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ABSTRACT

This publication contains a second set of working papers concerned with procedures of the accrediting agencies in the health fields, the accountability and social responsibility of accreditation, and the relationship of accreditation to certification, licensure, and registration. Texts of these papers are included: (1) "Dilemmas of Accreditation of Health Educational Programs" by W.K. Selden, (2) "An Approach to Accreditation of Allied Health Education" by J.W. Miller, (3) "The Relationship of Accreditation to Voluntary Certification and State Licensure" by K.L. Grimm, and (4) "The Law's View of Professional Power: Courts and the Health Professional Associations" by W.A. Kaplin. The first set of papers is available as VT 016 554 in this issue. (SB)

PART II — STAFF 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 II is concerned with some of the major dilemmas in accreditation, an approach and some of the practices to be pursued in accreditation, and its relationship to voluntary certification and state licensure. In addition, a paper prepared by a consultant to SASHEP is included and is concerned with issues related to the courts and the health professional associations.

Part I of the working papers was completed and published in October 1971. It contained papers concerned with structure, finance, research, and expansion, as they relate to the accreditation of health educational programs. A paper prepared by a consultant to SASHEP was also included in Part I and was concerned with alternate structures and responsibilities for a national body to supervise and coordinate all accreditation.

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Director

February 1972

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Study of Accreditation of Selected Health Educational Programs

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PART II: STAFF WORKING PAPERS

ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

February 1972 $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.

DILEMMAS OF ACCREDITATION OF HEALTH EDUCATIONAL PROGRAMS

William K. Selden

The health professions, the hospitals, and all of postsecondary education are confronted with a series of dilemmas concerning accreditation. Aware of this fact, the Advisory Committee on Education for the Allied Health Professions and Services of the American Medical Association took the initiative in proposing a study of accreditation and was assisted by its Panel of Consultants in developing the proposal for the study.

From this initial proposal evolved the Study of Accreditation of Selected Health Educational Programs, familiarly known as *SASHEP*. Sponsored by the Council on Medical Education of the American Medical Association, the Association of Schools of Allied Health Professions, and the National Commission on Accrediting, the study has been financed by a grant from the Commonwealth Fund. From its inception, SASHEP has been conducted on a principle similar to one followed in the practice of medicine, namely, that a physician should not diagnose his own physical condition and should definitely never attempt to perform surgery on himself.

On the basis of the explorations and analyses conducted by SASHEP to date, it is apparent that some form of surgery in accreditation may be necessary, and such surgery may affect many of the health professions that are engaged either directly or collaboratively in the process of accreditation. What surgery and what treatment may be required can be prescribed more adequately after the dilemmas of accreditation have been identified. It is the identification of the major dilemmas that is the purpose of this staff working paper.

Dilemma 1: Should There be Accreditation?

One does not now often hear it said that accreditation should be abandoned, but from time to time in the past, including the recent past, various widely respected individuals protested loudly that accreditation had long passed its place of usefulness, if it ever did fill such a place. Of these protesters, Henry M. Wriston, former president of Lawrence College, Brown University, The American Assembly, as well as the North Central Association of Colleges and Secondary Schools and the Association of American Universities, was one of the most articulate. His condemnation included such statements as: "The accreditation process inevitably is driven to judgments which are essentially superficial, transient in their validity, and a drain upon time, energy, and resources that ought to be put into the real obligations of the college or university."[1] On other occasions, he was even more explicit in his ridicule of accreditation, an activity that he stated "should drop dead."

These and other castigations made by former presidents of such institutions as Harvard, Princeton, Wesleyan, and Yale raised doubts about the values of accreditation in the minds of many educators and foundation officials. However, these skeptics never were able to propose an adequate alternative or substitute for accreditation other than that of open academic competition based on the politico-economic philosophies of laissez faire and caveat emptor, philosophies that are largely discredited for contemporary society.

As this author has previously noted, the development of accreditation, with all its weaknesses and strengths, is a unique product of the historical growth and social traditions of the United States.

> Although our educational heritage derives from Great Britain and Europe, we developed a method of controlling standards in higher education peculiar to this country as a result of a combination of forces which are of much historical significance. Founded as a Protestant country with many denominations jealous of each other, this nation adopted the principle that church and state should be separated. As time passed and most of the denominations assumed responsibility for founding colleges and supporting higher education [as well as hospitals], none would tolerate interference by the state in the operation of its educational institutions. In accordance with this political philosophy, the Constitution made no provision for a ministry of education; and by adoption of the Tenth Amendment in 1791, authority for education was delegated to the several states.
>
> The passage of the land-grant college act, the introduction of the elective principle, the conversion of undergraduate colleges into universities by the addition of graduate and professional education and research activities, the steady increase in the number of students and in different types of institutions offering postsecondary school education—all these factors required that some method of establishing and maintaining standards be devised. The spirit of the times would not have permitted government to assume this responsibility even had government been prepared to do so. Necessity forced the institutions, on the one hand, and the professions, on the other, to protect themselves and satisfy their individual needs. The result is our hodgepodge of accreditation.[2]

Even though accreditation is a hodgepodge—and this fact is the main reason for the conduct of SASHEP—it is generally accepted that educational institutions and programs of study require some type of external monitoring. No longer is it a question whether such monitoring shall take place. The questions are: What form of monitoring is appropriate for different types of institutions and specific programs of study? How shall the monitoring be conducted?

Who should ultimately be responsible for such monitoring? How will it be financed? Accreditation is not the only method of external monitoring, but it is one of the most important and influential.

For the purposes of this paper, it seems unnecessary to belabor, beyond mere identification of the issue, the question of maintaining some form of external control of educational standards. Attention can more profitably be called to the dilemmas over the controls exercised through accreditation.

Dilemma 2: The Functions of Accreditation

To many in health-related occupations, the most contentious issue in accreditation is the question of control. But more fundamental to this very important issue of control is the question, What functions should accreditation be expected to serve?

The Accreditation and Institutional Eligibility Staff of the U.S. Office of Education lists nine functions of accreditation.[3] These are:

1. certifying that an institution [or program of study] has met established standards;
2. assisting prospective students in identifying acceptable institutions;
3. assisting institutions in determining the acceptability of transfer credit;
4. helping to identify institutions and programs for investment of public and private funds;
5. protecting an institution against harmful internal and external pressures;
6. creating goals for self-improvement of weaker programs and stimulating a general raising of standards among educational institutions;
7. involving the faculty and staff comprehensively in institutional evaluation and planning;
8. establishing criteria for professional certification, licensure, and for upgrading courses offering such preparation; and
9. providing one basis for determining eligibility for federal assistance.

As has already been indicated in this paper and in the brief historical introduction contained in part I of the SASHEP staff working papers, accreditation was devised in the United States as a means by which educational institutions could conduct a form of self-regulation in the absence of formal governmental restraints or directions. In a similar manner, accreditation of programs of study was initiated by the profession of medicine in order to control the proliferation of inadequate schools and to force an upgrading in the preparation of medical practitioners at a time when licensure, a function of the civil governments, was being inadequately developed and unevenly enforced by the several states.

With this brief explanation, one can appreciate that the function of *certifying that an institution or program of study has met established standards* (function 1) was the primary purpose for which accreditation was devised and conducted. In the case of institutional accreditation, as conducted by the six regional associations of colleges and schools, the motivating forces were the need for more adequate means of articulation between secondary schools and colleges and the desire on the part of the self-selected better institutions to protect themselves from competition of inadequate and shoddy, and in some cases unethical, institutions.

From this function of certifying that an institution or program of study has met established standards, it was inevitable that other correlative functions would be developed; namely, *assisting prospective students in identifying acceptable institutions* (function 2) and *assisting institutions in determining the acceptability of transfer credit* (function 3). These three functions did provide some protection for the public, but they were initiated primarily for the benefit of those institutions that had attained or would attain the status of accreditation. These functions did not impinge upon or intrude more than a marginal extent into the domain of the public welfare, even as it was expanded in later years. They were considered solely the concern of educators and members of the professions, especially since only a small percentage of the population was enrolled in collegiate or professional education during these early years of accreditation and vocational advancement was dependent only in a small measure on formal education.

Additional functions of accreditation were later initiated as a result of the extensive study conducted by the North Central Association of Colleges and Secondary Schools forty years ago.[4] The function of *creating goals for self-improvement of weaker programs and stimulating a general raising of standards among educational institutions* (function 6) was first initiated by the Middle States Association of Colleges and Secondary Schools in the late 1940s. To assure the effectiveness of this function, another or companion function was fashioned, that of *involving the faculty and staff comprehensively in institutional evaluation and planning* (function 7). Again, these functions provided only indirect benefits to the public. They were initiated primarily for the benefit of the institutions and their programs of study; that is, the institutions that were already accredited members or were prospective members of the association.

The last of the functions that were generated primarily by the accrediting agencies and their members, partially in response to developing needs, is the *protection of institutions against harmful internal and external pressures* (function 5). For example, on various occasions when institutions have been threatened by political interference or have actually suffered such undue intrusions, accrediting associations have either indicated the possibility of disaccreditation of the institution or actually carried out such disaccreditation as a warning to the politicians to discontinue such practices. Various examples

could be mentioned, but one special case should be cited. The right of an accrediting association to take such action was upheld by the U.S. Circuit Court of Appeals when the North Central Association in 1938 dropped from its membership the North Dakota Agricultural College after the State Board of Administration had removed the president and seven senior staff members with no stated cause and no hearing.[5]

By pursuing this function of protecting institutions and programs of study against harmful internal and external pressures, accrediting agencies are serving as a countervailing force in a society whose political philosophy is based on the principle of a balance of forces. This philosophy, espoused by Montesquieu, underlies our form of government, which is based upon a division of responsibility among three equal branches and upon our federalism of national, state, and local governments. An extension of this philosophy has endowed various nongovernmental organizations, such as accrediting agencies, with the power, not the authority, to influence public opinion and the decisions of government officials.

The remaining three functions listed by the U.S. Office of Education are not self-generated, but are superimposed and are based on decisions reached by authorities outside the accrediting associations. However, the agencies and their members frequently are directly affected by these decisions. An example is the dramatic and massive distribution of capital funds made in the early 1950s by the Ford Foundation to all regionally accredited colleges and universities for faculty salaries. One might say that, in this decision-making process, the accrediting associations were helping to *identify institutions and programs of study for investment of public or private funds* (function 4), though this help was unwittingly provided. In such cases, the authorities responsible for the distribution of public or private funds merely make use of, or rely on, the lists of accredited institutions prepared by accrediting agencies. This function has provided an extra stimulus for institutions to seek accreditation, but it has not apparently caused undue influence on the part of the accrediting agencies themselves.

The same observation cannot be made with respect to the function of *providing one basis for determining eligibility for federal assistance* (function 9). The imposition of this function on the accrediting agencies and its stimulative effect on the importance and visibility of the accrediting process are now forcing a reevaluation of accreditation, the need for which reevaluation has only recently and belatedly been recognized.

The Veterans' Readjustment Act of 1952 (P.L. 550) can be identified as the point of departure. Section 253 of this act charges the U.S. commissioner of education with the responsibility to publish "a list of nationally recognized accrediting agencies and associations which he determines to be reliable authority as to the quality of training offered by an educational institution."

In an early draft of the bill, the administrator of the Veterans' Administration was designated as the official to be charged with this responsibility later

assigned in legislation to the commissioner of education. This initially proposed designation was altered after testimony urging a greater role for the Office of Education had been presented before the House Committee on Veterans' Affairs. Illustrative of this point of view is the testimony of Lewis Webster Jones, then president of Rutgers University, who was serving as a witness for the Association of Land-Grant Colleges and Universities.

> The Association of Land-Grant Colleges and Universities wishes the record to note that we have considerable interest in the suggestion of the United States Commissioner of Education that his office play at least some part in the veterans' education program. . . . we have had several decades of experience in dealing with the United States Office of Education and we believe this agency could be most helpful to the Veterans' Administration and to the States and the educational institutions in seeing that proper standards are being maintained in public and nonprofit schools through the traditional methods of voluntary cooperation and publicity.
>
> I think the voluntary method is the best.[6]

Following enactment of the Veterans' Readjustment Act, accreditation was to all intents and purposes no longer a voluntary method but a process of compulsory voluntariness. Few institutions could afford not to seek accreditation from the appropriate institutional and specialized accrediting agencies. In the twenty years since 1952, this condition has been further fortified by subsequent legislation which provides in essence the same requirement as stated in the Allied Health Professions Personnel Training Act of 1966 (P.L. 89-751), from which the following is quoted.

> *Section 795*–For purposes of this part–(1) The term "training center for allied health professions" means a junior college, college, or university . . . (D) which is (or is in a college or university, which is) accredited by a recognized body or bodies approved for such purposes by the Commissioner of Education, or which is in a junior college which is accredited by the regional accrediting agency for the region in which it is located or there is satisfactory assurance afforded by such accrediting agency to the Surgeon General that reasonable progress is being made toward accreditation by such junior college, and . . .

An enumeration of the federal acts in which authority is assigned to the U.S. commissioner of education to recognize accrediting agencies is quite impressive. These include the National Defense Education Act (P.L. 85-864), the Higher Education Facilities Act of 1963 (P.L. 88-204), the National Vocational Student Loan Insurance Act of 1965 (P.L. 89-287), the Higher Educa-

tion Act of 1965 (P.L. 89-329), the State Technical Services Act of 1965 (P.L. 89-182), the War Orphans' Educational Assistance Act of 1965 (P.L. 84-634), the Health Manpower Act of 1968 amending section 843 of the Public Health Service Act (42 U.S.C. 298b), the Vocational Education Amendments of 1968 (P.L. 90-576) amending section 8 of the Vocational Education Act of 1963 (P.L. 88-210), and the Nurse Training Act, as amended by the Health Manpower Act of 1968. In addition, a bill has recently been presented (H.R. 9212) to amend the provisions of the Federal Coal Mine Health and Safety Act of 1969 to extend black lung benefits to orphans whose fathers die of pneumonoconiosis, provided that, among other requirements, they attend a "school or college or university which has been accredited by a State or by a State-recognized or nationally recognized accrediting agency or body." (Although it is not known at the time of this writing what provisions will be contained in the anticipated legislation to expand federal support for health care, it can be predicted with reasonable confidence that, as a result of whatever legislation will be enacted, government involvement will be extended in most phases of the provision for and delivery of health care. Such extension may be expected to include increasing concern for minimum standards in all health educational programs and the processes of accreditation of them.)

The funds distributed or still to be distributed under the provisions of these and other federal acts run into the hundreds of millions of dollars. No educational institution or health center can afford to disregard the provisions for its potential eligibility, and accreditation has now been widely established as one of these provisions. Furthermore, by administrative action various federal departments and agencies make extensive use of the lists of institutions or programs of study accredited by agencies recognized by the U.S. Commissioner of Education. Examples include the following, as identified by the Accreditation and Institutional Eligibility Staff of the U.S. Office of Education.

Air Force–Student nursing programs are affiliated with Air Force Hospitals. Affiliated institutions must be accredited.

Armed Forces Chaplains Board–Potential military chaplains must have earned degrees from accredited institutions.

Civil Service Commission–Candidates sitting for certain Civil Service examinations must be graduates of accredited institutions.

Department of Defense–The Army, Navy, Marine Corps, and Coast Guard rely to an extent on the accredited status of institutions for early release programs, for determining the eligibility of personnel for educational benefits, and for granting other benefits to military personnel and their dependents.

National Institutes of Health–NIH employs information about the accredited status of institutions and their programs of study as part of the basis for the eligibility of applicants for research grants.

Department of State—Information on the nature and quality, including the accredited status, of institutions of higher education is provided to potential foreign students.

Not only can no institution run the risk of being ineligible for federal grants, it likewise must comply with requirements of accreditation in order that its alumni will be eligible for various governmental positions and other benefits. Accreditation is no longer voluntary.

What is more, to attain recognition the accrediting agencies themselves must meet criteria established and promulgated by the U.S. commissioner of education. These criteria are similar to those approved by the National Commission on Accrediting, a nongovernmental association of approximately 1,400 colleges and universities. To date there has been little disagreement on the part of the accrediting agencies and institutions with the provisions of the criteria. The lack of disagreement may be attributed to two factors: (1) the criteria have been constructive in nature, have not been unduly restrictive, and have helped to bring some clarity into the process of accreditation and (2) until recently the criteria have been enforced with little vigor.

However, the situation is changing. The U.S. commissioner of education and his staff are requiring periodic reviews of the accrediting agencies to ascertain that they comply with the criteria; otherwise they may lose their recognition. The commissioner is also proceeding further. In letters dated August 1971, the executives of accrediting agencies were notified that sex discrimination should not be condoned in any manner while these agencies pursue their policies and practices of accrediting institutions.[7] This development raises a fundamental question, not about the social benefits to be gained by reducing discrimination on the basis of sex or on the basis of race or religion, but a question of the appropriateness of the federal government's requiring nongovernmental agencies not merely to practice but to enforce compliance with governmental policies. In other words, this development highlights the fact that, commencing in 1952, the federal government has relied on accrediting agencies to perform part of the functions of selecting institutions to be the recipients of governmental grants and other benefits. It has provided no payments to the agencies for the performance of this service, and now it is explicitly telling these agencies what requirements they should enforce.

Furthermore, this development verges on the creation of another function of accreditation to be superimposed on the accrediting agencies, a function that tends to subvert an earlier established function, that of protecting an institution against harmful internal and external pressures. If government can require accrediting agencies to enforce its policies, what protection can the institutions expect to receive from the accrediting agencies when such policies may be politically motivated and socially harmful? (A related development should be noted. Provisions in the tax legislation of 1970 which has subjected founda-

tions to some added restrictions would encourage one to expect further governmental directions to be applied to accrediting agencies.)

Harold Seidman has expressed serious doubt over the advisability of the federal government's reliance on accreditation for purposes it was not intended to serve. He has written, "Congressional reliance on accreditation as a standard of eligibility appears to reflect common misconceptions about the objectives and potential of the accrediting process." He later adds, "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."[8]

At this point, it should be observed that no responsible body of persons has to date adequately considered within the context of desirable social policy the appropriate functions of accreditation and the capabilities of the accrediting agencies to fulfill these functions. The accrediting agencies have customarily reacted independently to external or internal pressures or developments of the moment. Their structures have not generally permitted them to perform otherwise. Conditions no longer permit this situation to continue. Both the functions and the structure of accreditation are in need of broad redefinition.

Such redefinition is also being stimulated by the increasing attention being given to the activities of certification and licensure. The last of the nine functions of accreditation identified by the U.S. Office of Education is that of *establishing criteria for professional certification, licensure, and for upgrading courses offering such preparation* (criteria 8).

Frequently there is an interlocking of individual and organizational relationships in some of the professional fields among accrediting committees and certification, licensure, and registration boards.[9] Although this function has usually been established as a result of decisions and actions outside the accrediting sector, it is undoubtedly true that the requirement that a person must be a graduate of an accredited program in order to sit for certification, licensure, or registration examinations meets with no opposition from members of the accrediting committees and, in fact, is usually applauded with gratitude.

In the case of nuclear medicine technology, as an example, it has been predicted that there will be substantial expansion in accreditation when admission to the registry examinations is dependent upon graduation from an accredited program. This prediction was made on the assumption that an expansion in both accreditation and registration will be beneficial. There was no indication that any consideration had been given to which of the four control mechanisms, or what combination of them, would be best suited to identify adequately and most efficiently those individuals qualified to practice in the field of nuclear medicine technology.

A similar situation prevails in most of the other health fields, where it is widely assumed that if accreditation, certification, licensure, and registration are sound for the profession of medicine they must likewise be sound for other

health professions. Other than with the individual professions themselves, where does the authority to advise and decide what methods of control and selection are best currently reside? This question and other implied questions lead to the dilemma of structure.

Dilemma 3: The Structure of Accreditation

Until 1949 any professional society or specialized group was relatively free to institute a program of accreditation if it wished to do so, even when, as in the case of chemistry, there were no obvious immediate benefits to be gained by society through the implementation of such a program. This condition led to the formation in the late 1940s of the National Commission on Accrediting, an association of colleges and universities created to exert some controlling force over the expansion and conduct of accreditation. Later, the principle that accreditation should be permitted to operate only when there was a demonstrable social need for accrediting a special field of study was included as one of the cardinal features in judging whether or not approval would be extended to a program of accreditation. In addition to the NCA, the U.S. commissioner of education is legally authorized to exert some control in the area of accreditation, and as previously noted, the exercise of this authority is being markedly expanded at the present time.

Both the NCA and the commissioner of education are confronted with a situation in which accreditation is so fragmented among numerous, disparate bodies and organizations that it has been almost impossible to institute reasonably common policies and practices. The structure of specialized accreditation, especially of health educational programs, is difficult to comprehend with all its variations and permutations,[10] but whatever the structural configuration, it is based on the widely assumed conceptions of a profession.

Professions

In recent years, professions and professionalism have been the subject of endless articles and books by sociologists. Most of these authors have uncritically accepted autonomy as a necessary ingredient of a profession. One of the numerous analysts of professions has observed:

> Autonomy . . . is one of the main features characterizing the established professions; that is, the professional community determines its own standards of training, recruitment, and performance. Once the professional becomes a recognized member of this community, he is relatively free from lay control and evaluation; the profession "becomes a monopoly in the public interest." By comparison the semi-professions are characterized by lower degrees of such self-determination; they are more exposed to control by administrative superiors and lay boards.[11]

In a similar manner, Howard S. Becker identifies some of the major symbols of a profession as: (1) recruitment must be strictly controlled; (2) entrance must be strictly in the hands of the profession; (3) approval and accreditation must be done by the members of the profession; and (4) since recruitment, training, and entrance into the practice are all carefully controlled, any member of the professional group can be thought of as fully competent to supply the professional service.[12]

Individuals generally aspire to be considered professionals, and this tendency is especially pronounced among individuals in the health fields. They wish to be identified as members of a profession, even though there are difficulties in analyzing the concept of a profession. As Geoffrey Millerson has noted, these difficulties result from semantic confusion with excessive use of the term; from structural limitations in devising fundamental characteristics; and most important of all, from adherence to a static model, rather than appreciation of the dynamic forces of society.[13] To these dynamic forces for change, the professions exert considerable resistance.

This resistance is inevitable since, as R. M. MacIver has observed, "Every group tends to cherish its own separate existence, is convinced of its own superior worth, regards its own ways as preferable to the ways of others, its own myths as exclusive deliverances from on high, and generally is suspicious, not infrequently contemptuous, of the outsider."[14]

As long as thirty years ago it was noted that

> professionalism is a concept freely used to seal off the group from critical inquiry. It spreads an odor of sanctity. Members of a profession are assumed to act in certain ways which are beyond criticism or even beyond the layman's comprehension. . . . The terminology of professionalism is fundamentally eulogistic.[15]

However, it must be recognized, especially by the members of professions, that conditions are changing and the accustomed and assumed independence of professions is now being subjected to public scrutiny. No longer are the acts of members of the professions beyond criticism or beyond the comprehension of many laymen. Robert K. Merton has reminded us that the layman is confronted with rising costs for professional services and sees himself paying "taxes to support the professional in his education and then again for higher fees for services rendered."[16] Eliot Freidson has observed that the layman is aware that professional "expertise may be used increasingly as a mask for privilege and power, rather than a means of advancing the public interest," and that "privileges of a profession have been granted by society and can and possibly should be limited by society."[17]

It is understandable that the health professional is interested in the identification and education of the future members of his profession; he wishes the new members to be competent to provide good health care and in no way

depreciate his own professional standing and economic interests. As the delivery of health care inevitably becomes more organized, the professional, who in previous years would have scorned unionism, adopts more of the union tactics to protect what he has grown to consider his rights and his privileges.

Unions

With some justification we bemoan the trends, but our lamentations do not alter the changing times. Impersonality is increasingly evident in the delivery of health care. The majority of professional people today are employees; the professions find it increasingly difficult to discipline their members, partially because of the wide variety of specialties; the learned aspects of the professions have become less prominent as technocratic professionals have tended to dominate; and commercialization of the professions is occurring on a wider scale.[18]

The delivery of health care is big business, and it will continue to grow larger.[19] Hospitals and other health care centers will become even more prominent in the provision of health care to more people by more employees. As Medicare, public funding, and other third-party payments increase, there will be more incentives and pressures for hospital employees—both professionals and other workers—to bargain in contrast to the conditions, now disappearing, that prevailed in our charitable hospitals of yesteryear.

We now find unionization widely adopted among government employees, including firemen, policemen, and sanitarians. Each group seeks its own benefits, partially in competition with each of the other groups. The employees of municipal hospitals are entrapped in this economic maelstrom. To seek enlarged memberships and to improve the income and working conditions of hospital employees, a number of established unions are competing with each other in all regions of the country. The names of some of the unions would belie their full intent: American Federation of Government Employees; Communication Workers of America; Hotel and Restaurant Employees and Bartenders International Union; Laborers' International Union; Retail, Wholesale and Department Store Union; National Marine Engineers' Beneficial Association; Service Employees' International Union; and American Federation of State, County, and Municipal Employees' Union.

Some of the professions themselves have already taken overt recourse to union activities. The growing American Federation of Teachers is an affiliate of the AFL-CIO. Its competitor, the formerly moderate National Education Association, has grown more militant, and in March 1971 announced its coalition with the American Federation of State, County, and Municipal Employees' Union. Traditional individualists such as actors, musicians, newspaper writers, as well as airplane pilots are now unionized and rather forcefully so. The trend for professional groups actively to protect the economic interests of their members is unmistakable. This movement is not bypassing the health professions.

In parts of the country, the nurses' associations have employed the strike as a weapon for higher pay and better working conditions. The Doctors' Asso-

ciation of the New York City Department of Health was formed for union purposes as long ago as 1961. Interns, residents, and postdoctoral fellows at the University of Michigan formed a unit for collective bargaining within recent months.

We must recognize that attitudes and conditions are changing and will continue to change as younger generations enter the health professions, engage in group practice, are employed on a full-time basis, and pursue greater specializations. We can anticipate that there will be more militancy in attitudes on the part of those engaged in the health occupations, and the actions and attitudes of one or more groups will influence all of the others, including the physicians.

According to an account in the *New York Times* of January 24, 1971, the Anti-Defamation League of B'nai B'rith reports that some politically oriented physicians and other health care workers in Boston, Chicago, New York, and Philadelphia are claiming that the underprivileged are being victimized by the profit-hungry medical-industrial complex and that these claimants are organizing for political action. Developments at Lincoln Hospital in the Bronx, New York, in the winter of 1970 with the polarization of staff, patients, and the surrounding community would indicate that little effort would be required to encourage larger groups of persons to believe the claims of the political activists in the health fields. These claims will predictably include the accusation that the health care system is replete with conflicts of interest.

Conflicts of Interest

In *The Scientific Estate*, Don K. Price has written that

> the more an institution or function is concerned with truth, the more it deserves freedom from political control . . . the more an institution or function is concerned with the exercise of power, the more it should be controlled by the processes of responsibility to elected authorities and ultimately to the electorate.[20]

It is between the horns of this dilemma that the health professions, with medicine leading the procession, presently find themselves.

In the United States, the development of the science of medicine has been surpassed in its breadth of attainments by no other country. Supported in recent years by the infusion of billions of government dollars but unrestricted by political control, medical science has enjoyed freedoms appropriate to its concerns for the discovery of truth. In this area of activity, medicine and its related professions have enjoyed the autonomy of operation consistent with the generally accepted concepts of a profession.

At the same time medicine has been engaged in pursuits of scientific discovery, it has been flexing its political muscle and has become increasingly involved in "the exercise of political power," for which it is officially controlled only by the judgments of its voting members. To meet the expectations of these members, the American Medical Association and other membership

organizations likewise must be concerned with the economic, political, and professional welfare of their respective members. This inevitable response accentuates the dilemma of conflict outlined by Price.

This dilemma is further accentuated by changing factors. With the increase in public expectations and demands for health care, with the increase in the numbers and classifications of health workers with their separate organizations, with the increasing complexity in the delivery of health care, with the increasing involvement of government through financing, and with the increasing visibility of health as a political issue of considerable magnitude, one may predict with confidence that in the future medicine and the professions complementary to medicine will compete more intently and obviously with each other for a larger share of the health dollar and will engage more openly in the exercise of power in matters related to health.

One example is sufficient to indicate the exercise of power. In 1970 the AMA stood sixteenth among organizations reporting their expenses for lobbying activities at the federal level with expenditures of $96,064.[21] In addition, in the same year the American Medical Political Action Committee, not the AMA but affiliated with the AMA, spent $693,412 in connection with the congressional elections of that year.[22] These figures do not include sums spent for political purposes for which reporting is not required. Whether society can continue to accept the concept of autonomy for all activities of a profession when it is and will continue to be even more heavily involved in the exercise of political power is a question of broad import.

Public Accountability

A related question concerns the advisability of permitting any profession to wield almost unilateral control over decisions on issues that immediately affect society and public policy.[23] With increasing frequency, this question is being raised in relation to many of our social structures, including business corporations, universities, the church, the military, unions, and various agencies of our civil government. For example, public confidence is undermined when "only seven states were found to have boards [responsible for control of pollution] without members whose business or professional ties pose possible conflicts of interest."[24] Judgments are discounted and even motives are questioned when strenuous efforts are made by the American Trial Lawyers Association, whose members may lose economically by the adoption of no-fault automobile insurance, to defeat in state legislatures bills that are expected to bring benefits to most segments of society. Public confidence in the military has sunk, not merely because of the revelations of atrocities in Viet Nam, but also because the recent military court trials appeared to the public as a case of the military's judging the military, and then doing so only after proddings by newspaper reports and public revulsion.

Amidst this widespread apprehension and unease with our methods of social control are criticisms of the structures of control in the health fields. The

composition of the Blue Cross boards and the Joint Commission on Accreditation of Hospitals, with their heavy reliance on and involvement of physicians and hospital administrators, are being subjected to open disapproval. In October 1971 a law suit was filed in a U.S. District Court to enjoin the Department of Health, Education, and Welfare from distributing Medicare funds on the basis of determinations of hospitals by the JCAH. One of the bases of the suit was the composition of the JCAH–only physicians and hospital administrators. This suit has potential significance for all organizations in accreditation.[25]

Regarding the ability of the health professions to regulate themselves, none have been more critical than physicians in their comments toward medicine. Quoting recent statements: "I don't think the public interest is best served by placing the entire task of continued monitoring of the quality of care on those of our peers who happen also to be our intimate colleagues and frequently our personal friends as well."[26] "In any other field it would be called a conflict of interest."[27] "Medicine's record for self-regulation has differed little from that of the military investigating the military-industrial complex or from labor unions controlling probes of labor unions. The name of the game is whitewash."[28] These are strong statements of denunciation. In a more reflective and judicious manner, Lester J. Evans, M.D., posits a fundamental question more germane to the subject of this paper: "The pressing question is whether in the current preoccupation with teaching there is equal concern with learning. Another facet of the question is whether it is prudent for a professional group to be the sole arbiters of who succeeds them."[29]

Accreditation is an important element in the process of identifying and selecting members of the health professions, including those as yet unidentified members who will be the leaders of the professions in the future. Not only the professions themselves but society in general must be concerned with the operations of the selection process. However, society's concerns may not necessarily fully coincide with those of the professions.

