

STATE LICENSURE:
THE PROFESSIONS OF SPEECH
PATHOLOGY AND AUDIOLOGY

BY

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STATE LICENSURE:
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By

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The current status of professional licensing in the disciplines of speech pathology and audiology was examined in light of literature pertaining to professionalism and general professional regulation. Initial analysis was undertaken through a compilation of the history of state licensure in these professions from 1967 to 1979. Focus was upon the problems faced by state associations as they attempted to secure favorable licensing legislation and upon the gradual alteration in the official position and support role of the American Speech and Hearing Association (now the American Speech-Language-Hearing Association). Particular attention was given to repercussions of landmark statutory enactments and to notable failures to achieve state legislation considered

favorable to the professions. It was concluded that the problems which have perplexed the legislative efforts of nonlicensed states are, with few exceptions, still in force. The critical time period for licensure having passed, states without licensure will find that the procurement of regulation will become increasingly difficult.

A second mode of analysis compared selected aspects of 30 state statutes regulating speech pathologists and audiologists. Areas of comparison included:

1. board supervisory authorities;
2. board membership criteria and appointment;
3. board composition and duties;
4. compensation of board members;
5. fee schedules for licensure;
6. renewal standards for licensure;
7. requirements for continuing education;
8. requirements for grandfathering and exemptions;
9. requirements for interim practice, trainees, supportive personnel, and reciprocal licensing;
10. compatibility of state licensure prerequisites with ASHA certification requirements;
11. supplementary licensing provisions;
12. enforcement of licensing provisions (revocation, suspension, and penalties);
13. sunset legislation.

Conclusions were specific to each area investigated.

For the third segment of this study, a 39-item questionnaire was mailed to the chairpersons of the 31 state boards licensing speech pathologists and audiologists. Twenty-four (77.4%) agency chairpersons

returned questionnaires. These questionnaires were then analyzed to draw conclusions from data received

1. relative to administration of state laws regulating speech pathologists and audiologists,
2. relative to chairpersons' opinions and beliefs concerning current controversial questions in the area of professional regulation,
3. relative to changes in board operation in the event of a given circumstance.

Responses gave evidence to the polarization that exists with regard to issues such as continuing education and specialty certification, and the agreement that is present in such areas as lay participation on state licensing boards and infringement by other licensing boards. Time limitations placed on board members, inexperience, and the part-time status of board representatives were found to be partially responsible for overall weaknesses noted in the enforcement of licensing statutes, information sharing, and the construction and implementation of special programs. However, licensing boards regulating the disciplines of speech pathology and audiology failed in many respects to satisfy the negative stereotype of professional licensing boards promulgated by many authors.

CHAPTER I

SOCIOLOGICAL ASPECTS RELATED TO PROFESSIONS: AN OVERVIEW

With more and more occupations seeking professional status and boasting of professional status, it seems reasonable to conclude that the established professional is in a most enviable position. It is here, however, that a paradox exists. For as Americans clamor to join the ranks of the professionals, and as new professions emerge almost overnight, the professions are undergoing a public scrutiny which is threatening the very foundations upon which these professions were built. Thus, the sweeping powers which many professions possess are being curtailed. Yet even those who cry the loudest that the professions have become dehumanized, corrupt due to internal control, and smug in their ability to effectively legislate against change, are quick to admit that they will accept nothing less than a "professional" career for their sons and daughters. Thus, the ranks of the professions swell, allegations notwithstanding, and the role of the profession in American life continues to expand.

In order to understand professional licensure, it is necessary to comprehend the nature of professions and professionalism. Therefore, this chapter will be devoted to a review of those characteristics which determine how professions and professionals react to the environment in which they must co-exist within the framework of society's laws and regulations.

It is apparent that the wealthier a country is, the greater the percentage of the labor force engaged in service-oriented work. Indeed, as Moore (1970) points out, the United States is increasingly being viewed as a "service economy" and "the professions appear to be perhaps the most rapidly expanding group in the service structure of this country" (p. 53). Since professions hold a position of great importance in a society such as ours, it is understandable that their regulation and control has been the object of much research and debate.

While it is not within the scope of this dissertation to provide a detailed history of the emergence of professions or of the professional ethic, Whitehead (1948) does develop an interesting distinction between professions being characteristic of the modern world as crafts were of the ancient world. Whitehead states that a craft is "an avocation based upon customary activities and modified by the trial and error of individual practice." A profession, in contrast, is "an avocation whose activities are subject to theoretical analysis, and are modified by theoretical conclusions derived from that analysis" (pp. 73-74). Lynn (1965) feels that these two activities are separated by an intellectual revolution. Gilb (1966), however, believes that "the American socioeconomic-political system is closer to its medieval ancestors than it is to the preindustrial system of the early nineteenth century" (p. 227).

Professions, Professionals, and Professionalization:
This Is Where It All Begins

While researchers may debate the similarities and differences between ancient craft guild activities and modern professional life,

they are in general agreement with regard to defining "a profession" and listing its essential attributes. As will be pointed out later, this agreement is not as universal with regard to perspectives on the process of professionalization.

A sociological approach, one that is espoused by Greenwood (1957) and others, views a profession as

an organized group which is constantly interacting with the society that forms its matrix, which performs its social functions through a network of formal and informal relationships, and which creates its own subculture requiring adjustments to it as a prerequisite for career success. (p. 45)

Gilb (1966), in attempting to answer the question, "What is a profession?" asserts that different professions have defined the term differently from era to era. However, she finds that all professions stress the application of special knowledge which requires long training on the part of its recipient, the exercise of discretion, and a willingness on the part of the practitioner to commit himself to some standard to which the pursuit of self-interest is subordinated. This commitment is referred to by Moore (1970) as "a calling" and involves acceptance of appropriate norms and values.

Seldon (1972), while admitting that there is no widely accepted precise definition of a profession, nevertheless posits six essential features of a profession:

1. skill based upon theoretical knowledge,
2. skill requiring education and training,
3. demonstration of competence by the passing of a test or tests,
4. integrity maintained by adherence to a code of conduct,

5. service provided for the public good,
6. organization of practitioners into a body, the professional association. (p. 25)

Thorner (1942) adds that the function performed by the profession must be socially necessary, while Greenwood (1957) postulates that all professions seem to possess, among other attributes, authority, community sanction, and a culture. Some of these attributes will be dealt with later in this text.

The study of the process of professionalization has been greeted with as much enthusiasm as has been the search for the parameters of a profession. Johnson (1972) contends that the term "professionalization" is used in four ways:

1. It is used to refer to broad changes in the occupational structure whereby professional or even white-collar jobs increase in number relative to other occupations.
2. It is used in a way which implies little more than an increase in the number of occupational associations attempting to regularize recruitment to and practice in a specific occupation.
3. It is used as a much more complex process in which an occupation comes to exhibit a number of attributes which are essentially professional and are said to be the core elements of professionalism.
4. It is used to refer to a process and there is sometimes the explicit argument put forth that this process occurs as a determinate sequence of events (pp. 21-22).

Wilensky (1964) has attempted to outline this "determinate sequence of events." Initially, there must emerge an occupational group which works full-time on a specific set of problems. It is most important that this work be non-manual, or only manual in so far as it is necessary to perform personal services. Professionalism, according to Wilensky, will more likely occur where an emerging occupation

already has some connection with an established profession. The remaining stages in the process of professionalization, as distinguished by Wilensky, can be viewed as efforts on the part of the occupation to secure its position in relation to the broader society.

1. The second stage is the establishment of training and selection procedures.
2. The third stage is the formation of a professional association.
3. The fourth stage is where the occupation agitates for public recognition and legal support for its control over entry and modes of practice.
4. The fifth stage is where the occupation will elaborate a formal code of ethics (pp. 142-145).

Goode (1960), rather than attempting to enumerate specific stages of professionalization, stresses the idea that one should think of a given occupation as falling somewhere along a continuum of professionalism. He posits two "core" characteristics: prolonged specialized training in an abstract knowledge and a collectivity or service orientation, as being extremely important in determining the degree of professionalization. Some occupations, such as nursing, rank high with regard to service orientation but low with regard to Goode's first "core" characteristic. In the case of the nursing profession, Goode feels that nursing "has been unable to demonstrate that its training is more than a lower-level medical education" (p. 903).¹

¹ Goode continues by stating that some occupations, for example social work, public accountancy, and librarianship, have made steady progress on both dimensions. It appears obvious that many emerging professions, such as speech pathology, must "walk a tightrope" between courting the favor of stronger, more established professions in their battle to survive and gain licensure and presenting the image that

Hughes (1958), one of the foremost writers in this area, views professions, professionals, and professionalization from yet another perspective, one of self-concept, status, and professional mandate.

My own experience in the study of occupations illustrates the point that concepts may be blinders. My first essay into the field was a study of the real estate agents in Chicago. . . . I started the study with the idea of finding out an answer to this familiar question, "Are these men professionals?" It was a false question, for the concept "profession" in our society is not so much a descriptive term as one of value and prestige. It happens over and over that the people who practice an occupation attempt to revise the conceptions which their various publics have of the occupation and the people in it. In doing so, they also attempt to revise their own conceptions of themselves and their work. The model which these occupations set before themselves is that of the "profession;" thus the term "profession" is a symbol for a desired conception of one's work and, hence, of one's self. The movement to "professionalize" an occupation is thus collective mobility of some among the people in an occupation. (p. 44)

Sanders and Lyon (1976) view professionalization as a process of self-labeling. Within this process there is little value in listing stages of professionalization or degrees of professionalism; professions are simply those occupational groups that can convince the public that their skills are necessary for the societal good and that their authority to control access to and utilization of these essential skills should be publicly sanctioned.

Tabachnik (1976) believes that the recent sanction of professionalism by politicians and by the public is due, in part, to several basic beliefs. Among these are

their training is no more, in Goode's words, "than a lower-level medical education."

1. the general belief that professionalism protects the public from irresponsible and incompetent practitioners, and therefore contributes to the virtual elimination of quackery.
2. the related belief that by raising the level of competency, political corruption will also disappear.
3. the belief that professionalism, via specialization, adds to a growing body of knowledge, resulting in the long term advancement of science. (p. 25)

Abrams (In Turner and Hodge, 1970) makes the point that as professions emerge, they may also recede.² He cites scribes, pharisees, and alchemists as cases in point. These processes of professionalization, de-professionalization, and re-professionalization, according to Gerstl and Jacobs (1976) are cyclical. He conjectures that we are now at what he calls "the point of advanced elitist professionalization" (p. 1) and, should history repeat itself, on the brink of a de-professionalization cycle. Gartner and Riessman (1972) assert

²The process of de-professionalization as discussed by Abrams, Gerstl and Jacobs, Gartner and Riessman, and others relates to entire professions. A study of the various "sub-cycles" of professionalization, de-professionalization, and re-professionalization within a given discipline may well allow one to anticipate changes in the professionalization cycle of the entire profession. Over a period of time it is possible that specialized areas or sub-sets of a profession may experience a professionalizing or de-professionalizing trend.

In the field of speech pathology, the decreased incidence of disorders of rhythm such as cluttering and stuttering (Van Riper, 1971, p. 51) may, over time, lead to some degree of de-professionalization of specialists in that area of concern. Conversely, advances in medicine now allow many stroke victims to survive who in previous years would have died soon after receiving the cerebral insult. The new medical technology responsible for keeping stroke victims alive has also created the need for increased numbers of well-trained specialists in the area of aphasia rehabilitation. One may assume a defensible position that this area of concern within the discipline of speech pathology is undergoing a gradual process of professionalization. One now hears quite frequently the unifying term "aphasiologist;" however this writer knows of no such encompassing term which unifies those interested in disorders of rhythm.

that this de-professionalization cycle has already begun, primarily because of distortions and limitations imposed on the idea of what the term 'professionalism' means.

Large numbers of professionals are functioning at a very low level. Teachers spend time helping children on with their boots, taking attendance, keeping order, filling out forms. . . . In essence, the professional is underutilized. He mechanically performs routine tasks; he has little initiative and he is bureaucratically controlled by the rules. His skills are wasted, and he becomes stultified and apathetic. (p. 271)³

³This concept has broad applicability to the discipline of speech pathology. The advent of "programmed" therapy, the increased need for accountability which is often reflected in time-consuming administrative detail, and the specialization into which those trained under a generalized orientation are forced to go, often require that a speech pathologist use only a very small percentage of his training in service to his clientele. Perhaps a reevaluation of our training methods needs to be undertaken. As Hughes (1958) remarks:

From all of this there flows the question common to all new professions and by no means uncommon among older ones: for what are the people being trained, anyway? A recent study of librarians gives the impression that the most successful librarian is no longer a librarian but an administrator. (p. 137)

The two primary bases for specialization within a profession are

1. the substantive field of knowledge which the specialist professes to command, and
2. the technique of production or application of knowledge over which the specialist claims mastery. (Moore, 1970, p. 141)

It is becoming increasingly necessary for speech pathology to evaluate the training and professionalization of its new careerists with regard to the increasing administrative responsibilities of each professional, and with regard to more effective utilization of specialized skills within realistically viewed specialized work environments.

The Profit Motive and Additional Elements of the Professional/
Nonprofessional Schism: Differences That Make a Difference

"The professional man, it has been said, does not work in order to be paid: he is paid in order that he may work" (Marshall, 1964, p. 145). This question of incentives and motivation is of primary importance in attempting to realize those characteristics which dichotomize professionals and nonprofessionals.

Thorner (1942) asserts that the question of the profit motive is not between business people who want to earn money and professional people who don't, as both are equally interested in earning money as a generalized goal. The contrast is, in Thorner's words, "between the two institutionalized patterns controlling the manner in which money ought to be made" (p. 323).

Thorner continues by indicating that the manner of remuneration for professionals is not made indirectly in the guise of a profit incident to a transaction involving material goods. The exceptions to this statement prove the rule, as occupations such as pharmacy and optometry rest on the fringes of professionalism as compared with teaching, law, or medicine.

Many professionals assert that they are engaged in a non-profit endeavor. Since the basic charge is for a professional's time, and since there is no raw material on which to show a markup, no profit can be visible (Lieberman, 1970). Of course it is to be understood that although many would contend that the monetary incentive is a relatively unimportant one for professionals, professions generally can only maintain respectability if they succeed in receiving a favorable monetary return. Marshall (1964) states the professional

viewpoint well when he asserts that professionals believe that, "money must flow in as an almost unsolicited recognition of their [the professionals'] inestimable services" (p. 145).

May (1976) stresses that most professionals serving consumer clients do not receive monetary incentives to increase their productivity. She reports that some research is currently being conducted to ascertain whether monetary incentives do in fact increase a professional's effectiveness in working with clients.⁴

Barber (1965), in writing of professional behavior, lists as one of his attributes of such behavior a system of monetary and honorary rewards which acts primarily as a set of symbols for professional achievement. These symbols are ends in themselves, and not simply a means to some end of individual self-interest.

Seldon (1972) and Gilb (1966) write of the role that professional associations play in guarding the economic interests of their members.

⁴In the practice of speech pathology it is entirely probable that some aspects of a desirable performance may not be measurable. How does one measure motivation to use a learned phoneme or the alleviation of gross misconceptions concerning one's problem? How does one weigh the efforts of a speech pathologist who has almost "cured" a stutterer of his mild problem with the efforts of a speech pathologist who has enabled a severe stutterer to make an excellent adjustment to living with his problem, while not necessarily effecting a great reduction in the number of dysfluencies per unit of time? Awarding monetary incentives based on client satisfaction is not an answer either, for many clients are unaware of "how far they have come" in addition to the fact that it may be necessary with certain types of therapies to provoke client dissatisfaction with himself (which may be transferred to the therapist) before any real progress can be realized. Moreover, many of those who would generally be thought of as a profession's most unprofessional practitioners (i.e., the charlatans) are quite adept at securing client satisfaction. Hughes' (1958) definition of a quack as "the man who continues through time to please his customers [clients] but not his colleagues" (p. 98) is very appropriate in this regard.

Seldon laments what he sees as a general retreat on the part of professional associations in health related fields from their traditional emphases upon educational, ethical, and scientific concerns. He writes, ". . . when at the same time the profession exerts pressures to increase the economic, political, and social benefits of its members, it can no longer be considered to be operating on the basis of altruism or as an unprejudiced party" (p. 27). Gilb views the professional association as a vehicle for gaining prestige and status for the profession as well as the individual professional. If this prestige and status are reflected in increased monetary rewards while concurrently giving the profession the reputation of rendering service rather than seeking profit, states Gilb, so much the better for the individual practitioner.

If differences in viewing the profit motive are one critical aspect in distinguishing professionals from nonprofessionals, certainly the nature of the work performed may act as another element to bifurcate these two groups.

Elliott (1972), in writing of the minimum standards that an occupation must meet to develop toward professional status, asserts that "one of the most important of these is that it should be non-manual . . . or only manual in so far as it is necessary to perform personal services" (p. 114). With the same line of thought, Lieberman (1970) writes that "first among equals in the professionals' claim to uniqueness is preoccupation with a specialized skill premised on an underlying theory" (p. 55). This is not the type of skill that may be mastered at a week long training course, but rather a skill which is

measured by the probability that the uninitiated would not succeed at the assigned task with varying degrees of patience.⁵

⁵"Professionals," according to Hughes (1965), "profess" (p. 2). In the case of emerging professions, professionals often find themselves either performing functions which were previously performed for free or, as Goode (1960) points out, claiming the right to "solve" a problem which was formerly solved by another (p. 902). In the former case, the lay public will be extremely hesitant to pay for previously free services unless the emerging profession can convince the public as to the superiority of their services over the free services received. In the latter case, cries of "encroachment" from other more established professions may well be heard. An emerging profession such as speech pathology must be careful not to give the impression that the special skill which they possess is one which, as Lieberman states, "a housewife may learn at a one week training course" (p. 55). Intensive training programs, professional jargon, codes of ethics and so forth help in this regard. However, newer technologies often do, in fact, place previously "sanctified" areas of the profession within the reach of those with limited education and training. In more established professions, for example in medicine, technology is so complex, community sanction is so pervasive, and authority and status are so elevated that the profession need not worry in this regard. In a discipline such as speech pathology, however, an interesting paradox can emerge. This is seen clearly in an area such as remediation of articulatory difficulties. While the profession strives to reduce therapy time, to make therapy more efficient, and to standardize certain procedures, such "programming" of the therapy process can eliminate to a large degree the need for subjective "professional" decisions and leave administration of therapy to those possessing relatively limited training. Three possibilities are then presented. Professionals may continue to perform "programmed" tasks which fail to make use of their full training, professionals may abdicate responsibility in such areas (with the possible erosion of their professional base) or professionals may evolve to higher level competencies and expand the horizons of their profession while, at the same time, expanding their professional status and authority.

Professional Services: The Ethic, the Expectation, the Reality

The service orientation which a professional possesses is yet another factor which must be considered in a discussion of the professional/nonprofessional schism. Lieberman (1970) maintains that the professional preserves his neutrality against encroachment by taking the fundamental position that the skills he has to offer are actually, or at least potentially, of benefit to all. The professional contends that he desires to serve all to the maximum of his ability and that his desire is not mitigated by the size of his compensation.

Thorner (1942), in writing about the tenuous position which pharmacy occupies with regard to being a profession, asserts that the ambivalence of pharmacy's position rests in the juxtaposition of viewing the pharmacist as a skilled professional with a strong service orientation toward mankind and viewing him as a seller of commodities for profit. This "compromise" of the service ethic continues to be a matter of debate in professions considering whether to allow their members to sell therapeutic equipment in addition to offering services.

While the professional is quick to assert that service is foremost in his mind, even to the point where, as Greenwood (1957) points out, "the work life invades the after-work life, and the sharp demarcation between the work hours and the leisure hours disappears" (p. 53), one should look to those receiving services for an opinion. Business Week ("How Licensing Hurts Consumers," 1977) quotes two economists, J. Gaston and S. L. Carroll, with regard to the fact that high quality service is available from professionals, but only for high income individuals. This "Cadillac effect" requires those on low

incomes, who cannot afford the price of service, to go without or rely on low priced, unlicensed, "quacks."

May (1976) pursues the question of differences in client, professional, and bureaucrat service expectations. If these three groups share common expectations as to how professional service should be performed, May feels professionals will be responsive to clients. If they do not, then the responsiveness shown by a professional toward a client will vary with the professional's autonomy and the extent to which he and his client share expectations.

Lieberman (1970) believes that the "primary" motivation is one of service. He lists three separate motivations that blend to energize the professional: the service goal, the profit goal, and the desire for autonomy (p. 68).

Johnson (1972) indicates that one reason government mediation is often essential is to stress social service. Professionals may have a personal service commitment but may lack adequate perspective on the broad social consequences of the provision of services in general.

While agreeing in principle that government mediation with regard to service allocation may be practical, Moore (1970) does cite one advantage of leaving resource allocation to the vagaries of the open market.

Reliance on the market as a way of allocating professional and related services has the dual disadvantage that the need for services may not coincide with the ability to pay and the prospective client may not be able to judge among competing alternatives. Yet a somewhat open market and somewhat accessible and decentralized legal system has the distinct advantage of permitting new specialties to get established. (p. 185)

May (1976) contends that public bureaucracies are better equipped to redistribute advantages, so one might assume that the state bureaucracy is the best place to redistribute professionals.⁶ Finally, Lebell (1973) specifies a number of recent trends with regard to professionals and the services they provide. One such trend, he indicates, is a growing public sentiment that the needs of society are not being fulfilled by the various professions to the extent claimed feasible.

⁶ If one prerequisite to becoming a licensed (or certified, registered, etc.) speech pathologist was to have the state "place you" for your first year of work, certain advantages might accrue. Among these:

1. Resources would be allocated more evenly, giving credence to the claims of "service" as a prime motivator for speech pathologists.
2. Compliance with public laws, such as PL 94-142, would be enhanced.
3. Fewer people might enter the profession (which, depending on one's perspective, is an advantage or a disadvantage).
4. Neonate speech pathologists might be required to work with speech, hearing, or language disorders to which they would otherwise have very little exposure.
5. Instead of isolated rural positions offering lower salaries than more popular urban positions, the state could supplement rural salaries to make them potentially more attractive.

Obvious cries of "socialization" and "abridgement of 14th Amendment rights to life, liberty, and the pursuit of happiness" would be heard. Thus, the age old question of society's right (or obligation) to subjugate individual freedoms for the common good is again brought to the forefront. Or rephrased, do we have to limit professional autonomy to provide better allocation of resources? Johnson (1972), in writing of various forms of mediative control in England, states that

the state may attempt to ensure a desired distribution of occupational services through the medium of the state agency which is the effective employer of all practitioners who have a statutory obligation to provide a given service. . . . The effect of state mediation has been to extend services to consumers who are defined on the basis of "citizenship" rather than social origin or the ability to pay fees. . . . However, the major significance of this form of control lies not in the social composition of the consumers but in the creation of a guaranteed "clientele." (p. 77)

The Professional Culture:
Values, Norms, Standards, and the Career Concept

The professional culture, according to Greenwood (1957), is another characteristic which sets the professional apart from his nonprofessional counterpart. The professional's commitment, or calling, requires that he accept the appropriate norms and standards of his profession so that he can identify with his professional peers and the profession collectively. Greenwood states that if one were to choose the single attribute that most effectively differentiates the professions from the nonprofessions, the acquisition of a professional culture would be that attribute (p. 52). He goes on to affirm that the culture of a profession consists of its values, norms, and symbols. These terms are explained below.

The social values of a professional group are its basic and fundamental beliefs, the unquestioned premises upon which its very existence rests. Foremost among these values is the essential worth of the service which the professional group extends to the community. . . .

The norms of a professional group are the guides to behavior in social situations. Every profession develops an elaborate system of these role definitions. There is a range of appropriate behaviors for seeking admittance into the profession, for gaining entry into its formal and informal groups, and for progressing within the occupation's hierarchy. . . .

The symbols of a profession are its meaning-laden items. These may include such things as: its insignias, emblems, and distinctive dress; its history, folklore, and argot; its heroes and its villains; and its stereotypes of the professional, the client, and the layman. (p. 52)

Least one believe that each of these sociological terms is operationally defined in a similar manner by different authors, Becker (1962) writes of the symbols for a profession with a totally different perspective. His interpretation of symbols includes

1. recruitment of new members being tightly controlled,
2. entrance to the profession being strictly in the hands of the profession,
3. responsibility for approval and/or accreditation of the educational preparatory programs resting with members of the profession,
4. consideration of any member of the profession as being fully competent because of the dictums outlined in one, two, and three above (p. 36).

Another important idea with regard to the professional culture which is discussed by many authors is that of the "career" concept. The term "career," in its general usage, is employed only in reference to a professional occupation. Thus, one can talk about the career of a lawyer or physician, but one does not speak of the career of a plumber or carpenter. Most authors agree that the essence of the career concept is a distinctly professional attitude toward work which encompasses many of the notions previously discussed in this chapter. However, Wilensky (1960) defines a career as more than simply a professional attitude. Viewed structurally, he sees a career as, "a succession of related jobs, arranged in a hierarchy of prestige, through which persons move in an ordered, predictable sequence" (p. 554).⁷ It is possible that this microcosmic interpretation of the career concept may eliminate a number of important considerations.

⁷ If one does, indeed, view a career as "a succession of related jobs, arranged in a hierarchy of prestige, through which persons move in an ordered, predictable sequence," then one may find it very difficult to defend speech pathology as a career. The "typical" speech pathologist may move through a succession of related jobs, but often the "hierarchy of prestige" concept is lacking. This prestige factor may assume a relatively low priority when compared with factors such as geographical location, proximity of work to one's

Professional Goals: Sanction, Control,
Authority, Autonomy, Mandate, and Monopoly

Community sanction may be viewed as another key determinant in defining the parameters of a profession or of a professional. Related to this, of course, are the concepts of professional control,

residence, work schedule (availability of half-time positions, etc.), and type of disordered population serviced. In fact, the Occupational Outlook Handbook (U. S. Dept. of Labor, Bureau of Labor Statistics, 1974) states quite clearly that "opportunity for advancement, as in most health service occupations, is generally not an important consideration for speech pathologists and audiologists" (p. 517).

While the origin of the word "career" is from the French "carriere," meaning a racing course, thus Webster's (Webster's New World Dictionary, 1957) definition of a "career" as

1. originally, a racing course; hence, 2. a swift course, as of the sun through the sky; hence, 3. full speed,
4. one's progress through life. (p. 221)

modern usage has somewhat altered both Wilensky's and Webster's definition. Today when one asks, "Is he going to make it his career?" one is often asking more about an investment of time, effort, or money than about the new careerist's desire to proceed swiftly to the zenith of his profession. One might even question the efficacy of speaking in terms of a "zenith" for many service professions, contending that each service professional has his own personal goals and aspirations within the profession; goals and aspirations which may never fit the traditionalist's notion of "progress in one's profession." Marshall (1964) illuminates the problem more fully.

In the church or the army, in law or medicine, a man at the head of his profession is on top of the world. He admits no superiors. But many of these new semi-professions are really subordinate grades placed in the middle of the hierarchy of modern business organization. The educational ladder leads into them but there is no ladder leading out. The grade above is entered by a different road starting at a different level of the educational system. . . . Mobility between generations is increased, but mobility during the working life of one generation is diminished. That appears to be the direction in which things are moving today, towards the transfer of individual competitiveness from the economic to the educational world, from the office and workshop to the school and university. (p. 161)

professional mandate, professional autonomy, and professional monopoly. The interrelationship of these ideas is so complete as to make it virtually impossible to discuss one without discussing the others.

Greenwood (1957) writes that every profession "strives to persuade the community to sanction its authority within certain spheres by conferring upon the profession a series of powers and privileges" (p. 48). Some of the powers which a profession seeks to control are the power of control over its training schools and the power of control over admission into the profession. Comparable control, states Greenwood, is not to be found in a nonprofessional occupation.

Often a profession is not strong enough at the outset to gain from the community a full set of professional controls. It may then begin to circumspectly attempt to achieve a modest measure of public recognition via public dissemination of information regarding the profession and by attempting to prove to the community just how zealously the profession wants to protect it from fraud, menaces to the public health and, in some instances, itself. From a relatively weak grant of public power, the professional group may ultimately be able to push for state licensure by convincing the community that it is in the community's best interest to license the profession. Licensure as a form of control will be discussed at length in the next chapter.

