decisions, CECo is unwilling to choose sole dependence on either coal or nuclear generation on the basis of a 20 percent cost advantage either way. As of 1978 CECo has six nuclear units of the 1100-MWe class under construction. We project that in the mid-1980's about 60 to 65 percent of our generation will be nuclear, about 30 percent will be coal, and the remainder will be oil. Generating unit commitments for the foreseeable future will be nuclear and coal. We believe that any policy that precludes or restricts either technology would be unwise for the United States as a whole.

References and Notes

1. Shippingport, Pa. (90 MWe).
2. Dresden 1, Morris, Ill. (200 MWe); Indian Point, Peekskill, N.Y. [265 MWe (now shut down)]; and Yankee Rowe, Rowe, Mass., 175 MWe.
3. Nine Mile Point, Oswego, N.Y. (610 MWe), and Oyster Creek, Toms River, N.J. (650 MWe).
4. Utilities that have fuel adjustment clauses in their rates pass on fuel cost increases (above a stipulated level) directly to their customers and thus make no profit on that portion of the rate. Nuclear fuel is generally not covered by such clauses. As part of the regular rate structure, it can only be increased in regular rate-making proceedings.
5. A typical unit train is 100 cars long, each car carrying about 90 tons of coal. Edison's coal-burning plants keep 32 such trains in operation, each making weekly round trips. It takes 10,000 to 20,000 gallons of diesel fuel per round trip, depending on route and weather conditions. A simple calculation reveals that this haulage requires about 500,000 barrels of oil per year.
6. For example, see C. Komanoff, *Power Plant Performance* (Council on Economic Priorities, New York, 1976).
7. A. D. Rossin, *Economics and Reliability of Light Water Reactors* (American Nuclear Society, LaGrange, Ill., 1976).
8. *Report on Equipment Availability for the Ten-Year Period 1967–1976* (EEI No. 77-64, Edison Electric Institute, New York, 1977).
9. M. E. Lapides, *Power Eng.* **80**, 52 (October 1977).
10. ———, *Nuclear Unit Productivity Analysis, 1976 Update* (EPRI NP-559-SR, Electric Power Research Institute, Palo Alto, Calif., 1977).
11. *The Edison Electric Institute's Comments and Critique of the Council on Economic Priorities Report* Power Plant Performance *and Its Later Update* (Edison Electric Institute, New York, July 1977).
12. L. J. Perl, *Review and Critique of the CEP Study* Power Plant Performance (National Economic Research Associates, Washington, D.C., 1977).
13. In 1972, CECo filed load projections showing an average peak load growth of 7.6 percent per year through 1982 and 7.1 percent per year thereafter (Byron Station Environmental Report, docket numbers STN 50-454 and 50-455, docketed 20 September 1973). Minimal load growth occurred in 1974 and 1975. The load projections now being used by CECo estimate load growth at 5.3 percent per year from 1978 to 1982 and about 5.0 percent per year thereafter. The reduction is due to a combination of slower economic growth and increased energy conservation. The new peak load projection for 1982 is 17,720 MWe, compared to 24,350 MWe in the 1972 forecast. Since a 5.0 percent growth rate after 1982 still calls for about 900 MWe of new capacity annually (plus replacement of obsolete plants, if any), CECo still expects to add a large nuclear unit almost each year in the late 1980's. It is important to note that the entire increase in U.S. electricity use from 1976 to 1977 was 4.9 percent and the peak load was up 6.5 percent (press release, Edison Electric Institute, New York, 11 January 1978).
14. Although it is not a viable option for new capacity under the National Energy Plan, the estimated cost for an oil-fired station without flue gas scrubbers is about $400 per kilowatt. We have limited station size for coal and oil to approximately 1100 MWe to comply with the Clean Air Act amendments of 1977, using available emission control technology. Two 550-MWe units were considered rather than a single 1000-MWe unit because we have not had experience with fossil units in the 1000-MWe class.
15. It has been the policy of the government to discourage the use of oil and gas for the production of electricity. The Department of Energy has the authority to demand conversion of oil- or gas-fired units to coal. In view of this and the obvious risks in further reliance on oil, utilities do not consider oil a viable alternative.
16. *Uranium Enrichment Services Activity Financial Statements* (ERDA 77-27 UC-2, Energy Research and Development Administration, Washington, D.C., March 1977).
17. G. R. Corey, testimony before the Environment, Energy, and Natural Resources Subcommittee of the Committee on Government Operations, U.S. House of Representatives, 88th Congress, 1st session, 19 September 1977.
18. *An Engineering Evaluation of Nuclear Power Reactor Decommissioning Alternatives* (AIF/NESP-009, Atomic Industrial Forum, Washington, D.C., 1976).
19. The Price-Anderson Act requires nuclear plant operators to obtain as much liability and property damage insurance as the private insurance industry is willing to offer, and beyond that provides government indemnity, increasing from $560 million originally to $1 billion by 1987, which is also paid for by premiums from the utilities (no government subsidy is involved). As private industry is willing to provide more, the government share will be phased out. Price-Anderson puts an upper limit on the liability of a utility for accident claims. Elimination of this upper limit would leave an open-ended potential liability on a corporation's books.
20. I. A. Forbes and J. C. Turnage, *Exclusive Paths and Difficult Choices* (Energy Research Group, Framingham, Mass., 1978).
21. A. B. Lovins, *Foreign Affairs* **55**, 65 (October 1976).
22. Press release, National Association for the Advancement of Colored People, Washington, D.C., February 1978.
23. Nuclear generation in the United States in 1977 was 240 billion kWh. This was equivalent to 125 million tons of coal or 430 million barrels of residual oil.
24. *Operating Unit Status Report* (NUREG 0020, Nuclear Regulatory Commission, Washington, D.C., April 1974 to February 1978).