It has been observed that some professions tend to comprise larger proportions of individuals who have come from economic and social backgrounds that are not broadly representative of society,[30] and furthermore it has been widely recognized that sex has long been a barrier to women wishing to enter the field of medicine. Have these conditions been best for society? Does the present structure of accreditation for the various health educational programs, with its heavy reliance on professional autonomy and independence, provide sufficiently for consideration and recognition of the broad needs of society? Or is there a built-in conflict of interest in the present structure and control of accreditation?

To this last question, George James, M.D., answers in the affirmative.

> Many professional organizations that are involved in standards for specialists or matters of accreditation are at the same time strongly

committed to programs of self-protection. It is natural for them to defend themselves and their members, but the news releases of many professional groups are particularly replete with extensive battles for status and money.

Conflict frequently arises between what are deemed to be the interests of the organizations and the interests of the public. One is easily led to a not-so-hypothetical question: If a very large medical organization spends millions of dollars fighting the medical programs the country needs and a majority of the people want without concern that this program insures a high quality of care, how long will the public continue to give such an organization sole control of the accreditation of institutions or the setting of standards for medical specialties? How can an organization's technical judgment be accepted on the one hand when its judgment on planning to make better health care more available appears so inadequate?

I think the questions are germane because what is done in matters of accreditation and the setting of standards has to flow out of some philosophy. The attainment of quality is inevitably influenced by the present views on medical care. The medical care of the future will be influenced by the voluntary associations' actions in accreditation and the types of standards which are established now.[31]

Regardless of what one may think of the merits or demerits of the various health care bills submitted for congressional consideration, the active and aggressive involvement of any professional association in the civil political arena raises direct questions as to its public accountability in various matters, including accreditation. The Citizens Board of Inquiry into Health Services for Americans claims that consumers should assume the responsibility for decisive health care decisions now falling on the physicians and other health professionals.[32] Other self-appointed vocal groups will pepper congressional hearings with similar claims. Will these proposals include policy decisions relating to accreditation, especially those aspects that touch on broad social issues? In the light of the growing agitation over accreditation, such proposals are a definite possibility.

George P. Berry, M.D., has stated:

The physician is apt to be less adequately informed on broad social issues than are many others: behavioral scientists, economists, clergymen, legislators, industrialists, labor leaders—to name a few. But it most decidedly does mean that medicine must have a chance to bring its unique competence to bear in full partnership with those who are planning for tomorrow's needs.[33]

Planning for tomorrow's needs does include the process of accreditation; and in the accreditation of educational programs for the profession of medicine and for the professions complementary to medicine, physicians do possess a unique competence. The exercise of this competence must be encouraged, not merely for the benefit of medicine, but primarily for the benefit of society. At the same time, however, there must be assurances that societal interests are fully recognized and honored, unfettered by conflicts of interest.

In officially recognizing that physicians collectively must exercise their competencies with regard to the educational standards of the other health professions, the Council on Medical Education of the American Medical Association adopted the following statement in August 1970.

> Increasingly today, the physician shares with other health professionals the responsibility for certain specific aspects of health care. The professional associations representing these allied health specialists should assume a major share of responsibility for establishing and maintaining educational standards in their respective fields. The medical profession is aware of its great responsibility in relating to all the allied health fields which find their focus, indeed their reason for existence, in the care of the patient. Where the medical care of the patient is concerned, the physician 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 cooperate with the collaborating organizations in coordination of the multiple and diverse components of the health care team through which the total care of the patient is provided.

With what *is* stated in this declaration few could quibble. What *is not* stated, on the other hand, has added to alarms and fears. In the first place, the statement provides for no recognition of the fact that educational standards and accreditation involve some issues of broad social policy. Second, the juxtaposition of two phrases—the physician's "legal, moral, and ethical responsibility" and the medical profession's "great responsibility in relating to all the allied health fields"—could easily lead one to conclude that medicine has not yet recognized the distinction that should exist between the relationship of the individual physician to an allied health professional, on the one hand, and the relationship of the AMA to any one of the numerous health professional associations or organizations, on the other. It is this distinction that must be understood and appreciated before true cooperation, coordination, and collaboration may be expanded to the accreditation of all health educational programs.

Coordination

Major steps toward further coordination in accreditation have been and are being made by various health professional organizations. Most significantly, the creation of the Advisory Committee on Education for the Allied Health Professions and Services and its Panel of Consultants by the AMA's Council on Medical Education has brought together on a regular basis representatives of the organizations directly responsible for the accreditation of the fifteen fields that comprise the immediate focus of this study. The creation of the committee and the panel have stimulated wider appreciation and understandings among the diverse health professionals, despite the fact that in the deliberations of these two groups much time and effort has had to be expended on procedural and jurisdictional issues.

With the present structure, one may anticipate that the jurisdictional issues will require increasing effort and time. Although the issue has not yet become a matter of major concern to the Advisory Committee, the development of the concept of the physician's assistant has begun to stimulate the internal politics of the health care field and has accentuated "the struggle for turf."[34] If proper care is not taken as this new profession evolves, we may expect future strains and altercations, similar to those currently existing between the American Society for Medical Technology and the American Society of Clinical Pathologists, to emerge.

In addition to the Advisory Committee on Education for the Allied Health Professions and Services, other groupings have been formed on a more informal basis to provide a means of interchange of information among some of the health professions. These include the Coalition of Independent Health Professions and the Federation of Associations of Schools of the Health Professions. The former comprises representatives of national organizations of bioanalysts, dieticians, medical technologists, nurses, occupational therapists, optometrists, pastoral counselors, physical therapists, podiatrists, psychologists, social workers, and speech pathologists and audiologists; the latter includes representatives of national organizations concerned with education for allied health, dentistry, hospital administration, medicine, nursing, optometry, osteopathy, pharmacy, podiatry, public health, and veterinary medicine.

These two informally organized groups do provide opportunities for exchange of information and ideas, but neither they nor the Advisory Committee and its Panel of Consultants are capable of meeting the concerns of Merlin K. DuVal, M.D., assistant secretary of HEW for health and scientific affairs, who has stated:

> The plethora of professions already in existence must fit together in some orderly manner. Our manpower pool is simply not great enough to permit anything but the most efficient organization of services.

> Inherent in the proliferation, which the health field has been experiencing, is the danger that too many of the allied health professions may elect to go their separate ways, speaking and even acting at cross-purposes with the rest of the allied health world--without consideration for the overall picture. If this sounds a bit strong, let me ask which of you, right now, can say that his profession is evolving in an orderly fashion and takes into consideration the evolutions occurring in the rest of the allied health field? Who is looking at his profession from a perspective that takes into account the development of the entire allied health field?[35]

Any restructuring of accreditation should take into account the developments in the entire health field, including the expansion of new occupational groups and new levels of occupations.[36] In 1960 the concerns more recently expressed by DuVal were recognized in the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services. This report, which was adopted by the House of Delegates of the AMA, stated:

> As these groups develop more advanced professional skills and specialized competence, they may tend to fragment within themselves and away from medicine unless the cohesive liaison and cooperative efforts they now so clearly seek with physicians at the local, state, and national levels are realized. Such "fragmentation" would have serious adverse effects upon good patient care. The Committee considers that this possibility of fission is one of the most serious problems facing physicians and professional and technical personnel allied to medicine.[37]

In this same report, the committee stated its firm belief "that the physician must be the 'unifying force' which brings this great diversity of scientific knowledge into the proper focus so essential to the care of the health of America."

In the years ahead, the interpretation that medicine gives to its role as a "unifying force" will have a major influence on the future of accreditation of health educational programs. If medicine will give tangible recognition to the fact that the maintenance of educational standards and accreditation involve many issues of broad social policy, and if medicine will recognize that its unique competence can best be exercised in accrediting health educational programs on a basis of true cooperation, coordination, and collaboration, accreditation is more likely to remain as a responsibility of the private sector.

Otherwise, government activity will assuredly increase in an area that until recently has been considered a social responsibility of the educational institutions and the professions.

Dilemma 4: Financing of Accreditation

The old adage that he who pays the piper can call the tunes signifies the relationship of the source of financial support to the structure of accreditation.

In the health fields, it has generally been the practice for the costs of accreditation to be borne primarily by the professionally controlled accrediting agencies. In many cases, accreditation is largely supported by the membership dues of the professional organizations, without recourse to assessments against the institutions or their programs of study. As the part I working paper on the financing of accreditation attests, the financial squeeze on the accrediting agencies has arrived, and conditions are changing. The issues are simple; the dilemmas, profound.

Increasing the number of fields and the number of educational programs subject to accreditation in a period of inflation has raised costs at a rapid rate. Mounting financial pressures present a serious problem that demands immediate attention, and these financial pressures are, in turn, reinforcing the need for a comprehensive reevaluation of accreditation including all its attendant costs.

In seeking solutions for the financial problems, several factors should be taken into consideration:

1. A program of accreditation should be conducted only if it is adequately financed and, in this respect, is financially capable of fulfilling what it is expected to accomplish.
2. Every program of accreditation should be conducted with continuous attention to economy of operation and cost effectiveness.
3. The sources of funding for accreditation should be sufficiently diverse that no one source can dominate the operation. The primary sources of funding of accreditation of health educational programs can normally be expected to include the institutions and programs of study subject to accreditation, as well as the professional organizations whose members possess technical knowledge in the fields of study. On a contract basis, the federal government, state governments, and other users of accreditation might also be included as sources of financial support.
4. The financial operations of all accrediting agencies should be regularly subject to audit by certified public accountants and made publicly available.

The widespread acceptance of these principles would help to resolve some of the dilemmas of accreditation funding. However, the final answer depends on agreement by all of the previously mentioned parties that accreditation is, in fact, socially useful, desirable, and sufficiently attuned to the interests of the public, as well as the interests of those providing the financial support.

Underlying all questions of financing is the fact that funding and the structure of accreditation are interrelated.

Dilemma 5: Validity of Accreditation

Since the 1880s, the federal government has made use of regulatory commissions to perform various functions of supervision and control. These bodies include the Interstate Commerce Commission, the Federal Trade Commission, the Securities and Exchange Commission, the National Labor Relations Board, and many others. The life cycle of these regulatory commissions has been classified as gestation, youth, maturity, and old age.[38] The last implies a sense of deterioration.

Following a similar analytical approach for the accrediting agencies, one might be tempted to observe that they have a life cycle of innovation, followed by standardization, and then stultification. Partially to avoid this last stage, greater emphasis than has generally prevailed should be devoted to validation of the accrediting criteria or essentials and to the procedures employed in the process of accreditation. Greater recognition should also be given to the inherent limitations of accreditation. As indicated in the part I working paper on research, the successful implementation of any program of research related to accreditation depends primarily on three factors: (1) on the attitudes and recognition of the need for research on the part of the officials of the accrediting agencies; (2) on the funding available; and (3) on the development or use of one or more organizations, each with a sufficient critical mass to conduct such research successfully. These factors relate, in turn, to a possible restructuring of accreditation, especially as it relates to the accreditation of health educational programs.

An observation by Corinne Lathrop Gilb is quite pertinent to this point.

> The modern economic system, with its anonymity and interdependence, could not function if there were no institutions to define occupational boundaries, rights, and obligations. From a social standpoint the problem has been how to keep those boundaries, once they are defined, from becoming so rigid that they preclude necessary adaption to changing technology, changing social organization, and changing needs and demands.[39]

Dilemma 6: Expansion of Accreditation

The last of the dilemmas identified in this staff working paper is related to the current growth and proliferation of accreditation evidenced both in the number of professional fields initiating or planning to initiate accrediting activities and in the number of levels of occupations and educational programs being subjected to accreditation.[40]

The pressures for expansion, which are inevitable, involve two factors that should be mentioned before concluding this paper. The first falls within the purview of SASHEP; the other is of concern to the study but does not lie within its mandate.

The first factor has been well identified by Robert K. Merton.

> The pressure toward expansion derives in part from advancement of professional knowledge. It often produces strains and stresses on the relationships between neighboring professions. This problem only underscores the importance of instituting and maintaining effective liaison between professions, for only if this is firmly established can the relationship bear the stresses which initially conflicting claims to jurisdiction imposes upon it.[41]

The recommendations to be contained in the final report of SASHEP will have to give specific attention to the factor of effective liaison among the health professions. Such attention will obviously include recommendations regarding effective cooperation, coordination, and collaboration in accreditation, as one of the means by which some effective controlling influence over expansion can be exercised.

The other means of control is effected through the overall national supervision of accreditation that is currently exercised by the U.S. commissioner of education on the basis of legislative authority and by the National Commission on Accrediting on the basis of voluntary compliance by its member institutions with the commission's policy decisions and recommendations. SASHEP is not charged to make recommendations at this level of control of accreditation. On the other hand, its final recommendations will have to be made on the basis of some assumptions about the total structure of accreditation, which at the present time is being subjected to reviews being conducted separately by representatives of the federal government and the National Commission.

The latter review involves an agreement of intent on the part of the National Commission and the Federation of Regional Accrediting Commissions of Higher Education (FRACHE) to merge. Such a merger, whatever form it may take, will likely increase the effective influence of the National Commission, at least in the immediate future. At the same time, it will create shock waves among the professional accrediting agencies, including those concerned with health educational programs of study.

At the writing of this paper, the review being undertaken by a task force in the office of the secretary of HEW may support recommendations that would potentially lead to expanded federal activity in the areas of accreditation. Such expansion would inevitably contravene precedents by which the nongovernmental sector has assumed the major share of responsibility for the accreditation of educational institutions and programs of study.

The future of national supervision and coordination of accreditation is at a crossroads. Although SASHEP is not expected to make recommendations in this important area of current concern, the study will have to assume (1) that there will be some type of national supervision of accreditation, (2) that broad principles of accreditation will be decided and enunciated by some national

authority or body, (3) that such a body will be broadly representative and will be primarily concerned with accreditation as it relates to the welfare of society, and (4) that all accrediting agencies will be expected, if not required, to comply with the policies established by this body.

Not only the national supervision and coordination but also the accreditation of all health educational programs is at a crossroads. As the proposal to the Commonwealth Fund seeking financial support for SASHEP stated:

> The number of health occupations will undoubtedly multiply, nourished by the expansion of knowledge, the increase in technology, and the specialization of society; and most of these health occupations will aspire to a professional status, including the function of accreditation of the educational programs preparing the future members of their respective professional occupations.
>
> If past practice is followed, each of these potential accrediting organizations will seek to perform its functions in a very independent manner. In fact, some of those which are presently conducting their accrediting functions under the supervision of the Council on Medical Education are quite restless and unhappy with their present relationships. On the other hand, an independence of accrediting organizations from each other would merely support "the tradition of individualism that permeates the entire health-service industry" and would serve "to perpetuate outmoded rigidities and institutional restraints."

Any changes and revisions in the accreditation of educational programs for the health fields must provide for cooperation and coordination, flexibility and innovation, as well as for many other qualities that are equally required in the ultimate delivery of health care.

FOOTNOTES

1. "The Futility of Accrediting," *Journal of Higher Education*, April 1960, pp. 327-9.
2. William K. Selden, "Why Accreditation?" *Journal of Higher Education*, April 1960, pp. 296-301.
3. *Nationally Recognized Accrediting Agencies and Associations: Criteria and Procedures for Listing by the U.S. Commissioner of Education and Current List* (Washington: U.S. Department of Health, Education, and Welfare, 1971).
4. *See* "Research in Accreditation of Health Educational Programs" in *SASHEP Part I: Staff Working Papers.*
5. *North Dakota* v. *North Central Association of Colleges and Secondary Schools*, 23 F. Supp. 694 (E.D. Ill.), aff'd, 99 F.2d 697 (7th Cir. 1938).
6. U.S., Congress, House, Committee on Veterans' Affairs, *Education and Training and Other Benefits for Veterans Serving on or after June 27, 1950*, 82d Cong., 2d sess., 1952, p. 1,628.
7. Letters addressed to Gary L. Filerman, executive director, Accrediting Commission for Graduate Programs in Hospital Administration, and others signed by Peter G. Muirhead, acting U.S. commissioner of education, August 23, 1971.
8. *See* "Accreditation of Postsecondary Education: Problems in Organization" in *SASHEP Part I: Staff Working Papers*, pp. F2 and F3.
9. *See* "The Relationship of Accreditation to Voluntary Certification and State Licensure."
10. *See* "Structure of Accreditation of Health Educational Programs" in *SASHEP Part I: Staff Working Papers.*
11. Nina Toren, "Semi-Professionalism and Social Control: A Theoretical Perspective," in *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*, ed. Amitai Etzioni (New York: Free Press, 1969), p. 169.
12. "The Nature of a Profession" in *Education for the Professions* (Chicago: National Society for the Study of Education, 1962), p. 33.
13. *The Qualifying Associations: A Study in Professionalization* (London: Routledge & Kegan Paul, 1964), p. 1.
14. R. M. Maclver, *The Webb of Government*, New York: Macmillan, 1947, p. 36.
15. Oliver Garceau, *The Political Life of the American Medical Association* (Cambridge, Mass.: Harvard University Press, 1941), p. 5.
16. "The Functions of the Professional Association," *American Journal of Hospital Pharmacy*, November 1969, pp. 636-41.
17. *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead, & Company, 1970), p. XVIII.
18. Irwin T. Sanders and Peter N. Gillingham, "The Professional School and World Affairs," *Report from the Committee on the Professional School and World Affairs*, (Albuquerque: University of New Mexico Press, 1968), pp. 378-9.
19. *See* "Expansion of Accreditation of Health Educational Programs," in *SASHEP Part I: Staff Working Papers.*

20. *The Scientific Estate* (Cambridge, Mass.: Harvard University Press, 1965), p. 191.
21. *AMA Newsletter*, August 30, 1971.
22. *AMA Newsletter*, July 26, 1971.
23. *See* "The Law's View of Professional Power: Courts and the Health Professional Association."
24. *New York Times*, December 7, 1970.
25. *See* "The Law's View of Professional Power: Courts and the Health Professional Associations."
26. John Stubbs, M.D., as quoted in *Washington Post*, April 7, 1971.
27. Lawrence L. Weed, M.D., as quoted in *Washington Post*, April 7, 1971.
28. Alex Gerber, M.D., *The Gerber Report: The Shocking State of American Medical Care and What Must Be Done About It* (New York: David McKay Co., Inc., 1971), p. 235.
29. *The Crisis in Medical Education* (Ann Arbor: University of Michigan Press, 1965), p. 46.
30. H. M. Vollmer and Donald L. Mills, eds., *Professionalization* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1966), p. 73. This book was published before the trends resulting from the Emmigration Act of 1965 could be analyzed. No longer do the countries of Northern Europe serve as the primary sources of immigration to the United States.
31. "Professional Associations' Responsibilities in the Field of Health Manpower," *American Journal of Public Health*, April 1967, pp. 548-49.
32. *Washington Post*, February 24, 1971.
33. "Search for New Rosetta Stones," *The Pharos of Alpha Omega Alpha*, January 1967, pp. 7-11.
34. Harry Schwartz, "Possible Cure for Doctor Shortage," *New York Times*, March 28, 1971.
35. "Allied Health Manpower from the Federal Viewpoint" (speech delivered at Invitational Conference on Certification in Allied Health Professions, University of Maryland, College Park, September 9, 1971).
36. Restructuring of accreditation should also give recognition to the recent tendency for programs of accreditation to be devised for occupational specialties even before they are fully defined and established. Examples are orthopedic assistants and physician's assistants.
37. *Final Report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services* (Chicago: American Medical Association, 1960).
38. Marver H. Bernstein, *Regulating Business by Independent Commission* (Princeton: Princeton University Press, 1955), p. 74.
39. *Hidden Hierarchies: The Professions and Government* (New York: Harper and Row, 1966), p. 81.
40. *See* "Expansion of Accreditation of Health Educational Programs" in *SASHEP Part I: Staff Working Papers.*
41. "The Functions of the Professional Association," *American Journal of Hospital Pharmacy*, November 1969, pp. 636-41.

AN APPROACH TO ACCREDITATION OF ALLIED HEALTH EDUCATION

Jerry W. Miller

From the medical profession's initiation of accreditation in 1905, the health professions have used this process as a means of providing recognition for educational programs and institutions that meet established standards of quality. Accreditation in the health fields experienced steady growth between 1905 and 1960, and the decade of the sixties produced rapid expansion, particularly in the allied health fields.[1] Throughout this period, basic elements and concepts of accreditation were adapted to new health fields, with little apparent consideration being given to the appropriateness or validity of the process for the new educational programs.

Even under ideal conditions, accreditation has extensive limitations. It operates in an arena that defies precise measurement and in which there is often professional disagreement over what type of product should be turned out and how it should be produced. It attempts to serve institutions with widely varying objectives and purposes. Reflecting all the limitations of educational and human measurement, the procedures and criteria of accreditation are necessarily general and inexact, forcing great reliance on professional expertise and subjective judgments.

Despite its limitations, accreditation survives, even thrives. It thrives because it provides an essential service to society by identifying, within the limits of its capability, educational institutions and programs of acceptable quality. Society is likely to continue to rely upon accreditation until a more suitable and effective alternative is devised.

In its current state of development, accreditation can generally provide reasonable, but not absolute, assurance that acceptable educational institutions and programs will produce acceptable products in certain educational settings. However, for some programs, accreditation may lack validity and efficiency, and thus it could be a disservice to society rather than a service.

The characteristics of many of the allied health educational programs accredited by the Council on Medical Education of the American Medical Association and its collaborating organizations vary significantly from those of other educational programs and institutions served by accreditation. The majority have extremely small enrollments and faculties and are located in educationally isolated hospital and laboratory settings. These differences pose important questions regarding the validity of accreditation in these fields.

The purpose of this paper is to discuss the basic procedures and concepts of accreditation as applied to fifteen of the eighteen educational programs currently accredited by the Council on Medical Education.

The Accreditation Process and Its Limitations

Accreditation is the process by which an agency or organization evaluates a program of study or an institution and recognizes it as meeting certain predetermined qualifications or standards. The process usually involves five steps: (1) establishment of standards or criteria; (2) self-evaluation or self-study by the institution or program in preparation for the accreditation visit; (3) evaluation of the institution by competent authorities to determine whether it meets the established standards or criteria; (4) publication of a list of institutions or programs that meet the standards or criteria; and (5) periodic review to ascertain whether accredited institutions or programs continue to meet the standards or criteria.

There is general agreement that to be effective, programs of accreditation must embody these steps or slight variations thereof. However, because of the limitations of the accreditation process and the absence of critical elements on which accreditation must rely, even their careful and zealous application does not necessarily produce valid assurances of the quality of every educational program and institution.

Viewed as a quality-control process, accreditation differs in important ways from other such mechanisms. In manufacturing, continuous sampling of products coming off a production line can provide a high degree of assurance that all the products meet quality standards. In human quality-control procedures, testing for certification, licensure, and registration provides assurances about the competence of individuals in certain occupational areas to the degree the tests are reliable and valid.

On the other hand, accreditation speaks to the quality of educational programs and only indirectly to the quality of the end product. Accreditation may, and most frequently does, consider data on certification, licensure, and registration examination scores and on initial employment of graduates in its periodic assessments of educational institutions and programs. But it does not and cannot stand at the campus gate to evaluate each finished product or graduate.

Accreditation can, however, provide reasonable, though not absolute, assurance that graduates of institutions and programs are likely to be of acceptable quality. It does this by determining that institutions and programs have the necessary curricula, facilities, faculties, organization, procedures, resources, and staffs to provide satisfactory educational opportunities and to make competent judgments about the proficiency of those they graduate. In this manner, accreditation speaks to the competence and integrity of institutions and programs, which, in turn, attest to the occupational proficiency of their graduates. Accreditation thus validates credentials awarded to individuals by institutions.

To provide such validation, accreditation is heavily dependent on the effective functioning of a critical educational mass. Essential elements of this critical mass include-

1. the professional expertise of a group of individuals who devote all or a substantial portion of their professional activities to the educational endeavor and who regularly interact with one another to provide stimulation and frequent checks on professional performance and

2. an organization and procedures that control the quality of the educational program and provide assurances regarding the integrity of credentials awarded.

Two additional characteristics of accreditation increase the importance of the critical educational mass to the validity of the process: (1) the generality of its criteria and (2) the variety of educational institutions and programs that accreditation must serve. Accreditation must permit flexibility in both curricula and organization to support the diversity of American education. By relying on a critical mass of professional expertise to make specific application of general educational principles and criteria, accreditation can still determine with reasonable assurance the quality of a variety of institutions and programs of study. In the absence of the critical educational mass, criteria would need to become more prescriptive and minute and accreditation more supervisory. This would likely limit the initiative of educators and stifle the effectiveness of their programs.[2]

The concept of a critical educational mass becomes even more important in view of another limitation of accreditation. It is both undesirable and logistically impossible for the process to provide close and continuous monitoring, a basic feature of other quality-control procedures.

Accreditation's monitoring is limited to periodic onsite reviews, annual reporting, and occasional special visits for programs or institutions experiencing problems. But periodic reviews, with varying intervals of three to ten years, cannot keep up with rapid changes and events, which may have a deleterious impact on institutions and programs of study. Accuracy of annual reporting is too difficult to assure. Furthermore, it cannot quantify or verbalize important educational ingredients that can only be assessed through onsite professional judgment.

These limitations of accreditation become less consequential for educational programs that possess a sufficient mass of professional expertise to provide a high degree of stability. The effectiveness of accreditation depends upon an institution or program's retention of a core of faculty and staff over a period of time to provide continuity and direction.

In view of the limitations of the process and its dependence on the presence of a critical educational mass, it seems important to examine the characteristics of allied health educational programs and some of the factors confronting the Council on Medical Education.

Characteristics of AMA-Accredited Programs

Over 80 percent of the AMA-accredited programs in allied health fields are located in hospitals and laboratories, where enrollments generally tend to be extremely small. The average enrollment for all AMA-accredited allied health programs is 12.2 students. Only six fields have average enrollments of fifteen or more per program.

In 1970, four fields produced an average of ten or more graduates per program; six had a per program average of five to ten; and three fields had a per program average of fewer than five graduates. Histologic technic had no accredited programs and no graduates. (These data are detailed in table 1.)

Although precise data are not available, accredited programs in colleges and universities tend to show much higher average graduation and enrollment rates per program than do hospital and laboratory programs. Based on data gathered in 1970 - data different from that presented in table 1 - the average number of graduates for AMA-accredited programs—hospital, laboratory, college, and university - was 4.6. The average number of graduates for college and university programs during that period was 13.2.[3] Of the 2,519 programs listed as accredited by the AMA on July 1, 1971, only 382 were sponsored by educational institutions, 242 by four-year colleges and universities, and 140 by postsecondary vocational institutions and junior and community colleges (see table 2).

Programs sponsored by laboratories and hospitals are characterized not only by small enrollments but also by small teaching staffs that include many individuals who have primary responsibilities for areas other than education. Except in programs for medical record librarians, medical record technicians, and occupational therapists, the essentials require that doctors of medicine, usually specialty certified, have ultimate responsibility for the educational program.[4] Almost without exception, direction of the educational program is a secondary responsibility for the physician, with the major responsibility for administration and direction falling to technologists, who may or may not devote full time to the position. Few hospitals or laboratories have as many as two persons who devote full time to their educational programs.

Consequently, there is little academic structure, such as a faculty senate, an office of an academic dean or vice president, or faculty committees, to embody institutional quality control and program review procedures and to provide long-term continuity, stability, and direction for the educational program. Theoretically, the affiliations between colleges and many of the laboratory- and hospital-based programs could serve these purposes; and increasingly, it appears that it is the policy of the AMA review bodies to encourage arrangements that are close enough to allow the granting of academic credit as well as degrees.[5] But the type and the nature of the current affiliations vary widely. For example, many institutions offer baccalaureate degrees in medical technology on the basis of three years of preclinical study and the successful

completion of a one-year clinical experience in any AMA-accredited program. In many cases, the institution awarding the degree has no provision for controlling or monitoring the clinical program, the heart of the training of the technologist to whom the institution is awarding a professional degree.[6] This type of educational practice is being discouraged by the National Commission on Accrediting.[7]

The clinical institution is most often accredited as the sponsoring institution and the educational institution as the affiliate, even though the latter awards the academic credential. Thus, accreditation in these instances fails to do what is usually expected, to validate the credential by requiring the awarding institution to maintain primary control and responsibility for the program.

In general, the smallness of accredited programs in allied health education in terms of both students and faculties, and their isolation, both physically and philosophically, raise questions about the validity of the current approach to accreditation.

AMA Approach to Accreditation of Allied Health Educational Programs

The Council on Medical Education of the American Medical Association sponsors a special accreditation program for each identifiable occupation at the therapist/technologist, technician, and assistant levels.

The AMA exercises supervision and final approval over fifteen such programs, which have been in operation for two years or more with some dating to the 1930s. Essentials for three additional specialties were approved by the House of Delegates of AMA in November 1971. These include the assistant to the primary care physician, the associate degree medical laboratory technician, and the specialist in blood bank technology and bring the total number of AMA accreditation programs in allied health education to eighteen.

Each of the specialties has its own accreditation committee to oversee the accreditation process. Each committee conducts separate site evaluations and takes separate actions on each program before forwarding its recommendations to the AMA Advisory Committee on Education for the Allied Health Professions and Services, which in turn forwards the recommendations to the Council on Medical Education for final action.

If the completion of questionnaires and other forms is equated with self-evaluation and self-study, all the committees either follow or plan to follow (some are so new that the specified period for reevaluation has not elapsed) the five basic steps in accreditation previously outlined in this paper.

With the exception of medical record librarianship, occupational therapy, and physical therapy, accreditation of the selected health educational programs focuses primarily on the clinical training of the allied health worker. Prerequisites for admission to the educational programs are prescribed and some didactic instruction is required.[8]

Accreditation is being conducted for educational programs in many specialties that produce few graduates and in fields where the total employment is extremely small when compared with the total number of workers in the health fields. Table 3 sets forth these data. The Department of Health, Education, and Welfare has estimated that some 3.8 million persons were employed in health occupations in 1969. If the catch-all classification "secretarial and office services including medical assisting" is eliminated, only about 300,000 of these workers were employed in occupations accredited by AMA. Of the 300,000, more than half were employed in medical laboratories or in radiologic technology.

In addition to their accrediting in small, specialized fields, in recent years AMA has sponsored the accreditation of educational programs in new and emerging fields where little is known about the demand or the marketplace for such workers or how they will be utilized. This action contrasts strikingly with the situation for other occupations and professions, where the demands for skills and services were evident and utilization established before accreditation programs were launched.

The practice of conducting a separate accreditation program for each occupational specialty is open to charges that it fragments allied health educational efforts in junior and community colleges and four-year colleges and universities, which are increasingly assuming primary responsibility for the training of allied health workers.[9] Such fragmentation seems likely to result in more narrowly trained workers whose lateral and upward mobility and utilization in the health fields may be limited. One aspect of this philosophical question is whether there is a public need to maintain a special accreditation program for specialities that may never number more than a few thousand workers.

The current approach has created a burdensome workload, which in turn raises questions about the effectiveness and validity of such accreditation. Review bodies swamped with applications for initial accreditation and reevaluation lack time to give in-depth consideration to programs. An ever expanding pool of volunteers is needed to make site visits, and training for these critical participants in accreditation is often lacking.[10] Moreover, the site visitors are often expected to pay their own travel expenses. In some cases, site visitors even forego salary from their regular jobs or are required to take vacation to participate.[11]

The emphasis on separate accreditation for each occupational specialty has resulted in logistical problems in the accreditation of allied health education. These, in turn, are creating financial strains.

