional and technical
occupational therapy
optometry
osteopathic medicine
pharmacy
physical therapy
podiatry
practical nursing
psychology
  clinical, counseling, and school
public health
radiologic technology
social work
speech pathology and audiology
veterinary medicine

In addition to these officially recognized programs of accreditation, the following eight fields are being accredited, without official sanction, on a collaborative basis with the American Medical Association:

certified laboratory assistant	medical assistant
cytotechnology	nuclear medicine technician
histologic technician	nuclear medicine technologist
inhalation therapy technician	orthopedic physician's assistant

For at least the following fields, plans, including the establishment of standards, are being developed to initiate accreditation collaboratively with the AMA:

assistant to primary care physician
blood bank specialist
electroencephalographic technician
emergency medical technician
medical laboratory technician
urologic physician's assistant

Independently of the AMA, there are other organizations that are involved, one way or another, in accreditation of educational programs in the health fields or of hospitals and other types of institutions providing health care. These include the American Corrective Therapy Association, Medical Library Association, American Orthoptic Council, American Society for Hospital Education and Training, National Association of Music Therapy, National Environmental Health Association, National Executive Housekeepers Association, and National Therapeutic Recreation Society. There are others that could be added to this list.

An interesting example of one of these organizations is the National Environmental Health Association, which was organized in 1937 as the National Association of Sanitarians "to set standards of education and excellence in performance, to promote professionalization, and to obtain better salaries" for its members. Spurred by the recently expanded concern for protection of the environment, the association is encouraging attention to the need for environmentalists in positions related to such activities and facilities as air control, campuses, hospitals and other health care facilities, housing, and radiological health. Its present membership comprises about 6,000, primarily employees of civil governments. In fact, they constitute the second largest single group, exceeded only by public health nurses, in official health agencies.

To help fulfill its goals, the association created a national accrediting council which has undertaken to establish standards for undergraduate curricula in environmental health and is developing programs for two-year courses of study for technicians and guiding graduate programs. There are at present thirty-six listed university programs for environmental education, three of which have already been accredited, even without approval from either the National Commission on Accrediting or the U.S. Commissioner of Education to conduct such accreditation.

As has been asked many times previously, Who controls the accrediting agencies? Who should decide, and on what basis, whether a program of accreditation should be extended or modified or, in fact, whether a program of accreditation should be initiated or terminated?

Concluding Comments

From the information provided in this working paper, it is apparent that accreditation of the health educational programs is expanding rapidly and simultaneously in many different directions. New specialized professions are being developed, and many of them wish either immediately or eventually to undertake accreditation. There are increasing numbers of educational programs in each of the various fields of study, both the technological and technical, as well as in the postprofessional levels. Questions related to the accreditation of continuing education, internships and residencies, programs in the armed services, and proprietary institutions add to the picture of confusion and uncertainty for the future of this massive nongovernmental, uncoordinated enterprise.

As the proposal for SASHEP stated, "With the present and future numbers of schools and programs in all of the health professions and occupations likely to seek initial or renewed accreditation, conditions may develop in which the current process of accreditation will simply be unable to meet the demands placed upon it. In other words, it may succumb under its increasingly ponderous weight to a different system. . . ."

The proposal added, "The pressures and issues in the accreditation of programs of education for the health professions have been mounting, especially during recent years. If they are not recognized and resolved on a cooperative basis, a situation is likely to develop in which it may be impossible to reach any amicable resolution."

The Final Report of the Committee to Study the Relationship of Medicine with Allied Health Professions and Services to the House of Delegates of the American Medical Association (dated June 1960), commonly referred to as the McKeown Report, stated, "The Committee is convinced that the physician of today is confronted with the most complex and variable pattern of relationships in the health professions that has ever existed."

In the past decade, the complexity has grown more acute and the pattern more variable. Partially as a result, misunderstandings and rivalries do occur. Confusion and disorder results. Unnecessary jurisdictions are being established and defended. Energies are wastefully expended in many unprofitable activities, and the delivery of health care suffers.

The presence of a sorcerer is obviously required to alter the structure, the financing, and the operations of accreditation of health educational programs. However, to be successful this magician must first have mastered the magic words.

The next task for SASHEP is to learn what incantations will solve the riddle.

TABLE 1

United States Population: 1900-1970

Year	Population	% Increase
1900	76,212,168	21.0
1910	92,228,496	21.0
1920	106,021,537	15.0
1930	123,202,624	16.2
1940	132,288,000	7.4
1950	151,718,000	14.7
1960	180,007,000	18.6
1970	203,165,699	12.9

TABLE 2

Percentage of Gross National Product Devoted to Health Care: 1929-1970

Year	GNP (x 1 billion)	% devoted to health care
1929	$103.1	3.6
1940	99.7	4.0
1950	284.8	4.6
1960	503.7	5.3
1970	974.1[a]	7.0

[a]In 1958 prices = $720 billion.

TABLE 3

Active Health Manpower in the United States: 1900-1980
(in thousands)

Occupation	1900	1950	1960	1970	1980
Total	350	1,683	2,493	3,921	5,491
Physicians (M.D. and D.O.)	123	220	259	323	418
Dentists[1]	30	78	89	104	122
Registered nurses	12	375	504	723	970
Selected health professions	55	135	159	179	219
Optometry[2]		15	16	18	22
Pharmacy	46	100	117	128	153
Podiatric medicine[2]		6	7	7	9
Veterinary medicine	8	14	19	26	35
Allied health manpower	15	286	515	927	1,372
Allied medical	5	140	279	535	795
Allied dental	5	83	120	140	179
Environmental health	5	63	116	252	398
Nursing auxiliaries	109	362	681	1,265	1,885
Licensed practical nurses	0	137	206	400	705
Nursing aides, orderlies, and attendants	109	225	475	865	1,180
Other health personnel	6	227	286	400	505

Sources: Manpower Supply and Educational Statistics for Selected Health Occupations. Health Manpower Source Book 20. Public Health Service pub. no. 263, section 20. (Washington: U.S. Government Printing Office, 1969).

