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ABSTRACT

Major changes are taking place in restructuring allied medical education, and we must be diligent participants in making these changes because we want quality--not "future schlock." National allied medical subcommittees are busily at work on changes for common courses and career mobility, continuing education, equivalency and proficiency examinations, instructor preparation, Federal and State legislation, research, terminology, fees for accreditation, and institutional and geographic approaches to program accreditation. A Joint Council for the Accreditation of Allied Health Education is proposed, and a new National Accrediting Agency for Clinical Laboratory Sciences has been formed. Studies of allied health education and accreditation are being completed to facilitate improvements in allied health education. Standards are being reviewed, with the objectives of consolidating them for effectiveness and to cut down on the costs in time and money. Surveys visits are being reviewed to study the feasibility of consolidating them, so there will be fewer site visits and more services in consultation and guidance. All of education is changing rapidly toward what we hope will be a learning process in which the student will learn more in less time. (Author)

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ACCREDITATION: THE AMA VIEW

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The American Society of Allied Health Professions is to be commended for sponsoring this Institute in concert with the Division of Allied Health Professions of the Emory University School of Medicine, and it is a privilege to speak with William Selden and Gordon Sweet in this session on accreditation, chaired by Keith Blayney.

My charge is to present the AMA view of accreditation of allied health educational programs. Probably the best way I can do that is to present a factual staff report of what the AMA has done and is doing to be of service to all concerned with education for allied medical professions and services.

Perhaps the most fundamental characteristic of AMA activity in the field is change: growth and development, improvement, evolutionary and revolutionary innovations in education, new and better ways of conducting allied health educational programs. Fortunately, I am able to report to you on many major changes which are taking place to restructure allied medical education, and the part that AMA is playing to participate constructively and productively in these changes.

AMA activities exemplify the AMA view that educational programs must have the necessary quality, including good instruction in clinical work; that about ten major problems cut across occupational lines and merit priority in our work; the base for cooperation in accreditation should be broadened; standards and survey visits should be consolidated to do a better job in accreditation at less cost in time and money to all involved; and there must be a sustained cooperative effort to improve the effectiveness of allied health education.

At the present time, this involves the cooperation of thirty-five organizations, which pay the expenses of their representatives to attend meetings and participate in this work; it involves the activity of a nine-member Advisory Committee on Education for the Allied Health Professions and Services -- a Committee on which Keith Blayney serves; it takes a substantial portion of the time of the AMA Council on Medical Education; and the AMA has twenty full-time staff members in the Department of Allied Medical Professions and Services working for allied health education.

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The time is long gone when medical practice consisted solely of the interactions between a physician and his patient. The maintenance of health and the diagnosis and treatment of disease now require the involvement of many professions. For each physician there are more than a dozen other health workers, and this ratio is increasing steadily. There are more than four million people working in health occupations, making this one of the largest occupational groups in the country.

America has changed -- from a country occupied in producing *things* by agriculture and manufacturing to a country now occupied primarily in producing *services*. The service industries now employ more than 65 per cent of al civilian workers. Almost 90 percent of all new jobs to be created in this decade will be in service industries.[1] Health and education are becoming the two largest occupations in the United States of America. Since World War II, the spectacular growth of higher education and of the allied health occupations are major factors which precipitate the need for restructuring allied medical education.

I would like to comment briefly on six aspects of this restructioning of allied medical education:

1. Future Schlock versus quality in education.

2. Some examples of the major changes taking place in allied medical education.

3. Changes being made in the accreditation machinery and process: the new proposal for a Joint Council and a half-dozen new studies of allied health education and accreditation.

4. Consolidation of standards -- blending *Essentials*, Guidelines, and application forms in a self-analysis.

5. Consolidation of survey visits -- on a college campus or within a hospital, and in a geographic area.

6. Allied health education, 1980 style -- the tomorrow which is already partly here today.

Perhaps I should begin by differentiating between the words medical and health. The words medical and health are not synonymous and should not be used interchangeably. Much more than medical care is needed to assure the state of total physical, mental, and social well-being (not merely the absence of disease) which is so often quoted from a World Health Organization document as a definition of health. Medical care is part of health care; allied medical personnel are part of the total allied health personnel. Physicians,other independent practitioners, and allied medical professionals provide medical services to patients. Allied health occupations can be considered to include a comprehensive range of professions and services, but I propose to refer to those allied

health occupations which work with or under the direction and supervision of physicians in providing services to patients -- the occupations which the Division of Allied Health Manpower called "Medical Allied"[2] and which we in the AMA call "Allied Medical". By the way, the Division of Allied Health Manpower is now in the Bureau of Health Resources Development of the Health Resources Administration.

Program accreditation can be defined somewhat narrowly as setting standards and listing the educational programs which meet or exceed those standards. I would like to limit myself to that definition, although we all realize that the American Medical Association and many other national organizations are working to be helpful to educators and students in a wide spectrum of interests and activities for allied health education.

1. FUTURE SCHLOCK VS. QUALITY

One of the exciting characteristics of education is that it is concerned with the future. In allied medical educations, we are preparing people for employment in the future. In answer to the question "What kind of a future?", each of us would perhaps answer, "Well, one thing I know: it's going to be different!" More than that: the changes are coming along faster all the time.

Popular interest in this accelerating rate of change has made Alvin Toffler's book, *Future Shock*, a best-seller.[3] He provides many examples of the fact that things are changing more and more rapidly all the time. Toffler writes about duration -- the span of time over which a situation occurs -- and he emphasizes the increasing rate of change.

Are the changes improvements, or is change being made for the sake of change? For example, are innovations being made because they help, or because that is how one gets a federal or foundation grant? Is vocational education getting better or is it getting worse? Are educational programs for allied health occupations decreasing in quality? Is clinical education too often cheap labor -- cheap in every sense of the word? Are the poorest of the allied health educational programs preparing graduates who are our future schlock? -- cheap, shoddy goods? None of us want that!

There is only one standard for medical care: each task in patient care services must be done correctly. When you and I are the patient, our care must be right. For example, it is not enough that blood is typed; it must be typed correctly!

Therefore, allied medical education must have the necessary quality. However, we do not want over-education: there is no point to requiring more years of vocational education than needed to develop the necessary proficiency, nor degrees as status symbols. The student must learn what is needed to qualify him or her for the allied medical job.

And that is why all of us are here: to help each other assure that allied health educational programs of the necessary quality are being conducted.