Need for Reform in Health Professions Accrediting

A multiprofessional mechanism offers a means of reform in health professions accrediting.

Donald C. Brodie and Robert P. Heaney

Accreditation in postsecondary education in the United States applies to institutions of higher learning and programs within those institutions, that is, institutional accrediting and program accrediting. Institutional accrediting is carried out by six regional accrediting bodies, whereas program accrediting in the health field is a responsibility of some 20 specialized accrediting agencies. Both types are coordinated by the Council on Postsecondary Accreditation (COPA) (*1*). This arrangement is nongovernmental in origin, in contrast to the system in most other nations where ministries of education within the government are responsible for setting and maintaining standards. Dickey and Miller (*2*) place the subject in a contemporary framework as follows:

> Accreditation . . . permits and encourages the professions to contribute to the assurance that their future members will be adequately educated and prepared to serve societal needs.
>
> The role of accreditation in American Society has grown to the extent that virtually every institution and many programs of study are forced to seek accredited status. Institutions may exist but few thrive without accreditation. Seen in this light, it is a misnomer to term accreditation voluntary. The function accreditation serves must be performed for a complex society. If it were not performed by private groups, government agencies would have to step in to fill the void. Because of its growing social role, many have termed accreditation a quasi-governmental function. But accreditation also serves narrower, less public functions (*2*, pp. 2–3).

The authors go on to acknowledge both the growing national commitment to education at all levels through the granting of public money and a concern for educational opportunities and fulfillment for the disadvantaged. Because education has become "recognized as indispensable to private individual benefit and to the public welfare" the accrediting process is now viewed as serving a social

Dr. Brodie is professor emeritus at the University of California–San Francisco and adjunct professor of medicine and pharmacy at the University of Southern California, Los Angeles 90033. Dr. Heaney is professor of medicine and vice president for health sciences at Creighton University, Omaha, Nebraska 68178.

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Summary. At least 50 vocational or professional groups, exclusive of specialties within categories, now provide a health service. Each group seeks to identify itself as a specialty health service. Many have established accrediting procedures for maintaining educational standards, and the number is increasing. So great is the demand from the accrediting bodies that universities and academic health centers find that the cost in terms of money, time, and duplication of effort has become exhorbitant, and thereby a major problem in the management of educational institutions. The duplication of effort leads to fragmentation of the entire accrediting process, and this, in turn, fosters inadequate sharing of health professions educational experiences. A model is presented that would lessen the burden of accrediting on educational institutions and simultaneously permit testing of the feasibility of a multiprofessional accrediting mechanism.

need, and the agencies that carry out the accreditation mission are seen to be fulfilling a social obligation.