M. Y. Pennell and D. B. Hoover, *Allied Health Manpower, 1950-80.* Health Manpower Source Book 21. Public Health Service pub. no. 263, section 21. (Washington: U.S. Government Printing Office, 1970).

Estimates for 1970 and 1980 prepared by Divisions of Allied Health, Dental Health, Manpower Intelligence, and Nursing, April 1971.

Note: Data are as of December 31, unless otherwise indicated.

[1]As of July 1 each year.

[2]For 1900, optometry and podiatric medicine together are estimated at 1,000.

TABLE 4

Estimated Employment in Health Occupations: 1900 and 1967

Health occupation	Number of workers		Percent of workers	
	1900	1967	1900	1967
All health occupations	350,000	3,515,000	100	100
Physicians (M.D. and D.O.)	123,000	305,500	35	9
Medical related	60,000	651,300	17	18
Dentists	30,000	98,700	9	3
Dental related	5,000	137,000	1	4
Registered nurses	12,000	659,000	4	19
Other nursing	109,000	1,095,000	31	31
Environmental health engineers, scientists, and technologists	11,000	54,500	3	1
Environmental health technicians, assistants, and aides		163,500		5
All other		350,500		10

Source: Public Health Service estimates.

Note: Reprinted from *Report of the National Advisory Commission on Health Manpower*, vol. 1 (Washington: U.S. Government Printing Office, 1967), p. 3.

TABLE 5

Selected List of Health Fields in Which New Health Job Titles and Occupations Are Being Developed or Anticipated

Administration:	comprehensive health planning
	health facility surveyors
	long-term care administration
	nursing home administrators
Anesthesiology:	anesthesia assistant
	anesthesia technician
	anesthesia technologist
	emergency medical technician
Biomedic electronics:	administrative technician
	field service technician
	operator-repair technician
	professional technician
Chest physician:	coronary care technician
	intensive-care technician
	pulmonary function technician
	respiratory care technician

Dentistry:	dental nurse dental therapist
Dietetics:	dietetic assistant food management or dietetic technician
Inhalation therapy:	cardiopulmonary technician circulation technologist respiratory technologist respiratory therapist
Medical records:	admissions registrar medical transcriptionist
Mental health:	mental health re-entry expediter mental health technolo-professional
Nuclear medicine:	professional nonphysicians in nuclear medicine radiation therapy technologist radiologic physician's assistant
Occupational therapy:	occupational therapy aide
Optometry:	optometric assistant optometric technician
Pharmacy:	doctor of pharmacy pharmacist's assistant
Physical therapy:	physical therapy assistant
Radiology:	radiation physicist radiobiologist radiologic technologist assistant radiologist administrator radiologist assistant radiology aide x-ray equipment repair technician

APPENDIX A

Estimated Persons Employed in Selected Occupations Within Each Health Field: 1969

Health field and occupation	Workers
Total [1]	3,825,800 to 3,894,100
Administration of health services	46,200
Administrator, program representative, management officer	46,200
Anthropology and sociology	[2] 1,400
Anthropologist—cultural and physical	600
Sociologist—medical	800
Automatic data processing in the health field	1,000 to 1,500
Systems analyst	1,000 to 1,500
Basic sciences in the health field	51,200
Research scientist (other than physician, dentist, veterinarian)	[2] 51,200
Biomedical engineering	10,500
Biomedical engineer	3,500
Biomedical engineering technician	7,000
Chiropractic and naturopathy	16,000 to 18,000
Chiropractor, naturopath, other drugless healer	[2] 16,000 to 18,000
Clinical laboratory services	119,500
Clinical laboratory scientist	4,500
Clinical (medical) laboratory technologist [3]	50,000
Clinical laboratory technician and assistant	65,000
Dentistry and allied services	238,700 to 243,700
Dentist	[4] 100,700
Dental hygienist	16,000
Dental assistant	90,000 to 95,000
Dental laboratory technician	32,000
Dietetic and nutritional services	36,000 to 37,000
Dietitian and nutritionist	[4] 30,000
Dietary technician, food service supervisor	6,000 to 7,000
Economic research in the health field	300 to 500
Economist—health	300 to 500
Environmental control	[2] 217,500
Environmental engineer	13,500
Scientist	11,000
Sanitarian	12,000
Industrial hygienist	1,600
Other environmental protection program specialists	16,400
Technicians and aides	163,000
Food and drug protective services	25,200
Food technologist	23,500
Food and drug analyst and inspector	1,700

See footnotes at end of table.

Health Resources Statistics: Health Manpower and Health Facilities, 1970; U.S. Public Health Service Publication No. 1509, 1970 Edition, pp. 7-9.

Health field and occupation	Workers
Health and vital statistics	[3] 1,350
Health statistician	1,100
Vital record registrar	150
Demographer	100
Health education	22,000 to 23,000
Public health educator	[3] 2,000 to 3,000
School health educator, coordinator	20,000
Health information and communication	9,500 to 10,600
Health information specialist and science writer	[3] 2,000 to 3,000
Health technical writer	7,000
Medical illustrator	[3] 500 to 600
Library services in the health field	9,500
Medical librarian	2,200
Medical library technician and clerk	7,300
Medical records	54,000
Medical record librarian	13,000
Medical record technician	41,000
Medicine and osteopathy	314,700
Physician (M.D.)	[4] 303,000
Physician (D.O.)	[4] 11,700
Midwifery	4,300
Lay midwife	4,300
Nursing and related services	1,900,000
Registered nurse	700,000
Practical nurse	370,000
Nursing aide, orderly, attendant	815,000
Home health aide	15,000
Occupational therapy	12,500
Occupational therapist	7,000
Occupational therapy technician, assistant	5,500
Optometry, opticianry, and other ocular services	54,450 to 59,450
Optometrist	[3] 18,000
Dispensing optician	11,000
Optical technician	[5] 15,000
Ophthalmic assistant	10,000 to 15,000
Orthoptist	[3] 450
Orthotic and prosthetic technology	3,600
Orthotist and prosthetist	[3] 3,600

See footnotes at end of table.