Gilb (1966) summarizes well the professional's desire for control. Gilb views the professional as an individual who wants to create an abstract standard which is enforced by his peers (code of ethics) or by the state (licensure) which will stand between the individual

professional and those who might have arbitrary power over him.

Goode (1972) believes that one response to the threat of the community controlling the profession is the social control which the professional community exerts over its members. Failure to discipline one's own would result in both a loss of societal prestige and a loss of community autonomy.

Barber (1965), while affirming the importance of societal control and colleague control, stresses the need for self-controls.

. . . the requisite understanding is available in full measure only to those who have themselves been trained in and apply that knowledge. It follows that some kind of self-control, by means of internalized codes of ethics and voluntary in groups, is necessary. . . . Further controls on professional behavior exist, of course, in the informal agencies of public opinion and in governmental legal agencies. But these forms of social control are less important than in nonprofessional areas. (p. 18)

Gilb (1966) discusses the role of the professional association in attempting to achieve professional cohesion and gain control over the profession. The professional association, according to Gilb, desires this control in order to "make the profession's work more uniform and predictable and to check excessive intraprofessional competition" (p. 53). Professionals desire colleague control, as opposed to public, client, or employer control, not only over the profession but also over the conditions and the standards of the profession's work.⁸

⁸Employer control, as referred to by Gilb, is generally not considered by authors with the same intensity as are peer controls, community controls, legal controls, client controls, and self-controls. However, for the speech pathologist, employer control is often of considerable consequence. With approximately two-thirds of the currently employed speech pathologists working in the public schools, it is not surprising that many speech pathologists feel rather

Clients may exercise market controls directly by deciding whether to buy particular professional services and by selecting the services of particular professionals. Professionals, needless to say, feel great dismay at their vulnerability to these controls. May (1976), in a discussion of client control, makes the following observations.

1. Employer clients have more control over salaried professionals than consumer clients do.
2. Employer clients exercise less market control over professionals when the supply of professionals is smaller than the demand for their services.
(p. 13-14)

Moore (1970) affirms that professionals in strictly independent practice respond only to initiatives taken by clients. Thus clients

confused concerning the chain of command. Does one take orders from the chief speech pathologist or from the principal who directs the school in which the speech pathologist works? What orders does one accept from an "employer" (i.e., principal) who is not a member of one's own profession and whose primary concerns may not always be those of the speech pathologist and those he serves? Questions such as these need to be answered or at least discussed prior to actual confrontation. Moreover, the principle of unity of command, as discussed by Haimann (1973) and others, should be applied to the type of situation described above.

The uninterrupted line of authority from the administrator to the team leader assures that each superior exercises direct command over his subordinate and that each subordinate has only one superior to obey. This is known as the principle of unity of command. It is a principle which every administrator should follow while arranging line authority relationships. Unity of command means that there is one person in each organizational unit who has the authority to make the decisions appropriate to his position.
(p. 98)

have more control over professionals who perform services for a fee than over salaried professionals.⁹

How does a professional counter client controls and seek to extend his professional authority over the client? One means of doing so, suggested by Moore (1970), might be to have the professional convince the client that his particular problem is in need of a "team" approach. Thus, the professional may form a dossier on the client based on the belief that the client's problem is properly contextual and not an isolated one. In this way, according to Moore, the professional can begin to counter the control of the employing client and establish a professional control of his own.

It is apparent that many forces interact in the establishment of professional controls. Licensing is simply one of them. Lieberman attempts to take an overview of the problem, but the role of laymen today is, with regard to the regulation of some professions, vastly different from that described by Lieberman in 1970.

We seem to be at an impasse in the conduct of our public affairs. The people are not economically motivated to contest the market power of professionals; the legislatures are not politically disposed to establish necessary controls; the courts declare themselves constitutionally powerless to regulate often outrageous conduct. And the

⁹There is great potential for abuse here. At times, a speech pathologist in the employ of a client may become so overly sensitive and responsive to the wishes of the client that he violates professional ethics. For example, a speech pathologist may acquiesce to a client's demand for "stuttering" therapy although no problem exists. If, after counseling, the client continues to demand a formalized therapeutic program, the speech pathologist may rationalize his decision to proceed with unnecessary therapy by stating that if he doesn't provide the service, the client will look elsewhere.

general impotence is a psychological phenomenon, the fear of expertise being sufficient to deter laymen from accepting responsibility for modern problems. (p. 220)

Professional autonomy and professional authority are two prime considerations of those practicing professions. Autonomy, according to May (1976), refers to the institutional component of a professional's authority. It is quite different from authority which is legitimized by his training. The professional's authority comes forth in a one-to-one relationship with the client and Freidson (1968) asserts that when the professional clientele is unorganized and the number of professionals is small in relation to demand, professional authority is at its highest. It is fair to say that professionals working in private practice exercise their individual authority under conditions of increased autonomy. May (1976) makes the following statements relative to professional autonomy.

1. When an organization's goal achievement requires their full cooperation, professionals will enjoy more autonomy.
2. Managers who are professionals may be more sympathetic to the professionals' desire for autonomy and may permit them more self-determination.
3. Professionals who are in demand have more autonomy than those who are not.
4. . . . professional autonomy is not a function of the amount of control. Rather, as professional autonomy increases, so does the professionals' ability to determine the content of the administrative controls. (pp. 17-21)

Moore (1970) notes that while autonomy may be reduced by licensing in other areas, such is not the case with professions. Generally, among professionals, judgment tends to remain within the professional fraternity.

Lieberman (1970) believes that the extension of professional autonomy is a dynamic act. The professional promotes the assertion that all within his realm belongs to him. This belief is generally promulgated through the professional association with the results that the dominion of the profession is increasingly expanded to encompass the social aspects of the discipline.

Allied very closely with the concept of professional autonomy is that of professional mandate. Hughes (1958) comments frequently on this concept.

Many new and some old occupations have sought for themselves the envied status of *profession*; some of them succeed in gaining that esteem, that broad license to control their work and that social mandate over affairs pertaining to it that the term *profession* connotes. (1958, p. 7)

An occupation consists, in part, of a successful claim of some people to *license* to carry out certain activities which others may not, and to do so in exchange for money, goods, or services. Those who have such license will, if they have any sense of self-consciousness and solidarity, also claim a *mandate* to define what is proper conduct of others toward the matters concerned with their work. (1958, p. 78)

License, as an attribute of an occupation, is ordinarily thought of as legal permission to carry on a kind of work. . . . Professions also, perhaps more than other types of occupations, claim a legal, moral, and intellectual mandate. Not merely do the practitioners, by virtue of gaining admission to the charmed circle of colleagues, individually exercise the license to do things others do not do, but collectively they presume to tell society what is good and right for the individual and for society at large in some aspect of life. (1958, p. 79)

Thus, a profession seeks to insure its collective authority and autonomy by convincing society as to the validity of its mandate and the benefits of internal control (even if such control appears to be issuing from without). Once a profession successfully exercises a

mandate, once a profession can claim to monopolize expertise in a particular area, then, as Lieberman (1970) points out, professionals can achieve by indirection what anti-trust laws prohibit.

Professionals cannot privately get together to limit the number of competitors by refusing to employ them or by making it difficult for the competitor to compete, so they provide laws from state legislatures which authorize them to achieve remarkably similar effects by quasi-public regulation. To this end they are aided even by the federal government. (p. 138)

When this right to practice a particular profession depends on the approval of some agency, and when official approval is based on factors related to the occupation, Lieberman believes that the profession has established the foundation for the exercise of monopoly power. Moore (1970), however, states that not one of the older, more established professions has been able to command a complete monopoly with regard to its claimed field of competence.

Greenwood (1957) writes of the "monopoly of judgment" which is achieved by client subordination to professional authority. When an occupation is undergoing the process of professionalization, one of its primary aspirations is to acquire this monopoly. Many authors feel that when this monopoly of judgment is achieved, the professional has a license to deviate from lay conduct in action and in thought with regard to the matter which he professes.

Barron (1966) elaborates on two cases in which the acquisition of monopoly powers may be beneficial to both the buyer and the seller. One of these situations is the "natural monopoly" case while the other is referred to by Barron as "the case of no second chance." In the first instance, it becomes apparent that one producer can supply the

entire market with a product or service at a lower real cost, using fewer resources, than can several producers. In a "natural monopoly" situation, Barron feels the existence of more than one producer will have the effect of

1. providing each seller with excess capacity and/or,
2. providing ruinous competition to the point where sellers, attempting to cut costs, may reduce the quality of the product or service (p. 642).

The "no second chance" monopoly is applicable in situations where the assumption that a consumer will learn from his mistakes is not a valid one. In some situations, errors cannot be rectified because the consumer may not be around to correct them. Such may be the case from eating adulterated foods or drinking methyl alcohol sold as grain alcohol. Barron believes that the public licensing of businesses and professions contains elements of both "natural monopoly" reasoning and "no second chance" reasoning (p. 642).

Professional Abuses and Conflict of Interest:
No Wonder the Public Is Angry

Without client confidence, the profession could not maintain its monopoly. A monopoly can be abused.

The professional group could peg the price of its services at an unreasonably high level; it could restrict the numbers entering the occupation to create a scarcity of personnel; it could dilute the caliber of its performance without community awareness. . . . (Greenwood, 1957, p. 50)

If the profession, in the eyes of the community, abuses its monopoly, then the monopoly may be revoked or at the very least reviewed. Just what constitutes "abuse" is often unclear, and this topic will be discussed at length with regard to professional licensing in Chapter 2.

However, to briefly illustrate that the potential abuses cited by Greenwood in the above quotation are indeed realistic, further elaboration will be undertaken at this time.

Greenwood's first point, that the professional group may peg the price of its services at an unreasonably high level, is expanded upon by Consumer Reports ("Consumers Seek Public Voice," 1976). Writing with regard to the Virginia State Board of Examiners in Optometry enforcing a statute prohibiting optometrists from working for, or leasing space in, commercial establishments, Consumer Reports concludes:

The powers of licensing boards are so far-reaching that there's a clear potential for abuse. Whenever a board restricts entry into a trade or profession, competition is reduced and existing practitioners can command higher prices for their scarce services. Strict curbs on professional advertising serve to reduce price competition. (p. 372)

Greenwood's second point, that the professional group could restrict the numbers entering the occupation to create a scarcity of personnel, is addressed in an article published in the January 8, 1975, Wall Street Journal. In 1973, 2,149 aspiring general contractors took the Florida Construction Industry Licensing Board's examination to test their competence. Each of the 2,149 examinees failed the examination, with the resulting effect that some Florida state legislators suggested that "the total failure had been a calculated effort by the board to limit competition by barring new entrants to the field" (Montgomery, 1975, p. 1).

Larson (1977) also views the manipulation of licensing examinations and the artificially stringent standards for admission to

training with suspicion. Since professionals with vested interests in maintaining the price of services and the prestige of their profession are the very individuals who develop the standards for both training schools and licensing boards, such abuses are likely to continue. The primary question generated by Larson, however, is for how long this reduction of supply can be publicly justified by the "pure objectivity" of meritocratic standards, especially when the cost of training also tends to increase (p. 52).

The fact that a profession can dilute the caliber of its performance without community awareness, Greenwood's third point, can be reflected in numerous ways. "Grandfathering" and continuing education are but two.

"Grandfathering," as used here, refers to establishing a way in which all persons who were practicing a profession prior to enactment of a law can obtain a license without having to meet the requirements which are specified in the law. Goode (1972) illustrates the effect of grandfathering on the caliber of professional service.

. . . when the standards for entrance are raised substantially. This is, in effect, an announcement that certain older members of the professional community have not been adequately trained. However, allegiance to the professional collectivity outweighs the service obligation to the public and "grandfathering clauses" lessen the severity of that indictment. (p. 25)

Street (1977), writing about lay participation on state licensing boards, quotes California Department of Consumer Affairs Deputy Director Michael Krisman.

They [California marriage and family counselors] go to the legislature saying "You've got to regulate us, you've got to protect the public from all these quacks." Then they grandfather in all the quacks they complain about. (p. 310)

Johnson (1972) goes one step further when he comments:

Charlatanism and quackery are . . . a creation of professionalism and not the cause of it. That is to say that periods in which it is claimed charlatanism is rife and needs to be stamped out are just those periods when an occupation is attempting to establish or struggling to maintain a monopolistic position. (p. 57)

The lack of a plan for continuing education can certainly adversely affect the performance of a professional, generally without the community's knowledge. Although individuals often must meet rigid requirements to acquire a license, licensed professionals may not have to indicate that they have maintained their skills at a satisfactory level or show an understanding of new technology.¹⁰

¹⁰ While the issue of continuing education in the disciplines of speech pathology and audiology will be discussed in a subsequent chapter, it is of interest to note here that continuing education is not required to maintain one's ASHA certification, nor is it required to renew one's license in the vast majority of those states licensing speech pathologists and audiologists. As long ago as May 1973, the American Speech and Hearing Association concluded:

There is a strong feeling among many in the profession that there should be an inclusion in the licensure bill of a continuing education clause. The desirability of having licensed professionals update their level of knowledge and their clinical skills is obvious to both the CGR [Committee on Governmental Regulations] and to most legislators. However, the question of what constitutes adequate continuing education for our profession is presently being considered by several ASHA committees. (ASHA, 1973a, p. 20)

Apparently the "jury" is still deliberating, and comments such as the following are unlikely to aid in bringing about a positive verdict.

To change from continuously respected certification to mandatory recertification with imposition of life-long requirements may connote the same impact of dishonor to the offended graduate or professional as would a university that imposed lifelong requirements on all its graduates with the threat of withdrawing recognition of its awarded degrees. After years of costly preparation . . . coercion by one's professional organization -- or by any governmental or other body -- to matriculate in any manner with threat of loss of professional livelihood may be interpreted as a form of extortion. Therefore, for ASHA to withdraw its commitments

Such abuses or potential abuses are often epitomized in the conflict of self-interest versus community interest. Barber (1965) writes that since knowledge provides powerful control over nature and society, and since a profession evolves around a systematized body of abstract knowledge, that knowledge should be used primarily in the community interest. Hughes (1958) does not believe that individual self-interest should be wholly neglected in professional dealings, but rather should be subserved indirectly.

However, critics are increasingly coming to view the profession as a group of individuals whose primary function is one of self-interest, namely self-perpetuation. Lieberman (1970) contends that, while the professional will publicly proclaim that his only function is to perform a service, the service function is incidental to the primary purpose of the profession. This primary purpose is to maintain the system which supports the profession. Lieberman states:

Maintenance of the legal system as construed by lawyers is the principal function of the lawyer. . . . What degrades the profession degrades the legal system. . . . What is not good for lawyers is bad for law. In short, lawyers are the legal system, and doctors the public health. Professionals might deny this, but they take actions based on it, and the contradiction is serious. (p. 5)

In a latter portion of his book, Lieberman further decries the idea of the public interest notion.

and prerogatives of certification may pose a genuine threat to its integrity and the integrity of the profession. (Becker, 1974, p. 352)

Such a comment indicates an acute awareness of the need for integrity on the part of the professional association, and an appalling lack of awareness of the need for integrity on the part of each professional toward those whom he serves.

When a highly specialized group speaks out in a matter that directly concerns its economic well-being by saying that it has the public's interest at heart, it is engaging in the highly developed American art of bombast -- a subject worthy of more serious study than it has been given. (p. 146)

Finally, Barron (1966), with regard to self-interest and community interest, indicates that community interest is often compromised because the profession being licensed controls its own licensing function. Moreover, if the court is of the opinion that the state legislature believes a licensing law will have any relation to the public interest, the court will generally not overturn it (p. 657).

It is not surprising, then, that public sentiment has turned somewhat against professionals within the last several decades. Lieberman (1970) comments on this widespread ambivalence toward the professional in our country by indicating the paradox which exists between the desperate need for specialists and the "uneasy belief in the stupidity, inefficiency, even cupidity of professionals" (p. 62). Hughes (1958) contends that in the hearts of many laymen is an aggressive suspicion of all professionals which can occasionally flare into fanatical anger. Some professions are engaging the services of public relations firms to help eradicate not only the obvious manifestations of suspicion and anger, but also to locate and dispose of the more latent and perhaps more chronic feelings of suspicion against those who are licensed to perform services for them.

Codes of Ethics: The Professions State Their Case

While the retention of public relations firms to protect and promote the public image of a profession may be fairly recent, the promulgation of professional codes of ethics is not. These codes allow the

profession simultaneously to retain power and to present a collective image of dignity and honor. They serve to protect the profession from the pervasive fear that the public will lose confidence in the profession. This fear is a very real one, for professions are not simply discarded by a suspicious public; rather they are subjected to "outside" controls which will assure the public that they are performing their functions more capably.

Furthermore, such codes tend to reinforce the homogeneity which follows from uniform training within a profession and from licensing laws (Gilb, 1966). Such codes were developed in many professions toward the beginning of the twentieth century with the explicit rationale that an honest community of professional practitioners could be fashioned. It was felt that professionals would not abuse their positions of public trust if they knew that suspension or expulsion from their professional association was a means of sanctioning them.

Thus, professional associations devised codes of ethics which amounted to private systems of law. Moore (1970) affirms that these are characteristic of all formally constituted organizations with the exception of two notable features which are not prominent in the administrative regulations of public or private bureaucracies.

1. The codes highlight proper relations with clients or others outside the organization rather than procedural rules for organizational behavior.
2. Codes are also commonly understood as not self-enforcing. In the bureaucratic setting, regulations are supposed to be monitored, and discipline imposed, by hierarchical superiors. The professional association, being nominally a society of equals, must adopt other procedures; normally these will rest primarily on an internal, quasi-judicial body commonly known as a "committee on ethics" which will review complaints and, if necessary, recommend disciplinary action. (p. 116)

Professional codes of ethics are generally based on a dedication to truth, justice, or some other abstraction that aids the profession in its attempt to justify the power and autonomy granted it by the lay community. Such codes retain the notion of an inherent morality. Unethical behavior is not simply improper for practical reasons, but for basic moral reasons as well. However, Lieberman (1970) contends that morality is more likely to be legislated by majority vote (p. 83).

Turner and Hodge (1970) believe that ethical codes, whether written or unwritten, allow for a substantial area of equivocation outside of the ethical rules. Because codes of ethics include relatively few prescriptions and/or proscriptions, and because such codes have generally high levels of abstraction, there is often a great deal of ambiguity at the level of action (p. 29).

Marshall (1964) writes that ethical codes are centered on the conviction that a relationship of trust is present between the professional and the client which is not evident in dealings between a buyer and a seller. Such codes are necessary due to the impossibility of drawing up and enforcing a contract which would stipulate just what the client is to receive from the professional. Marshall specifies two reasons for this.

1. One is that professional service is not standardized. It is unique and personal.¹¹

¹¹The veracity of Marshall's statement regarding the unique and personalized nature of professional service has been challenged by a number of authors. Moore (1970) states:

Marshall asserts that professional service is "unique and personal." That is a very interesting and conspicuously false notion. If every professional problem were in all

2. [The second reason] is the ignorance of the client. He hardly knows what to ask for, let alone how it can be provided. He must surrender all initiative and put himself in his lawyer's hands or under his doctor's orders. (p. 148)

Greenwood (1957) bifurcates a code of ethics into its formal and informal parts. He views the formal portion as the written code to which the professional usually swears allegiance as he is admitted to practice. The informal portion consists of an unwritten code which, according to Greenwood, nevertheless carries the weight of the more formal pronouncements in the written code. Discipline consists of subtle and not-so-subtle colleague pressures which may be reflected in consultation and referral practices. Greenwood comments that "the consultation-referral custom involves professional colleagues in a system of reciprocity which fosters mutual interdependence. Interdependence facilitates social control . . ." (p. 51).

More extreme forms of discipline can occur via professional

respects unique, solutions would be at best accidental, and therefore have nothing to do with expert knowledge. (p. 55)

In the practice of speech pathology, as well as the practice of many other professions, it would seem fair to say that the practitioner amalgamates general principles of the discipline with unique aspects of his own training and personality to provide personalized service. All problems are unique, but just to what degree depends on one's viewpoint. The client believes his problem to be truly unique. He suffers, and from his perspective the professional treats his unique emergency with callous routine procedures. However, the professional's ability to deal adequately with the situation may be the result of having dealt with thousands of similar cases. Perhaps the enlightened professional is one who can ascertain and investigate what is unique in the client, even if the problem which presents itself is routine.

association censure or, in extreme cases, barring of the offender. Goode (1960) notes that as an occupation becomes more professionalized, the norms of practice (code of ethics) enforced by the profession are more stringent than legal controls. Wilensky (1964) contends that in some cases a formal code of ethics may appear during the initial stages of the push for professional status. However, his research, which examined a total of 13 established professions or professions in process, indicates that in ten of the professions under consideration the formal code of ethics came in the final stages of professionalization (p. 145).

The Professional: Relationships with Clients,
Colleagues, and Trends of the Future

The professional's relationship with his clients and colleagues deserves further elaboration than can be given solely in a discussion of codes of ethics. The intermix of these relationships is at the very heart of the licensing question, a question which will be explored in subsequent chapters.

Greenwood (1957) calls attention to the need for emotional neutrality which provides yet another disparity in the services offered by professionals as opposed to those offered by nonprofessionals. Whereas a nonprofessional may withhold services to customers for a number of reasons, the professional is obligated to provide service to whomever requests it. The professional is motivated to a greater extent by what Greenwood terms "the impulse to perform maximally" (p. 50) and to a lesser extent by tangible reinforcements. The nonprofessional can compromise with the customer, diluting the

quality of that which he offers the customer in order to correspond to that which the customer will pay. Theoretically, such is not the case in professional/client relationships.

A nonprofessional occupation has customers; a professional occupation deals with clients. The difference, according to Greenwood, lies in the fact that the customer shops until he finds the quality and quantity of services and/or commodities he desires at the price he is willing to pay. His freedom of decision lies in the fact that he has the capacity to view his own needs and the ability to judge the worth of competing services or commodities which will satisfy them. This is not true in the professional relationship. As Moore (1970) states:

The client is in no position to judge competence, except, possibly, at the extremes, and even there his view may differ from that of the expert; what appears to be extreme competence may appear to colleagues as mere showmanship, and what appears as extreme incompetence may appear to colleagues as reasonable conduct in a situation fraught with difficulties and possibly bad luck. (p. 111)

The viewpoint shared by Greenwood and Moore is not a universally accepted one. More recently, a number of authors have attacked the efficacy of occupational licensure on a number of fronts. One argument used by those favoring delicensure or alternative forms of occupational/professional control is that the client is not in the rather helpless state described by Moore. Barger (1975) contends:

The customer himself should be the supreme judge of who is competent to perform the service he requires. If the members of a trade or profession believe that certain standards or practices are considered desirable in their field, they ought to have the right to publicize this fact and even to urge customers to accept such standards

and practices before making service commitments.
(p. 198)¹²

May (1976) ascertains three properties of the professional/client relationship. These are

1. the extent to which colleagues supervise a professional's performance,
2. the extent to which clients exercise market controls over the professional,
3. the extent to which an agency exercises administrative (hierarchical) controls over the professional-client relationship. (p. 7)

With regard to colleague control and the professional client relationship, May writes that collegial control is greater with salaried professionals working in a bureaucratic setting than with fee-for-service professionals working in isolation. Professionals working under greater collegial control will generally tend to keep abreast of new technical advances in their field to a greater extent

¹²It is interesting to note that Barger uses the term "customer" throughout, although talking about consumers of professional as well as nonprofessional services or commodities. Such viewpoints seem to assume that if professions educate the public as to the standards that they (the collective profession) expect from their members, the public will be able to separate "the wheat from the chaff" with regard to those practicing the profession who can adequately fill the requirements of the customer/client. It is difficult to visualize the individual with an excruciating toothache, an emotionally-laden stuttering disorder, or a prescription for a drug to remedy a severe bleeding ulcer as taking the time to study the "standards or practices [that] are considered desirable in [a given] field" and to decide whether or not a given professional meets such standards before "making service commitments." The profession as a collectivity can urge the public to accept only a high level of practice, but those in pain, those in grief, those with low intelligence, those who are illiterate, and those who are apathetic are, most likely, going to receive an acceptable level of service only if standards of service are controlled at some level above that of the consumer. Public education as an alternative to licensing will be discussed more fully in Chapter 2.

than more isolated professionals (p. 11). Moreover, May sees the balance between a professional's loyalties to his client and to his profession as being affected by the nature and amount of experienced colleague interaction.

Wilensky (1964), in order to focus upon the relationship between colleague and client control, constructed an index of client orientation. The results of his research confirm the conflict between client and colleague orientations, and his findings imply that "a client orientation will be an increasing threat to professionalism" (p. 155). However, insofar as self-employment fosters a client orientation, the professional segments of the service sector are becoming less vulnerable as they become more salaried.

Greenwood (1957) discusses colleague relationships in terms of behavior that is cooperative, equalitarian, and supportive. Out of place are the blatant competition for clients and the "in-house" attitudes toward discovery and invention found in the industrial and business world. Gilb (1966) writes:

Unity requires that competition be curtailed. Among these rules a cardinal principle has been "Thou shalt not compete unduly with thy fellow professionals." The rules pertaining to advertising are quite specific. . . . (p. 67)

Rueschemeyer (1972) contends that all professions have norms restricting or prohibiting advertising. He outlines four ways in which these norms relate to the structure of social controls in the professions, the third and fourth point bearing heavily on the question of colleague relationships.

1. The restriction of advertising serves to emphasize symbolically the subcultural distinction between the professions and the business world. . . .
2. Advertising would presuppose that the customer can legitimately make up his mind about the qualities of the various members of the profession.
3. Advertising would increase competition among the professionals who under pressure might give in to temptations to deviate from professional norms.
4. The restriction of advertising serves to make the members of the profession concerned with the performance of their "brethren" since it limits the possibilities to excel individually. (p. 28)

Another facet of the collegial relationship is that of peer review. Hughes (1958) asks:

Who has the right to say what a mistake or failure is? The findings on this point are fairly clear; a colleague-group (the people who consider themselves subject to the same work risks) will stubbornly defend its own right to define mistakes, and to say in the given case whether one has been made. (p. 93)

Several rather recent trends have developed in the area of a professional's relationship with his colleagues and with his clients. Lebell (1973) writes of the increasing incidence of professionals joining together to form firms (p. X). Hughes (1958), foreseeing the same trend developing, finds that although professions are apparently prospering under this arrangement, there is the possibility of endangering the supposedly simple relationship of professional with client (p. 132).

Another seemingly undeterrable trend is that toward the use of the paraprofessional. Gartner and Riessman (1972) write:

Contact with paraprofessional co-workers generally tends to increase the sensitivity of the professional to the demands of the community. In addition, the paraprofessional brings the values and needs of the consumer directly

into professional practice. Of necessity, the professional becomes reoriented to the consumer in new and significant ways. The paraprofessional also affects the professional by raising new and constructive questions about how the various agencies operate. In this sense, the paraprofessional functions as an observer/monitor of the professional within the work system. He also embodies new styles of work and new ways of relating to people, which to some extent may rub off on the professional. (p. 273)

A third major trend in the professional's relationships with those whom he serves and with whom he works is the trend toward client organization. Lebell (1973) believes that the client tends to feel that the only time the practitioner spends concerned with his problem is that time spent directly with him. The consumer does not take into account practitioner time involved in searching, learning, examination of "dead ends," and what Lebell refers to as "subconscious percolation" (p. 178). Thus, clients are increasingly demanding that professionals be held accountable for their time. This call for professional accountability as to how services are performed and time spent, and the desire on the part of clients to share with the professional the responsibility for resource allocation, are the two chief factors May (1976) sees in the move toward client organization (p. 24).

Certainly the three trends discussed briefly above are not inclusive of the current trends taking place in professional-client-colleague relationships. For example, the trend toward specialization of professional services constitutes another broad area of investigation. The discussion presented herein is provided solely to give the reader some insight into a few of the factors involved in the complex of relationships that emerge when professionals deal with clients and/or fellow professionals. Some of these relationships

will be discussed with increased specificity as they relate to the licensing of professionals in general and the licensing of speech pathologists and audiologists in particular.

Professional Associations: Their Inception, Relationships
with Government, and Rationale for Existence

The phenomenal growth of professional associations, both in terms of numbers and influence, has had a profound impact on the professional and those he serves. Moore (1970) asserts that such mundane matters as the terms and conditions of employment often led to the formation of a self-styled professional association, but that more strategic considerations such as exclusion of incompetents, protection of the honorable monopoly, criteria for admission to the occupation, and maintenance of performance standards also prompted the birth of many such associations.

