

# Professional Licensure, Organizational Behavior, and the Public Interest

HARRIS S. COHEN

*This paper analyzes the close nexus between professional associations and the process of state licensure. Licensure is viewed as an extension of the concern for self-regulation that characterizes professionalism. Notwithstanding the important mission of protecting the health and safety of the public, in many cases, licensure has provided a means of according status and recognition to a body of specialized knowledge, resulting in a "state-protected environment" wherein the profession is virtually autonomous.*

*Several recent proposals that may have far-reaching impact on the natural insularity of licensing boards are critically discussed. These include public representation, reorganization of boards, institutional licensure, and jointly promulgated regulations. In the context of a growing demand for greater public accountability and responsiveness in the credentialing of health manpower, these proposals may be of pivotal importance if innovative developments in the utilization and distribution of manpower are to be realized.*

The past few years have witnessed a growing sensitivity to the problems associated with state licensure of health practitioners. Numerous articles have been written critical of one or another facet in licensure (Hershey, 1971; Forgotson, Roemer, and Newman, 1967; Carlson, 1970; Akers, 1968; Grimm, 1972; Cohen, 1973; Sadler and Sadler, 1971). States, professional associations, and health organizations are seriously addressing the issues of licensing and credentialing. In 1971, the Department of Health, Education, and Welfare submitted to the Congress a comprehensive report on the subject (U.S. Department of Health, Education, and Welfare, 1971). However, despite the broad interest in these issues, they are rarely examined in a context in which the major legislative struggles of "to license or not to license"—to borrow an expression of William Curran's (1970)—as well as the specific jurisdictional boundaries that are defined (or left undefined) in the practice acts might be more meaningfully analyzed. This paper will attempt to develop a conceptual framework of licensure as a political process critical to the organizational autonomy and self-regulation of the health professions.

## The Professions and the Licensing Process

A view that is gaining wide acceptance in the sociology of pro-

fessions is that professional status results from an interactive process based upon the profession's claims to specialized competence. As Bucher and Stelling (1969: 4) note, the professional "claims that he, uniquely, possesses the knowledge and skills to define problems, set the means for solving them, and judge the success of particular courses of action within his area of competence. To the extent that others accept these claims, the professional is accorded the license and mandate that Hughes has written of as being central to being professional." Freidson (1970: 137), too, describes the autonomy and special privilege accorded professions as predicated upon three claims: "First, the claim is that there is such an unusual degree of skill and knowledge involved in professional work that nonprofessionals are not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible—that they may be trusted to work conscientiously without supervision. Third, the claim is 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."

The profession's autonomy is critically linked to the credentialing system, wherein the basic prerequisites and standards of competence are established for professional practice. This system includes—but is by no means limited to: (1) *licensing* by the state, (2) *certification* by the professional association, and (3) the *accreditation* of educational programs. The professions traditionally have sought exclusive control of each component in the credentialing system; and they have succeeded in many instances in forging the three processes of licensure, certification, and accreditation—and other processes as well—into "one comprehensive health-manpower credentialing system" (Grimm, 1972: 11). Thus graduation from a program approved by the profession's accrediting arm is often a prerequisite for taking the certification or licensure examinations.

Autonomy in the credentialing system is tantamount to self-regulation, as reflected in most of the health practice acts in this country which delegate authority to the licensed profession to regulate itself. To quote Freidson (1970: 44), "the state uses the profession as its source of guidance, exercising its power in such a way as to support the profession's standards and create a

sociopolitical environment in which the profession is free from serious competition from rival practitioners and firmly in control of auxiliary workers. Within that state-protected environment, the profession has sufficient power of its own to control virtually all facets of its work without serious interference from any lay group.”

