

The History of Sections in the American College Health Association

William A. Christmas, MD

Abstract. The founders of the American College Health Association (ACHA) recognized the importance of regional groups (affiliates) and worked actively to foster their formation and continued existence. In 1932, D. F. Smiley, MD, described the concept of establishing ACHA regions and suggested combining institutional membership in both the national and regional organizations. Significant affiliate representation in the association's governance structure finally became a reality in 1987, when regional representatives became permanent members of the board of directors. Standing committees of the association were transformed into the present ACHA sections in 1957, and a new category for individual membership established for college health professionals interested in participating in educational activities of the new sections. In many ways, the changes in the association's governance that occurred in 1987 are reminiscent of the original structure of the 1920-1970 era, when the organization was much smaller and essentially an association of college health center directors.

Key Words. American College Health Association, governance, history, sections.

The American College Health Association (ACHA) celebrated its seventieth birthday on December 31, 1990. The decade of the 1980s was a productive one for ACHA: institutional membership reached new highs, AIDS-education programs achieved national recognition, and a new governance structure was adopted at the 1987 annual meeting in Chicago. More recently, the board of directors initiated discussions concerning membership structure, affiliate relations, and the formation of new sections. I served on the board from 1984 to 1989, and it was my experience to suppose that each issue presented to us was brand-new. My colleagues and I thought we were forever charting new waters when, in fact, we were often sailing on seas already visited. If corporate memories are short, then association memories

are but a blink of an eye because of the rapid turnover of the volunteer leadership of our organization.

The term *section* has had two important meanings in the history of ACHA. During ACHA's first 50 years, the term was used to designate what we now call our affiliate associations. This designation changed in 1957, when ACHA established internal sections to address the needs of specific professional and special-interest groups. Because of these changes in terminology, the origins and development of *local* sections (now ACHA affiliate organizations) and *ACHA* sections have become blurred. I am offering this brief history of the two different kinds of sections and a short description of the three eras of ACHA governance structure in the belief that a better knowledge of ACHA history will place some of our current and future deliberations in better perspective. Although the original name of ACHA was the American Student Health Association, this was changed to the present name in 1948; for clarity, I shall use the acronym ACHA throughout.

Local Sections (Affiliates)

At the initiative of John Sundwall, MD, University of Minnesota, assisted by Warren E. Forsythe, MD, University of Michigan, a national organization of college health officers was formed in 1920.¹ When organizational meetings were held in March of that year, however, the founders disagreed over whether to form an independent organization or to become attached to an existing national group, such as the American Public Health Association.² The debate was resolved in favor of an independent organization, and the first annual meeting of the association was held in Chicago on December 31, 1920. Dr Sundwall became the first president and served for two 1-year terms (1920 and 1921).

From the beginning, the founders recognized that ACHA could not meet the needs of many college health professionals because of the high cost in time and money associated with attending annual meetings. The

William A. Christmas is director, University of Vermont Student Health Center, Burlington, and chairman, ACHA Ad Hoc Committee on Structure and Function.

organizers had the wisdom and foresight to provide for the establishment of local sections that "may be formed in any locality, with the advice and consent of the executive committee, for the purpose of promoting interests in harmony with the objectives of the association."³ At the fourth annual meeting in January 1924 (there was no meeting in 1923), H. S. Wingert, MD, of Ohio State University, formally proposed the formation of a local section.⁴

By 1932, D. F. Smiley, MD, of Cornell, reported in his presidential address⁵ at the 13th annual meeting that "Ohio had held her eighth meeting, New York her second, and Pennsylvania her first." He emphasized the importance of meeting every year with others in the field of college health and noted that it was beyond the means of some institutions to send their staffs to the ACHA annual meeting. Smiley then proposed a tentative scheme for dividing the country into districts based on the concentration of institutions of higher learning in each region. He proposed 13 groupings, many of which are similar to today's ACHA regions and have familiar names—Pacific Coast, Rocky Mountain, and Mid-Atlantic. He also proposed to offer further encouragement from the national organization by refunding \$2.50 of the \$10 annual institutional dues to the treasurer of the local section each year for every institution that was a member of both a local section and the national association. Dr Smiley noted that this would obviate the necessity of collecting two sets of dues every year. This dues-sharing arrangement was adopted by ACHA in 1933,⁶ but the mechanics of administration eventually became too unwieldy in the precomputer era, and the policy was abandoned in 1958.⁷

At the 1956 annual meeting, members considered several revisions of the bylaws, including one that pertained to representation of the local sections in the ACHA governance structure. Article III⁸ specified that "due consideration shall be given to equitable representation from the various active sections" in the nomination of candidates for members-at-large of the council. Although laudatory, this change did not guarantee representation in ACHA to the local sections.