2. CHANGES IN ALLIED MEDICAL EDUCATION

It is a pleasure to report on some examples of the changes being made in allied medical education. The AMA Council on Medical Education has an Advisory Committee on Education for the Allied Health Professions and Services which has subcommittees addressing themselves to some of the major issues in all of allied health education. Each of these subcommittees is staffed by an executive secretary who has accepted the assignment as a professional commitment, which involves ratchet-like progress. I'd like to give some examples of this productive activity.

Common Courses and Career Mobility

Sister Anne Joachim Moore, President of St. Mary's College, a junior college in Minneapolis, is a member of the Advisory Committee and serves as Chairman of a Subcommittee on Common Courses and Career Mobility. John J. Fauser, Ph. Assistant Director of the AMA Department of Allied Medical Professions and Services, is Secretary of the Subcommittee.

The Subcommittee has prepared a selected bibliography of studies, articles, and existing efforts to implement the concepts of core curriculum and career mobility and a "glossary of terms" related to these topics. In 1972, the Council on Medical Education adopted a position statement on common courses and career mobility that had been developed by the Subcommittee. The Subcommittee directs its attention to the following areas of concern:

1. To examine descriptions of programs with shared courses, especially those with well-established objectives and evaluation procedures.
2. To consider the common sharing of initial student clinical experiences as a basis for identifying commonalities in the clinical area.
3. To gather information on successful common courses for distribution to those seeking such help.
4. To share and discuss common profiles of career mobility which have been developed.

In pursuing its goals, the Subcommittee attempts to gain input from the medical profession, hospitals, educational institutions, and the allied health professions.

Continuing Education

H. Robert Cathcart, a member of the Advisory Committee, is Chairman and Warren G. Ball, D.D.S., an Assistant Director of the AMA Department of Allied Medical Professions and Services, is Secretary of the Subcommittee on Continuing Education for the allied health professions.

Because of the need for assuring continued competency, and in view of the rapid pace of technological developments with the allied health professions and services, the need and demand for effective, well-organized programs of continuing education for allied health professions has become increasingly apparent. Although all professional organizations provide opportunities for continuing education of their membership, it is felt that greater emphasis should be placed on an inter-disciplinary approach based on the components of the health care team.

The Subcommittee has defined continuing education as a formalized learning experience designed to expand the knowledge and skills of allied health professionals who have completed preparatory educations. As distinguished from advanced education, continuing education courses tend to be more specific in nature, and of generally shorter duration. The Subcommittee also determined that in-service education is regarded as a program administered by the employer, designed to upgrade the knowledge and skills of employees, essentially related to specific job assignments. The Subcommittee has identified the following sources of continuing education for allied health professionals: professional organizations (medical specialty and allied health), schools of allied health professions, medical schools, voluntary health agencies, regional medical programs, hospitals, and commercial firms.

To determine the current status of continuing education for the allied health professions, a number of surveys are to be conducted. Among these will be surveys of professional organizations and educational institutions, as well as agencies involved in certification and registration. The Subcommittee will also explore the development of appropriate incentive mechanisms similar to the AMA Physician's Recognition Award. Regarding the financial aspects of continuing education, the Subcommittee supports the concept that the continuing education of allied health professionals should be identified with the legitimate costs of patient care. Consideration will be given to the feasibility of development of a comprehensive periodic listing of programs offered by professional organizations and education institutions. However, preliminary discussion has revealed that this function may be more useful and effective as a service of individual professional journals.

Equivalency and Proficiency Examinations

Dr. Len Hughes Andrus is Chairman, and Dr. Gene Beckley is Secretary of a Subcommittee on Equivalency and Proficiency Examinations. The members of the Subcommittee include John R. Proffitt, Director of the Accreditation and Institutional Eligibility Staff of the U.S. Office of Education; Dr. James P. Steele, a member of the U.S. Commissioner of Education's Advisory Committee on Accreditation and Institutional Eligibility; and Dr. Edmund D. Pellegrino who is now Vice-President for Health Affairs of the University of Tennessee.

Since 1960, startling advances have occured in the medical field. Due largely to the introduction and refinement of sophisticated machines, this "new" medical technology created the need for specialized technicians. To retrain qualified employed personnel or to train new personnel there soon was a burgeoning of company, private laboratory, military, hospital, and collegiate sponsored programs. At the same time the junior/community college boom took place. It was not long before they joined hands with the hospital and the laboratory in training and educating allied health personnel in these specialized fields. The result in many allied health fields, was that educational centers shifted partially or entirely from the hospital to the educational institution.

Traditional approaches to education were also challenged in the sixties. Educators became concerned with behavioral goals as opposed to the traditional limited emphasis on course and program content. It was recognized that learning could take place out-side of the classroom and credit was awarded for work experience and similar "outside" activities. The "university without walls," the "open university" and the "free" university came into being. This represented a further broadening of the learning market places. As a result it became rather difficult to speak of a single educational center for an individual; it was more accurate to speak of educational centers attended by individuals in pursuit of career goals within a specialized allied medical field.

Since a student might have paused to learn at several stops along the way to a career, the determination of whether or not the goal had been attained depended on evaluation of the training at each stage or educational center along the path to the goal. Everyone endorsed the concept of providing for career mobility. But questions arose. What credit, if any, woud be given for previous training? How could the previous training be measured? The question of giving credit for the training and the transferability of credits were not the sole concerns during this period. As the number of the programs and their graduates increased, questions also arose in regard to the registration of the graduates. Was the incentive-14-week-military-trained medical lab technician as capable or more capable than the graduate of the two-year community/junior college? Could he or she be registered? How could the clinical laboratory assistant trained in a year or less become a medical lab technician? If so, when, and under what conditions could he or she be permitted to take the registry exams?

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The AMA Council on Medical Education realized that equivalency and proficiency examinations might be an answer to these and similar questions which were, and still are, being asked. However, few such exams had been developed for these new fields. The Council therefore, established a Subcommittee for Equivalency and Proficiency Examinations. Its goal was:

a. To examine the entire field of equivalency and proficiency exams,
b. To determine if such exams could be developed for allied medical areas and, if so;
c. to provide guidelines for the development of the same.

At the present time the Subcommittee is examining the whole area of equivalency and proficiency examinations. When the current national survey is completed, it is hoped that a Task Force composed of members of the Subcommittee, the federal government, the health professions organizations and other groups with expertise in equivalency and proficiency evaluation will work toward determining whether such exams can be developed for the allied medical health areas. If so, it is hoped that guidelines for the development and use of the exams will follow.