### *Professional Autonomy*

In analyzing professional autonomy, it is important to emphasize that the individual health professions possess *varying* degrees of autonomy even when their members are credentialed by the licensure process. The literature on professions and professional behavior tends to focus upon the specific, and in some ways unique, role played by organized medicine—as exemplified by the American Medical Association and state medical societies—without calling attention to dramatic differences in the degree of autonomy possessed by other professions. In the final analysis, the measure of a profession’s control and self-regulation in the licensure process will depend on its relative political strength vis-à-vis other professional and interested groups in the state. Thus, the literature on professions tends to describe “ideal types,” modeled on the status and authority already accorded by the state to *certain* health professions to regulate their own professional practice. Other health professions will tend to pattern their credentialing procedures upon the older and more established professions.

The disparate statutory composition of licensing boards in the health field illustrates this variability. Practice acts in most health disciplines require either that all or a majority of board members be licensed practitioners in the respective licensed category. Other categories—including dental hygienists, nurse midwives, and, in some states, practical nurses—are regulated by boards that do not include a single member of the particular licensed category, but rather are dominated by members of another related profession (Pennell and Stewart, 1968). Thus, while the character of the board is in essence the same in both instances with the majority of membership “having direct professional and economic interests in the areas regulated by the boards” (Grimm, 1972: I18), the relative autonomy of the *licensed* profession is rather varied.

Another aspect of professional autonomy in the licensing process relates to the basic motivation behind the establishment of

state licensure. In 1972, legislative bills were introduced in 30 states to consider the merits of licensing one or more of 14 categories of health personnel that were not previously licensed.<sup>1</sup> Some of this legislative activity may have been initiated by essentially external sources, such as in the case of ambulance attendants and emergency medical technicians, with the primary motivation being the protection of the public safety. These bills generally vest the licensing authority in departments of health or other state agencies, and only rarely provide for the establishment of a specialized board of examiners. This pattern, however, is relatively uncommon in the licensure of health personnel. More often than not, the professional associations themselves are the key actors in generating licensing legislation. There are even instances in which state associations were founded for the express purpose of promoting such legislation, although (Akers, 1968: 465) "sometimes in a defensive move to prevent other, already established, professions from regulating them."<sup>2</sup> As Moore (1970: 125) has pointed out, professions have sought governmental licensure (1) as a means of public recognition, (2) as protection from competition by the relatively untrained, and (3) "to establish a preemptive jurisdiction over services that may in fact be in considerable and justified jurisdictional dispute."

As noted above (U.S. Department of Health, Education, and Welfare, 1971: 28), licensure also fulfills the "fundamental role of establishing minimum standards to protect the health and safety of the public." However, there has yet to be developed an objective

<sup>1</sup> This information is based upon a study by this writer of the response by professional organizations and states to a recommended moratorium on the further licensure of health occupations. (See U.S. Department of Health, Education, and Welfare, 1971: 73-74.) The following are the categories of personnel considered in 1972 for licensure: ambulance attendants and emergency medical workers, chiropractors, dental technicians, directors of clinical laboratories, EEG technicians, medical technologists and technicians, naturopaths, nurse anesthetists, opticians, physical therapy assistants, psychologists, psychotherapists, radiology technicians, and speech pathologists and audiologists.

<sup>2</sup> See also Stevens (1971: 105). These statutes, at first "permissive," i.e., persons may work in the field without being licensed but may not use the protected title, and later, as the profession becomes more established, "mandatory," i.e., only persons licensed may practice at all, have been dubbed "friendly" licensing laws. See Forgotson and Roemer (1968: 347).

measure of the range of health services that pose substantial threat to the public safety to warrant governmental licensure. Certainly an argument could be made for licensing all health practitioners without exception, insofar as the health of the public is at stake. But this would mean the possible licensing of scores of different occupational categories which, of course, would be untenable on numerous grounds. The issue of public safety, remaining as it is a very imprecise and ambiguous concept, is often secondary to other considerations, such as a profession's desire for autonomy and self-regulation. Thus, while numerous practice acts are formally justified in terms of protecting the public safety, the actual factors accounting for the promotion of such legislation may have had more to do with the above sociopolitical considerations than with the profession's concern for protecting the public from the charlatan or undertrained practitioner.<sup>3</sup>

<sup>3</sup> The language in two recently introduced bills illustrates the use to which the element of public safety is put in justifying legislation:

AN ACT . . . to provide for the licensing and regulation of psychotherapists, to impose a penalty on persons practicing psychotherapy without a license, and generally related to psychotherapists and the practice of psychotherapy.