The entire system of higher education came under critical review by an independent task force funded by the Ford Foundation in 1970. The report of the task force (*3*), commonly referred to as the Newman report, called for a broad-based reform in higher education. Among those areas singled out for change was the accrediting process in general. Here we focus on one segment of the accrediting process, namely accreditation in health professions education, with particular reference to the need for restructuring the present inefficient and fragmented system into one that is multiprofessional in character and unicameral in structure.

Deficiencies in the Traditional System of Health Care Delivery

Biomedical research of the past 40 years has added much to human expectation for a better quality of life through improved health status. Accompanying this development has been the recognition that serious deficiencies exist in the traditional systems for delivering health care to many people. As a result, social pressures have initiated changes in the delivery system, many of which already are reflected in the educational programs of the autonomous yet interdependent health professions.

Two dominant concepts have emerged from the intermingling of the forces of change. The first deals with the preeminent position of the patient and his needs—the ultimate focus of all health care activities. The second views an integration of effort on the part of those who provide are—the health team effort—as a condition of the future. The latter recognizes that the traditional isolated approach to health professions education must give way to new educational pathways which will permit students and practitioners to experience the interrelationships they must share for further development and integration of the two concepts.

If a team approach to the delivery of health care is a worthy goal, the stage is set for a new era in health professions practice and education from which new concepts of interprofessional education and training will emerge. Already, measures to correct existing deficiencies in the delivery system are following a three-pronged attack. The first is to improve the accessibility of the system to those to whom it is inaccessible. The second is to improve the quality of care for those who receive substandard levels of care. The third is to contain the costs of care. If, in fact, the way of the future in health professions education evolves along an interprofessional axis, it is reasonable to accept the thesis that a multiprofessional mechanism for accreditation will contribute to the achievement of both the educational and patient care objectives.

Changing Attitudes and Patterns in Health Professions Education

Many forces have contributed to the spirit of change that has prevailed in health professions education in recent years. Society has called for more health workers, students, for relevance to the needs of people, and young faculty, for innovation in teaching methods in order that education might become more responsive to the daily needs of people than in the past. Medical centers have gone into the community to care for people by establishing clinics. The health team concept has stimulated reform in both academic structures and programs.

While the reduction of federal monetary support of health professions education since 1973 has lessened the financial resources available for innovation, it remains true that the educational forces cited in the foregoing are shaping new approaches to health professions education and new patterns of professional practice. At a conference on health education in 1967 (*4*), the following statements were made by William N. Hubbard, dean of the University of Michigan's medical school, and Rozella Schlotfeldt, dean of Western Reserve's school of nursing, respectively:

> As society's health needs change, the role of every one of the professionals related to health is changing. This must inevitably be so if my basic assertion is correct, that the professions are the product of society's needs and are not self-generating (*4*, p. 6).

> If, however, the concept of cure encompasses therapies which help people attain maximum health, function, and comfort, then there are many health professionals who participate in the therapeutic programs for persons whose physical, emotional, and social circumstances keep them from enjoying a full measure of physical and mental health (*4*, p. 11).

Three years later, at a conference on pharmacy manpower at the University of California in San Francisco (*5*), the theme was continued when William S. Apple, executive director of the American Pharmaceutical Association, and E. F. Pellegrino, then dean of medicine at the State University of New York at Stony Brook, respectively, said:

> . . . I would like to see more serious consideration given to a merger of all health professional schools and the development of an educational system which produces a basic health practitioner in three or four years (*5*, p. 11).

> Education for the health professions—and parenthetically all education—must, in a complex society, become more attuned to socially useful end points; that is, to the production of individuals who can perform specific tasks in a highly organized, institutionalized, technologically oriented system of health care (*5*, p. 84).

At the first truly interprofessional health education conference held at the Institute of Medicine in 1972 (*6*), a speaker, when confronted with one of the questions being considered under the topic of "Educating for the Health Team," said:

> One of the difficulties . . . is the fact that we know that things should be changed and that we are caught up in a status quo situation. We should be able to identify these problems and structure programs directly to meet these needs. . . . The problem is that we are entrenched in a system that has gotten hold of all of us and each one is bogged down by his own traditions (*6*, appendix 3, p. 14).