Instructor Preparation

Kenneth G. Skaggs, Specialist in Occupational Education for the allied health professions in the American Association of Community and Junior Colleges, is Chairman of a Subcommittee on Instructor Preparation. The Subcommittee members include Jerry A. Johnson, Ed.D., who is President of the American Occupational Therapy Association; and the Secretary of the Subcommittee is Dr. Gene Beckley, who earned his Ph.D. in higher education administration. This Subcommittee is assembling information on instructor preparation, with special attention to the development of faculty for allied health programs. The following policy statement of the Council on Medical Education concerning instruction preparation was adopted in November at Anaheim:

> All current *Essentials* when revised and future *Essentials* shall contain provisions insuring that the faculty in the allied health professions will have adequate and appropriate training in the area of curriculum design and teaching techniques. Institutions shall demonstrate that they have adequate programs to insure proper on-going instruction in curriculum design and teaching techniques.
>
> Any self-analysis used in the accreditation process of allied health programs by an institution should address the question of teach preparation to insure evaluation of teaching effectiveness of allied health instructors.

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Legislation, federal and state

Williams M. Samuels, Executive Director of the American Society of Allied Health Professions, is Chairman of a Subcommittee on Legislation, and I serve as Secretary of the Subcommittee.

The Subcommittee has drafted a proposal for an AMA statement on federal legislation for allied health education. It is in the pipeline to the Advisory Committee and then the Committee on Legislation of the Council on Medical Education, which may choose to transmit it or a revised version of it, to the AMA Council on Legislation. If acceptable, the statement will be provided to the 28 national professional medical specialty and allied health organizations which collaborate with the AMA Council on Medical Education in providing assistance to all concerned with allied medical education. The draft, which is subject to minor or major changes, is as follows:

> In the belief that allied health manpower will play a major role with physicians in providing health care services for the nation, the American Medical Association endorses the provision of federal funding for education of this national resource of allied health manpower.

[NOTE: This first paragraph was adopted by the Council November 30th in Anaheim; the rest of the draft, which follows, is to be submitted to the Advisory Committee and Panel of Consultants and Special Advisors in April.]

> Used broadly, the term allied health manpower covers all the professioanl and technical workers who support, complement or supplement the functions of those who have primary responsibility for health care services.
>
> It is recommended that federal legislation be passed which relates primarily to the broad goal of improving the availability, accessibility acceptability, quality, and financing the comprehensive health services needs of society. Federal legislation for allied health education should address itself to each segment and the role that segment must play to develop a total system of allied health education. Priority should be given to support of the following elements:
>
> A. Institutional support for operating expenses
>
> 1. Basic support of training programs
> 2. Improvements in curricula
>   a. Grants
>   b. Contracts
> 3. Equivalency and proficiency examination
> 4. Evaluation of educational programs

5. Studies
   a. Functions
   b. Needs

B. Student support

1. Scholarships for the educationally disadvantaged
2. Contracts with students
   a. To serve in under-supplied areas
   b. To attract personnel into occupations in short supply
3. Guaranteed loans
4. Funds for retraining and continuing education

C. Construction: renovation and new construction

1. Capital Grants
2. Guaranteed loans

Federal funding for the following activities also are considered to be worthy of support:

Assistance in development of coordination, quality, distribution, planning and allocation of resources;

Research and development in education for better teaching;

Credentialing;

Advanced traineeships.

The Allied Health Professions Training Act (as extended by P.L. 93-45) provides support for various types of activities relating to training in the allied health professions. The act authorizes special improvement grants; special project grants; and traineeships for the training of allied health professions personnel, health services technicians, administrative or supervisory personnel, or persons to serve in allied health professions which require advanced training. The Administration has proposed that the Allied Health Professions Training Act not be renewed. The American Medical Association has previously supported the Allied Health Training Program, and has found no reason to change its position in this regard. We support the allied health education programs as stated in the Allied Health Professions Personnel Training Act, but we see the need for future reviews of individual programs on their respective merits. Accordingly the AMA would encourage the Secretary of Health, Education, and Welfare to arrange for the conduct of studies:

A. To identify the various types of allied health personnel and the activities in which such personnel are engaged and the various training programs currently offered for allied health personnel;

B. To establish classifications of allied health personnel on the basis of their activities, responsibilities, and training;

C. Using appropriate methodologies, to determine the cost of education and training allied health personnel in each classification;

D. To identify the classifications in which there are critical shortages of such personnel and the training programs which should be assisted to meet such shortages.

Military Allied Medical Education

The Surgeons Genral of the three military medical services designated the top administrative officers responsible for the education of military medics to serve as a task force of the Department of Defense, and also to serve on the AMA Subcommittee on Military Allied Medical Education. Captain James. E. Wilson, MC, USN, is Chairman, and I am Secretary of the Subcommittee.

More than ten million Americans receive their medical care from the Army, Navy, and Air Force medical services. Education and training for military allied medical workers demand the same standards as those for the civilian components. The objective of the Department of Defense - AMA Subcommittees on Military Allied Medical Education is to make military and civilian educational programs even more effective.

The Subcommittee recommended the following policies, which have been adopted by the AMA Council on Medical Education:

1. The Council requests all accreditation review bodies involved in allied health education to initate accreditation activities through a single designated contact office in each branch of the services;

2. The Council expressed its willingness to accredit an allied health educational program conducted by a military service, rather than at one specific locations,

3. The Council will refer to the appropriate review committees for their consideration that survey teams and review committees give special attention to the fact that the clinical portions of military allied medical educational programs include unusually extensive formally supervised clinical education experience.

Other goals established by the Subcommittee include development of common terminology, correlation of curricula, transfer of credit, interorganization communications, and qualification of military allied medical personnel for registration and certification in the several allied health areas. One of the major concerns is the transition of the military medic into the civilian health team.

A compilation of the activities and interests of the Subcommittee and other information useful to former corpsmen, professional counselors, potential employers, and other allied health groups including boards of registry is published as a *Compendium of Military Allied Medical Education*.[4]

Research

Dr. Claude H. Organ, Jr., a surgeon and past president of the National Medical Association, is Chairman of a Subcommittee on Research. Mr. Philip O. McCarthy, Research Associate in the AMA Department of Allied Medical Professions and Services, is Secretary of the Subcommittee.

The Subcommittee on Research was appointed to work on the validation of the approval process -- providing an empirical data base for evaluative procedures which are found to be sound and strengthening the approval process through changes. Each step to the process is being studied to assure that the methods used in approve educational programs are, in fact, accomplishing the task they should. Those steps involved are 1) standards for approval, 2) application for approval and program self-study, 3) the on-site visit, and 4) evaluation of the reports.

All of us in education are concerned about evaluation. The Subcommittee on Research is committed to research which determines how to measure the quality of educational programs -- to encourage and cooperate with those who are conducting research which will validate sound questionnaires and meaningful site visits which do in fact evaluate quality in education.