WHEREAS, Individuals with mental and emotional problems from time to time have sought the help of certain persons conducting either individual psychotherapy or group psychotherapy; and

WHEREAS, Some of the individuals operating as psychotherapists lack the training and experience necessary to recognize existing and developing mental illness, or to recognize when the methods and techniques which they use are having harmful effects on the personality structure or the emotional or mental health of the individual; and

WHEREAS, The State, in the interest of the public health, safety, and welfare, wishes to protect individuals from psychotherapy which endangers their emotional and mental health; and

WHEREAS, it is realized that some persons operating as psychotherapists, although they do not have an academic background in psychology or psychiatry and although they employ heterodox methods, can perform necessary and needed services for the residents of this State, and

WHEREAS, It is not in the interest of the State or its citizens to limit the practice of psychotherapy entirely to persons of certain academic backgrounds, but only to assure that persons with existing or developing mental or emotional disorders be protected from destructive psychotherapeutic

Another facet of professional autonomy in the credentialing process is evident in the close collaboration between the professional association and the governmental agency charged with administering the practice act, particularly when the agency is a specialized board of examiners (Akers, 1968: 470–472). As with the initiation and promotion of the practice acts, the professions themselves generally were the driving force behind legislation to establish specialized boards. David Truman (1951: 418) has noted that when groups have sought regulation, such as in the licensing of occupations, the independent examining board or commission has typically been regarded as the most appropriate form for their purposes, because it assures privileged access for the initiating group. The tendency of regulatory agencies to become the ally or public sponsor of the regulated interest has been noted even when the demand for government regulation originated from outside the profession. As Truman (1951: 418) remarks, “Experience indicates . . . that the regulated groups will have more cohesion than those demanding regulation, that they can therefore keep close track of the work of the commission, and that consequently little will be done by a commission beyond what is acceptable to the regulated groups.”<sup>4</sup>

### *Professional Associations*

The associations’ access to the examining boards is facilitated in methods and techniques and be referred to appropriate psychotherapists; now therefore . . .

*Maryland House Bill No. 1068 (1972)*

AN ACT Providing for a Board of Registration of Radiologic Technologists.

It is declared to be the policy of the Commonwealth of Massachusetts that the health and safety of the people of the state must be protected against the harmful effects of excessive and improper exposure to ionizing radiation. Such protection can, in some major measure, be accomplished by requiring adequate training and experience of persons operating ionizing radiation equipment in each particular case under the specific direction of licensed practitioners as defined herein. It is the purpose of this article to establish standards of education, training and experience and to require the examination and certification of operators of ionizing radiation equipment.

*Massachusetts House Bill No. 4099 (1972)*

<sup>4</sup> In this respect, the state licensing agency has much in common with other forms of regulatory agencies. See Krislov and Musolf (1964: chapters 3 and 4).

those states and professions where board members are appointed by the governor from a list of nominations submitted by the professional associations, or, as in medicine, where the laws of 23 states provide that the medical society shall have a *direct* voice in the appointment of board members (Derbyshire, 1972: 161). Commenting on the latter method of board appointment, Derbyshire points out that “politics is theoretically removed from the board in that the members of the medical society are in a better position to judge the qualifications of the doctors than is the governor.” *Medical politics*, however, is hardly eliminated in the process. Again quoting Derbyshire (1972: 161), “the medical societies are by no means always likely to recommend the most highly qualified people for appointment. All too frequently, they ignore professional and educational attributes, endorsing some faithful political stalwart who has worked his way up in the councils of the medical society.”