Logistics of AMA Accreditation

Even the current logistics of accrediting more than 2,500 educational programs in allied health education have already created a heavy burden. Anticipated expansion of accreditation to other health occupations and the virtual certainty that more and more programs will seek accreditation appear to confirm a statement in the proposal for SASHEP: "... 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. . . ."

As table 4 illustrates, some of the review bodies are already falling behind in periodic revisitations. The future seems to hold mounting problems. For example, assuming that the current approach to accreditation is continued, the Joint Review Committee on Education for Radiologic Technology would be required to conduct 382 visits per year in order to abide by its policy of periodic reviews of accredited programs every three years. Furthermore, the committee would be required to consider 382 site visit reports and take 382 actions during each twelve-month period. Applications for initial accreditation and special visits would be in addition to this load.

On the other hand, some AMA accredited programs are so small—histologic technic and orthopaedic physician's assistant, for example—and the work load of the review committee so light that it may be difficult to sustain interest or to accredit a sufficient number of programs to maintain a viable accreditation effort.

The logistics of the current approach to accreditation can be impractical also for institutions. For example, one university school of allied health education selected from the 1971 *Directory of Approved Allied Medical Educational Programs* produced the following statistics: six accredited programs with a total student capacity of 142. Actual enrollment, which is likely to be less, was not ascertainable.

Under the current system, this institution was required to complete six sets of questionnaires and forms, host six site evaluation teams, be subjected to the recommendations and actions of six different review bodies, and complete six annual reports. In the future, if matters continue on their present course, it is likely that the institution will be required to pay six different accrediting fees, and all for 142 students or fewer. This university is by no means an isolated example.[12]

The emphasis on accrediting each occupational program separately and on applying the accrediting process independently to each clinical institution, even though it has an affiliation with an institution of higher education, are the two main components of the logistical problem.

The AMA has recognized this and has an active Task Force on an Institutional Approach to Program Evaluation. The discussions of the task force have centered around three possibilities: (1) adding one or two specialists for each

allied health program to the visiting team of the regional accrediting association; (2) scheduling simultaneous visits for all allied health programs, possibly including such other health field accrediting agencies as the American Dental Association and a representative of the regional association; or (3) scheduling a "multi-disciplinary survey" with "minimal interdisciplinary involvement" to include coordinated scheduling of visits by the various review bodies.[13] All the approaches being considered by the task force would continue to include the preparation of a report for each program and separate actions by all the affected review bodies.

The current logistics of accreditation of allied health programs appears to be especially vulnerable on the point of financial efficiency. Expenditures for accreditation in allied health education for fiscal year 1971 divided by enrollment on October 1, 1971, would approximate $15 per student per year.[14] This figure does not take into consideration hidden costs incurred by institutions, expenses of individuals who are not reimbursed for travel expenses and loss of income, and the thousands of hours of donated time of individuals who serve on review committees and visiting teams. If these items were included, the cost per student could easily quadruple.

A Caveat

The foregoing discussion of accreditation and the characteristics of AMA-accredited programs should not be construed to mean that programs small in enrollment and faculty are necessarily of inferior quality. Nor should the inference be drawn that small programs should necessarily be eliminated or consolidated. The purpose of the discussion is to suggest that the dependence of accreditation upon certain factors prevents the process from providing adequate assurances about the quality of small programs in isolated educational settings.

Summary Observations — Questions

The approach to accreditation of allied health programs currently followed by the Council on Medical Education raises important questions with regard to the validity of the accreditation process. Despite the marked improvements introduced in the past few years, the logistics involved in accrediting these programs appear to require some major revisions if not a new approach. Furthermore the financial implications of continuing on the present course seem to dictate change. And there are significant philosophical questions regarding the training and utilization of allied health workers inherent in the current approach.

These issues give rise to several basic questions for SASHEP.

1. Is accreditation valid for small educational programs in isolated clinical and laboratory settings?

2. In view of current logistical and financial problems, can the current approach to accreditation be sustained?
3. Is there a public need to maintain special accreditation programs for occupations that may never number more than a few thousand workers? Or can other means of quality control, such as registration or certification, more effectively meet this need?
4. Can all allied health educational programs be accredited in a single approach by a single agency?
5. Should accreditation hold the educational institution that awards the academic credential responsible for the total educational program, requiring the institution to monitor the clinical experience?

Alternatives

Depending upon how these questions are answered, one might consider the following alternatives to the present system in formulating recommendations for change:

1. *Design the accreditation procedure in such a manner that the educational institution is responsible for the total education of the student.*

Under such an approach, the educational institution that offers the academic credential could be required to assure the professional competence of both the didactic and clinical faculties and the quality of the clinical experience for educational purposes. By assuring that institutions had the professional expertise and procedures necessary to accomplish this task, accreditation could provide through this means close and continuous monitoring of educational efforts in clinical settings. One institution under such an approach could provide quality-control checks for several clinical programs, dramatically reducing the logistical problems now faced.

2. *Accredit the total allied health offerings of an institution in a single composite approach, relying upon certification, registration, and licensure, where currently required, to provide occupational identity and greater assurances of individual competence.*

Such an approach would allow educators greater latitude in preparing allied health educational workers and would likely enhance career development and lateral and upward mobility. This could greatly simplify the accrediting process, further reducing logistical and financial problems inherent in the current approach.

3. *Continue to provide a means of accrediting small programs in hospitals and laboratories that have no affiliation with educational institutions, but under different and more strenuous procedures.*

Provisions for continued accreditation of small laboratory- and hospital-based programs could take into consideration the inherent limitations of the

accreditation process. For example, to provide reasonable assurance about the quality of the programs and their graduates, annual visits might be required.

SASHEP deliberations may result in the identification of other alternatives to the present approach to accreditation of allied health education. All the alternatives, including the present approach, need to be assessed for their validity and efficiency, with the former being given primary consideration.

TABLE 1

Enrollments and Graduates of AMA-Accredited Programs
In Allied Health Education

PROGRAM	Programs Accredited 7-1-71	Total Enrollment 10-31-70	Average Enrollment 10-31-70	Total Graduates Calendar '70	Average Graduates Calendar '70
Certified Laboratory Assistant	212	2,083	9.8	1,764	8.3
Cytotechnology	117	325	2.8	427	3.6
Histologic Technic	0	0	0.0	0	0.0
Inhalation Therapy	82	2,069	20.5	439	5.4
Medical Assisting	12	423	35.2	130	10.8
Medical Record Librarian	25	215	8.6	280	11.2
Medical Record Technician	29	715	24.6	249	8.6
Medical Technologist	773	5,501	7.1	4,937	6.4
Nuclear Medicine Technologist & Technician	17	229	13.4	162	9.5
Occupational Therapy	36	1,252[a]	34.8	691	19.1
Orthopaedic Physician's Assistant	4	77	19.2	14	3.5
Physical Therapy	50	1,855	37.1	1,349	27.0
Radiation Therapy Technologist	16	49	3.1	77	4.8
Radiologic Technologist	1,146	15,870	13.8	5,975	5.2
Totals	**2,519**	**30,663**	**12.2**	**16,494**	**6.5**

Source: Data supplied by AMA Department of Allied Medical Professions and Services.

[a]Students formally admitted by accredited programs to matriculate in occupational therapy.

TABLE 2

Institutional Locations of AMA-Accredited Programs
In Allied Health Education
July 1, 1971

PROGRAM	Hospitals and Laboratories	Postsecondary Through 2 Years	Colleges and Universities	Total Programs
Certified Laboratory Assistant	159	45	8	212
Cytotechnology	90	0	27	117
Histologic Technic	0	0	0	0
Inhalation Therapy	52	17	13	82
Medical Assisting	0	11	1	12
Medical Record Librarian	7	0	18	25
Medical Record Technician	4	23	2	29
Medical Technologist	724	0	49	773
Nuclear Medicine Technologist & Technician	11	1	5	17
Occupational Therapy	0	0	36	36
Orthopaedic Physician's Assistant	0	3	1	4
Physical Therapy	2	0	48	50
Radiation Therapy Technologist	13	0	3	16
Radiologic Technologist	1,075	40	31	1,146
Totals	**2,136**	**140**	**242**	**2,519**

Source: Data supplied by AMA Department of Allied Medical Professions and Services.

TABLE 3

Graduates of AMA-Accredited Programs
And Estimated Health Occupations Employment

OCCUPATION	Graduates Produced In Calendar 1970[a]	Estimated Number Employed In 1969[b]
Certified Laboratory Assistant	1,764	65,000
Cytotechnologist	427	
Histologic Technician	0	
Inhalation Therapist	439	10,000 to 12,000
Medical Assistant	130	[c]
Medical Record Librarian	280	13,000
Medical Record Technician	249	41,000
Medical Technologist	4,937	50,000
Nuclear Medicine Technologist and Technician	162	[d]
Occupational Therapist	691	7,000
Orthopaedic Physician's Assistant	14	–
Physical Therapist	1,349	14,500
Radiation Therapy Technologist	77	75,000 to 100,000
Radiologic Technologist	5,975	
Totals	**16,494**	**275,000 to 302,500**

[a]Data supplied by AMA Department of Allied Medical Professions and Services.

[b]*Health Resources Statistics: Health Manpower and Health Facilities, 1970*; U.S. Public Health Service Publication No. 1509, 1970 Edition, pp. 7-9. These figures are not limited to graduates of accredited programs or to professionally certified individuals.

[c]275,000 to 300,000 employed in secretarial and office services, including medical assisting.

[d]Included with clinical laboratory and radiologic technology personnel.

TABLE 4

Review Body Policy And Practice For Reevaluation Visits
November 1, 1971

PROGRAM	Policy for Revisits	Current Practice
Certified Laboratory Assistant	5 Years	5 to 8 Years[a]
Cytotechnology	5 Years	5 Years
Histologic Technic	5 Years	new
Inhalation Therapy	5 Years	7 to 10 Years
Medical Assisting	5 Years	new
Medical Record Librarianship	5 Years	6 Years
Medical Record Technician	5 Years	6 Years
Medical Technology	5 Years	5 Years
Nuclear Medicine Technology and Technician	No Policy	new
Occupational Therapy	5 Years	10 Years
Orthopaedic Physician's Assistant	No Policy	new
Physical Therapy	8 Years	8 Years
Radiation Therapy Technologist	No Policy	new
Radiologic Technologist	3 Years	5 to 6 Years

[a]The Committee on Certified Laboratory Assistants of the Board of Schools of Medical Technology expects to be current in its reevaluations by July 1972, according to the Chairman of the Board of Schools of Medical Technology.

FOOTNOTES

1. *See* "Historical Introduction to Accreditation of Health Educational Programs," *SASHEP Part 1: Working Papers.*
2. The present essentials for allied health education, written primarily for clinical and laboratory programs that do not possess the critical educational mass, in many cases prescribe in detail the length and type of curriculum. As educational institutions move toward core curricula for training a variety of health workers, the current essentials may have a limiting effect.
3. Data supplied by the AMA Department of Allied Medical Professions and Services in response to SASHEP questionnaires.
4. For example, *see* "Essentials of an Acceptable School of Medical Technology" and "Essentials of an Acceptable School of Radiation Therapy Technology" (Chicago: American Medical Association, 1968).
5. *See*, for example, "Essentials of an Acceptable School of Medical Technology" (Chicago: American Medical Association, 1968).
6. Verna L. Rausch and Karen R. Karni, "A Tilt at a Windmill? -A Study of Medical Technology Education" (unpublished study, School of Medicine, University of Minnesota, 1971), p. 7.
7. Letter from Executive Director, National Commission on Accrediting, dated August 26, 1971, to institutions offering degrees in medical technology.
8. For example, *see* "Essentials of an Acceptable School of Cytotechnology" (Chicago: American Medical Association, 1967).
9. Essentials for a school of certified laboratory assistants require that "training programs are to be conducted in a manner entirely separate and distinct from concurrent training programs of other laboratory personnel."
10. Only five of the fifteen fields have conducted site visitor training sessions. Of the five, two have only recently begun to hold such sessions and one other conducts the training only sporadically.
11. The budget of the Joint Review Committee on Education for Radiologic Technology, for example, provides only $15,000 for fiscal year '72 for site surveys. This committee relys heavily on site visitors' paying their own expenses.
12. For a discussion of the attitudes of officials of institutions regarding accrediting, *see* "Financing the Accreditation of Health Educational Programs," *SASHEP Part 1: Working Papers*, pp. C11-15.
13. Report of the Task Force, November 10, 1971.
14. Based on figures cited in "Financing the Accreditation of Health Educational Programs," *SASHEP Part 1: Working Papers*, p. C27, and enrollment data supplied by the AMA Department of Allied Medical Professions and Services for enrollment in accredited programs on October 1, 1971.

THE RELATIONSHIP OF ACCREDITATION TO VOLUNTARY CERTIFICATION AND STATE LICENSURE

Karen L. Grimm

Indeed, in one way or another, the profession of medicine, not that of law or the ministry or any other, has come to be the prototype upon which occupations seeking a privileged status today are modeling their aspirations.[1]

Laws and institutions must go hand in hand with the progress of the human mind. As that becomes more developed, more enlightened as new discoveries are made, new truths disclosed and manners and opinions change with the change of circumstances, institutions must advance also and keep pace with the times.[2]

Initiated by different groups, at different points in time, in response to diverse social and economic conditions, the processes of accreditation, certification, and licensure were originally conceived as independent procedures geared to separate, distinct goals and objectives. Today, in the hands of a wide variety of health professions, accreditation, certification, and licensure are bound together by a complex array of interlocking relationships, which through time have forged all three processes into one comprehensive health-manpower-credentialing system.

Accompanying this structural evolution was a revolution in expectations. Once conceived with limited and somewhat prosaic objectives in mind, the companion processes of accreditation, certification, and licensure are now collectively called upon by society to assume the weighty responsibility of identifying competent personnel to staff its health care system. In the course of this metamorphosis, the patterns of control, procedures, and mechanics of accreditation, certification, and licensure have changed little since their inceptions in the nineteenth and early twentieth centuries. However, the social milieu in which they must operate, the purposes they are called upon to serve, and the issues they are expected to address have undergone dramatic transformation.

To what extent have the processes of accreditation, certification, and licensure been willing and able to adapt to the new demands placed upon them by a rapidly changing health care system? Does the present pattern of control over these processes give adequate recognition to their potential complementary effects as well as to their combined impact upon society?

The descriptive material in this paper, except where otherwise footnoted, is based largely on the responses to questionnaires on accreditation, certification, and licensure returned to SASHEP in the spring and summer of 1971.

What role does accreditation play in the current matrix of credentialing processes? Is it duplicative of certification and licensure? Is it complementary? Does it conflict? What modifications in the structure and process of accreditation might be introduced to better adapt it to the credentialing role it is now expected to play?

It is with these questions in mind that this paper will explore, first, the relationship of accreditation to the process of voluntary certification and, second, the relationship of accreditation to state licensure.

Voluntary Certification

Beginnings

Today, certification is performed by twenty primary medical specialty boards, eight dental specialty boards, twelve osteopathic specialty boards, one podiatric specialty board, seven veterinary specialty organizations, and more than twenty-five other independent and allied health professional groups (see tables 1 and 2). Progenitor of these many offspring is the American Board of Ophthalmology, which, effectively though unintentionally, established the model upon which all later health personnel certification programs were to be based.

Medical specialization has a long and varied history; however, certification is a relative newcomer to the American medical scene. One of the first groups of specialists to organize were the ophthalmologists who, by the middle of the nineteenth century, had already banded together into the American Ophthalmological Society, through which they began to address themselves to common professional interests and concerns.[3] As the society grew and matured, the realization "that the existence of unqualified men in their ranks lowered the standards of the entire specialty" prompted several society members to turn their sights to the need for upgraded training in the ophthalmic field.[4] By the early twentieth century, state licensure, advanced degrees, and independent examinations had all been proposed as possible methods of stimulating ophthalmologists to seek the additional training advocated by the society. However, all of these proposals were to remain dormant until 1911 when a specially constituted committee, prompted by the renewed desire of the American Ophthalmological Society "to strengthen its requirements for membership and to exclude those inadequately trained," proposed that an examining board, modeled somewhat after those of the British Royal Colleges of Physicians and Surgeons, be established to certify competence in ophthalmology.[5] Composed of representatives from the American Ophthalmological Society, the American Academy of Ophthalmology, and the American Medical Association's Section on Ophthalmology, the new American Board of Ophthalmic Examinations administered its initial examination in 1916. The first American medical specialty board had been born.

The formation of additional medical specialty boards followed in rapid succession, and medicine slowly reorganized itself to take note of their

existence. In 1933, an Advisory Board for Medical Specialties (now the American Board of Medical Specialties) was formed to coordinate the activities of existing boards and inhibit unnecessary proliferation of new boards. Several years later, the American Medical Association's residency approval program was replaced by the currently used review committee system, which allows for substantial board participation in the residency approval process.[6]

Expansion of the certification system brought not only structural modifications but also major, though subtle, shifts in the purposes, goals, and objectives of board certification. Originally, board certification was intended to serve primarily as a pragmatic tool to determine and classify private association memberships. Today, all medical specialty boards maintain registries that hospitals, physicians, medical schools, and the general public are actively encouraged to consult and utilize in identifying those presumably competent to render specialized medical services: and society, having no alternate yardstick by which to measure specialist competence, has to a large extent adopted for its own use the standards promulgated by the professionally controlled certifying boards.

As a result of both board encouragement and widespread public acceptance, specialty board certification is currently relied upon and utilized by many segments of society. Hospital staff privileges, once primarily contingent upon membership in county or state medical societies, today are in many areas granted only to board-certified or board-eligible physicians.[7] Federal agencies, following Civil Service and military guidelines, utilize board certification as a criterion in hiring, promoting, and classifying personnel. States, charged with licensing health care facilities for the protection of their citizens, rely upon board certification as an index of quality in the formulation and enforcement of hospital codes.[8] State licensing statutes recognize board certification as one method of qualifying for licensure in selected health fields.[9] Health facility accrediting agencies rely upon board certification as one criterion by which to judge the quality of hospital and clinical laboratory staffing arrangements.[10] Medicare regulations call for board-certified or board-eligible specialists to fill selected staff positions in hospitals and clinical laboratories.[11] Though originally designed to confer peer and public recognition on those who had attained specialized knowledge above and beyond that necessary to practice medicine, it would appear that board certification is fast becoming a widely accepted and utilized measure of the *minimal* professional competence needed to practice medicine in certain specialty fields.

Growth

Looking to medicine as a model for their own professional aspirations, other health professions eagerly embraced the concept of certification and began implementing their own certifying programs. Today, these programs are lodged either in a single professional association or in separate boards composed of

representatives from several health professional organizations. In either case, certifying agencies are usually composed solely of health professionals selected by the agency itself, or by its sponsoring health professional association(s) (see table 3).

The control exercised by the certifying body over both the procedural and the substantive aspects of certification is usually substantial. In many cases, certifying bodies have complete authority over the setting of qualifications for certification; in most other cases, board decisions must be referred to the boards' sponsoring organizations only for pro forma approval. In most cases, the preparation and administration of examinations is done primarily by the board; in relatively few instances are professional testing agencies engaged to perform these services.[12] Moreover, since financing is provided primarily through the collection of examination, registration, and renewal fees, most certifying bodies are not only financially solvent but also, to a great extent, economically independent.

The basic certifying process is similar in all health fields. Most health personnel certifying bodies require a stated amount and type of formal educational preparation, experience, or a combination of the two, as prerequisites to sitting for one or several certifying examinations (see table 4). A few certifying bodies recognize several alternate routes to certification, but most require specific formal educational preparation and allow for no deviation from the stipulated educational requirements. Often, certifying requirements also specify that the educational portion of the training must be received in a program accredited by a professionally sponsored and controlled accrediting agency. In such cases, the relationship between accreditation and certification is likely to be both close and intricate, and the profession's ability to exert control over individual entry into the field is likely to be substantial.

Relationship to Accreditation

At the present time, a few health professions sponsor only certification programs; however, the majority sponsor both accreditation and certification programs as two closely related aspects of one standard-setting process (see table 2). In many health professions, both the accreditation and certification programs are located within a single professional association. In other cases, a separate board composed of representatives of several health professional associations performs the certifying function, while a second board, representing the same professional organizations, oversees the companion accrediting process. In both situations, considerable care is usually taken to facilitate communication and interaction between the accrediting and certifying programs.

Individuals applying for certification are soon made aware of the close interrelationships between the two processes and of the professional control that binds them together. As has been briefly noted, graduation from a program accredited by a profession's accrediting arm is often a prerequisite for taking certifying examinations, and those who have not received their training

in such programs are usually ineligible for certification (see table 4). In a few cases, equivalent education or training may be accepted in lieu of graduation from an accredited program, but because the subject matter of certifying examinations is usually closely tied to the curricula recommended or required in accrediting essentials, graduation from an accredited program may in effect be necessary though not formally required. In health professions having no formalized accrediting programs, certifying boards usually approve educational preparation on the basis of predetermined course requirements.

Certifying agencies that require or recommend graduation from an accredited program typically utilize certification as an advance screening mechanism to determine which students should be allowed to take the agency's qualifying examination(s). As a result of this practice, certification often is viewed more as a logical culmination of the educational process than as an independent mechanism designed to test individual competency. In the words of one health professional association,

> Registration is not a permit for employment nor a proficiency examination. Rather it is verification that the holder possesses the competencies the educational program was designed to provide.[13]

The testing requirements for certification further attest to its use as a means of validating educational preparation and accrediting standards. Most certifying agencies require successful performance on one or several qualifying examinations in addition to completion of an approved program of study; however, since examination content is usually closely related to the material taught in accredited programs, certifying examinations often constitute little more than final examinations for those from approved programs. In most cases it would appear that

> previously-qualified students are subjected to narrowly-focused, specialized examinations that are primarily related to formalized academic experience. In short, the examinations actually revalidate academic study rather than assess current competency or past experience.[14]

Consequently, certification is often regarded as little more than a convenient shorthand method of identifying graduates of accredited programs.

The close articulation between certification and accrediting standards has significant impact, not only upon individual students applying for certification, but also upon educational institutions and programs of study. Educational administrators find they must obtain accreditation to establish student eligibility for certification. Program directors find they must tailor their curricula to national professional accrediting standards in order to enable their students to pass national certifying tests. Some schools make graduation itself contingent upon passing registry examinations.[15] Not surprisingly, high pass rates

on certifying examinations emerge as one visible manifestation of the substantial influence of professional standards on educational institutions and programs of study.[16]

From the profession's point of view, the close interrelationship between accreditation and certification is not only natural but necessary. Professions that embark upon certification programs before implementing accrediting programs soon perceive the need to establish baseline standards by which candidates for certification may be easily assessed and upon which certifying examinations may be based. In many cases, the initial years of certification have provided valuable experimental guidance in the development of accrediting standards. On the other hand, professions that establish accrediting programs before implementing certifying procedures soon turn to certification examinations as one means of evaluating the graduates of accredited programs and of testing the validity and effectiveness of the accrediting process.

Most professions that sponsor both accreditation and certification programs view the two processes as complementary screening mechanisms, collectively intended to identify qualified personnel to staff the health care system. It is maintained that one type of screening is provided by the educational process, which monitors and evaluates student performance on an ongoing basis. Consequently, graduation from a professionally accredited program of study is commonly seen as the public's first line of defense against incompetent practitioners. It is argued, however, that since some unqualified individuals may slip through the screen provided by the educational process, certification is needed as an additional safety check to test individual knowledge and capabilities. Both based on the same common core of knowledge and skill that professional expertise and judgment have identified as essential for competent practice, accreditation and certification are most often viewed by the professions as two distinct, but closely interrelated, practices devoted to the one overriding objective of evaluating the competence of those who wish to enter the health manpower pool.

The social desirability of maintaining close linkages between accreditation and certification cannot be ascertained with any certainty at the present time. Proponents maintain that both processes are necessary to protect the health of the public; critics claim that the close interrelationships between the two credentialing mechanisms are utilized in a monopolistic manner to consolidate professional control over individual entry into the health care field. Due to the absence of critical baseline data needed to subject these contentions to objective study, the final resolution of this issue must be left in abeyance.

However, whereas the practice of requiring graduation from an accredited program as a precondition for certification may be neither unreservedly supported nor criticized at the present time, the related practice of binding eligibility for certification to membership in a professional association is undoubtedly open to serious question. A few associations, harking back to the example set by the American Ophthalmological Society, still utilize certification as a

means of evaluating prospective members and require certification as one criterion for association membership.[17] Under ordinary conditions, this practice probably cannot and should not be faulted by the public, which cannot presume to dictate criteria for membership in a private association. However, the converse of this policy—the requiring of membership in a given professional association for initial certification, renewed registration, or both—is a common practice vulnerable to criticism on several counts. (Table 4 indicates the widespread nature of this practice.)

Based on the contention that the profession cannot adequately exercise control over the individual practitioner nor vouch for his competency if he is not a member of his professional association, the requirement of association membership is viewed as entirely justifiable by many health professional organizations that maintain certifying bodies. Yet, from the individual applicant's point of view, the requirement of association membership may be seen in a more coercive light, especially if the lack of certification has the effect of severely limiting his employment prospects and opportunities. In such cases, a health professional's ability to practice may become directly dependent upon his willingness to pay membership dues to a private association, much as a lawyer's right to practice is often contingent upon his membership in a state bar association.[18] Moreover, even when certification is not a de facto precondition for employment, the lack of certification may work considerable hardship on the individual by denying him the financial and psychological rewards that typically accompany certified status. The appropriateness of making certification contingent upon membership in a private association raises an issue of substantial social importance.

Changing Goals

It would appear that many of the motivating factors that prompted the formation of the American Board of Ophthalmology, including the desire for increased professional recognition and status, were equally active in the founding of later professional certifying bodies. However, though motivated by many of the same concerns as those that triggered the founding of the first certifying board, other health professions also have sought to mold and adapt the certifying process to meet their own particular needs, times, and professional goals. Change—both in the functions and objectives of certification—has been the inevitable but foreseeable result.

Paralleling the gradually changing functions of specialty board certification, the certification practiced by other health professions has also undergone transformation. Like the medical specialty boards, other health certifying bodies also actively encourage the public to use certification designations as criteria for judging individual competency; and society, responding to these certification programs in much the same manner as it responded to medical specialty certification, has shown itself more than willing to rely upon the professions to perform this vital service.

Today, employers of health personnel rely heavily upon certification to identify individuals of presumed competency. In some cases, employers are grateful to the professional sector for its aid in screening prospective employees and readily utilize the certifying services it provides. Individual employers, seeking to fill specific openings, request certifying bodies to provide names of qualified individuals and use registry lists to verify the qualifications of job applicants; classified advertisements announce employer intentions to hire only certified individuals; federal Civil Service and military personnel systems utilize certification as one measure of competence in evaluating individuals for entry and placement; and hospital personnel officers rely heavily on certification as a guide in classifying hospital personnel.

In other cases, subtle outside pressures to hire certified personnel may be brought to bear, with the result that employers sometimes regard certification more as a hindrance than as a positive benefit. For example, hospitals seeking accreditation from the Joint Commission on Accreditation of Hospitals may feel substantial pressure to hire the certified personnel recommended in JCAH Standards;[19] hospitals, extended care facilities, and home health agencies wishing to establish their eligibility for Medicare funds may feel constrained to look for the certified personnel referred to in government program regulations and directives;[20] and schools seeking accreditation from professional accrediting agencies may feel themselves obliged to hire the certified personnel required or recommended in accrediting essentials.[21] There is little doubt that certification, though voluntary, can exert considerable influence and control over the utilization of health personnel.

The effectiveness of certification is also promoted by state agencies, which often utilize certification as a basis upon which to grant authority to practice. In health professions governed by both voluntary certification and state licensure, professional certification is often accepted in lieu of the state licensing examination for initial licensure, reciprocity privileges, or both. For example, in most states, physical therapists were grandfathered into practice on the basis of the certification granted by the American Registry of Physical Therapists. Likewise, the diploma granted by the American Board of Professional Psychology is usually accepted in lieu of state licensing examinations; registration by the American Registry of Radiologic Technologists is recognized in lieu of state examinations in the three states that currently license radiologic technologists; and the certification granted by the eight dental specialty boards is used as the basis for licensure in all twelve states requiring the licensing of dental specialists. In similar manner, state clinical laboratory acts usually recognize certification by the Registry of Medical Technologists (ASCP) in lieu of specific education, experience, or testing requirements promulgated by the state; moreover, in at least one state, ASCP certification is a necessary prerequisite for state licensure.[22]

Like medical board certification, certification in other health professions has come to be relied upon and utilized by many segments of society. However, unlike medical board certification, the certification provided by most other health professions has been asked to assume another additional role—a proscriptive, regulatory role it was never intended to play.

Certification and Licensure—Which is Which?

Today, certification is commonly believed to represent a higher standard of quality than that minimally required to practice, while licensure is defined as a process which, by requiring and enforcing minimal standards, is designed to protect the public from incompetent and unqualified practitioners.[23] However, there is growing evidence to suggest that the distinctions between the two processes are becoming increasingly blurred in the eyes of both the professions and the public.

Medical specialty boards typically disclaim any intention of excluding uncertified specialists or general practitioners from practice. In similar manner, the certification practiced by most other licensed health professions is intended to function, not as an exclusionary device, but rather as a mechanism designed to provide recognition to individuals who have acquired knowledge and competence beyond that minimally required to practice. However, in contrast to this type of certification, the certification programs currently sponsored by most unlicensed health professions appear to have the regulation and enforcement of minimal standards foremost in mind, and their success is judged accordingly. As one recent government report has noted, "Many associations have set *minimum* certification requirements for beginning workers which in effect attempt to *prevent* employment of uncertified persons."[24]

A sampling of various statements of purpose issued by certifying bodies bear out this observation. For example, it is stated that the Registry of Medical Technologists (ASCP) was founded for the purpose of establishing "the *minimum* standard of educational and technical qualifications for various technical workers in clinical, research, and public health laboratories."[25] The American Registry of Radiologic Technologists was founded for the purpose of providing "a means of recognition for the *qualified* technologist."[26] The certification procedures of the American Occupational Therapy Association were originally instituted "for the *protection* of hospitals and institutions from *unqualified* persons posing as occupational therapists,"[27] and are currently intended to function as "*entry* qualifications for rendering occupational therapy services."[28] Similarly, it is maintained that the certifying program of the American Speech and Hearing Association is intended "to *protect* the public by providing a means by which it can be assured of at least a *minimum* level of competence in the delivery of clinical service to the communicatively disordered."[29]

Attempting to bypass the myriad problems associated with state licensure, many health professional associations apparently opt for certification as a hopefully viable alternative to state licensure for protecting the health of the public. Reflecting this sentiment, the president of one professional association states:

> If state legislatures can be persuaded to postpone enactment of licensure laws, I believe that we can demonstrate through the work of the Registry, the AAIT Technician Certification Board and the Association's expanded continuing education efforts, that our stress on excellence provides the best possible protection for the public.[30]

Like the American Association of Inhalation Therapists, many health professional associations continue to oppose state licensure in the hope that certification will be able to provide adequate protection for the public. However, other health professions, apparently disillusioned with the performance of certification in providing such assurance, have already turned to state licensure to assume the responsibility for protecting the public from unqualified personnel. The underlying reason for this shift in focus is clearly stated by one association that has chosen the state licensure option.