No one can deny that there is a ferment of change in health professions education, and no one will challenge the statement that reform will be painful. The traditions in all professions are entrenched too deeply, and the barriers that have

established the splendid isolation of the past are too rigid to permit change without struggle and controversy. But the interrelationships among the several groups are changing; organizational structures within universities and schools are broadening and acquiring degrees of accommodation that in the past have not existed; curricula are being changed so as to reflect a degree of social consciousness heretofore barely discernible; coordination of effort between the scientific and clinical disciplines is bringing about an integration of knowledge and skills for improved instruction; joint appointments at interdisciplinary and interprofessional levels are being made with increasing frequency; hospitals and clinics are becoming learning centers for those students who will provide direct patient care in their careers; and conferences and rounds for physicians, nurses, and pharmacists are now a frequent occurrence in health center teaching hospitals. One has only to refer to the recent paper by Hogness and Akin (*7*) to appreciate the extent of changes in student populations and the intermingling of students that now goes on at academic health centers.

Among the conclusions reached by the steering committee after the interprofessional health education conference in 1972 (*6*) was the following:

> All health professionals need a better comprehension of how their respective functions interrelate with one another. While each must understand his own unique role, he must also know the specific contributions others can make to the resolution of the clinical problems at hand. Only then can the total effort of all health professions be coordinated to meet the concerns and interests of the consumers (*6*, p. 23).

Heaney (*8*) has outlined a theoretical basis for integration of health professions education in a multiprofessional health sciences center. He cited three premises that are appropriate for the present discussion, since they capture not only the spirit of change, but seem self-evident truths in themselves.

1) There is an essential, intrinsic unity of the health sciences—a unity of content, purpose, and, for the most part, orientation as well.

2) Separation of health professionals into the four major categories of medicine, dentistry, pharmacy, and nursing is arbitrary and hence imposes unnecessary and possibly harmful constraints upon their educational production.

3) The personal and functional goals of health professions students, even within apparently homogeneous categories, are diverse.

Apparently, until recently, there was no reason to believe that relationships with other professional groups were necessary either in practice or in education. This traditional attitude has now been challenged by educators, practitioners, and students, and has been shown to create deficiencies in both patient care and education.

Program Accreditation in the Health Field

Accreditation in the health field today is carried out by groups who perform specialized accreditation functions for their respective professions or occupational fields. In several of the health fields (medicine, osteopathy, dentistry, podiatry, optometry) accrediting is a function principally of the corresponding professional society. In certain of these fields, the committee or council of the professional society which is responsible for accreditation includes representatives from the corresponding professional school association (medicine, dentistry, podiatry, optometry). Some also include representatives from the cognate group of state boards of examiners (dentistry, podiatry, optometry). But in all such cases, the parent body of the accrediting group is the society of practicing professionals into whose numbers the graduates of the accredited schools will enter.

There are a few notable exceptions to this pattern. For example, nursing accreditation is under the direction of the National League for Nursing (NLN), which is distinct both from the principal association of professional nurses (American Nurses Association) and from the professional school association (American Association of Colleges of Nursing). Whereas the NLN Board does include two public members, none of its accrediting councils contains such members, nor does it explicitly represent examining or licensing bodies. By contrast, the American Council on Pharmaceutical Education, responsible for accrediting pharmacy schools, is an organization with a tripartite sponsorship, that is, the American Pharmaceutical Association, the American Association of Colleges of Pharmacy, and the National Association of Boards of Pharmacy. In addition to three members appointed by each of the sponsors, the council has a tenth member appointed by the American Council of Education. This member is not a pharmacist, and has no pharmacy association prior to his appointment. He serves the council as a generalist from the educational "public."

Defects in the System of Program Accrediting

The system of program accrediting just described exhibits many serious defects. Most glaring and already under attack from several quarters is the dominant pattern of program accreditation by an arm of the cognate profession. This relationship has been criticized severely on the grounds that a conflict of interest arises and the public interest is ill served when a professional society controls the standards of education, the number of accredited schools, and hence the number admitted to the profession.

The U.S. Office of Education has taken cognizance of this defect in the existing system, as has the Newman report which recommended

> . . . that 1) the composition of established accrediting organizations should be changed to include representatives of the public interest; and 2) federal and state governments should reduce their reliance on the established organizations for determining eligibility for Federal support (*3*, p. 66).

These recommendations can be interpreted as opting for additional controls by the U.S. Office of Education (*9*).