The organization’s ability to nominate or appoint members to the examining boards—who, in most cases, will constitute the majority discipline on the board—is clearly another means of perpetuating the profession’s autonomy and self-regulation. Conversely, in cases where this is lacking and the profession is either not represented on the board at all or comprises a minority of the board, the regulated profession will tend to be apprehensive of a process in which decisions related to quality are determined by groups external to the profession. In a recent article, examining the pros and cons of licensing in the field of occupational therapy, one author (Crampton, 1971: 207) cited the composition of the examining boards “which, by law, may turn out not to be comprised in whole or in part of the professionals for whom the law was enacted,” as a major problem facing the profession.

The association’s interaction and influence with the examining board does not cease at the point of selecting board members; in conjunction with the boards, the associations initiate moves for new legislation, decide what provisions should be added, deleted, or changed to correct inadequacies in existing laws, and work for the passage or defeat of bills that relate to the profession’s jurisdictional boundaries and credentialing mechanisms (Akers, 1968: 467; Gilb, 1966: 151–153). Similarly, the associations participate in the formulation of the administrative rules and regulations that

govern the conduct and practice both of the boards and of individual practitioners licensed in the state. In fact, some of the major political struggles in the area of manpower licensure continue well after the debate and controversy have been resolved in the legislative branch only to be resumed with equal or greater vigor in the administrative branch in determining the meaning and effect of the enacted legislation.

## Recent Proposals for Change

Several recent proposals have been made that would introduce countervailing interests in the governance of licensing boards. This is not to imply that the professions typically function in such a way that the interest of the general public is ignored. Certainly, as indicated by Kaplin (1972: J33), when the profession applies "its special expertise in order to protect the public from professional incompetence, its decision may benefit rather than harm society."

However, there has been deep concern for some time with the effects of specific group biases in limiting the social responsiveness and accountability of professional associations. As Robert MacIver (1966: 53) wrote, in a paper first published in 1922: "The possibility that there may still be an inclusive professional interest—generally but not always an economic one—that at significant points is not harmonized with the community interest is nowhere adequately recognized. The problem of professional ethics, viewed as the task of coordinating responsibilities, of finding, as it were, a common center for the various circles of interest, wider and narrower, is full of difficulty and far from being completely solved. The magnitude and the social significance of this task appear if we analyze on the one hand the character of the professional interest and on the other the relation of that interest to the general welfare."<sup>5</sup> This concern is reflected in some of the current literature which describes professional credentialing as a sociopolitical process dealing not only "with narrow, clear-cut questions of professional competency but also with issues of broad social concern." Consequently, as Grimm (1972: 119; see also U.S. Department of Health, Education, and Welfare, 1971: chapter 1)

<sup>5</sup> For another early, but still timely, critique of professional self-regulation, see Fesler (1942: 46-60).



points out, "the infusion of ideas from the community would help to combat the natural insularity of the boards."

### *The Public and Licensure*

One approach to credentialing that is receiving considerable attention is to expand the composition of licensing boards to include public members with interests outside the respective fields being licensed. A leading proponent of this approach, William Selden (1970: 125; see also Grimm, 1972: 118-120), suggests that the addition of nonmembers of the professions on licensing boards "would provide greater and more consistent assurance that the public welfare is the overriding criterion on which its decisions are made." The Department of Health, Education, and Welfare (1971: 76), in its recent report on licensure, went even further to recommend that several interests be added to the boards which might be representative of: consumers; other health professions; various modalities of health care delivery, such as group practice and public institutions; educators; and others in policy-making positions in health care.

As a direct response to these proposals, numerous bills have been introduced within the past year to amend certain practice acts for the purpose of adding public members to the boards. This certainly has important potential in the direction of infusing greater public accountability in the licensure process. However, the effect of such changes in board composition will ultimately depend on a number of factors, including the status and autonomy of the public members; the extent to which public members are permitted to challenge decisions made by professional members of the boards; the extent to which they accept the responsibility of challenging such decisions; and the availability of an organized constituency or power base from which to exert leverage on other board members when it is felt that they are not acting in the public interest. In light of these considerations, a recent Labor Department report (Shimberg et al., 1972: 379-381) recommended the inclusion on licensing boards of a technically competent representative of a state government agency instead of a nonprofessional public member.