> The principal-reason for choosing this route of credentialing was the failure of a certification process that had preexisted. Any credentialing process should ensure the public of a reasonable standard of proficiency of the credentialed person, deter those not qualified from presenting themselves as qualified, and define a legally supported description of the scope of activity of the credentialed person. It was believed that uniform state licensure would accomplish these purposes where the previously existing certification process had not.[31]

Likewise, another association recently endorsed a policy favoring state licensure because it was realized that the existing certification mechanism had not "effectively controlled the employment of nonqualified individuals, or the placement of those with little education and experience in supervisory positions."[32]

Further confusion between the proper role and functions of certification as opposed to those of state licensure results from the incorporation of certification standards into licensing statutes and the perception of certification as a mere steppingstone to state licensure. It is widely assumed that licensure requires minimal standards, whereas certification is intended to recognize achievement beyond that necessary to practice. However, in several cases, the requirements set by certifying boards are proposed to serve as the minimal

standards to be utilized by licensing bodies.[33] From all indications, it would appear that for many professions certification standards are intended to function as the minimal requirements for practice.

Whether by professional encouragement, societal acceptance, or a combination of the two, it is obvious that certification has undergone substantial change in the course of the past fifty years. Originally intended to recognize advanced achievement in a specialty, certification is now, in many cases, utilized to measure basic professional competence. Originally established as a process distinct from, and in addition to, state licensure, it is now, in many cases, regarded by both the professions and society as an alternative mechanism to fulfill the purposes only licensure was, and is, intended to serve. Originally fashioned with professional needs, desires, and aspirations foremost in mind, it is now both lauded and justified primarily on the basis of its service to society.

In the course of the past half century, the outward forms and mechanics of certification have remained virtually unchanged. However, the objectives and functions of certification have undergone a startling and significant transformation. Whether the present certification process is structurally and functionally attuned to current *societal* needs, demands, and expectations merits serious consideration.

State Licensure

Beginnings

Prompted by the desire to protect both the profession and the public from incompetent and unscrupulous practitioners, medical societies by the early years of the nineteenth century had succeeded in persuading state legislatures to pass laws requiring the licensure of physicians.[34] In the mid-1800s, the spirit of laissez faire effectively quashed these nascent regulatory attempts, and, in some cases, forced the repeal of previously enacted licensing statutes.[35] However, at the end of the century, the American Medical Association and its constituent state societies succeeded in reviving direct licensure by state boards, with the result that by 1900 forty-one states had enacted laws governing the entry of physicians into the practice of medicine.[36]

Where medicine blazed the path, other health professions soon followed. Seeking to exert the same control over their members as the AMA did over the medical profession, other health professional associations soon sought to have licensing laws enacted to protect both their professions and the health of the general public. Many succeeded, and, in most cases, the model for state licensure established by the AMA has been, and continues to be, closely followed by other professions seeking state licensure.

Just as early state legislatures delegated the primary responsibility for formulating and enforcing medical licensing laws to the medical profession, so too do states continue to rely upon other health professions for both formulating and enforcing their own licensing statutes. Model statutes are usually drawn

up by national health professional organizations; and state associations, often founded for the express purpose of securing passage of licensure laws, run the proposed bills through the legislative mill.[37] State licensing boards are usually selected from lists provided by state health professional associations, and professionally drafted codes of ethics are many times incorporated into board regulations.[38]

State boards usually maintain close relationships with their counterpart state associations. Some boards turn a substantial portion of their disciplinary responsibilities over to state association grievance committees and subsidize the activities of their companion associations; in other cases, state associations subsidize the investigative operations of their counterpart licensing boards. Often office space, employees, and facilities are shared.[39]

On the national level, national health professional associations may be given substantial responsibility for disseminating information on state board requirements and activities, operating interstate reporting services, preparing examinations for use by state boards, and evaluating the credentials of foreign-trained health professionals. Even more important, national professional associations may also be given sole responsibility for identifying programs of study deemed acceptable to admit prospective health professionals to state licensing examinations. It is through this important delegated privilege that the professional association gains substantial power to determine not only the quality but also the quantity of personnel available to staff the health care system.

Relationship to Accreditation

The close relationship between accreditation and state licensure that currently exists was forged by the medical profession early in the twentieth century. As early as 1880, the Illinois Board of Health, functioning as the state's licensing authority, prepared a list of "acceptable" medical schools on the basis of criteria similar to those proposed by Nathan Davis of the American Medical Association; however, it was not until 1901, when an administrative reorganization of the AMA gave additional impetus and visibility to the twin concerns of education and licensure, that the two processes began to become firmly linked in the minds and actions of the AMA.[40]

In the first decade of the twentieth century, accreditation and licensure quickly became merged into one master system designed to upgrade educational standards and to exclude the unqualified. In 1904, the newly reorganized and renamed Council on Medical Education, at its first conference held in conjunction with state licensing boards, adopted an "ideal" standard for medical education. In 1906, the council exposed inadequate schools through the utilization and publication of licensing examination scores and in 1907 began to inspect and grade the schools as a guide to state licensing boards.[41] By 1910, the stage had been well set for the publication of the Flexner Report and the implementation of a fully developed accrediting program.

In light of the close working relationships and the identity of interests between state licensing boards and the AMA, it is little wonder that the accrediting standards adopted by the AMA soon were incorporated into state licensing statutes and board regulations. Today, all medical examining boards require graduation from an AMA-AAMC-accredited medical school as a prerequisite for state licensure.[42] As a result, all medical schools quite rightly regard accreditation as necessary for their survival and actively seek to obtain and maintain accredited status.

Following the medical model, other health professions also sought, and to a large extent succeeded, in having professionally determined accrediting standards accepted as a basic criterion for state licensure. A survey of licensing statutes currently on the books reveals that many statutes specifically require graduation from a professionally accredited school or educational program as a prerequisite for admission to state licensing examinations (see table 5). Other statutes specify that, while programs must be "approved by the board," the board "may" rely upon the standards and lists provided by national accrediting agencies in making its determinations.[43] In addition, a number of statutes, while not explicitly requiring graduation from an accredited program or recommending reliance on national accrediting standards, nevertheless incorporate the educational standards outlined in professional accrediting essentials, require education equivalent to that offered in professionally accredited programs of study,[44] or stipulate that licensing examinations be based upon the curricula required or recommended by national professional accrediting agencies.[45]

When state statutes are silent on the specific requirements for program approval, board rules and regulations, which have the force of law, usually spell out the accrediting guidelines to be utilized by the board in determining the acceptability of educational preparation.[46] In other cases, boards may as a matter of course require graduation from an accredited program though no written directives require that they do so. Furthermore, certain specific practices of the board, including the utilization of examinations specifically geared to accredited coursework requirements, may necessitate graduation from an accredited program though no requirement to this effect is to be found in either statutory provisions, board regulations, or routine practices of the board.

Most state boards choose to rely upon the lists provided by national accrediting agencies and therefore do not conduct their own independent approval programs. However, the statutes for a few health professions—notably nursing—not only require that programs be board approved but also specifically provide for the implementation of board approval programs to ensure that the statutory directives are carried out. In response to these delegations of authority, most nursing boards conduct their own extensive intrastate accrediting programs.[47] (In other health professions, the requirement of board approval is usually met by the inclusion of one or two state board representatives on national accrediting site visit teams.) Furthermore, in a few states, centralized state administrative agencies continue to conduct comprehensive in-state approval programs upon which board acceptance is based (see table 5).

However, while a few state boards and centralized state departments continue to conduct their own intrastate approval programs, most boards, of necessity, rely almost exclusively upon the lists provided by national accrediting agencies for the evaluation of out-of-state educational preparation. A prospective licensee able to produce a diploma from a nationally accredited school will usually be admitted to the state licensing examination of his choice. Likewise, the licensed individual who wishes to move to another state usually will be initially screened on the basis of his educational credentials. The graduate of a nationally accredited program will often be admitted to practice without examination; in contrast, the graduate of a nonaccredited program usually will not even be allowed to sit for the required licensing examination(s).

Well aware of the close relationship between state licensing provisions and accrediting standards, most national professional associations seek to ensure continuing communication between state boards and their counterpart national accrediting agencies. In some professions, this is accomplished through the inclusion of accrediting representatives on national boards of examiners[48] or, conversely, through the inclusion of state board members in national accrediting agencies.[49] In other cases, annual meetings between the national association of state boards and the appropriate national accrediting agency are intended to serve the same purpose. Whatever the means, the motivation for promoting close cooperation between state licensing agencies and national accrediting bodies is clear: licensing provisos must be made to keep pace with upgraded educational requirements, and accrediting standards must be formulated and implemented in full cognizance of their potential effect on state licensing laws.

In many respects, national accreditation has served state licensing agencies well. The accrediting programs of health professional associations have relieved most state licensing boards of the responsibility for evaluating educational programs and the expense of mounting their own full-scale accrediting programs.[50] Whereas the incorporation of specific coursework requirements into licensing statutes may ossify educational standards and inhibit necessary and desirable educational innovation, the requirement for national accreditation provides a built-in mechanism by which educational prerequisites for licensure may be kept automatically abreast of changing educational needs and requirements. Moreover, there is little doubt that interstate mobility has been greatly facilitated by the existence of national educational standards and norms. By providing state boards a readily usable yardstick for evaluating licensure candidates, national professional accreditation has, in effect, established national baseline standards for selected categories of health personnel.

Still, the utilization of national professional accreditation as a criterion for state licensure may also have the detrimental effect of barring otherwise qualified individuals from obtaining state licensure. Conversely, it would appear that for those graduated from accredited programs, the licensing examination often constitutes little more than a "technical formality" to be undergone in deference to a possibly outmoded, double-jeopardy system of quality control.[51] In

the words of one observer, "Is [the licensing] examination a methodology for testing recall or for testing competence to serve?"[52]

From the accrediting agency's point of view, the incorporation of voluntary accrediting standards into state licensing statutes and regulations lends authority to the standards and promotes the effectiveness and general acceptance of the accrediting program. There is little doubt that "private accrediting activities would be far less effective if it were not for public laws recognizing and enforcing the private standards."[53] In addition, the incorporation of accrediting standards into state licensing laws allows national accrediting agencies to utilize the results of state and national board examinations as one means of evaluating the quality of educational programs and the validity of their accrediting standards.

Originally conceived as separate processes geared to somewhat different goals, accreditation and state licensure have, over time, become linked together in the pursuit of one overriding objective the identification of qualified personnel and the exclusion of the presumed unqualified from practice. Like certification, state licensure no longer can be considered a self-contained process beholden primarily to professional interests, but rather must be further examined in the light of present-day demands and current interlocking relationships.

The Current Health-Manpower Credentialing System

The Issue of Professional Control

Accepting the claim that only the professions themselves have the requisite expertise to set standards for professional education and practice, society has, in the past, delegated exclusive control over the standard-setting activity to groups and associations representing professional interests. These groups, in turn, have responded by forging numerous and complex interrelationships among the mechanisms through which this control is exerted. However, there is increasing evidence to suggest that the patterns of control accepted by society in the past may not be so uncritically accepted in the future. Whereas

> only a few years ago, issues such as licensing, certification, and accreditation were generally thought to be the concern of only the professional individuals and organizations that were affected by them. . . . today, these matters are not immune from public criticism; and the responsibility of both public and private leadership is to fuse health-manpower credentialing with the public interest.[54]

As never before, health professional control over the processes of accreditation, certification, and licensure is being subjected to scrutiny and criticism. Critics are quick to point out that accreditation, certification, and licensure are justified on the basis of service to the public and that, on this basis, society has

given the professions carte blanche to set standards that can affect not only the quality and utilization but also the number of personnel available to deliver health care. Though it is admitted that the control over standards exercised by the professions has usually been attuned to society's best interests, it is also suggested that this has not always been the case.[55] Nor is it to be expected that the professions will always put societal interests above professional concerns for

> the goals of professional associations include both protection of the profession and protection of the public. The two goals, of course, need not be conflicting and are most often served simultaneously. . . . They do conflict some times, however, and it is true that when both cannot be served, professions often promote that which best suits their interests even though this may be contrary to the public good.[56]

From all indications, it would appear that the dangers inherent in allowing exclusive professional control over entry into the health professions are neither imaginary nor insignificant.

The Potential for Exclusion

One criticism of current credentialing procedures centers on the system's alleged ability to exclude qualified individuals from entering the health manpower pool. For example, it is contended that military personnel, having successfully completed nonaccredited military training programs, are usually ineligible to sit for certification and licensing examinations. Likewise, it is alleged that the economically deprived may be discouraged from entering certain health professions by unnecessary lock-step educational requirements promulgated by national professional associations through their accrediting and certifying arms. As one authority insists:

> The processes that we are concerned about build Chinese walls of exclusion around an increasing number of occupations. We have a new guild system of credentials, licenses, certificates--largely built on the base of education--which keeps people out of many occupational channels.[57]

A recent state government study adds:

> The training, certification, and licensing of supporting personnel are determined by a confusing array of professional, craft, and governmental regulations and restrictions that tend to make dead-end streets of many areas of supporting medical service and limit the opportunity for advancement in skills, leadership, and economic rewards.[58]

There is undoubtedly some truth in these observations. However, it is also evident that the health professions, aided by both government interest and funds, are making substantial progress towards developing alternate methods of evaluating competency and facilitating the entry of additional qualified personnel into the health manpower pool. Proficiency examinations for selected categories of laboratory and physical therapy personnel have already been implemented, and similar proficiency and equivalency tests for other health professions are in planning and developmental stages.[5 9] Taking a slightly different approach, the American Medical Association's Task Force on Military Allied Medical Education is actively attempting to encourage the entry of military personnel into the civilian health care sector through further extension of AMA accreditation to military training programs and through the development of more effective interfaces between existing military and civilian health personnel credentialing systems. Several registries, acting on their own initiatives, have already taken action to make military personnel eligible for certification (see table 4).

In apparent cooperation with these efforts, the Joint Commission on Accreditation of Hospitals now recognizes "equivalents" to formal education, accreditation, and certification as legitimate criteria for the evaluation of hospital staffing arrangements.[60] Similarly, many schools are currently experimenting with credit-by-examination programs.[61] Tacitly endorsing these combined approaches, the Department of Health, Education, and Welfare has recently put its substantial weight behind the equivalency movement by recommending "the development of meaningful equivalency and proficiency examinations in appropriate categories of health personnel," calling upon the states "to assist in the implementation of this effort by amending licensing laws . . . that will recognize such examinations for purposes of granting advanced educational or job placement," and requesting educational institutions, accrediting agencies, and certifying bodies "to continue to formulate programs that accept alternatives to formal education for entry into career fields."[62]

From all indications, it would appear that action is being taken on many fronts to identify and break down existing barriers to optimal manpower utilization. Since quality care is an elusive goal and the educational and experience requirements for its achievement are not easily defined, the progress in evolving alternative mechanisms to evaluate quality and competency will likely be both slow and painstaking. However, encouraged by the awakening skepticism toward all credentialing forms and procedures, traditional formal learning processes, and current methods of assessing quality, efforts to create additional points of entry into the health manpower pool will probably be mounted with ever-increasing frequency in the years ahead.

The Potential for Overeducation

Closely related to the problem of exclusion is the current system's potential for promoting overeducation. One apparently inherent and natural goal toward

which all professions strive is the raising of their collective professional status and performance opportunities. This goal, in turn, is often translated into the desire to upgrade standards for entry into the profession. As a result, hospital schools may be forced to give way to programs housed in academic institutions, and accrediting programs may be revised to encourage the desired transition. In other cases, requirements for licensure may be raised.[63] In unlicensed professions, educational requirements for certification may be upgraded.

In some instances, increased requirements may benefit society as well as the profession. However, if unrelated to actual job requirements, upgraded standards for practice may have the detrimental effect of limiting competition in fields already short of manpower, thereby raising the costs of providing adequate medical care. Alternatively, health providers may be forced to employ underqualified personnel. In addition, overtraining may result in increased job dissatisfaction and employment turnover as well as unnecessary expenditures of time and money on the part of both educational institutions and their students.

The crucial underlying problem is that of assuring adequate quality *and* availability of health personnel. Obviously, unnecessary and unjustifiable overemphasis on the first objective may well endanger the second. As one observer has noted, in setting standards, "caution is necessary lest the tendency to upgrade by exclusion, which lowers the amount of care available to the public, creeps into the process."[64] Yet, overemphasis on quantity at the possible expense of quality may have an equally detrimental effect on the functioning of the health care system. Clearly, the public interest demands that society's need for additional health personnel be carefully and impartially weighed against its equally strong desire for high-quality medical care.

Lay Representation: A Promising Antidote?

Having become aware of the crucial role health professional associations play in influencing the quality and quantity of health personnel, the public is turning its sights with heightening interest and concern to the mechanisms through which professional control is exercised.

The composition of licensing boards represents one point of concern. As has been noted, many state licensing boards are composed solely of representatives of the health profession supposedly being regulated. In other cases, the boards are composed of members of one profession, which exercises complete control over the licensing of another, related profession. In either case, almost all state licensing boards, unlike most other regulatory agencies, are composed solely of individuals having direct professional and economic interests in the areas regulated by the boards.[65]

Implicit in this unusual delegation of authority is the assumption that professionals are responsible "that the profession itself may be trusted to undertake the proper regulatory action on those rare occasions when an individual does not perform his work competently or ethically."[66] However, there is some evidence to suggest that this assumption may not be altogether well

founded,[67] and charges of control by vested interests are being heard with increasing frequency.

One proposed remedy to provide greater public accountability in the licensing process calls for the inclusion of one or several lay representatives on all state licensing boards. As one observer has noted:

> Probably at no time in the history of our country has there been more demand for citizen participation in the affairs of life that affect his existence. Yet, the opportunity for the consumer to present his viewpoint in the licensure and certification procedure is rare indeed.[68]

Assuming that licensing boards deal not only with narrow, clear-cut questions of professional competency but also with issues of broad social concern, proponents of lay representation maintain that the infusion of ideas from the community would help to combat the natural insularity of the boards. Apparently agreeing with these arguments and concerns, various government studies have recently recommended the inclusion of lay representatives on state licensing bodies,[69] and several states have already taken steps to include public representatives on their examining boards.[70]

On the other hand, opponents of lay representation claim that licensure is so dependent upon technical knowledge and expertise that a public representative would have little, if anything, to contribute to the licensing process. Significant difficulties in implementing the somewhat nebulous concept of *public* are also predicted. Clearly, it remains to be seen whether token public representation on state licensing boards will, in fact, improve the licensing process and insure the type and degree of public accountability presumably desired.

Though not as widely advocated as public representation on state licensing boards, lay representation on specialized accrediting bodies has also been proposed by a number of observers of the health manpower scene. Assuming that the primary function of accreditation is to serve the needs of society, the proponents of lay representation argue that such a mechanism is needed to insure that the accrediting process is truly operated in the public interest. Responding to this argument, several accrediting agencies have already included representatives of the public on their boards,[71] and others are considering similar changes.[72]

The consumer movement has apparently affected not only public regulatory boards but also private voluntary associations and programs holding themselves out to be protectors of the public interest. From all indications

> it would appear that the public demands to know and will receive the basis upon which judgments regarding the quality of health care are made; and the techniques and procedures for review will be developed for all to see and share.[73]

It is thought by some that lay representation on accrediting, certifying, and licensing boards represents the best means by which these objectives can be met.

The Issue of Performance

One set of criticisms leveled at the current credentialing system revolves around the issue of professional control and the potential dangers it introduces into the health care system. Another set of criticisms focuses on the system's inadequacies in carrying out its presumed responsibilities.

In the process of being forged into one credentialing system, accreditation, certification, and licensure have individually and collectively undergone subtle, though substantial, shifts in purposes, goals, and objectives. Of the three processes, only licensure was originally intended to protect the public from incompetent practitioners; today accreditation and certification are being called upon to perform much the same function. Not surprisingly, there is increasing evidence to suggest that the three processes, having been developed in response to needs and objectives different from those of today, are not adequately equipped to meet the demands and expectations of the present time.

As has been noted, the same certification mechanism that was originally designed to screen candidates for membership privileges in a private association is today, in many cases, intended to exclude the unqualified from practice. Discussions of licensure posit certification as a possible alternative to state licensure, but point out that certification has many of the faults of licensure, namely, "slowness in responding to changing service roles; lack of routes to certification or registration other than through completion of formal educational programs; duplicative educational requirements; restriction of upward and lateral career mobility; and lack of a mechanism to assure continuing competency."[7 4]

These allegations may be true; however, what is often overlooked is that the certification mechanism was not originally designed to identify individuals *minimally* qualified to practice, nor was it designed to be responsive to the problems mentioned above. By identifying personnel believed to be competent to render high-quality medical care, certification has provided–and continues to provide–a vital and valuable service to society. However, like accreditation and licensure, certification labors under certain inherent limitations that have significant impact upon the functions it reasonably can be expected to serve.

Above all, certification is a *voluntary* system, based upon widespread public recognition of the meaning of certified status and employer acceptance of its validity and worth. In the light of this fact, it is not surprising that most certifying agencies have had only modest success in prohibiting the employment of uncertified individuals. Nor does it appear likely, given current conditions, that certification can successfully function as a compulsory system capable of excluding the unqualified from practice. If incorporated into the

personnel standards of a comprehensive national health insurance system, voluntary professional certification could conceivably function as a de facto compulsory system; however, given existing methods of financing health care, it appears both utopian and unfair to expect certification to fulfill functions only licensure is now equipped to serve.

Many of the inadequacies of state licensure can also be attributed, at least in part, to the phenomena of changing times and expectations. Evolved before the explosion of scientific knowledge and the emergence of supportive health professions, state licensure has undergone little change since its revival almost one hundred years ago. Since that time, the advent of new occupations achieving licensure has brought in its wake significant problems concerning advisable scopes of practice, legally permissible delegation of tasks, and overspecialization and detrimental fragmentation in the delivery of health care. The knowledge explosion has focused attention on the problem of educational obsolescence, the inability of licensing statutes to keep abreast of changing educational needs and requirements, and the need to protect the public from unqualified specialists. Increased geographic mobility has highlighted the shortcomings of current endorsement and reciprocity practices. Other current problems, including manpower shortages and spiraling costs, have focused attention on the barriers to vertical and lateral mobility posed by state licensing statutes as well as the inhibiting effects of licensure on innovation and experimentation in the delivery of health care.[7 5]

There is little doubt that the power and responsibility for effecting necessary changes in state licensure reside primarily in the licensing agencies themselves. It is argued that licensing boards, by virtue of their heavy reliance on national accreditation and national board examinations, have already relieved themselves of substantial responsibility for evaluating entry qualifications and could, therefore, devote increased time and attention to overcoming the serious impediments to improved manpower utilization, distribution, supply, and quality posed by existing licensing laws. Some observers have specifically suggested that licensing boards shift their focus of attention from the evaluation of the educational preparation of licensing applicants to the monitoring of the quality and continued competence of practicing health professionals; a few have even proposed that graduation from nationally accredited or approved programs serve as the sole criterion for licensure, as it currently does in some foreign jurisdictions. In any event, it appears reasonable to predict that licensing boards will be asked and expected to assume progressively greater responsibility for insuring the optimal functioning of state licensing laws. As Ruth Roemer, a recognized authority on the legal regulation of health personnel, has noted:

> Vast improvements in educational programs and the drive for national standards in education, assisted by a strengthened system of accrediting, suggest that perhaps the time has come to conceive of

licensure as having a broader purpose than regulation of minimum qualifications.[76]

Changing patterns in the delivery of health care, the evolution of scientific knowledge, and the development of national accreditation have converged to render the process of state licensure, if not obsolete, at least less than optimally effective. Various steps, including the adoption of continuing education requirements, the crediting of previously gained experience and education toward licensing requirements, and the broadening of delegatory provisions, have already been implemented by some states endeavoring to adapt licensure to present day needs and demands. In addition, institutional licensure has been proposed as a preferable alternative to the licensure of individual practitioners. Others forecast that the advent of national health insurance will alleviate licensing problems by minimizing, if not entirely negating, public reliance on the licensing process. In any event, it would appear that no long-term resolution of these problems will be effected without careful examination of the purposes able to be served by licensing in the light of those able to be performed by voluntary accreditation and certification.

The Role of Accreditation in the Health-Manpower Credentialing System

Like certification and licensure, accreditation was born in an earlier era when the demands placed upon it were somewhat more limited than they are today. On the assumption that the quality of inputs into the health care system in large part determines the quality of health care ultimately delivered, society initially accorded to accreditation the primary responsibility for identifying educational programs believed to have the ability to train qualified health personnel. However, largely through the incorporation of accrediting standards into licensure and certification requirements, this rather restricted scope of responsibility has undergone not only expansion but also qualitative change.

Although it has become common to define certification and licensure as mechanisms designed to test individual competency and quality, while accreditation is believed to address the quality of educational preparation, it would appear that this distinction is fast becoming more semantic than real. At the present time, accreditation is widely utilized as a sole measure of individual competency; in numerous other instances, accreditation is teamed with certification or licensure to identify qualified personnel. Considered in toto, there is little doubt that accreditation is heavily relied upon to identify *individual* practitioners of presumed competency.

Some question the appropriateness of utilizing accreditation, either singly or in combination with certification and licensure, as a personnel credentialing mechanism. Others accept health-manpower credentialing as an appropriate function of accreditation but question the manner in which it currently seeks

to fulfill its substantial credentialing responsibilities. In assessing both the current and potential effectiveness of accreditation as a credentialing agent, the following questions should be considered:

1. *Through its incorporation into licensing statutes, accreditation has the power to exert considerable control over both the quality and quantity of available health personnel.*

Is the current *structure* of accreditation reflective of its substantial public trust responsibilities?

Is the current *process* of accreditation conducive to generating public confidence in the determinations of accrediting authorities?

2. *Certifying and licensing examinations often serve to validate accredited educational preparation.*

Are the processes of certification and licensure duplicative of accreditation?

Should licensure and certification be granted without examination to graduates of accredited programs?

In the absence of licensing examinations, is the accrediting process sufficiently reliable to vouchsafe the competency of individual practitioners?

What criteria should govern the selection of any one or several credentialing mechanisms for any given health profession?

3. *Certifying bodies and licensing boards utilize accreditation standards both as a screening device for prospective applicants and as a basis for examinations; accrediting agencies utilize the results of certification and licensing examinations to evaluate accreditation standards, educational programs, and the overall validity of the accrediting process.*

Are the functions of accreditation, certification, and licensure complementary?

Do the close operational relationships between accreditation, certification, and licensure enhance or jeopardize the overall effectiveness of the health-manpower credentialing system?

Should licensure and certification be dependent upon graduation from an accredited program, or does this requirement unnecessarily limit entry into the health manpower pool?

Should certification and licensing examinations be based upon the subject matter taught in accredited programs, or does this practice compromise the functioning of licensure and certification as independent assessment mechanisms?

Is the utilization of licensing and certification examination scores a valid method of evaluating educational programs and accrediting standards, or are other, more independent, evaluative mechanisms needed to provide an adequate, reliable data base for accrediting agencies?

If close operational relationships between accreditation, certification, and licensure are desirable, what type of accrediting structure would facilitate this goal; or, if close operational relationships are thought to be socially undesirable, what type of accrediting structure would serve to minimize the opportunities for close collaboration between the three processes?

4. *Accreditation and certification are, at least theoretically, designed to promote high standards for education and practice; licensure is intended to certify minimal competence.*

Does the incorporation of certification and accreditation standards into licensing statutes bring the goals of accreditation and certification into conflict with those of state licensure?

Are the educational standards promulgated by national professional accrediting agencies the *minimal* thought to be required to produce competent personnel or the *optimal* desired to upgrade professional education and practice?

Should the educational requirements for state licensure be equivalent to national accrediting standards; or do national accrediting standards, when adopted by state licensing bodies, unnecessarily restrict the number of minimally qualified individuals able to enter the health manpower pool?

Are national certification standards set at a minimal level, or are they set at a level higher than that thought to be minimally required for safe and competent practice?

Should certification standards be proposed and adopted as the minimal requirements for state licensure, or do these practices jeopardize the basic functions licensure and certification individually are intended to serve?

The current health-manpower credentialing system is obviously complex and the interrelationships among its three component members intricate. One recent report, in noting the large array of screening devices utilized to govern entry into the medical profession, has observed that

> the elements of this governing structure were developed at different times to meet different needs. Each has been constructive. Yet it seems unlikely that anyone would design from the beginning a system of such diffuseness and complexity.[7 7]

The same can be said of the present, overall health-manpower credentialing system. What is needed is an effective and efficient system that minimizes unnecessary duplication, promotes beneficial complementary relationships, reduces potential goal conflicts among its component members, and assures that the public interest will be well and adequately served. It is to these needs, among others, that any future system of specialized health accreditation will have to be responsive.

FOOTNOTES

1. Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Co., 1970), p. xviii.
2. Thomas Jefferson, quoted by Robert H. Kroepsch in *Health Manpower: Adapting in the Seventies* (New York: National Health Council, 1971), p. 143.
3. George Rosen. "Origins of Medical Specialization," *Ciba Symposia*, September-November, 1949, p. 1,138.
4. Commission on Graduate Medical Education. *Report of the Commission on Graduate Medical Education* (Chicago: University of Chicago Press, 1940), p. 204.
5. *Ibid.*, p. 205.
6. Council on Medical Education and Hospitals. "Background and Development of Residency Review and Conference Committees," *Journal of the American Medical Association*, 7 September, 1957, pp. 60-64.
7. *See*, for example, Harry T. Paxton, "How Hard Is It to Get Hospital Privileges?," *Hospital Physician*, August 1969, pp. 52-53; and William D. Holden, "Specialty Board Certification as a Measure of Professional Competence," *Journal of the American Medical Association*, 10 August, 1970, p. 1,017.
8. For example, New York hospital regulations specify that surgery and complicated OB cases must be restricted to board-certified physicians. *See* Anne R. Somers, *Hospital Regulation: The Dilemma of Public Policy* (Princeton, N.J.: Princeton University Press, 1969), p. 110.
9. Maryland Y. Pennell and Paula A. Stewart, *State Licensing of Health Occupations*, Public Health Service Publication No. 1758 (Washington: U.S. Government Printing Office, 1968), pp. 19, 32.
10. *See* Commission on Laboratory Inspection and Accreditation, *Standards for Accreditation of Medical Laboratories* (Chicago: College of American Pathologists, 1970), pp. 4-5; and Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals* (Chicago: Joint Commission on Accreditation of Hospitals, 1970), pp. 11, 57, 107, 135.
11. *Code of Federal Regulations*, Title 20, Chapter III, Part 405, Sections 1038(b), 1040(a), 1040(c), 1312(b), and 1314(b).
12. Of the certifying agencies surveyed by SASHEP, only the American Board of Orthotics and Prosthetics, the American Medical Record Association, the American Occupational Therapy Association, the National Registry in Clinical Chemistry, and the Technician Certification Board of the American Association for Inhalation Therapy utilize professional testing services in the *preparation* of examinations. Only six certifying agencies - the American Dietetic Association, the American Occupational Therapy Association, the American Registry of Inhalation Therapists, the American Speech and Hearing Association, the National Board for Certification in Dental Technology, and the Technician Certification Board of the American Association for Inhalation Therapy - engage professional testing agencies to *administer* their examinations.

13. American Society of Radiologic Technologists, "Resource Paper for Invitational Conference on Certification" (paper submitted to the Invitational Conference on Certification, College Park, September 7-10, 1971).

14. U.S. Department of Health, Education, and Welfare, *Report on Licensure and Related Health Personnel Credentialing* (Washington: U.S. Government Printing Office, 1971), p. 8.

15. *See*, for example, Verna L. Rausch and Karen R. Karni, "A Tilt at a Windmill?: A Study of Medical Technology Education" (unpublished study, School of Medicine, University of Minnesota, 1971), p. 8.