A second principal defect lies in the fact that single program accrediting fails both to evaluate the interprofessional components of health professions education and to encourage efforts at the sharing of learning experiences across professional disciplines. It is precisely these components that are necessary for coordination of health care services. Hence the present accrediting process, under the banner of high educational standards, serves to perpetuate precisely those features of our health care system most in need of change.

Third, there is the inordinately high cost to the institution which has followed upon proliferation of program accreditation. There are today at least 50 distinct vocational or professional groups providing a health service, exclusive of specialties within categories. Each group seeks to identify itself with a specialty health service, and many have established education and training programs to provide practitioners with the knowledge and competencies they require for practice. In order to maintain independence, and in some instances to achieve professional status (recognition), accrediting procedures for maintaining the standards of the educational programs have been developed. As a result, universities and academic health centers constantly are asked to open their doors and books to visiting accreditation teams. In addition to the visits from the specialty ac-

crediting agencies, the universities receive visits on a regular basis from the regional accrediting bodies.

So great has the demand become from the accrediting bodies that universities and academic health centers find that the cost has become exhorbitant, in terms of money, time, and duplication of effort. The duplication of effort leads to fragmentation of the entire accrediting process, which, in the final analysis, is not in the public interest. This state of affairs prompted the Association of Academic Health Centers (AAHC) to recommend in 1977 "that efforts to unify accreditation procedures should continue and that, pending the outcome of such efforts, the Council on Postsecondary Accreditation and the Office of Education place a moratorium on recognition of separate accrediting authority for existing health related professions" (*10*).

Need for Research and Innovation in Accreditation

In 1970, the Commonwealth Fund provided support for a *Study of Accreditation of Selective Health Educational Programs* (*11*), the sponsoring bodies of which were the American Medical Association, the Association of Schools of Allied Health Profession, and the National Commission on Accrediting. Although the primary focus of the study was the existing accrediting process being conducted in 15 selected health professional fields "on a collaborative basis under supervision of the American Medical Association," the scope of the study was much broader and embraced "the entire gamut of the health professions and services" (*12*). The report of the study commission was published in 1972, and included among "the issues confronting the allied health accrediting section," was "Research in Accreditation." The commission's position on this issue was strongly critical and included the following statement:

> Of the many criticisms leveled at accreditation, none are more difficult to refute than those aimed at the validity of accrediting procedures and standards. Criteria for accreditation are still adopted by most accrediting agencies solely on the basis of subjective judgments even though the state of the art would permit the use of more scientific techniques of evaluation.
>
> To date, little research in regard to either the criteria or procedures of accreditation has been performed.
>
> Whatever the specific reasons for the past and current lack of accreditation-related research and validation, it is improbable that the public will continue to accept a system based only on subjective individual judgments. The validity of accreditation will not be able to stand indefinitely on the sole basis of individual presumptions of supposed worth. Only if objective evaluative techniques replace—or at least supplement—subjective evaluations will accreditation be able to maintain its credibility.
>
> Despite some inherent difficulties, research designed to validate the development, substance, and application of accrediting criteria is basic to the future viability of accreditation in all fields. . . . Acceptance of research as a high-priority concern of all agencies responsible for accreditation in the health fields should be promoted; and adequate financial resources should be made available to support the necessary research in allied health educational accreditation (*12*, pp. 11–12).

There is no evidence of any organized or experimental attempt to bring innovation to the existing structure, although a wealth of evidence has been provided to substantiate the need for changes in both structure and process. No attempts apparently have been made to consider how a multidisciplinary or interprofessional approach could be applied to the existing accreditation system in order to broaden the base of accreditation and improve its efficiency and accountability. Any attempts to evaluate programs through a cross-disciplinary mechanism have failed. At a meeting held in the office of the National Commission on Accrediting just prior to the formation of the Council on Postsecondary Accreditation it was stated (*13*) that "There has been a long history of largely unsuccessful efforts in this direction." One might question if these efforts were sincere attempts to correct some of today's obvious deficiencies or if they were, perhaps, mere exercises.

The lack of research in accreditation is a point of vulnerability of the accrediting system in higher education. There are numerous reasons why such research has not been conducted, including the meager financial resources available to most accrediting bodies, the lack of research methodologies and evaluation techniques that can be applied to the accrediting process, and an unwillingness to alter the status quo. However, if the accrediting system is to continue to be accepted as a socially useful institution, either by its "voluntary" participants or by the public whose interests it purports to serve, it must develop a more scientific basis for its function than it now possesses.