There is another dimension to this work, and I hesitate to suggest that it is less important. It has to do with statistics -- facts with which to think. Professionals should direct the gathering, analysis, and dissemination of data. It is basic, but it is of critical importance. The Research Associate in the AMA Department of Allied Medical Professionals and Services, is our spearpoint -- our point man -- in this work.

Terminology

Dr. Urban H. Eversole of the Lahey Clinic Foundation in Boston is a member of the Advisory Committee and Chairman of the Subcommittee on Terminology. Dr. Eversole is a distinguished member of the AMA House of Delegates, and has a long history of dedicated service for the allied health occupations. Don Lehmkuhl, Ph.D., an Assistant Director of the AMA Department of Allied Medical Professions and Services, is the Secretary of the Subcommittee.

The Subcommittee is interested in the vexing problems of terminology; they are involving appropriate national groups of health educators and clinicians to reach consensus on meanings of key words used in communication about health careers education. Misunderstanding, confusion and ill-will sometimes develop among students, educators and clinicians in various health-related occupations. The source of these undesirable reactions can often be identified as lack of uniformity in terminology applied to the various occupational groups. When a given term has different meanings for different people, communication disintergrates and problems multiply.

A partial solution lies in attempting to reach consensus about what particular terms are going to mean. Though some groups have developed definitions and a glossary of terms to suit their own needs, specific terms often have a different connotation when applied to situations in other but related fields. Cases in point are the terms "therapist," "technician," and "technologist". Terminology is a difficult,

complex subject which cannot be resolved by one group; nor can it be resolved at one meeting of representatives from many groups. Therefore, we must progress toward general acceptance of terminolgy that can be applied to all health occupations. In this way the needs of society, and the needs of each separate organization can be met with a minimum of unnecessary effort being expended to clairfy what is meant, and to undo damage caused by using terms which may induce emotional reactions in another member of the health team. Continued efforts will be made to resolve problems related to standardization of terminology by the Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services, their Panel of Consultants, and the Council on Health Manpower, as well as other appropriate groups involved in this task.

3. Changes in Accreditation Machinery and Process

Organized medicine has a long-standing precedent of asking educators to make independent studies of medical and allied medical education, with special reference to the accreditation of educational programs. Here are three outstanding examples:

Medical Education

It was the Council on Medical Education of the American Medical Association which asked the Carnegie Foundation for the Advancement of Teaching to review medical education. The two-year study was begun in 1908 by Dr. Abraham Flexner of the Carnegie Foundation. On site visits he was accompanied by Dr. N.P. Colwell, then Secretary of the AMA Council on Medical Education. The Flexner Report[5] was well received, with the result that the 160 schools in 1905 were reduced by consolidation and closures to 95 in 1915, and 80 by 1927.

Graduate Medical Education

In the 1960's the American Medical Association again expressed its continuing concern by requesting an external examination of the internship and the residency -- the constituent parts of graduate medical education. Upon recommendation of the Council on Medical Education, the Board of Trustees of the American Medical Association authorized the establishment of a Citizens Commission on Graduate Medical Education, with a majority of the Commission members from outside the field of medicine. The Chairman was John S. Millis, Ph.D., then President of Western Reserve University in Cleveland. In the Preface of the August 1, 1966 report titled *The Graduate Education of Physicians*, Dr. Millis explained that the "The Citizens Commission on Graduate Medical Education has operated as a Committee of the whole and has not employed a staff. Data, opinion, and relevant evidence have been presented to the entire Commission. Thus, the ensuing report represents the conclusions formed by the members. It is not a staff report in which a committee has concurred."[6]

The Millis report as well as reports of previous studies, such as Lowell T. Coggeshall's *Planning for Medical Progress Through Education* for the American Association of Medical Colleges in 1965, were blue-prints for changes in graduate medical education during the years which followed. Notice that it took six or seven years to implement some of the recommendations. One example is the recent formation of the Liaison Committee for Graduate Medical Education.

Allied Medical Education

The American Medical Association, American Society of Allied Health Professions, and National Commission on Accrediting sponsored a Study of Accreditation of Selected Health Educational Programs It was the Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services which prepared the proposal for the SASHEP study and the grant application. The Commonwealth Fund financed this independent study. Arland F. ChristJaner, President of the College Entrance Examination Board and formerly a university president, served as Chairman of the Study Commission, and William K. Selden, retired Executive Director of the National Commission on Accrediting, was employed as the Staff Director. The Assistant Director was Jerry W. Miller, who is now Director of the Commission on Accreditation of Services Experiences, American Council on Education. A majority of the members of the SASHEP Commission were educators. SASHEP published its *Commission Report* in 1972.[7] An AMA-ASAHP-NCA Study Committee on Accreditation held four meetings in 1973 and drafted a proposal for the establishment of a Joint Council for the Accreditation of Allied Health Education for the supervision and accreditation of allied health education.

The functions of this new Joint Council would be:

A. To serve as an official accrediting agency for educational programs in the allied health field.
B. To receive recommendations concerning accreditation of individual programs of allied health education from review committees in the various allied health fields and to take the final action on the accreditation of those programs.
C. To coordinate and encourage the development of improved review and evaluation procedures by the review committees in the various allied health fields.
D. To establish more effective administrative procedures for the conduct of accreditation in allied health education.
E. To develop and recommend, to the sponsoring organizations of the Joint Council, policies and procedures which will improve the process of accreditation in allied health education.
F. To sponsor and cooperate in the conduct of studies and research relating to the evaluation of allied health educational programs, including the validation of accrediting standards and procedures.
G. To provide effective liaison with certifying, registering, and licensing bodies and to sponsor and cooperate in studies concerned with the operations and relationships of accrediting to certification, registration, and licensure.

The Joint Council would operate on the basis of authority delegated by the sponsoring organizations. The Joint Council would have authority to take final action on the accreditation of allied health educational programs upon recommendation from the various joint review committees. This is now being done by the AMA Council on Medical Education in collaboration with 28 medical specialty and allied health organizations. The Joint Council would also take final action on approval of *essentials* of all allied health educational programs, after they have been approved by the AMA Council on Medical Education and the parent bodies of the appropriate joint review committees. This is now being done by the AMA House of Delegates in concert with the 28 collaborating organizations. The Joint Council would develop by-laws to govern its operating procedures, within the limits of policy established by tne sponsoring organizations, and would establish a mechanism for appeal of its accreditation actions.