Gilb (1966) reports that many national organizations were founded by only a handful of men, with memberships remaining small for years. She continues:

Limited membership of professional associations at all geographical levels was partially due to their deliberately exclusive character. Although all associations wished to have enough members to operate successfully and to substantiate a claim to represent the whole profession, most were organizations of the "elite" who wished to "elevate" their respective professions and felt they could do so only if they confined association membership to the "better" members of the profession. (p. 31)

Gilb also notes that, within their self-imposed limits, early associations laid the foundations for much of what was to be accomplished in the future. They established professional libraries, pursued the problems of professional education and professional standards, and

created standards and channels of communication that would later provide a unifying force for the profession.

Moore (1970) believes that the early formation of professional associations provided "the lever with which the gap between the ideal and the actual could be narrowed" (p. 59). This lever, according to Moore, was government cooperation by means of the various licensing statutes, statutes which would aid in the effort to standardize performance.

However, government cooperation and aid were sometimes slow in coming. In the early portion of the twentieth century, the professional organizations' ties with government actually lessened to some extent, and it was becoming apparent that professional associations were, in Gilb's (1966) words, "mobilizing independently to influence state government from the outside" (p. 41). Yet professions began to realize that it was becoming increasingly necessary to use the sanctions of the state to accomplish such tasks as screening, disciplining, and presenting the proper public image. It is important to note, according to Gilb, that "they [the professional associations] turned to state action willingly, not reluctantly, because they could not control purely through private sanctions either their own members . . . or their rivals and competitors" (p. 41).

Today professional associations tend to rely to a great extent on government -- primarily that of the state -- to provide them with the recognition, tools, and sanctions to control the circumstances of their work. Gilb (1966) contends that when professionals seek governmental aid, they do so with the following aims in mind:

1. to control preparation, entry, and practice;
2. to maximize favorable public opinion and so obtain guarantees of freedom on the job;
3. to rationalize work;
4. to maximize economic returns;
5. to facilitate their work. (p. 135)

Professional associations have however, in the eyes of some, become appendages of state government. The problem, as viewed by many writers, has become not one of "How can government help the professions?" but one of "How can government control the professions?" Professions, often through their professional associations, have been allowed to govern themselves and, as Lieberman (1970) states, "where the state ends and the 'private' association begins is increasingly difficult to determine" (p. 233).

While it is convenient to blame the professional and his association for corrupting the lofty ideals which they promulgate, the blame for controlling themselves to their own advantage (and not to that of the public) may not reside solely in the private sector. It is true that when the sellers are given power to decide what is in the buyers' best interest, a situation occurs which is untenable to many in the lay community. However, it may be that the attitude of state governments toward control has fostered a series of abuses. This laissez-faire posture is reviewed by Lieberman (1970).

We are seeing laissez-faire at its last outpost. That wispy "principle" is applied to private associations and the government is deterred. Not only is there economic justification for leaving the professions to themselves, there is a political one, they say, and nothing is more sacred in America than that combination. But it is a short step from piety to blasphemy and it

has already been taken. For laissez-faire was always grounded on the belief that no one man or group could significantly influence price or production in the economic realm. That this assumption is untenable in the professional sphere is manifest. And the right to be free from political intervention by public government similarly rests on the premise that the group does not have governmental power. This power the professionals do hold. (p. 177)

Lieberman, in a later portion of his book, indicates that it is imperative a line between public and private be drawn to impose responsibilities on those who wield power over the lay community through control of the professions.

The professional association, needless to say, is quite capable of justifying its existence. As Marshall (1964) points out, professional associations attempt to guarantee the expertise of their members, impose a code of ethics which, among other things, requires that the professional give only his best at all times, and protect their field from encroachment by "outsiders." While "protecting their field from encroachment" may be viewed by some as a euphemism for "creating an artificial scarcity of personnel," nevertheless such associations undoubtedly serve the public interest to some degree even if such service is auxiliary to the achievement of less humanistic goals.

Gilb (1966) sees a primary goal of the professional association as achieving cohesion. Cohesion is necessary for control, and control is necessary for cohesion. At the same time the professional association is attempting to define the profession's boundaries and establish the profession as a distinct entity, separate from the rest of the work force, it is also attempting to integrate the profession into the work force and into the pattern of community life.

Moore (1970) states that perhaps the major rationale for the professional organization is "precisely in dealing with various interests and publics outside the professional group, as distinct from maintaining communications within a self-contained community" (p. 160). When one realizes the extent to which professional associations have attempted to exert political pressure and the extent to which they "have gradually turned from a naive and indirect to a realistic and direct approach to power, and . . . have turned from irregular, amateur lobbying to lobbying on a year-in, year-out, professionalized basis" (Gilb, 1966, p. 143), one is most tempted to agree wholeheartedly with Moore's statement. Moore (1970) himself writes about the efforts of many professional associations to directly influence the course of legislation, stressing that such associations are generally tax-exempt and, as such, are not supposed to devote a sizable amount of their resources toward endeavoring to affect the outcome of legislation (p. 165).

Lebell (1973) asserts that the tax-free status enjoyed by such associations helps to preserve the status quo. However, this point alone does not adequately convey the nature of Lebell's view of the professional association.

Professional societies tend to become hydra-headed monsters in grappling with the variety of functions they assume. Consequently they have difficulty keeping pace with the need for constantly changing interaction between the profession and society. A large, multi-tiered committee structure provides a title for any member willing to serve but such a structure thereby precludes dynamic response to new needs. Revenue from advertisers in the professional journal and from "trade-show" participants in technical meetings has a not inconsiderable impact on society's policies. Finally, there

is the constraint of preserving the society's tax-free status, which practically provides a blanket rationalization for avoiding change or even controversy. (p. 23)

The role of the professional association, and more specifically the role of the American Speech-Language-Hearing Association, with regard to licensure and other forms of control will be discussed throughout the remainder of this text. The foregoing discussion has provided an overview of the variety of activities which are carried on by these associations and, more importantly, the varying perspectives from which these activities can be viewed. Once the complexity of the issues is understood, one can form a base from which to examine the professional association and its role in the control of the profession it represents.

Emerging Professions and New Careerists:
Nobody Said It Was Going to Be Easy

While the general discussion presented earlier relating to the "process of professionalization" attempted to delineate some of the essential attributes of this process, more needs to be said at this point with regard to the emerging professions and the professionals who serve in them. Barber (1965) defines the emerging or marginal profession as "an occupation which is not so clearly high or so clearly low on both the first two attributes of professionalism -- generalized knowledge and community orientation -- that its status is clearly defined by itself and others" (p. 22). Such an occupation is conceived, according to Moore (1970), when the value placed on certain work tasks or activities becomes separated from other, similar tasks, and the distinction or separation becomes publicly recognizable. Rules to

regularize these activities soon follow, and with the genesis of differential activities and normative patterns, a new occupational role is formed. While there is a lack of homogeneity with regard to community orientation and the amount of knowledge possessed by members, the "elite" are clearly professional and these individuals take the responsibility for the advancement of professionalism in the discipline. Inadequacies in the profession are noted by those at the forefront; however such inadequacies are often compared with those experienced in the formative years of what are now well established professions.

Wilensky (1964) notes that, in general, university training schools have appeared before the creation of national professional associations in the more established professions. The reverse pattern is more typical of newer emerging professions (p. 144). Wilensky also indicates that at some point the emerging profession is likely to change the name of the occupation. This change may help to reduce identification with the previous, less professional occupation.¹³

¹³Wilensky's point is well taken, although other reasons than simply reducing an emerging profession's identification with a previous less professional occupation may precipitate the change. A profession may attempt to secure public acceptance of a name change that tacitly implies that the profession has expanded its horizons, that it now has assumed additional status or come to the point where it sees itself as involved in a process rather than a simple act or series of acts.

The term "correct" suggests the commission of an act or number of acts which makes something wrong into something right. Thus, the term "speech correction" indicates that one who performs this task sees something wrong and makes it right. Not only is the term "correction" rather static, but it also brings to mind such synonyms as "reparation," "reprimand," and "punishment." The term "therapy" is much more dynamic, bringing to mind a process or system. Therefore the speech therapist is seen as engaging in the healing arts, as being interested

Elliott (1972) believes that professional titles indicate that new careerists are members of a distinct occupational group which is associated with the performance of some set of services or tasks.

Elliott sees such titles as being relatively specific and he asserts that around these titles a definite set of expectations and stereotypes develops. Barber (1965) writes that rather early in the development

in the rehabilitation of those with speech/language disorders and not with simply "fixing" the speech of the disordered person, much as a mechanic "fixes" a flat tire. People who "fix" are not professionals.

While the term "speech therapy" expands, the term "speech pathology" further expands and also elevates. "Pathology" encompasses a professional interest in more than just rehabilitation. Few would dispute that speech therapy involves a process or systematized approach to help those with speech/language difficulties. However, speech pathology is cerebral. It implies long study and minute examination. Like the term "therapy," it implies a process, but a much higher level process. The therapeutic process is seen as distinctly practical, the process or processes involved in pathology are viewed as abstract, and this sense of abstraction tends to further elevate the professional in the eyes of his client. That the term "pathology" is most often associated with medicine, one of the most prestigious professions, certainly cannot help but give many the idea that the speech pathologist is, in reality, a "speech doctor."

Today, some within the field assert that further expansion is necessary. The term "communicologist," some believe, would indicate that the speech pathologist is not simply interested in the study of "disease" processes and their reversal, but rather is an expert in the entire field of communication. Conversely, others within the field are advocating labels which are much more specific as to one's area of specialization. Thus, the "aphasiologist" is more interested that one know he is an expert in aphasia than that his knowledge encompasses the whole spectrum of communication. Likewise with the "language pathologist," although it would appear that a reading specialist could also lay claim to this label.

For the reader who is interested in a more complete listing of suggested names for professionals who function within the realm of speech-language pathology and audiology, Asha magazine ("Speech Language Pathologist," 1978) has almost 100 such titles, ranging from aphasiologist to voxologist. For the practicing speech pathologist, such a listing may be indispensable for learning who one's colleagues are.

of the emerging professions the leaders of the profession establish titles, such as "fellow," as an incentive for the less professional to become more so.

However, this takes time because, as Hughes (1958) states,

many people in the occupation do not have the full new training, and because those who have power of appointment to places do not fully accept the occupational group's right to say who can be hired for the work. The professional group will go through a process of self-consciously studying its work and deciding what functions are really professional and what can be delegated to nonprofessional or less-than-professional people. (p. 135)

Not only is the question of what to delegate important to the new careerist, but so also is the question of professional role boundaries important. This question involves the acceptance of work delegated from above. May (1976) points out that new careerists may become "specialists in dirty work" (p. 35) if professionals are allowed to use them in that capacity. One of the more easily identifiable sources of antagonism in hospitals, according to May, is the feeling among many new careerists that the physician constantly calls upon them to do his "dirty work" in the name of the role of healing the sick, although none of the prestige, autonomy, or monetary benefits filters down to their level. However, when new careerists are in short supply, they tend to redefine their functions upward while at the same time passing their dirty work on to a lower echelon (Wilensky, 1964, p. 144). Hughes (1958) comments in this regard.

Actually in the medical world there are two contrary trends operating simultaneously. As medical technology develops and changes, particular tasks are constantly downgraded; that is, they are delegated by the physician to the nurse. The nurse in turn passes them on to the maid. But people and occupations are being upgraded within certain limits. The nurse moves up nearer the

doctor in techniques and devotes more of her time to supervision of other workers. . . . New workers [new careerists] come in at the bottom of the hierarchy to take over the tasks abandoned by those occupations which are ascending the mobility ladder. Others come in outside the hierarchy as new kinds of technology find a place in the medical effort. Satisfactory definitions of role for these new people are notoriously lacking, and that in a system in which rigidly defined roles and ranks are the rule. (p. 73)¹⁴

¹⁴Defining the role of the speech pathologist in such a rigid system as described by Hughes can be particularly difficult. Speech pathology is one emerging profession with at least three distinct systems into which it must be integrated: the medical system, the educational system, and the lay community. It is not surprising, then, that speech pathologists working in hospitals and those working in schools often appear to the lay community to have little in common. This conception, plus the tremendous pressure to specialize brought about by the information boom, may tend to fragment this emerging profession at the very time unity is needed to demonstrate that speech pathology is a separate complex of skills.

Least one believe that speech pathology has already "emerged," the International Standards Classification of Occupations (International Labor Office, 1958) does not list speech pathology as an occupation, despite boasting a rather inclusive list which contains such occupations as whale harpooner, beam warper, umbrella maker, wine taster, and putty-less skylight glazier.

The International Standards Classification of Occupations for 1968 (International Labor Office, 1969) lists "speech pathology" under the category of "Other Medical, Dental, Veterinary and Related Workers." The single paragraph under this heading, quoted below, hardly gives one insight into the field of speech pathology or the functions of a speech pathologist.

This group includes medical, dental, veterinary, and related workers not elsewhere classified, for example those treating sickness through the application of various herbs and medicinal plants; those treating patients with a system of physical culture and drugless treatment of disease by methods aimed to stimulate and assist nature; those treating body ailments and nervous disorders through mental influence and suggestion; those diagnosing and treating minor ailments of the human foot such as corns, callouses, deformed toenails, flat feet and other disorders and advising patients on further treatment, proper feet care, and suitable footwear. (p. 67)

Just where does this leave the new careerist in an emerging profession? Gross and Osterman (1972) write of disillusioned high school and college students who have examined many of the established professions and found them to be severely lacking with regard to honesty, humanism, and the service ethic. These students have extended their beliefs about the nature of professionalism as currently practiced to include all professional practice, old or new. Students are taught that one enters a profession to serve ideals such as teaching, healing, or justice, but these students realize from their life experiences that one does not simply heal, teach, or serve justice -- one becomes a doctor, teacher, or lawyer. In their minds the professions have become "established, institutionalized, and rigid" (p. 11). This attitude, usually formed from experiences with more established professions, may be every bit as strong when emerging professions are the topic of discussion.

However, Gross and Osterman are not pessimistic about the fate of the new professional in the emerging profession.

In short, a national movement of new professionals is growing, united by a network of publications and new organizations. This movement, devoted to social change, client control, and anti-credentialism, has already performed important services and is growing with each graduating class. (p. 23)

Thus, the new careerist in an emerging profession asks to be judged on his competency, rather than the impressiveness of his credentials, in performing what he believes to be a unique service. However, no emerging profession attains the respected position it so desperately covets without a struggle. As Goode (1960) points out, the larger patterns of professionalism consist of "innumerable smaller

encroachments, attacks, retreats, and absorptions" (p. 902). Whether the emerging profession will attach and encroach, or retreat and be absorbed, is chiefly related to the status it is able to achieve with colleagues and clients and to its ability to achieve a significant measure of upward mobility for the individual practitioner and for the profession as a whole.

Status and Mobility: Can Licensing be Far Behind?

The status of a profession changes. It changes in relation to its own past, to other professions that are ascending or descending the status scale, to its clients, and to its public. Changes, according to Hughes (1965), include more independence, more recognition, a higher place, a clearer distinction between those in the profession and those outside, and a larger measure of autonomy in choosing colleagues and successors (p. 7).

Moore (1970) has delineated a subscale of organization with respect to achievement of, or approximation to, professional status. His order is as follows:

1. recognition of common occupational interests, with some priority over all other simultaneously competing interests;
2. some mechanism of control to maintain standards of performance;
3. control of access to the occupation, so that qualifications for inclusion are essentially under the control and jurisdiction of current practitioners. (p. 10)

Moore continues by indicating that formal education qualifications are the general rule for many occupations in our society, especially those that strive for and are accorded the status of professions.

Hughes (1965) believes that a necessary validation of alterations in professional status is that the profession in question be introduced for study into the universities. One way in which an occupation can document its elevated status is by being able to take its choice of the individuals preparing to enter the labor market and then requiring a long period of academic training before allowing them admittance to the "charmed circle." Thus, the competition for status is accompanied by prolonging professional training at the outset by multiplying prerequisites for entry to professional school, and prolonging professional training at the finish by extending the course of study and requiring students to undergo various apprentice or internship programs (p. 8). That professions appear doomed to constantly increase the quantity of training without ever elevating the quality of training is a point that has been made by many writers.

Gilb (1966) contends that a profession with a weak power base may sometimes attempt to elevate its status via employer persuasion. When a profession lacks homogeneity or does not possess the requisite power to secure passage of a state licensure bill, the professional association itself may begin examining and issuing certificates. Gilb believes the next step toward acquiring control over a profession is "certifying by the state of all those with a certain level of professional training and attainment, while not precluding others from using the title or trying to gain employment in the field" (p. 61). Status may be further reflected in requiring licensure for individuals who wish to engage only in certain areas of the profession. Thus, Gilb sees a profession as passing through a number of stages of self

consciousness, beginning with voluntary certification and concluding with stringent, mandatory licensing.

Status and licensing seem inseparable. When asked if teachers need licensing, Thomas Holcomb, legislator and former teacher sponsoring a licensing bill in Michigan, replied:

Teaching is one of the few professions that does not have the recognizable and automatic recognition that a license carries with it. I think that when you can produce a license in . . . a profession, others realize that that person has achieved certain standards [status] and has been recognized by the state as having done so. (Heisner, 1976, p. 184)

If a profession's status can be reduced by lack of a licensure law, its status can further be reduced by a "competing" profession's ability to secure such a law. Sweeney and Sturdevant (1974), writing of an Ohio licensing law for psychologists and school psychologists, reflect on the effect that this law will have on school counselors.

The real threat to school counselors under the new law is directed by inference at their comparative status in the professional order rather than their right to practice. The school counselor is certified as a teacher; the school psychologist is now explicitly certified under the same section of the Revised Code as the school counselor *and licensed* by the State of Ohio Board of Psychology. This latter distinction not only affords the school psychologist a professional posture unavailable to the school counselor but also allows the school psychologist's constituents privileged communication -- a protection not available through the school counselor. (p. 578)

As school counselors find themselves in the shadow of school psychologists, so too do many quasi-professions in the medical realm find themselves unable to expand their status because of the physician's omnipotence. Wilensky (1964) points out that while the physician is still officially a guest at the hospital, he wields a great deal of power and, upon occasion, takes complete control with regard to the

management of daily hospital affairs. Medicine, using both legal and nonlegal means, maintains its status and authority and steadfastly resists encroachment into what it considers its dominion.

Professionals engaging in professions where upward mobility of the profession as a collectivity is effectively blocked (as with school counselors and the medical quasi-professions mentioned above) may seek upward and/or lateral mobility on an individual basis. Roemer (1974), writing with attention to trends in the regulation of health manpower, believes that although general agreement exists that opportunities for the professional to move laterally to related occupations and upward to more highly skilled jobs are necessary, the mechanisms for engendering these types of mobility are still poorly defined (p. 31).

The foundation which has been laid in this chapter will enable the reader to understand the reasons for the multitude of often incongruous viewpoints concerning professional control which will be discussed in the following chapter. Chapter 2 will focus upon traditional controls, occupational barriers, trends in licensure, alternate forms of control, and various legislative considerations, as well as attempt to briefly examine licensing in a number of professions. With this background, a consideration of state licensure laws in speech pathology and audiology will be initiated in a subsequent chapter.

CHAPTER 2

LICENSURE AND ALTERNATE FORMS OF CONTROL: REGULATING THE PROFESSIONS

Within the last 150 years there has been an extraordinary increase in state legislation dealing with professional and occupational licensing. The trend in the decade just completed has been to regulate more and more occupations, a trend which nevertheless has encountered strong opposition from a number of sources. An example of such opposition can be seen in a 1970 position paper of the American Medical Association (AMA, 1970). Due to the fact that the American Medical Association's Council on Health Manpower viewed with alarm the increasing proliferation of what they termed "narrowly defined, legally circumscribed health service roles" (p. 8), the following recommendation was made by the Council to the House of Delegates of the American Medical Association.

That the House of Delegates call for a nationwide moratorium on licensure of any additional health occupations, and that the American Hospital Association and the American Public Health Association be encouraged to join in supporting such a moratorium. (p. 8)

This resolution was adopted by the House of Delegates, and subsequently received the support of both the American Hospital Association and the American Public Health Service, as well as the support of a number of other influential organizations.

Despite attempts such as that described above, "one occupational group after another has sought legislative and administrative support

for enactment and enforcement of legislation . . . to provide for issuance of a state license as [a] prior condition for entrance into the occupation" (Council of State Governments, 1952, p. 2).

Statistics confirm the magnitude of the increase. The Council of State Governments (1952) reported that in 1951 there were over 75 different professions, skill trades, or other occupations which required differing combinations of qualifications, examination, and license in order to practice. The Council noted that there were more than 1,200 occupational licensing laws in the states at that time (p. 2). Angel, in 1970, indicated that almost 500 professional and nonprofessional occupations were currently licensed by one or more states (p. 15), and Mackin (1976) found that there were almost 2,800 statutory provisions that required occupational licensing in 1976 (p. 507). Business Week ("How Licensing Hurts Consumers"), in a 1977 article, revealed that United States Labor Department statistics indicated that licensed workers made up 25% of the employed labor force in some states (p. 127). In view of such statistics, it is apparent why the question of licensing and alternate forms of control assumed prominence in the decade of the 1970's and will continue to provoke heated debate in the decade to come.

A Brief History of Individual Licensure

The first attempt to regulate the practice of medicine in America took place in Virginia in 1639. This effort was not motivated by a wish to eliminate the unskilled from the colony, but rather resulted from claims of excessive charges. Except for such additional statutes as those passed in Massachusetts (1649) and New York (1665), the

colonies did not endeavor to regulate the practice of medicine until late in the eighteenth century. The revision of the 1639 Virginia statute in 1736, however, did clearly benefit those with university training. It attempted to differentiate between the charges of surgeons, apothecaries, and those who had only served an apprenticeship to a physician (Council of State Governments, 1952, p. 15).

Tabachnik (1976) points out that in the early nineteenth century (1820-1860), legislators began to believe that licensing laws actually hindered the development of the professions by granting monopolistic powers. Some states, partially because they felt such laws offered no protection to the consumer, began to repeal medical and legal licensing statutes with the result that by 1840, "only 11 of 30 states maintained regulations for admission to the bar; and by 1845 only eight of 30 states had effective medical legislation" (p. 26).

Prior to the Civil War the practice of a profession was considered a right and not a privilege. The consumer was solely responsible for determining the qualifications and abilities of the professional who served him. With the advent of the Civil War came a revival of the idea that to practice a profession was a privilege rather than a right, and that the consumer was entitled to some degree of protection (Gilb, 1966, p. 60).

This belief was partially responsible for the fact that occupational groups began to organize themselves into associations in the late 1840's and early 1850's. The American Medical Association (1847), the American Pharmaceutical Association (1852), the American Dental Association (1859), and the American Veterinary Medical Association

(1863) were among the earlier associations to be founded. These associations were given the opportunity to control or assume representation on state licensing boards, and they promoted legislation designed to protect their ethical codes and their standards of competence and to aid them in the establishment of lists of qualified practitioners (Angel, 1970, p. 15). Nevertheless, by the outbreak of the Civil War "no effective state licensing system was in operation and standards of professional competence were badly in need of reform" (Council of State Governments, 1952, p. 19).

The efforts of local, state, and national associations began to slowly upgrade these standards of training and competence in the late 1800's. These attempts were led by the American Medical Association and the American Bar Association; they often had to overcome strong opposition from respected members of both professions who felt that regulation via licensing was an infringement of their personal rights. As Tabachnik (1976) states:

The argument appears to be that those competent in their fields favored higher standards and strict licensing in order to eliminate quackery, while the incompetent wished no regulation so that they could peddle their wares without interference. According to these official accounts, under the enlightened leadership of the A.B.A. and A.M.A., after a long struggle standards were slowly restored. (p. 26)

As other emerging professions viewed the struggle and sensed the outcome, they began to contemplate the benefits and drawbacks of launching an effort to upgrade training, competence, and performance in their own realm. It soon became apparent to many such professions that the consumers of their services would concede autonomy to the profession only if, in Goode's (1960) words,

its members are able and willing to police themselves; will grant higher fees or prestige only when both its competence and its area of competence seem to merit them; or will grant an effective monopoly to the profession through licensure boards only when it has persuasively shown that it is the sole master of its special craft and that its decisions are not to be reviewed by other professions. (p. 903)

Professional associations likewise came to realize that once licensing legislation was achieved, and the status of the profession was confirmed both internally and externally, the association was likely not only to achieve increased prestige but also to undergo a substantial increase in membership. The rapid advancements in communication in the early 1900's made it possible for state associations across the country to learn quickly that a particular state association in their discipline had succeeded in its sponsorship of licensing legislation. "Model laws" were soon constructed and distributed, and state associations representing many diverse professions, occupations, and trades decided they had little to lose and much to gain by convincing state legislators of the need for licensure in their areas. Of course, the critical reason the professions always tendered in their legislative struggle was that licensure was necessary "to protect an unwary public from charlatans and from well-meaning but poorly prepared practitioners" (Gross, 1977, p. 586).

Hence, the early years of the twentieth century saw a frenzy of licensure activity unequalled to this day. The Council of State Governments (1952) found that the five year span from 1911 to 1915 was the period of greatest activity, with the passage of 110 state statutes licensing 24 occupations (p. 22). Gilb (1966) writes that the first state licensing of accountants took place in 1896 (p. 61), with the

initial licensing of architects and engineers occurring shortly after the turn of the century. Angel (1970) indicates that the first successful statutes licensing nurses were adopted in 1903 by New York and Virginia, and that by 1910, 25 states had enacted licensure laws in this area (p. 15). Levine (1978) gives a capsulated account of the history of licensure for nurses in the twentieth century.

Between 1900 and 1938 there was a period of voluntary or permissive licensing, during which only persons holding a license were permitted to use a particular title or designation, while unlicensed individuals would not use the protected title, but could work in the field. In 1938, a push for mandatory or compulsory licensure began whereby only individuals with a license were permitted to practice the occupation and unlicensed persons were prohibited from working. The 1969 statute requiring licensing of the Child Health Associate in Colorado initiated the third phase -- that of expanding function. (p. 9)

Although, as previously pointed out, the initial licensing of many professions and occupations occurred during the last decade of the nineteenth century and the first decade of the twentieth century, Lieberman (1970) affirms that it was not until the 1920's that doctors, dentists, pharmacists, accountants, beauticians, and others were licensed on an extensive basis. "Always," states Lieberman, "these regulations were justified by an appeal to the precarious position of the public health in an unregulated, but nevertheless complex, modern society" (p. 189). When such regulations were imposed, the profession or occupation lost a measure of its independence. However, when that loss was viewed against the gain of the right to legal monopoly along with the right to seek and obtain legal action to protect the profession, the loss of independence assumed diminutive proportions. Professional associations had long realized that private, associational

sanctions were often wholly inadequate, and the right to use the legal system to their advantage outweighed the possibility that this same legal system might be used against them.

Consequently, profession after profession inundated the state legislatures (often comprised of legislators who were totally ignorant with regard to the functions, services, or actual needs of the lobbying profession) with requests or demands for the imposition of legal controls. With no definite guidelines to follow, the choice of whether to grant licensure or to withhold licensure was often arbitrary. This point is clearly illustrated by Freund who, writing in 1928, states that "a view of the entire field of legislation operating with the aid of licensing or certification requirements fails to reveal a clear principle determining the choice between granting or withholding discretion" (p. 70).

The period from 1930-1960 saw an abundance of emerging professions seeking and obtaining legal controls. The Council of State Governments (1952) viewed five trends as influencing this licensing process:

1. the organization of occupational groups into national societies and associations,
2. the increase in the number of occupations licensed,
3. the increasing centralization of the control of licensing,
4. the trend from occupational certification to compulsory licensing,
5. the continued demand for raising and tightening of license qualifications. (pp. 20-25)

Although the earliest statutes licensing physical therapists were enacted prior to 1930, the majority of states ratified licensure laws

related to the practice of physical therapy in the 1940's, 1950's, and 1960's. While only ten states licensed physical therapists in 1952 (Council of State Governments, 1952, p. 22), all 50 states and Puerto Rico had licensing laws regulating physical therapists by 1970 (Angel, 1970, p. 37). Dental hygienists, nurses, midwives, chiropractors, and medical laboratory technicians were among the emerging professions which sought and often obtained state licensing during the 1960's (Gilb, 1966, p. 62), while the first statute regulating speech pathologists and audiologists took effect in 1970.