Health field and occupation	Workers
Pharmacy	138,700
Pharmacist	128,800
Pharmacy assistant and aide	[5] 9,900
Physical therapy	23,500
Physical therapist	14,500
Physical therapy technician, assistant	9,000
Podiatry	[4] 7,000
Podiatrist	7,000
Psychology	12,000
Psychologist—clinical, counseling, and other health	[3] 12,000
Radiologic technology	75,000 to 100,000
Radiologic (X-ray) technologist, technician, assistant	[3] 75,000 to 100,000
Secretarial and office services in the health field	275,000 to 300,000
Receptionist, secretary, assistant, aide	275,000 to 300,000
Social work	28,000
Social worker—medical and psychiatric	23,700
Social work assistant and aide	[5] 4,300
Specialized rehabilitation services	11,000
Corrective therapist	1,100
Educational therapist	[5] 500
Manual arts therapist	[5] 900
Music therapist	[5] 2,200
Therapeutic recreational specialist	6,000
Home economist in rehabilitation	[5] 300
Speech pathology and audiology	18,000
Speech pathologist and audiologist	18,000
Veterinary medicine	24,700
Veterinarian	[4] 24,700
Vocational rehabilitation counseling	12,000
Vocational rehabilitation counselor	12,000
Miscellaneous health services	51,500 to 54,000
Surgical technical aide	23,400
Inhalation therapy technician	10,000 to 12,000
Electrocardiograph technician	9,500
Electroencephalograph technician	3,000 to 3,500
Ambulance attendant	5,600

[1] Each occupation is counted only once. For example, all physicians are in medicine and osteopathy.

[2] 1958 estimate repeated in absence of sufficient information on which to base revision.

[3] With bachelor's degree or ASCP certified.

[4] Estimate indicates active rather than total.

[5] 1965 estimate repeated in absence of sufficient information on which to base revision.

[6] Limited to hospital employees in 1969.

APPENDIX B

Estimated Growth in Accreditation of Selected Health Educational Programs: 1965-75

Professional Field	Year	Total accredited programs	Total graduates from accredited programs	Number of separate accreditation visits	Number of individuals involved in one or more accrediting visits	Estimated number of nonaccredited programs	Estimated number of graduates of non-accredited programs
		A	B	C	D	E	F
Blood bank specialty	1965						
	1970						
	1975	75	300	25	25		
Certified laboratory assistant	1965	100	660	5 est.			
	1970	210	1,570	10 est.		65	
	1975	300	3,000				
Cytotechnology	1965	84	332	30	20 est.		
	1970	118	416	30	20 est.		
	1975	100	400	25	40		
Dental assisting, hygiene, and laboratory technology	1965	118	2,851	28	37		
	1970	276	5,303	73	104		
	1975	434	8,862	130	200		
Dentistry	1965	49	3,181	8	32		
	1970	53	3,749	12	51		
	1975	58	4,070	20	84		
Dietetics	1965	62	702	18	1		
	1970	78	872	34	10		
	1975	120	1,350	50	20		
Dietetic supportive personnel[a]	1965	20	1,000				
	1970	84	5,380				
	1975	312	18,650				
Hospital administration	1965	19	200	3	7	4	25
	1970	27	595	8	18	6	19
	1975	36	850	10	25	5	30
Inhalation therapy	1965	10	30 est.	10	10		
	1970	60	1,010 est.	10	20		
	1975	140	3,500	100	50		
Medical assisting	1965						
	1970	7		7	14		
	1975	100		100	200		
Medical laboratory technician[b]	1965						
	1970	11	237	3			
	1975	115[c]					
Medical lab. technician–ISCLT	1965	5	543	9		7	750
	1970	4	364			10	900
	1975	15	750	3			
Medical record librarianship	1965	28	180	6	2		
	1970	26	235	3	1	5	
	1975	40	450	10	3		
Medical record technician	1965	13	69	2	1		
	1970	26	206	6	1	13	
	1975	80	650	20	4	15	
Medical technology–ASCP-ASMT	1965	784	3,065	248	490 est.		
	1970	788	4,408	108	210 est.		
	1975	750	5,500	160	300		

To: William K. Selden, Director
Study of Accreditation of Selected
Health Educational Programs

From: Harold Seidman

Subject: Structure for National Supervision of Accreditation

In accordance with your letter of June 16, 1971, I have conducted an independent study of the present structure for national supervision and coordination of accreditation and prepared the attached staff paper identifying and evaluating possible alternatives to current arrangements. The paper is intended for the consideration of the study commission and its staff. The findings and conclusions are based on a review of the relevant literature and on discussions with a number of knowledgeable persons, including representatives of the federal government, Council of State Governments, the Education Commission of the States, and seven accrediting associations. I have made every effort to assure accuracy, but there may well be some errors of fact or interpretation.

Within the time available, it was not possible to undertake an in-depth analysis of either the structure or the effectiveness of existing accrediting organizations. The focus of my paper is on national organization, although I do raise questions or indicate my impressions about collateral matters where these have a bearing on the issue of national organization.

ACCREDITATION OF POSTSECONDARY EDUCATION: PROBLEMS IN ORGANIZATION

Harold Seidman

Accreditation and Public Accountability

Inability to adapt to environmental requirements is a symptom of inbreeding. As with most highly inbred societies, the guild-like organizations controlling educational standards and institutional and specialized accreditation in the United States are resistant to change. Few accrediting agencies have demonstrated capacities for realistic self-appraisal and rejuvenation. New demands have been met in the main either by forced assimilation into existing systems or by creation of additional accrediting agencies, not by institutional reform and modification of standards, procedures, and techniques of evaluation.

Organs of control are peculiarly susceptible to organizational dry rot. Their policies and actions are rarely subject to the test of the market place or the electorate. When the power to control is backed by significant legal or quasi-legal sanctions, those subject to control have no option but to comply. Unless there are provisions for independent oversight and review or built-in arrangements for meaningful outside participation in the system and objective validation of standards and procedures, ritual may be substituted for substance, with institutional myths and symbols being worshipped for their own sakes long after they have lost their original meanings.