Major changes in the nature or function of the Joint Council would be subject to approval of the sponsoring organizations, with particular reference to composition; Accreditation procedures; Financing; and Policies governing function. Such major changes, at initial consideration would be approved by all of the sponsoring organizations. After a negative vote by one or more sponsoring organizations, a positive vote by the representatives of a majority of the sponsoring organizations would be required for reconsideration. After the matter has been under reconsideration for at least two years, a three-fourths positive vote of the sponsoring organization would be sufficient to effect the new policy.

The Joint Council would consist initially of three representatives of the American Medical Association; three of the American Hospital Association; three of the American Society of Allied Health Professions; a representative from each of three or perhaps as many as six from the higher education organizations selected as representative of education -- including the American Association of Community and Junior Colleges, American Association of State Colleges and Universities, and the Association of Academic Health Centers; possibly three representatives of the public (selected by representatives of the participating organizations) a representative of the federal government (designated by the Secretary of the Department of Health, Education, and Welfare); and one representative from each of the 27 medical specialty societies and allied health professional societies currently collaborating with the AMA as a consortium for allied health education. That is a total of 41 or more representatives from 34 or more organizations.

With the addition of each new occupation, one representative would be added for each collaborating medical specialty society and each allied health professional society, except that an organization already represented would not be entitled to increase its representation with the addition of new occupations. Each organization would select its representative as it sees fit. The Chairman and Vice Chairman would be elected by the members of the Joint Council and would be from different organizations. The term of office and the manner of election would be determined by the Joint Council.

The expenses of the representatives of the sponsoring organizations would be borne by those organizations; expenses of the public representative would be shared equally by the sponsoring organizations; and expenses of the federal representative would be borne by the federal government. Expenses of the meetings of the Joint Council and its subcommittees, other than the expenses of the organizational representatives, would be shared equally by the sponsoring organizations.

The costs of accreditation in allied health education are currently borne jointly by individual medical specialty societies, individual allied health professional societies, and the American Medical Association with certain survey and review costs defrayed by fees from institutions seeking accreditation of their programs. These same costs would continue to be shared by these organizations for the time being, but the Joint Council would undertake a study of the costs of accreditation of allied health education and make recommendations to the sponsoring organizations concerning their allocation in the future. The following general guidelines would be taken into consideration by the Joint Council:

1. The expenses of meetings of joint review committees should be borne by the parent bodies of the review committees.

2. The costs of site surveys should be defrayed by fees charged to institutions seeking accreditation of their programs.

3. Each sponsoring organization of the Joint Council should pay some fee for representation on the Joint Council.

Staff services of the Joint Council would be provided by the American Medical Association. Staff services for the various joint review committees are currently provided by individual medical specialty societies, individual allied health professional societies, and the AMA. These same staff services would continue to be provided by those organizations. Central administration and coordination of the accreditation activities are currently carried out primarily by AMA staff. AMA would continue to provide these services.

The proposal for the Joint Council for the Accreditation of Allied Health Education has been approved by the AMA House of Delegates. The National Commission on Accrediting has expressed strong support for the proposal, but the five institutional member organizations of the NCA also propose three public representatives selected by the entire Board of the Joint Council that the federal representative by a non-voting member of the Joint Council, and that instead of the NCA naming three representatives the following six organizations each designate one representative:

American Association of Community and Junior Colleges
American Association of State Colleges and Universities
Association of Academic Health Centers
Association of American Colleges
Association of American Universities
National Association of State Universities and Land-Grant Colleges

At the November 20th meeting of the American Society of Allied Health Professions in Boston, the ASAHP Board of Direcors voted that : "The Board of Directors accepts the proposed concept for the establishment of a Joint Council for the Accreditation of Allied Health Education with instructions to the negotiating team that the four points of concern (Purpose, Authority, Composition, and Staffing) are points to strive for in further negotiations with the American Medical Association and the National Commission on Accrediting."

National Accrediting Agency for Clinical Laboratory Sciences

A related development is the restructuring of the joint review committee for allied health occupations in clinical laboratories. ~~On October 22nd in Chicago, representatives of the American Society~~ for Medical Technology and the American Society of Clinical Pathologists signed incorporation papers creating the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS). The new agency replaces the ASCP Board of Schools, which has served the profession for twenty-five years. The new Agency will be composed of a review board, committees, and staff. The board will be composed of fourteen members with the following representation: three members will be medical technologists-educators who are Medical Technology; three members will be clinical pathologist educators who are fellows of, and selected by, the American Society of Clinical Pathologists; two will be supportive level practitioners selected by the appropriate sponsoring or participating organizations; and the remaining members to be selected by the board will be a general supervisory technologist, a clinical laboratory director, two educators (one of whom is employed in a less-than-four-year-program, and one in a four year program, and neither of whom is an MT or an MD), and two public representatives whose primary livelihood is not derived from the health industry or in any way directly related to the institutions or programs being accredited.

Studies of Allied Health Education and Accreditation

Of course the SASHEP study was not the only study being conducted of allied health accreditation; there are others. Here are a few current examples:

1.) The American Vocational Association has been conducting a National Study for Accreditation of Vocational/Technical Education. Lane C. Ash, Project Director, and Assistant Director Helen Kempter and Research Assistant Margaret McNeil have published a report titled *Instruments and Procedures for the Evaluation of Vocational/Technical Education, Institution, and Programs* as an activity of this continuing study, and Mr. Ash in now field-testing the red book in Maine, West Virginia, and Oklahoma. Mr. ASh is currently working part time on the Study.

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2.) The Newman Commission has included in its purview the accreditation of educational programs for the health occupations. "The Credentials Monopoly", Chapter 9 of the *Report on Higher Education*, reports that "Employers act against their own self-interest by continuing to raise the educational standards for the jobs they have to fill." The Newman task force reports that "The enormous value of a liberal education has little to do with getting a credential." In the section on "Lowering the Credentials Barrier", the Newman group writes to "break the credentials monopoly [of colleges and universities] by opening up alternative routes to obtaining credentials" and concludes: "New paths to certification are needed." The final chapter includes a section on "Revision of the Role of Accrediting Organizations"; they conclude: "We believe that the composition of established accrediting organization should be changed to include representatives of the public interest....[8]

3.) The U. S. Office of Education has employed two consultants Doctors A. D. Albright and Samuel P. Martin -- to participate in a study of activities for accreditation of educational programs for the 24 allied medical occupations currently of special concern to the AMA Council on Medical Education. The U. S. Commissioner of Education's Advisory Committee and the Office of Education's Accreditation and Institutional Eligibility Staff are giving priority to their review of revised applications for recognition of the AMA Council on Medical Education and the 28 collaborating organizations to accredit educational programs for these 24 allied medical occupations.