The decade of the 1970's has witnessed a revival of consumer interest in licensing activities, and this interest has led to a reassessment of the principles upon which state control was founded. Questions related to the efficacy of individual licensure, the value of institutional licensure, lay participation on state licensing boards, and the effect of increased specialization on the licensing process have constantly been referred to in the literature. These questions appear to be especially acute in the area of health related occupations.

The Philosophy of Licensing

Why regulate the professions? Moore (1970) contends that "the rationale for regulation is precisely the opposite of an open market for services, on the grounds that an open market will cause harm to the ill-advised and ill-informed" (p. 112). Angel (1970) believes that "occupational and professional licenses are issued to safeguard the life, health, safety, welfare and property of the citizen. . . . to shield the public from incompetent practitioners and from fraud" (p. 15),

while Occupational Outlook Quarterly ("Occupational Licensing: Help or Hindrance?" 1973) indicates that "the purpose of occupational and professional licensing is to insure that only qualified persons perform tasks that might endanger the public health and safety" (p. 32).

Barger (1975), viewing regulation in a less humanitarian light, states that "any kind of certification program that eventually calls upon the power of the state to control access to a field is occupational licensing and usually is an attempt to win a favored position for the people already in the field" (p. 200).

While agreeing that the explanations presented above are essentially correct, Behavior Today ("Pressure Builds to Improve," 1976) writes of mounting complaints concerning restrictions upon competition and the soaring costs of obtaining services. Among questions being asked are the following.

1. Is licensing really needed?
2. Does it improve standards?
3. Is it worth the cost?
4. Are requirements really related to the job?
5. Are licensing boards responsive to public interest?
6. Are there other ways to achieve the same ends? (p. 1)

Before attempting to discover how researchers have attempted to answer these and other related questions, a consideration of traditional state controls is a necessity.

Traditional Means of Control

While the trend in occupational and professional licensure has been in the direction of compulsory licensing, nevertheless the licensing of a particular trade or discipline often commences with the prohibition of a particular title rather than of the practice. This is sometimes referred to as optional or voluntary certification or registration (Council of State Governments, 1952, p. 24). Such registration does not restrict the practice of the profession, but rather allows those who have met certain qualifications to use the title if they so choose. For example, under these conditions, the title "registered speech pathologist" could be used only by individuals meeting predetermined criteria, although anyone could legally engage in the practice of speech pathology. Gilb (1966) writes of much the same thing under the rubric of "mandatory title licensing" (p. 62). Again, it is the title rather than the right to work at a profession which is being regulated. Barron (1966) refers to such a system as "optional licensing." Under this arrangement the right to practice an occupation or profession is not dependent upon being licensed, however regulatory agencies could establish guidelines to aid potential entrants in meeting standards for the use of the term "licensed" or "state approved" (p. 663).

It is apparent by this time that many authors refer to essentially similar types of control with the use of differing designations. For example, Gilb chooses to view the mandatory aspect of title licensing. Hence, it is mandatory that one meet a particular set of standards to call oneself "licensed," "state-approved," "certified," or

"registered." Barron chooses to regard the optional aspect of title regulation. Accordingly, it is optional for the person who wishes to practice a profession as to whether he wishes to pursue those established standards which would allow him the use of a particular title.

Roemer (1974) attempts to alleviate some of the confusion which may exist between the terms "certification" and "registration."

Certification, the process of granting recognition to an individual who has met certain standards, may apply either to basic or to specialty qualifications. Registration, a term often used interchangeably with certification, is actually listing a name in a register of an agency if a person has completed certain training. Both certification and registration are intertwined with accreditation of educational programs. . . . The basic requirement for certification is the completion of an approved educational program. . . . (p. 29)

Barron (1966) sees registration as a system wherein all members of a profession who provide services would be required to register with the state. Each professional would take an examination, with no minimum score required, and be issued a registration certificate which would attest to his experience, education, and examination grade(s). Prospective consumers would assume responsibility for reading and evaluating each professional's qualifications. As will be seen later, this type of "public disclosure" is often offered as an alternative to professional and/or occupational licensure.

Sweeney and Sturdevant (1974) endeavor to compare certification laws with licensure laws. A certification law, according to these authors, regulates the use of a professional title while licensure regulates not only the title but the practice of a profession as well (p. 575). However, Roemer (1974) views the distinction as one of voluntary versus legal rather than one of regulation of title versus

regulation of practice. Certification, as viewed by Roemer, is a "voluntary mechanism by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association" (p. 26). On the other hand, licensure is considered to be "a legal mechanism by which a governmental agency authorizes persons who have met minimal standards of competency to engage in a given profession or occupation" (p. 26). The fact that licensure laws have behind them the police power of the state, whereas certification generally is a much weaker form of nongovernmental control, makes such licensure laws much coveted. This is despite the fact that, as Wilensky (1964) points out, licensing and certification in the battle for professional authority are relatively unimportant events (p. 145).

A differentiation between voluntary licensing and compulsory licensing must also be established. Under voluntary licensing (that which Barron [1966] refers to as "optional licensing," and Sweeney and Sturdevant [1974] designate as "certification") those who are unlicensed are prohibited from the use of a given title or designation; however their right to practice in the occupation or profession is not affected. An example of a voluntary law is the one that permits optional registration for practical nurses. In a number of states, an individual may offer herself for employment as a practical nurse as long as she does not use the title "licensed practical nurse" (Angel, 1970, p. 18).

Compulsory licensing, on the other hand, allows those holding a valid license to practice in the profession or occupation while unlicensed individuals are prohibited from practicing. The licensing

of physicians is typical of the compulsory type of licensing. Angel (1970) indicates a number of exceptions to compulsory licensing requirements.

Exclusions and exceptions from licensing requirements are always made for federal employees, and often for state and municipal workers as well. Sometimes those engaged in research or educational pursuits are exempt from license requirements, as are students and auxiliary personnel working under the supervision of an individual who is licensed. Out-of-state licensed practitioners who render occasional services may also be exempt from licensure. . . . (p. 17)

While licensing acts as a traditional form of control, some writers believe that the control which initial licensing produces is reduced by "automatic" renewal policies. Angel (1970) suggests that usually the only information required for renewal of a license is the present name and address of the practitioner (p. 26). Occupational Outlook Quarterly ("Occupational Licensing: Help or Hindrance?" 1973) states categorically that "the public is deluded by licensing laws which do not require re-examination or evidence of continued competency" (p. 33). The article continues:

Although persons who wish to enter licensed occupations may need to meet rigid requirements, licensed practitioners seldom have to show that they have maintained their skills or kept up with changing technology within the occupation. Usually licenses may be renewed indefinitely on payment of the appropriate fee. (p. 33)

Thomas Holcomb, quoted by Heisner (1976), indicates that many teachers are opposing the passage of a law that would license teachers in Michigan on the grounds that they would be subject to examination for license renewal (p. 184). The threat of having to update their knowledge to maintain their licensed status apparently offsets the benefits of licensing for many of Michigan's public school teachers.

Thomas (1974) believes emphatically that "the notion of one-time licensure for practice of any of the healing arts is an idea whose time has passed" (p. 80). She points out that in 1974 the half-life of health care knowledge was 2.5 years, and that by 1980 the estimated half-life of health care knowledge will be only 18 months. Thus, health care personnel should be required to give evidence that they have fulfilled current requirements for those jobs which they occupy.

Certainly the question of license renewal bears heavily on continuing education, a topic which will be further developed in this text. It is sufficient to note at this point that a number of critics are extremely dubious of a professional's ability to serve the public effectively when his authority is vested in a license issued 20 or 30 years ago and automatically renewed periodically.

The Role of the University, Professional, or
Training School and the Question of Accreditation

Barber (1965) believes that "university professional schools are the leading, though not the sole, innovators and systematizers of ideas for their professions" (p. 21). Barber continues by stating that the university professional school attends to the ethical training of its students by explicitly teaching professional codes, by intermixing such ethical training with what apparently is only the teaching of substantive knowledge, and by presenting appropriate staff behavior that serves to act as a model for the student. Thus, Barber sees the role of the university professional school as one of "moral watchdog" for the profession, and he believes that the relative insulation of such schools has the advantage that it enables them to be "freer of those

commitments to other organizations and other interests that practicing professionals have, and therefore . . . more nearly able to maintain the highest intellectual and moral standards" (p. 21).

It is this image of high intellectual and moral standards which the emerging profession wishes to convey to the lay community. As Goode (1960) points out, occupations undergoing the process of professionalization tend to gain in income, power, and prestige and can therefore demand and obtain students of a higher caliber (p. 903). Once licensure is secured, added leverage is achieved for the professional schools. Kimball (1965) reflects that, since a compulsory degree generally acts as a prerequisite for licensure, "the educators for the licensed professions have first crack at the future practitioner" (p. 246).

This process of professionalization, encompassing a move from registration or certification to compulsory licensing, generally is accompanied by a raising or tightening of standards. This trend has two noteworthy aspects:

1. The greater degree of training now required, especially in approved institutions accredited by the occupation, makes the licensed practitioner a more competent individual than his counterpart of a generation ago.
2. The increased emphasis upon educational qualifications . . . and in some instances additional supervised experience (apprenticeship) has increased the over-all time and experience involved in gaining the requirements necessary for certification or licensing. (Council of State Governments, 1952, p. 27)

Kasper (1977), viewing this second trend with dismay, writes of the increased prices which consumers must pay to finance higher licensing standards in the field of medicine. He believes this increased

emphasis upon educational qualifications referred to by the Council of State Governments "inevitably prevents some needy patients from obtaining physician services and thereby tends to lower the average quality of care for the population as a whole" (p. 169). Kasper uses this argument to help support a case for the use of less qualified M.D.'s, paramedics, midwives, and allied health professionals.

Kinsinger (1973) warns, however, that the cost of many separate technical curriculums is too high. Writing with regard to health care programs, Kinsinger contends that many new educational and technical programs are developed at educational institutions having little or no previous experience in the health field. He posits the inauguration of a new curriculum emphasis, or "core curriculum," for all technical level personnel in allied health fields. Although recognizing the need to begin with the basic work force of physicians, dentists, and nurses, Kinsinger believes

extending and modifying the services they provide will require technicians with a "career base" -- that is, technical health workers who have a broad background in both acute-care and in health maintenance problems when applied to individuals and their life style and a grounding in health-care fundamentals that will make them valuable as extenders for many of the professionals who must continue to provide leadership. (p. 13)

Educators in the professional and training schools would, of necessity, abandon a great many of their traditional time-consuming activities as lecturers and examiners and concentrate on their roles as health delivery system analysts within this framework. They would pay particular attention to the means by which the students under their leadership could be utilized most effectively to serve public health needs.

Pellegrino (1977) likewise affirms that it is critical for all health care workers to be given "some generic form of education which they can use as the base for amplification later if a career change is indicated" (p. 28). He views the regionalized academic health center as a multischool cooperative venture which will help eliminate the problems of fragmentation, proliferation, isolation, overspecialization, and duplication of services.

Whether one is speaking of a regionalized academic health center, a university school of mechanical engineering, or a one room night school for prospective journalists, the question of accreditation invariably assumes tremendous import. Certification, registration, and accreditation are frequently tied together. The United States Department of Health, Education, and Welfare (1971) defines accreditation as "the process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards" (p. 7). Kelly (1977) states that accreditation is a part of the credentialing system and, as such, generates as much controversy as the other mechanisms. She points out that accreditation is voluntary, presumably indicates excellence in a particular program and, most significantly, allows for crucial federal funding (p. 568). Roemer (1974) defines accreditation as, "a voluntary mechanism by which an agency or organization (unfortunately a multiplicity of agencies and organizations) recognizes a program of study or an institution as meeting certain predetermined qualifications or standards" (p. 26). She continues by identifying the key issues related to accreditation in the area of health educational programs.

These issues, which will be briefly discussed, are

1. accountability of accreditation,
2. structure of accreditation,
3. financing of accreditation,
4. expansion of accreditation,
5. research in accreditation,
6. relationship of accreditation to licensure and certification. (p. 29)

The question of accountability is vital due to the fact that private agencies (such as professional associations) are functioning in a public role. Wilensky (1964) believes that it is somewhat of a misconception that professional associations generally form a training school and then establish accreditation. "Where professionalization has gone farthest," contends Wilensky, "the occupational association does not typically set up the training school; the schools usually promote an effective professional association" (p. 144).

The structure of accreditation is similarly important to a profession. Statutes usually specify that those applying for licensure must receive their training in schools approved by state licensing agencies. Often licensing boards accept the/a national association's list of accredited schools; however they may also accept the approval of appropriate regional college accrediting bodies. The state department of education in some states is the state agency which has the responsibility to inspect and accredit schools within the state (Angel, 1970, p. 32).

The financing of accreditation may be borne largely by professionals who pay dues to professional accrediting associations or through

fees for licensure or renewal paid to state licensing agencies.

Roemer (1974) contends that since the cost of accreditation of health educational programs has been sustained largely by the health professional organizations, a sufficiently broad financial base has not been established with regard to financing accreditation in this area (p. 29).

The expansion of accreditation, the fourth issue delineated by Roemer, deals with the rapid proliferation of accrediting programs and agencies. Fields (1978), writing about the problem of determining who should be considered psychologists and what programs actually train them, expounds upon one way this discipline is attempting to cope with the expansion of accrediting agencies and the lack of consistency in evaluating credentials. Because of confusion partially brought about by the expansion of accreditation, a steering committee comprised of representatives from a number of influential associations and organizations recommended the establishment of a national commission, to be called the National Commission on Education and Credentialing in Psychology, which would operate similarly to an accrediting agency. College and university programs would pay to have their programs evaluated, and a positive evaluation by the commission would designate a program as a "certified psychology program."

Defenders of the commission refer to the absence of a national definition for "psychologist" which has caused some individual state boards of examiners in psychology to license applicants who would not qualify in another state. Many psychologists, however, fear forced evaluations. Fields states that

some psychologists believe that even though institutions would voluntarily decide whether to try to have their programs designated by the proposed commission, the existence of such a body would force almost all administrators to pay to have their programs evaluated. Others believe the commission could lead some states to tighten their licensing laws, so that only graduates of designated programs could be licensed.

Supporters of the proposed commission counter that state licensing authorities could still evaluate individually the educational backgrounds of graduates of undesignated programs, just as they do now. The designation system simply would reduce the number of applicants for whom that would be necessary, they say. (p. 9)

Roemer's (1974) definition of accreditation as "a voluntary mechanism," it would seem, might well be in danger. A commission similar to the National Commission on Education and Credentialing in Psychology, the National Commission for Health Certifying Agencies, was formally organized at its constitutional convention in December 1977.

The primary purpose of the Commission is to assure the health and safety of the public by the development and encouragement of high standards of professional conduct among the health certifying agencies. To achieve this the Commission will establish national standards for certifying bodies that attest to the competency of individuals who participate in the health care delivery system. The Commission will grant recognition to certifying bodies that apply for and meet the established standards. It also will monitor the adherence to these standards by the certifying body which it has recognized, thereby assuring public accountability. The membership in the Commission is voluntary. ("National Commission for Health Certifying Agencies," 1978, p. 1)

Roemer's (1974) fifth issue in health care accreditation, that of research in accreditation, will not be elaborated upon here. However, Roemer's sixth and final issue, that of the relationship of accreditation to licensure and certification, is a key issue since graduation from an accredited school is often a prerequisite under state statutes for licensing or certification. Cottingham (1978) illustrates the

difficulties that counselors are facing with this relationship of accreditation to certification or licensure.

Currently, counselor preparation programs are not officially accredited, validating skills provided for trainees, as is the case with APA-approved programs in psychology. Hence, program accreditation as a basis for professional counselor certification or licensure is not available. Credentialing eventually must link program approval and counselor certification or licensure. (p. 334)

Occupational Entry and Licensing: Requirements, Limitations, and Barriers

The desire to maintain control over entry into an occupation is nothing new. Lieberman (1970) states that as early as 1321, London guilds were attempting to curb membership by charging exorbitant fees for entrance, establishing long apprenticeship periods, dismissing apprentices just prior to the completion of their training period, and putting severe limitations upon the number of apprentices who might legally be associated with a given trade (p. 39).

Whether one views entry qualifications as safeguards in the public interest or as artificial restrictions upon the freedom of one wishing to enter an occupation is largely a matter of perspective and is intimately related to one's value system. Some, like Barron (1966), believe that "entry requirements in excess of those necessary to protect the public are apparently absent in the professions for which recognized curriculums have been developed in major colleges and universities" (p. 651). Others, for example Montgomery (1975), contend "it isn't uncommon for [state licensing] boards to try to limit access to a given occupation in apparent disregard for the public interest" (p. 1). Since Montgomery continues by elaborating upon perceived

injustices perpetrated by medical and dental boards, apparently the fact that both medicine and dentistry have recognized college and university curriculums is not a primary consideration for Montgomery in the reduction of overly stringent entry requirements.

Although specific qualifications for occupational entry and licensing vary greatly, some general requirements or qualifications can be postulated. Angel (1970) states that applicants for occupational licenses may have to meet four different types of qualifications. These are

1. personal qualifications,
2. educational qualifications,
3. experience qualifications,
4. examination qualifications. (p. 23)

Personal requirements traditionally include moral character, minimum age, minimum state residency, and in some cases, health status. However, the minimum requirement in each of these areas, according to Angel, "generally seems to have slight effect, or none at all, on the actual ability of technically competent applicants to secure licenses" (p. 29). Thus, such matters assume relative unimportance in a discussion of occupational limitations and barriers.

Educational requirements doubtless assume more importance. Gilb (1966) points out that "for some professions . . . a certificate or license is issued to anyone of good moral character who has completed the specified education in approved schools or colleges" (p. 62). This is becoming less and less true with regard to the professions; however the various professions have placed an ever increasing emphasis upon

formal education as a prerequisite for licensure. Some believe this emphasis is often extreme, and as such constitutes a barrier to occupational entry and licensing. Since the professional association is often the accrediting agency that imposes more stringent educational and apprenticeship requirements, it is not surprising that it has received the brunt of the criticism in this area. Goode (1972) states quite candidly that "typically a profession, through its association and its members, controls admission to training and requires far more education from its trainees than the containing community demands" (p. 19). Johnson (1972) writes that the professional association will also endeavor to impose a uni-portal system of entry into the occupation or profession (p. 54). Such a system recognizes the completion of arduous education prerequisites, but does not allow that competence can be achieved in any but this manner. Roemer (1974) indicates that "it is becoming increasingly clear that all educational programs are being called on to provide multiple entry points" (p. 32). She recommends that individuals with experience or other nonacademic qualifications begin to receive recognition in the licensing process. Levine (1978) stresses the need for equivalency and proficiency examinations.

This might be a means of making the career-ladder concept a reality by providing alternative routes for entry into professional schools and/or credentialing systems. It could also help to minimize what is perceived as rigid categorization of health care personnel. With the massive amount of information now necessary to render safe care, it is doubtful that categories will ever be totally eliminated; but if mobility is increased between the categories, this might suffice. (p. 113)

Kinsinger (1973) criticizes an educational system which he views as inflexible and unfair for health care workers. He writes emphatically of the need to review the present educational system as it relates to the allied health professions to prevent "dead-ended health workers caught by career barriers built into the present educational system" (p. 15).

In addition to formal education requirements, those who wish to enter and be licensed in many professions must fulfill apprenticeship or internship requirements. In other occupations, a clinical experience constitutes a portion of the formal education program, while some professions require both a formal clinical experience and an apprenticeship or internship. Angel (1970) reports that many licensing statutes provide for various combinations of education and experience, and that applicants can qualify for licensure by fulfilling any of these combinations.

At the opposite extreme from those professions requiring completion of a rigorous educational curriculum are those occupations or trades wherein experience constitutes a prime determinant of licensure. While such occupations may escape criticisms leveled at those professions which are viewed as requiring overly stringent academic prerequisites which are above-and-beyond those needed to protect the public welfare, they nevertheless are not without their own difficulties. Consumer Reports ("Should Mechanics Be Licensed?" 1976) details one such difficulty related to limiting entry of auto mechanics into this newly licensed field.

A second problem with licensing is that it must somehow provide for those already practicing the trade. If they are automatically licensed(under a "grandfather

clause") and if the apprenticeship requirements are used to limit the number of people entering the field, the result could be a shortage of trained licensees. That could push up the cost of repairs without guaranteeing more competent work. . . . (p. 204)

Hence, it is apparent that occupational entry limitations are not imposed solely by requiring a tremendous investment of time and money for a formal education. Goode (1960) states it succinctly when he writes that "any plan to raise standards defines some practitioners as incompetent" (p. 904). That a profession or occupation must grandfather individuals who would be classified as incompetent under less strict standards, a procedure which might well limit entry into the field for potentially competent practitioners, is a problem that is not easily resolved. So too, an artificially prolonged apprenticeship requirement can constitute an unnecessary barrier which is unfair to those wishing to enter the occupation and unfair to those having to pay inflated prices to purchase services from the relatively few practitioners.

A fourth category of entry qualifications, those related to examinations of competency, has received a good deal of attention. Angel (1970) writes that written examinations are a usual requirement for all occupations in the health field, while oral examinations are generally mandatory for those wishing to be licensed in the fields of chiropractic and veterinary medicine. Disciplines requiring practical or clinical examinations include dental hygiene, dentistry, optics, optometry, pharmacy, podiatry, and veterinary medicine (p. 25). Such exams are usually constructed by either the state licensing board or by the state licensing board in cooperation with the national association.

Mackin (1976), writing with regard to licensing and counselors, contends that an individual may possess the experience, understanding, and empathy necessary to become a successful counselor, but may fail in this ambition because of the inability to pass an examination as a prerequisite for licensure. He writes of the frequent misuse of examinations and the overdependence on test scores. Mackin comments:

One alternative is to create valid licensing tests. A truly valid licensing test would not. . . . discriminate against a student who does not perform well on traditional tests but who is nevertheless competent to perform a given job. . . . A second alternative is to abolish licensing tests altogether. This alternative would perhaps prevent the increased governmental social control suggested by the first alternative. It may also be a more realistic alternative. Few employers have been able to validate tests challenged as discriminatory, and it is doubtful that development of valid licensing tests will be any more than an abstract goal unobtainable for years to come. (p. 510)

Occupational Outlook Quarterly ("Occupational Licensing: Help or Hindrance? " 1973), in reviewing a number of conclusions reached by the Educational Testing Service's intensive research into occupational licensing in four fields, asserts that

licensing tests are often substandard, and testing procedures and policies create difficulties for some applicants. . . . For example, written examinations often contain multiple-choice questions which are ambiguous or which deal with inconsequential matters. Essay questions are widely used, but few boards have devised procedures for grading such exams in an objective way. Performance tests may fail to test crucial job skills and are likely to be evaluated by judges who do not have objective evaluation guidelines. (p. 33)

Barron (1966) gives several examples of seemingly irrelevant questions which have been asked on the written examination for cosmetologists.

Which *one* of the following is *not* a muscle of the mouth:

1. Quardatus Labii superioris;
2. Zygomaticus;
3. Obicularis oculi;
4. Obicularis oris.

Attachment of the muscle to the bone is known as the:

1. Aponeurosis;
2. Origin;
3. Insertion;
4. Fascia.

Oxygen is carried to the body cells by the:

1. White corpuscles;
2. Leucocytes;
3. Red corpuscles;
4. Platelets. (p. 654)

Montgomery (1975) makes mention of physicians and dentists in Florida who organized to challenge what they viewed as restrictive state licensing regulations. Some of these regulations related to the examination question, for although all of the physicians and dentists challenging these regulations were licensed in other states, they had been unable to obtain a license to practice in the state of Florida. In contrast to many other states, Florida did not grant automatic reciprocity to licensed doctors and dentists from other states. Prior to receiving licensure in Florida, new residents were required to successfully complete a comprehensive examination in general medicine or dentistry, as well as one in their specialty (p. 1). Such examinations were viewed as intentional, measured attempts at exclusion by what one member of the group, Dr. Norris C. Elvin, called Florida's "arrogant, overworked, overpaid" physicians (p. 1). The situation in 1979 is apparently unchanged. Mr. Fred Varn, Executive Director of the Florida State Board of Dentistry in Tallahassee, Florida, relates that reciprocity is still denied to licensed physicians and dentists from other states. According to Mr. Varn, a bill related to endorsement of physicians from other states failed to gain passage in the Florida

Legislature in 1978, and it is possible such a measure will again be introduced in 1979.¹

Reciprocity, endorsement, and waiver constitute important concepts in any discussion of occupational entry requirements, limitations, or barriers. As noted above, the inability of one competent in his field to practice in another state without re-examination may constitute an unreasonable barrier to license acquisition in the practitioner's new state. However, the use of reciprocity, endorsement, and waiver may facilitate the provision of services from state to state and, as such, help to eliminate what the Educational Testing Service ("Occupational Licensing: Help or Hindrance?" 1973) calls, "a near chaotic situation insofar as skilled worker mobility is concerned" (p. 33).

Angel (1970) indicates that the term reciprocity has come to acquire many different meanings to the various state licensing agencies. Angel believes the term "reciprocity" is intended to mean, "the actual value accorded an out-of-state license when an accredited person from one state seeks licensure in another" (p. 27), and that there is more uniformity with respect to reciprocal agreements among the states whenever national professional organizations exercise a powerful influence. Angel describes the process of licensing by reciprocity.

In licensing by reciprocity, for a given occupation, a licensing board in one state will recognize licensees of a second state if the board in the latter will extend the same recognition to licensees of the former. In addition, licensing requirements must be equivalent in the two states before formal or informal reciprocal agreements are made. Applicants for reciprocal licensure must generally meet the same requirements as those seeking licensure by endorsement. (p. 28)

¹Varn, F. Personal communication. March 13, 1979.

The terms "reciprocity" and "endorsement" are sometimes used interchangeably by state licensing agencies; however Angel (1970) specifies that

in licensing by endorsement, the members of the state board in the state where the license is being sought, determine whether the qualifications of the applicant were equivalent to those required in their state at the time the applicant was initially licensed. Most states also specify that initial licensure must have been by an examination which was comparable to theirs. (p. 28)

State Licensing of Health Occupations (1976) reports that while reciprocity and endorsement provisions generally are applied only to out-of-state licensees, some states have begun licensing Canadian and foreign-trained health care practitioners by reciprocity. This eliminates the need for the establishment of a third system of licensing these applicants (p. 16).

Licensure is also possible by waiver, a condition in which applicants not meeting one or more of the state board's requirements are licensed if they possess other qualifications which the state board judges to be equivalent. Professional recognition is often cited as a reason for waiving certain education requirements, but it should be understood that licensure by waiver occurs infrequently.

It appears clear that licensing requirements may, indeed, act as occupational barriers and limitations. Moreover, such barriers have existed for many years, it being the state of public enlightenment that has undergone a transformation rather than the barriers or limitations themselves. The professions use the same rationale, only the lay community no longer accepts it without questioning its validity. Kidder (1976) explains this rationale.

Legal requirements indicate a second feature of professionalization -- the use of licensing as a barrier. The theory of expertise justifies the use of legal restrictions so that the public will be protected from "quacks" -- i.e., those whose skills have not been proven against prevailing methods of evaluation and/or those whose practice violates the paradigms of expertise of the dominant professional community. Licensing can, of course, be responsive to norms other than expertise (e.g., considerations of supply and demand for the service), but in the licensing of professionals, expertise is the sole "up front" justification. (p. 153)

This "up front" justification is proving to be increasingly inadequate as critics review the activities of professional associations and licensing boards in this area. Barron (1966) affirms that "any restriction upon the freedom of individuals to enter an occupation, whether publicly or privately imposed, is a 'monopolistic' restriction on the operation of the market. . . . Thus, licensing results in higher prices than would exist in its absence" (p. 643). Kasper (1977) contends that "those excluded by licensure's restrictions are forced into lower-preference occupations. There is strong evidence that such restrictions tend to fall on minorities. . . ." (p. 170) while Asha magazine ("Congress, FTC Probe Professional Associations," 1977) reports concern about the "future direction of professional associations amid growing interest on the part of Congress and the Federal Trade Commission in enforcing antitrust legislation. The activities of professional associations in controlling qualifications, numbers and scope or practice of their members have recently come under scrutiny . . ." (p. 673).