Accreditation procedures are currently being criticized for contributing to the perpetuation of the guild system associated with professional education.[1] Our unique system of voluntary, nongovernmental, peer evaluation in education has much to commend it, but past accomplishments are no guarantee of future survival. As the secretary of health, education, and welfare stated in his *Report on Licensure and Health Personnel Credentialing*, "New forces are facing higher education today: they pose the question of whether or not accreditation can be fused with public accountability."[2] This is the basic question that must be resolved by those who wish to preserve the degree of independence from government control now enjoyed by educational institutions in the United States.

Dr. Seidman served for many years on the staff of the U.S. Bureau of the Budget, retiring as assistant director for management and organization. He is co-author of *The Government Corporation* and author of *Politics, Position, and Power: The Dynamics of Federal Organization*. He has served as consultant to the President's Advisory Committee on Executive Organization and is currently visiting professor of political science at Leeds University, England, and at the University of Connecticut.

1. Elliott Richardson, *Report on Licensure and Related Health Personnel Credentialing* (Washington: U.S. Department of Health, Education, and Welfare, 1971), p. 3.

2. *Ibid.*

Accreditation today is clearly a function affected with a public interest. Kaplin and Hunter argue persuasively that an accrediting agency "is not a truly voluntary association since accreditation is a virtual necessity for the successful operation of a school. Neither is it a truly 'private association,' for it fulfills a public function and may more properly be classed as a quasi-public agency. . . . The stronger the reliance of society upon the standards of the agency, the greater is the harm the agency can impose upon an excluded school and the greater is the monopoly power of the agency."[3]

State licensing laws and regulations commonly limit application for licenses to those who have graduated from schools approved by recognized accrediting agencies. Such accrediting agencies as the American Bar Association, the American Dental Association, and the American Medical Association may be specifically vested with public power through statutory designation as recognized accrediting agencies. In these circumstances, the accrediting agencies are performing a state-delegated function of formulating licensing standards and constitute a kind of secondary licensing authority.[4]

Accrediting agencies also perform government-delegated functions in determining eligibility for participation in certain federal programs of aid to education. The U.S. Commissioner of Education is required by law to publish a list of nationally recognized accrediting agencies and associations that he determines to be reliable authorities on the quality of training offered by educational institutions and programs. Accredited or preaccredited status with one of the recognized accrediting bodies is established by law as the essential criteria for federal funding, thus giving the accrediting agencies what amounts to a life and death power over the institutions concerned.

Questions may well be raised about the propriety and desirability of present interlocking arrangements for accreditation, licensure, and eligibility for federal funding. Accreditation is being used for purposes for which it was never designed and which it is perhaps incapable of performing. Existing evaluation techniques were developed to assure compliance with minimal standards and do not measure satisfactorily either the quality of training or the output. Congressional reliance on accreditation as a standard of eligibility appears to reflect common misconceptions about the objectives and potential of the accrediting process.

The *suitability* and *effectiveness* of accreditation as applied to each of the purposes for which it is presently being used ought to be critically examined. Are all of the nine functions of accreditation enumerated in the criteria published by the U.S. Office of Education compatible? To what extent has the introduction of such possibly alien elements as eligibility for federal funding and licensing examinations influenced the judgment of evaluators and skewed the accreditation process? Are accrediting bodies, as now constituted, capable

3. William A. Kaplin and J. P. Hunter, "The Legal Status of the Educational Accrediting Agency: Problems in Judicial Supervision and Governmental Regulation," *Cornell Law Quarterly* 52 (1966): 114-15.

4. *Ibid.*, p. 118.

of interpreting federal laws and determining legislative intent? Answers to these questions are beyond the scope of this paper, but they do have a bearing on the organizational issues.

If accrediting agencies accept the privileges of exercising public power, then they must be willing to accept the responsibilities that go with it. Vesting of public power in private bodies without public accountability is subject to grave abuse. Accreditation may be employed to limit competition among schools or professions, or to advance professional status without regard to the interests of our educational institutions or the general public. It may constitute a major obstacle to innovation and enhance the danger that higher education in the United States will become a "restrictive and stagnant market place dealing only in programs that meet the needs of special interest groups."[5]

Deficiencies of Existing Organization

To maintain public accountability and responsiveness to community needs, it is essential that organizations be so structured and administered that–

governing bodies are broadly representative of community interests;

access to decision-makers is not limited to those representing particular professional or economic interests;

adequate safeguards against conflicts of interest are provided;

proceedings are conducted openly with all affected institutions and individuals having a right to be heard;

the right of the public to know is recognized and there is full public disclosure of policies and decisions;

provision is made for adequate public notice of proposed standards and interested organizations and individuals are afforded an effective opportunity to express their views before a final decision is taken;

actions and results are subject to independent review and validation.

Judged by these tests, most accrediting organizations would be found wanting. Accreditation systems are structured in such a way as to subordinate the welfare of the educational institution as an entity and of the general public to the interests of groups representing limited institutional or professional concerns. Nobody concerned with accreditation, including the National Commission on Accrediting, is wholly free of the taint of partisanship.

As now constituted, each of the six regional associations and thirty-two agencies recognized by the Office of Education for their specialized accreditation of schools and programs represents and speaks for narrowly based constituencies with diverse and often conflicting views and objectives. According to Charles F. Ward, the regional associations, which accredit institutions and should represent the broadest constituency, are governed by self-perpetuating

5. Lloyd E. Messersmith and Leland L. Medsker, *Accreditation of Vocational-Technical Curricula in Postsecondary Institutions* (Berkeley: Center for Research and Development in Higher Education, University of California, Berkeley, 1969), p. 66.

boards of trustees overwhelmingly dominated by senior college and university presidents, vice-presidents, and deans. He reports that "persons without a vested interest or representatives of the public interest were not found in the power structure of any of the regional associations."[6] While there is token representation of government or public interests in a few of the specialized accrediting agencies, e.g., the Liaison Committee on Medical Education, these organizations are normally subject to ultimate control by governing bodies elected by and responsible solely to a particular professional association. Exceptions are the Accrediting Commission for Business Schools, the National Association of Trade and Technical Schools, and the National Home Study Council, each of which accredits proprietary institutions. For example, the charter of the Accrediting Commission for Business Schools, created by the National Association and Council of Business Schools (NACBS) in 1952, provides that the commission's powers and decisions "shall not be subject to review by members of the board of directors of the parent organization." Of the thirteen commissioners, not less than three or more than five are to be appointed by the board of directors of NACBS from outside the business school field. However, the commission remains a creature of the NACBS and is dependent upon it for support, thus to a degree compromising its independence and autonomy.