At the annual meeting in 1958, Samuel I. Feunning, MD, University of Nebraska, who was chairman of the local sections committee, brought to the council's attention the confusion between "special interest sections," as the special standing committees of ACHA were then being called, and "local sections." He recommended changing the name of the latter, and, as a result, the local sections became known as college health associations affiliated with the ACHA. Thus, the New England Section became the New England College Health Association, an affiliate of the ACHA.

By 1962, the affiliates, as they were then known, had become administratively more independent of their parental organization. Thomas V. Urmey, MD, of Williams College, observed in his presidential address at the annual meeting that year that "the local affiliates seem

to have almost no organic connection with the parent body."⁹ As the decade advanced, the ACHA leadership became increasingly interested in the relationship between the national organization and its affiliates. Henry B. Bruyn, MD, of the University of California at Berkeley, noted in 1967 that although the Committee on Affiliates had been established in 1959, it was abolished in 1963 in favor of making the ACHA vice-president the affiliate coordinator. Dr Bruyn resurrected Dr Smiley's proposal of 1932, which had recommended that membership in the regional affiliate and the national organizations be combined. He also recommended that regional affiliate organizations should be represented on the governing council of the ACHA (see Table 1). The stage was now set for the affiliates to gain representation in the council of delegates when a major change in the ACHA governance structure occurred in 1970.

The new 1970 governance structure was complex. It was meant to involve as many members as possible, but the sheer size of the council of delegates probably was not seen as an adequate forum for the affiliate representatives. During the 1970s, the affiliate organizations continued to value their autonomy, even though they were technically part of the national organization. When Margaret Bridwell, MD, University of Maryland at College Park, became ACHA liaison with the affiliates in the early 1980s, she worked hard to strengthen the ties between these groups and the parent organization. Later, during her two years as ACHA president (1985–1987) she encouraged a reevaluation of the governance structure of ACHA. This culminated in 1987 in a major revision of the bylaws that partitioned the country into six regions, much as Dr Smiley had proposed in 1932, and gave the affiliates six permanent seats as regional representatives on ACHA's board of directors. As the size and stature of our organization has grown in recent years, its connections with the affiliate organizations have been noticeably strengthened. In fact, a trial proposal for combination membership and dues was approved by the board of directors in December 1988 in San Antonio. Since that meeting, a number of affiliates have adopted united membership, including Pacific Coast, Mid-America, Central, Southwest, Rocky Mountain, New England, Mid-Atlantic, and, next year, Ohio.

Internal Sections of ACHA

The sections of ACHA that we know today evolved from the standing committees defined by the bylaws 70 years ago. The original constitution³ provided only for an executive committee and directed that the president appoint "such committees as may promote the work of the association." At the sixth annual meeting in 1926,¹⁰ the constitution was amended to define five standing committees—Informational Hygiene; Health Service; Hygiene of Physical Activities; Administrative Hygiene; and Departmental Organization, Administration, and Integration. These committees were originally composed of a chairman and four members, but this limit on size was