Such comments and reports dealing with the exercise of artificial and possibly harmful restrictions to occupational entry constitute a portion of a more generalized attack on professional and occupational

licensure. This assault will be more fully documented later in this chapter, and alternatives to licensure will be briefly discussed.

Legislative and Judicial Considerations

As has been documented previously, many professional practitioners are quite willing to forego their traditional political conservatism to seek governmental intervention when they believe that such intrusion best serves their interests. Licensing serves as a conspicuous example.

Kelly (1977) states that licensure is the police power of the state and that "it is through the state legislative process that the decision is made as to what group is licensed and with what limits . . ." (p. 563). The Council of State Governments (1952) specifies a number of legislative considerations to be contemplated when licensure is at issue. Initially, the Council sees the need to establish a clear definition of the area to be licensed and a delineation of the area of prohibition (p. 60). Lieberman (1970) states that often the legislature defaults on this "threshold question" of defining the profession which will subsequently be given rule making power (p. 169). Roemer (1974) writes of the legal repercussions which can emanate from the definition of a discipline's scope of functions in a formal licensing law regulating an emerging health profession.

The physician's scope of functions is all inclusive, but other licensed personnel are authorized to perform only a segment of those functions. Fortunately, these definitions are usually couched in quite general terms, but nevertheless they specify the bounds of allowable practice. The legal effect is that liability can be imposed for overstepping these bounds, particularly if harm should result to the patient. (p. 27)

Cottingham (1978) points out that when the scope of a profession has

not been adequately delineated, the courts may create their own definition of the profession. Thus, professionals may have their areas of expertise prescribed for them (p. 331).

A second legislative consideration discussed by the Council of State Governments (1952) deals with the problem of establishing a regulatory agency and granting to it a degree of discretion. The Council lists five kinds of public agencies which have received licensing authority. These are

1. completely independent licensing boards,
2. departments of education or public instruction,
3. departments of health,
4. offices of the Secretary of the State,
5. central licensing departments. (p. 61)

Moore (1970) comments upon the extremes which may be the outcome of legislative discussion in the area of assigning regulatory agencies and granting power to these agencies.

At one extreme is the uncommon situation in which a state board of examiners is authorized, to be appointed normally by state officials. These examiners then set the kinds of knowledge or demonstrated competence that they consider important for admission to an occupation. . . . At the other extreme is the situation in which the license is *pro forma*, being granted upon presentation of "credentials," the most important of which is successful completion of the training approved by an accredited school. (p. 124)

A third legislative consideration indicated by the Council of State Governments (1952) revolves around the need for state legislatures to assess the role to be assumed by private professional associations. Lieberman (1970), highly critical of the laissez-faire attitude of state legislatures toward professional associations, affirms:

When legislatures become agencies for ratifying policies of separate groups, there is reason to expect that private groups will seek at some point to impose their own policies on the public directly. . . . Overt legislative delegation of authority to private groups combines with the acquiescence of legislatures and courts in the customary power of other groups to enforce private standards; in either case, traditional controls . . . are unavailing. Laymen do not have access to the decision-making process of "private" groups. (p. 168)

Hence, Lieberman accuses the state legislatures and the courts of neglecting consideration of the proper role and function for professional associations, with the result that, in the author's words, "traditional controls . . . are unavailing." Goode (1972) contends that part of the problem may reside in the fact that the professions generally occupy a disproportionate number of seats in state and national legislative houses. Consequently, any legislation which pertains to the professions is shaped by the professions (p. 19). Sweeney and Sturdevant (1974), writing with regard to licensing and school counselors, assess the effects on Ohio counselors of legislation passed in 1972 which "follows closely the recommendations of the APA [American Psychological Association] Committee on Legislation" (p. 576). This legislation, brought about to a great extent by the power of the APA in the Ohio legislature, has resulted in what the authors believe are a number of deleterious effects upon school counselors in that state. The authors enumerate a number of these, not the least of which is that "membership in psychological associations -- previously considered a voluntary professionally responsible choice -- may seem an economical and professional requisite for job mobility and credibility" (p. 577). Lieberman (1970) believes

that professional associations have succeeded in avoiding public regulation because the lay community has accepted the associations' contentions that, while the Fifth and Fourteenth Amendments prohibit federal and state governments from depriving individuals of life, liberty, and property without the due process of law, these amendments do not prohibit "private" associations or members thereof from operating in such a manner (p.199).

A fourth legislative consideration specified by the Council of State Governments (1952) relates to legislative decisions with regard to violations and sanctions. Angel (1970) writes of the difficulty in determining violations of particular sections of licensing statutes because of the fact that standards of performance are expressed in broad terms. State Licensing of Health Occupations (1976) indicates that generally licensing agencies investigate a practitioner's compliance with statutory provisions only when a complaint is filed. Thus, the extent to which licensing laws are enforced is based upon the voluntary compliance of each professional and the willingness of the professional association and the consumer to monitor the behavior of individual practitioners (p. 10). Of course, offenses may be committed by those who are not in the profession. Kelly (1977), commenting on violations of licensure laws in the field of nursing, contends that "violation of the law by nonlicensed individuals results in such ridiculously low fines (and seldom imprisonment) that it is no real deterrent" (p. 563).

Finally, the Council of State Governments (1952) points out that the legislature may want to ponder the question of whether or not to permit reciprocity in occupational and professional licensing and, if

reciprocity is allowed, under what conditions it may take place. Since the concepts of reciprocity, endorsement, and waiver have been discussed previously, any further discussion related to these terms will focus on their use in the licensing of speech pathologists and audiologists.

Little has been said to this point concerning the role of the judiciary system in professional licensing. A number of authors (Barron, 1966; Montgomery, 1975; Mackin, 1976) have undertaken to present a judicial review of licensing or a compilation of court decisions related to some aspect of licensing. A review of specific cases is outside the scope of this chapter; however some general trends may be noted.

The Council of State Governments (1952) reports that the courts of the 1940's and early 1950's believed that decisions regarding the enactment of educational and experience requirements as prerequisites to practicing an occupation or profession were matters best decided by state legislatures. The role of the courts in terms of licensing was primarily devoted

1. to defining the intangible boundaries between various occupations such as barbers and beauticians, between physicians, osteopaths, chiropractors and other practitioners of the healing arts. . . .
2. to reviewing as the highest appellate body, administrative decisions of the licensing agencies. (p. 6)

Barron (1966) detects a judiciary trend toward allowing legislatures more freedom to use police power for licensing purposes (p. 657). He substantiates this view by citing a number of relevant court decisions. Lieberman (1970) reflects the consumeristic attitudes of the late 1960's and 1970's as well as the renewed interest in professional accountability.

In order to redress the balance between expert and layman, it is necessary for the Supreme Court to embark on at least a limited judicial revolution in yet another area: The power of producers must be balanced by setting limits on its exercise. The Court cannot order consumer groups into being, or demand their representation in the legislature, but it can bring consumer power onto the same field as producer power by restricting the scope of the latter. (p. 244)

Mackin (1976) points out the willingness of the Supreme Court to "analyze the realities of the occupational licensing situation" (p. 510) with regard to the bias existing on some regulatory boards which prevents a fair and impartial hearing for those of the profession presenting grievances.

The nature of legislative and judiciary considerations in the decade to come is unclear. Much time and effort will undoubtedly be invested in centralizing the licensing function, reorganizing regulatory agencies, instituting periodic review of the effectiveness of state boards (sunset review), and providing for consumer participation on regulatory boards. The consideration of alternate forms of control and questions relating to new avenues for licensing will no doubt engender considerable debate.

While the 1980's will certainly witness a continuation of the strong anti-licensing, anti-credentialing sentiment which pervaded the decade of the 1970's, one should keep in mind that a significant undercurrent of opinion is present which favors extension of the licensing principle to areas previously considered sacrosanct. For example, Roger W. McIntire of the University of Maryland, quoted in Science News ("Licensing Proposal for Parenthood," 1973), believes that parents should be required to obtain a license. McIntire notes that at the present time any adult may engage in parenting, and that present

knowledge regarding population control should be used to limit parenthood to those who are qualified because "we cannot afford the luxury of any fool adding to our numbers at any time. . ." (p. 305). If this is a representative example of the type of legislative/judiciary question which the next decade offers, then the licensing/credentialing controversy may well take on dramatic new proportions.

Professional Associations and Politics

While Chapter 1 provided a brief overview of the professional association's relationship to the licensing function (see pages 41-46), more needs to be said at this point regarding the activities of professional associations in politics, especially with regard to their roles as lobbyists and pressure groups. As was revealed in Chapter 1, the professions were somewhat perplexed with the question of how to maintain autonomy while at the same time reap the benefits of state regulation. Hence, somewhat paradoxically, the professions endeavored to use the power of the state to succeed in obtaining greater autonomy. As Gilb (1966) indicates, professions even used government to protect themselves from government, as when teachers sought tenure laws to serve as protection from the common practice of school board officials using teaching positions as patronage (p. 45). Professions found that, once occupational solidarity had been achieved to some degree, they could obtain from the state legislature the public authorization to regulate themselves. Lieberman (1970) summarizes the situation.

On the whole the professions have managed to avoid the question of whether the state accommodates itself to the needs of the professions. They have avoided it and hoped the issue would not be raised because accommodation is a two-way street; an admission would jeopardize autonomy.

The issue is easily avoided by asking for -- and getting -- self-regulation. That there is regulation quiets fears because the public sees the professions as subserviant to the state. What the public does not see is the agency of regulation, and this suits the professions. (p. 175)

Consequently, many professional associations become "private governments," promulgating and enforcing regulations pertaining to the behavior of their "citizens" and interacting with a myriad of other "governments." These associations began to evolve into preliminary arenas of public lawmaking as they realized the importance of shaping their own destinies, and as they realized that an aggressive political posture could often intimidate legislators who were ignorant or apathetic concerning legislation directly affecting the profession.

Johnson (1972) states:

As vocational education, research, and resources are more and more supplied or affected by state actions, various occupations find themselves increasingly anticipating, responding to, and seeking to control such actions. In so doing they are forced to relate their policies to the social and political consequences of their actions. Consideration of . . . law reform will bring practitioners more and more explicitly into the political arena. (p. 84)

Gilb (1966) advances two suppositions concerning professional associations as private governments and as preliminary arenas of public lawmaking.

1. The initial structuring of the association and the development and change of its structure are determined by the socioeconomic-political context into which the association fits, as well as by a dynamic within the association itself.
2. The structure of the association alters with the passage of time in ways that . . . appear to be similar for the different professional associations, and these changes in turn alter relations with public government. (p. 109)

Barber (1965) specifies a number of social factors that aid in understanding the diversity of political behavior among professionals. Among the factors specified are the following.

1. The diversity of political behavior among professionals can be accounted for in part in terms of the relative degree of applicability of the professional's knowledge to the political process.
2. Full time participation in politics is also dependent on the relative degree of freedom for the professional to absent himself from his regular practice.
3. The amount of gain for one's professional career to be derived from political participation also helps to determine diverse patterns of professional behavior in this sphere.
4. The relative amounts of income, prestige, and work satisfaction characterizing the different professions help to determine diverse modes of political participation. (p. 30)

It appears to be more and more evident that while in theory the professional practitioner must maintain an aura of neutrality, in fact the professional must often engage in exceedingly political acts to establish this appearance of neutrality. Such political acts are accomplished by the association bringing pressure to bear upon members of the legislature. Gilb (1966) writes:

A pressure group is one that does not have fully developed access to public government. Most professional associations are in such a position at one point in their development. Incompleteness of access is in part a result of lack of unity on legislative issues, which has characterized the early stages of most professional organizations in whatever decades those early stages have come. (p. 141)

As a professional association proceeds in its development, Gilb sees a number of steps which the professional association can take to help increase its prestige and "clout." Some of these steps are

1. to move the association's headquarters to Washington, D. C.;
2. to hire professional staff;
3. to increase attention to research of all kinds;
4. to establish journals for national, state, sectional, or local bodies;
5. to initiate public relations activities not necessarily centered around a legislative issue, but simply to establish the prestige of an organization (p. 141).

Moore (1970) writes that direct efforts to influence the direction and progress of legislation take the standard American form of lobbying. Generally, a member of the association's administrative staff or a special public relations consultant attempts to give testimony before key legislative committees and to convince individual legislators as to the correctness of the association's position (p. 164).

The Legislative Process

The process of securing passage of a licensure bill is complex, arduous, and often expensive. Lieberman (1970) points out that the dues paid by professionals to their association are, in effect, "compelled contributions to lobbying funds" (p. 170) and, once one examines the licensing process in detail, it is easy to understand why national and state associations must place a high priority on maintaining full coffers. The American Speech and Hearing Association (ASHA, 1973a) understates the case when they stipulate that "the financial solvency of the state association is a major consideration in determining the feasibility of pursuing state licensure" (p. 29). Among alternatives suggested by ASHA for generating funds to support a legislative effort

are a special assessment of the membership, a dues increase, and money raised through special contributions (p. 30). Considering that in 1973 the average cost of retaining a lobbyist was approximately \$5,000 a year (ASHA, 1973a), a cost to the association regardless of whether passage of the bill is obtained, a state association might be wise to initiate all of the funds-generating ideas suggested by ASHA. The services of a lobbyist are not mandatory; however Gilb (1966) makes a strong case for the acquisition of "legislative advocates."

Once bills are in the hopper, the whole process of legislation seems to favor the proposals or positions put forth by high-prestige organizations whose legislative advocates work on a year-round basis and are continually in attendance during the legislative session. They are intimately acquainted with the legislative terrain and have established points of access and influence far in advance. They know what legislators to select to carry their bills. They can pressure the bill's sponsor into acting on a bill that might otherwise lie inert. (p. 152)

The contents of a bill, of course, will vary considerably depending upon the specific requirements of the profession inaugurating it. Nevertheless, certain commonalities exist across professions relevant to the purpose of licensure, the need for licensure, the feasibility of licensure, and the obstacles to licensure. With regard to this purpose factor, the American Speech and Hearing Association ("ASHA Regional Legislative Consultants," 1971) writes:

A licensure law, like any other law, sets forth a basic premise, a number of principles, and a set of guidelines. The actual strength of a licensure law -- the degree to which it meets its intended purpose -- will not reside in the premises, principles, and guidelines themselves, but rather in the judicial interpretation of their meaning and intent in relation to an unpredictable variety of circumstances.

Thus, we must be aware that while a licensure law is basically aimed at the protection of the public, it simultaneously places the definition of our profession,

our practice, and our standards and ethics in the crucible of judicial interpretation. Therefore, when undertaking the development of a licensure law, we must be fully cognizant that a poorly conceived and implemented law will create problems far beyond the inability to effectively handle the unqualified, the unethical, or those who engage in malpractice. (p. 295)

In a similar manner, Asha magazine ("Comments on Licensure," 1972) warns:

Proponents must also be prepared to face the difficult decision between no bill at all and one that abdicates professional independence, which, after all, is one of the primary objectives of licensing. Such preparation requires a working knowledge of the legislative process and a constant lookout for efforts by opponents to chip away at the strengths of a given bill. The small, seemingly unimportant chips can add up to something big. (p. 74)

Consequently, the level of financial support for the legislative undertaking, the amount of backing from within the profession, and the degree of opposition from outside the profession are important considerations in assessing the feasibility of attempting to secure passage of a licensing law (ASHA, 1973a). The professions are many times aided in their efforts because their proposals are frequently written in technical language and legislators, realizing they lack the expertise necessary to fully comprehend the bill, often assent on faith. Moreover, the tendency of state legislators to be passively receptive as opposed to actively creative and the inclination of middle class legislators to defer to high prestige professionals help in obtaining a favorable legislative response. Certain negative perceptions on the part of legislators can, in a like manner, reduce the chances of passage. Warnath (1978) notes that national associations should maintain a very low profile because it is possible that they may be viewed as "outside intrusion into a state concern" (p. 51).

The ASHA Manual on State Licensure of Speech Pathologists and Audiologists (ASHA, 1973) discusses what it believes to be a preferred sequence of preparation to be used in the development and introduction of a licensure bill. This sequence is outlined below:

1. development of a consensus position and rationale statement within the state association membership,
2. development of a legislative support mechanism,
3. selection of an author and discussion of the bill with legislators,
4. acceptance of a variable timetable for decision-making after the bill has been introduced. (p. 22)

While professional associations act to a degree as private governments, it is often surprising how little internal control an association will have over its members. In former times, individuals holding exalted positions within an association were inclined to operate on the assumption that what was of benefit to the discipline within which professionals worked was of benefit to each professional working therein. The rank-and-file members of a profession did not dispute this assumption, and harmony was maintained. However, this situation has changed dramatically in recent years, there now being greater articulation of sub-groups and authority levels within a profession as the various elements of a profession strive for identity and recognition. Neglected interests within a profession may approach the legislature separately or may attempt to be included within the scope of a licensing bill proffered by a related profession. Rosen (1969) addresses this problem as it relates to the fields of speech pathology and audiology.

The struggle for identity has occupied many of us almost since the foundation of the field. Are we primarily teachers who specialize in a particular

curriculum area? Are we identified with a specific area of applied psychology? Are we paramedical specialists? special educationists? social workers? technicians? Others have projected all these and many more images upon us, and sometimes we have adopted these as self-images. All these areas are indeed encompassed in our job responsibilities. As a profession, however, the acceptance of ourselves as a sub-specialty under any of these headings would lead to the loss of our autonomy as professionals and to the downgrading of our services to clients. (p. 10)

The development of a consensus position and rationale statement can, therefore, be a monumental task. However, if the legislature detects a lack of agreement within the profession, the chance of securing passage of the bill is extremely slim. In securing a consensus position, the American Speech and Hearing Association (ASHA, 1973a) recommends the appointment of a licensure steering committee composed of representatives from all job settings, panel discussions and audience reaction sessions at state or regional conventions, and a membership poll assessing individual positions on the licensure concept in general and on the proposed bill in particular (p. 22). Critical aspects of the bill, such as "grandfathering" and "exclusion," must be thoroughly understood by each member of the state association prior to requesting a formal vote. Warnath (1978) addresses these two aspects.

Grandfathering and exclusions will allow many to practice who some members believe are unqualified. Part of the political process in reducing opposition to the bill is the need to exclude certain competing groups from the provisions of the bill. Additionally, there is the need for a waiver of some standards for members of the organization sponsoring the bill that may go into effect after a period of time. As mentioned earlier, strong opposition to a bill, particularly from those within the sponsoring organization, can make passage of a licensing bill almost impossible. . . . to eliminate the possibility of internal opposition to the bill, a grandfather clause is usually included. . . . The irony of licensing is that, during the first year or two, the licensing board finds

itself in the position of affirming the right to practice legally to a number of colleagues to whom they would never trust the welfare of a client. (p. 53)

Development of a legislative support mechanism involves securing expert witness testimony, generally from members of the legislative steering committee, and eliciting broad-based grass roots support from the state association's membership. A plan must be formed for mobilizing the membership to respond in a given manner should circumstances necessitate it. However, careful advanced content analysis and drafting of the bill may eliminate the need for "crisis" behavior. Gilb (1966) states:

Advantage comes not simply from knowledge of the law or technical skills of drafting, for these can be obtained from politically neutral craftsmen, but also from mastery of the strategic considerations that enter into determining the content of a bill: whether several bills or one omnibus bill is more appropriate, how much to ask for, how much bargaining leeway to allow, how to bury controversial items, how to highlight politically advantageous requests, when to be precise and when to be vague or ambiguous. The way a bill is couched may greatly influence the probable numbers and kinds of participants in the legislative process. On the other hand, in tempering bills to make them pass smoothly over the legislative terrain, the authors have permitted that terrain to influence their point of view and hence the form and substance of the law that eventually emerges. In this way special interests and public pressures interact and blend. (p. 208)

The sponsor of a licensing bill (also referred to as the author of the bill) should be a respected legislator who is, if possible, personally committed to the bill. It is also beneficial if the sponsor is a member of one or more of the committees that will review the bill and if he is a member of the political party that is currently in power (ASHA, 1973a). The sponsor of a bill generally works with a member of the other house when the bill is under consideration there, and the

sponsor's intensity in connection with the bill is easily perceived by his colleagues at this time. If the sponsor does not consider the bill to be crucial, or if other legislative matters or personal concerns divert his attention from the bill, the politically astute professional association will attempt to exert a sufficient amount of pressure to maintain the forward progress of the bill. It is aphoristic that while all bills are treated equally by their sponsors, some are treated more equally than others.

The assignment of a bill to a particular legislative committee may be another crucial variable affecting passage of the licensing bill. It is possible for the power of assignment to be used deliberately to influence the fate of professional licensing bills; however this appears to be a rare occurrence. It is more often the case that the manner in which bills are drafted prompts a particular initial assignment -- an omnibus bill may be shuttled to one committee while several more limited bills may be divided among two or three committees, depending upon each bill's primary emphasis. If a committee does not act favorably on a bill, it is very doubtful if passage can be secured. Committee response is not only dependent upon the committee members' reaction to the bill itself, but it is also influenced by the respect and prestige accorded the sponsor and by whether the bill arrives at committee early or late in a legislative hearing or a legislative session.

Committees generally do not seek controversy when no controversy is evident. When controversy is apparent but involves only a few persons, the committee may function in a manner similar to a pretrial conference in a court of law. The committee will hear proponents, opponents, and then often defer action on the bill for several weeks to allow both parties to reach agreement.

A Case for Licensure

Although professional abuse of self-regulation has fostered numerous diatribes against professional and occupational licensure and has resulted in the advancement of numerous alternatives, a few writers specify isolated benefits to be gained by licensure and a handful continue to steadfastly defend this form of regulation. Barger (1975) maintains that arguments favoring licensure concentrate on reduction in fraud or diminishment of incompetence (p. 198). Kasper (1977) believes that the most powerful argument for occupational licensure is "that it (potentially) guarantees a minimum standard of practitioner competence in an area too technical for the average consumer to make an intelligent, informed decision" (p. 168). Without licensure, the quality of service that consumers would be able to purchase would be below that which they would be willing to purchase. Barron (1966) states that "licensing is economically justified if the burden of higher prices is less than the social costs that would arise from damage to the public health, safety, welfare, or morals that would occur in the absence of licensing" (p. 643). Thus, Barron views the amount of licensure necessary as a value judgment to be made by those responsible for its application. Lieberman (1970), neglecting the burden of higher prices, addresses this issue of "damage to the public health, safety, welfare, or morals" by contending that by licensing professionals we may have better assurance of professional responsibility than would be true by litigating alleged malpractice on a case-by-case basis (p. 240).

Cottingham (1978), writing in connection with the impelling forces for counselor licensure, makes a salient point regarding lack of licensure and third-party payment.

Counselors may eventually offer mental health services under medicaid, medicare, or pending national health insurance. If such is the case, their present ineligibility as third-party payees with insurance companies would preclude any financial reimbursement. The counseling profession must first establish its credibility with the public and with the insurance industry on an outcome-per-case cost basis with in-house quality controls. (p. 331)

Cottingham's apparent belief that licensing will be a prerequisite for federal reimbursement under a national health insurance plan may be well founded, for the very impetuses that are propelling the United States toward a national health care system will no doubt mandate that tax dollars be expended only upon qualified care provided by qualified practitioners. Certainly those licensed in their respective health fields will be at a great advantage regardless of what requirements the federal government imposes upon those who serve within the system.

Business Week ("How Licensing Hurts Consumers," 1977) points out that while most recent research has been detrimental to the case for licensing, one major study indicates that stricter licensing of dentists may be in the patient's best interest. Arlene S. Holen of the Center for Naval Analyses, quoted by Business Week, contends that "in occupations where the cost of searching for information and the cost of an adverse outcome are both high, licensing can be well worth it" (p. 130). Holen's study demonstrates that dentists practicing in states possessing stricter licensing requirements are involved in fewer malpractice suits and benefit from increased demand for their services due to the fact that consumers feel reassured. Moreover, Holen reports that more stringent dental licensing laws do not produce higher costs for the consumers of dental services. Cost variability of such

services from state to state is no greater than that of other health related expenses.

Thomas Y. Hobart, Jr., a member of the New York State United Teachers and American Federation of Teachers, is a staunch advocate for teacher licensure. Hobart claims that

teachers will benefit because there will be an upgrading in the quality of education. . . . We feel that standards set (by licensing) will assure the community that those candidates for the classroom are prepared to start teaching. I think licensing will be a benefit to all citizens, as well as to the teachers themselves. . . . Licensing will weed out a few people. I can forecast this happening in the teaching profession, and I think it is bound to have an effect on the quality of teaching. (Heisner, 1976, p. 184)

Finally, Levine (1978) comments that since individual licensure is the method of regulation familiar to most professionals, and since after 150 years the difficulties inherent in licensing have been well documented, "the wisdom of retaining a familiar system and attempting to alter it to alleviate the faults can be argued" (p. 112). She continues by asserting that since a viable alternative does not appear to be forthcoming, "individual licensure appropriately modified could eliminate the need for developing and testing alternatives" (p. 112).

Attack on Licensing and Credentialing

Even a cursory reading of the text to this point will have revealed to the reader the disenchantment felt by many with regard to the present day licensing and credentialing of professionals. A number of the arguments against licensing have of necessity been previously mentioned; however an attempt will now be made to consolidate and amplify these arguments and to illustrate a number of other criticisms aimed at these traditional means of regulation. It should be noted that, although some

writers offer nothing but destructive criticism of licensing and certification, a number of authors advance what they believe are viable alternatives. These alternatives will be discussed in a later section of this chapter.

In considering the allegations against licensing and credentialing, it is important to evaluate the source. A number of writers, such as Barger (1975), are avowed champions of the free marketplace and as such would eliminate anything that attempted to regulate, modify, or influence the age-old relationship between buyer and seller. Others, as Gross (1977), are members of a discipline that has long struggled to escape from the domination of a well-organized, established, licensed profession. Hence, attacking licensure in general may be, in effect, a lashing out at the particular circumstances which lead one to feel cheated or abused. The opposite may also be true, for it is difficult to believe that when a powerful licensed profession advocates a moratorium on licensure of health occupations, they are doing so only out of concern for the public welfare and not, at least partially, out of concern for their position in the licensing hierarchy (see AMA, 1970). The perspective from which fiery anti-licensure rhetoric comes may be narrow indeed! Still others are motivated in criticizing licensure by fears of being discovered as incompetent by licensure and re-licensure examinations (see Heisner, 1976) or by injustices which could be corrected without "throwing the baby out with the bathwater." This is not to make the assumption that an individual's personal relationship with licensing disqualifies him from proffering criticism of the entire licensure system; however the reader should keep in mind that there is

often a tendency to generalize based upon limited personal experience.

At the crux of the licensure and certification question for many writers is the issue of public protection. The Journal of the American Medical Association ("Licensure of Health Occupations," 1969) writes:

The voluntary certification programs developed by the various professions and occupations also assure public protection by improving education and training programs, accrediting such programs, and requiring compliance with professional and ethical standards. . . .

The explosion of scientific and technical knowledge with the resulting increased demand for newly developed, special skills has brought the effectiveness of both licensure and voluntary certification programs into question. (p. 2154)

Barger (1975) states that he finds scant evidence that licensing protects the consumer of professional services from fraudulent or deceitful practices, and he goes so far as to assert that not only has licensure failed to protect the public from incompetence, but it has on occasion "forced it on the unsuspecting public" (p. 199). Kasper (1977), assuming for the sake of argument that the purpose of licensure is to protect the public, asks whether the consumer requires additional safeguards beyond the normal range of consumer protections. If additional protection is necessary, Kasper questions if licensure is the best means to that end (p. 168). Writing with reference to medical licensure and public protection, Kasper asks:

But do consumers of medical services really need the purported protection of licensure? In addition to their normal common sense, patients are protected by the operation of market forces such as the doctor's desire for continued patronage and the availability of alternate physicians to supply services a doctor fails to provide patients. Further protections are provided by law. Incompetent or careless doctors can be sued for damages arising from malpractice or breach of contract. Civil and criminal prosecutions for fraud and other offenses are also used to police physician conduct. Finally,

physicians undertake certain ethical obligations by virtue of their office, and these, too, afford some protection to patients. (p. 168)

One is reminded here of Lieberman's (1970) assertion, as documented in the previous section of this text, that in licensing professionals we may obtain more professional responsibility than would be true by litigating malpractice on an individual case basis. Barron (1966) believes that "general public law covers most, if not all, of the behavior . . . that is of any use to the public. The majority of these rules of conduct serve only as devices to reduce competitive behavior" (p. 664). Business Week ("How Licensing Hurts Consumers," 1977) goes one step further when they contend that licensing can actually threaten the physical welfare of the public. In quoting from a study conducted by Gaston and Carroll, Business Week writes that the licensing of electricians "is significantly related across all 50 states to the rate of death from accidental electrocutions" (p. 130). The seven states with the most stringent licensing requirements, according to this study, have as many as ten times more accidental electrocutions than the national average.