4.) Dr. Harold Orlans of the Brookings Institution and the National Academy of Public Administration Foundation are conducting a 13-month study funded by a $142,000 contract with the U. S. Office of Education to evaluate the worth of federal reliance on private accrediting agencies to determine eligibility for federal financial aid program for higher education. The study group is assessing the extent to which the government's use of private, voluntary agencies serves the public interest and what changes may be warranted in establishing federal eligibility requirements. Federal money is still flowing into allied health schools, and the protection of public fund is involved. The final report will be issued jointly by Brookings and the Academy.

5.) HEW'S Division of Allied Health Manpower has awarded a 14-month, $219,808 contract to the consulting firm of Booz·Allen, and Hamilton to finance a study of the most common problems impeding effective clinical training in the allied health professions and to make recommendations to overcome them. A 13-member task force of experts in the health and education fields is assisting the consulting firm. The Booz·Allen Public Adminstration Services is concluding this "National Assesment of Clinical Training for the Allied Health Professions" now, and we are awaiting the report of their study of clinical training.

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6.) J. Warren Perry, Ph.D., dean of the School of Health Related Professions at the State U. of New York at Buffalo, is on a nine-month leave of absence to direct the national Study of Allied Health Education (SAHE) for the American Association of Community and Junior Colleges. Mr. Kenneth G. Skaggs, Staff Specialist of the American Association of Community and Junior Colleges, is Associate Director of SAHE. Dr. Mary Hawthorne, formerly on the Staff of the University of the Health Sciences, U.S. Air Force, Sheppard Air Force Base, Texas, is the new Assistant Director. The Robert Wood Johnson Foundation has provided a one-year grant of $185,000 to support this planning phase of the study. The aim of the program is to gather and disseminate information that will help community and junior colleges in strengthening their roles in professional education for ambulatory and primary health care practice. Among the areas to be covered in the AACJC study will be the need, distribution and functions of physician support programs, and identification of the variety of support programs appropriate for community and junior college implementation.

The Study is intended to identify some of the major problems in allied health education today, various methods of approaching these problems, and the obstacles to be considered before any such progress can be made. Three major sources of information for the study are being developed:

1) a national advisory committee;
2) a series of seven regional meetings to discuss allied health problems with people who are working in the field;
3) a special group of consultants consisting of representatives from professional agencies and organizations.

The National Advisory Committee will direct its attention to the following areas of concern:

1) Improvement of procedures in recruiting, counseling, and placement of students in allied health professional and technical work.
2) Assessment of multiple avenues of teacher preparation for allied health instructors.
3) Costs of allied health educational programs, including the areas of administration and management.
4) Need for improvement of curriculum and assesment of allied health instructional techniques, including study of new educational media.
5) Development of more effective clinical education programs, and the formulation of innovative approaches to clinical training for allied health.
6) Collection and dissemmination of information, including the need for better articulation between and among all levels of allied health educational programs.

The SAHE planning report is expected to be completed by next spring.

4. Consolidation of Standards

To assure that allied medical education programs establish and maintain at least the minimal standards needed for students to learn what they need to know and be able to do on the job, three kinds of documents are provided:

1. *Essentials* -- *Essentials* are policy documents. These are the standards for an educational program. The proper auxiliary verbs to be used in wording are: shall and must. Shall is used in laws, regulation or directives to express what is mandatory. Must is an imperative need or duty; a requirement; an indispensable item. *Essentials* are adopted by accrediting agencies and serve as the legal basis for regulating the quality of educational programs. Any requirement to which a program is being held accountable must be included in the *Essentials*.

2. *Guidelines* -- Guidelines are the explanatory material for the *Essentials*. They give examples of how *Essentials* may be interpreted to allow for flexibility, yet remain with the framework of the *Essentials*. The proper auxiliary verbs to be used in the wording of Guidelines are: should, may, and could. It is permissible to have shall and must in the Guidelines if it is reiteration of an *Essential*. Should is used to express ethical obligation or propriety. May expresses freedom or liberty to follow a suggested alternative. Could is used to suggest another alternative for meeting the intent. Guidelines are not adopted by accrediting agencies but are developed to assist in the interpretation of the *Essentials*. The Guidelines should be reviewed by a unit of the accrediting agencies other than the one responsible for directly enforcing the *Essentials* to ensure that they explain the existing *Essentials* rather than state new ones.

Suggested Format -- *Essentials* and Guidelines may be prepared in separate documents or if written together, the *Essentials* should be in bold type followed by the Guidelines in lighter type.

3. *Application forms* --Questionnaires, usually quite detailed serve as the basis for compiling pre-survey documentation for study and reference by the survey team before and during the site visit. The completed questionnaires and the accompanying documentation usually seem to fill a three-inch ring binder.

Obviously some articulation and coordination is needed. We have asked Philip O. McCarthy, Research Associate in the AMA Department of Allied Medical Professions and Services, to study the feasibility of blending these three documents into one consolidated set of standards which will become the basis for maximum benefits to all involved but with the mimimum necessary expenditures of time and money.

What we have in mind is proposing to the collaborating organizations and the review committees they sponsor that all of us work with directors of AMA approved education programs to assimilate the *Essentials*, the Guidelines, and the pre-survey application form into one consolidated package. Eliminating duplication and eliminating questions and requests for information which have nothing to do with the evaluation of quality can result in a shorter self-analysis.

We are asking the review committee to consider the practicability of developing an approval process something like this:

A. *Self-Analysis* - An educational institution interested in developing an educational program, or interested in having an existing educational program accredited by the AMA and the collaborating organizations, would write to the AMA Council on Medical Education.

1. The AMA Department of Allied Medical Professions and Services would respond by sending the standards and questionnaire on educational programs for the particular allied medical occupation

2. A new Self-Analysis Outline would consist of revised *Essentials* as major headings, the Guidelines as subheadings, and the questionnaire as a check list to make sure that all the necessary factors are considered and answers are included in the documentation. Obviously, the *Essentials* would be revised to eliminate all requirements of hours, credits and years, and the revised *Essentials* would include performance standards to the extent that this is feasible. Similarly the Guidelines and questionnaires would be completely reworked into the new format.

3. The institution would use the outline as a kind of check-list in the conduct of the self-analysis. This recognizes the fact that the college or university or hospital is, of course, the first to evaluate the need for an educational program and the quality of that educational program.

4 One outcome of this self-analysis would be that the data is distilled into a succinct factual narrative report. This would serve as the first draft for the final report concerning accreditation.