TABLE 1
Changes in ACHA Governance and Structure, 1920-1992

Era 1 (1920-1970)	Era 2 (1970-1987)	Era 3 (1987-)
Structure		
<i>Membership</i>	<i>Council of Delegates</i>	<i>Voting Assembly</i>
Representatives of member institutions	Officers Delegates from member institutions Delegates from affiliates Delegates from sections All past presidents Executive director, <i>ex officio</i>	Officers Representatives of member institutions Members of board of directors Section representatives All past presidents
<i>Council</i>	<i>Executive Board</i>	<i>Board of Directors</i>
Officers All past presidents Members at large (6) Chairs of ACHA sections (added in 1962)	Officers Speaker of council of delegates Moderator of representative assembly Students (2) Executive director, <i>ex officio</i>	Officers Regional representatives (6) Members at large Students Executive director, <i>ex officio</i>
<i>Representative assembly</i>		
One representative from each member institution		
Function of Governing Bodies		
<i>Membership</i>	<i>Council of Delegates</i>	<i>Voting Assembly</i>
Conducts the annual business meeting of the association, establishes overall organizational policies, elects the officers, and annually reviews the activities of the association.	Chief governing and administrative body of the association. Receives and takes action on reports of officers, executive board, executive director, commissions, and committees of the association. To expedite its work, the council employs a system of reference committees to review and make recommendations on reports. Elects the officers of the association and makes changes in the constitution and bylaws.	Conducts the annual business meeting of the association, establishes overall organizational policies, elects the officers, and annually reviews the activities of the association. The resolutions committee provides a vehicle for agenda items to come before the voting assembly. Any member of the association can present a resolution to the resolutions committee, which will forward their recommendations to the board of directors. Any resolution not approved by the board of directors must be included on the agenda at the next meeting of the voting assembly.
<i>Council</i>	<i>Executive Board</i>	<i>Board of Directors</i>
Responsible for conducting the affairs of the association, subject to the approval of the membership. The executive committee of the council acts for the council between meetings of the council.	Responsible for implementing the policies established by the council. It functions as the council during the interval between annual meetings.	The board of directors is the chief operating body of the association. It implements policies of the association as established by the voting assembly. The board is responsible for all committees, oversight of the executive director, expenditure of association funds, and the annual awards of the association.
<i>Representative Assembly</i>		
Elects delegates to the council.		

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later eliminated. Each committee was made responsible for one full session of the program at the annual meeting. In the 1941 constitutional revision,¹¹ these five committees became standing committees of the association, were consolidated into four, and were renamed Health Instruction, Health Service and Physical Activities, Environmental Hygiene, and Administration. A committee on research was added and the council provided for the appointment of special committees by the president. Events during World War II curtailed the work of ACHA, and only one general meeting (in 1944) was held between 1941 and 1945.¹²

The post-war period saw the beginnings of dramatic advancements in medical technology and changes in medical practice. ACHA, too, felt the need for change. Lewis Barbato, MD, reported in 1959 that the annual meeting was no longer a gathering of health service directors but was fast becoming a broadly based, interdisciplinary group of persons concerned with the total healthcare program for the academic community.⁹ In 1958, John Summerskill, PhD, Cornell University, who was ACHA secretary-treasurer, established the *ACHA Newsletter*, which was later renamed *ACHA Action*. In the second issue, he summarized the changing needs of the membership,¹³ noting a continuing shift away from education and hygiene to medical responsibility for ill and injured students. He also cited several factors, including expansion of clinical services, increasing enrollments, a greater proportion of students in residence on campus, and striking progress in medical science, to support his premise.

Until this time, the ACHA arena for professional education and discussions was found in the standing committees of the association. As ACHA increased in size and complexity, the system of standing committees became obsolete and could not meet the educational needs of the membership. After due consideration, the ACHA council voted in 1957¹² to establish *sections* within the organization to permit improved communication between persons working within the same field of special interest in student health. The sections suggested by the council were Administration; Environmental Health and Safety; Health Education; Medical Service; Mental Health; Nursing Service; Research; and Tuberculosis Control. In his report of the Committee on Local Sections (affiliates) that year, Bruce S. Roxby, MD, Temple University, concluded:

It is evident that the newly created sections to replace association committees in various fields of interest will play an increasingly important role in the function of the ACHA. In time the place of the local sections may be altered significantly.

In order to avoid confusion in nomenclature it would appear advisable for a new term to be adopted to replace local *section*. The word district, area or region might clarify the revised organizational structure.¹⁴

At the same time that the ACHA sections were formed, the council established the category of individual membership. Until then, there had been only one category of

membership—institutional. Several members of the council worried that directors of small college health services would drop institutional membership and take individual membership because of the lower cost; others felt that individual membership might lead to institutional membership in the future, and the latter group prevailed.¹⁴ Summerskill wrote in the *Newsletter* that “an individual interested in college health work—whether or not his institution is a member of ACHA—can now become a member of one of the eight sections of the association.”¹³ It was envisioned that individual members of sections would actively meet to discuss program planning, to exchange information relative to their discipline, and to conduct seminars on topics of mutual interest. By 1962, almost half of the program of the annual meeting was devoted to meetings of the sections.⁹

The nature of organizational change is such that a positive change may subsequently have a negative effect. James Dilley,⁹ executive director of ACHA from 1967 to 1984, noted in 1968 that healthcare in the United States was emphasizing the team approach. He felt that the section, the vehicle designed for the expression of the individual in ACHA, was based on professional discipline and therefore limited in its approach to problem solving. It is, therefore, not surprising that during the 1980s ACHA saw a proliferation of special committees with multidisciplinary memberships that were called task forces. At the same time, interest on the part of groups in establishing new sections based on both professional and/or administrative duties in college health has continued.