The question of public protection is far from being the only avenue of attack on licensure and credentialing. Gross (1977) affirms that "the most insidious effect of licensing is that it is a major support of a system that creates a dependency on professionals, a dependency that reduces the ability of people to care for themselves" (p. 587). Gross and Osterman (1972) likewise write with respect to professional dependency and licensure's perpetuation of the "myth of professional invincibility" (p. 22), but they tend to focus more upon the supposition that the professional license or certificate acts to create a monopoly

on the practice of skills and serves an economic function, as when the availability of needed skills is maintained at an artificially low level to reap high returns.

Kasper (1977) comments on the high cost of licensure by calling attention to the expensive operational costs involved. Moreover, Kasper contends that licensure often inhibits the introduction of less expensive technologies by helping to perpetuate an expensive, overly standardized system (p. 169). In this respect, Kasper sees licensure as "essentially a static response to a dynamic process" (p. 170). Moore (1970) reflects an attitude similar to Kasper's. Although Moore attests to the value of licensing insofar as restricting charlatanry and reducing consumer uncertainty are concerned, he is quick to acknowledge that licensure "may also be a source of stultification, preventing new approaches with possibly superior claims" (p. 242). Rogers (1973) reflects upon this relationship between regulation and innovation.

And I have slowly come to the conclusion that if we did away with "the expert," "the certified professional," . . . we might open our profession [psychology] to a breeze of fresh air, to a surge of creativity, such as it has not known for years. In every area, medicine, nursing, teaching, brick-laying, or carpentry, certification has tended to . . . narrow the profession, has tied it to the past and discouraged innovation. If we ask ourselves how the American physician acquired the image of being a dollar-seeking reactionary, a member of the tightest union in the country, opposed to all progress and change, and especially opposed to giving health care where it is most needed, there is little doubt that the American Medical Association has slowly, even though unintentionally, built that image in the public mind. (p. 383)

Occupational Outlook Quarterly ("Occupational Licensing: Help or Hindrance?" 1973) reacts to the lack of innovation in occupational training programs.

Licensing requirements maintain the status quo in occupational training programs. Licensing boards generally define training requirements in hours or years completed. Because applicants must spend a specified amount of time in training, educators have little incentive to develop more effective, more efficient, or shorter training programs. . . . schools are compelled to teach toward two sets of objectives: preparing students to do a job efficiently, and teaching what they need to know to be licensed. (p. 34)

Barger (1975) censures the licensing process for making it easy for the professions, especially medicine, to control entry into the discipline by deciding who should be allowed to attend professional schools and who should not (p. 197). Barron (1966) asserts that if entry requirements must be retained in licensing laws, such requirements should be decided upon and enforced by the state, and not the profession.

As a practical matter, one might ask how the licensing function could be removed from the hands of the profession or occupation being licensed. The answer is, essentially, in the same manner that licensing of drivers is removed from the hands of drivers themselves. It is true that "professional" drivers administer the requirements for entry into the licensed driver field. The important point is that they do not earn their living as professional drivers selling their services to the public, but as employees of the state. They are paid for licensing, not for engaging in the profession of licensing. (p. 664)

Roemer (1974), recognizing that licensing laws create many rigidities, writes that in many instances licensing boards consist solely of members of the profession seeking licensure. These boards often produce "segmented manpower policies, made with little representation of other professions, providers, or the public" (p. 27). Roemer isolates a number of other difficulties which she believes were engendered by licensing laws.

1. They barred movement within an occupation and between related occupations by specifying hard and fast educational requirements.

2. They failed to protect the public adequately because they required no updating of qualifications.
3. They discouraged mobility of health personnel across state lines because of restrictions on recognition of the licenses of other states.
4. They blocked recognition of qualifications in education or experience other than those specified. (p. 27)

Many writers in this area appear more than willing to verify and elaborate upon Roemer's statements. Applicants for licensure frequently are given inadequate information by licensing boards concerning licensing requirements and procedures. Often, in response to the inquiries of potential licensees, such boards simply mail the individuals copies of the applicable state statute. Seldom is there an attempt to anticipate and respond to questions which applicants are most likely to have ("Occupational Licensing: Help or Hindrance?" 1973). Occupational licensing has also been accused of discriminating against minorities and the poor (Rogers, 1973; "How Licensing Hurts Consumers," 1977) and of "maintaining the interests of exclusive clubs against those of the public" (Gross, 1977, p. 586). Barger (1975) writes of individuals who do well on examinations "but fail dismally in the practical application of the knowledge they are supposed to possess" (p. 199), while Kasper (1977) points out that without licensure statutes, insurance companies would be motivated to assume a more active interest in the quality of care rendered by practitioners to those whom they insure (p. 169).

The federal government has, on repeated occasions, attempted to evaluate the merits of licensure within a given area. Barger (1975) asserts that "the Federal Trade Commission chairman was quoted as

saying that occupation licensing hasn't prevented fraud, incompetence, or price gouging" (p. 195) and Business Week ("How Licensing Hurts Consumers," 1977) reports that "federal agencies are beginning to mount a drive to stem its [licensing's] headlong growth. In bringing licensing to heel, they will be relying on a host of new studies demonstrating that, for most occupations the cost far outweighs the benefits" (p. 127). Schorr (1977) writes of the growing concern in Washington with regard to state licensing, and he quotes a deputy assistant attorney general as telling a Senate Small Business subcommittee hearing that restrictions imposed by licensure "mean less competition, and less competition means poorer service at higher prices" (p. 48). Finally, the U. S. Department of Health, Education, and Welfare (H.E.W.), in a 1977 publication, attempts to summarize the findings of earlier H.E.W. studies dealing with licensure in health occupations.

The studies showed that State licensure of the health occupations had evolved into a system of varying requirements, responsibilities, and controls that tends, in many instances, to impede effective utilization of health personnel, to inhibit geographic and career mobility, and to foster variable licensure standards and procedures in different regions of the country. Furthermore, licensing agencies often tend to emphasize formal education and other requirements for entry into a profession but devote much less attention to assuring the continued competence of those who are licensed. In some cases, the involvement of professional associations in the activities of licensure boards raises questions about the independence and objectivity of the boards. (p. 4)

The criticisms to which licensing has been exposed have had their effect. Behavior Today ("Pressure Builds to Improve," 1976) writes of the momentum to improve occupational licensing in the states which has been produced by the assault on licensure. "Changes are very

definitely coming. . . . Three or four years ago people weren't even admitting there were problems" states Karen Greene, a manpower analyst for the U. S. Department of Labor (p. 1). Ms. Greene delineates Colorado, California, and Florida as states in the vanguard of regulatory reform. While the quest for licensing reform continues and will continue, those initiating, augmenting, and evaluating these reforms will do well to remember, as Roemer (1974) asserts, the best protection of the quality of service providers "is not licensure, but rather the educational preparation, both academic and practical, that each student receives" (p. 31).

Alternatives to Traditional Forms of Control

If not licensure, then what? Barron (1966) argues effectively that the alternatives to licensing are not clearly comprehended, and this lack of understanding often leads to the unquestioned acceptance of arguments advanced for licensing. This statement appears accurate, and an attempt will be made here to briefly outline some of the alternatives offered by those dissatisfied with conditions as they now exist.

Moore (1970) rephrases the question posited in the previous paragraph and then continues by providing an answer which apparently is quite satisfactory to many critics of licensure.

Licensing authenticates a professional (and a variety of other occupations) if indeed a client seeks him out. How is authentication otherwise established? To hang out a shingle is proper in private practice in Western Europe and the overseas heirs of European traditions. Such chaste streetside notices (perhaps supplemented by "professional cards" in local newspapers and by listing in telephone directories) are likely to carry only initials relating to earned degrees. . . . (p. 219)

Barger (1975), in basic agreement with Lieberman, believes that the public has fared quite well in its relationship with many unlicensed professions and occupations, and he affirms his belief in the wisdom of the American consumer by asserting that, "if he thinks for himself and exercises good judgment, [he] can still function far better in choosing a professional person or skilled tradesman than can any licensing board" (p. 201). Gross (1977) laments the bandwagon psychology which assumes that the choice is between licensing and more restrictive legislation, and that given this choice licensing is eminently preferable. He suggests an alternative to licensure wherein a means by which consumers can protect themselves is integrated into the legal structure. Like Barger, Gross has an abiding belief that an informed public is the best means of regulating the professions, and since consumers "have experience with the service and its consequences and the potential to do something about it," the professions must be required to provide the consumer with "sufficient information to make sense of their experience and to overcome their mystifying dependence" (p. 588). Kasper (1977) favors replacing licensure with a system combining the public disclosure of a professional's education, training, and experience with voluntary accreditation and certification. Such a system would, according to Kasper, maintain the benefits of licensure without maintaining the high cost of licensure. Social adjustments would be necessary, especially with regard to educating consumers for intelligent decision making. Moreover, Kasper contends that such an alternative would "require somewhat more humility about our collective ability as a society to improve the lot of consumers and somewhat more

faith in the basic intelligence and educatability of human beings" (p. 171). Kasper's idea is not new. Friedman, in 1962, proposed a similar alternative.

In consequence, certification without licensure is a half-way house that maintains a good deal of protection against monopolization. It also has disadvantages, but it is worth noting that the usual arguments for licensure, and in particular the paternalistic arguments, are satisfied almost entirely by certification alone. If the argument is that we are too ignorant to judge good practitioners, all that is needed is to make the relevant information available. If, in full knowledge, we still want to go to someone who is not certified, that is our business. . . . (p. 149)

Sweeney and Sturdevant (1974) advance a number of alternatives to be considered by counselors who wish to maintain the counseling profession's identity against the encroachment of psychology. One such alternative suggests that "in light of recent trends toward competence-based counselor training programs and certification, APGA members may wish to develop strategies for licensure in other than the traditional mode" (p. 580). Little elaboration upon this alternative is attempted by the authors; however reference is made to a certification plan based upon performance criteria which is used in the state of Washington.

Mackin (1976) supports working for change within the present licensing framework as an alternative to maintaining the system as it is currently operated or discarding licensure altogether. He focuses his attention upon needed reform in the area of licensing examinations.

If licensing tests were abolished, control over occupational aspirants could be exerted by other means without sacrificing the public safety and welfare. Such means could include strengthening the prelicensing training. Greater control over training schools and programs could be exerted by professional associations. . . . The result might be that people who were able to succeed in their training, regardless of their ability to pass a posttraining test, would be eligible to be licensed. (p. 511)

Roemer (1974) disagrees:

In the United States, our pluralistic system would seem to indicate continuation for some time to come of some form of examination, in addition to educational preparation. Therefore, educators of allied health manpower, licensing boards, the health professions, and the professional testing agencies are addressing themselves to devising more meaningful examinations to test competence. (p. 32)

Like Mackin and Roemer, Consumer Reports ("Consumers Seek Public Voice," 1976) chooses to advocate reform rather than abandonment.

Unlike these authors, however, Consumer Reports concentrates upon the makeup of licensing boards rather than upon the efficacy of licensing examinations. Such boards should have consumer representation, a "victory" which could "eventually result in lower prices and enhanced competition in services vital to the public" (p. 373).

Levine (1978) writes that numerous alternatives to individual licensure in the health professions have been suggested in the literature, however she states that most of these have been "discussed but dismissed" (p. 110). Levine lists peer certification, uniform license codes, and amendment of medical practice acts to allow delegation of tasks by physicians as examples. Barron (1966) decries this summary dismissal of alternatives.

The reaction to some, or all, of these alternatives may be exemplified by the statement, "It just wouldn't work. Everybody knows that without licensing the public welfare would deteriorate due to the chaotic conditions that would result." This is precisely the attitude that enables professions and occupations to engage in price-fixing against the consumer and in exclusionary tactics aimed at possible new entrants to the profession. Carried to its logical conclusion, this attitude would allow a return to the guild system. (p. 657)

Pellegrino (1977) advocates "task analysis" as an alternative to the unbridled licensure of health care technicians, and his suggestions appear to have applicability for areas outside the realm of health care. Pellegrino stresses the need for a reduction in the ultra-specific categorization of technicians and for a consolidation of their functions. A primary step in working toward these goals is "to hark back to the spectrum of functions now being performed by the whole category of allied health workers and, by the method of task analysis, reduce these to their commonalities and similarities" (p. 26). Subsequent to completing this initial step, these tasks must be reduced to as few categories as possible. It is then feasible, according to the author, to realign these tasks based upon perceived similarities and to redistribute them to the various health professions that have a basic education adequate for their successful completion. Pellegrino indicates that by using this approach it is possible to consolidate professional functional groupings, and he gives an example of five such groupings applicable for a hospital setting. These are

1. Diagnostic Services,
2. Manual and Manipulative Therapies,
3. Chemical and Dietary Therapies,
4. Psychosocial Therapeutics,
5. Preventive Health Care, Patient Education. (p. 27)

Institutional licensing has been the focus of renewed interest in the past few years. Kasper (1977) writes:

Licensing only individual doctors, nurses, and other individuals in an institutional setting is comparable to licensing tires and carburetors but not cars. In fact, it is much worse than that, for it prevents the

institutional provider from experimenting with different combinations of medical personnel in order to find better ways to deliver health care services. In short, licensure focuses on the input characteristics of medical care (the training of doctors and nurses) when what is ultimately important is the outcome (healthy patients). (p. 171)

The institutional licensing plan most often debated, the Hershey plan, proposes that individual licensure be retained for those independent practitioners coming into direct contact with the consumer, but that facility licensure be extended to incorporate individuals working within an institution in a dependent capacity. Furthermore, the plan suggests the use of a job description classification to be created based upon the recommendations of a state-appointed board. Every employer of health workers would submit task list job descriptions to this board for review, the board then determining the education, training, and experience qualifications necessary for each task. Also determined would be the standards by which individual performance would be measured and evaluated. Institutions would be subject to on-site inspection to ascertain whether employees were performing to the satisfaction of the board, and institutions would be held strictly accountable by law for maintaining an acceptable level of service. Thus, nonphysician professionals presently licensed would lose their individual license and enter a large pool of health care workers whose potential usefulness would be relative to their ability to qualify for the hybrid jobs designed by the institution of their employment.

Roemer (1974) believes the Hershey plan has the advantage of allowing for greater innovation and flexibility in the use of health care workers in institutional settings. Moreover, Roemer contends

that "institutional licensure would recognize legal responsibility of health care institutions for the quality of care they provide by expanding institutional responsibility for performance of personnel" (p. 29). Roemer does take note of the general concern that the Hershey proposal may serve to lock individuals into unique job descriptions and, consequently, work toward the growth of even greater numbers of health care occupations.

Levine (1978), writing with regard to the unlicensed employee pool discussed above, asks what guarantee will be forthcoming that these health care workers are indeed qualified. She hypothesizes that such a proposal might be viewed as "a foolish cost effective move to get two or three less expensive people to perform fragments of the task originally performed in total by one more expensive professional" (p. 112). In addition, Levine points out that "quality" must be operationally defined and quantified. Based upon these and other observations, Levine states that she believes it is doubtful whether successful implementation of institutional licensure could be achieved under present conditions. She further notes

that in general the arguments for individual licensure are the same as those against institutional licensure and vice versa. . . . A person cannot stand in the middle ground; he is forced to make a decision for or against one, thereby automatically rejecting or accepting the other, for the two are diametrically opposed, and mutually exclusive. (p. 111)

Thomas (1974), in obvious disagreement with Levine, suggests that it is not necessary to make a choice between these two methods of licensure which Levine views as being so contrary. Rather, Thomas advocates the use of a combination of both institutional and individual licensure.

That is, licensure of a given institution must be expanded to include the means to assess facilities, equipment, and staffing to determine if these are being maintained in a manner consistent with the current best interests of the consumer.

Simultaneously, licensing laws governing healing arts professionals need to identify competencies that can be measured to assess currency of practice at any given point in time. The "fit" between these two licensing procedures is the surest guarantee that both health facilities and the care administered in them will most nearly meet the current needs of the consumer. (p. 80)

A review of some of the many alternatives offered to licensure may still have the reader asking, "If not licensure, then what?" Public disclosure demands an expensive, continuous, public education program that would attempt to make the consumer aware of the qualifications he should look for in hundreds of professions and occupations. A public which for years has manifested almost total apathy with regard to the need for examination of professional credentials will probably continue to do so. Our modern life style necessitates numerous encounters with practitioners from many disciplines, and consumers have neither the time, patience, nor interest to examine each practitioner's qualifications. The unscrupulous practitioner will always be "one jump ahead" of a public which is asked to protect itself, and large, modern offices, fancy diplomas from mail-order schools, and "cut-rate" fees would doubtless secure much patronage for unqualified practitioners in the absence of licensure. Kasper (1977) writes that "it seems highly unlikely that the Mayo Clinic, for example, would fail to deliver quality health care in the absence of mandatory licensing of individual doctors" (p. 169). Barron (1966) states:

If I want a "safe" yacht salesman, I can hire someone who has been building yachts for ten years to inspect my prospective purchase, and I can hire an attorney to

examine the contract. I can call the Better Business Bureau, or I can consult my friend or my banker who now owns a yacht. If I want a "good" barber, . . . I can spend ten minutes observing finished customers leave the premises of a barber, or I can ask a friend who already has a good haircut to refer me to his barber. (p. 662)

If everyone lived next door to the Mayo Clinic or had the time to examine in detail the work of each professional whose services were being contemplated, these comments might have merit. Or, if each purchase that was made or service that was secured was as important to us as buying a yacht, the time and money utilized in hiring an attorney, a yacht inspector, etc. might be worthwhile. However, the funds that would be expended by the individual purchasing the yacht in order to ascertain that his yacht craftsman was competent would probably exceed any excess cost which might be attributable to the licensing function. Moreover, if one inspected the dental work of every dentist (assuming one were competent to do so) until he found one that suited him, and the haircuts of every barber, and the results of every psychiatrist, and so forth, one would have time for little else in life. Public disclosure as an alternative to licensure is highly impractical and would undoubtedly lead to greater abuses and more consumer dissatisfaction than is presently the case.

Institutional licensure, which claims to be more interested in the quality of patient care (output) than with the specific credentials being brought into the institution by a professional (input), fails to take into account the need for identification, self-realization, and self-actualization among institutional employees. Thomas (1974) delineates a key failing of institutional licensure.

Research conducted over the past two decades provides overwhelming evidence that the most productive, the most innovative, and the most quality-conscious employees are those who have a marked degree of freedom in the delivery of their services, who identify with a recognized group of experts in their fields, and are directly accountable for the results of their acts. . . . For a solid majority of these individuals, lumped into a general pool of health workers, it will become unthinkable that attention to the special needs of a patient might have a superior claim over the performance of lists of tasks spelled out in state-approved job descriptions. The important reference group will become the employer, not the consumer. (p. 78)

Perhaps then, attention should be focused upon creating changes from within. Certainly a prime area in which critics are clamoring for change is in the composition and functionings of state licensure boards. This will be the next topic for examination.

State Licensure Boards

Licensing boards constitute the arms of state government that regulate trades and professions. Gilb (1966) reports that one of the primary reasons why many professions reorganized early in the twentieth century was to "help create a licensing board where none existed or -- where one already did -- to tighten the profession's liaison with the board and to bolster its effectiveness" (p. 42). The usual pattern was to create an independent licensing board, although in some states licensing boards were established within departments that regulated similar areas. When a state chose to follow an independent board pattern, the necessity of formulating a separate law to regulate the organization and operation of each board often resulted in a proliferation of such boards beyond the state's ability to monitor them. Consequently, a number of states began to realize that "centralization

makes possible some measure of responsibility to the elected representatives of the people" (Council of State Governments, 1952, p. 32), and that the economies brought to routine operations by centralization were worth the reorganization effort. A number of states extended the centralization concept one step further, deciding to centralize to the point of creating a single state department within which would reside the multitude of individual licensing boards. Hence Illinois, in 1917, created the Department of Registration and Education which supervised the activities of 14 occupations and professions, and the state of Washington established a separate Department of Licenses in 1921 (Council of State Governments, 1952, p. 24).

Today, the trend toward centralization continues. Barron (1966) discusses the centralized California system.

Licensing procedures in California are representative of those used in most states. The majority of *individuals* licensed to practice an occupation in California are licensed under the Department of Vocational Standards. The Department contains twenty-three boards, two commissions, and two bureaus. Other state agencies issue licenses to individuals, but their effect is similar to those issued by the Department. The Department of Professional and Vocational Standards is essentially a figurehead, since the separate boards are largely autonomous. (p. 643)

While advocates of centralized licensing point to increased coordination, reduced duplication of "routine" work, and a diminished role for the interests of private associations in determining board policy, there are those who assert that centralizing the licensing function leads to control of professions and occupations by individuals who are not familiar with or may be apathetic to problems specific to an occupation. Moreover, critics of centralized licensing frequently contend that

centralization is conducive to a strengthening of executive controls over licensing boards which may easily lead to the exertion of partisan political influences. Finally, opponents of centralization assert that independent licensing boards have a genuine interest in protecting the public health and welfare, and that independent boards are "closer" to the people they serve.

Despite these contentions, the call for centralization continues and will apparently continue for some time to come. Angel, writing in 1970, reports that at that time over a third of the states had centralized their licensing processes to some degree. The Educational Testing Service applauds this trend.

. . . licensing boards would be more efficient and more accountable to the public if they were centralized under one State agency, where they would be answerable to an agency head who could set standards and require detailed reports about the activities of each board. The central agency could also provide a variety of housekeeping services to the boards, such as replying to inquiries, processing applications, collecting fees, and administering and scoring examinations. Such an arrangement would leave the boards free to concentrate on substantive matters such as examination specifications and qualification standards. ("Occupational Licensing: Help or Hindrance?" 1973, p. 35)

In many states, however, small, independent licensing agencies maintain control of the licensing function. Schorr (1977) estimates that the total number of state licensing boards exceeds 1500, and he reports that Illinois alone has 32 boards that regulate almost 100 professions. The number of individuals serving on a licensing board varies from profession to profession, and Angel (1970) affirms that few boards have as many as ten members (p. 23). Lieberman (1970) attests to the variable tenure of board members within and between states (p. 23). Members of most state boards are individuals with a

direct interest in the area being regulated by the board. Generally, board members are appointed by the governor, with the chief executive of the state choosing appointees from the membership rolls of the state association. Thus, a licensed practitioner who works within a state but chooses not to belong to the state association may be excluded from consideration. Moore (1970) notes that often legislation concerning board appointment "is vague on criteria of membership on the commissions, seemingly leaving selection to the appropriate official's discretion. In other instances, the qualifications for members of licensing boards are made explicit in terms of 'qualified' members of the appropriate occupation" (p. 126).

Consumer Reports ("Consumers Seek Public Voice," 1976) writes that "typically, the boards are empowered to determine, among other things, who may gain a license to practice, whether professional advertising is allowed, where and how licensees may sell their services, when disciplinary action is appropriate, and how consumer complaints are handled" (p. 372). Angel (1970) states that the functions of a board are two-fold -- to regulate admittance into the occupation in question and to support and enforce occupational work standards (p. 21). Angel views the duties of licensing boards as consisting of

1. examination or other determination of eligibility of applicants for licenses;
2. issuance of licenses;
3. suspension, revocation, and restoration of licenses;
4. enforcement of licensing statutes;
5. approval and supervision of schools. (p. 30)

Other duties of licensing boards can include the collection of fees, the distribution of information to applicants relevant to the state statutes and board policy and, in some cases, the fixing of minimum prices.

The financing of state licensing boards may be accomplished in several ways. Probably the most common method is through the collection of fees for license application, license issuance, and license renewal. The Council of State Governments (1952) estimates that in 1951, approximately two-thirds of all state boards were financed solely by fees collected (p. 46). These fees, according to Angel (1970), may either be retained by individual boards in their own state board accounts or deposited with the state treasurer in a special board fund. In this latter case, the withdrawal of funds by a licensing board may require a special appropriation act by the legislature despite the fact that the legislative appropriation generally equals the amount deposited. Angel continues:

Generally, the amount allotted to each board for operating costs is determined by the volume of the fees collected.

Funds collected from members of a licensed occupation are frequently used solely to regulate that occupation. On the whole, licensing boards are largely independent of control by other agencies of state government. In some states, funds in excess of a set amount revert to the general or state fund at the end of the year. (p. 32)

Akers (1968, in Lieberman, 1970) indicates that sometimes an association will donate money to a licensing board for enforcement work, and occasionally a board may contribute funds to the association either directly or by paying the rent on association office space. Indirect contributions can likewise be made by "paying a full-time salary to a part-time employee who can then donate his services to the

association. . ." (p. 23). Warnath (1978) contends that licensing boards are notoriously underfunded. He reports that many legislators habitually vote against establishing any licensing board which would require funding from the state, a situation which requires boards to exist independently on the fees which they can collect. Such underfunding may prevent boards from providing applicants with sufficient information, and may inhibit a board's ability to force unlicensed individuals to cease the practice of activities which the board was theoretically established to oversee. Not only may a board find itself unable to deal with the unlicensed, but monitoring and policing the activities of licensees may create definite problems.

Even if a Board would have the money to defend itself against a suit brought by someone whose license it revoked because of client complaints, its chances of winning such a legal confrontation would be so low that it would be unlikely to be able to do more than to talk informally with the alleged offender. Those who believe that the establishment of a Board of Examiners will automatically "clean out" bad practitioners need to think through the full implications of what would be required of a Board in time, energy, and financial resources. . . . (Warnath, 1978, p. 53)

Kelly (1977) reports that of almost a million employed nurses, the total number of suspensions, revocations, probations, and reprimands is considerably less than 0.5%. The overwhelming majority of these are for drug related offenses, while almost none are related to incompetence (p. 565). Consumer Reports ("Should Mechanics Be Licensed?" 1976) contends, with reference to licensing boards and disciplinary power, that a major flaw in the 30 year old Ontario system for licensing mechanics is that no provision has ever been instituted for license revocation. In 1973, an Ontario government task force assessed the system as it was operating and recommended abolition.

With the increased emphasis by state legislatures on sunset review, it would appear that licensing boards will be obligated, as part of their justification for continued existence, to more efficiently carry out the established procedures for dealing with recalcitrants. Such procedures are usually delineated in the state statutes; however sometimes they are prescribed in the state's administrative procedure act or relinquished to the discretion of the board. Angel (1970) states that usual requirements include a written notice of charges lodged against the individual and a hearing at which time the practitioner may submit evidence in his defense. Often such hearings are conducted by the individual licensing boards, and Angel points out that "the power to issue formal revocation orders may rest with the board or the head of the licensing department, and, in a few instances, is vested in the courts" (p. 31). In those states where professional and occupational licensure is centralized, a member of the department staff may act as a hearing officer. His findings are subject to consideration by the board and, in some cases, by the department head.

The Council of State Governments (1952) notes the existence of disciplinary committees in a number of the more established professions such as medicine and law. Such committees act to screen charges of professional misconduct and to handle relatively minor cases. If further action is deemed necessary, the matter is placed before the state board or agency legally empowered to render a decision.

The inability of professional licensing boards in Florida to effectively police the practices of their licensees has prompted Florida Governor Robert Graham to warn such boards that "they could face extinction if the Legislature is unsuccessful in increasing control over

their rules and regulations" ("Graham Threatens to Abolish," 1979, p. 10A). Graham's statement was prompted by criticism that several of Florida's licensing boards, including the Florida Board of Medical Examiners, have been hesitant to discipline their licensees. This reluctance, critics maintain, is inherent under the current arrangement wherein the various professions are expected to discipline themselves. The Florida Legislature is currently examining means of eliminating this problem.

The House is considering a bill that would strip the professional licensing boards of power to discipline the professions regulated by the boards. . . .

