817 HHESS HB 401

it to a more appreciative audience. You may or may not have a legitimate beef on your loss of a printing job, but attacking our dental project is sure not the way to correct it. We would give serious consideration to supporting legislation which takes government at all levels out of the printing business and puts it back with private enterprise because we feel the taxpayer should not be put in the position of competing with his own money for work.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

cc: Governor Jay Hammond
Bob Atwood, Anchorage Times
Dr. Frederick McGinnis
Senator Glenn Hackney
Senator W. E. Bradley
Senator Ed Willis
Senator Bob Ziegler
Senator Pat Rodey
Senator John Sackett
Senator Bill Sumner
Rep. Alvin Osterback
Rep. Frank Ferguson

...Alaska. By 1907, it had become a ...d coal and oil center, but by the mid-forties, Katalla had become a ghost town -- a vestige of a bygone era in Alaska's history.

...nboots

...d it; the kids understood ...sed it, but I sensed it was

these people were former ...esidents of Katalla, wh...e ...fined till the mid-thirties ... refinery burned. Now ...e just winter residents, the trapping. This was ...e '40's when fur trapping ...orable profession even to ...onists, with no overtones ...gers species" and all ...les, the price of fur was ...y good. The permanent ... of Katalla was about two ...sen and "Wolf" Larsen. ...ber all kinds of odds and ... gathering around the big ...e at Bill Hansen's cabin. ...s gathered around the ...e very practical reason -- ...re the light was. One gas ...p hung on a nail above ...nd we all sat at the table ...d, or eat. The gas mantle ...he big round table were ..., in my opinion, that ...e so close in the old days. ... of course, was the main ... the two room cabin.

... one time, early in the ...e of the men brought in 30 ... remember my ...ense of ...t in the world would we ...0 ducks? But the whole ... pitched in, cleaned and ...e whole smear of them; ... roasted up and a grand ...had by all, there at that ...e in Bill Hansen's cabin. I ...he ducks were actually

The Great Lander

FREE

SHOPPING NEWS & SOURDOUGH SAVER CLASSIFIEDS

Volume 10, No. 37 Anchorage, Alaska September 13, 1978

State Purchasing Scandal --

'Tis Your Money...And Here's How the State Wastes It!

Two weeks ago the Great Lander went to war with the state of Alaska on its bid and purchase procedures. We declared that the state was ignoring the low award bid procedure as prescribed by law -- worse yet that thousands and even millions were going out with no bids at all -- many to Outside firms leaving Alaskan vendors and taxpayers holding the bag.

As one prime example, the court system admitted to 49 violations amounting to $62,000 in form buying alone. An appeal for public information has kept our telephone ringing. And we hope it continues, through the day and into the Arctic night.

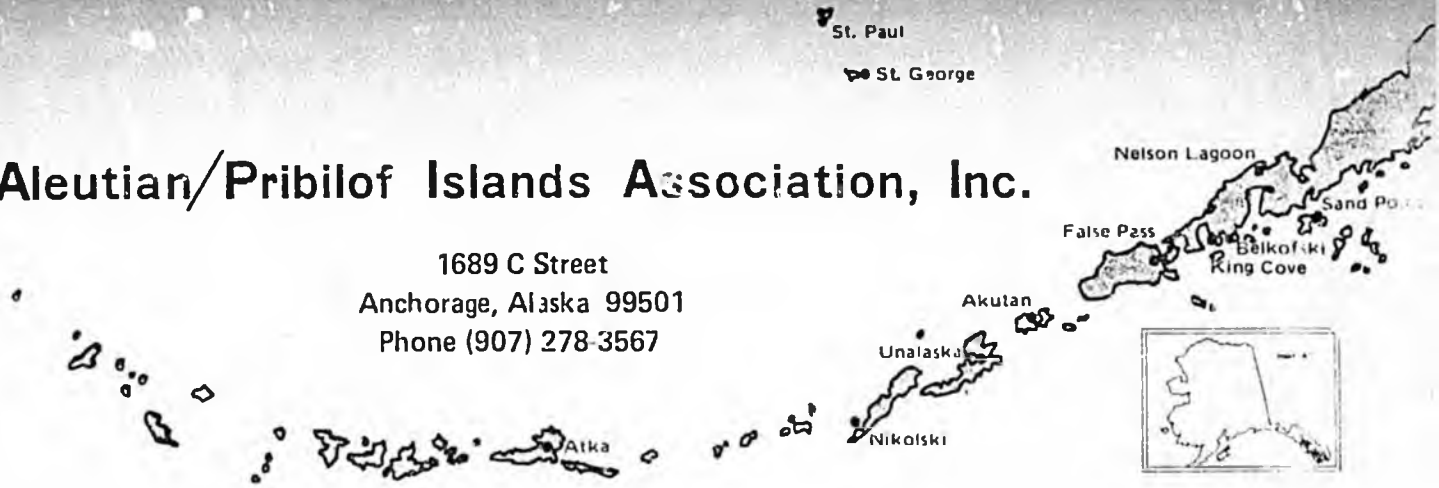
Here are some of the incidents brought to light in a single week:

