Specialized Accreditation: Endangered Species in an Era of Change

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The American public tends to place a great deal of trust in those mechanisms that protect or serve the public interest. For example, we usually take it for granted that the hair stylist, plumber, or exterminator are competent because we recognize that each of these practitioners must pass a test or meet specified standards to qualify for a license. Similarly, we assume that public water supplies meet acceptable standards throughout the country, and we almost never ask to see the health permits required of restaurants—even when we travel. In short, we expect our interests to be served through the enforcement of standards—even if we aren’t quite sure which agency is responsible for protecting us in a given situation.

This may help explain why there is little interest and even less understanding of the mechanism known as accreditation that is designed to ensure that minimum educational standards are maintained among postsecondary and professional education programs in the United States. In fact, a recent study (1) showed that even faculty and administrators in higher education may have a limited understanding of the nature or types of the accreditation processes that affect their activities.

Presently, nine regional bodies and four national associations assume responsibility for the institutional accreditation activities in this country. When institutional accreditation is granted, a college or university as a total entity has met prescribed standards. This procedure is in contrast to specialized or programmatic accreditation, which is designed to recognize the quality of an individual program of study that may be housed within a college or university. Specialized accreditation is most often granted by professional associations holding claim to the expertise required for the evaluation of a given field of study.

Specialized Accreditation and Its Emergence in the Health Professions

The history of medical education provides a good example of the development of specialized accreditation. During the nineteenth century, it was common for medical
education to take place within proprietary settings where little instruction was provided in basic or clinical sciences and limited opportunity existed for practical clinical application (2).

As a consequence, wide variability existed in the preparation of individuals who held a medical degree. This state of affairs prompted the Council on Medical Education of the American Medical Association (AMA), along with the Carnegie Foundation, to develop minimum educational standards, which were termed “Essentials.” When medical schools were surveyed to determine their adherence to these standards in the early 1900s, specialized accreditation in medicine was born.

Developments in the allied health professions have shown a tendency to emulate medicine, and the history of specialized accreditation offers no exception. In 1933, the AMA’s Council on Medical Education agreed to a request by the American Occupational Therapy Association (AOTA) to survey existing schools of occupational therapy. These surveys led (in 1938) to the development of revised and upgraded essentials for occupational therapy education programs (3). Occupational therapy thus became the first allied health discipline in the country to implement a specialized accreditation process in collaboration with the AMA. Similar arrangements evolved for other allied health disciplines during the following four decades.

In 1978, the AMA, in concert with 40 collaborating professional organizations, established the Committee on Allied Health Education and Accreditation (CAHEA), which serves as an umbrella agency for the specialized accreditation of over 20 allied health disciplines. The Accreditation Committee of the AOTA, one of 16 review committees that presently collaborate with CAHEA, assumes a major role in the accreditation of professional level programs in occupational therapy.

Criticism of Specialized Accreditation

The creation of CAHEA represented a practical accommodation to the prolific growth of the allied health disciplines, along with an attempt to respond to increasing public criticism about the maze of specialized accreditation requirements that accompanied that growth. In the early 1970s, there was increasing concern that the ability of the accreditation process to serve the public welfare would be jeopardized if professional societies representing each emerging allied health discipline were to evolve accreditation standards and processes without some type of public accountability. Recognizing this, the AMA took the initiative in proposing that a comprehensive study of health educational accreditation be performed.

Thus, a Commission for the Study of the Accreditation of Selected Health Educational Programs (SASHEP) was created through the joint sponsorship of the AMA, the Association of Schools (now the American Societies of Allied Health Professions, and the National Commission on Accrediting. In its final report (4), the SASHEP Commission identified a number of problems related to specialized accreditation in the allied health professions, including the following:

- that the structure of accreditation of specialized fields of study tended to serve the interests of their sponsoring professional organization rather than the needs of the public,
- that jurisdictional tensions and duplication resulting from multiple accrediting agencies for the same discipline were wasting resources and creating unhealthy competition and confusion,
- that the direct and indirect costs of specialized accreditation were becoming excessive and burdensome when viewed in relation to their perceived benefit to programs and institutions,
- that little research had been accomplished to validate the effectiveness of accreditation standards and procedures, and
- that when certification and accreditation are vested in a single professional organization, limiting professional certification to graduates of accredited programs could be unnecessarily restrictive and could discourage the development of innovative and nontraditional approaches to competency attainment.

In its recommendations, the SASHEP commission identified a number of alternatives to address these problems, the most drastic of which included discontinuation of specialized accreditation in favor of total reliance on certification and licensure as methods to protect the public against incompetent practitioners (4, p 32).

The eventual creation of CAHEA was directly related to another alternative recommended by the Commission, that of vesting final authority for the specialized accreditation of allied health disciplines in a new structure with broad representation that would collaborate with, but not be controlled by, the AMA. While CAHEA did not evolve with the extent
of decision-making autonomy recommended by the SASHEP Commission, its new structure has fostered improved coordination of allied health accreditation activities. Perhaps more importantly, the SASHEP Commission has adopted policies and procedures that, it can be argued, have made the specialized accreditation of allied health programs under its aegis more responsive and accountable to the public interest than was previously the case. Despite these improvements, criticism concerning specialized accreditation, both within and outside the allied health professions, has not only continued, but increased.

Thrasher (5) suggests that this criticism may reflect public impatience with accrediting agencies, which were slow to respond effectively to changes in postsecondary education during the explosive growth of the past quarter-century. For example, accreditation agencies found it difficult to contend with extension programs, proprietary schools, and other nontraditional courses of study that emerged during this period. As a consequence, the public was forced to rely on state regulatory agencies to monitor the quality of many such programs. It is worth noting that the status of accreditation agencies changed during that same period from private-voluntary mechanisms to quasipublic regulatory agencies. This first occurred during 1952 when accrediting bodies were designated in federal legislation as “reliable authorities” for determining the eligibility of colleges and schools seeking to participate in federal assistance programs.