The Legislature has been increasing the power of the Department of Professional and Occupational Regulation over those licensing boards as the boards come up for review in the state's "Sunset" process. However, the House bill would institute the changes in one fell swoop. (p. 10A)

Governor Graham has indicated that, should the House bill fail, he may consider vetoing legislation related to re-enacting licensing boards on an individual basis as they are examined under sunset review.

Probably the most prevalent criticisms aimed at licensing boards revolve around the issues of self-regulation and consumer (public) representation. As early as 28 years ago, the Council of State Governments (1952) was beginning to recognize the problem of associational regulation of licensing boards (basically, self-regulation). In enumerating six criticisms raised against licensing boards, the Council noted that such boards "may incorporate the ethics, standards, and particular interests of private associations into administrative regulations and thus give the status of public law to essentially private rules" (p. 4). Montgomery (1975) writes that increasingly

critics are focusing on the conflict of interest inherent in allowing professional and occupational associations to recommend for appointment those board members who will supervise them. Barron (1966) contends that board members cannot help but be influenced, even if only subconsciously, by the fact that the decisions which they make will affect not only their own welfare, but the well-being of their colleagues. More importantly to Barron, however, is the fact that board members cannot avoid being exposed to the influences of well-organized professional associations. Consequently, Barron argues that board members should be employees of the state so that their livelihood is not dependent upon the success of the professional service in the marketplace. Schorr (1977) decries the fact that "in the name of assuring quality service, these same professional groups continue to regulate themselves, often to their own financial advantage -- thanks to their political clout and their influence over state licensing boards" (p. 48). Gilb (1966) asserts that professional associations have opposed a number of attempts to curtail their influence over licensing boards. Some of the measures opposed by professional associations include

1. grouping licensing boards together in one department or division under one director,
2. giving that director veto power over board actions,
3. establishing budgetary controls and perhaps pooling licensing fees and placing them in the state's general fund rather than having them retained in separate accounts,
4. creating independent hearing officers and pooling investigators rather than having these functions performed by each board's staff,

5. adding one or more lay members to each board,
6. insuring more rotation of board members. (p. 193)

The issue of lay participation on professional licensing boards is no less a controversy than self-regulation. In a manner, of course, public representation may effectively diminish self-rule, hence some sources ("Consumers Seek Public Voice," 1976; Schorr, 1977) prefer to deal with one issue rather than two, and tend to view consumer representation as a panacea for self-regulation.

The infiltration by the public into the inner sanctums of the professional and occupational power base has had a profound effect. When Abraham Flexner, author of the historical report on "Medical Education in the United States and Canada," recommended in 1908 that all state medical boards which ruled on matters such as accreditation and physician licensing should be composed of physicians and not laymen (Wittlin, 1965, p. 98), a precedent was set which consumer groups are finding difficult to challenge. Montgomery (1975) comments:

In order to make state boards more responsive to the public, several states have passed laws requiring them to seat members from outside their profession. But opposition has been strong among trade and professional associations, who argue that the general public can't adequately evaluate the activities and qualifications of their members.

Florida is one state where such opposition successfully defeated a bill requiring lay membership on boards. "We'll fight it to the death," says Scotty Fraser, a lobbyist for the Florida Medical Association. Arguing that consumer members can neither hurt or help licensing boards, he says they would be "just a big waste of energy . . . an insult." (p. 20)

However, in the interim between the publication of Montgomery's article in 1975 and the present, the lay public has managed to make meaningful inroads into many licensing boards previously monopolized

by professionals. Schorr (1977) writes that California has led the crusade for consumer participation, and that the 38 California licensing boards which monitor the activities of approximately one million practitioners are now required to obtain from one-third to a majority of their board members from outside the professions they direct (p. 48). Street (1977) reports that one difficulty for public members of professional licensing boards is the determination of public sentiment on issues before the board. Public representatives hear testimony only insofar as the profession's interests are concerned, and objectivity is therefore difficult to achieve. Street continues with her observations concerning the responses of public board members in California.

On most of the boards, the new public members are asking such tough questions as "How does this protect the public health and safety?" and "Who cares?" . . .

If, as seems to be the case generally, the new public members are advocating broad, minimal standards of competence and ignoring professional standards of excellence, they are doing what the Department of Consumer Affairs wants them to do. . . . nearly all of the public members want to open up professions to more candidates and to gear exams to public protection. But they will not be able to get much done overnight. The full impact of the public-member bill will not be felt for another year or two as [Governor] Brown replaces the [Governor] Reagan appointees. Changes in board staffs will follow. The by-word will then no longer be "what's good for the industry is good for the public." (pp. 309-311)

While self-regulation and public representation dominate as topics of interest, some are looking elsewhere for answers to the criticisms which have been plaguing professional and occupational licensing boards. For example, the Educational Testing Service has proffered a number of suggestions, among which were included

1. to offer tests at more convenient locations,
2. to assist applicants who are not fluent in English,

3. to advise applicants who fail licensing tests about their areas of weakness,
4. to develop a well-defined appeals procedure and inform applicants of such,
5. to support nondiscrimination policies of the State and Federal governments. ("Occupational Licensing: Help or Hindrance?" 1973, p. 34)

While the influx of consumers into the decision making process of professional and occupational licensing boards may not, and hopefully will not, wrest control of such boards from members of the profession, consumer input can effectively prod such boards from an apathetic maintenance of the status quo toward an active initiation of needed reforms. A very real danger exists that consumerism may be carried to an extreme -- that the pendulum may swing too far. Consumer representatives will be effective as long as they take suggestions such as those offered by the Educational Testing Service and spur licensing boards to act upon them. The gap between what is good for the profession and what is good for the public is often not as great as some would have us believe, and it seems apparent that many perceived faults of licensing boards are due to acts of omission rather than acts of commission. That is, licensing boards do not necessarily act in the profession's behalf but rather fail to act in the public's behalf. It is sometimes easier to view a licensing board's lack of response to a problem as a deliberate attempt to protect the profession as opposed to an inertia derived from underfunding, lack of awareness of the problem's scope, or apathy brought on by the part-time nature of a board member's responsibilities. This is certainly not to say that licensing boards do not at times deliberately act for the benefit of the profession and against the benefit of the public, however

there are many professionals who, for example, see a more stringent policing of licensees as being in both the profession's and the public's interest. Members of all professions and occupations are under a moral mandate to see that it is these individuals who are given an opportunity to serve as professional members of licensing boards. Consumer representatives can exert their most powerful and constructive influence not simply by challenging unilateral board decisions, but by actively lobbying at the state level for adequate licensing board funding, by actively researching answers to the many problems which confront such boards, and by actively demonstrating the myriad ways in which the needs of the profession and the needs of the public can be met simultaneously.

Chapter 3, a history of state licensing in speech pathology and audiology from 1967-1979, will trace the chronology of events which led to the enactment of the 30 state statutes regulating speech pathologists and audiologists. An understanding of the interaction between the national association and various state associations, and between these agencies and the state legislative process, is necessary for an appreciation of the many concerns which played a vital role in the formulation of state licensing laws. Selected aspects of these statutes will be examined and compared in Chapter 4.

CHAPTER 3

A HISTORY OF STATE LICENSING IN SPEECH PATHOLOGY AND AUDIOLOGY, 1967-1979

Prior to the 1970's, regulation within the fields of speech pathology and audiology emanated primarily from within these disciplines themselves. The American Speech and Hearing Association (now the American Speech-Language-Hearing Association) exercised a considerable degree of control over these professions by recognition of basic professional education via clinical certification. Furthermore, through the American Boards of Examiners in Speech Pathology and Audiology (ABESPA), established by ASHA in 1957, the Association participated in the accreditation of programs providing professional education.

The American Speech and Hearing Association (ASHA), in the absence of government regulation, sought to enhance the public image of speech pathology and audiology by mandating strict requirements for the acquisition of the Certificate of Clinical Competence (CCC). The practitioner in speech pathology and/or audiology was required to satisfy certain educational and clinical prerequisites and to have obtained a master's degree prior to making application for Association membership. Moreover, a clinical fellowship year of supervised employment was required before the practitioner could be eligible to receive the Certificate of Clinical Competence. Thus, one of the primary purposes of ASHA's certification program was "to provide an indication to the public that an individual possesses certain minimal professional qualifications. . . ." ("Issues Facing Us," 1974, p. 488). Likewise, certification was viewed as a

flexible medium for upgrading and developing professional standards.

Flower (1973) writes:

If the prime characteristic of ASHA's standards program is professional self-regulation, a dominant secondary characteristic is its viability. Scarcely a year passes without substantive changes in several aspects of the standards program. The Association hopes that these changes denote sensitivity to changing professional roles and changes in the scope of our professional services. In reality, the changes also reflect the readiness of the members of the profession to define themselves and their services more precisely and to impose more stringent criteria for professional practice. Although some Association members may regard changes in standards as denoting intolerable indecision, they are actually symptomatic of the increasing good health of the standards program. The frequency of modifications in the standards program will probably increase in the years immediately ahead. (p. 235)

The Association seemingly believed throughout the decade of the 1960's that strict self-regulation would be sufficient to insure public acceptance of the new disciplines, to insure the orderly, controlled growth of the professions, and to insure an adequate defense against encroachment on the part of government and/or competing professional areas. This is not to imply that the Association was oblivious to what was occurring around it relative to government regulation, increased consumer interest and enlightenment, and licensing in allied professions.

The federal government was in the midst of providing substantial sums of "titled" monies which were earmarked for special purposes. Acceptance of these monies indicated acceptance of the federal provisions for their use, and acceptance increased the likelihood of dependence upon such federal dollars in the future. While these monies were eagerly received, there was often a failure to realize that these funds and the stipulations for their use were the means by which increasing

federal control would be exerted. By the late 1960's, private organizations were becoming acutely aware of the federal government's desire to increase its participation in many areas. While legislation governing the practice of a profession is generally conceived to be a state rather than a federal responsibility, many professions began to ponder just what their most advantageous position would be within the states in order to qualify for federal programs such as national health care.

Consumer advocacy, although still in its infancy, was becoming increasingly popular as the fast paced lifestyle of the 1960's provided little time for consumers to establish personal relationships with the various professionals who supplied their needs. No longer was the butcher a next-door neighbor and the physician a close family friend, but the professional was becoming a stranger who, nevertheless, often performed very personal services. Consumer-client trust was beginning to erode, and professional associations were beginning to realize that consumers who distrusted a professional were not likely to have their trust reaffirmed simply because "cronies" in the professional's association were willing to substantiate his competence and integrity. Such consumeristic outcry could eventually lead to punitive government regulation, and private associations began to ruminate upon the wisdom of securing legalized self-rule in the name of the consumer.

Finally, private associations such as ASHA were witness to the tremendous surge of licensing attempts by emerging professions in the 1960's. The traditional time frame employed in the process of professionalization was being shortened dramatically for many of these emerging professions, and some members of ASHA began to ask why two professions which had already emerged were without licensure. Were

speech pathology and audiology failing to participate in a "good thing"? Even the conservative Association noted "that the history of other professions shows that as a profession matures, there is a progressive move toward statutory control of its practice" ("Governmental Regulation," 1969, p. 39). Perhaps there was even an inkling on the part of ASHA that the unbridled licensure of the 1960's could not continue unchecked into the next decade, and that failure to consider regulatory alternatives would not merely be postponing a decision but rather having the decision made for the professions. If ASHA did entertain such a notion, it was indeed prophetic in light of the American Medical Association's proposed moratorium issued in 1970 (see page 56 of this text).

The Association's Position, 1966

In 1966, consideration of changes occurring both internal and external to the Association prompted the Committee on Governmental Regulation to issue a statement delineating the Association's philosophy and policy with regard to governmental regulation. This statement reflected ASHA's perception of both subtle and direct governmental attempts at regulation; however ASHA's response was one of continued resistance to such regulation rather than one of attempting to use governmental regulation to the Association's own advantage.

Increased government regulation of the fields of speech pathology and audiology is not desirable at this time. The American Speech and Hearing Association does not seek and will not encourage direct governmental regulation through licensing, certification, or registration acts at any level of government. The Association is aware that increasing indirect government regulation of speech pathology and audiology is taking place through regulation of other professions and businesses, through

government purchase of services, through judicial precedent, through consumer legislation, and through subsidization. ("Governmental Regulation," 1967, p. 31)

Whatever the stated reasons for the Association's anti-licensure posture, it is likely that trepidation regarding the fate of the Association's certification program (and in the Association's view, self-rule) in the face of a possible epidemic of state licensing was present. Thus, ASHA's 1966 statement affirmed quite succinctly that "licensing, registration, or government certification of speech pathologists or audiologists should not be sought by any group unless there is a clear and urgent purpose" (p. 32).

It is not surprising in light of the relatively low profile kept by the profession during this time that Angel (1970), in preparing an alphabetical listing of the better known professions, occupations, and businesses operating in the United States, made no mention of speech correction, speech therapy, or speech pathology. His state-by-state breakdown delineating state control of various professions made note of the optional or voluntary registration of speech therapists in only three states (Maine, New Mexico, and Wyoming). No mention was made of speech therapists or audiologists in connection with any other state. Table 1 compares the legal status of physical therapy, occupational therapy, and speech therapy within the states just prior to 1970. It is interesting to note that, of the three states providing optional registration for speech therapists, one state has failed to enact a licensing law as of September 1979, while the other two states enacted licensing laws relatively late (Wyoming was 19th of the 30 states currently licensing speech pathologists and audiologists and Maine was

TABLE I

THE LEGAL STATUS OF PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND
SPEECH THERAPY WITHIN THE STATES PRIOR TO 1970

Listing of state examining boards issuing licenses			
State	Physical therapy	Occupational therapy	Speech therapy
ALABAMA	State Board of Examiners	Local Permit	None
ALASKA	State Medical Board (Optional Registration)	None	None
ARIZONA	Arizona State Board of Physical Therapy Examiners	None	None
ARKANSAS	State Medical Board of Arkansas (Physiothera- pists)	None	None
CALIFORNIA	Board of Medical Examiners	American Occupational Therapy Association	None
COLORADO	State Board of Physical Therapy	None	None
CONNECTICUT	State Board of Examiners	State Board for Occupational Licensing	None
DELAWARE	State Examining Board of Physical Therapists	Delaware State Tax Department	None
DISTRICT OF COLUMBIA	Board of Examiners in Physical Therapy	District Department of Occupations and Professions	None
FLORIDA	Florida State Board of Medical Examiners	Local Permit	None
GEORGIA	Georgia State Board of Physi- cal Therapy	Local Permit	None
HAWAII	State Department of Health	State Department of Health	None
IDAHO	Board of Medical Examiners	Occupational Licensing Bureau	None
ILLINOIS	Department of Registration and Education	State Department of Health--Bureau of Exami- nation and Licensing	None

TABLE 1
continued

Listing of state examining boards issuing licenses			
State	Physical therapy	Occupational therapy	Speech therapy
INDIANA	State Board of Medical Regis- tration and Examination	State Board of Health	None
IOWA	State Department of Health	State Department of Health	None
KANSAS	Kansas State Board of Healing Arts	Kansas State Board of Healing Arts	None
KENTUCKY	State Board of Physical Therapy	Department of Health	None
LOUISIANA	State Board of Medical Examiners	None	None
MAINE	Board of Examin- ers in Physical Therapy	Optional Registration	Optional Registration
MARYLAND	Board of Physical Therapy	Optional Registration	None
MASSACHUSETTS	Board of Regis- tration in Medicine	Optional Registration	None
MICHIGAN	State Board of Physical Therapy Registration	Optional Registration	None
MINNESOTA	State Board of Medical Examiners	Optional Registration	None
MISSISSIPPI	State Department of Health	Optional Registration	None
MISSOURI	Board of Regis- tration for the Healing Arts	Optional Registration	None
MONTANA	Board of Medical Examiners	Optional Registration	None
NEBRASKA	State Department of Health	Optional Registration	None
NEVADA	Board of Physical Therapy Examiners	Optional Registration	None

TABLE I
continued

Listing of state examining boards issuing licenses			
State	Physical therapy	Occupational therapy	Speech therapy
NEW HAMPSHIRE	State Board of Registration in Medicine	None	None
NEW JERSEY	State Board of Medical Examiners	Optional Registration	None
NEW MEXICO	Board of Medical Examiners (Op- tional Regis- tration)	Optional Registration	Optional Registration
NEW YORK	State Education Department (Phys- iotherapist)	None	None
NORTH CAROLINA	Board of Medical Examiners (Op- tional Regis- tration)	Optional Registration	None
NORTH DAKOTA	Board of Medical Examiners	Optional Registration	None
OHIO	State Medical Board	Optional Registration	None
OKLAHOMA	Medical Board	Optional Registration	None
OREGON	Oregon State Board of Health	Optional Registration	None
PENNSYLVANIA	State Board of Medical Educa- tion and Licensure	Optional Registration	None
RHOAD ISLAND	Board of Examiners in Physical Therapy (Optional Regis- tration)	Optional Registration	None
SOUTH CAROLINA	State Board of Examination and Registration of Physical Therapists	Optional Registration	None

TABLE I
continued

Listing of state examining boards issuing licenses			
State	Physical therapy	Occupational therapy	Speech therapy
SOUTH DAKOTA	State Board of Medical and Osteopathic Examiners (Op- tional Regis- tration)	Optional Registration	None
TENNESSEE	State Board of Medical Examiners	Optional Registration	None
TEXAS	None	Optional Registration	None
UTAH	Committee of Physical Therapists	Optional Registration	None
VERMONT	Board of Physical Therapy Registration	Optional Registration	None
VIRGINIA	Board of Medical Examiners	Optional Registration	None
WASHINGTON	Department of Professional Licensing	Local Permit or Certificate	None
WEST VIRGINIA	State Board of Examiners and Registration of Physical Therapists	Optional Registration	None
WISCONSIN	Medical Examin- ing Board	None	None
WYOMING	Wyoming State Board of Physical Therapy	Optional Registration	Optional Registration

Source: Angel (1970)

29th). From this very small sample it seems evident that optional registration is not a steppingstone to state licensure. Whether such optional registration may hinder future attempts to secure passage of a licensure law is an interesting research question.

The Association's Position, 1968

The proliferation of newly licensed professions, a changing perspective on governmental control, increased consumer demands, and internal pressures resulted in an extensive study on the subject of certification and licensure by ASHA's Executive Committee and Committee on Governmental Regulation. Hearings on this topic were held in March 1968, with testimony presented relative to licensure and certification by witnesses from the fields of psychology, law, social work, and occupational therapy. A policy statement concerning governmental regulation was prepared by the Executive Committee in July 1968, and published in February 1969. Contained within this statement was Association acknowledgement "that there are sectors of the Association (groups, states) which perceive the need for such control [statutory control]. These groups view it as particularly important that the Association take a position on this activity" ("Governmental Regulation," 1969, p. 39).

The Association's position in 1968 recognized that the state licensing of speech pathologists and audiologists was inevitable (Florida was already preparing a state regulation bill which it planned to introduce into the Florida Legislature in 1969, with or without Association support). However, official ASHA policy dictated that the Association did "not seek to encourage or discourage legislation

designed to control the practice of speech pathology and audiology through licensure or certification laws" ("Governmental Regulation," 1969, p. 39). While this statement mitigated the Association's 1966 proclamation that state licensing should not be sought "unless there is a clear and urgent purpose" ("Governmental Regulation," 1967, p. 31), state associations were urged to "defer licensure or certification efforts until model legislation has been developed by the Association and its effectiveness ascertained" ("Governmental Regulation," 1969, p. 39). The Association continued by affirming its responsibility for the provision of licensing guidelines and by asserting its willingness to provide consultative assistance.

While expounding an essentially neutral position, the Association was nevertheless concerned that impetuous state associations lacked the expertise, if not the motivation, to formulate well-conceived, adequately drafted, and appropriately implemented legislation (see "Comments on Licensure," 1972, page 97 of this text). ASHA had already surmised what Moore (1970) was to write several years later: "It is much easier to get a new -- and possibly silly -- law enacted than it is to get an existing silly law rescinded or sensibly amended" (p. 130).

Manifesting this concern, ASHA's 1968 position statement attempted to present a number of impressions received from testimony proffered at the March 1968 hearings. These impressions, it was hoped, would cause state associations to reassess their positions and delay licensure attempts. Below are examples of statements reflecting these impressions.

No firm estimate can be given as to the development cost for any particular state; and any association or group seeking the enactment of regulatory legislation must be prepared to assume the necessary financial

commitment. In New Jersey, for example, efforts to pass a law licensing psychologists cost in excess of \$16,000 during the final three years. ("Governmental Regulation," 1969, p. 40)

A general principle in state regulatory legislation is that the fees paid by individual applicants for certification or licensure must pay the entire financial cost of the program. The practical effect of this principle is to make the cost per person expensive in states with few participants. (p. 40) [Total ASHA membership in 1968 was 12,201 according to Fricke, Bruder, and Watts (1969). The range was 17 members (Alaska) to 1,465 members (California).]

Some evidence seems to exist that nonstatutory programs, particularly those administered by a national program such as ASHA, tend to be more flexible than statutory programs. For example, if an accrediting agency sought a change in standards, such an agency would find it easier to deal with one national organization than with 50 different states. (p. 40)

While endeavoring to retard a headlong rush into state control which would ultimately prove detrimental both to ASHA and to the profession as a whole, the Association nevertheless complied with their stated policy to provide consultative leadership. This was accomplished by advising state associations with respect to the need for and the effects of grandfathering provisions, sources of support and opposition, the timing of legislative attempts, specialty versus general legislation, and risks involved in statutory regulation.

In order to conform to laws related to depriving practitioners of their right to practice in a previously established means of livelihood and to help eliminate the opposition of certain groups, the Association affirmed the necessity of grandfathering certain individuals. A temporary reduction in the standards of a profession was seen to be "the typical price paid by all professions for this type of legislation" (p. 41).

Opposition to a licensure bill was discussed as originating both from within and from outside of the profession. The possibility of internal opposition from private practitioners desiring to tie licensure to the doctoral rather than the master's degree was considered, as was the threat of opposition from public school practitioners who might view licensing, in addition to state board of education certification, as superfluous. External opposition, especially as might arise from the American Medical Association, the American Civil Liberties Union, the American Psychological Association, or various hearing aid dealers' organizations, was outlined.

In contrast to earlier statements in this report designed to postpone premature state licensing attempts, the Executive Committee and the Committee on Governmental Regulation concluded that

there appear to be advantages in initiating legislative activity too soon rather than too late. If the profession originates the request itself, the odds are favorable that the profession may secure a law in which its own members hold either key or exclusive positions on the regulatory board. Usually, in such instances, the association or group which makes the request has had sufficient experience to present a set of standards, and a mode of implementing the standards. Under these circumstances, unless unusual opposition develops, the initiating group becomes the controlling group. ("Governmental Regulation," 1969, p. 42)

State licensure was viewed by the Association as taking place at the broadest possible level. While acknowledging that successful multi-level legislation might be possible, the Association determined that licensing efforts should be limited to the two specialties of speech pathology and audiology. ASHA had previously, in 1966, stated that the "requirements of licensure or certification acts should reflect the requirements of the ASHA Certificate of Clinical Competence,

and should be changed as the ASHA requirements change" ("Governmental Regulation," 1967, p. 31).

Finally, ASHA's 1968 statement summarized what it felt were the advantages to be accrued through beneficial legislation. An adequately drafted bill limited exclusions and restricted board membership to representatives of the profession. Additionally, grandfathering provisions in such a bill should be minimal and should focus upon protecting those currently working within the profession as opposed to winning their consent. Standards should be sufficiently high to provide a challenge to the training program and to assure that association requirements were met. Furthermore, while state-to-state variability might serve to reduce the ease of mobility, such variation could be viewed as advantageous from the standpoint of assessing the effectiveness and impact of alternative state strategies.

The First State Law and the Association's Position, 1969

The nation's first state law regulating speech pathologists and audiologists was passed by the Florida Legislature on June 6, 1969, with an effective date of July 10, 1969. While not technically a licensure law - the law requiring that speech pathologists and audiologists be certified by the state rather than licensed - the Florida law provided a model which has served as a basis for subsequent legislation in many states.

The impetus for this legislation, which was sponsored by the Florida Speech and Hearing Association (now the Florida Language, Speech, and Hearing Association), stemmed from a series of incidents which emphasized the necessity for legal enforcement of accepted

professional standards in the state of Florida. These occurrences tended to substantiate the belief of many FLASHA members that speech pathology and audiology in Florida were characterized by the following problems.

1. Individual and organizational protests against "quacks" lacked effectiveness and could possibly lead to litigation against the qualified professional who openly opposed the quackery.
2. The lack of a legal definition of the services and titles of the profession could allow them to be misinterpreted as a sub-specialty of another discipline.
3. Any individual or organization who considered speech and hearing specialists as lacking sufficient regulation could attempt to impose restrictions or could propose legislative control of the profession. ("The Florida Speech Pathology and Audiology Act," 1969, p. 544)

In consideration of these and related problems, the FLASHA Committee on Governmental Regulations was formed in 1964-65 to explore existing laws pertaining to speech pathology and audiology, to monitor legislation currently under consideration which might affect the professions, and to weigh the merits of enacting a licensure or certification law in the state of Florida. In 1965, this Committee submitted to the FLASHA Executive Council a working draft of a certification law for speech pathologists and audiologists which was modeled after the law which certified psychologists in the state.

After considerable effort on the part of the FLASHA Governmental Regulations Committee, a working draft of a certification proposal was submitted for endorsement to the American Speech and Hearing Association's Executive Committee in October 1966. ASHA's Executive Committee reviewed this draft and decided to withhold ASHA endorsement of a legislative attempt due to FLASHA's inability to demonstrate "that a

clear and urgent need existed" ("The Florida Speech Pathology and Audiology Act," 1969, p. 545).

After an overwhelming majority of FLASHA members voted in May 1967 to continue efforts toward securing statutory regulation, legal counsel was appointed and the support of allied professions was solicited. Relief was sought from burgeoning expenses via a dues increase, and a membership vote to double the annual dues from \$5.00 to \$10.00 enabled FLASHA's Executive Council to budget an expenditure of \$5,000 to be used for legal and lobbying fees. A firm of attorney/lobbyists was retained to undertake further revisions in the bill and to guide and monitor the bill as it passed over the numerous legislative hurdles.

Senate Bill 746 and House Bill 1181 were introduced as companion bills on April 24 and 25, 1969. In its appeal for support, the bill stressed

that it protected the public from unscrupulous, unqualified, and unethical practices; defined the profession into law; was the first law of its kind in the nation; upheld professional standards of education, training, and experience as promulgated by ASHA and FLASHA; restricted no qualified practitioner; supported itself financially; did not create a new agency; was actively endorsed by a number of state associations and educational and rehabilitation agencies; and was not opposed by any organization, agency, or association in related fields. ("The Florida Speech Pathology and Audiology Act," 1970, p. 73)

Senate Bill 746 was passed in the Florida Senate on May 30 with 33 votes for, 1 against. House approval followed on June 6 by a vote of 87 for, 6 against. The bill was consequently placed on file with the Secretary of State's office and became law, without the Governor's signature, on July 10, 1969. After the bill became statute, ASHA noted that the Florida law

defines the terms speech pathologist, audiologist, speech pathology aide, and audiology aide; requires that they be certified by the state; and sets up an advisory council to recommend examination procedures, minimum educational requirements, and a code of ethics. We also understand that the examination and educational requirements for certification may be waived by the Commissioner of Education for any of several reasons, one of which is that the applicant holds the Certificate of Clinical Competence of the American Speech and Hearing Association. ("New Florida Law Regulates," 1969, insert between pp. 330-331)

In September 1969, three months after passage of the Florida Speech Pathology and Audiology Act, the 1969 Annual Report of The American Speech and Hearing Association's Committee on Governmental Regulation was submitted to ASHA's Executive Board. This report viewed the Florida law as one primarily of title protection, with practice being defined only as it related to title. While this was true to some extent, the concept of title protection or title licensing as promulgated in the Florida law differed significantly from that discussed by many authors (see pages 65-66 of this text). This report also included a number of perceived limitations in the Florida law which would restrict its use as a "model" licensure law for the profession. These included the fact that the Florida law

1. emphasizes title protection rather than protection of practice;
2. involves a registration of persons bearing certain titles by the State Department of Education -- an arrangement which is uniquely suited to the Florida situation and, possibly, unsuited to other state situations;
3. does not specifically tie the license to the masters degree, a provision that the profession might want inserted in a model licensing law. (ASHA, 1969, p. 4)

Due to these and other perceived limitations of the Florida law, the

ASHA Committee on Governmental Regulation developed in 1969 a model bill to provide prototype legislation. This model law was updated in June 1975.