Radio Equipment. Fred Jones of General Electric, in Anchorage, says the state has purchased approximately $1,500,000 worth of mobile radio equipment since 1973 without bid. He says a contract held by Motorola expired that year and that pleas to Don Harris, head of state transportation, and to Mel Holverston, of the division of communications, for a bid procedure have gone unheeded. "They pay lip ... Forms, an Outside firm, who entered a higher bid.

Regular Printing. The Anchorage Printing Co. with a bid of $128,000 was low bidder on a state call to print its elections pamphlets. The state went into negotiation with Craftsmen Press of Seattle the following day and awarded that firm the job. Formal bids were never cancelled and re-advertised as required by law.

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



QUESTIONS AND HONEST ANSWERS ON THE MOBILE CLINIC

1. Why was the unit stuck out on St. Paul all winter?

   Answer Because we were told by the State enforcement people we would be arrested if we operated it. They took down the license number of the vehicles and names and addressed of all volunteers then threatened them with arrest.

2. Why was most of the work done outside the Van?

   Answer It was not. Though large numbers were examined outside the parent van, some cleaning was also done in this manner on portable units which were an integral part of an operating system. Without the parent operative units outside van service would not have been practical. Our system allowed 7 chairs to operate all at the same time saving time and allowing for a flow of screened patients to the operative unit.

3. Was the mobile concept cost effective?

   Answer No it was not because we had to feed and house all of the volunteers for 14 days while we went through all the red tape getting started.

   As it turned out we accomplished over $100,000 worth of dental services. It could have been $200,000 without all the interference.

4. Did APIA apply for licenses or permits?

   Answer We were prevented from applying for anything by the dental board. We were informed that there was no application procedure or way to apply since the board had met in December and decided not to issue any permits to anyone no matter what the legislation says.

   Dr. Hanson and Dr. Wright re-stated this information in the APIA offices. Dr. Hanson said there would never be any permits issued to anyone as long as he had anything to say about

it no matter what the Legislature decided nor how the present law read.

5. Is there any other way to qualify?

   Answer No!

6. How do the present hygienists in training qualify for permits?

   Answer They do not qualify. They operate illegally but are not bothered by the dental board for some unknown reason.

7. Is there a record of what was accomplished before the unit arrived in St. Paul?

   Answer Yes there is. It was a buck shot hit and miss attempt.

   St. Paul: Reported population of 419. Although this community had more dental days care per year than all the other villages from 1974 - 1977, reports from visiting dentists were of rampant dental disease, high suger consumption and little or no community dental plan. Lack of coordination with the school program. 30 children reported as not showing for check ups in one period. Floridation system broken down for 3 years.

   St. George: Average of 6.4 days of care a year since 1974. For a community of 154 people - emphasis on children's teeth only.

AFTER THE UNIT OPERATED

1. New health attitude about dental care. Everyone in town was served. Mothers brought their children. Relatives brought their friends. The floridation unit was repaired. A total community dental health program was started. All examinations were documented together with x-rays and completed charts furnished by the PHS Dental Service Unit. Records left behind for the next visiting PHS dentist were so complete the next group of PHS dentists were able to pick up where the volunteers left off. This was indeed a good demonstration of how effective the 2 agencies could work together without the outside interference of the Dental Union and the State Dental Board. As a result of this joint venture, St. Paul has the best dental health in all of bush Alaska.

With the elimination of red tape, delays and political pressures, every $20,000 spent for transportation and room and board for volunteers will produce $100,000 worth of excellent dental treatment and care.