When accreditation is controlled by a professional association whose principal function is to advance or protect the status and economic well being of its members, there is an inherent potential for serious conflicts of interest. This risk is especially acute for those associations that exercise jurisdiction over allied professions not eligible for full association membership and excluded from decision-making councils. The American Medical Association approves educational programs in fifteen allied medical occupations including inhalation therapy technician, laboratory assistant, medical assistant, medical record librarian, medical technologist, and physical therapist. Representatives of the allied occupations participate in drafting the standards or essentials and provide experts for evaluation teams. The allied occupations are not represented either in the AMA House of Delegates, which approves the essentials and proposed revisions, or on the Council on Medical Education, which is the accrediting agency. The House of Delegates of the American Dental Association and its Council on Dental Education perform in approximately the same roles with respect to allied dental occupations.

Peer evaluation and evaluation by associations representing professional interests are by no means identical concepts. On the contrary, the vesting of final authority over accreditation in the House of Delegates of the ADA, AMA, and also the American Bar Association inevitably enhances the relative power of the practitioner as opposed to that of the educational institutions, faculty, students, and general public. Maintenance of the present roles of the Houses of

6. *The Current State of Accreditation of Postsecondary Education in the United States* (Raleigh, N.C.: Center for Occupational Education, North Carolina State University at Raleigh, 1970), p. 11.

Delegates of these associations may be necessary to assure continuing financial support for accreditation, but it is not a concomitant of peer evaluation and may inject irrelevant issues into the accreditation process.

Accrediting organizations tend to regard themselves as private clubs whose admission standards and activities are of no proper concern to nonmembers. So far as we could determine, no systematic effort other than publication in journals of limited and specialized circulation is made to keep the public informed or to seek outside views on proposed standards. Failure to observe the basic principles of due process in promulgating standards poses the threat of intervention by the courts.

Michael H. Cardozo, executive director of the Association of American Law Schools, has warned:

> Accrediting agencies, although private, would be well advised to adopt the administrative practices imposed by law on government agencies in dealing with the public. They call for affirmative answers to several questions: Have the standards of the accrediting agency been adopted in accordance with the principles of due process? Have those affected by the standards been given an opportunity to be heard before the standards are finally adopted?[7]

The standards applied by accrediting organizations are challenged on several grounds. Lloyd H. Elliott, president of George Washington University, John R. Proffitt, director, Accreditation and Institutional Eligibility Staff, U.S. Office of Education, and many others before them have criticized the emphasis on such criteria as student-teacher ratio, faculty credentials, and physical facilities when there is no reference to the quality of output. James D. Koerner argues that the standards merely sanctify "any practice in which a majority of institutions engage," "rest on no basis of research or theory," and are "excessively fuzzy and nebulous."[8] The HEW *Report on Higher Education* asserts, "In the name of protecting the standards of education, regional and specialized accrediting organizations pressure new institutions to develop facilities, buildings, and educational requirements on the pattern of established conventional colleges and universities."[9] Different and not always consistent standards and evaluative criteria are applied by each of the regional and the specialized accrediting agencies, but these are not clearly related to different objectives. Ward claims, "It appears fair to say that the evaluation process in accreditation has not advanced one step in terms of principle or technique since its inception.

7. "Recent Developments in Legal Aspects of Accreditation," *Journal of the American Medical Association*, July 27, 1970, p. 594.

8. "Who Benefits from Accreditation: Special Interests or the Public?" mimeographed report of Seminar on Accreditation and the Public Interest, sponsored by the U.S. Office of Education and the National Commission on Accrediting, November 6, 1970.

9. U.S. Department of Health, Education, and Welfare, *Report on Higher Education* (Washington: HEW, 1971), p. 66.

In its present state accreditation has to be considered an art without a vestige of science."[10]

Without independent research and validation of accreditation standards, there is no satisfactory way of assessing the merits of these criticisms. Neither the National Commission on Accrediting nor the accrediting agencies have the necessary resources to undertake the required research. To date there have been no scientific studies either to ascertain the reliability with which standards or evaluative criteria can be applied or to determine the validity of such standards. The accrediting agencies cannot be relied upon to review objectively the results of their operations. To maintain public confidence and assure public accountability, a process of independent review and validation must be built into the system.

The National Commission on Accrediting and the Office of Education have not addressed themselves effectively to the issue of public accountability. Established criteria for recognition do not require that governing bodies include public members and that due process be observed in formulating and promulgating standards. The NCA would need to put its own house in order before it imposed such requirements on accrediting agencies.

The issue of public accountability is central, but it is more readily solvable than other weaknesses in the existing structure. The plain fact is that we do not have a national system of accreditation but a complex of autonomous, fragmented, and loosely coordinated accrediting agencies. This balkanized structure is wasteful and inefficient and places an undue burden on the accredited institutions. More important, it ignores the high degree of interdependence among the elements that constitute an educational institution and the impact of proposed actions in one area upon other elements in the system and the total institution.

There are serious gaps in the structure, particularly with respect to post-secondary vocational-technical education and proprietary institutions. The unwillingness of national and regional accrediting agencies to accredit programs within vocational-technical schools led the governing board of the Council of State Governments in 1969 to resolve that "the Committee of State Officials on Suggested State Legislation give consideration to model legislation which would provide for accreditation programs under state auspices and interstate compacts." Lip service to the principles of voluntary nongovernment accreditation will not stem the pressure for government intervention if the voluntary agencies are unable or unwilling to respond to identified public needs.