16. *See* Maryland Y. Pennell, John R. Proffitt, and Thomas D. Hatch, *Accreditation and Certification in Relation to Allied Health Manpower*, National Institutes of Health Publication 71-192 (Washington: U.S. Government Printing Office, 1971), pp. 20, 22, 23, 25, 26, 27, 28, 29, 33.

17. Among the health professional associations that require their members to be certified are the American Association of Nurse Anesthetists, the American Medical Record Association, the American Occupational Therapy Association, the American Society of Clinical Pathologists (for affiliate membership of medical technologists), and the American Society of Radiologic Technologists.

18. Dayton David McKean, *The Integrated Bar* (Boston: Houghton Mifflin, 1963), pp. 21-29.

19. JCAH, *Accreditation Manual for Hospitals*, pp. 13, 57, 63, 96.

20. *Code of Federal Regulations*, Sections 1026(c), 1028(d), 1031(b), 1038(e), 1038(f), 1038(g), 1040(g), 1126(c), 1229(b), and 1230(b).

21. Accrediting standards that require or recommend that educational programs be taught or supervised by certified practitioners include those of the American Association of Nurse Anesthetists, the American Dental Association (for dental technology programs), the American Medical Record Association, the American Occupational Therapy Association, the American Psychological Association, the American Speech and Hearing Association, the Joint Review Committee on Inhalation Therapy Education, the Joint Review Committee on Educational Programs in Nuclear Medical Technology, the Joint Review Committee in Radiologic Technology, and the National Association of Schools of Music (for music therapy programs).

22. Pennell and Stewart, *State Licensing*, p. 33.

23. *See*, for example, Council on Health Manpower, American Medical Association, "Licensure of Health Occupations" (statement adopted by the AMA House of Delegates, Boston, 1970), p. 3; and Edward H. Forgotson and Ruth Roemer, "Government Licensure and Voluntary Standards for Health Personnel and Facilities: Their Power and Limitation in Assuring High-quality Health Care," *Medical Care*, September-October, 1968, p. 346.

24. Pennell, Proffitt, and Hatch, *Accreditation and Certification*, p. 12. (Italics added)

25. Kano Ikeda, "The Registry of Technicians: Proposed Working Scheme," *The Journal of Laboratory and Clinical Medicine*, February 1929, p. 491, quoted by Lall G. Montgomery in "A Short History of the Registry of Medical Technologists of the American Society of Clinical Pathologists" (unpublished report, 1967). (Italics added)

26. American Society of Radiologic Technologists, "Resource Paper for Invitational Conference on Certification" (paper submitted to the Invitational Conference on Certification, September 7-10, 1971). (Italics added)

27. Questionnaire on Certification submitted by the American Occupational Therapy Association to SASHEP, May 1971. (Italics added)

28. American Occupational Therapy Association. "Resource Paper for Invitational Conference on Certification" (paper submitted to the Invitational Conference on Certification, September 7-10, 1971). (Italics added)

29. Questionnaire on Certification submitted by the American Speech and Hearing Association to SASHEP, June 1971. (Italics added)

30. Robert A. Dittmar, "Licensure: Friend or Foe?," *AAIT Bulletin*, March 1970, quoted by Ralph Kuhli, Director, Department of Allied Medical Professions and Services, American Medical Association, in a speech delivered at the Iowa Career Education Conference, August 12, 1971.

31. American Physical Therapy Association, "Resource Paper for Invitational Conference on Certification" (paper submitted to the Invitational Conference on Certification, September 7-10, 1971). As of 1971, all states have passed laws licensing physical therapists. In December 1971, the American Registry of Physical Therapists was officially closed.

32. American Society for Medical Technology, "Resource Paper for Invitational Conference on Certification" (paper submitted to the Invitational Conference on Certification, September 7-10, 1971).

33. For example, the American Society of Radiologic Technologists has proposed that the standards of the American Registry of Radiologic Technologists serve as the minimum federal standards for licensing radiologic technologists. Likewise, the American Society for Medical Technology has proposed that Board of Registry standards serve as the basis for state licensure of medical technologists.

34. Richard H. Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins Press, 1967), p. 27.

35. *Ibid.*, p. 30.

36. Pennell and Stewart, *State Licensing*, p. 111.

37. Ronald L. Akers, "The Professional Association and the Legal Regulation of Practice," *Law and Society Review*, May 1968, pp. 465-70.

38. Pennell and Stewart, *State Licensing*, pp. 9-10.

39. Akers, "Professional Association," pp. 470-72.

40. Shryock, *Medical Licensing*, pp. 47, 53.

41. *Ibid.*, pp. 60-62.

42. Edward H. Forgotson, Ruth Roemer, and Roger W. Newman, "Legal Regulation of Health Personnel in the United States," in *Report of the National Advisory Commission on Health Manpower* II (Washington: U.S. Government Printing Office, 1967), pp. 304, 308. In most states foreign medical graduates are admitted to state licensing examinations only after passing a screening examination prepared by the Educational Council for Foreign Medical Graduates (ECFMG).

43. *See*, for example, Colorado Revised Statutes, Section 48-1-27.

44. *See*, for example, Rhode Island General Statutes, Section 5-44-9.

45. *See*, for example, Florida Statutes Annotated, Section 490.041.

46. *See*, for example, *Virginia Code*, Section 54-788.1; and *Rules and Regulations, Virginia State Board of Veterinary Examiners* (Richmond, Va.: Department of Professional and Occupational Registration, 1968), Section D-1, p. 3. The Virginia law licensing veterinarians states that any prospective licensee must have graduated from a veterinary college approved by the board. However, the Rules and Regulations of the Virginia State Board of Veterinary Examiners state: "The Board recognizes as a public service the development of essential requirements for an acceptable veterinary school by the American Veterinary Medical Association, and in the public interest adopts as the basis for its approval of veterinary colleges and universities whose graduates may be qualified to be examined by the board for certificates to practice veterinary medicine and surgery in Virginia, the standards and essentials prescribed by the American Veterinary Medical Association for veterinary colleges accredited by that association."

47. Forgotson, Roemer, and Newman, "Legal Regulation," pp. 415, 449-51, 464-66.

48. For example, the National Association of Boards of Pharmacy includes one representative from the American Council on Pharmaceutical Education.

49. *See* "Structure of Accreditation of Health Educational Programs," *SASHEP Part 1: Working Papers*, pp. B35-36.

50. For further discussion of the financial implications of national accreditation, *see* "Financing the Accreditation of Health Educational Programs, *SASHEP Part 1: Working Papers*, pp. C18-20.

51. HEW, *Report on Licensure*, p. 38. *See also* Forgotson, Roemer, and Newman, "Legal Regulation," pp. 305-07.

52. Matthew F. McNulty, Jr., "Assuring High Quality in the Health Professions Through Licensure or Certification," in *Quality in Health Care* I (New York: National Health Council, 1968), p. 47.

53. Corinne Lathrop Gilb, *Hidden Hierarchies: The Professions and Government* (New York: Harper & Row, 1966), p. 59.

54. HEW, *Report on Licensure*, pp. 1-2.

55. "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," *Yale Law Journal*, May 1954, pp. 971-74.

56. Akers, "Professional Association," p. 477.

57. S. M. Miller, "Breaking the Credentials Barrier," *Training in Business and Industry*, March 1969. (Reprinted by the National Institute for New Careers, University Research Corporation, Washington, reprint series number 11, August 1969.)

58. *The Law and Health Personnel: A Study of Minnesota Law Related to Selected Health Manpower Categories* (study prepared by the Institute for Interdisciplinary Studies, American Rehabilitation Foundation, for the Comprehensive Health Planning Program, Minnesota State Planning Agency, St. Paul, 1970), p. 97.

59. *See,* for example, HEW, *Report on Licensure,* pp. 55-56, 103; U.S. Department of Health, Education, and Welfare, National Institutes of Health, *Equivalency and Proficiency Testing: A Survey of Existing Testing Programs in Allied Health* (Washington: U.S. Government Printing Office, n.d.); and Dallas Johnson, "Up the Career Ladder: How to Get the People Where They Want To Go," *Modern Hospital,* December 1971, pp. 75-77.

60. JCAH, *Accreditation Manual for Hospitals,* pp. 13-14.

61. HEW, *Equivalency and Proficiency Testing,* pp. 45-50.

62. HEW, *Report on Licensure,* p. 75.

63. Several studies have noted this occurrence. *See,* for example, *Occupational Licensing in the States* (Chicago: The Council of State Governments, 1952), p. 49; *Professional and Occupational Licensing in the West* (San Francisco: The Council of State Governments, 1964), p. 8; and "Regulating Professions and Occupations" (report of the New Jersey Professional and Occupational Licensing Commission submitted to the Governor and Legislature, State of New Jersey, January 7, 1971), pp. 44-45.

64. Robert T. Flint, "Professionalism and the Health Occupations," *Journal of American Dental Hygienists Association,* fourth quarter, 1967, p. 197.

65. Pennell and Stewart, *State Licensing,* p. 7.

66. Freidson, *Profession of Medicine,* p. 137.

67. *See,* for example, HEW, *Report on Licensure,* pp. 32-33; Horace R. Hansen, *Medical Licensure and Consumer Protection: An Analysis and Evaluation of State Medical Licensure* (Washington: Group Health Association of America, 1962), pp. 1-17; and *One Life - One Physician: An Inquiry into the Medical Profession's Performance in Self-Regulation* (Washington: Public Affairs Press, 1971), pp. 66-77.

68. McNulty, "Assuring High Quality," p. 44.

69. *See,* for example, "Regulating Professsions and Occupations," p. 7; and HEW, *Report on Licensure,* p. 76.

70. Forgotson, Roemer, and Newman, "Legal Regulation," pp. 296, 498; and Akers, "Professional Association," p. 479.

71. "Structure of Accreditation," pp. B30, 35, 36.

72. The accrediting committees of the American Occupational Therapy Association and the American Speech and Hearing Association are considering the addition of public representatives to their boards.

73. Samuel R. Sherman, "Quality Health Care: What Is It?" (keynote speech at the 1968 National Health Forum), in *Quality in Health Care* I, p. 18.

74. Council on Health Manpower, American Medical Association, "Licensure of Health Occupations," pp. 3-4.

75. *See* Nathan Hershey, "The Inhibiting Effect upon Innovation of the Prevailing Licensure System," *Federation Bulletin,* June 1970, pp. 165-80; and Edward H. Forgotson and John L. Cook, "Innovations and Experiments in Uses of Health Manpower: The Effect of Licensure Laws," *Law and Contemporary Problems,* autumn 1967, pp. 731-50.

76. Ruth Roemer, "Legal Regulation of Health Manpower in the 1970's: Needs, Objectives, Options, Constraints, and their Trade-offs," in *Health Manpower: Adapting in the Seventies* (New York: National Health Council, 1971), p. 39.

77. Citizen's Commission on Graduate Medical Education, *The Graduate Education of Physicians* (Chicago: American Medical Association, 1966), p. 96.

Table 1
Dental, Medical, Osteopathic, Podiatric, and Veterinary Certifying Agencies, 1971
By Field

Dental Specialty Boards		Medical Specialty Boards		Osteopathic Specialty Boards		Podiatric Specialty Board		Veterinary Specialty Organizations	
Board	Date Established	Board	Date Established	Board	Date Established	Board	Date Established	College or Board	Date Established[8]
Board of Dental Public Health	1950	American Board of Anesthesiology	1937	American Osteopathic Board of Anesthesiology	1956	American Board of Podiatric Surgery	1970	American College of Laboratory Animal Medicine	1957
Board of Endodontics	1964	American Board of Colon and Rectal Surgery	1949	American Osteopathic Board of Dermatology	1945			American College of Veterinary Microbiologists	1968
Board of Oral Pathology	1948	American Board of Dermatology	1932	American Osteopathic Board of Internal Medicine	1942			American College of Veterinary Pathologists	1951
Board of Oral Surgery	1946	American Board of Family Practice	1969	American Osteopathic Board of Neurology and Psychiatry	1941			American Board of Veterinary Public Health	1951
Board of Orthodontics	1929	American Board of Internal Medicine[1]	1936	American Osteopathic Board of Obstetrics and Gynecology	1942			American Board of Veterinary Radiology	1966
Board of Pedodontics	1942	American Board of Neurological Surgery	1940	American Osteopathic Board of Ophthalmology and Otorhinolaryngology	1940			American College of Veterinary Surgeons	1967
Board of Periodontics	1940	American Board of Obstetrics and Gynecology	1930	American Osteopathic Board of Pathology	1943			American Board of Veterinary Toxicology	1967
Board of Prosthodontics	1946	American Board of Ophthalmology	1916	American Osteopathic Board of Pediatrics	1940				
		American Board of Orthopaedic Surgery	1934	American Osteopathic Board of Proctology	1941				
		American Board of Otolaryngology	1924	American Osteopathic Board of Radiology	1939				
		American Board of Pathology[2]	1936	American Osteopathic Board of Rehabilitation Medicine	1954				
		American Board of Pediatrics[3]	1933	American Osteopathic Board of Surgery	1940				
		American Board of Physical Medicine and Rehabilitation	1947						
		American Board of Plastic Surgery	1937						
		American Board of Preventive Medicine[4]	1948						
		American Board of Psychiatry and Neurology[5]	1934						
		American Board of Radiology[6]	1934						
		American Board of Surgery[7]	1937						
		Board of Thoracic Surgery (Affiliate of the American Board of Surgery)	1949						
		American Board of Urology	1935						

Notes

1. Also offers certification in 4 subspecialties.
2. Also offers certification in 11 divisions.
3. Also offers certification in 2 subspecialties.
4. Also offers certification in 4 divisions.
5. Also offers certification in 1 subspecialty and 3 divisions.
6. Also offers certification in 10 divisions.
7. Also offers certification in 1 subspecialty.
8. Represents the date certifying organization was recognized by the American Veterinary Medical Association.

Table 2
Survey of Credentialing Procedures for Selected Health Professions, 1971

Profession	Accreditation		Certification		Licensure	
	Date Begun*	Current Accrediting Agency	Date Begun	Current Certifying Agency	Dates Statutes Enacted	Current Number of States Licensing Profession
Clinical Chemist	1966	American Board of Clinical Chemistry[1]	1949	American Board of Clinical Chemistry	–	–
	1935	American Chemical Society[2]	1967	National Registry in Clinical Chemistry[3]	–	–
Corrective Therapist	1959	Accreditation Council, American Corrective Therapy Association	1953	American Board of Registration, American Corrective Therapy Association	–	–
Dental Assistant	1960	Council on Dental Education, American Dental Association	1948	Certifying Board of the American Dental Assistants' Association	–	–
Dental Hygienist	1947	Council on Dental Education, American Dental Association	–	–	1889–1951	50
Dental Laboratory Technician	1948	Council on Dental Education, American Dental Association	1958	National Board for Certification in Dental Technology	1968	1[4]
Dentist	1916	Council on Dental Education, American Dental Association	1929–1964	8 specialty boards[5]	1841–1935	50
Dietitian	1931	Dietetic Internship Board, The American Dietetic Association	1969	Committee on Professional Registration, American Dietetic Association	–	–
Electroencephalographic Technologist	–	–	1964	American Board of Registration of Electroencephalographic Technologists	–	–
Health Physicist	–	–	1960	American Board of Health Physics	–	–
Hospital Administrator	1969	Accrediting Commission on Graduate Education for Hospital Administration	–	–	1947	1
Inhalation Therapist	1962	Council on Medical Education, American Medical Association, in collaboration with the Joint Review Committee for Inhalation Therapy Education	1960	American Registry of Inhalation Therapists	1969	1
Inhalation Therapy Technician	–	–	1969	Technician Certification Board of the American Association for Inhalation Therapy	–	–
Medical Assistant	1969	Council on Medical Education, American Medical Association, in collaboration with the American Association of Medical Assistants	1961	Certifying Board, American Association of Medical Assistants	–	–
Medical Laboratory Technologist/Technician	1936	Council on Medical Education, American Medical Association, in collaboration with the Board of Schools (ASCP)	1928	Registry of Medical Technologists (American Society of Clinical Pathologists)	1936–1970	10
	1959	Accrediting Bureau for Medical Laboratory Schools	1939	American Medical Technologists		
Medical Librarian	–	–	1946	Committee on Certification, Medical Library Association	–	–
Medical Record Administrator	1943	Council on Medical Education, American Medical Association, in collaboration with the American Medical Record Association	1932	Education and Registration Committee, American Medical Record Association	–	–
Medical Record Technician	1953	Council on Medical Education, American Medical Association, in collaboration with the American Medical Record Association	1954	Education and Registration Committee, American Medical Record Association	–	–

Sources: Questionnaires submitted to SASHEP by accrediting and certifying agencies.
Also Maryland Y. Pennell, John R. Proffitt, and Thomas D. Hatch, Accreditation and Certification in Relation to Allied Health Manpower (Washington: U.S. Government Printing Office, 1971); and Maryland Y. Pennell and Paula A. Stewart, State Licensing of Health Occupations, Public Health Service Publication No. 1758 (Washington: U.S. Government Printing Office, 1968), updated.

Notes
* Denotes year accrediting standards were initially adopted.
1. The American Board of Clinical Chemistry approves predoctoral and postdoctoral programs in clinical chemistry. Approval is based primarily on written submissions from the applicant institution though the Board reserves the right to conduct site visits as part of the approval process.
2. Accredits only general undergraduate programs in chemistry.
3. Registry of Medical Technologists (ASCP) also certifies chemists.
4. Dental laboratory technicians are registered annually in South Carolina.
5. Accreditation of postgraduate training programs is conducted by the Council on Dental Education, American Dental Association.

Table 2 – Continued

Profession	Accreditation		Certification		Licensure	
	Date Begun[a]	Current Accrediting Agency	Date Begun	Current Certifying Agency	Dates Statutes Enacted	Current Number of States Licensing Profession
Microbiologist	1962	Committee on Postdoctoral Education Programs, American Academy of Microbiology	1961	American Board of Medical Microbiology	–	–
			1961	National Registry of Microbiologists[6]	–	–
Music Therapist	1952	National Association of Schools of Music	1957	Certification-Registration Committee, National Association for Music Therapy	–	–
Nuclear Medical Technologist	1970	Council on Medical Education, American Medical Association, in collaboration with the Joint Review Committee on Educational Programs in Nuclear Medicine Technology	1962 1964	American Registry of Radiologic Technologists Registry of Medical Technologists (ASCP)	–	–
Nurse Anesthetist	1941	Approval of Schools Committee, American Association of Nurse Anesthetists	1931	Credentials Committee, American Association of Nurse Anesthetists	–	–
Nurse Midwife	1963	Approval Committee, American College of Nurse Midwives	1971	Testing Committee, American College of Nurse Midwives	1953–1971	6[7]
Nurse (Practical)	1945	Accrediting Review Board, National Association for Practical Nurse Education and Service	–	–	1913–1957	50
	1965	Council of Practical Nursing Programs, National League for Nursing				
Nurse (Professional)	1920[8]	Councils of Baccalaureate and Higher Degree, Associate Degree, and Diploma Programs; National League for Nursing	–	–	1903–1941	50
Occupational Therapist	1935	Council on Medical Education, American Medical Association, in collaboration with the American Occupational Therapy Association	1931	Committee on Registration and Certification, American Occupational Therapy Association	–	–
Occupational Therapy Assistant	1958	Accreditation Committee, American Occupational Therapy Association	1959	Committee on Registration and Certification, American Occupational Therapy Association	–	–
Optometrist	1945	Council on Optometric Education, American Optometric Association	–	–	1901–1939	50
Orthotist-Prosthetist	–	–	1948	American Board of Certification in Orthotics and Prosthetics	–	–
Pharmacist	1932	American Council on Pharmaceutical Education	–	–	1874–1945	50
Physical Therapist	1936	Council on Medical Education, American Medical Association, in collaboration with the American Physical Therapy Association	9	9	1926–1971	50
Physical Therapist Assistant	1970	Review Task Force, American Physical Therapy Association	–	–	1967–1971	11
Physician, (D.O.)	1913	Bureau of Professional Education, American Osteopathic Association	1939–1956	12 specialty boards[10]	1896–1966	50

Notes
6. Registry of Medical Technologists (ASCP) also certifies microbiologists.
7. Includes only those states that have statutes providing for the separate licensure of nurse midwives.
8. Earliest nursing accreditation activities were conducted by the National Organization for Public Health Nursing.
9. American Registry of Physical Therapists, founded in 1935, closed in December, 1971.
10. Approval of postgraduate training programs is conducted by the Bureau of Professional Education, American Osteopathic Association, in consultation with appropriate specialty boards.

Table 2 – Continued

Profession	Accreditation		Certification		Licensure	
	Date Begun*	Current Accrediting Agency	Date Begun	Current Certifying Agency	Dates Statutes Enacted	Current Number of States Licensing Profession
Physician (M.D.)	1905	Liaison Committee on Medical Education	1916–1969	20 primary specialty boards[11]	1817–1917	50
Podiatrist	1921	Council on Podiatry Education, American Podiatry Association	1970	1 specialty board[12]	1906–1949	50
Psychologist	1948	Committee on Accreditation, American Psychological Association	1947	American Board of Professional Psychology	1945–1970	42
Radiologic Technologist	1944	Council on Medical Education, American Medical Association, in collaboration with the Joint Review Committee on Education for Radiologic Technology	1922	American Registry of Radiologic Technologists	1964–1969	3
Social Worker	1927	Council on Social Work Education	1963	Academy of Certified Social Workers, National Association of Social Workers	1945–1971	9
Speech Audiologist and Pathologist	1963	American Boards of Examiners in Speech Pathology and Audiology, American Speech and Hearing Association	1952	Committee on Clinical Certification, American Speech and Hearing Association	1971	1
Veterinarian	1913	Council on Education, American Veterinary Medical Association	1951–1967	7 specialty boards[13]	1890–1962	50

Notes

11. Accreditation of postgraduate training programs (residencies) is performed by residency review committees, which are usually comprised of representatives of the Council on Medical Education, American Medical Association, and the corresponding specialty board. In some instances, members of appropriate specialty societies also hold membership on the review committees. Administration of the residency approval program is primarily the responsibility of the Council on Medical Education.
12. Postgraduate training is approved by the Council on Podiatry Education and the Board.
13. Specialty boards approve postgraduate training programs.

Table 3
Survey of Certification in Selected Health Professional Fields, 1971
By Certifying Agency

Certifying Agency	Categories of Health Personnel Certified	Sponsoring Organizations	Composition of Certifying Agency		
			Number	Field	Selection
American Board of Clinical Chemistry (A3CC)	Clinical Chemist Toxicological Chemist (Doctoral level only)	American Association of Clinical Chemists (AACC) American Chemical Society (ACS) American Institute of Chemists (AIC) American Society of Biological Chemists (ASBC)	13 (10) (3)	Clinical Chemists	Elected by ABCC upon nominations from sponsoring organizations Elected at large
National Registry in Clinical Chemistry (NRCC)	Clinical Chemist (Baccalaureate, Masters, and Doctoral levels) Clinical Chemistry Technologist (Baccalaureate level)	American Association of Clinical Chemists (AACC) American Board of Clinical Chemistry (ABCC) American Chemical Society (ACS) American Institute of Chemists (AIC) American Society of Biological Chemists (ASBC)	8	Clinical Chemists	Elected by NRCC upon nominations from sponsoring organizations
American Board for Certification, American Corrective Therapy Association	Corrective Therapist	American Corrective Therapy Association (ACTA)	7 (5) (1) (1)	Physiatrists Educator Corrective Therapist	ACTA
Certifying Board of the American Dental Assistants' Association	Dental Assistant	American Dental Assistants' Association (ADAA) American Dental Association (ADA)	7 (6) (1)	Dental Assistants Instructor of dental assisting	ADAA
National Board for Certification in Dental Laboratory Technology (NBCDLT)	Dental Technician	National Association of Certified Dental Laboratories (NACDL) (Trustor)	7 (6) (4) (2) (1)	Certified Dental Technicians Laboratory owners Educators Dentist	NACDL
Committee on Professional Registration, The American Dietetic Association	Dietitian	The American Dietetic Association (ADA)	7	Dietitians	ADA
American Board of Registration of Electroencephalographic Technologists (ABRET)	Electroencephalographic Technologist	American Encephalographic Society (AES) American Society of Electroencephalographic Technologists (ASET)	13 (6) (7)	EEG Technologists Electroencephalographers	ABRET
American Board of Health Physics (ABHP)	Health Physicist	American Association of Physicists in Medicine (AAPM) American Public Health Association (APHA) Health Physics Society (HPS)	7	Health Physicists	Nominated by AAPM, APHA, HPS
American Registry of Inhalation Therapists (ARIT)	Inhalation Therapist	American Association for Inhalation Therapy (AAIT) American College of Chest Physicians (ACCP) American Society of Anesthesiologists (ASA)	12[1] (8) (4)	Physicians Registered Inhalation Therapists	ACCP and ASA AAIT
Technician Certification Board of the American Association for Inhalation Therapy	Inhalation Therapy Technician	American Association for Inhalation Therapy (AAIT)	12[2] (4) (2) (6)	Registered Inhalation Therapists Certified Inhalation Therapy Technicians Physicians	AAIT AAIT 6 medical specialty societies[3]
Certifying Board, American Association of Medical Assistants	Medical Assistant	American Association of Medical Assistants (AAMA)	15 (9) (7) (2) (4) (3) (1) (1) (1)	Medical assistants Certified AAMA members President, President-Elect, AAMA Physicians Members of AAMA Chairman of Advisory Board Attorney Educator	 Appointed by AAMA AAMA membership Appointed by AAMA Elected by Advisory Board Appointed by AAMA Appointed by AAMA

Notes
1. In addition, the membership includes the Executive Director of the Registry who serves ex officio.
2. Includes only voting members; 20 consultants also serve on the board.
3. The American Academy of Pediatrics, the American Association of Thoracic Surgeons, the American College of Allergists, the American College of Chest Physicians, the American Society of Anesthesiologists, and the American Thoracic Society each nominate one member.

Table 3 – Continued

Certifying Agency	Categories of Health Personnel Certified	Sponsoring Organizations	Composition of Certifying Agency		
			Number	Field	Selection
Committee on Certification, Medical Library Association	Medical Librarian	Medical Library Association (MLA)	4	Medical Librarians	MLA
Education and Registration Committee, American Medical Record Association	Medical Record Administrator Medical Record Technician	American Medical Record Association (AMRA)	15 (6) (5) (1) (2) (1) (1) (5) (1) (4) (2)	Registered Record Librarians Physicians Educators Ph.D. in education Directors of Medical record programs President and President-Elect, AMRA	 AMRA American Hospital Association American Medical Association American College of Surgeons AMRA AMRA membership
American Medical Technologists (AMT)	Medical Technologist Medical Laboratory technician Certified Technician	4/	12 (9) (3)	Medical technologists	 Elected by member delegates Appointed by AMT
Registry of Medical Technologists, American Society of Clinical Pathologists (ASCP)	Medical Technologist5/ Medical Laboratory Technician Laboratory Assistant	American Society of Clinical Pathologists (ASCP)6/ American Society for Medical Technology (ASMT)	11 (6) (5)	 Clinical Pathologists Medical Technologists	 ASCP ASMT
American Board of Medical Microbiology (ABMM)	Clinical and Public Health Microbiologists (Doctoral level only)7/	American Academy of Microbiology (AAM) American Society for Microbiology (ASM)	12 (5) (7)	Microbiologists	 Appointed by AAM Nominated by 7 scientific organizations8/
National Registry of Microbiologists (NRM)	Microbiologist (Baccalaureate, Masters, and Doctoral levels)	American Academy of Microbiology (AAM) American Society for Microbiology (ASM)	59/	Microbiologists	Selected by AAM upon recommendation of Registry
Certification-Registration Committee, National Association for Music Therapy	Music Therapist	National Association for Music Therapy (NAMT)	3 (1) (2)	Music therapists Clinical worker University professors	NAMT
Credentials Committee, American Association of Nurse Anesthetists	Nurse Anesthetist	American Association of Nurse Anesthetists (AANA)	3	Certified Nurse Anesthetists	AANA
Committee on Registration and Certification, American Occupational Therapy Association	Occupational Therapist Occupational Therapy Assistant	American Occupational Therapy Association (AOTA)	10	Registered Occupational Therapists	AOTA
American Board of Certification in Orthotics and Prosthetics	Orthotist, Prosthetist, Orthotist/Prosthetist Orthotics Assistant, Prosthetics Assistant, Orthotics/Prosthetics Assistant Orthotics Technician, Prosthetics Technician, Orthotics/Prosthetics Technician	American Academy of Orthopaedic Surgeons (AAOS) American Orthotic and Prosthetic Association (AOPA)	/ (4) (3)	 Certified Orthotists and/or Prosthetists Orthopaedic Surgeons	 AOPA AAOS
American Board of Professional Psychology (ABPP)	Psychologist (Doctoral level)10/	Autonomous	12	Psychologists	ABPP

Notes

4. AMT functions both as a Registry and a Society.
5. Registry also offers categorical certification in blood banking, chemistry, cytotechnology, hematology, histologic technic, microbiology and nuclear medicine technology; and specialist certification in chemistry, cytotechnology, hematology, and microbiology.
6. Registry is maintained as a standing committee of ASCP; however, ASMT elects representatives to the Board of Registry.
7. Board also offers certification in the specialties of bacteriology, immunology, mycology, parasitology, and virology.
8. These include: the American Association of Immunologists, the American Dental Association, the American Medical Association, the American Society for Microbiology, the American Society of Parasitologists, the American Veterinary Medical Association, and the Mycological Society of America.
9. In addition, membership also includes 2 associate, non-voting members.
10. Offers certification in four specialties: Clinical psychology, Counseling Psychology, Industrial and Organizational Psychology, and School Psychology.