Another critical factor that should be considered with regard to lay representation is the *number* of positions to be designated for public members. Some proponents of public representation

on licensing boards are urging (Derbyshire, 1972:161) that a single position be granted to a public member. Indeed, a good number of the legislative bills recently introduced for the purpose of restructuring board composition would expand the present boards by adding *one* or *two* public members to the total board membership. The net effects of such token structural change would probably not be very far-reaching, especially in boards that traditionally have been dominated by the licensed profession. Other commentators (Selden, 1970: 124) are quite emphatic in urging that a *substantial* number of public members be placed on the boards. It would appear that unless board composition were to be *dramatically* altered, the considerable influence of professional associations on the governance and decision making of licensing boards would continue unchecked by other interests. What is suggested, therefore, is a means of introducing greater pluralism in the credentialing system.

### *Reorganization of Licensing Boards*

A related proposal aimed at broadening the perspective of licensing boards and enhancing their potential accountability to the public would centralize the licensing function within a single departmental unit, such as a state health or education department. In the words of a recent monograph (U.S. Department of Labor, 1969: 3), "With administration centralized, occupational groups can continue to be major forces in establishing and enforcing regulatory policies, but through a state agency which can reconcile the interest of the general public with those of the private associations." (See also Shimberg et al., 1972: 372-373.) In this connection, William Selden proposes a single state licensure board for all of the health professions that would be organized with subcommittees for each of the professions. The subcommittees, with majority membership from the licensed profession and including members from related professions and the general public, "would be charged with responsibility for developing policies regarding licensure for their respective professions, subject to the approval of the state board" (Selden, 1970: 126; see also Carlson, 1970: 871-872). As we pointed out elsewhere, however, this form of reorganization might prove ineffective in regulating the professions or even in mandating coordination or joint planning. State licensing boards

tend to have considerably stronger links to their respective professional associations than to other public agencies—even when these boards are located within state departments of health or education (U.S. Department of Health, Education, and Welfare, 1971:30).<sup>6</sup>

An alternative model of board restructuring would establish a single licensing board with but *one* representative of each licensed profession. Thus, instead of perpetuating the profession's autonomy and influence by delegating major policy responsibility to subcommittees—which for all practical purposes would probably function as boards—this approach would alter very dramatically the pattern of professional self-regulation that has developed in the health field. We are not suggesting that this approach is politically feasible; it does, however, provide an alternative that at least merits public consideration in weighing the pros and cons of the state-protected environment that presently characterizes licensure in the health professions.

### *Institutional Licensure*

A third proposal, that has been labeled “institutional licensure,” and is currently receiving much attention, would introduce a clearly interdisciplinary character to licensing. The implications of a system that delegated the responsibility for competence and quality of practitioners to institutions have been critically examined from several perspectives, including (1) the opportunity for greater legal and administrative flexibility in allocating responsibilities within institutions, and (2) the effects that such a system might have on the present status of the health professions. These issues are largely unresolved at this time and are certainly well-deserving of the discussion that has been generated by both the Department of Health, Education, and Welfare recommendation calling for the further study and demonstration of institutional licensure (U.S. Department of Health, Education, and Welfare, 1971: 77), and the treatment of this concept in the literature (Hershey, 1969a: 71–74; Hershey, 1969b: 951–956; Carlson, 1970: 872–878; Roemer, 1971: 50–51; Tancredi and Woods, 1972: 103).

A point that is sometimes underemphasized is that institutional licensure conceivably could provide the opportunity and impetus for greater interprofessional coordination. Ideally, the

<sup>6</sup> This writer was co-author of the Report on Licensure.

basic credentialing policies in such a system would emanate not from any one discipline, but rather from a representative committee or commission that would reflect the views of several disciplines—including medicine, nursing, hospital administration, allied health, labor unions, and other interests in personnel credentialing. Such an approach might lessen the autonomy of certain or all of the professional associations (depending on how broadly one conceives of institutional licensure)<sup>7</sup> in regulating the professions. But it might also increase the scope of professional policy making, insofar as individual professions would be afforded the opportunity of contributing meaningful inputs in defining the scope of other related professions—an end product that could be extremely valuable to the public, but that is probably unattainable under the present system of licensure. Thus, the “team approach” to licensure may be viewed not only as a means of providing for flexibility within the health care institution, but also as a means of introducing countervailing interests to the existing system wherein professional associations control their respective credentialing systems (Roemer, 1971: 51).