We cannot over emphasize our intention in our request for support of this program of dental care for the Aleutian/Pribilof people. We do not have as a goal the embarassment of PHS, Indian Health Service or private practitioners. We appreciate all past efforts to check dental disease in our islands. The records clearly show that the present system is not working satisfactorily and a new approach is needed. We ask only that the new approach be given the support it deserves. The worst that can happen is the communities will get a little more dental care and the mobile unit can be used by any agency wanting to use it for delivery of service to our area.

The best that can happen is that we will have discovered and tested a new functional, less expensive way to bring dental health care to bush Alaska and other areas will be using the money they now waste on poor programs to duplicate this method of service.

When the units were here for inspection by the dentists, Dr. Hanson walked right past the units refusing to even look inside. Let's not depend on this kind of open mind to make a decision on this service.

Reprinted from American Psychologist, Vol. 33, No. 11, November 1978
Printed in U. S. A.

The Myth of Professional Licensing

STANLEY J. GROSS *Indiana State University*

ABSTRACT: *The public and most professionals believe that occupational licensing protects service consumers against charlatans and incompetents. This review of historical, economic, and sociological research indicates a specious association between licensing and the competence of practitioners. Rather, the evidence reveals licensing to be a mystifying arrangement that promises protection of the public but that actually institutionalizes a lack of accountability to the public. The collusion between the state and the professions is maintained by myth. Acknowledging the failure of licensing is preparatory to defining the problem of how to protect the public.*

Licensing is presently a "hot" issue for psychologists, social workers, and counselors (Forster, 1977; Hardcastle 1977; Matarazzo, 1977; Prest, 1976; Swain, 1975). The helping professions are following in the footsteps of the health and legal professions in attempting to gain legal sanction for autonomous practice, expecting to gain similar status for these professions as well as the approval of third-party payers. Though the several helping professions are at different points in their progress from registration to certification to licensing[1] in each of the 50 states, there is an almost universal assumption that licensing is a "good thing." This myth is most often expressed as a belief that "licensing protects the public against incompetent practitioners." This largely uncritical stance appears to be the attitude of the vast majority of the public and professionals alike. Even highly critical consumer-oriented groups (Adams, 1975) appear mystified by the licensing notion, believing it to be an initial screening device for determining quality service.

This article examines the research and scholarly opinion related to the incredibly varied licensing system that results from the collaboration between the state and the professions. Licensing is used in the literature to refer both to the arrangement whereby practice is restricted as well as to all collaboration between a state and a profession, including registration and title certifications. This article is not concerned with professionally controlled credentialing arrangements that do not benefit from association with restrictive legislation. It focuses on those occupations that have gained autonomy as the result of licensing statutes. Excluded from this analysis are occupations for which autonomy is precluded either by statutes that write in a subservient role for the professional (e.g., as in nursing) or by institutions that maintain control of the service setting (e.g., as in school teaching).

A great deal of the research on which this article is based focuses on the medical profession, but this is appropriate. Medical licensure is the model that other professions aspire to, so experience with that model is instructive. Unfortunately, there is little research referring specifically to psychologists or other helping professionals, the history of such arrangements being so recent. It is possible, though not likely, that some of the conclusions might be different for them.

The history of licensing in the health professions centers on the attempts of special interests to impose or to sabotage a monopoly on the practice of healing. Licensing has been the instrument used to restrict practice to professionals, who have claimed it was in the public interest to do so. There is no good evidence to support these claims. Of the evidence found, some is inconclusive or insufficient on some points, but mainly the research refutes the claim that licensing protects the public. This knowledge is crucial to the current debate yet

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Requests for reprints should be sent to Stanley J. Gross, Graduate Studies in Education, Indiana State University, Terre Haute, Indiana 47809.

[1] Friedman (1962) defines them as follows: *Registration*—"individuals are required to list their names in some official register if they engage in certain kinds of activities. There is no provision for denying the right to engage in the activity to anyone who is willing to list his name" (p. 144). *Certification*—"the governmental agency may certify that an individual has certain skills but may not prevent, in any way, the practice of an occupation using these skills by people who do not have such a certificate" (p. 144). *Licensing*—"requires some demonstration of competence . . . and anyone who does not have a license is not authorized to practice and is subject to a fine or a jail sentence if he does engage in practice" (p. 145).

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is almost completely ignored outside of the scholarly disciplines used in this investigation which are devoted to the study of such phenomena.