This change in status, which resulted in greater authority, also brought with it increased public expectations for accountability. As Kaplin (6) has noted, a consensus is emerging that accreditation agencies have a critical public trust, an obligation to serve the public interest. This means that they must make decisions about the quality of educational programming in an informed, autonomous, and impartial manner. Furthermore, to truly serve the public interest, accrediting agencies must include public representation and follow the principles of due process in the conduct of their activities. To the extent that specialized accrediting agencies have failed to live up to these principles, they have diminished their public credibility and provided ammunition for their critics.

Perhaps one of the strongest recent attacks on specialized accreditation was contained in a 1982 report from the Carnegie Foundation for the Advancement of Teaching, in which specialized accrediting agencies were identified as a major source of outside interference in the traditional governance of the nation’s colleges and universities (7). The report contended that oversight requirements from specialized associations conducting accreditation activities had become so detailed and demanding that they infringed on matters of institutional prerogative, thus jeopardizing the greater good of the institution. Examples of accreditation requirements that were viewed as obtrusive were cited in the report. One such example was an Essential adopted by the AOTA mandating specific qualifications for directors of occupational therapy programs.

More recently, the National Advisory Committee on Accreditation and Institutional Eligibility adopted a motion to limit the scope of recognition of specialized accreditors in those situations where institutional accreditation had been granted. Although this recommendation was made in the context of recognition for government funding and has not been approved by the Secretary of Education, it should be viewed as a clear warning of public sentiment for those involved in specialized accreditation. Unfortunately, this view reflects the misguided belief that institutional and specialized accreditation processes are essentially duplicative, with neither having a unique role.

Such a viewpoint undoubtedly is fostered by the existence of some redundant and therefore probably unjustifiable standards promulgated by specialized accrediting agencies. In some instances, an accredited program must be part of a university or college with institutional accreditation. In meeting standards for both accrediting bodies, the university commonly is obliged to present evidence about its faculty, finances, and physical plant to both agencies. Considering the number of specialized accrediting bodies with which most large universities must contend and considering the resources that programmatic self-study and site visit preparations demand, it is perhaps understandable that academic administrators are now insisting that such redundancies be eliminated. Moreover, in view of the prevailing national disposition toward deregulation, it should not be surprising that some of these same administrators are suggesting (albeit unpersuasively) that specialized accrediting agencies be eliminated altogether as a means of solving the cost and redundancy problems (8).

In response to such criticism, President Richard Millard (9) of the Council on Postsecondary Ac-

The American Journal of Occupational Therapy 365
creditation has written that specialized accrediting agencies

...frequently work in areas for which the adequacy of education is essential to public safety and welfare. They are involved with the preparation of professionals on whose judgment, performance, and practice the larger well-being and satisfaction of the public depends. Although some professional associations may be overly prescriptive, one should not confuse legitimate conditions of effective education in these areas with complaints of institutions that do not have resources to offer professionally sound programs (p 35).

**Will Specialized Accreditation Survive the 1980s?**

When one considers the history and purposes of specialized accreditation in the allied health professions within the context of emerging trends in health, education, and regulation in America, it becomes difficult to forecast the future. However, according to Kells (10), association-housed specialized accrediting agencies will survive only if they correct current weaknesses. To do so, they must devote increased attention to the development and validation of outcome-oriented standards and collaborate much more extensively with academic institutions and regional accrediting bodies to eliminate redundancies and costs. This can be accomplished through joint site visits and the development of common data bases, possibly facilitated through electronic (computer-assisted) review and reporting mechanisms. Even with such changes, Kells predicts that ties between state licensure laws and accreditation requirements will become more lenient and begin to disappear (p 88).

Recognizing these imperatives, the Accreditation Committee of the AOTA has been devoting its attention to the development of more cost-effective and efficient methods in its programmatic review and site visit requirements. Some important changes have already been implemented, including reduced documentation requirements for reaccreditation applications and the use of site visit teams with fewer surveyors. Consideration is also being given to extending the intervals between mandatory site visits and improving the processes of selection and training for persons who perform site visit and review activities.

If accommodation is to take place through standard setting, this must occur outside the Accreditation Committee. Educational standards (known as Essentials) for the profession are developed and ratified by the association membership through its elected representatives. It is thus appropriate for all members of the profession to express their viewpoints about how educational programs can best prepare competent entry-level occupational therapists. In so doing, however, care must be exercised to avoid pursuing professional self-interest at the expense of adopting valid, reasonable, and defensible educational standards. Otherwise, the involvement of professional organizations in the educational process could eventually decline altogether. This would occur if colleges, universities, and the public determined that institutional accreditation and state regulation were less expensive and more effective in serving the public interest than specialized accrediting agencies.

With over a half century of history behind it, specialized accreditation in the health professions may be entering an era where its very survival will be threatened. Its preservation will be ensured only if professional societies that recognize the unique and vital role of specialized accreditation adopt only reasonable and justifiable standards. This is more likely to occur if association members become more knowledgeable about the history and role of specialized accreditation and better informed about circumstances affecting its current and future status.

**REFERENCES**

1. Parrish R: A Study of Postsecondary Faculty Member and Administrator Knowledge and Motivation Concerning Institutional and Specialized Accreditation (EdD dissertation). Rutgers Univ, East Brunswick, NJ, 1983