Table 3 – Continued

Certifying Agency	Categories of Health Personnel Certified	Sponsoring Organizations	Composition of Certifying Agency		
			Number	Field	Selection
American Registry of Radiologic Technologists (ARRT)	Radiologic Technologist[11]	American College of Radiology (ACR) American Society of Radiologic Technologists (ASRT)	8 (4) (4)	 Radiologic technologists Radiologists	 ASRT ACR
Academy of Certified Social Workers of the National Association of Social Workers	Social Worker	National Association of Social Workers (NASW)	10	Social Workers	NASW
Committee on Clinical Certification, American Speech and Hearing Association	Speech Audiologist Speech Pathologist	American Speech and Hearing Association	18	Speech Audiologists and Pathologists	ASHA

Note

11. Also offers certification in nuclear medicine technology and radiation therapy technology.

Table 4
Minimum Requirements for Initial Certification in Selected Health Professional Fields, 1971
By Certifying Agency

Certifying Agency	Prerequisites: Education	Prerequisites: Experience*	Prerequisites: Association Membership	Prerequisites: Other	Examinations: Written	Examinations: Oral	Examinations: Practical	Examinations: Other
American Board of Clinical Chemistry	Ph.D in Chemistry or other appropriate science; or M.D., degree	3 years		Good moral character Professional and character references	X	X[1]		
National Registry in Clinical Chemistry Clinical Chemistry Technologist Clinical Chemist	Baccalaureate degree with appropriate coursework Baccalaureate or higher degree with appropriate coursework	1 year 6 years[2]		Good moral character U.S. Residency	X X			
American Board for Certification, American Corrective Therapy Association	Baccalaureate degree in physical education	400 hours in ACTA-approved internship[3]	American Corrective Therapy Association	Minimum age, 18 U.S. Citizenship	X	X	X	
Certifying Board of the American Dental Assistants' Association	Completion of 1-year ADA accredited program		American Dental Assistants Association[4]	U.S. Citizenship	X		X	
National Board for Certification in Dental Laboratory Technology	Completion of 2-year ADA-accredited program[5]	3 years[5]			X		X	
Committee on Professional Registration, The American Dietetic Association	Baccalaureate degree with appropriate coursework	ADA-approved internship	The American Dietetic Association**		X			
American Board of Registration of Electroencephalographic Technologists	High School diploma	18 months			X	X	X	
American Board of Health Physics	Baccalaureate degree with appropriate coursework[6]	6 years[6]		Minimum age, 28 Professional references	X	X[1]		
American Registry of Inhalation Therapists	Associate degree from AMA-approved school[7]	1 year	American Association for Inhalation Therapy	Good moral character Minimum age, 20	X	X		
Technician Certification Board of the American Association for Inhalation Therapy	High School diploma or equivalent	24 months[8]	American Association for Inhalation Therapy**		X			
Certifying Board, American Association of Medical Assistants	High School diploma or equivalent	3 years[9]		6 months continuous employment under physician supervisor within 24 months prior to application	X			
Committee on Certification, Medical Library Association Grade 1 Grade 2 Grade 3	Graduation from fifth-year American Library Association-accredited school plus MLA approved course in medical librarianship[10] Graduation from fifth-year American Library Association accredited school plus MLA approved course in medical librarianship (or equivalent exam) Graduation from fifth-year American Library Association accredited school plus doctoral degree in a life science	MLA approved internship[12] 5 years			X[11] X[11]			

Notes

* Does not include experience required as an integral part of formal educational preparation.
** Association membership required for renewal of registration.
1. At the discretion of the board, only the written exam may be required.
2. Graduate education may be substituted on a year-for-year basis.
3. Credit for a maximum of 160 hours may be allowed for on-the-job experience or student teaching.
4. Requirement may be waived upon submission of notarized letters vouching ethical conduct.
5. 5 years experience is accepted in lieu of combined education and experience requirements.
6. In exceptional cases, experience may be substituted for educational requirements; additional education may also be substituted for up to 2-1/2 years of experience.
7. Alternate requirements are: (1) Baccalaureate degree or professional nursing degree or diploma plus 6 semester hours in AMA approved school plus 1 year experience in inhalation therapy. (Nurses who have had at least one year of intensive care or recovery room experience may be given credit for 6 months toward experience requirements).
8. Graduation from an AMA-accredited program may be substituted for experience.
9. Alternate requirement for single testing is: (1) Associate degree plus 1 year of experience. For dual testing (clinical and administrative), requirements are: (1) High school diploma plus four years experience or (2) Associate degree plus two years experience.
10. Alternate requirements are: (1) Completion of MLA-approved internship or (2) Passing of examination equivalent to MLA approved course in medical librarianship.
11. Examination utilized only as an alternative to completion of MLA course in Grades 1 and 2.
12. Alternate requirement is: Masters degree in an applicable life science plus 1 year of library experience.

Table 4 – Continued

Certifying Agency	Prerequisites: Education	Prerequisites: Experience*	Prerequisites: Association Membership	Prerequisites: Other	Examinations: Written	Examinations: Oral	Examinations: Practical	Examinations: Other
Education and Registration Committee, American Medical Record Association								
Medical Record Technician	Completion of 1-or 2-year program accredited by AMA-AMRA[13]				X			
Medical Record Administrator	Baccalaureate degree from AMA-AMRA accredited school				X			
American Medical Technologists								
Certified Technician	High school diploma or equivalent	24 months			X		X	
Medical Laboratory Technician	Completion of 1-1-1 2 year program accredited by the Accrediting Bureau of Medical Laboratory Schools[14]	6 – 12 months		Good moral character Citizenship or residency in Western Hemisphere nation	X		X	
Medical Technologist	Completion of 1-1-1 2 year program accredited by the Accrediting Bureau of Medical Laboratory Schools[14]	3 years[15]			X		X	
Registry of Medical Technologists, (ASCP)								
Certified Laboratory Assistant	Completion of 1-year AMA – approved program			Recommendations from program director and supervisor	X			
Medical Laboratory Technician	Associate degree from AMA – approved school[16]				X			
Medical Technologist	3 years collegiate education plus 1 year in AMA-accredited medical technology program				X			
American Board of Medical Microbiology	Ph.D., D. Sci., M.D., D.D.S., D.V.M., or D.P.H.	5 years			X	X		
National Registry of Microbiologists								
Registered Microbiologist	Baccalaureate degree with appropriate coursework				X			
Specialist Microbiologist	Master's or doctoral degree with appropriate coursework[17]	4 years[18]			X[18]			
Certification-Registration Committee, National Association for Music Therapy	Baccalaureate degree in music therapy or equivalent		National Association for Music Therapy**		X[19]			
Credentials Committee, American Association of Nurse Anesthetists	Professional nursing degree or diploma plus completion of 18-month AANA-approved course			Good moral character Minimum age, 21 Compliance with state legal requirements governing licensure and practice	X			
Committee on Registration and Certification, American Occupational Therapy Association								
Occupational Therapy Assistant	Graduation from AOTA-approved program			Recommendation of program director				
Occupational Therapist	Baccalaureate or higher degree from AMA-AOTA accredited school				X			
American Board of Certification in Orthotics and Prosthetics								
Orthotic or Prosthetic Technician	Tenth-grade education or equivalent	2 years			X	X	X	
Orthotic or Prosthetic Assistant	Twelfth-grade education or equivalent	3 years			X	X	X	
Orthotist or Prosthetist	High school diploma	4 years[20]		Professional references	X	X	X	
American Board of Professional Psychology	Ph.D. from APA-accredited school or equivalent	5 years[21]	American or Canadian Psychological Association	Present employment in specialty Endorsements of professional and ethical conduct		X	X	

Notes

13. Successful completion of AMRA correspondence course can be substituted for associate degree (2-year course) or 1 year course (Certificate of Completion).
14. Alternate requirements are: (1) 1 year in Armed Forces School plus 1 year of experience or (2) Associate degree from a junior college plus 6 months of experience.
15. Alternate requirements are: (1) 90 semester hours at a college or university in specific courses plus 1 year of experience or (2) Baccalaureate degree in medical technology or biological science plus 1 year of experience.
16. Alternate requirements are: (1) Completion of 1-year military training program plus 60 hours of collegiate work (or an associate degree) or (2) Certification as a laboratory assistant plus 60 hours of collegiate work (or an associate degree).
17. Alternate requirement is: Baccalaureate degree with appropriate coursework plus 5 years experience.
18. Until June 30, 1974, the examination will be waived for all those who are eligible to take the exam. Until the same date, degree requirements will be waived for members of the Registry with 7 or more years of experience in microbiology who are serving in a supervisory capacity or its equivalent at the time of application.
19. Examination required only if initial registration is allowed to lapse.
20. Alternate requirements are: (1) Baccalaureate degree plus one year of experience or (2) Associate degree plus two years of experience.
21. Predoctoral internship may be credited toward experience requirement.

Table 4 — Continued

Certifying Agency	Prerequisites: Education	Prerequisites: Experience*	Prerequisites: Association Membership	Prerequisites: Other	Examinations: Written	Examinations: Oral	Examinations: Practical	Examinations: Other
American Registry of Radiologic Technologists	Graduation from AMA-accredited program			Good moral character U.S. Citizenship	X			
Academy of Certified Social Workers, National Association of Social Workers	Master's degree from school accedited by the Council on Social Work Education	2 years	National Association of Social Workers					X[22]
Committee on Clinical Certification, American Speech and Hearing Association	Baccalaureate degree with appropriate coursework	9 months	American Speech and Hearing Association		X			

Notes

22. Evaluation by supervisor and two peers.

Table 5
Provisions of State Licensing Statutes Governing the Approval of Educational Programs for Selected Categories of Health Personnel, 1970
By Profession and State

State	Dentist: Requires approval or accreditation — By the licensing board	Dentist — By ADA	Dentist — By the board and ADA*	Dentist — By the board or ADA	Dentist — Not Specified**	Dentist — Other	Dental Hygienist: Requires approval or accreditation — By the licensing board	Dental Hygienist — By ADA	Dental Hygienist — By the board and ADA*	Dental Hygienist — By the board or ADA	Dental Hygienist — Not Specified**	Dental Hygienist — Other	Nurse, Practical: Requires approval or accreditation — By the licensing board	Nurse, Practical — By NAPNES	Nurse, Practical — By the board and NAPNES*	Nurse, Practical — By the board or NAPNES	Nurse, Practical — Not Specified**	Nurse, Practical — Other	Nurse, Professional: Requires approval or accreditation — By the licensing board	Nurse, Professional — By NLN	Nurse, Professional — By the board and NLN*	Nurse, Professional — By the board or NLN	Nurse, Professional — Not Specified**	Nurse, Professional — Other	Optometrist: Requires approval or accreditation — By the licensing board	Optometrist — By AOA	Optometrist — By the board and AOA*	Optometrist — By the board or AOA	Optometrist — Not Specified**	Optometrist — Other	Pharmacist: Requires approval or accreditation — By the licensing board	Pharmacist — By ACPE	Pharmacist — By the board and ACPE*	Pharmacist — By the board or ACPE	Pharmacist — Not Specified**	Pharmacist — Other	Physical Therapist: Requires approval or accreditation — By the licensing board	Physical Therapist — By AMA and/or APTA*	Physical Therapist — By the board and AMA/APTA*	Physical Therapist — By the board or AMA/APTA	Physical Therapist — Not Specified**	Physical Therapist — Other
Alabama	X						X						X						X									X				X1/					X				
Alaska		X3/					X						X							X								X				X4/				X				
Arizona	X						X						X						X						X			X			X					X				
Arkansas		X					X						X							X						X		X				X				X				
California	X						X						X						X						X			X			X5/					X				
Colorado		X						X					X						X						X5/			X			X5/					X				
Connecticut	X						X						X						X						X			X			X					X				
Delaware	X						X						X						X						X1/			X								X				
Florida			X				X						X						X						X			X								X				
Georgia				X11/						X			X							X8/					X			X			X					X				
Hawaii	X						X						X													X		X				X				X				
Idaho	X						X						X						X						X			X								X				
Illinois				X							X8/		X						X									X			X8/					X				X8/
Indiana	X						X						X						X						X			X								X				
Iowa				X			X						X						X									X				X				X				
Kansas			X				X						X						X							X										X				
Kentucky	X						X						X						X						X			X								X				
Louisiana	X						X						X						X						X			X				X				X				
Maine		X								X			X						X						X							X				X				
Maryland	X						X						X						X						X						X					X				
Massachusetts				X			X						X						X						X						X					X				
Michigan				X			X						X						X												X					X				
Minnesota	X						X						X						X						X											X				
Mississippi	X						X											X8/	X					X8/						X1/					X				
Missouri		X						X					X						X						X											X				
Montana		X5/					X						X						X										X13/						X1/				
Nebraska					X8/	11/	X						X						X							X														X8/
Nevada	X						X						X						X										X15/			X			X				
New Hampshire				X			X						X						X						X							X				X				
New Jersey	X						X						X						X						X											X				
New Mexico		X						X					X						X						X											X			X11	
New York					X8/						X8/							X8/					X8/						X8/						X8/					X8/
North Carolina	X						X						X						X						X							X				X				
North Dakota	X						X						X						X						X5/						X5/				X5/				
Ohio			X							X			X						X						X						X					X				
Oklahoma			X				X						X						X						X						X					X				
Oregon	X						X						X						X						X							X				X				
Pennsylvania	X						X						X						X						X							X				X			X	
Rhode Island			X								X8/		X						X										X8/				X8/					X8/
South Carolina					X18/		X						X						X						X						X					X				
South Dakota				X			X						X5/						X						X						X					X				
Tennessee	X						X						X						X						X						X					X				
Texas					X11/		X						X						X						X						X									
Utah					X8/						X8/		X						X						X8/	X														X8/
Vermont		X						X					X						X						X11/							X				X				
Virginia				X			X						X						X						X						X					X				
Washington	X										X		X						X						X						X					X				
West Virginia	X						X						X						X						X						X					X				
Wisconsin	X						X						X						X							X					X					X				X19/
Wyoming				X						X			X						X						X13/	X										X				

Key to Abbreviations

ADA – American Dental Association
NAPNES – National Association for Practical Nurse Education and Service
NLN – National League for Nursing
AOA – American Optometric Association
ACPE – American Council on Pharmaceutical Education
AMA – American Medical Association
APTA – American Physical Therapy Association
AOA – American Osteopathic Association
APA – American Podiatry Association (previously the National Association of Chiropodists) (NAC).
APA – American Psychological Association
CSWE – Council on Social Work Education
AVMA – American Veterinary Medical Association

Notes

* Includes statutes which require graduation from an "accredited program [or school] approved by the board."
** Includes statutes which require graduation from an "approved," "accredited," "recognized," or "reputable" school, but do not stipulate by what agency the educational program or school must be approved.
--- Data not available.
1. Statute requires accreditation by the American Association of Colleges of Pharmacy.
2. Statute requires institutional accreditation.
3. Statute also requires accreditation by the American Association of Dental Examiners.
4. Statute requires accreditation by the National Association of Boards of Pharmacy.
5. Statute requires or allows board to rely on national professional accrediting standards and/or lists.
6. Statute requires that program be accredited by the American Psychological Association or another accrediting agency recognized by the Board of Regents of the Universities and State Colleges of Arizona.
7. Statute requires that the medical school be accredited either by the Council on Medical Education of the American Medical Association or the Council on Medical Education of the National Eclectic Medical Association.

Table 5 — Continued

Physical Therapy Assistant						Physician, D.O.						Physician, M.D.						Podiatrist						Psychologist						Social Worker						Veterinarian						
Requires approval or accreditation						Requires approval or accreditation						Requires approval or accreditation						Requires approval or accreditation						Requires approval or accreditation						Requires approval or accreditation						Requires approval or accreditation						
By the licensing board	By APTA	By the board and APTA*	By the board or APTA	Not Specified**	Other	By the licensing board	By AOA	By the board and AOA*	By the board or AOA	Not Specified**	Other	By the licensing board	By AMA and/or AAMC	By the board and AMA/AAMC*	By the board or AMA/AAMC	Not Specified**	Other	By the licensing board	By APA (NAC)	By the board and APA (NAC)*	By the board or APA (NAC)	Not Specified**	Other	By the licensing board	By APA	By the board and APA*	By the board or APA	Not Specified**	Other	By the licensing board	By CSWE	By the board and CSWE*	By the board or CSWE	Not Specified**	Other	By the licensing board	BY AVMA	By the board and AVMA*	By the board or AVMA	Not Specified**	Other	State
	X					X						X						X										X2/							X						Alabama
						X							X														X2/						X						Alaska
X							X					X5/						X										X6/							X						Arizona
									X				X7/								X			X											X						Arkansas
						X						X						X						X						X						X						California
								X							X			X								X										X						Colorado
						X						X						X						X												X						Connecticut
						X5/										X8/		X						X																		Delaware
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Notes

5. Statute requires approval by a state agency or official other than the licensing board.
9. Statute gives licensing board the option of approving schools on the basis of board-conducted site visitations or lists prepared by national professional accrediting agencies.
10. Statute requires graduation from a program accredited by the American Psychological Association or the equivalent.
11. Statute specifies that approval is based upon the educational standards required by a national professional accrediting agency.
12. Statute requires graduation from a school approved by the American Veterinary Medical Association and the U.S. Department of Agriculture or evidence of sufficient practical training as determined by the board.
13. Statute requires accreditation by the International Association of Boards of Optometry.
14. Statute requires approval by the State Department of Health and the board.
15. Statute requires approval by the board and the "recognized professional agency."
16. Statute requires approval by the American Veterinary Medical Association and/or the U.S. Department of Agriculture.
17. Statute requires approval by the American Osteopathic Association and the State Board of Professional Regulation.
18. Statute requires accreditation by the American Association of Dental Faculties.
19. Statute requires that educational standards be equivalent to those of the University of Wisconsin.

THE LAW'S VIEW OF PROFESSIONAL POWER: COURTS AND THE HEALTH PROFESSIONAL ASSOCIATIONS

William A. Kaplin

Health care is indisputably one of society's preeminent concerns. The quality of care, and the efficiency and accessibility of the delivery system, have become major social and political issues whose importance is increasing daily. "Better health care is clearly a national priority of the highest order."[1]

As public concern over health care has increased, the delivery system has been subjected to greater and greater scrutiny from all sectors of society. Questions of How does it work? expand into questions of How *well* does it work? which, in turn, become questions of How can it be made to work better? The search for answers eventually becomes a search for standards by which to measure the capacity and performance of the participants in the health care system—the dentists and physicians, the allied health professionals, the professional schools and health education programs, the hospitals, laboratories, and clinics. Yet standard setting in the United States has been almost exclusively the province of the health professions themselves and therefore has been relatively isolated from public scrutiny and the pressing demands of the public interest. The new wave of public concern regarding health care and the accompanying search for standards have thus created tension in the system, and this tension is increasingly leading to the redefining of the role of professionalism in health care and to the rethinking of the roles of government and the general public in the system.

In all this activity, the courts and legislatures necessarily have a role to play, for they are, after all, the ultimate formulators of public policy.[2] As public concern for the health care system expands, so do the demands for courts and legislatures to participate in the scrutinization of the system and in the search for standards. In turn, these demands are leading to a reshaping of the law's role in relation to health care. This paper is concerned with one segment, a major segment, of that problem: the role of courts in moderating the use of professional power by associations in the health professions, particularly with regard to their standard-setting functions.

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Professional Power and Standard Setting

A great variety of professional associations participate in the process of setting standards for the health care system. Most powerful, of course, is the American Medical Association. It has been said that

> no other voluntary association commands such power within its area of interest as does the AMA. It holds a position of authority over the individual doctor, wields a determining voice in medical education, controls the conditions of practice, and occupies a unique position of influence in shaping government health policies.[3]

But many other professional associations do share, or are seeking to share, standard-setting responsibility with the AMA and the state and local medical societies affiliated with it. The various medical specialty boards and associations (e.g., the American Society of Clinical Pathologists) have great influence over the medical specialties. In their respective domains, the American Dental Association, the American Optometric Association, the American Osteopathic Association, and the American Pharmaceutical Association assume roles similar to that of the AMA. In nursing, the National League for Nursing is one important influence. And in the newer health occupations, the rapidly expanding allied health professions, each occupation has its own professional association seeking to obtain greater control over its own domain.[4]

Moreover, there are associations of institutions—most notably the American Hospital Association and the Association of American Medical Colleges—that have become more and more involved in standard setting as the hospitals, particularly the teaching hospitals, and the medical schools have become the focal point of the modern health care system.[5] Within the hospitals there are organized medical staffs, each in effect a professional association in miniature, which are becoming more influential in the standard-setting realm.[6]

The standard-setting functions in which these associations engage are many and diverse but are often closely interrelated. Membership selection, for instance, is an important, albeit sometimes indirect, standard-setting mechanism of the professional associations. But membership in certain professional associations is vital to a health professional not merely because of the adverse implications concerning fitness, which inhere in an exclusion or expulsion; it is also important because other standard setters may rely upon association membership as a necessary prerequisite to the conferral of some *other* professional status. For a physician, local medical society membership may be a prerequisite for hospital staff privileges[7] or specialty certifications[8] as well as for membership in the state medical society and the AMA.

Certification and registration are other standard-setting devices often employed by professional associations.[9] These too may be prerequisites for

hospital privileges,[10] and in some of the allied health professions may be required for membership in the professional associations.[11] In turn, eligibility for certification or registration may depend upon another standard-setting device--accreditation.[12] Graduation from an accredited program of study is often a prerequisite not only for certification or registration[13] but also for membership in the professional association[14] and for licensure itself.[15]

Licensure, also a major standard-setting device, differs from the others in that it is government sponsored. But despite this public sponsorship, licensure is still controlled by the private professional associations. State licensing boards are generally composed of members of the pertinent professions who are often nominated or appointed by the state professional society;[16] and membership in the state society may be a prerequisite for membership on the licensing board.[17] Moreover, as suggested above, state boards generally rely upon the accreditation standards of the national professional associations in judging the educational qualifications of licensure applicants.[18]

These interrelated standard-setting devices obviously have great impact upon the operation of the health care system. They permit the professional associations to control access to the system at every vital point and thus to govern both the quality and the quantity of health manpower. And they permit the professional association to control closely the education and training that members of the health professions receive. These effects of standard setting are particularly significant in light of the current crisis in health care because so many of the recommendations for change are aimed at the problem of manpower shortages and the need for educational reform.[19] Improvement in the health care system is inseparably tied to changes in the health professions' standard-setting activities; it is therefore entirely appropriate that the increasing public concern over health care be focused in large part upon the issue of professional standard setting and professional power.

With issues of this import, so vitally affecting every individual and institutional participant and every consumer in the health care system, the courts will inevitably become more heavily involved. Every time a participant runs afoul of some aspect of the standard-setting process, there is a potential court case; e.g., the physician who is denied local medical society membership or hospital privileges, the allied health professional who is rejected for certification, the professional school or hospital for which accreditation is denied or withdrawn. Conversely, there may be a potential court case whenever a participant succeeds in some aspect of the standard-setting process but other participants, or perhaps consumers, believe the professional association's decision to be erroneous; e.g., a local medical society member who contests the society's refusal to expel another member, the local citizenry who contest the accreditation of a local hospital.

Factors Influencing Judicial Intervention

The initial, and often the most significant, question encountered in litigation concerning professional power is whether the court will become involved at all.[20] Historically, American courts, following their British predecessors, have been very reluctant to intervene in the affairs of private associations. In recent years, however, a trend away from such a blanket predisposition has become noticeable, particularly in relation to professional associations.[21]

Courts have varied in their willingness to identify with this new trend. It is often difficult to determine when and why a particular court will take cognizance of an associational dispute, and the factors influencing courts to assume jurisdiction are often inadequately articulated or not articulated at all. There is clearly a need to isolate those factors and to study the underlying policy considerations that have, and that should in the future, govern the question of when courts should intrude upon areas dominated by professional power.

At the outset, each private association must be viewed individually in terms of its own particular function in society. This means, first, that courts must clearly differentiate between professional associations and other types of associations, such as social clubs, religious societies, and fraternal or benevolent associations, which have entirely different relationships to society. Second, courts must differentiate between different types of professional associations in terms of their own individual purposes, goals, and expectations and those of the profession they represent. In short, some organizing principles must be devised to shape the law's development in relation to professional associations.[22]

With respect to the initial question of whether judicial review of an association's internal affairs is warranted, these organizing principles should encompass at least four paramount policy considerations: (1) the association's need for autonomy, (2) the nature and extent of the expertise that the association develops and applies, (3) the degree to which the functions of the association and the profession are of concern to the general public, and (4) the extent to which the association's actions can harm the public or a member or prospective member of the association. The greater the association's need for autonomy, and the greater its expertise, the smaller the likelihood of judicial intervention. The greater the public concern regarding the association's activities--and the greater the harm that the association can impose upon members, prospective members, or the public--the stronger the likelihood that courts should intervene.

Autonomy

Probably the major, albeit often unarticulated, reason for the judiciary's historical reluctance to review associational matters is the association's desire for, and need for, autonomy. It was believed that group autonomy should be protected because

> the health of society will usually be promoted if the groups within it which serve the industrial, mental, and spiritual needs of citizens are genuinely alive. Like individuals, they will usually do most for the community if they are free to determine their own lives for the present and the future. . . . Legal supervision must often be withheld for fear that it may do more harm than good.[23]

These beliefs are essentially an outgrowth of the political and social theory of pluralism, which holds that social value inheres in the existence of many, diverse private associations operating within society. Such a pattern of social and political organization presumably stimulates voluntarism and dynamism within society and diffuses power by its reliance upon private centers of influence operating independently of the state. The result is an "open" and "elastic" "pluralist society," which promotes individual freedom by providing the social and political structure that makes such freedom possible.[24] Politically, such a society presupposes a system of private associations that act as interest groups within their own limited spheres of operation, with the state balancing and working adjustments among the various societal interests.

Clearly, professional associations are private power centers that act as interest groups for their respective professions. As such, they fit within the concept of pluralism and presumably can lay strong claim to the autonomy that in theory supports the concept. But for the professional groups, unlike many other types of associations, there is also a second, related social and political foundation supporting the claim of autonomy: economic laissez faire. Comprehensive professional autonomy "constitutes the kind of entrepreneurial position that nineteenth-century Western liberal notions of 'freedom' readily embrace."[25]

Using these bases for support, professions have historically attempted to expand the scope of their operational autonomy, often claiming government itself as an ally. Full-blown professional autonomy has come to mean essentially that the profession: (1) determines its own standards for the education and training of members and prospective members; (2) is recognized through a system of governmental licensure, control over which is delegated by government to the profession itself; (3) shapes the legislation that affects it; and (4) is free from lay evaluation and control.[26] The health professions, dentistry and medicine in particular, have probably come the closest of all professions to this concept of full-blown professional autonomy. Not only are they protected by comprehensive systems of licensure which grant them effective professional monopolies in their respective areas of operation, but they have also developed comprehensive systems of accreditation, certification, and registration which, in conjunction with licensure, assure control over the establishment of standards for education and training.

The medical schools and other professional schools of the health professions are central to this pattern of institutionalized autonomy. First, they provide a specialized body of knowledge, which is the exclusive domain of the profession. Since in theory no one but a member of the profession can grasp this special knowledge, there is no one else, in theory, who can criticize, monitor, or otherwise impinge upon the profession's autonomy. Secondly, "the professional school and its curriculum . . . also constitute convenient institutional criteria for licensure, registration, or other exclusionary legal devices" which buttress professional autonomy.[27] In both these aspects, the function of accreditation is vital because it is perhaps the major professional force operating upon and shaping the professional school. As such, it is a major building block in the structure of professional autonomy and a primary determinant of the degree of autonomy a profession is able to achieve.

Professional autonomy, seen in this light, is an *organized* autonomy which is rooted in an underlying professional ideology emphasizing *individual* autonomy but which seeks to protect this individual autonomy through highly structured professional associations that collectively represent the members of the profession in their relations with government. This organized autonomy and the concept of professional expertise upon which it is partially based,[28] have provided the health professions with considerable protection not only from governmental regulation but also from judicial examination of, and interference with, their internal affairs. Such judicial deference to professional autonomy reflects old and respected notions of the values of pluralism and laissez faire individualism, which courts have believed would be supported by a policy of noninterference. But in the United States in the late twentieth century, it is becoming increasingly apparent that the societal values of professional autonomy are not limitless. Some limits stem from countervailing considerations, which are discussed in following sections of this paper; others are inherent in the concept of autonomy itself.

Autonomy, insofar as it is supportive of social and political pluralism, is largely intended to promote the privateness and the voluntariness of group action, thus allowing associations to evolve as buffers against centralized governmental power in particular areas of life. The law that has developed to cover the situation, in fact, is called the law of "voluntary, private" associations.[29] Yet most of today's professional associations, particularly in the dental and medical professions, are no longer truly "voluntary" nor truly "private."[30] Because government so often relies upon the standard-setting and self-regulating activities of professional associations, membership and good standing in one or more such associations may be a matter of professional or economic necessity rather than voluntary choice. It is increasingly true that "substantial compulsion is exercised through private as well as through public power in our society. Private association does not inherently spell increase in voluntarism."[31]

Moreover, because government often relies upon private associations and delegates governmental power to them, the line between public and private activity is more and more blurred. Goals that once may have been accomplished through independence from government may now be accomplished through cooperation with government; activities that once were private may now be quasi-public. Especially in the professions, *private association*, rather than connoting privateness, may connote a hidden hierarchy of public/private interlocks.[32]

The result has been some departure by professional associations from the goals for which pluralism stands. And as the voluntarism and privateness of professional associations decline, the value of their autonomy to society must be seen in a new light. Courts, no less than the rest of society, cannot afford to ignore these changed circumstances in weighing the importance to be accorded professional autonomy as it bears upon the judiciary's role in solving professional power disputes.

Expertise

Much of the health professions' claim to autonomy is premised upon their possession of an expertise concerning health care, which is asserted to transcend the competence, perhaps even the comprehension, of persons not belonging to that particular profession. In order for this expertise to be nurtured and applied for the benefit of society, the argument goes, the profession must be free from intervention by government or by private interests, which do not possess the requisite expertise. In short, to operate expertly, it must operate autonomously.

Undoubtedly, there is wisdom in this claim. The health professions, through their professional schools and their research programs, protect and develop a body of knowledge that is vital to society. In order for this knowledge to be used in society's best interests, professional standards must be developed to guide its application. In the health care area, where professional action is so dependent upon esoteric scientific knowledge and so vitally affects the life of virtually every citizen, standard-setting necessitates a high level of expertise. No one but the professionals themselves, who have received the training obtainable only in professional schools and the experience obtainable only after graduation from such schools, have the special competence necessary to the standard-setting role.

The public has generally accepted this role of the health professions and has accorded certain of them, medicine in particular, a high degree of public esteem. Government, too, has come to rely heavily upon the standards set by the professions, especially with respect to accreditation and the related licensure function. And the courts, as might be expected, have clearly followed the public's and government's lead in respecting professional expertise. "The court must guard against unduly interfering with the . . . [association's] autonomy

by substituting judicial judgment for that of the . . . [association] in an area where the competence of the court does not equal that of the [association]. . . ."[33]

When courts are asked to become involved in professional affairs, however, the inquiry should not end with a discovery that the associations possess a special competence. The degree of deference to be paid professional expertise should depend upon at least two other questions: (1) Was the association in fact applying its expertise in making the decision or undertaking the action that is before the court? (2) Is the association's expertise in fact capable, in and of itself, of satisfactorily resolving the matter in dispute?

1. *Was the association applying its expertise?* As this question implies, decisions of professional associations can be based upon considerations other than expertise, even though the claim of expertise may at times be used as a mask to hide other considerations that influence the decision-making process. This tendency is inherent in the nature of professional associations, which characteristically represent not only the broad interests of society but also the narrower interests of their own members.[34] Since these two sets of concerns do not always coincide,[35] a potential conflict of interests inheres in the situation.

> On the one hand, the maintenance of professionally established quality standards is generally accepted as a socially desirable function of professional organizations; this is particularly true of medical care, where the quality of services provided may mean the difference between life and death. On the other hand, the professional organization is inevitably concerned with protecting and advancing the economic interests of its members. Since it is inherently difficult to translate "quality" into objectively quantifiable terms, there arises the possibility of an internal contradiction in the dual role of the professional organization as protector of society's welfare through the regulation of quality and as defender of the economic interests of the members of the organization.[36]

When the professional association is actually relying upon its expertise, it is genuinely fulfilling its standard-setting role and is likely to be operating in the public interest. When considerations other than expertise influence professional action, the association may be acting primarily as a professional "union" for its members, and it is less clear that societal interests are being served.