Though reference is made in this article to professional self-interest and lack of accountability to the public, no implication that individual practitioners or professional associations are deliberately or intentionally self-serving is intended. In fact, one reason for this article is that practitioners as well as the public are mystified, such mystification being an important contribution to and evidence for the existence of a system of thinking, feeling, and behaving that maintains licensing. The difference between what people believe to be true about licensing and what is cited in this article indicates that the belief is maintained by myth and argues for the necessity of the consciousness raising attempted herein. The article reviews the historical antecedents of current licensing arrangements, relates the guild-like structure of professions to the licensing charter, examines the effectiveness of state licensing boards—particularly their actions to maintain professional self-interest, considers the centrality of the license to the entire system, and explores the supposed link between licensing and quality service.

Historical Antecedents

In the 13th century, Frederick II, Emperor of the Holy Roman Empire, wrote the first medical practice law. Its provisions included (a) examination by a teacher of medicine, (b) punishment for offenders by confiscation of goods and a year in prison, (c) three years devoted to the study of logic, (d) one year of practice under the direction of an experienced physician after five years of study, (e) the setting of fees, (f) free care of the poor, and (g) a prohibition on a physician owning an apothecary shop (Derbyshire, 1959).

Krause (1977) points to a pattern, dating from ancient Egypt and Greece, of a medical practice hierarchy that differentiated the curers of the masses and the curers of the elite. At the top of this hierarchy was temple medicine with its priests serving the aristocracy. At the next level were the community practitioners who practiced a fee-for-service medicine for those who could afford it, which served as the model for practice today. At the bottom was folk medicine practiced in an oral tradition, often by women. Ehrenreich and English (1973) described these practitioners:

> Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. (p. 3)

Ehrenreich and English (1973) also noted the dichotomy in medical practice that emerged in 13th-century Europe, where "witches" practiced among the people while the ruling classes were served by university-trained physicians. Licensing laws came into vogue as the means "to prohibit all but university-trained doctors from practice" (Ehrenreich & English, 1973, p. 17). Though the effectiveness of these laws was limited because of the great need for service and the inability and unwillingness of university-trained physicians to serve the masses, it is important to note this early reliance on the authority of the state to legitimate an occupation. This attempt to monopolize medical practice in situations of imbalance between need and available service was unrealistic given the large number of unlicensed medical advisors and would eventually lead to a temporary abandonment of licensing in the 19th century in the United States (Kett, 1968).

Licensing laws were used as an exclusionary technique in France during the 14th century (Ehrenreich & English, 1973). As the result of the requirement for university training, the practice of healing was restricted to the upper classes, to men, and to those in the favor of the Church (which controlled the universities), most of whom were ecclesiastics (Spector & Frederick, 1952). By the 16th century as the universities became more secularized, the university-trained professionals no longer were compelled to take religious orders. Emerging from the grip of the church, the associations of physicians became similar to craft guilds. These, however, were not destroyed by the impact of commercialism, centralized governments, and laissez-faire economics, as the craft guilds and the feudal system were to be (Spector & Frederick, 1952).

As occupations, professions were a special case, first in serving the social elite and later in being populated by the elite. Professions, like land, broke the direct connection between work and income for the English gentleman, permitting him to make a considerable sum of money without engaging in a "despised" trade. Gerstle and Jacobs (1976) concluded, "One could carry on commerce

by sleight of hand while donning the vestments of professional altruism" (p. 3).

In the United States, a flood of legislation prior to 1800 gave the power to regulate medical practice to the guildlike associations of professionals, the state medical societies (Spector & Frederick, 1952). The development of medical schools at about the same time instituted a two-tiered hierarchy of regular medical practice that included those trained through apprenticeship only and those who added medical school to their qualifications. Both categories were licensed, though Shryock (1967) has observed that legislatures were more impressed with the latter group. Three parallels with the present day were evident prior to the 19th century. First, licensing was associated with the interests of the dominant elite—the Church and aristocracy in Europe and the commercial class in America (Reiff, 1974). Second, sanctioning power was given to guildlike professional organizations as the means by which these interests were to be maintained. Third, admission to the guild maintained the profession's upper-class identification by requiring where it could and otherwise preferring a period of prolonged university training unavailable to the lower classes.