5. If the chief administrative officer of the institution decides they are ready, he could formally request accreditation for the educational program.

B. *Audit* - The institution requesting accreditation would send its self-analysis documentation to the AMA Department of Allied Medical Professions, which would transmit copies to the appropriate review committee.

1) The review committee would review the self-analysis documentation, and if it is apparent that the educational program is ready, a survey team would be appointed and a date set for a site visit.

2) In business and banking, an independent auditor comes in to audit the books kept by the business. Similarly the survey team would come in to make a site visit to audit the factual information in the institution's narrative report. Of course, the survey team would be likely to observe additional facts and add them to the report. Obviously the main function of the survey team would be to evaluate the quality of the educational program; so the survey team would add its observations, suggestions, and recommendations throughout the report -- identifying them as the additions of the survey team. At the end of the visit, the survey team would make the usual oral report of its suggestions and recommendations to the chief administrative officer of the institution and the director of the educational program.

3) The written report -- now consisting of the original factual narrative written by the institution's staff, plus the information, observations, suggestions and recommendations added by the survey team -- would be checked by the chief administrative officer for factual accuracy and then submitted to the review committee.

C. *Review* - The review committee would follow the usual procedure used now:[9]

1) The members of the review committee are mailed a copy of the report for their study.

2) At the next regular meeting of the review committee, one or two members of the review committee and perhaps of the survey team present the report.

3) The review committee agrees upon a recommendation concerning accreditation and transmits it to the AMA Council on Medical Education (or, if and when the new Joint Council is organized, the recommendation would go to the new Joint Council for the Accreditation of Allied Health Education).

D. *Accreditation* -

1) The recommendation from the review committee is received by the Council on Medical Education's Advisory Committee on Education for the Allied Health Profession and Services. which consolidates review committee recommendations and transmits them to the Council on Medical Education.

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2) The Council on Medical Education acts on these recommendations. It is the Council on Medical Education which now accredits 2700 educational programs for 24 allied medical occupations.

3) The letter of notification of Council action is sent to in institution by the Secretary of the Advisory Committee on Education for the Allied Health Professions and Services.

5. Consolidation of Survey Visits

Hospitals as well as college and university administrators are disturbed by the many separate site visits to accredit various educational programs. So are we, on the staff of the AMA: it is disturbing to visit one educational program at an institution and not spend some time with the people involved in other AMA - accredited educational programs in the same institution.

Furthermore, it is expensive to send a survey team into a city to look at one educational program, but not visit the other educational programs for the same occupation in the same community. Not only is it expensive to make repeated visits, but we do not realize the full potential of exploring relationships between programs.

In short, we have a problem; and we are determined to do something about it.

1.*Fees* - First, we want some information and action on the financial costs of accreditation, The Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services has a Subcommittee on Fees for Accreditation Services. The Chairman is Dr. Frank G. Dickey, Executive Director of the National Commission on Accrediting. The members include Kenneth S. Jamron, who represents the American Hospital Association on the Panel of Consultants and Dr. A. Nichols Taylor, consultant from the Association for Academic Health Centers. The executive secretary of the Subcommittee is Mr. L. M. Detmer, an Assistant Director of the AMA Department of Allied Medical Professions and Services.

This Subcommittee is gathering facts about fees, and financial audits of the budgets and expenditures of review committees.

2.*Institutional and Geographic Approach* - Second, we have at work an active Subcommittee on Institutional Approach to Program Evaluation. The Chairman is Dr. J. Rhodes Haverty, Dean of the School of Allied Health Sciences at the University of Georgia. Mr. John R. Proffitt, Director of the Institutional Eligibility and Accreditation Staff of the U. S. Office of Education, is a member. The executive secretary of the Subcommittee is Dr. Warren G. Ball, an Assistant Director of the AMA Department of Allied Medical Professions and Services.

Among the alternative mechanisms currently under consideration by the Subcommittee are the following:

1. *Participation in institutional surveys conducted under the auspices of the regional accrediting body.*
   This would involve an expanded survey team including at least one and possibly two representatives of each of the professional program areas subject to evaluation. There would be no additional direct expense to the educational institution, beyond the normal fees of the regional agency. Individual program evaluation reports would be forwarded to the regional accrediting body for inclusion in its institutional survey reports, as well as to each of the appropriate review bodies, for consideration and preparation of recommendations to the AMA. It is understood that institutional accreditation would not be contingent upon individual program approach and that each program would be evaluated on the basis of its own merit. Survey schedules would be largely dependent upon those of the regional agency.

2. *Institutional survey of allied health professional programs, with regional accrediting agency representation.*
   This alternative involves no attempt to schedule site visit evaluations concurrently with those of the regional association. However, a representative of that organization would be invited to participate actively. Invitations could also be extended to other accrediting agencies within the health professions (i.e., American Dental Association, American Dietetic Association, AOTA, APTA,) to schedule simultaneous program evaluations. Evaluation reports would be submitted to both the regional accrediting body and to appropriate review bodies for consideration and, again, individual program approval would not be contingent upon approval of other programs conducted by the educational institution.

3. *Multi-disciplinary survey of institutions with three or more programs within AMA accreditation purview.*
   This alternative is thought to be appropriate for hospital based programs as well as those of educational institutions offering a small number of allied health professional programs. It involves only an effort to coordinate the schedules of various review bodies in arrangements for concurrent program evaluation with minimal inter-disciplinary involvement. It is not anticipated that regional accrediting body participation would be indicated.

One indication of how seriously we take these two Subcommittees and the work they are doing is the fact that when representatives of 36 organizations met this year as a consortium for allied medical education they devoted a major plenary session to the subject of fees at the spring meeting and to the subject of consolidated survey visits at the fall meeting.

Many other organizations involved in programs accreditation are equally concerned:

FRACHE - NCA - CRSAA Conference

October 2-3 in Arlington, Virginia, 56 chief staff officers from 41 organizations involved with accreditation met in a conference co-sponsored by the Federation of Regional Accrediting Commissions of Higher Education, the National Commission on Accrediting, and the newly formed Council of Recognized Specialized Accrediting Agencies. This conference on evaluation procedures was concerned with complaints about duplication of reports, numerous evaluation visits and unnecessary diversion of institutions of high education from other institutional interests.

The conference discussed data-gathering: the regional accrediting commissions and program accrediting agencies require some form of annual data from the institutions, and multiple requests might be an unnecessary imposition. Perhaps similar generic data can and should be shared. The coordination of joint evaluation visits must begin with the institutions, not the agencies; and the institutions can facilitate this by centralizing accrediting activities through one campus official or office. Coordination at the self-analysis phase of accrediting might do much to limit the size of survey teams. Conference participants seemed to agree on a five year cycle for re-survey, or at most ten years.