A Hypothesis

The current status of health professions education, of health care delivery, and of accreditation in health professions education and the existing climate for reform, suggest that significant changes are taking place. In each area a phasing out of a historical period is occurring simultaneously with a phasing in of a new period. In brief:

1) Health professions education is passing from the era of a categorical approach to one that, although yet poorly defined, will be broadly multi- and interprofessional in nature.

2) Health care practice is passing from an era that has been practitioner- and disease-oriented to one that is first and foremost patient-oriented, comprehensive in nature, and derived from a conceptual base of shared responsibilities for patient care, where and when indicated.

From the changes that can be seen, and from the obvious overlap between health professions education and health care practice, we propose the following hypothesis: If health care services are to become increasingly patient-oriented and comprehensive, if health professions education to some degree is to become multi- and interprofessional in nature, and if the accrediting process is to become more accountable to the public interest than in the past, the goals of accreditation are more likely to be achieved if the process is conceived and implemented from an interdisciplinary or multiprofessional base, or both.

A Model for Interprofessional Accrediting

Here we propose a model that would lessen the burden that accrediting now imposes on educational institutions, and at the same time would permit testing the feasibility of a multiprofessional accrediting mechanism. The model provides for an authoritative body known as the Health Professions Accrediting Council and would be composed of members selected from the present constituencies of the categorized accrediting agencies in medicine, osteopathy, dentistry, pharmacy, nursing, optometry, podiatry, and allied health, together with representation from the public at large and from the humanities and the behavorial sciences. This body would be unicameral and autonomous. It would be responsible for accrediting isolated categorical programs where they exist, but would provide a framework and mechanism for simultaneous multiple program accrediting. The latter would be made through a single visit to an Academic Health Center (or a general university campus). In either case, visitations would be made by a

single multiprofessional team. All accrediting teams would have a core composition, for example, one physician, one nurse, one pharmacist, and one educational generalist. The composition of teams would be augmented by additional members according to the needs of a given program (medicine, dentistry, nursing, allied health) in the candidate institution.

In addition to evaluation with respect to applicable professional standards, the team would evaluate explicitly both the interprofessional context and content of the subject programs and the broader institutional capability to support programs in certain general categories. In this sense they would function in a manner similar to that of the regional agencies doing institutional accrediting, and like certain of them, might use a self-study approach which tested an institution's performance against its own stated goals. In any event, the documentation required for multiple program visitations would be standardized, thereby improving the efficiency of the process to both the accrediting council and the educational institution.

Such a mechanism would provide:

1) A model for testing the feasibility and evaluating the outcomes of multiprofessional accrediting, and for developing criteria for accrediting.

2) A flexible structure and process for multiprofessional accrediting for both categorical and institutional programs.

3) An opportunity for research in accrediting as a means of improving the accountability of the process and enhancing its value to society.

The model provides for an experimental approach to accrediting during times of social stress and change, and at a time when the limitations of the traditional system are all too well recognized.

Implementation

The model itself could not catalyze a reform in accrediting, because vested interests are involved. One would like to think that the kind of change indicated herein could come through a voluntary mechanism, simply because of its utility to society as a whole; that all concerned parties (American Council on Education, Association for Academic Health Centers, Council on Postsecondary Accreditation) could come around a common table and lay the groundwork for a new voluntary system that would be attuned to today's needs. In the absence of a voluntary change it seems that either the government will have to fill the void or the present cumbersome structure will collapse from its own top-heaviness.

What would happen, for example, if a major academic health center were to say "Enough! No more!" and simply terminate its quasi-voluntary participation in program accrediting. Several universities have already refused further federal assistance under the Health Professions Educational Assistance and Nurse Training Acts, and with appropriate advance preparation of their state governments such institutions could minimize the licensure problems that might be associated with moving outside the voluntary accrediting system. One such action might well topple the whole outmoded apparatus, leaving nothing in its place.