The inflexibility of the existing structure encourages the proliferation of accrediting agencies and professional associations. Such proliferation has many undesirable consequences. For example, the report of the Department of Health, Education, and Welfare on accreditation and certification points out, "It is difficult to conceive of career ladders for upward mobility when each

10. Ward, *Current State of Accreditation*, p. 40.

level forms its own professional association."[11] Speaking as they do with many and discordant voices, the regional associations and specialized accrediting agencies inevitably impair their own influence and credibility with educational institutions, governments, and the general public.

The Office of Education and the National Commission on Accrediting have been able to slow, but not to halt, the trend toward proliferation. While in this and in other areas both have made a significant contribution, neither of them is now organized and equipped to provide necessary central leadership and coordination. The role of the Office of Education is necessarily restricted to accreditation as it affects federal funding, and efforts by the office to expand its role would be subject to challenge on legal and constitutional grounds. The NCA represents a limited constituency, university presidents and recently trustees, and cannot claim validly to speak for either the educational community or the community at large.

The threat to the voluntary, nongovernment system of accreditation comes as much from the inside as the outside. Outside intervention can be avoided most effectively by prompt and meaningful measures of self-evaluation and reform. A paragraph in the accreditation and certification report provides guidance and an implicit warning.

> Accreditation is an exceptionally complex mechanism, and it should have an adequate base of consensus among all the groups it affects. *Control over accreditation must be vested with the community and not with any one segment of the community.*[12]

Reorganization Objectives

In considering reorganization proposals, it is essential that underlying objectives be fully disclosed and understood. It is proposed, therefore, that reorganization should have as its basic objectives the establishment of–

1. a *national* system.
2. a *nonexclusive system* embracing institutional and specialized accreditation and nonproprietary and proprietary institutions.
3. an *open* system designed to assure that noninstitutional and nonprofessional interests have an opportunity to participate effectively in the formulation of standards and in the administration of accreditation.
4. a *fair and equitable* system giving proper regard to due process and avoidance of conflicts of interests. Standards and accreditation decisions should not be subject to approval by professional groups with potentially conflicting interests.

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11. M. Y. Pennell, J. R. Proffitt, and T. D. Hatch, *Accreditation and Certification in Relation to Allied Health Manpower* (Washington: U.S. Department of Health, Education, and Welfare, 1971), p. 11.

12. *Ibid.*, p. 12.

5. an *independent* system free of control by either government or vested institutional or professional interests.
6. an *efficient* system which eliminates proliferation and duplication and assures consistency in standards and in their application.
7. a *flexible and adaptive* system which can respond to new developments in education and the changing needs of our society.
8. a system which *focuses on the institution as a whole* and recognizes that the elements constituting an educational institution are interdependent.
9. a *validated* system based on independent research including review and validation of standards.
10. a system *limited in objectives* to those that accreditation can be reasonably expected to achieve.

Reorganization Proposals

Reorganization proposals may be grouped in three broad categories: (1) creation of a federal agency to take over the functions of accreditation or assignment of the functions to the states or an interstate compact agency, (2) establishment of a public corporation or statutory agency with powers to regulate and coordinate the voluntary agencies, and (3) reform of the existing system by agreement and without outside intervention.

Government Model

Advocates of government accreditation on the European model, such as Lloyd H. Elliott, believe that "our machinery of accreditation has outlived its usefulness, that voluntary efforts are helpless in the face of today's problems." Elliott proposes establishment by Congress of a National Board of Education that "through its powers to allocate or withhold funds would also have the power to place institutions on an approved list or to remove them from such a list." He argues that a national body is necessary "if all of the various aspects of accreditation are to be coordinated to avoid the continued exaggeration of differences as standards are redefined and then applied in various parts of the country or among various accrediting bodies." The board might retain the existing agencies, which would function under its control, or phase them out.[13] Proposals to turn the job over to the states or to an interstate agency have thus far been limited to vocational-technical schools, and no one has yet advocated that the states assume responsibility for all accreditation.

Turning accreditation over to the states would not achieve many of the desired objectives except improved public accountability and would be calculated to make matters worse. Fifty different state systems would continue fragmentation, but in a different form. The current involvement of states in the

13. "Accreditation or Accountability: Must We Choose?" (Paper delivered at the meeting of the Middle States Association of Collegiate Registrars and Officers of Admission, Atlantic City, December 1, 1970).

accreditation process constitutes part of the problem. On past performance, there is no reason to anticipate that states in general would be more receptive to fresh ideas and innovation than the voluntary agencies. Accreditation could not be insulated against political pressures, which are intense at the state level.

Proposals for federalization of accreditation cannot be as lightly dismissed. In most countries of the world, a ministry of education or other centralized authority controls educational standards. The United States systems of accreditation are an exception. Federalization can be achieved in ways that minimize the dangers of political control and maintain a high degree of responsiveness to the educational community. Such agencies as the National Science Foundation are criticized for being too responsive to the science-education establishment. The twenty-four-member National Science Board is appointed by the president, but he must give due consideration to nominees of the Association of American Colleges, the Association of Land-Grant Colleges and Universities, and the National Association of State Universities. Such advisory arrangements as those established for the National Institutes of Health also leave substantial power in the hands of the educational and scientific communities. A board of education could be structured like the National Science Board, with significant powers delegated to advisory councils composed of representatives of schools and professions.

Federalization potentially could achieve most, but by no means all, of the desired objectives. Independence, as well as flexibility and adaptiveness, would be sacrificed. A corps of professional career evaluators inevitably would become the captive of its own precedents and would be more resistant to change than teams drawn from the outside community and not dependent on accreditation for a livelihood. Stability is both the strength and the weakness of the bureaucracy.

Federalization would raise serious constitutional questions since control of education is reserved for the states. Accrediting agencies often are specifically named in state licensing laws, and it is doubtful that the federal government could enact preemptive legislation in this area. To overcome the constitutional objection, Elliott ties his proposal to eligibility for federal funding, but this would limit jurisdiction to institutions receiving federal funds and give disproportionate weight to issues bearing on financing.

Quasi-Government Agency

Elliott's proposal for outright federalization has to date attracted little, if any, public support. A growing and influential group appears, however, to share his view that existing institutions are incapable of self-regeneration and that Congress must provide a solution. This group prefers that federal intervention be sugar coated and that the appearance of independence be preserved by vesting power in either a public corporation or statutory board.