It is thus important that courts differentiate situations where expertise is dominant from situations where it is not and that they accord greater deference to professional judgment in the former area than in the latter. The classic case of *Falcone v. Middlesex County Medical Society* provides an example of this approach. In invalidating a local medical society's rejection of the plaintiff-physician's application for membership, the court remarked:

> When the County Society engages in action which is designed to advance medical science or elevate professional standards, it should and will be sympathetically supported. When, however, as here, its action has no relation to the advancement of medical science or the elevation of professional standards but runs strongly counter to the public policy of our State and the true interests of justice, it should and will be stricken down.[37]

Similarly, in the landmark case of *Greisman v. Newcomb Hospital,* where the court overturned a hospital's refusal to grant the plaintiff-physician staff privileges, it was careful to note that the action was "unrelated to sound hospital standards. . . ."[38]

Such conclusions presuppose a judicial awareness of the appropriate boundaries of expertise. In other words, to determine whether a professional association is in fact applying its expertise in undertaking a certain course of action, that profession's expertise must be defined and its limits carefully demarcated. This is an inquiry upon which social scientists are only beginning to embark;[39] courts have not yet undertaken the inquiry, although they may be expected to do so as the state of the art increases.

The problem of delimiting professional expertise is an extremely important one, for excessive deference to expertise is in some ways potentially inconsistent with the democratic ideal of individual freedom. As society's reliance upon the expert increases, the layman's ability to control the details of his everyday life decreases. Actions premised upon the application of professional expertise may be insulated from the judicial and legislative processes and from the critical eye of public debate; the layman may be precluded from participation in decision making even when the decisions are allegedly made for his own benefit.[40]

In order for a modern technological society and its courts to cope with this tendency by confining expertise to areas where it should predominate over lay opinion, it is necessary to distinguish "true" expertise from the "social and political power of the expert."[41] In terms of a particular profession's work, this requires a separation of the technical content of the work from its "nontechnical zones" such as working conditions, resources, and relationships with colleagues.[42] The former involves the direct application of expertise; the latter may involve expertise only indirectly, or not at all.

For the health professions, the "content" of work is centered on diagnosis and treatment, whose justification derives from the scientific foundation of medicine; the nontechnical zones, on the other hand, have more to do with the organization and management of diagnosis and treatment, i.e., with the institutions of medicine.[43] While the doctor of medicine, to take the dominant health profession as an example, can claim expertise in the science of medicine, he cannot claim expertise in the "liberal arts, humanities, and social sciences of medicine."[44] Thus, while he is an expert in diagnosis and treatment, he is not

necessarily an expert in the economic, political, and social problems of medicine's institutions.

These distinctions at least suggest appropriate limits for the expertise possessed by professional associations in the health professions. The association is in fact applying its "true" expertise only when its decision or action concerns the development or content of the scientific knowledge of medicine and is based upon that body of knowledge.

2. *Is the association's expertise capable of resolving the problem?* Even when the association is in fact applying its expertise, a court might determine that the particular matter at hand cannot be resolved solely by application of that expertise. The matter may involve a complex of factors whose resolution also demands application of the expertise of other professions or demands not only expertise but the moderating influence of lay opinion.

As the previous discussion suggests the solution of many health care problems may require the expertise of the social and applied sciences as well as of the health professions.[45] Where the problem is one of organization or delivery of health services, for instance, expertise in business management and engineering may be as important as medical expertise.[46] As the Carnegie report on higher education and health remarks, there is now in progress an "extension of medical concerns beyond science into economics, sociology, engineering, and many other fields."[47]

Similarly, in some situations lay opinion may be an important partner of medical expertise. In hospitals, for instance, it is theoretically neither the expert staff nor the expert hospital director who formulates policy, but rather the lay board of trustees.[48] And it is good to remember that the early twentieth-century revolution in medical education was accomplished not primarily by the profession but largely by a layman, Abraham Flexner.[49] In essence, the expertise of the health professional may be limited by the fact that "in the complex modern world, the needed expertness is that of the generalist who can weave together into a workable whole the separate expertness of the specialists."[50]

The limitations of expertise just discussed are directly pertinent to the accreditation of health educational programs. Some accreditation standards, for instance, rather than representing applications of the association's true expertise, may be premised primarily upon considerations of professional self-interest or upon considerations relating to the nontechnical zones of work. Some standards regarding class size and admission policies arguably fall into this category.[51] Other accreditation standards, though reflecting the profession's true expertise, may involve matters that cannot be satisfactorily resolved solely by tapping that expertise. Standards concerning the management of the professional school or its relation to the health care delivery system, for instance, may involve business, economics, or engineering considerations as much as medical expertise. Standards involving general educational or social policy may touch upon areas where the expertness of the generalist is as important as

that of the professional. And perhaps most significant, some curricular standards may reflect value judgments regarding teaching technique more than judgments based upon scientific knowledge of medicine. "The reliability of the knowledge which the teacher teaches . . . is considerably greater than the reliability of the knowledge of how to teach that knowledge."[52]

Public Concern

Professional associations differ strikingly from such traditional private associations as fraternities and clubs in the amount of impact they have upon public affairs. The traditional private organizations with which courts are accustomed to dealing often operate in their own island of privacy isolated from the larger society and its concerns. But professional associations operate in areas of vital public interest and, in so doing, often thrust themselves into the public arena. The public is accordingly affected to a much greater degree by the activities of professional associations and has a much greater concern for their operation.

—Since the public is so much more concerned with the operations of professional associations than with those of other private associations, so should the courts be. In the *Falcone* case, the court gave currency to this notion when it remarked that the defendant, a county medical society, was "not a private voluntary membership association with which the public has little or no concern. It is an association with which the public is highly concerned and which engages in activities vitally affecting the health and welfare of the people."[53]

The description can aptly apply to virtually all professional associations in the health field. Society has accorded the health professions responsibility for setting standards that govern almost every aspect of health care. And health care has long been considered one of the primary concerns of society. Probably no one has stated the matter more clearly than Thomas Jefferson, speaking almost 175 years ago: "Without health there is no happiness. An attention to health, then, should take the place of every other object."[54]

Since that time, public concern for health care has, if anything, increased, and the current health crisis has brought this concern, and the accompanying public awareness, to a peak. In the process, government has increasingly fulfilled its "fundamental obligation" to promote and improve health care by delegating power to, and otherwise relying on, the health professions and their professional associations. Thus, as public concern over health care has broadened, so has the professional associations' power to control health care.

It is the standard-setting role that thrusts professional associations most deeply into the public arena. Since this role gives considerable external impact to the actions of professional associations, associational decisions that concern standards cannot be considered as solely "internal affairs."[55] The exertion of collective power to influence societal decisions concerning health care is a goal of professional associations; society relies upon the professional standards formulated in pursuance of this goal. The actions of association and society reinforce one another and heighten the societal impact of association action.

And as this societal impact increases, so too does the public concern with the professional association's activities.

When the association thus operates in an area of vital public concern, there is an overriding public interest in its operations which transcends the particular interests of the association. Since courts are guardians of the public interest, they should be more concerned with the affairs of professional associations than with associations exerting less impact upon society. The greater the public concern regarding a particular aspect of an association's affairs, and the greater the impact of those affairs upon the public interest, the greater should be the likelihood of judicial involvement in those affairs.

Accreditation of health educational programs, as one of the health professions' major standard-setting functions, is a prime example of associational activity in an area of vital concern to the public. Accreditation is related not only to society's interest in health but also to its interest in education. And education, like health, is demonstrably an area of great public concern. As the court in a major accreditation case recently remarked, "With a rapidly expanding population, broad social changes, and the complexities of modern life, higher education in the United States is a matter of national concern. A sound educational system is essential to our pluralistic society."[56]

Health education accreditation operates at the confluence of these twin concerns of health and education. Society relies more and more on accreditation as a means of identifying schools and programs that meet acceptable standards of academic excellence. Government itself relies upon professional accreditation for numerous purposes; state licensing boards use it, for example, in ascertaining eligibility for licensure, and the federal government uses it to determine eligibility for federal funding.[57] Given this heavy investment of public reliance, the accrediting activities of professional associations can have significant impact upon the public interest. The resulting increase in public concern regarding accreditation is indeed leading to increasing judicial concern, as evidenced particularly by the recent *Marjorie Webster* litigation.[58]

Harm

As the ability of a professional association to exert impact upon society increases, so does the association's potential for harming individuals or the public at large. Harm is a commodity that courts are accustomed to dealing with, as most lawsuits are premised upon the fact of injury to personal or proprietary rights. Since courts are sensitive to such claims of harm, the likelihood of judicial involvement in association affairs can be expected to increase as the seriousness of the harm inflicted by association action increases.

Harm resulting from the action of private associations has most often arisen in situations where membership was at issue. The cases fall into two basic categories: expulsion, i.e., the termination of an existing membership, and exclusion, i.e., the denial of an application for membership. Although courts have traditionally been less hesitant to intervene in the former situation than in

the latter,[59] this distinction should be of little significance in dealing with modern-day professional associations. "In either case the critical question would seem to be the extent of harm suffered by the person excluded or expelled."[60]

Nor is the professional association's potential for inflicting serious harm limited to situations involving membership. Such potential inheres in virtually all of a professional association's standard-setting activities, whether the standard is set indirectly through membership policies (e.g., as in the case of admission to a local medical society) or directly through such devices as accreditation or certification. Although a school or program denied professional accreditation or an individual denied certification may not have been denied membership in the accrediting or certifying body, since membership is not necessarily a consequence of professional accreditation or certification, it has been denied a valuable status whose absence can cause significant harm. Such a denial of status can be as harmful as an exclusion or expulsion from membership and should therefore be accorded the same treatment by the courts.

Consideration of the nature and extent of the harm to individuals or to society that may result from particular association decisions serves to distinguish professional associations from other types of private associations. The classic *Falcone* opinion again provides the rationale.

> When courts originally declined to scrutinize admission practices of membership associations they were dealing with social clubs, religious organizations and fraternal associations. Here the policies against judicial intervention were strong and there were no countervailing policies. When courts were later called upon to deal with trade and professional associations exercising virtually monopolistic control, different factors were involved. The intimate personal relationships which pervaded the social, religious and fraternal organizations were hardly in evidence and the individual's opportunity of earning a livelihood and serving society in his chosen trade or profession appeared as the controlling policy consideration.[61]

In making use of this distinction, courts have emphasized the importance of the status or distinction accorded by the professional association. The greater its importance, the greater is the harm its absence inflicts. And the greater the harm, the more likely it is that "courts . . . [will scrutinize] the standards and procedures employed by the association notwithstanding their recognition of the fact that professional societies possess a specialized competence in evaluating the qualifications of an individual to engage in professional activities."[62]

Sometimes courts have said that the professional status bestowed by the association must be a "virtual prerequisite to . . . practice," or an "economic necessity," or a "necessity for successful operation."[63] But if such phrases are

too literally construed, they present overly restrictive characterizations of the harm required to precipitate judicial involvement. At least where the association is operating in an area of vital public concern, the status of which the party is deprived need not be a necessity in the strict sense nor need the harm be strictly economic. Deprivation of substantial "advantages," be they educational, financial, or professional in nature, should be sufficient to trigger judicial review.[64]

Any stricter characterization of the harm required would unduly focus attention on the plaintiff's (the deprived party's) injury, when courts should be concerned with harm accruing not only to the plaintiff but also to society. The harm that the plaintiff suffers at the hands of the professional association is a paramount consideration in these cases because an injury to plaintiff may also be an injury to society. For instance, if a physician is denied membership in a local medical society and thus is deprived of access to the society's education programs or becomes ineligible for staff privileges at local hospitals, not only is he harmed but his patients and, ultimately, society may also be harmed. Similarly, if a medical school is denied accreditation and thus experiences the multiplicity of disadvantages that accompany unaccredited status, not only are the school and its students and faculty harmed, but perhaps society as well.[65]

Harm to society in some ways is the more important consideration in professional association cases. Not only does it divert the court from narrow and technical inquiries concerning "economic necessity," but it also provides less occasion for the association to claim that its autonomy has been unjustifiably infringed.[66] Since autonomy is premised upon the societal value of private associations, it follows that when the association is harming society there is less reason to respect its autonomy with regard to the matter causing the harm. Moreover, when harm to society is the focus, the court investigates and considers societal goals rather than merely the goals of the association, a job for which the court is presumably better prepared than the association.

Four Factors in Action: The Monopoly Power Theory

The strength with which each of the four factors presents itself in a particular case will vary according to the type of association involved and the nature of the action the association has undertaken. When the association is one representing a health profession, however, and the action is one that affects professional standards, the latter two factors (public concern and harm) are likely to outweigh the former (autonomy and expertise) to a degree sufficient to justify judicial involvement.

Such a result is sometimes expressed in a shorthand manner under the rubric *monopoly power*. While the monopoly power theory, in its current state of development, does not explicitly recognize each of the four factors and balance them against one another, it is premised upon policy considerations similar to those that the four factors reflect. In particular, the theory focuses upon private associations wielding authority "in an area of vital public concern."[67]

To possess monopoly power, an association must control access to some important professional status or privilege, so that an individual practitioner (e.g., in the case of association membership or certification) or a professional school (e.g., in the case of accreditation) must turn to the association to obtain the benefits the status or privilege affords. When this occurs, the association has a stranglehold upon some aspect of the profession, which enables it to exert significant impact upon those who desire access to the status or privilege the association controls.[68] And because the association operates in an area of vital public concern, its actions can also have significant external impact upon society. This capacity to affect both the profession and the general public is a source of great power, which, because only the association can bestow the particular status or privilege, is in the nature of monopoly power. The more the public relies upon the association, the greater its monopoly power becomes; and the greater its monopoly power, the greater the association's capacity to harm both members of the profession and society.

The monopoly power theory, then, basically focuses upon the related factors of harm and public concern and asserts that when a particular exercise of association power involves these two factors to a sufficient degree, that power will be considered as monopoly power. Judicial intervention is justified in such situations in order for the courts to protect against abuse of this power; in other words, monopoly power must be exercised responsibly, and it is a function of the courts to assure that it is.

The trend toward greater and greater concentrations of private power, and increasing reliance by government and the public upon such concentrations of power, has enlarged the reservoir of monopoly power held by professional associations.[69] In particular is this true in the health professions. Government has given various health professions legal monopolies over the performance of their work; professional associations organize and protect this legal monopoly, thus becoming in some ways virtual monopolies.[70]

Courts have taken increasing notice of this trend since the groundbreaking *Falcone* decision in 1961. There, in analyzing the powers of a local medical society, the court spoke of "professional associations exercising virtually monopolistic control", and determined that

> the County Medical Society . . . is an association with which the public is highly concerned . . . . Through its interrelationships, the County Medical Society possesses, in fact, a virtual monopoly over the use of local hospital facilities. As a result it has power, by excluding Dr. Falcone from membership, to preclude him from successfully continuing in his practice of obstetrics and surgery and to restrict patients who wish to engage him as an obstetrician or surgeon in their freedom of choice of physicians. Public policy strongly dictates that this power should not be unbridled.[71]

Subsequent cases have applied this theory to other local medical societies,[72] associations controlling specialty certification,[73] hospital staffs,[74] and, with some qualifications, accrediting associations.[75]

Legal Theories Supporting Judicial Intervention

If, after balancing factors such as those suggested in the discussion of factors influencing judicial intervention, a court determines that intervention into a particular associational problem is warranted, it must next select a legal theory that will provide a specific basis for involvement and a touchstone for determining the manner and extent of that involvement. As might be expected, several theories have been employed for this purpose, and the courts have not achieved anything approaching a consensus concerning the most suitable theory on which to rely in the various problem areas of professional power.

Contract Theory

The contract theory holds that a private association is a conglomerate of contractual relationships. The association's rules form the basis of the contract, and each association member in effect contracts with the association and with every other member, thus agreeing to abide by the rules. When the association or a member violates the rules, a breach of contract is said to result.[76]

The contract theory provides only narrow grounds for judicial involvement in associational affairs. By its terms, it can apply only to disputes between the association and a member, leaving untouched the large problem area concerning disputes between the association and applicants for membership (or other status) or other nonmembers in the general public who are adversely affected by association action. Even when the dispute is between the association and a member, the contract theory affords relief only in circumstances where an association rule applies to the dispute and the association has violated it.

Moreover, the contract theory is the most rigid of the theories applicable to private associations. It depends upon artificial legal technicalities concerning the nature of intra-associational relationships and does not take account of the association's function in or impact upon society. It has been aptly described as "a legal fiction which prevents the courts from considering attentively the genuine reasons for and against relief."[77]

Tort Theory

Application of the tort theory in association cases initiates a search for association action that unjustifiably causes injury to a member or some third party.

There is no single tort theory on which to rely; several have potential applicability depending on the circumstances.

When the dispute is between the association and a member, the theoretical tort may simply be one of wrongful interference with the membership relationship. Such was the case in *Higgins v. American Society of Clinical Pathologists*,[78] where the plaintiff sought recertification as a pathologist and reinstatement of his name in the association's registry. The court relied upon the tort theory in granting relief, asserting that "the real reason for judicial relief . . . is the protection of the member's valuable personal relationship to the association and the status conferred by that relationship. . . . 'The wrong is a tort, not a breach of contract. . . .'"[79]

Other tort theories with potential applicability to association action could be invoked not only by members but also by an applicant for membership and sometimes by other third parties. The tort of defamation has obvious relevance to cases concerning accreditation, certification, or other symbols of professional status, since their withdrawal or refusal can vitally affect professional reputation.[80] When the problem is the association's misuse of competitive techniques as a means of interfering with professional pursuits, the torts of "interference with prospective advantage" or "concentrated refusal to deal" may be applicable.[81] In situations not readily encompassed by any of these theories, the theory of "prima facie tort" may be useful; it provides an analytical technique for focusing generally upon the intentional infliction of injury and requiring a justification for such action in terms of the competing private and public interests involved.[82]

Public Trust Theory

This theory is closely aligned with the concept of monopoly power and thus emphasizes the association's relationships to society. Although its beginnings can be traced to cases involving labor unions and public service businesses,[83] the theory was forcefully applied to professional associations in the *Falcone* case. There, after discussing the local medical society's monopoly power, the court declared:

> Public policy strongly dictates that this power . . . should be viewed judicially as a fiduciary power to be exercised in a reasonable and lawful manner for the advancement of the interests of the medical profession and the public generally.[84]

Subsequently, the case of *Pinsker v. Pacific Coast Society of Orthodontists* expanded upon this theme:

> The fact that respondent associations hold themselves forth to the public and act within the dental profession as the sole association

> recognized by the A.D.A., itself a virtual monopoly, as the arbiter of ethical and educational standards for the practice and certification of orthodontists dignifies these organizations with a public interest and a concomitant fiduciary responsibility.[85]

Most recently, evidence of this theory can be seen in the *Marjorie Webster* litigation where, in discussing accrediting associations, the district court remarked that "in view of the great reliance placed on accreditation by the public and the government, these associations must assume responsibility not only to their membership but also to society."[86] Such a view of accreditation appears consistent with that recently expressed by Frank G. Dickey, executive director of the National Commission on Accrediting: "Philosophically, accrediting agencies in general espouse their public trust function and largely because of this role society has allowed these agencies to operate."[87]

The public trust theory is the frankest and most flexible of the theories that courts have utilized in private association cases. Rather than depending upon legal technicalities or complex legal concepts, it merely recognizes the influential role of professional associations in modern society and attaches to that role the duty to act responsibly and in the public interest. More than any of the others, this theory is particularly adapted to the special problems posed by professional associations and takes account of the four factors that have been suggested as influencing judicial involvement in professional affairs.

Antitrust Theory

The antitrust theory might be pressed under common law restraint-of-trade concepts, state antimonopoly statutes or constitutional provisions, or the federal Sherman Antitrust Act. All three sources encompass similar legal principles, since the Sherman Act and many of the state provisions incorporate the common-law concepts of restraint of trade.[88]

The precise applicability of antitrust theories to the health professions is somewhat unclear, although it is clear that they apply to such anticompetitive situations as conspiracies against particular organizational forms of professional practice.[89] Similarly, although the general applicability of antitrust concepts to educational accreditation was recently rejected by the court of appeals in the *Marjorie Webster* case, that court did acknowledge applicability to accrediting activities that are prompted by commercial motives.[90] And in an earlier case, the same court approved the application of the antitrust laws to hospital accreditation.[91]

Antitrust law, as these cases reveal, is a technical legal specialty, which has an important but thus far limited role in curbing excesses in the exertion of professional power. For the most part, this role is directed toward situations where the members of a professional association have engaged in concerted action that is commercially motivated or has an anticompetitive purpose and effect. Antitrust theories would thus appear to have their greatest usefulness

where a professional association acts in a conflict-of-interest situation by pursuing its own economic self-interests at the expense of the broader public interest in competition within that profession or between that profession and others.[92]

Constitutional Theory

Because the United States Constitution was designed as a limitation only upon the exercise of governmental power, it is not normally construed to reach private activity. But for many years courts have recognized that some ostensibly private activity has sufficient relationship to governmental activity to be considered public or quasi-public and thus subject to the constraints of the Constitution. Such a result is justified under what is termed the state action theory, which is used particularly under the Fifth and Fourteenth Amendments to determine the reach of the due process and equal protection clauses.[93]

Essentially, courts have used three theories as means of reaching private action. Whenever a private corporation, association, or other body (1) exercises power formally delegated to it by government (federal, state, or local) or (2) fulfills what is essentially a governmental function at the sufferance of the government or (3) obtains a significant amount of its power, prestige, or resources from its contacts with government, acts may be considered as state action subject to consitutional limitations. All three theories potentially have application to professional associations in the health professions.

Delegated Power Theory—In many states, the state associations of various health professions have, by statute or administrative regulation, been delegated power to nominate or appoint members of the licensing boards for their particular professions.[94] In several important cases, courts have declared that the state association acts as an agent of the state in performing this function and that its actions that reasonably relate to such performance, especially membership selection, are subject to the Fourteenth Amendment. When membership in a local society is a prerequisite to membership in the state association, the local society has been held to the same constitutional standards.[95]

In the *Marjorie Webster* case, a similar theory was applied to the regional accrediting agencies, which the United States commissioner of education has recognized, pursuant to his authority under the aid-to-education statutes, as reliable authorities on the quality of training offered at educational institutions. The district court found that such agencies "have operated as service agencies for the federal government in determining eligibility for funding."[96] The same reasoning might well be applied to the many professional accrediting associations that the commissioner recognizes, including those in the health professions, thus subjecting their accrediting activities to the strictures of the due process clause.

Governmental Function Theory—This theory somewhat overlaps the delegated power theory: it focuses less upon formal relationships with government, however, and more upon the performance—whether or not pursuant to some delegation of power—of an activity traditionally undertaken by government.

The standard-setting role of professional associations is particularly important under this theory, since standard setting in matters of both health and education is often considered to be a governmental activity. Thus, when it is performed by private groups in lieu of government and with government's acquiesence, the private groups might sometimes be said to be exercising governmental functions.

This theory may also have potential application to professional accrediting activities.[97] In addition, it has been utilized as an alternative to the delegated power theory in situations where an association in the health professions is intimately involved in the selection of governmental officials. In *Hawkins v. North Carolina Dental Society*, the court held the defendant's activity to be state action by reasoning that

> here the Dental Society appears to be functioning clearly as the agent of the State in the selection of the dental members of the state's boards and commissions. Our conclusion is not dependent, however, upon a finding of fact to that effect. It is enough that North Carolina in some of its manifestations has involved itself in the Society's activities and that the Society's exercise of its powers of practical control or significant influence in the selection of state officials is a public function performed under the general aegis of the state.[98]

Government Contacts Theory Seeds of this theory, which somewhat overlaps the government function theory, can be seen in the previous quotation. The theory can be used to reach private activities that are not traditionally governmental if, in performing such activities, the private group derives a substantial amount of power and capability from its contacts with government.

Private hospitals, in particular, have been subjected to this theory, thus rendering such actions as staff appointments subject to the due process and equal protection clauses; the most significant "contact" is usually the receipt of government funds under the Hill-Burton Act.[99] But the principle potentially has a much broader application to professional associations, since

> government, for the stronger professional associations, is a continuum, a matter of continual interaction and close integration between private and public governments. . . [These associations] borrow the sanctions and the legitimization of public government in order to accomplish their own ends.[100]

All three of these constitutional theories have been assuming increasing importance in recent years and should continue to do so as private power becomes more and more significant in American life and more closely aligned with government. "The conditions of modern institutional life tend strongly to

break down the distinction between the law of the political state and the internal law of associations,"[101] and as they do so, it becomes more likely that courts will consider "private" action to be sufficiently public to be subject to constitutional restraints. Probably nowhere is this tendency more manifest than with the health professional association.

Scope Of Judicial Review

Once a court decides to take cognizance of and review the action of a professional association, it immediately confronts a second and equally pressing problem: What kind of review should it undertake? In other words, it becomes necessary to delineate the parameters of the judicial review process as it operates upon problems of professional power. What will be the scope of the review: How deeply and how broadly will the court dig into the rules, policies, and practices of the professional association, and by what standards will the court measure the validity of the association's action?

The answer depends in part upon a balancing of the same four factors suggested for determining whether judicial involvement is warranted at all. The greater the weight accorded the latter two factors (public concern and harm) in relation to the former (autonomy and expertise), the broader and deeper the review should be. The legal theory relied upon to support intervention is also important, since each theory has some suggestion of a standard for review built into it. And a third consideration, in determining the breadth and depth of judicial review, is the character of the reasons proffered for the alleged invalidity of the association action.

The major distinction under the third consideration is one between alleged procedural invalidity and alleged substantive invalidity. When the association action is challenged because of a procedural defect in the process by which the decision to act was made, the court is likely to scrutinize the association's action much more closely than it would if the challenge were directed at the substantive standards and policies of the association. In other words, the difference is between an attack upon the procedures followed and an attack upon the criteria relied upon. Courts are well equipped to handle problems in the former category, whereas professional associations have no special competence in making determinations concerning procedural fairness; hence a broad scope of review is likely. But in the latter category, where the association is engaged in its standard-setting role, professional expertise may be deeply implicated. When it is,[102] courts are likely to act deferentially because they cannot lay claim to a special competence similar to the association's; hence a narrower scope of review.[103]

From the ebb and flow of considerations such as these, a variety of statements have emerged concerning the scope of judicial review of professional

association action. The statements are usually somewhat cryptic, and the considerations relied upon in adopting a particular scope of review are sometimes not explicitly delineated. Little consensus has yet been reached concerning the appropriate "test" to apply in particular cases. It is possible in a broad sense, however, to detect three levels of judicial review that have been employed by the courts, each more probing than the one preceding.

The First Level

At the first, and shallowest, level of judicial review, courts will determine only whether the association has violated its own rules. This is the type of limited review traditionally accorded private associations. It is premised upon the contract theory, which holds that action taken in contravention of associational rules is a breach of the associational contract for which judicial relief is generally available.[104]

This first level of review applies with equal force to substantive and procedural rules—so long as the rule is clear enough to be understood by the court. But when a rule is so vague that the court must provide its own interpretive gloss before it can determine whether the rule was violated, it is more likely to defer to the association and accept its interpretation if the rule is a substantive one.

Review on the first level is usually simple and straightforward. But, being limited to situations where there is a rule governing the action taken and where the rule is sufficiently clear for the court to determine that it has been violated, this level is highly restrictive. While it has general usefulness in private association cases, it is neither adapted nor adaptable to the special problems concerning professional associations and is therefore of limited value in solving them.

The Second Level

The second level is somewhat of a catchall. It encompasses a variety of tests for gauging the validity of association action, most of them described by shorthand phrases with little supporting theoretical analysis. These second-level tests all share a common background and design; they represent attempts to satisfy a need, perceived in certain cases, for a more flexible and probing style of judicial review than is afforded on the first level, but a review that will still protect the autonomy of private associations from undue encroachment by the courts.

Perhaps the oldest, and narrowest, test utilized at this level is that of good faith. It is primarily a substantive test that permits limited judicial inquiry into the reasons for the action and that authorizes invalidation of any action not motivated by a legitimate objective of the association, i.e., not undertaken in good faith.[105]

A similar standard appeared in *North Dakota v. North Central Association*, the first major accreditation litigation, where the court suggested that association decisions be free from "fraud, collusion, [or] arbitrariness."[106] Or, more generally, the test has been that association action not be "arbitrary" or

"unreasonable"[107] or that it "meet judicial standards of fairness and reasonableness."[108] Although the first of these three tests seems, like that of good faith, to be primarily substantive, the other two comprise a balance of both substantive and procedural considerations. Other shorthand tests employed at level two are primarily procedural. The most prominent formulations here are natural justice[109] and rudimentary due process.[110]

Of all these catch phrases, *reasonableness* is the most often used, especially with professional associations, and is probably the best single descriptor of level two review of professional action. Reasonableness is central to the application of all the theories of review previously discussed, except contract. Although a vague concept, it is sufficiently flexible to be adapted to the problems of professional power by a court willing to set forth some benchmarks for ascertaining reasonableness in that special context.

When used to measure the procedural validity of association action, reasonableness is tantamount to a rudimentary due process standard. A requirement that an association's procedures be reasonable is essentially a requirement that they provide at least the minimal protections commonly associated with due process. Thus in a procedural context, where the term *due process* is more direct and familiar, it should be used as a standard of review in lieu of the more general *reasonableness*.

The Third Level

The third, and deepest, level of judicial review is the one that best takes account of the health professions' position in society and of the special problems created by their exertion of professional power. Level three review cuts to the heart of these problems, the vital relationship between professional power and the public interest. At this level, the validity of association action depends upon its consonance with the public interest, i.e., with public policy.

This review, like that at level two, could be resorted to under any of the applicable legal theories save contract, but it is particularly compatible with the public trust theory. Together, this theory and the implementing standards that level three review provides seek to fortify the judicial conception of *profession* as a public service pursuit[111] and to keep the health professions, in particular, true to their self-proclaimed goal of protecting the public interest.[112] In general, both the theory and the level three standards support the view that

> there has been and should continue to be a valid plurality of interests connected with each of the health professions. However, the pretensions of each group or sub-group need to be tested against fact, reality, and the larger public interest.[113]

The difficult problem for the court at level three, of course, is to determine what the public interest is with regard to any particular issue concerning professional power.[114] The search is basically one for prevailing social values.

Constitutions, statutes, the regulations and policies of administrative agencies, executive pronouncements, and judicial decisions are generally considered to be sources of social values and may thus be bellwethers of the public interest. But often the public interest may not be clearly demarcated by these sources, and the court will have to extrapolate from them or embark upon its own investigations, guided by the parties to the case and the testimony of experts in the field, into the predominant needs and demands of society.[115] In the latter area, particularly, the court should accord substantial deference to the professional association's determination if it is a substantive one based upon its true expertise.

If the court's search were to yield no answers, level three review would fail for lack of a public interest standard by which to gauge the validity of associational action, and the court would revert to level two review. But in the health care area such a result is becoming increasingly unlikely; as governmental interest and activity in, and the amount of scholarly and professional attention accorded to, the health care field increases and the public's needs and demands become more insistent, the public interest is becoming clearer.

In the procedural realm, the search for public policy will normally be easier than in the substantive realm. This is because the due process guarantees of the Constitution serve as a persuasive guide. In some cases, the Constitution may apply directly to the action of a professional association,[116] thus making the provision of due process a requirement of constitutional law rather than merely of public policy. In other cases, where the Constitution is not found to apply directly, the court may nevertheless accept its due process clause as the predominant source of public policy and determine that the public interest requires that similar due process guarantees, more stringent than those provided at level two, be accorded all persons adversely affected by professional action.[117]

In the substantive realm, no single public policy is so prominent as due process. The public interest will vary depending on the nature of the association action and the relevant social values. In searching for the substantive public interest, the court should avoid merely accepting the professional association's view, because the association's conception of the public interest will necessarily be affected by the presence of its own special interests.[118] Moreover, the court should remember that "the public interest is more than the arithmetical sum of the private interests of the nation."[119] The search, then, is for a transcendent public interest superior to the private interest of any, or all, of the private groups in the social and political structure.