Representation of Sections in the ACHA Governance Structures

For the first 50 years of its existence, ACHA was principally an association of college health service directors. It was also of relatively modest size, and it functioned well with a simple structure (see Table 1). The original bylaws provided only for an executive committee,³ which directed all affairs and activities of the association. The entire membership, that is, representatives of member institutions, elected officers and new members. In the 1933 bylaws,⁶ the council appeared and it assumed the functions of the executive committee. The executive committee, however, was empowered to act for the council between annual meetings. The 1956 bylaws⁸ attempted to encourage affiliate representation on the council, and in 1962, the chairs of the ACHA sections were made members of the council.

As Dr Boynton has noted,¹² a major reorganization of the bylaws, based on the governance structure of the American Medical Association and drafted by Leonard Schiff, MD, occurred in 1970. For the first time, all three constituencies of the association—member institutions (institutional members), the ACHA sections (individual members), and the affiliate organizations—were formally represented in the council of delegates, which was the chief governing body. This was the first time in

the history of ACHA that individual members, through membership in a section, had any voice or vote in the governance of the association. In the 1987 revision of the bylaws, this representation would be maintained in the voting assembly. The 1970 revision provided for a complicated system of reference committees and commissions that offered a forum for all members of the association to be heard. This was created so that the executive board, council of delegates, and the membership could interact effectively.

Over the next 17 years, it gradually became apparent that this system, although all-inclusive, was too complex for an organization the size of ACHA. Although all parts of the organization had ample opportunities to affect ACHA policy formulation, the delay in decision making (sometimes amounting to several years) resulting from its structure rendered ACHA unable to react in a timely manner to the needs of the membership and to new opportunities. This led, in 1987, to a second major revision of the ACHA governance structure. It streamlined the structure and returned it to a form similar to the original. A voting assembly, which establishes ACHA policy, elects the officers of the association and approves changes in the bylaws. The board of directors is the operating body of the association and is responsible for implementing the policies adopted by the voting assembly.

An important innovation is the designation of six regional areas of the country into which one, two, or three affiliate organizations have been placed. The members of each region elect a representative who sits on the ACHA board of directors. By this mechanism, the affiliate organizations for the first time have achieved significant representation on the board of directors. This has resulted in a board that is larger than it was in previous eras. With amendments to the bylaws approved at the 1991 annual meeting in Boston, the board is now approaching 20 members.

The present governance structure has been in place for 4 years. Many ACHA members are uncertain about how it should function. There are now fewer fora for members to have their voices heard. In 1990, an ad hoc committee on structure and function was created to help assess this area and make recommendations to the board of directors for improvement. At the 1992 annual meeting, the voting assembly agreed to have individual members of the association elect officers, beginning with the 1993 annual meeting. In the next few years, the ACHA leadership will need to increase efforts to educate all members about how the new structure functions. In addition, we must develop arenas for more dialogue between the leadership and membership, especially at the annual meeting.

The creation of the ACHA sections has had a significant impact on the operation of ACHA. On the one hand, it has melded groups from a professionally heterogeneous membership to achieve common educational goals. On the other hand, it has created a perceived need by these groups for political representation in the ACHA governance structure—something that was not intended in 1957 when they were created. Currently, there are questions about the value of and need for both institutional and individual membership as well as concern about the power equation between the two, which strongly favors the institutional member. The issues of relevance and power of institutional versus individual membership will continue to be debated. The future role of the ACHA sections, which, because they are discipline specific, tend to fragment ACHA membership, will need to be closely scrutinized to discover how the organization can achieve integration while preserving a multidisciplinary approach (personal communication from M. M. DeArmand, MD). The impressive diversity of ACHA membership contains both the potential for great accomplishments and the seeds that, if they germinate, could tear the organization apart. For more than 70 years, ACHA has depended on the efforts of an evanescent leadership and the positive support of the entire membership to flourish.

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