All sides of all these and other questions concerning the consolidation of accreditation activities were discussed at the conference, and it became obvious that there were good reasons to act but also to postpone action on all these subjects. Nevertheless, the conferees agreed to these activities to be carried forward by NCA, FRACHE, and CRSAA:

1. Notify all institutions of the results of this conference and emphasize the efforts being made at the national level to help institutions achieve the degree of coordination of accrediting activities which they desire.

2. Make available to each of the specialized agencies through FRACHE on-site visit schedules of the regional accrediting commissions as a preliminary step to further study of a more common visiting cycle by all the specialized agencies.

3. See to it that copies of all correspondence concerning accrediting of programs by the specialized agencies go to the chief administrative officer of the institution, in addition to the primary contact person (usually the dean or department head of the special program).

4. Appoint through the auspices of the three national groups a representative task force to plan and seek outside funding for an indepth study of the nature and purposes of the self-study and other techniques of preparation required of the institutions before an evaluation visit. This study effort would try to determine whether a consistent approach to such preparation is feasible and could be achieved. All data now required of institutions between visits would be examined to determine whether one such annual report might satisfy the needs of all the agencies.

5. Send through NCA to each of the conference participants a copy of the current HEGIS reporting form.

6. Continue this type of conference once or twice a year with advance preparation of papers which discuss specific aspects of voluntary, nongovernmental accreditation of post-secondary education.

6. ALLIED HEALTH EDUCATION, 1980 STYLE

Restructuring allied health education is being done by many other organizations and influences as well as the medical and allied health organizations I have mentioned. Earlier I referred to Alvin Toffler's best-selling book, *Future Shock*.[3]

Toffler disagrees with the writers who predict a future of uniformity; Toffler reminds us that one of the characteristics of the technology of mass production is diversity. He says our super-industrialized society is producing the greatest variety of unstandardized goods and services, with diversity costing no more than uniformity. He describes the bewildering choices and the problem of "over-choice": for examples, a supermarket with thirty-five kinds of honey and the options offered by automobile manufacturers.

This diversity is becoming characteristic of education. It is not generally realized that the medical school has been made into a kind of supermarket. Allied medical education is moving swiftly toward diversity. Maximum individual choice is the democratic ideal. My guess is that no two allied health students of the future will move along the same educational track. I might add that AMA approval of educational programs by the Council on Medical Education and the twenty-eight collaborating organizations encourages innovation and experimentation by providing the security of understanding, cooperation, and support.

Computers are scheduling more flexibly, with wider ranges of course offerings and more varied clinical educational experiences. The multi-campus university has become routine, and campuses are being decentralized to facilitate clinical work with ambulatory as well as hospitalized patients and to facilitate independent study. The classroom and laboratory are in part decentralized to the individual study carrel in the library or the multi-media audio-visual study center and even the student's own room in the dormitory or at home. Just as students formerly borrowed books they now borrow hard-copy readouts from computerized information retrieval systems; students borrow sound and video tapes and material from the language and learning laboratory; students use single-purpose multi-media instructional units. Study can continue at any hour, and any day of the week. The whole point is to help each student to advance at his own personal pace.

The educated man will be the one who has learned how to learn. The AMA Council on Medical Education is concerned primarily with the quality of that education for an allied medical occupation. The educational program can be based in public or private schools,

colleges, and universities; vocational and technical institutes; schools run by corporations or the military services; or at home.

Since change has become our way of like, how can we protect ourselves against the shock of change? By seeking advance information about what lies ahead, and making a habit of anticipation. Education must look to the future, rather than perpetuate the past. We must teach for tomorrow. Students must learn to anticipate the increasing rate of change and the directions of change.

How can students make selections when there are so many choices? Do we impose the values of our past, or try to anticipate the values of the future in which the students will work? Part of the job of the teacher and the learner is to systematically organize formal and informal activities which help to identify, define,and evaluate our values. We must be sure to teach what will be needed on the job. We must help the student to learn to consider alternatives and select from the increasing ranges of choices. We must identify what it is we want in our occupational life, and make choices which occupy us in meaningful, productive services for patients. This contributes to the mental health of the student, the allied health professional, and the patient.

* * * *** *** ***

Sometimes we seem to enjoy frustration. We alomst like to think that nothing is happening, that change is too difficult and too slow, and that the Establishment won't allow change.

I have tried to show that exactly the opposite is true. Major changes are taking place right now in restructuring allied medical education:

1. We must be diligent participants in making these changes because we want quality -- not future schlock!

2. National allied medical subcommittees are busily at work and welcome your involvement and participation in changes for common courses and career mobility, continuing education, equivalency and proficiency examinations, instructor preparation, federal and state legislation, research, terminology, fees for accreditation, and institutional and geographic approaches to program accreditation.

3. A Joint Council for the Accreditation of Allied Health Education is proposed, the ASCP Board of Schools is now replaced by a new National Accrediting Agency for Clinical Laboratory Sciences, and a half-dozen studies of allied health education and accreditation are in process or being completed to facilitate improvements in allied health education.

4. Standards are being reviewed, with the objectives of consolidating them for effectiveness and to cut down on the costs in time and money.

5. Survey visits are being reviewed to study the feasibility of consolidating them, so there will be fewer site visits and more services in consultation and guidance.

6. And all of education is changing rapidly to what we hope will be a learning process in which the student will learn more in less time.

This is no time for pessimism. This is a time for realistic optimists to participate in restructuring allied medical education.

State and local medical associations, and the American Medical Association are helping with this. Medicine is organized in a federation, so that physicians can be more effective in working for the art and science of medicine. That includes education -- not only for physicians, but also for the other members of the medical care team.

The AMA Baord of Trustees stated that:

> "Every allied health occupation owes its existence to the need for some patient service. And where the care of the patient is concerned, the physician has a legal, a moral, and an ethical responsibility which he cannot avoid. Allied health workers share the responsibility but only the physician has the responsibility which extends over the complete range of patient services. As the major professional association for practicing physicians, AMA feels keenly its responsibility to all physicians to provide coordination and direction to allied health education, in order that appropriate standards for patient services may be established and maintained... There is great interest today in the development of inter-disciplinary educational programs in which the physician and various allied health workers will learn together the health team approach to the care of patients. This would appear to call for increasing cooperation between medicine and allied health disciplines in the maintenance of education standards."

I can only add that the other half of that action is now the increasing cooperation between the organizations representing education and those which represent medicine and allied health professions. There is much to be done, and we can do it if we work together.

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