Gary L. Filerman, executive director, Association of University Programs in Hospital Administration, suggests that consideration be given to restructuring NCA as a broadly representative public corporation with professional and

regional agencies organized as constituent public utilities. The *Report on Licensure and Related Health Personnel Credentialing*, submitted to Congress by the secretary of HEW in June 1971, recommends that "among other alternatives, specific consideration be given to the possibility of establishing a congressionally chartered public corporation to promote the national coordination of accreditation."[14] These proposals are so vague as to defy analysis. Implicit in them is the assumption that there is some magic about a public corporation that differentiates it from a traditional government agency. Such is not the case.

The public corporation is not a precise, definable institutional type. It is not clear whether proponents of an accrediting corporation are advocating (1) a federally chartered private corporation, (2) a government corporation, or (3) a government-sponsored and -controlled public corporation.

There are some forty-odd private organizations incorporated by acts of Congress. These range from such organizations as the American National Red Cross, the Foundation for Medical Education, and the National Academy of Sciences to the Jewish War Veterans and the Blue Star Mothers of America. Except for provisions related to audit, no federal control is exercised over these organizations, and no special privileges are granted to them other than those that could be obtained under state incorporation laws. The principal advantages of a federal charter are prestige and avoidance of state regulation. Federal chartering of an accrediting corporation would have few significant advantages and would take considerable time since Congress is not disposed to act promptly on such legislation.

Government corporations are authorized by law to achieve public purposes. So far as purpose is concerned, a government corporation cannot be distinguished from any other government agency. The functions of a corporation are the same as those of any administrative agency; the differences are to be found in the methods employed to perform the functions and in the techniques utilized by the president and Congress to fulfill their constitutional responsibilities. The differences are limited to (1) legal status (right to sue and be sued), (2) certain freedoms concerning expenditures, (3) method of financing, and (4) procedures for budget and audit control (business-type budget and commercial-type audit).

Under established criteria the use of the government corporation is limited to programs that are predominantly of a commercial character, that are revenue producing and potentially self-sustaining, and that involve a large number of business-type transactions with the public.[15] An accrediting corporation would meet none of these criteria.

There are a number of corporations that fall within a twilight zone and have the characteristics of both a government and a private agency. These include the Corporation for Public Broadcasting, the Federal Reserve Banks, and the National Home Ownership Foundation. The Federal Reserve Banks do

14. Richardson, *Report on Licensure*, p. 142.
15. U.S. Congress, House Document 19, 80th Congress, pp. M57-M62.

exercise certain regulatory powers over member banks, but comparable powers are not delegated to other twilight zone corporations.

The activities of the Federal Reserve Banks are subject to review and ultimate control by a government agency, the Board of Governors of the Federal Reserve System. The board of each bank consists of six directors elected by the member banks—one of whom must be engaged actively in agriculture, one in industry, and one in commerce—and three public directors appointed by the Board of Directors, subject to approval by the Board of Governors. Power to establish standards for membership in the system and to examine and supervise member institutions is vested in the Board of Governors, not in the banks, although examinations may be made by the banks with examiners selected or approved by the board. If this model were employed for accreditation, functions performed by the board of governors would be vested in either the secretary of HEW or in a board of education as proposed by Lloyd H. Elliott.

The National Home Ownership Foundation and the Corporation for Public Broadcasting are by law not agencies and instrumentalities of the United States. While this designation does exempt the corporations from the civil service laws and other statutes applicable to government agencies, it by no means frees them from government control. The foundation has an eighteen-member board of directors consisting of fifteen appointed by the president plus the secretaries of agriculture and housing and urban development and the director of the Office of Economic Opportunity, who serve ex officio. The fifteen directors of the Corporation for Public Broadcasting are appointed by the president, with the advice and consent of the Senate. Both the foundation and the corporation are largely dependent on congressional appropriations. While the foundation and corporation may not be government instrumentalities as a matter of law, in a practical sense this has little significance when the government appoints the directors and controls financing. Such government agencies as the National Science Foundation and the National Institutes of Health in many respects enjoy greater autonomy than the twilight zone corporations.

William K. Selden has proposed for the purpose of stimulating discussion that accreditation should be coordinated and supervised by a national, independent, nongovernmental body supported by statutory recognition. The form and extent of statutory recognition is not explained. The board would be composed primarily of individuals who represent the public interest, as well as individuals who represent the interests of the institutions, their programs of study, the professions, and civil government.

The board would be empowered, among other things to—

> establish policies, or criteria, to which all accrediting agencies or organizations shall adhere;
>
> require that all accreditation be conducted to serve the interests of society;
>
> review periodically, for purposes of approval or disapproval, the policies, procedures, and practices of all accrediting agencies and organizations;

approve or disapprove the extension of accreditation to new types of institutions or programs of study;

require the coordination or consolidation of accreditation conducted by different agencies or organizations;

institute legal action against individuals and/or organizations that fraudulently claim to or fraudulently conduct accrediting activities;

encourage, finance, and sponsor studies that will assist in improvements in accreditation;

conduct studies and make public recommendations with respect to the policies and practices of licensure and other measures of control of quality as conducted by the states;

conduct studies and make public recommendations with respect to the uses of certification and registration as conducted by various bodies, both governmental and nongovernmental;

provide open hearings before making decisions on recognition of accrediting agencies or alteration of their areas of jurisdiction.

Accreditation would be conducted by national independent, nongovernmental bodies, not incorporated for profit. The accrediting agencies would be governed by boards of control including in their memberships a maximum of fifty percent plus one of representatives, both educators and practitioners, from the fields of study subjected to accreditation. Boards would include representatives of the public and others representative of the interests of complementary professions and/or vocations.

The Selden proposal does not provide specifically that accreditation focus on the institution as a whole, although it calls for maximum cooperation and coordination among accrediting agencies. Furthermore, it only indirectly implies an independent validation of results. In all other respects, his plan is consistent with and would support the recommended objectives of reorganization.