The second quarter of the 19th century brought about surprising changes in these developments in the United States. In response to the egalitarian sentiment of the times, there was a wholesale deregulation of the professions of law and medicine. By the time of the Civil War, "no effective state licensing system was in operation" (Spector & Frederick, 1952, p. 191). The popular rhetoric explaining this eventuality has a modern sound. It included complaints that the professions (a) made things so complicated that intelligent persons who ordinarily could be expected to take responsibility for themselves could not argue in a court of law or obtain the information needed to properly take care of themselves, (b) were monopolies in restraint of trade, (c) maintained a subordinating class system that hoarded privileges and blocked the entry of the lower classes, and (d) retarded developments and blocked talent in nonorthodox realms of practice (Tabachnik, 1976). More fundamentally, the demands of a growing population and an expanding frontier ushered in a wave of democracy and individualism (Spector & Frederick, 1952) and a popular health movement (Ehrenreich & English, 1973) that upset the machinery by which professional practice was controlled. The professions then became more socially inclusive as the society became more egalitarian.

Beginning in the 1870s, however, the bar associations and the medical societies began promoting a relationship between competence and licensing that culminated in our present complex system (Tabachnik, 1976). In effect, the professions, no longer able to call upon the class system to maintain their privileged status, turned toward government to secure public confidence and a monopoly of skill (Gerstle & Jacobs, 1976). In the 20th century, the trends have been (a) for licensing to include an ever greater number of occupations, (b) for the type of licensing to go from title certifications to compulsory licensing of practice, and (c) for the raising and tightening of standards—including moving from an apprentice system to one centering training in educational institutions, lengthening the period of training, and adding internships after training (Spector & Frederick, 1952). Though there have been some reactions to professional dominance expressed during the last decade by client revolts and by pressures toward community control, the present strength of professional power makes "threats to established patterns of dominance appear minimal" (Gerstle & Jacobs, 1976, p. 18).

Profession as Guild

Gerstle and Jacobs (1976) described a craft guild as follows:

> They restricted competition, set prices, defined the quality of raw materials and craftsmanship, controlled entrance and training, and enacted detailed ordinances touching on the craftsman's relations with fellow members, non-members, members of other guilds, future members, dependent workers, and consumers. (p. 2)

Though professionals may wish to deny any similarity between their associations and guilds because of the crass commercialism or the association with unionism suggested by the guild label, the analogy is helpful in understanding the centrality of licensing to professional practice. The charter of autonomy is given to the professional via the licensing arrangement on the basis of public acceptance of the idea of professional expertise and altruism (Haug & Sussman, 1969). The charter is essential. Without it, professionals would not be able to control the potentially shorable knowledge that is the basis of their expertise, nor would they bother to guide practitioners to make the costly pretense of the altruistic ideal (Haug & Sussman, 1969; Reiff, 1974). To maintain the charter,

the professional must mystify the public by making the service appear to be expert and difficult.

Modern professionals conceal their economic interests, but these are nonetheless apparent in professional procedures. Reif (1974) describes the professional as an entrepreneur dealing with knowledge as a commodity, "supplying man with holding for a price service as a form of labor" (p. 455). According to Krause (1977), for physicians "the key variable is power gained through possession of the medical skill. The power is legitimized —made official—through licensing laws which prohibit others from practicing medicine" (p. 35). Controlling the knowledge, making it a commodity, creates a scarcity economy over which the professionals have monopolistic control. Though there is talk about a free market, "Health care providers themselves are not responsive to market pressures exerted by consumers, because demand levels are not determined by consumers but by physicians" (Carlson, 1979, p. 857). By having absolute control over the spigot, professionals can arrange things so that they themselves are benefited rather than their clients. For example, Carlson (1970) points to the choice of a fee-for-service system as opposed to a prepayment system. In a fee-for-service system, services, "the need for which is determined by the providers of those services, are continuously bought by users" (p. 858). According to Carlson (1970), this induces inelasticity in demand by restricting user choice and leads to increases in costs. The alternative, prepayment, gives providers and consumers a common goal—maintenance of health. Krause (1977) points out that in a fee-for-service system it is to the physicians' economic advantage to overtreat who is ill, while in a prepayment system it is to their advantage to underdefine this group.

The charter of autonomy includes the necessity to define the terms of practice and "legal, moral, and intellectual mandate to determine for the individual and society at large what is bodily, moral, ethical, deviant, normal or abnormal" (Reif, 1974, p. 452). Thus, a system of logic and perception may be erected which organizes ethics and rationalization to protect professionals from the effects of their decisions. Those dependent on them suffer from their mistakes, ignorance, self-deception, and bias, since professionals have the right (indeed the mandate) to define when a mistake has been made. In this way a situation is created in which feedback from experience is so limited that self-corrective action is unlikely. These trappings of power led Gerstle and Jacobs (1976) to observe the "shift of emphasis on the part of professionals from control over the quality of the product or service to control of price" (p. 9). Such power is widely emulated, so much so that many want their occupations to become professions. Gerstle and Jacobs (1976) observed that the mystique of the professional is considered so socially useful for so many purposes that there is no consideration that it could be a liability.