The Levels of Review in Action

In practice, the scope of review adopted by a particular court can seldom be neatly categorized into one of the levels suggested above. Partly this is because an insufficient amount of attention has been accorded the problem of review standards; partly it is because courts may simultaneously pursue more than one

level of review. In *Falcone,* for instance, the court required that the medical society act "in a reasonable and lawful manner for the advancement of the interest of the medical profession and the public generally."[120] In *Greisman v. Newcomb Hospital,* the test was "reasonably and for the public good."[121] And in *Marjorie Webster,* the court of appeals remarked that professional standard setting must be "reasonable, applied with an even hand, and not in conflict with the public policy of the jurisdiction."[122]

Probably the best attempt thus far at sorting out the various standards of review and drawing them into a workable pattern is that in *Blende v. Maricopa County Medical Society.* There, in reviewing a local medical society's rejection of the plaintiff-physician's membership application, the court first examined the society's articles and by-laws and determined that the society had complied with all procedural rules, a level one inquiry. Next, the court considered and rejected the argument that the society had acted in bad faith, a level two inquiry. Then, advancing to a combined level two and level three approach, the court stated that the society could reject the application "only on a showing of just cause established by the Society under proceedings embodying the elements of due process."[123]

Under this approach, due process is the test of procedural validity and "just cause" the test of substantive validity. And just cause embodies a standard of reasonableness that, in turn, requires a consideration of the public interest.

> When determining whether "just cause" has been shown, the court must consider whether the grounds for exclusion were (1) supported by substantial evidence and (2) reasonably related to legitimate professional purposes of the Society. The judicial process involved in determining such a standard of reasonableness is essentially one of balancing individual, group and public interests: the right of the individual to practice his profession without undue restriction; the right of the public to have unrestricted choice of physicians; and the justification for the Society's action. When examining the justification for the exclusion, the court should consider several factors: the social value of the goal of the Society's action; the appropriateness of the Society as a means for achieving the goal; and the reasonableness of this particular action of the Society in relation to the goal.[124]

Measuring the society's action against this reasonableness-public interest standard, the court found it invalid.

The Special Problem of Due Process

The concept of due process has been briefly discussed, first as a major focus of the constitutional (state action) theory for judicial involvement in professional affairs and, second, as a major component of the standards utilized at the

second and third levels of judicial review.[125] But the concept deserves more extensive treatment, for it holds a special importance in the developing law of professional associations. Although due process could easily be the subject of an entire paper, this section will attempt only a brief overview of the concept and its importance to the matters raised in this paper.

Due process is usually understood as a constitutional concept embodied in the Fifth and Fourteenth Amendments to the United States Constitution. But in professional association law, due process has been, and is increasingly being, relied upon as a public policy concept limiting the exertion of professional power even where the association's action is not considered state action subject to constitutional restraints.[126] Although constitutional due process may theoretically be somewhat more stringent than the public policy concept, each has substantially the same content and impact in relation to professional power problems and they can usefully be discussed together. For purposes of this paper, their requirements will be considered the same.

Basic Distinctions

Like the law regarding scope of review previously discussed, due process law has both substantive and procedural aspects; substantive due process is concerned with the validity of the association's standards and policies, while procedural due process is concerned with the validity of the process by which the association formulates these standards and policies and applies them in making decisions. The former concept has less specific content than the latter and is not often referred to, by name, in the cases. It embodies a general reasonableness requirement like that utilized in level two review, and such a requirement is usually imposed upon associations without specifically labeling it as substantive due process.

Procedural due process, on the other hand, embodies a variety of specific requirements, which may vary from case to case depending upon the type of proceeding and the impact of the decision reached therein. The basic distinction is between procedures the association uses in formulating general standards and policies (rulemaking procedures) and those it uses in applying those standards and policies to decide specific cases (adjudicatory procedures). Although adoption of comprehensive rule-making procedures may be wise as a matter of policy, and may increase a court's confidence in the substantive validity of an association's standards, such requirements have not yet been imposed by law on professional associations. This paper's concern with due process, then, centers upon the problem of affording procedural due process in an adjudicatory context. What procedures, for instance, must be followed by a medical society when it excludes or expels a particular physician? What procedures must be pursued by a professional accrediting agency when it refuses to accredit or disaccredits a particular program of study?

Procedures Required By Due Process

Whenever a professional association engages in an adjudicatory function, due process will generally require that the party or parties that may be adversely affected be accorded these procedural guarantees: (1) opportunity for a fair hearing on all material issues in controversy, (2) prior notice of the proceedings and of the charges levied, (3) prior notice of the standards by which the party is to be judged, and (4) a decision on the record and statement of reasons therefor.[127] The stringency with which the law enforces these requirements will depend upon the circumstances of the particular case. In general, the stringency will increase as the harm that may befall the affected party increases and as the importance of fact finding, as opposed to the formulation of expert opinion, in the decision-making process increases.

Fair Hearing–The hearing is the crux of the due process concept. It guarantees a forum for the affected party to fully and freely present the facts and arguments supporting his side of the controversy before any adverse action is taken against him. The affected party should have the right to appear personally at the hearing and to present witnesses, written testimony and documents, and other evidence in his behalf.[128] He should be accorded the opportunity to confront the evidence against him and to refute it.[129] The hearing panel must of course be impartial.[130]

The precise procedures used in conducting particular hearings may vary considerably; there is substantial flexibility inherent in due process, and courts are not likely to demand either the format or the formality of a judicial trial. As a court explained recently in regard to accreditation, for which due process standards may be less stringent than for a disciplinary decision:

> The nature of the hearing . . . may properly be adjusted to the nature of the issue to be decided. In this case, the issue was not innocence but excellence. Procedures appropriate to decide whether a specific act of plain misconduct was committed are not suited to an expert evaluation of educational quality. . . .
>
> Here, no trial-type hearing with confrontation [of adverse witnesses], cross-examination, and assistance of counsel would have been suited to the resolution of the issues to be decided. The question was not principally a matter of historical fact, but rather of the application of a standard of quality in a field of recognized expertise.[131]

Notice of Proceedings and Charges–The opportunity for a hearing would obviously be of little benefit to an affected party if he had no adequate opportunity to prepare for it. Due process requires, therefore, that the party be given advance notice of the hearing and its format and be accorded a sufficient amount of time between notice and the hearing's commencement to prepare a

defense. It also requires that the party have advance notice of the charges levied against, or deficiencies attributed to, him. This second form of notice must be sufficiently definite and understandable to provide an adequate basis upon which to organize the defense.[132]

Notice of the Judgmental Standards—Specification of the charges or deficiencies can be fully meaningful to the affected party only if he also has advance notice of the standards by which these charges or deficiencies will be evaluated. Thus due process normally requires that the association have preexisting standards and that the affected party be apprised of those standards with which he allegedly has not complied.

There is also a second, broader reason for requiring advance notice of preexisting standards, to provide affected parties with a guide against which to measure their professional performance or conduct. Due process looks unkindly upon professional action that penalizes a member, or perhaps a prospective member, for noncompliance with a standard that was not in existence, or of which the party did not have actual or constructive notice, at the time the alleged noncompliance took place.

To provide adequate notice, standards must normally be in writing and stated with sufficient definiteness to be intelligible. This does not necessarily mean that extensive definition or technical detail is required. A professional association is "entitled to make a conscious choice in favor of flexible standards to accommodate variation in purpose and character among its constituent institutions [or members], and to avoid forcing all into a rigid and uniform mold."[133] In general, the more deeply the association's professional expertise is implicated in the formulation and application of its standards, the more flexibility due process will afford.

Record Decision and Statement of Reasons—The decision reached as a result of the hearing cannot be made on any basis the association sees fit; it must be based upon the record of the proceedings that culminated in the hearing. In other words, the decision must be based upon the charges or deficiencies specified by the association, the standards the association alleged to have been violated, and the factual evidence that was compiled at the hearing. To assure that the decision is in fact premised upon these considerations, the association should provide a statement of reasons for its decision.[134]

These safeguards seek to guarantee that the affected party's awareness of and participation in the proceedings will be meaningful. They are a guard against arbitrariness designed, as are all procedural due process guarantees, to assure the integrity of the decision-making process and the substantive validity of the decisions reached, thus protecting both the affected party and the public interest against abuses of professional power.

Conclusion

This paper has outlined the stance that courts in the past have assumed, and the stance that future courts should assume, when confronted with problems concerning the exercise of professional power in the health professions. The focus has been primarily upon the role of the courts in situations where there is no applicable state or federal statute. Although legislatures have considerable constitutional power to do so,[135] they have not assumed a significant role in controlling abuses in the exertion of professional power.[136] In the absence of any specific statutory text, courts have acted independently to develop modernized common-law concepts capable of handling the knotty problems that have arisen.

There is no reason to believe that the trend toward judicial involvement in the affairs of the health professions will not continue. And if increasing awareness of the vital relationship between professional standard setting and the public interest prompts legislatures, as it has prompted the courts, to become involved in professional affairs, judicial involvement will increase even more as courts assume the additional function of interpreting and applying statutory enactments.

Professional associations in the health professions should take careful note of these trends and attempt to adjust to the increased public scrutiny to which their affairs will undoubtedly be subjected. Such scrutiny does not presage an end to professional autonomy nor an undermining of professional expertise; it only suggests that the deference which is accorded to autonomy and expertise will be weighed in the future against a broader backdrop of public interest factors.[137] The job of the professional associations will be to assure the courts and the public that their professional power is not being abused—as they might do, for example, by instituting procedures for validating standards and insuring that they are in fact based upon professional expertise, by allowing participation of other professions or the public in standard setting that is not based soley upon such expertise,[138] or by providing appropriate due process guarantees for parties adversely affected by the enforcement of professional standards.[139] The interest of the courts extends no further.

FOOTNOTES

1. U.S. Department of Health, Education, and Welfare, *Report on Licensure and Related Health Personnel Credentialing* (Washington, D.C.: U.S. Government Printing Office, 1971), p. 1.
2. "Public policy is the cornerstone—the foundation—of all Constitutions, statutes, and judicial decisions; and its latitude and longitude, its height and its depth, greater than any or all of them." *Pittsburgh, Cincinnati, Chicago, and St. Louis Railway Co. v. Kinney*, 95 Ohio St. 64, 68, 115 N.E. 505, 506 (1916). As the legislator and the judge formulate public policy, "the choice of methods, the appraisement of values, must in the end be guided by like considerations for the one as for the other. Each is indeed legislating within the limits of his competence." Benjamin Cardozo, *The Nature of the Judicial Process* (New Haven, Conn.: Yale University Press, 1921), p. 114.
3. Comment, "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," *Yale Law Journal* 63 (1954) 1,018. *See*, generally, Elton Rayack, *Professional Power and American Medicine: The Economics of the American Medical Association* (Cleveland: World Publishing Co., 1967).
4. *See* Maryland Y. Pennell, John R. Proffitt, and Thomas D. Hatch, *Accreditation and Certification in Relation to Allied Health Manpower* (Washington, D.C.: U.S. Government Printing Office, 1971), pp. 1-2, 5-6.
5. *See* Health Policy Advisory Center, *The American Health Empire: Power, Profits, and Politics* (New York: Random House, 1970), pp. 29-39.
6. *See* C. Wesley Eisele, ed., *The Medical Staff in the Modern Hospital* (New York: McGraw-Hill, 1967).
7. *Maricopa County Medical Society v. Blende*, 104 Ariz. 12, 448 P. 2d 68 (1968); *Falcone v. Middlesex County Medical Society*, 34 N.J. 582, 170 A. 2d 791 (1961).
8. Rayack, *Professional Power*, p. 8.
9. For definition of terms, *see* p. ii.
10. Rayack, *Professional Power*, pp. 211-13; Comment, "American Medical Association," pp. 952-53.
11. Pennell, Proffitt, and Hatch, *Accreditation and Certification*, p. 7.
12. For definition of term, *see* p. ii.
13. Pennell, Proffitt, and Hatch, *Accreditation and Certification*, p. 9.
14. *Ibid.*, p. 7.
15. *See* HEW, *Report on Licensure*, pp. 14, 18. For definition of term, *see* p. ii.
16. HEW, *Report on Licensure*, pp. 46-47, 57-58.
17. *Berryhill v. Gibson*, 40 U.S.L.W. 2148 (M.D. Ala. 1971).
18. Pennell, Proffitt, and Hatch, *Accreditation and Certification*, p. 1; Comment, "American Medical Association," p. 970. This practice was upheld by the courts as long ago as 1922; *Jones v. State Board of Medical Registration*, 111 Kan. 813, 208 Pac. 639 (1922). But *see Duson v. Poage*, 318 S.W. 2d 89 (Tex., 1958).

19. *See*, for example, Carnegie Commission on Higher Education, *Higher Education and the Nation's Health* (New York: McGraw-Hill, 1970).

20. In some cases, there may be an easy, although temporary, answer to this question. If the aggrieved party has not exhausted all internal remedies that the association makes available to him (assuming resort to such remedies would not be futile and could provide proper redress), the court will not become involved. *See*, generally, "Judicial Control of Actions of Private Associations," *Harvard Law Review* 76 (1963): 1,069-80. This "exhaustion of remedies" doctrine has generally been applied only to association members, though there are good reasons for applying it to nonmembers as well. Comment, "Exhaustion of Remedies in Private, Voluntary Associations," *Yale Law Journal* 65 (1956): 386-87. Application of the doctrine is a consideration preliminary and subsidiary to those discussed in this paper.

21. *See* especially *Falcone v. Middlesex County Medical Society*, 62 N.J. Super. 184, 162 A. 2d 324 (1960), aff'd, 34 N.J. 582, 170 A. 2d 791 (1961).

22. *See* Abraham Edel, "Commentary: Shared Commitment and the Legal Principle," in J. Roland Pennock and John W. Chapman, eds., *Voluntary Associations* (New York: Atherton Press, 1969), pp. 31-34.

23. Zachariah Chafee, "The Internal Affairs of Associations Not for Profit," *Harvard Law Review* 43 (1930): 1,027.

24. John W. Chapman, "Voluntary Association and the Political Theory of Pluralism," in Pennock and Chapman, *Voluntary Associations*, pp. 89-93.

25. Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead, & Co., 1970), p. 44. For a discussion of the ill effects of medical laissez faire, *see* Rosemary Stevens, *American Medicine and the Public Interest* (New Haven, Conn.: Yale University Press, 1971).

26. William J. Goode, "Encroachment, Charlatanism, and the Emerging Profession: Psychology, Medicine, Sociology," *American Sociological Review* 25 (1960): 903.

27. Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Atherton Press, 1970), p. 135.

28. *See* discussion headed "Expertise."

29. *Corpus Juris Secundum*, Vol. 7, "Associations" section 1 (1937); *American Jurisprudence 2d*, Vol. 6, "Associations and Clubs" sections 1-3 (1963).

30. *See* generally, Pennock and Chapman, *Voluntary Associations*, pp. viii-ix. As to accrediting agencies, see William A. Kaplin and J. Philip Hunter, "The Legal Status of the Educational Accrediting Agency: Problems in Judicial Supervision and Governmental Regulation," *Cornell Law Quarterly* 52 (1066): p. 114.

31. Willard Hurst, "Commentary: Constitutional Ideals and Private Associations," in Pennock and Chapman, *Voluntary Associations*, p. 64.

32. Corinne Lathrop Gilb, *Hidden Hierarchies: The Professions and Government* (New York and London: Harper and Row, 1966). *See also* Harris, "Voluntary Association as a Rational Ideal," in Pennock and Chapman, *Voluntary Associations*, pp. 50-53, 59.

33. *Blende v. Maricopa County Medical Society*, 96 Ariz. 240, 393 P. 2d 926, 930 (1964).
34. Health Policy Advisory Center, *American Health Empire*, pp. 21-24; Freidson, *Profession of Medicine*, pp. 361-68; Hurst, "Commentary," pp. 66-67.
35. Probably the example most often discussed is the physician shortage, where the profession's economic interest in limiting physician supply is alleged to conflict with society's interest in an adequate manpower pool. *See*, for example, Rayack, *Professional Power*, pp. 72-78, 81-98.
36. *Ibid.*, p. xiv.
37. 34 N.J. 582, 170 A. 2d 791, 800 (1961).
38. 40 N.J. 389, 192 A. 2d 817, 825 (1963).
39. *See* especially Freidson, *Profession of Medicine*, pp. 335-82.
40. *Ibid.*, pp. 335-38.
41. *Ibid.*, p. 336.
42. *Ibid.*, pp. 45-46.
43. *Ibid.*, p. 341. *See also* John H. Knowles, "The Balanced Biology of the Teaching Hospital," in John H. Knowles, ed., *Hospitals, Doctors, and the Public Interest* (Cambridge, Mass.: Harvard University Press, 1965), pp. 28, 39-41.
44. *Ibid.*, p. 28.
45. *See also* Carnegie Commission, *Higher Education*, pp. 3-4, 45-46.
46. The point has been well made with specific reference to hospitals: "It is conceivable that business and engineering could eventually take over and provide the two ingredients that are so often alleged to be missing: an incentive to managerial efficiency, and a systems approach to the organization of services." Anne R. Somers, *Hospital Regulation: The Dilemma of Public Policy* (Princeton, N.J.: Industrial Relations Section, Princeton University, 1969), p. 14.
47. Carnegie Commission, *Higher Education*, p. 4.
48. Somers, *Hospital Regulation*, pp. 18-21; Knowles, "The Balanced Biology," pp. 36-37.
49. *See* Edward D. Churchill, "Medical Education in the Hospital," in Knowles, *Hospitals, Doctors*, pp. 223-25.
50. Walter Gellhorn, *Individual Freedom and Governmental Restraints* (Baton Rouge, La.: Louisiana State University Press, 1956), p. 144; *see*, generally, pp. 143-44.
51. *See* Gilb, *Hidden Hierarchies*, pp. 55-60.
52. Freidson, *Profession of Medicine*, p. 344 note 8.
53. *Falcone v. Middlesex County Medical Society*, 170 A. 2d at 799.
54. Quoted in *Ellis v. City of Grand Rapids*, 257 F. Supp. 564, 572 (W. D. Mich. 1966). As the court in this case remarked, "This high priority has prevailed in both public and private values throughout the history of this country. . . . The health of free people is forever present in the minds of free men."

55. *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. 712, 717-19 (1969). *See* Zachariah Chafee, "Internal Affairs," p. 993.

56. *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. 459, 471 (D.D.C. 1969). *See also* Carnegie Commission, *Higher Education*, p. 2: "Higher education, as it trains the most skilled health personnel, has a great responsibility for the welfare of the nation."

57. *See*, generally, Kaplin and Hunter, "Legal Status," pp. 117-18, 125-28.

58. *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. 459 (D.D.C. 1969), *rvsd.* 432 F. 2d 650 (D.C. Cir. 1970). *See* William A. Kaplin, "The Marjorie Webster Decisions on Accreditation," *Educational Record* 52 (summer 1971), pp. 219-24.

59. The rationale has been that a member gains certain membership rights, particularly the rights embodied in the associational "contract," that he is entitled to protect. *See* discussion headed "Contract Theory." The nonmember has the benefit of none of those rights.

60. *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d at 656 note 29. *Accord, Blende v. Maricopa County Medical Society*, 393 P. 2d at 928 note 1. As to accrediting decisions, *see* Kaplin and Hunter, "Legal Status," p. 130.

61. *Falcone v. Middlesex County Medical Society*, 170A. 2d at 799,

62. *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d at 655.

63. *Ibid.; Falcone v. Middlesex County Medical Society*, 170 A. 2d at 796-97; *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. at 469.

64. *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d at 655; *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. at 717-19; *Davis v. Morristown Memorial Hospital*, 106 N. J. Super. 33, 254 A. 2d 125, 128-29 (1969).

65. Whether society is in fact harmed depends, of course, on the justification for the association's action. If the association is applying its special expertise in order to protect the public from professional incompetence, its decision may benefit rather than harm society. Thus the court's consideration of the societal harm factor must be intertwined with its consideration of the expertise factor discussed in the section headed "Expertise."

66. *See* discussion headed "Autonomy."

67. *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. at 469.

68. Chafee, "Internal Affairs," pp. 1,021-23.

69. *See*, generally, Gilb, *Hidden Hierarchies*; Hurst, "Commentary," pp. 63-64.

70. As to the American Medical Association, *see* Freidson, *Profession of Medicine*, pp. 27-33.

71. *Falcone v. Middlesex County Medical Society*, 170A. 2d at 799.

72. *Blende v. Maricopa County Medical Society*, 96 Ariz. 240, 393 P. 2d 926 (1964).

73. *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. 712 (1969); *see also Higgins v. American Society of Clinical Pathologists*, 51 N. J. 191, 238 A. 2d 665 (1968).

74. *Greisman v. Newcomb Hospital*, 40 N.J. 389, 192 A. 2d 817 (1963).

75. *Marjorie Webster Junior College v. Middle States Association.* As to accrediting and monopoly power, *see* William A. Kaplin, "Judicial Review of Accreditation: The *Parsons College* Case," *Journal of Higher Education* 40 (October 1969): 545-47.

76. Chafee, "Internal Affairs," pp. 1,002-07; *North Dakota v. North Central Association*, 99 F. 2d 697, 700 (7th Cir. 1938).

77. Chafee, "Internal Affairs," p. 1,007.

78. 51 N. J. 191, 238 A. 2d 665 (1968).

79. *Ibid.*, pp. 669-70, quoting in part Chafee, "Internal Affairs," p. 1,007.

80. Recent cases suggest, however, that recovery for defamation in such situations may require a showing that the association acted with malice when it withdrew or refused the professional status. *See Rosenbloom v. Metromedia*, 403 U.S. 29 (1971); *Credit Bureau of Dalton v. CBS News*, 40 U.S.L.W. 2189 (N.D. Ga. 1971); but *see Grove v. Dunn and Bradstreet*, 438 F. 2d 433 (3d Cir. 1971).

81. *See* Note, "Arbitrary Exclusion from Multiple Listing: Common Law and Statutory Remedies," *Cornell Law Quarterly* 52 (1967): pp. 570, 581-82.

82. *Ibid.*, pp. 582-83.

83. *See James v. Marinship Corporation*, 25 Cal. 2d 721, 155 P. 2d 329 (1944).

84. *Falcone v. Middlesex County Medical Society*, 170 A. 2d at 799.

85. 75 Cal. Rptr. at 718-19.

86. *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. at 470. The court of appeals' reversal was not based upon any disagreement with this statement by the district court.

87. *Shared Responsibility in Accreditation* (Annual Report of the Executive Director, National Commission on Accrediting, 1971). *See*, generally, as to accreditation's public trust responsibilities, William K. Selden, "A New Translation of an Old Testament," *Educational Record* 49 (winter 1968): 113-14. For similar views of the medical profession's public trust responsibilities, *see* Walter S. Wiggins, "Generic Problems in Graduate Medical Education," in C. Wesley Eisele, ed., *The Medical Staff in the Modern Hospital*, (New York: McGraw-Hill, 1967), pp. 353-54.

88. *See* Note, "Arbitrary Exclusion," pp. 574-81.

89. *American Medical Association v. United States*, 317 U. S. 519 (1943); *Group Health Cooperative of Puget Sound v. King County Medical Society*, 39 Wash. 2d 586, 237 P. 2d 737 (1951); *Cf. United States v. Oregon Medical Society*, 343 U. S. 326 (1952); *Riggall v. Washington County Medical Society*, 249 F. 2d 266 (8th Cir. 1957).

90. *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d at 654-55. For a broader view, more akin to that expressed by the district court in *Marjorie Webster*, *see* Note, *Harvard Law Review* 84 (1971): 1,921.

91. *Levin v. Joint Commission on Accreditation of Hospitals*, 354 F. 2d 515 (D.C. Cir. 1965).

92. For an example of antitrust litigation between professions, *see American Society for Medical Technology v. American Society of Clinical Pathologists*, Civ. No. 69 C 1028 (N.D. Ill. 1971) (currently on appeal).

93. *See*, for example, *Amalgamated Food Employees Union v. Logan Valley Plaza*, 391 U. S. 308 (1968); *Burton v. Wilmington Parking Authority*, 365 U. S. 715 (1961).

94. *See* HEW, *Report on Licensure*, and this paper's discussion of licensure.

95. *Hawkins v. North Carolina Dental Society*, 355 F. 2d 718 (1966); *Bell v. Georgia Dental Association*, 231 F. Supp. 299 (D. Ga. 1964); *Firestone v. First District Dental Society*, 299 N. Y. S. 2d 551 (1969).

96. *Marjorie Webster Junior College v. Middle States Association*, 302 F. Supp. at 478; *see also* 302 F. Supp. at 470. The court of appeals did not overrule this part of the district court's opinion.

97. Kaplin and Hunter, "Legal Status," pp. 118-19. For possible application of the theory to local medical societies, *see* Note, "Judicially Compelled Admission to Medical Societies," *Harvard Law Review* 75 (1962): 1,188.

98. 355 F. 2d at 722-23.

99. *Sams v. Ohio Valley General Hospital Association*, 413 F. 2d 826 (4th Cir. 1969); *Simpkins v. Moses H. Cone Memorial Hospital*, 323 F. 2d 959 (4th Cir. 1963).

100. Gilb, *Hidden Hierarchies*, p. 156.

101. Lon L. Fuller, "Two Principles of Human Association," in Pennock and Chapman, *Voluntary Associations*, p. 14. *See*, generally, note 32, and accompanying text.

102. *See* discussion headed "Expertise."

103. *See Blende v. Maricopa County Medical Society*, 393 P. 2d at 930; *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d at 656 note 28.

104. *See* Chafee, "Internal Affairs," pp. 1,018-20. Sometimes a court will utilize this level of review but include a specific proviso that the association's rules "must not contravene . . . any principle of public policy." *Medical Society of Mobile County v. Walker*, 16 So. 2d 321, 324 (Ala. 1944); *accord, Bernstein v. Alameda-Contra Costa Medical Association*, 139 Cal. App. 2d 241, 293 P. 2d 862 (1956). This is a step in the direction of level three review.

105. *See*, generally, Chafee, "Internal Affairs," p. 1,020.

106. 23 F. Supp. 694, 699 (E.D. Ill.), *aff'd*, 99 F. 2d 697 (7th Cir. 1938).

107. *See*, for example, *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. at 720; *Davidson v. Youngstown Hospital Association*, 19 Ohio App. 2d 246, 250 N.E. 2d 892, 896 (1969).

108. *See*, for example, *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. at 720.

109. *See*, generally, Chafee, "Internal Affairs," pp. 1,015-18.

110. *See*, for example, *Parsons College v. North Central Association*, 271 F. Supp. 65, 71 (N.D. Ill. 1967).

111. *See*, for example, *In Re Rothman*, 12 N. J. 528, 97 A. 2d 621, 631-32 (1953).

112. *See* Wiggins, "Generic Problems," p. 354: "There is a certain substance to the *profession* of medicine which calls upon the *conscience* of its members both collectively and individually to honor the common good of the public it serves. At the core of this substance and central to medicine's responsibility as a learned profession is the role of stewardship of a body of knowledge essential to the public welfare. Our value to society is measured ultimately by the extent to which we exercise our stewardship to the benefit of the society which has entrusted it to us."

113. Pennell, Proffitt, and Hatch, *Accreditation and Certification*, p. 11.

114. *See*, generally, Harris, "Voluntary Association as a Rational Ideal," in Pennock and Chapman, *Voluntary Associations*, pp. 53-60.

115. Such a search for public policy would be in the finest tradition of the law. As Justice Oliver Wendel Holmes wrote long ago, law includes, as its major considerations, "the felt necessities of the time, the prevalent moral and political theories, institutions of public policy, avowed or unconscious. . . . Every important principle which is developed by litigation is in fact and at bottom the result of more or less definitely understood views of public policy."

116. *See* discussion headed "Constitutional Theory."

117. *See Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. at 719-20; *Sussman v. Overlook Hospital Association*, 95 N. J. Super. 418, 231 A. 2d 389, 393 (1967).

118. *See* Harris, "Voluntary Association," pp. 54-56.

119. Arthur Selwyn Miller, "The Constitution and the Voluntary Association," in Pennock and Chapman, *Voluntary Associations*, p. 252 (paraphrasing 1962 statement by President John F. Kennedy); *see also* Grant McConnell, "The Public Values of the Private Association," in Pennock and Chapman, *Voluntary Associations*, p. 159.

120. *Falcone v. Middlesex County Medical Society*, 170 A. 2d at 799.

121. 40 N. J. 389, 192 A. 2d 817, 824 (1963).

122. *Marjorie Webster Junior College v. Middle States Association*, 432 F. 2d 650, 655 (D.C. Cir. 1970).

123. 96 Ariz. 240, 393 P. 2d at 929-30.

124. 96 Ariz. 240, 393 P. 2d at 930.

125. *See* discussions headed "Constitutional Theory," "The Second Level," and "The Third Level."

126. *See* discussion headed "The Third Level."

127. As to accreditation, *see*, generally, Kaplin, "Judicial Review of Accreditation," pp. 549-53. As to hospital staff privileges, *see*, generally, Arthur F. Southwick, "Legal Aspects of Medical Staff Function," in Eisele, *Medical Staff*, pp. 75-76. As to disciplinary decisions, *see* generally, Braemer, "Disciplinary Procedures for Trade and Professional Associations," *Business Lawyer* 23 (1968): 959 *et seq.*

128. *Sussman v. Overlook Hospital Association*, 231 A. 2d at 393.

129. *Virgin v. American College of Surgeons*, 42 Ill. App. 2d 352, 192 N. E. 2d 414 (1963); *Reid v. Medical Society of Oneida County*, 156 N.Y.S. 780 (1915), *aff'd*, 163 N.Y.S. 1129 (1916).

130. *Berryhill v Gibson*, 40 U.S.L.W. 2148 (M.D. Ala. 1971); *Blenko v. Schmeltz*, 362 Pa. 365, 67 A. 2d 99 (1949).

131. *Parsons College v. North Central Association*, 271 F. Supp. at 72.

132. *See* Annotation, "Suspension of Expulsion From Professional Association and the Remedies Therefor," 20 A.L.R. 2d 531, 542-43 (1951).

133. *Parsons College v. North Central Association*, 271 F. Supp. at 73.

134. *Pinsker v. Pacific Coast Society of Orthodontists*, 75 Cal. Rptr. at 720; *Davis v. Morristown Memorial Hospital*, 106 N. J. Super. 33, 254 A. 2d 125, 131 (1969).

135. State legislatures have broad authority under the state police powers, a vital part of which is the power to regulate health and professional standards. *Barsky v. Board of Regents*, 347 U.S. 442, 449-52 (1954). Congress would have power to act, the limits of which are uncertain, under the spending clause by attaching conditions to the expenditure of federal funds—*see Steward Machine Co v. Davis*, 301 U. S. 548 (1937)—or under the interstate commerce clause—*see Maryland v. Wirtz*, 392 U.S. 183 (1968).

136. For analyses of influences in the legislative process that have inhibited such developments, *see* Gilb, *Hidden Hierarchies*, pp. 196-223; Ronald L. Akers, "The Professional Association and the Legal Regulation of Practice," *Law and Society Review* 2 (1968): 465-70.

137. *See* discussion headed "Factors Influencing Judicial Intervention."

138. *See* discussion headed "Expertise."

139. *See* discussion headed "The Special Problem of Due Process."