Milton Friedman (*14*) has, in fact, seriously proposed that deregulation of the accrediting and licensing process in health professions would best serve the public interest. Whereas we are inclined to disagree with Friedman, we do recognize that self-regulation may be facing its last chance to prove that it can do the job. Accreditation, as it has been known, has moved from crisis to crisis in a system fraught with fragmentation, compromise, duplication, inconsistencies, and special interest groups. Heretofore, leadership has always come forth and means have been found to deal with new and recurring problems, and there has always been an attempt to provide standards, procedures, and policies that would serve the broader interests of higher education and its institutions (*15*). A new leadership is now required to provide the initiative to reform accrediting in the health professions and perhaps in other groups of professions with common interests (*16*).

References and Notes

1. *Provisions and Procedures for Becoming Recognized as an Accrediting Agency for Postsecondary Educational Institutions or Programs, Accreditation* (Council on Postsecondary Accreditation, Washington, D.C., 1975), vol. 1, p. 3.
2. F. Dickey and J. Miller, *A Current Perspective on Accreditation* (American Association for Higher Education, Washington, D.C., 1972).
3. Task Force on Higher Education, F. Newman, chairman, *Report on Higher Education* (Department of Health, Education, and Welfare, Washington, D.C., 1971).
4. R. Deno, Ed., *Pharmacy-Medicine-Nursing Conference on Health Education, Proceedings* (Univ. of Michigan, Ann Arbor, 1967).
5. J. Graber and D. Brodie, *Challenge to Pharmacy in the 70's, Proceedings of Invitational Conference on Pharmacy Manpower, 10–12 September 1970* (Publ. HSM 72-3000, National Center for Health Services Research and Development, Department of Health, Education, and Welfare, Rockville, Md., 1970).
6. *Educating for the Health Team, Report on Conference on the Interrelationships of Educational Programs for Health Professionals* (Institute of Medicine, National Academy of Sciences, Washington, D.C., 1972).
7. J. Hogness and G. Akin, *N. Engl. J. Med.* **296**, 656 (1977).
8. R. P. Heaney, *Trans. N.Y. Acad. Sci.* **36**, 324 (1974).
9. In any event, this second recommendation highlights a curious feature of the U.S. accrediting system, namely that government appears to be subordinating its regulatory function to an accreditation function that is not, and has heretofore never been, under government control. Thus, eligibility to sit for state licensure depends on graduation from an accredited program, and eligibility for categorical federal assistance (either to the student or to the institution) likewise depends on accreditation status of the subject program.
10. "AAHC seeks halt in growth number of health accrediting agencies . . ." *The Blue Sheet* **20**, 3 (1977).
11. J. Miller, *Study of Accreditation of Selected Health Educational Programs*, part I (Staff Working Papers, in Commission Report, sponsored by the American Medical Association, Association of Allied Health Professions, and National Commission on Accrediting, Washington, D.C., 1972), p. B-1.
12. *Study of Accreditation in Selected Health Educational Programs, Commission Report* (National Commission on Accrediting, Washington, D.C., 1972), p. 2.
13. Letter from James M. Phillips, acting executive director, National Commission on Accrediting, to Daniel A. Nona, director of educational relations, American Council on Pharmaceutical Education, Chicago, 25 November 1974.
14. M. Friedman, *Capitalism and Freedom* (Univ. of Chicago Press, Chicago, 1962).
15. For example, the National Commission on Accrediting was created in 1948 to provide a mechanism for accrediting the existing accrediting agencies, to provide, according to Selden, "a means of preventing the activities from getting out of hand" [W. Selden, *Accreditation in Higher Education*, L. E. Blauch, Ed. (Department of Health, Education, and Welfare, Washington, D.C., 1959), p. 22]. Again in 1975, when federalization of all accrediting bodies (regional and special) was believed essential in order to preserve the voluntary accrediting system, the Council on Postsecondary Accreditation was created to supplant the National Commission.
16. Upon completion of this article, we learned that the Council on Postsecondary Education (COPA) has announced that it "has taken [steps] to deal with the growing problem of fragmentation and duplication of accreditation activity at the postsecondary level. . . . It will initiate efforts to meet with representatives of the American Medical Association, the American Hospital Association, the Association for Academic Health Centers, and other appropriate organizations to discuss cooperative efforts to address the problem in the health-related professions." [Council on Postsecondary Education, *Higher Educ. Natl. Affairs* **26**, 6 (1977)].

17. We thank J. C. Weaver, J. S. Miller, and F. J. Dickey for comments on the manuscript.