The Boards

The mechanism by which monopolistic control is maintained is the state licensing board. The charter is, in effect, given to a public body by a state legislature, and its members are generally appointed by the state's governor. On the surface it appears that these boards would act in the public interest, but in fact, they are "captured" by the profession they are supposed to regulate. In most cases, particular professions proposed the licensing law establishing the board, their representatives negotiated with the legislators during its passage, and their representatives fill a majority, if not all, of the seats on the board (Cohen, 1975). Shimberg (1976), in reviewing the effect of "sunset" laws, indicates that even when public members are included they often become coopted. Using "umbrella" agencies to supervise a number of professional boards in a state has not made these boards more accountable. Pfeifer (1974) also found inclusion of the lay public on boards to have little observable effect on their accountability.

"If there is a tie between competence and licensing, there ought to be some evidence of that tie in the work of licensing boards. Unfortunately, there is not. As Cohen and Mirke (1974) have suggested, in addition to assessing initial competence, the boards should monitor continuing competence and should discipline errant practitioners. A related public interest matter is the availability of licensed professionals. Boards ought to be active, according to Cohen and Mirke (1974), in affecting the redistribution of practitioners and in developing new patterns of utilization of related professionals. Referring to health care personnel supply and demand, Krause (1977) concludes, "Self-interest of the crudest sort still plays a role in the way these issues are handled. As usual, the needs of the consumer are pushed aside" (p. 193). Licensing boards do very little in these areas and instead restrict themselves to the administration of

entry examinations. Even in this role they do poorly, measuring minimal competence only (Cohen & Miike, 1974).

So, what do licensing boards do? Pfeffer (1974), reviewing the limited research, concluded, "Occupational licensing operates to restrict entry and enhance occupational incomes" (p. 104). He reported observed relationships (a) between the enactment of licensing laws and the decline in the numbers of training institutions and trainees, (b) between the control of competitive behavior among professionals and an oversupply of professionals (to maintain the illusion of professional dominance), and (c) between the restrictiveness of a profession and its independence from local economic conditions. In this regard, Krause (1977) reports that the number of medical school graduates was held constant from the 1930s to the 1960s despite rapid population growth. Moore (1961) found that restrictions on entry benefit the practitioners in the field at the time the restrictions are imposed. He reported the imposition of citizenship requirements for regulated occupations in Illinois in 1939, at a time when there was a large influx of trained practitioners from Europe.

The particular means of controlling entry is the manipulation of the examination pass rate. Maurizi's (1974) study of 18 occupations indicated that

> a 10 percent increase in excess demand (applications) generates a decrease in the pass rate varying, primarily from 1 percent to 10 percent depending on the occupation, and that a 10 percent increase in average practitioner incomes produces up to a 10 percent decrease in the pass rate . . . . The power of the licensing boards is often used to prolong the period of higher incomes resulting from increases in excess demand for the services of the occupation in question. (p. 412)

Maurizi (1974) suggested that over the long run the increase in income at the time restrictions were imposed would attract more new entrants, which in turn would result in a decline in income for members of a profession if entry restrictions were not manipulated. The relationship between restriction imposition and income is apparently not all that certain. Maurizi (1974) said his data had no power to explain the relationship for half of the occupations he studied. Pfefier (1974), studying three occupations, found no evidence of a relationship between the licensing of an occupation per se and the incomes of its practitioners. He did find, however, a relationship between examination failure rates and incomes—the higher the proportion of successful applicants, the lower the income (Pfeffer, 1974). Cohen and Miike (1974) and Krause (1977) report the practice of permitting foreign physicians to practice in chronic-disease hospitals and mental hospitals—either ignoring citizenship requirements or lowering passing examination grades for those who will work in less desirable settings or in geographical areas of high need.