In common with the proposals for a Federal Board of Education and a public corporation, the Selden plan raises serious constitutional questions. Furthermore, it poses a logical dilemma. On the one hand, it is argued that the current voluntary system cannot be reformed unless accreditation is supervised and coordinated by a national body established by statute and empowered to establish and enforce standards; to approve or disapprove policies, procedures, or programs; to require coordination; and to institute legal actions. On the other hand, it is stated as a matter of principle that accreditation should be conducted by nongovernmentally controlled agencies or organizations. Yet to defend and support the delegation of such powers to a statutory board, one would have to develop a case for federal intervention. There is no precedent for delegating regulatory powers to nongovernment organizations, and any such delegation would be subject to legal challenge.

At this point proposals for federal legislation are premature and ignore political realities. Congress is reluctant to intervene in disputes among government agencies, much less among private organizations. Favorable action by

Congress would require near unanimity among accrediting agencies and educational institutions on a specific proposal, and if such unanimity could be obtained then reforms could be accomplished without congressional action.

Reform Existing System

Self-reform is difficult and painful, but it is the only approach calculated to assure maintenance of a voluntary, nongovernment system of accreditation. If accrediting agencies are unwilling to cooperate and to subordinate their individual interests to the common good, reform is likely to be imposed from the outside and without their advice or consent. Institutions that preach the value of self-evaluation and self-improvement to others ought to be willing to practice it themselves.

A phased approach is most feasible and conducive to constructive results. The most logical place to start is with the National Commission on Accrediting and the Federation of Regional Accrediting Commissions of Higher Education (FRACHE) which represent educational institutions and have much the same constituency. If these two organizations cannot come into agreement on a reform program, then agreement with and among the specialized agencies with their diverse constituencies is most unlikely. NCA and FRACHE must provide the leadership and set the example for the others.

Claude E. Puffer has presented to FRACHE a comprehensive plan of reorganization which calls for serious consideration.[16] Puffer recommends conversion of FRACHE (after merger with NCA) into a National Institutional Accrediting Commission capable of providing central direction and coordination and of acting as an authoritative, aggressive spokesman for all agencies engaged in institutional accreditation. Members of the commission would include not only representatives of the postsecondary accrediting commissions but also members of the public and noncommission members from institutions of higher education. Puffer does not mention members designated by the federal government and the Education Commission for the States, but it would be consistent with his recommendations to include them.

The proposed commission would perform the following functions:

determine standards and make policies but not itself act as an accrediting agency;

exercise oversight and general supervision over the regional accrediting commissions and see that standards were being upheld and being applied uniformly throughout the United States;

redistrict areas served by present regional commissions;

broaden the scope of institutional accreditation to include vocational-technical education and proprietary institutions;

hear institutional appeals from challenged regional commission decisions;

16. *A Summary Report on Institutional Accreditation in Higher Education* (Chicago: Federation of Regional Accrediting Commissions of Higher Education, 1970).

improve coordination with specialized agencies, including coordination of visits;

sponsor and conduct research;

develop a well organized public relations program to explain institutional accreditation;

take other appropriate actions to improve higher education.

In addition, it is suggested that the proposed commission assume the NCA function of preparing and distributing a list of accrediting agencies whose policies and procedures are consistent with standards established by the commission. This list could be utilized by the U.S. commissioner of education.

Action on the Puffer plan, as modified above, should not be delayed until agreements can be negotiated on a grand design embracing both institutional and specialized accreditation. On the contrary, merger of the NCA and FRACHE in a new organization is essential to enhance the relative power of the institutions vis-à-vis the specialized agencies at the bargaining table. Fragmented as they now are, the specialized agencies could play one institutional agency off against the other. Furthermore, the most persuasive argument for reform is proof based on experience, not theory.

The new commission should seek the collaboration of the Office of Education and the Education Commission for the States in promoting the establishment of an educational research laboratory, to be organized as a nonprofit corporation with an independent board of trustees. The laboratory could be funded initially by grants from the federal government and private foundations. The commission would contract with the laboratory to undertake research in techniques of evaluating educational institutions and programs and to appraise the results achieved by the application of existing standards. Laboratory reports should be submitted directly to the commission and not be filtered through the accrediting agencies or members of the commission staff. The relationship of the laboratory to the commission would be much like that of the Rand Corporation to the Air Force. This arrangement would assure the necessary degree of independence in conducting research and validating results.

The new commission should not recognize any accrediting agency whose decisions and policies on accreditation are subject to review and approval by governing bodies of professional associations with potentially conflicting interests. At a minimum such organizations as the Council on Medical Education of the American Medical Association should be granted the degree of autonomy accorded the Accrediting Commission for Business Schools. Where accreditation extends to allied occupations, these should be represented on the accrediting body. Complete separation from the parent organization would not be required; so no problems would be raised with respect to state licensing laws.

Once the new commission is in existence and functioning effectively, it should invite the specialized agencies to collaborate with it in developing the design for the next generation accrediting agency. The basic objective should be to create a national accrediting organization with inclusive membership and jurisdiction over all types of accreditation.

Such an organization could be structured as follows:

A conference in which each of the affiliated organizations would be represented and have one vote.

A governing board consisting of twenty-one members selected as follows: one designated by the secretary of HEW, one designated by the Education Commission for the States, nineteen elected by the conference for fixed overlapping terms. Of the elected members, no more than nine should represent or be members of affiliated organizations. No affiliated organization should have more than one member on the governing board.

An executive committee of five members, not more than two of whom should be members of affiliated organizations. The committee would be appointed by the governing board.

The governing board would be the policy-making body, and its decisions would not be subject to review and approval by the conference, except for the imposition of dues and assessments on affiliated members. The principal functions of the conference would be to elect the members of the governing board and to serve as a forum for the interchange of information among accrediting agencies.

The organization would be financed from membership dues and a fixed percentage of all accrediting fees. Where no accreditation fee is charged, the assessment could be a fixed percentage of the budget for accreditation. As an alternative, expenses could be pro-rated among the affiliated organizations in accordance with an equitable formula based on size of membership, number of institutions accredited, and ability to pay.

The organization would function as a standard-setting, oversight, and coordinating body and would perform functions comparable to those of the commission recommended in the report prepared by Claude E. Puffer.