### *Joint Regulation*

Legislation recently enacted in a few states is consistent with the above proposal and its implications for interprofessional coordination and policy making. These laws mandate the responsibility for promulgating scope of practice regulations for emerging fields and expanded roles, such as the case of nurse practitioners, to *both* the medical and nursing boards of examiners.<sup>8</sup> While it is too soon to evaluate the net effects of such cooperative efforts in credentialing, a rather strong argument can be made to justify this approach as being responsive to the cracks that are beginning to appear in the present system of licensure. The joint regulation approach may also be viewed as a prototype of joint boards or some variation on

<sup>7</sup> For a discussion of institutional licensure, see U.S. Department of Health, Education, and Welfare (1971: chapter 10).

<sup>8</sup> See Idaho Code, sec. 54-1413 (1971), “An Act . . . authorizing a professional nurse to perform acts recognized as appropriate according to rules and regulations promulgated by the Idaho State Board of Medicine and the Idaho Board of Nursing”; and Maryland House Bill No. 468 (enacted May 31, 1972), “An Act . . . to exempt individuals to whom duties are delegated by licensed physicians from the necessity of obtaining a license to practice medicine.”

the theme of board restructuring, as examined above. There is, however, some indication that when jurisdictional issues are at stake, professional associations may prefer a private approach rather than resorting to statutory or administrative definitions of jurisdiction which "may fence the profession in as well as others out." As Gilb points out, "some professions, such as psychologists in some states, have found it so difficult to arrive at an enforceable definition of their work that they have had to forgo licensing and rely on registration, certification, or the licensing of use of a title, with no clear-cut definition of the work it describes" (Gilb, 1966: 182; Moore, 1970: 124-125).

In sum, these four approaches—public representation, reorganization of boards, institutional licensure, and jointly promulgated regulations—would provide a system of professional checks and balances in the states' regulation of health practitioners. The fundamental issues in credentialing would be addressed from a perspective broader than that of a single interested profession. The pros and cons of these alternatives will undoubtedly continue to be debated both within and among the professions. This is natural; credentialing traditionally has been, and continues to be, of central concern to the professions. As the professional associations and the public become more cognizant of the imposing public responsibilities that have been granted the professions by the state, measures to infuse greater pluralism and public accountability may need to be adopted, by both the public and private sectors, to ensure the public safety as well as the continued contribution and viability of the professions.

Harris S. Cohen, PH.D.

Acting Chief

Political and Legal Analysis Branch

National Center for Health Services Research and Development

Health Services and Mental Health Administration

Rockville, Maryland 20852

## References

Akers, Ronald L.

- 1968 "The professional association and the legal regulation of practice."  
Law and Society Review 2 (May): 463-482.