Licensing Is the Key

It has been observed that licensing has rarely been sought by the public; rather, it has been sought by the professionals who wished to be licensed (Cohen, 1975; Friedman, 1962). In effect, the legal mechanisms of the state legitimize the occupation. Freidson (1970) observed,

> The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society—the state. In the case of medicine, much, though by no means all, of the profession's strength is based on legally supported monopoly over practice. This monopoly operates through a system of licensing that bears on the privilege to hospitalize patients and the right to prescribe drugs and order laboratory procedures that are otherwise virtually inaccessible. (p. 83)

Hardcastle (1977) calls the need for legal protection an "expedient of an occupation on the make" (p. 14). The occupation becomes "made," ironically, as a profession through the use of public institutions and in opposition to the public interest. Friedman (1962) called the results of licensing "unendurable" even in medicine where the case for licensing was the strongest.

Though there is no evidence of any relationship whatsoever between licensing and the quality of care, the likelihood of licensing laws being removed is remote. Carlson (1970) describes licensing as going from a presumed remedy to a problem: "Licensure would likely fall of its own weight except for a reverence for professionalism" (p. 860). Licensure statutes are defended vigorously because their loss to the professions means (a) the loss of a captured board that acts in their interest free of the influence of outsiders and (b) the loss of the power given to the profession as the result of making the violation of the professional monopoly punishable as a crime (Pfeffer, 1974). So licensure is terribly important to the professionals, and yet the public is gullible (Moore, 1961), loosely organized, and lacking expertise when compared to the highly motivated trade and professional groups (Shimberg, 1976). The result is the maintenance of self-serving licensing systems regardless of their justice or usefulness.

The existence of licensing laws indicates a shift of opinion in the last century from the notion that people know what is best for themselves to the notion that "society" is the best judge (Moore, 1961). In this regard, Krause (1977) observes that the public does not judge expertise. Technically incompetent general practitioners have as many patients as competent ones. The conclusion is thus made by many that the public cannot protect itself and that licensing is, therefore, a necessity. However, the control of information by professionals does not permit a testing of the capacity of consumers to take care of themselves. The belief that information is the key to quality care is supported by the necessity, even with licensing statutes, for individuals to gain a considerable amount of information in order to effectively choose a therapist (Gross, 1977).

This complex structure surrounding licensing permits professionals to hide from the public's view their dependence on the licensing statute. Fortunately, it isn't really that necessary for the integrity of the profession, but it is for monopolistic economic control. There are several professions (e.g., university professors, dietitians, librarians, engineers) that are generally unlicensed partly because they practice in institutions. Goode (1960) suggests that pressure for licensing is greatest for occupations that deal with clients as individuals and where competence cannot be easily demonstrated. Reviews of licensing suggest that certification and registration arrangements would accomplish the protection of the public as well as the compulsory licensing of practice would (Friedman, 1962; Moore, 1961). Professional associations credential practitioners and accredit training programs without dependence on state law. More than 100 years ago it was recognized that the licensing laws had provided the professions with their power, so it was these laws that became the target for attack (Tabachnik, 1976). This may not happen in this century, but it is useful and important to note that the problem of licensing is brought about through the complicity of state governments (Gerstle & Jacobs, 1976; Tabachnik, 1976).

There is a rather strong push currently to reform licensing laws (e.g., national credentialing, institutional licensure; Cohen, 1970; Roemer, 1973). Though it is appealing to believe that there is hope for the system, the fact that professionals would remain in control in the alternatives suggested is discouraging. The crucial aspects of the problem, the absence of accountability and the maintenance of the monopoly, would not change (Illich, 1976). Further, the underlying reason for reform is obscured by the hope of reform. According to Krause (1977), the grip of physicians on maintaining control of their work is weakening under pressure from new technology and new specialty occupations. The old craft-guild model is not up to controlling it all without some help from the state legislature. The help might follow the pattern of nurse licensing laws in which the nurse's subservience to the physician is written into the law (Krause, 1977), or new laws may be suggested that institutionalize the physician as the manager of a system of health service delivery. In these ways, then, "reform" aids the physician to adapt to the problem of role obsolescence. Still, licensing is the key.

Licensing and Quality

The link between licensing and competence is the basis for societal support for licensing arrangements. I have questioned that link. It is instructive to add the evidence that licensing does not seem to be effective in preventing incompetent practice, and in the specific case of medicine with which we are most concerned, there isn't much interest in the discipline of incompetent practitioners. Derbyshire (1969), a former president of the Federation of State Medical Boards, intensively studied the problem of discipline and estimated that 5% of America's doctors are unfit to practice. He also reported that 38 states do not even specify professional incompetence as a reason for disciplinary action.

The political nature of this problem is revealed by the contrasting views of the action of the state boards in the area of discipline. Derbyshire (1969) apparently conducted two studies of state board disciplinary actions. Referring to the first study, he is vague about the number of incompetents, but of the 1,000 disciplinary actions taken over a 5-year period, he says *many* were because of incompetence. He goes on to say,

> Critics have said this is not a significantly high number. But if one makes a modest estimate that each of these physicians treats an average of 800 new patients every year, this means that 800,000 people have fallen into the hands of unscrupulous or incompetent physicians during the five year period. Viewed in this light the "insignificant" figure assumes important proportions. (Derbyshire, 1969, p. vii)

Shryock (1967), also referring to the first study,

thinks the number is *not large* and wonders how effective the board actions were but concludes that "the medical members of the boards were making *some* effort at professional self-discipline in the public interest" (p. 114; emphasis added). Cohen (1973), on the other hand, referring to Derbyshire's (1969) later study of 938 board actions over a 4-year period says "*only* 400 were based upon some form of incompetence" (p. 3; emphasis added). Krause (1977), having reviewed studies of discipline, is not specific, but he takes a stronger stand: "The most striking finding of all studies is the near total avoidance of any policing of peers by the licensing board members even in cases of extreme malfeasance" (p. 284). Since physicians are autonomous, they can and do determine the extent to which professional incompetence is defined as a social problem. The lack of action on this problem indicates that it is to their self-interest to obscure the problem.

Board staffs, according to Cohen (1973), are inadequate to carry out investigations, and the statutory provisions for such investigations are marked by ambiguity and a lack of precision. Malpractice suits appear to be the only effective feedback technique available that is likely to affect the physicians' willingness to consult and to refrain from procedures for which they are unqualified (Klaw, 1975). Krause (1977) reports that one half of all surgical operations are performed by physicians untrained or inadequately trained in surgery. Since physicians are permitted under licensing laws to use procedures for which they have not been trained, the likelihood is that economic motives (earning higher fees, losing a patient to another doctor) will maintain the threat posed by the incompetent physician. Federally mandated Peers Standards Review Organizations pose more problems than prospects for change (Laptzin, 1974; Newman & Luft, 1974; Zitrin & Klein, 1976). Israel (1973) has commented, "Among the features hindering effective implementation (of the review process) is the tradition of autonomy in private practice, and the associated reluctance of physicians to interfere in each others' practices and to be publicly critical of each other" (p. 130).

There are some who see licensing as the determiner of incompetence. Illich (1973, 1976) has been articulate about health delivery systems creating dependency on physicians. This dependency, which reduces the ability of people to care for themselves, is joined with a mystification by which people ignore the possibility that they could care for themselves. Iatrogenic disease is a major factor in iatrogenic (physician-caused) illness, which is variously estimated (a) to include from 50% of all illness (Illich, 1976) to 20% of medical patients (Stuart, 1970), (b) to jeopardize one third of hospitalized patients (Walker, 1973), and (c) to more than double the length of hospital stays (Stuart, 1970). Those who want to see licensing laws changed to permit "paraprofessionals" to perform licensed medical functions describe licensing laws as restricting the productivity of personnel (Roemer, 1973), locking practitioners into activities prescribed by statute which are not in accord with their abilities (paraprofessionals can do many tasks better than physicians but are not permitted to), and escalating health care costs (Carlson, 1970).

The experience with deprofessionalization in the second quarter of the 19th century is viewed differently in different quarters. Tabachnik (1976) reports that in America, deprofessionalization stimulated the growth of medical schools, increased the number of doctors, raised average standards, and was not as bad as the then-leaders of American medicine expected it to be. Shryock (1967), on the other hand, treats it as a calamity—a time of rampant quackery and deterioration in the quality of practice. It is never clear in his analysis if quality is related to incompetence or to the social class and educational background of the physicians.

In summary, licensing arrangements do not seem to be providing the structure for effective solutions to the problems of delivering quality care in the health and helping services. Instead, the evidence overwhelmingly supports the conclusion that licensing maintains a structure that is in the self-interest of the service giver and in opposition to the public interest. Licensing actually results in the institutionalization of a lack of accountability to the public. This information may cause some to question a collusion between the state and the professions which is justified in altruistic terms but which appears not to merit public confidence. This information has not been introduced into any of the debates about licensing in the professional literature. Acknowledging this information can be the first step toward a clearer definition of the problem of how to protect the public and maintain professional integrity.

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