- Bucher, Rue *and* Joan Stelling  
 1969 "Characteristics of professional organizations." *Journal of Health and Social Behavior* 10 (March): 3-15.
- Carlson, Rick J.  
 1970 "Health manpower licensing and emerging institutional responsibility for the quality of care." *Law and Contemporary Problems* 35 (Autumn): 849-878.
- Cohen, Harris S.  
 1973 "State licensing boards and quality assurance: A new approach to an old problem." Pp. 49-65 in U.S. Department of Health, Education, and Welfare. *Quality Assurance of Medical Care*. Washington, D.C.: U.S. Government Printing Office.
- Crampton, Marion W.  
 1971 "Licensing of occupational therapists." *American Journal of Occupational Therapy* 25 (May-June): 206-209.
- Curran, William J.  
 1970 "New paramedical personnel—To license or not to license?" *New England Journal of Medicine* 282 (May 7): 1085-1086.
- Derbyshire, Robert C.  
 1972 "Better licensure laws for better patient care." *Hospital Practice* 7 (September): 152-164.
- Fesler, James W.  
 1942 *The Independence of State Regulatory Agencies*. Chicago: Public Administration Service.
- Forgotson, Edward H. *and* Ruth Roemer  
 1968 "Government licensure and voluntary standards for health personnel and facilities." *Medical Care* 6 (September-October): 345-354.
- Forgotson, Edward H., Ruth Roemer, *and* Roger W. Newman  
 1967 "Legal regulation of health personnel in the United States." Pp. 279-541 in Report of the National Advisory Commission on Health Manpower, II. Washington: U.S. Government Printing Office.
- Freidson, Eliot  
 1970 *Profession of Medicine*. New York: Dodd, Mead.
- Freidson, Eliot *and* Buford Rhea  
 1965 "Knowledge and judgment in professional evaluations." *Administrative Science Quarterly* 10 (June): 107-124.
- Gilb, Corinne Lathrop  
 1966 *Hidden Hierarchies: The Professions and Government*. New York: Harper and Row.

Grimm, Karen L.

- 1972 "The relationship of accreditation to voluntary certification and state licensure." SASHEP Staff Working Papers, II, 11-142. Washington: National Commission on Accrediting.

Hershey, Nathan

- 1969a "An alternative to mandatory licensure of health professionals." *Hospital Progress* 50 (March): 71-74.
- 1969b "The inhibiting effect upon innovation of the prevailing licensure system." *Annals of the New York Academy of Science* 166 (December): 951-956.
- 1971 "New directions in licensure of health personnel." *Economic and Business Bulletin* 24 (Fall): 22-35.

Kaplin, William A.

- 1972 "The law's view of professional power: Courts and the health professional associations." SASHEP Staff Working Papers, II, J1-J37. Washington: National Commission on Accrediting.

Krislov, Samuel *and* Lloyd D. Musolf (eds.)

- 1964 *The Politics of Regulation*. Boston: Houghton-Mifflin.

MacIver, Robert M.

- 1966 "Professional groups and cultural norms." P. 53 in Howard M. Vollmer and Donald L. Mills (ed.), *Professionalization*. Englewood Cliffs, New Jersey: Prentice-Hall.

Moore, Wilbert E.

- 1970 *The Professions: Roles and Rules*. New York: Russell Sage Foundation.

Pennell, Maryland Y. *and* Paula A. Stewart

- 1968 *State Licensing of Health Occupations*. Washington: U.S. Government Printing Office.

Roemer, Ruth

- 1971 "Licensing and regulation of medical and medical-related practitioners in health service teams." *Medical Care* 9 (January-February): 42-54.

Sadler, Alfred M. *and* Blair L. Sadler

- 1971 "Recent developments in the law relating to the physician's assistant." *Vanderbilt Law Review* 24: 1193-1212.

Selden, William K.

- 1970 "Licensing boards are archaic." *American Journal of Nursing* 70 (January): 124-126.

Shimberg, Benjamin, Barbara F. Esser, *and* Daniel H. Kruger

- 1972 Occupational Licensing and Public Policy, Report to U.S. Department of Labor. Princeton: Educational Testing Service.

Stevens, Rosemary

- 1971 American Medicine and the Public Interest. New Haven: Yale University Press.

Tancredi, Lawrence R. *and* John Woods

- 1972 "The social control of medical practice: Licensure versus output monitoring." *Milbank Memorial Fund Quarterly* 50 (January): 99-125.

Truman, David R.

- 1951 The Governmental Process: Political Interests and Public Opinion. New York: Knopf.

U.S. Department of Health, Education, and Welfare

- 1971 Report on Licensure and Related Health Personnel Credentialing. Washington: U.S. Government Printing Office.

U.S. Department of Labor

- 1969 Occupational Licensing and the Supply of Nonprofessional Manpower, Manpower Research Monograph No. 11. Washington: U.S. Government Printing Office.