In studying the licensure of speech pathologists and audiologists, the Committee encountered two potentially serious problems. These related to the separate licensure of speech pathologists and audiologists and to multi-level licensure laws. The Committee's recommendations in connection with these matters were that speech pathology and audiology be licensed in a single law (p. 5) and that "the profession should link licensure requirements to the Certificate of Clinical Competence and should avoid multi-level licensure" (p. 6).

Finally, the Committee reaffirmed its position as published in February of 1969.

The Committee sees no need to revise the policy statements concerning the licensure of speech pathologists and audiologists. . . .

In the judgment of the Committee, the precipitous entry of a large number of state associations in the licensure scene could pose some thorny problems. The success of the Florida bill should not mislead other state associations concerning the potential problems inherent in regulatory legislation. (p. 6)

The Move Toward Licensure and the Association's Position, 1971

Despite ASHA's warnings, state associations quickly viewed the benefits which were accruing to Florida practitioners through statutory regulation. A number of writers in the late 1960's and early 1970's extolled the benefits of licensure while vehemently or tacitly urging state associations to move toward legislative regulation. Rosen, writing in 1969, asserted that "government regulation in its ultimate form is the licensing of practitioners in a field" (p. 13). He further

noted, with respect to other professions having achieved licensure, that "licensure provides them with official recognition which will be denied us until we have acquired similar legislative and legal status" (p. 13). Benjamin Levine, General Legal Counsel for the New Jersey Speech and Hearing Association (NJSHA), reiterated much the same theme several years later at a NJSHA convention.

One of the first steps toward that goal [gaining your own professional identity] is to gain recognition as a profession with its own distinctive responsibilities. In turn, the gaining of that public recognition requires the gaining of legal recognition, that is, recognition by the state, in the form of permitting qualified practitioners to be licensed. . . .

Unless you are properly licensed according to legislatively determined standards, you have little, if any, right to complain of competition from persons representing themselves as qualified to treat speech and hearing disorders. And unless you are recognized as having legal status, you are generally powerless to act in concert to convince public authorities of the value of your point of view -- the very practical, as well as legal, problem of status. ("Governmental Affairs," 1972, p. 423)

It must be remembered, however, that the Florida Speech and Hearing Association began the initial planning for its legislative thrust in 1964, five years prior to enactment of the Florida Speech Pathology and Audiology Act. Consequently, it is not surprising that other state statutes regulating speech pathologists and audiologists did not quickly follow the Florida law. Although the state of New York had informed ASHA's Committee on Governmental Regulation of its plan to submit a licensure bill into the state's 1970 legislative session (ASHA, 1969, p. 4), the next bill to receive legislative approval was Florida State Legislature House Bill 4140, an amendment to the Florida Speech Pathology and Audiology Law. This amendment, which became law on July 2, 1970, basically provided for

1. a reduction in the initial certification fee from \$100 to \$25;
2. a reduction of the annual renewal fee from \$50 to \$25;
3. a provision for a single certification fee for individuals who qualify for dual (speech pathology and audiology) certification;
4. a provision for students, interns, and individuals who are accruing their paid professional experience under the supervision of a licensed speech pathologist or audiologist. ("Florida Speech Pathology and Audiology Law Amended," 1970, p. 419)

In May of 1971, ASHA reaffirmed its commitment to provide licensing guidelines and to supply consultative services (original commitment in "Governmental Regulation," 1969, p. 39). It was becoming increasingly evident to ASHA that an avalanche of licensing bills would soon descend upon state legislatures, and that lack of support and guidance from the national office at this time might well allow irreparable damage to occur. Hence, ASHA's call for a united effort:

Whether legislation to govern the practice of speech pathology and audiology is needed within a given state is a decision that must be made by the state association. However, to insure that the best interests of both the communicatively impaired and the profession that treats them are served, we must develop and maintain a united position on licensure at both the state and national association level. Even though the need for licensure is a matter for each state to decide, we must be aware that such licensure will affect the profession as a whole. ("ASHA Regional Legislative Consultants," 1971, p. 295)

To help establish and maintain this united position, the national association appointed eight regional consultants to

1. stimulate and enhance legislative awareness and action at the state level whenever or wherever necessary,
2. orient and lend direct and expeditious assistance at the state level on all legislative matters that affect the profession of speech pathology and audiology.

3. create a means by which the states' needs and concerns are communicated to ASHA and ASHA's needs and concerns are communicated to the states. ("ASHA Regional Legislative Consultants," 1971, p. 296)

With the use of such consultants, ASHA was able to both render the promised consultative aid and to carefully monitor the "legislative rumblings" within a particular state.

The Proliferation of Licensure, 1972-1978

The California Speech and Hearing Association's attempt to become the second state to regulate speech pathologists and audiologists was terminated on December 20, 1971, when Governor Ronald Reagan vetoed regulatory legislation several days after such legislation had been passed by the California House and Senate. The California experience demonstrated to other states contemplating legislative assaults that internal and external opposition could effectively frustrate a well-planned effort to secure licensing.

Internal opposition among some California professionals resulted from a number of controversial amendments which were perceived as diluting the original thrust of the proposal. While the bill was originally designed to establish a Speech Pathology and Audiology Examining Committee consisting exclusively of speech pathologists and audiologists and which would be under the supervision of a state examining board for the social sciences, California otolaryngologists maintained that the Committee should fall within the jurisdiction of the California Board of Medical Examiners. The composition of the Committee was similarly at issue, with one amendment adding an otolaryngologist and another reducing the number of speech pathologists and audiologists and allowing for five "public" Committee members. The

effect of this amendment would have been to provide for a nine member committee of which only three members would have been from the speech and hearing professions. Other related amendments severely weakened the power of the Committee as established in the original bill, and the combined effects of the proposed amendments caused some original proponents of the bill to welcome its veto.

External opposition was manifested by the State Department of Consumer Affairs, whose argument was summarized in Governor Reagan's veto message.

The entry of the state into new areas of regulation is justified only if there is evidence of a compelling public need for such additional regulation. There has not been such a showing with respect to the need to license speech pathologists and audiologists.

Additionally, the bill could have the effect of limiting the supply of speech pathologists and audiologists and thereby threaten many worthwhile programs in this area that are currently being conducted. ("California Licensure Vetoed," 1972, p. 73)

The American Medical Association's request for a two-year nationwide moratorium on licensure of allied health professions (see page 56 of this text), subsequently adopted by the United States Department of Health, Education, and Welfare, was viewed as having little effect upon the California Legislature. Whether this call for a moratorium affected Governor Reagan's decision to veto the bill was not known.

Thus, 1970 and 1971 passed without additional state enactment, the Florida Speech Pathology and Audiology Act remaining as the sole piece of state legislation regulating speech pathologists and audiologists. The year 1972, however, was to witness the passage of five state statutes licensing speech pathologists and audiologists. The first of these was signed into law in March by Virginia Governor Linwood Holton. No

opposition to the bill's passage was expressed, and the bill was signed into law less than two months after it was first introduced into the Virginia Legislature.

In April of 1972, Kentucky became the third state to secure regulatory legislation. The Kentucky law was drafted by the state association's legislative committee using both ASHA's model law and the Florida law as a reference. The resulting draft was then distributed to each member of the state association for his or her perusal, after which comments and suggestions relative to the proposed bill were solicited from the membership at a statewide meeting. The committee decided to forego the services of a legislative advocate in favor of working through specific legislators who were known to view the bill favorably. This decision appeared to be wise and economical, as the Kentucky bill encountered little opposition on its way to passage.

Similar frugality was exhibited by the Maryland Speech and Hearing Association, as less than \$100 was spent in their successful campaign for state licensure. Maryland's law, one which was essentially in keeping with ASHA's model bill, provided for academic and clinical experience requirements for licensure equivalent to those necessary to obtain ASHA's Certificate of Clinical Competence. One major deviation from ASHA's model bill, however, was a stipulation requiring the formation of two examining boards. One board was to examine and license speech pathologists while the other was to perform similar functions for audiologists. The fact that the Maryland statute was passed by the state legislature without amendment or opposition was an indication that some state associations were beginning to learn from the successes and failures of others.

While Maryland's bill was being signed into law by Governor Marvin Mandel in June 1972, California Senate Bill 796 was struggling to stay alive in the state legislature. Following Governor Reagan's December 1971 veto, a reworked bill had been introduced into the California Senate in March of 1972. By the summer of 1972, the proposed legislation had been passed by the Senate and the Assembly Health Committee and was awaiting a hearing by the Assembly Ways and Means Committee when the legislature reconvened in November. Senate Bill 796 differed from the ill-fated December 1971 bill in that it allowed for part-time experience in meeting the requirements for licensure and it stipulated "that the Examining Committee shall invite a liaison member of the Hearing Aid Dispensers' Examining Committee to its meeting whenever the business of the Committee concerns itself with hearing aids and/or the dispensing of hearing aids" (Hagen, 1972, p. 110). Furthermore, additional wording was added to that portion of the bill describing the practice of audiology. As Hagen (1972) notes, the negotiations responsible for these changes effectively eliminated much of the previous opposition.

As a result of these negotiations, we achieved the following: the CMA Otolaryngology Advisory Committee is in unanimous support of our bill; the Hearing Aid Dealers' Association of California has withdrawn its opposition to it; the Hearing Aid Dispenser Examining Committee voted to support our bill; the Department of Consumer Affairs has moved from an "oppose" position to a neutral position; and the Department of Health Care Services has similarly taken a neutral position. (p. 109)

Before the California Legislature could reconvene in November, the state of Louisiana became the fifth state to license the practice of speech pathology and audiology. The bill was signed into law on July 5, 1972, by Governor Edwin Edwards. Opposition from the Louisiana

Medical Society was primarily responsible for the following compromise changes:

1. inclusion of one physician on the board of examiners, but without a vote;
2. exemption of a physician's employee who tests hearing under the direct supervision and control of the physician, with the stipulation that such a person may not be called an audiologist;
3. waiver of the examination and education requirements, on request, for an applicant who holds state board of education certification as a teacher of the speech defective and hard of hearing. ("Licensure Legislation Passes in Louisiana," 1972, p. 676)

Although basically equivalent to ASHA standards, the Louisiana licensure requisites differed from those required by ASHA for the Certificate of Clinical Competence in one critical area. As noted in number 3 above, teachers of the "speech defective and heard of hearing" -- individuals holding the bachelor's degree and certified by the state -- were eligible to be licensed without meeting the examination and educational prerequisites delineated within the statute. ASHA's response to such a compromise, as might be expected, was hardly favorable.

Nonetheless, such a law has at least two untoward effects: first, it seriously undermines ASHA's national competency standards and the perception of those standards on the part of other professions, government, and the public; and second, it may interfere with arrangements between neighboring states concerning interstate practice (i.e., reciprocity). In future state licensure efforts, ASHA intends actively to represent both its certification standards and the interests of those speech and hearing professionals whose livelihoods and the interests of whose clients depend on interstate practice. (ASHA, 1976, p. 3)

Governor Reagan finally signed the California bill into law almost exactly a year from the date of his initial veto. The nine member Speech Pathology and Audiology Examining Committee established under

the law was to be composed of three speech pathologists, three audiologists, and three public members (one of whom was to be an otolaryngologist). The California law was also specific with regard to the supervision of individuals obtaining their first professional experience and the supervision of speech pathology and audiology aides.

It was evident by the middle of 1973 that state licensing was rapidly gaining momentum. Indiana, Tennessee, Oklahoma, and Rhode Island all were successful in obtaining state regulation by May, and ASHA reported that "replies from 34 of the remaining 41 (40 states and D.C.) state association presidents reveal that all but two states are actively pursuing licensure, and both of those expect to become involved with a licensure effort within the next year" ("Four New Licensure Laws Pass," 1973, p. 371). This engrossment in state licensure prompted some to speculate upon the future of ASHA's Certificate of Clinical Competence. Flower (1973) theorized that

within the foreseeable future, licensure will probably replace the Certificates of Clinical Competence as the most commonly used definition of a qualified practitioner. . . . Nevertheless, this does not reduce the importance of the clinical certification program, it merely alters its basic purposes.

We have already asserted that an important characteristic of our standards program is its viability, its potential for reflecting changes in the practices of our profession. In contrast, because of the precarious nature of legislative processes, once established, changes in licensure standards will be effected more slowly. Therefore, licensure programs can never achieve the viability of our self-governed clinical certification program. Although licensure may be the legal requirement for professional practice, clinical certification will remain a better index of actual qualifications. Further, clinical certification will continue to represent the standard to which licensure programs will be compared when they are ultimately updated. (p. 235)

Kenneth L. Moll, in preparing an Asha Special Report, specified several important functions which could be performed by the ASHA certification program even assuming uniform nationwide licensure.

First, the nature of the voluntary certification program could be modified from one that provides recognition to an individual who meets minimal qualifications for being a general practitioner of speech pathology or audiology to one that recognizes one's qualifications to practice in a specialty area. Certification would then be somewhat comparable to the "boarding" of individuals in specialized areas of medicine. . . .

A second purpose that can be served by a certification program, even if uniform, nationwide licensure occurs, relates to the potential for such a program to serve as a mechanism for the upgrading and further development of professional standards. ("Issues Facing Us," 1974, p. 488)

Connecticut and South Carolina obtained state licensure in June of 1973; however that same month Governor Nelson Rockefeller vetoed the ASHA endorsed New York licensure bill. Rockefeller cited the bill's extensive exemptions and liberal grandfather clause in explaining his veto; however the basis for his negative reaction stemmed from his belief that proponents of the New York bill had failed to show that sufficient need existed for an elaborate licensing plan. This was the second time that the New York Speech and Hearing Association had succeeded in obtaining legislative approval of their bill only to have it vetoed on the Governor's desk.

July 1973 proved to be the most productive month ever for state licensing advocates as Oregon, Missouri, and Delaware all joined the ranks of the licensed. The total number of states that had secured regulatory legislation now stood at 15; however it would be eight months before Georgia would become the 16th state to license speech pathologists and audiologists.

Governor Jimmy Carter signed the Georgia State Licensure Bill into law on March 21, 1974. Like Louisiana, Georgia's law differed somewhat from ASHA's requirements for the Certificate of Clinical Competence. These differences were related primarily to degree requirements necessary for licensure and, not surprisingly, ASHA viewed such dissimilarities as presenting problems for the profession.

State laws which permit licensure of practitioners who have achieved a bachelor's degree plus "X" amount of graduate credits (e.g., Louisiana and Georgia) may also pose reciprocity problems. Such qualifications may or may not be equivalent to ASHA's CCC standard. But the equivalency issue is better left to a State's Board of Examiners. However, such laws will probably cause "image" problems since the profession could be viewed as a bachelor's degree profession by the government, the public, and other professions. (ASHA, 1976, p. 3)

Georgia amended its licensure bill to require that all public school clinicians hold a master's degree in either speech pathology or audiology effective in 1978.

Hawaii became the 17th state to acquire licensure as Acting Governor George Ariyoshi signed the bill into law on May 24, 1974. The Hawaii statute, one which closely followed the guidelines set forth by ASHA in their model law, became effective on January 1, 1975. New York, after a five year effort, succeeded in becoming the 18th state to receive state licensure, and the last to do so in 1974. Governor Malcolm Wilson signed the New York bill in June of 1974, with an effective date of April 1, 1976.

The year 1975 promised to be a banner year for state licensure. John P. Nicolais, ASHA Governmental Affairs Deputy Director for State Licensure, indicated that "at least 28 states and the District of

Columbia will introduce state licensure bills for the 1975 legislative session, and four other states are seriously considering a licensure effort" ("28 States to Introduce Licensure Bills," 1975, p. 36). Many states were endeavoring to be innovative, and some were seeking to adapt their appeals to the particular circumstances in which they found themselves. Mississippi, Montana, New Jersey, and Texas altered the traditional grandfather clause to give a temporary license to those not meeting all the licensure requirements at the time the bill was passed. Such individuals would then be given four or five years in which to complete the full licensure requirements. More licensing bills were incorporating stipulations relating to continuing education; however in the vast majority of instances the specifics of the continuing education program were not developed. Several state associations, realizing that the political situation in their state was such that the establishment of an independent licensing board was impossible, sought alternative solutions. Asha ("28 States to Introduce Licensure Bills," 1975, p. 36) reported that speech pathologists and audiologists in Minnesota were applying for credentialing under the Allied Health Credentialing Act, an act administered by the State Board of Health. Minnesota had failed to secure credentialing legislation in 1974. Texas and Mississippi likewise were to promulgate licensing legislation which would place their licensing committees under the authority of the State Department of Health. Colorado was eagerly anticipating licensure, as the Colorado Speech and Hearing Association had secured rescission of a state moratorium on licensure which had severely hampered legislative efforts in the past.

While Mississippi, Montana, New Jersey, Texas, Minnesota and Colorado were all viewed by ASHA as states possessing innovative associations which were capable of achieving licensure in 1975, only two of these states, Mississippi and Montana, were to actually enact credentialing legislation during this year. Practitioners in the other four states (New Jersey, Texas, Minnesota, and Colorado) were still without regulatory legislation as of September 1979.

Although a number of the more innovative states failed in their efforts to see regulatory legislation enacted during 1975, nine states did succeed. Wyoming and Arkansas had bills signed into law in February, and Utah became the 21st state to regulate speech pathologists and audiologists on March 11. North Dakota secured legislative enactment on March 27, just three months after the legislation was first introduced, and the Mississippi bill was signed into law by Governor William Waller on April 4. Despite Senate opposition which threatened to add unfavorable amendments to the House version of the bill, the Montana bill became law in May. Ohio followed in June to become the 25th state to enact a licensing statute, and North Carolina obtained statutory regulation in July. In December, Alabama became the ninth and final state to achieve licensing in 1975.

The year 1976 saw an end to the deluge of state licensing. It had been over six years since enactment of the first state law regulating speech pathologists and audiologists, and the intervening years had given state associations ample time for the preparation and submission of appropriate legislation. Some associations had succeeded with minimal effort, others had prevailed only after struggling for years

against substantial internal and/or external opposition. Six years would prove to be the critical time span, and states in which licensing proponents could not muster sufficient support to secure favorable legislation within this six year period were, with few exceptions, to remain without regulation for a number of years to come.

Iowa and Maine were the two states to achieve licensure in 1976. Iowa's law mandated that a licensee possess the master's degree; however specific coursework was not stipulated. Moreover, only 275 hours of clinical practicum (as opposed to 300 hours for ASHA certification) were required to obtain a license. Consequently, Iowa's licensing requirements were viewed by ASHA as being incompatible with ASHA regulations for certification. Maine's statute, which took effect July 1, 1976, was basically in keeping with the tenets of ASHA's model law.

The year 1977 passed without the enactment of any new state licensing legislation. This is not to be construed as meaning that all the licensing "battles" had either been won or lost, as many were still raging. The District of Columbia and the state of New Jersey were two sites wherein the struggle for state licensure remained intense in 1977.

In March 1977, representatives of the American Speech and Hearing Association appeared before the District of Columbia City Council Committee on Public Services and Consumer Protection to offer testimony regarding Council Bill 2-9, a bill which would regulate speech pathology and audiology in the District of Columbia. Although admitting room for improvement, ASHA believed the bill to be basically sound, as can be seen in this excerpt from the testimony.

Council Bill 2-9 is a good, and an important, bill. It is important, we feel, to protect the District's consumers by assuring that they will receive speech and hearing services from competent, adequately trained individuals. The standards contained in Council Bill 2-9 are nationally recognized by federal and state programs such as Crippled Children's Vocational Rehabilitation, the Veterans Administration, special education, and Medicaid. These standards are also contained in the laws of 29 states -- including Maryland and Virginia -- that presently license speech pathologists and audiologists. (ASHA, 1977a, p. 2)

Despite ASHA support and testimony, Council Bill 2-9 failed to gain enactment and the District of Columbia continues without licensure as of September 1979.

New Jersey, a state which had been trying to secure regulatory legislation for a number of years, solicited ASHA support for its 1977 attempt to have Senate Bill 99 enacted. Again, ASHA testimony on behalf of the bill was most favorable.

Senate Bill 99 is designed to protect the public -- and it should be noted that the communicatively handicapped are a group deserving special concern and protection. The examining committee which the bill would create, has extensive consumer representation. And it should be noted that the bill will not require specific service or in any way affect the cost or accessibility of services. Instead, it will assure that the communicatively-impaired are treated by competent, ethical professionals capable of providing the services which these consumers urgently require. (ASHA, 1977b, p. 4)

Although the testimony of ASHA representatives proved instrumental in allowing Senate Bill 99 to win unanimous support in the New Jersey Senate, a veto by Governor Brendan Byrne after the legislature had adjourned brought the 1977 legislative efforts of speech pathologists and audiologists in New Jersey to an unfruitful conclusion.

While the District of Columbia and New Jersey were striving to initiate licensing in 1977, North Carolina was successfully trying to

preserve intact its licensing statute which had been signed into law in 1975. A licensure repeal bill introduced into the legislature failed to even be voted upon in the subcommittee headed by the bill's sponsor, and a second bill which would have changed the minimal education necessary for obtaining a license from a master's degree to a bachelor's degree was never considered on the floor. However, the North Carolina experience affirmed what sunset legislation was to reaffirm -- favorable legislation could be taken away as quickly as it could be given.

Last minute gubernatorial vetoes effectively halted licensure efforts on the part of state associations in Texas and Washington, two states in which the legislatures had previously passed the proposed legislation by wide margins. Texas Governor Dolph Briscoe vetoed the Texas bill in part because he felt that abuses within the fields of speech pathology and audiology were not sufficient to justify the creation of a new regulatory agency. He also believed that the many exemptions delineated in the bill would severely reduce the number of individuals to be covered under the bill's provisions. Moreover, the Governor maintained that "currently the Texas Board of Examiners in the Fitting and Dispensing of Hearing Aids is the state licensing agency in this field, and no abuse of their function has been demonstrated" ("Licensure Bills Vetoed," 1977, p. 915). While speech pathologists and audiologists practicing in Texas were not regulated by the Texas Board of Examiners in the Fitting and Dispensing of Hearing Aids, the Governor's apparent error made his veto no less frustrating for members of the Texas Speech and Hearing Association.

The Washington bill, Senate Bill 2050, was vetoed by Governor Dixy Lee Ray despite passing by a vote of 74-14 in the House and 28-9 in the Senate. Hearing aid dealers constituted the prime opposition to the bill, and it was reported that two of the Governor's neighbors and early campaign supporters were hearing aid dealers ("Licensing Bills Vetoed," 1977, p. 915).

In March of 1978, Nebraska became the 30th state to license speech pathologists and audiologists. The Nebraska statute was enacted despite the severe opposition of the Nebraska Hearing Aid Association. Hearing aid dealers maintained that audiologists simply offered the same services as physicians and hearing aid salesmen, and they supported legislation which would license speech pathologists without licensing audiologists in an attempt to divaricate the two professions. In spite of what Asha referred to as the hearing aid dealers "well-financed last-ditch effort to persuade the governor to veto L. B. 406" ("Nebraska Becomes 30th State," 1978, p. 412), Nebraska Governor James Exxon signed the Nebraska bill into law on March 20, 1978.

It seems likely that the deceleration in state licensing which occurred in 1976, 1977, and 1978, will continue in 1979, for the problems which have plagued the legislative efforts of nonlicensed states throughout the decade of the 1970's are, with few exceptions, still in force. The critical time period for licensing having passed, the remaining 20 states and the District of Columbia will doubtless find that once a precedent for failure has been established in a state legislature by the repeated inability to secure enactment of sponsored legislation, the procurement of regulation will be an arduous task

indeed. Chapter 4 will provide a comparison of selected aspects of the 30 state licensing laws, while Chapter 5 will focus upon speech pathology and audiology licensing boards and the perceptions of their chairpersons.

CHAPTER 4

A COMPARISON OF SELECTED ASPECTS FROM THIRTY STATE STATUTES REGULATING SPEECH PATHOLOGISTS AND AUDIOLOGISTS

In February 1975, the American Speech and Hearing Association (now the American Speech-Language-Hearing Association) published a brief comparison and contrast of the 18 state laws which were in effect at that time to regulate speech pathologists and audiologists ("Summary of 18 State Laws," 1975). ASHA's Office of State Legislation, Governmental Affairs Department, issued a similar "Comparison of Selected State Licensure Laws for Speech Pathologists and Audiologists" in April of 1976. While this Office of State Legislation document acknowledged the enactment of 29 licensure laws, the comparison undertaken was limited to the 18 state laws reviewed in the February 1975 publication and was almost identical in format and content with the earlier comparison. It is one purpose of this chapter to expand these comparisons to include all 30 of the state laws currently regulating speech pathologists and audiologists.¹ Moreover, this chapter will endeavor to develop additional comparisons not made in either the February 1975 or April 1976 report.²

¹On May 26, 1979, a licensing bill regulating speech pathologists and audiologists was passed in the Nevada State Legislature. The bill was signed into law on June 1, 1979, with the licensing board appointed on August 1, 1979. Unfortunately, the specifics of the Nevada law were received too late for inclusion in this comparison.

²Since the issuance of these earlier comparisons, the American Speech-Language-Hearing Association has abstracted the 30 state

Table II provides a pre-comparison reference view of the 30 licensing laws governing speech pathologists and audiologists. Included are the legal citations for each state law, the order in which the laws were enacted, and the effective date for each statute. Figure I illustrates the pattern of statutory enactment from 1969 to September 1979.

A Comparison of Elements Relating to State Licensing Boards:
Supervising Authorities, Membership Criteria and Appointment,
Compensation, Composition, and Duties

State licensing boards in speech pathology and audiology are commonly designated by a variety of titles. Such designations include, but are not limited to, "licensing committee," "board of examiners," "committee of examiners," and "council of advisors." Eighteen of the 30 licensing agencies (viewing Maryland's two boards as a single entity) which regulate speech pathologists and audiologists are not autonomous, but rather are under the auspices of a state supervisory authority. Ten of these 18 supervisory authorities are state departments of health or other medical regulatory departments (e.g., Oregon's Health Division, Department of Human Resources). Two state boards, Florida's and New York's, report to the state department of education. A number of other states, such as Montana and Hawaii, are supervised by authorities apparently created by the state government primarily for the purpose of regulating a number of semi-independent agencies. Table III lists

licensing laws to develop unpublished compendiums of these laws. The author is deeply indebted to Mr. Morrison Cain and Mrs. Donna Brown-Grossman of the American Speech-Language-Hearing Association for providing him with copies of these summaries.

TABLE II

LEGAL CITATIONS, ORDER OF ENACTMENT, AND EFFECTIVE DATES FOR
STATE LICENSURE LAWS IN SPEECH PATHOLOGY
AND AUDIOLOGY

State	Legal citation	Order	Effective date
ALABAMA	ALA. CODE tit. 34, §§28A-1 <u>et seq.</u> (Supp. 1973)	26	December 1975
ARKANSAS	ARK. STAT. ANN. §§1801 <u>et seq.</u> (1977)	20	February 1975
CALIFORNIA	CAL. BUS. & PROF. CODE §§2530 <u>et seq.</u> (1974) (West)	6	July 1, 1974
CONNECTICUT	CONN. GEN. STAT. §§20-408 <u>et seq.</u> (1975)	11	July 1, 1974
DELAWARE	DEL. CODE ANN. tit. 24 §§3701 <u>et seq.</u> (1974)	15	July 23, 1973
FLORIDA	FLA. STAT. §§468.139 <u>et seq.</u> (1977)	1	July 10, 1969
GEORGIA	GA. CODE §§6701 <u>et seq.</u> (1977)	16	March 26, 1974
HAWAII	HAW. REV. STAT. §§468E-1 <u>et seq.</u> (1976)	17	January 1, 1975
INDIANA	IND. CODE ANN. §§25- 35.6-1 <u>et seq.</u> (1974) (Burns)	7	January 1, 1974
IOWA	IOWA CODE §§147.151 <u>et seq.</u> (Supp. 1979)	28	January 1, 1977
KENTUCKY	KY. REV. STAT. §§334A.010 <u>et seq.</u> (Supp. 1977)	3	June 16, 1972
LOUISIANA	LA. REV. STAT. ANN. §§2651 <u>et seq.</u> (1975) (West)	5	January 1, 1973
MAINE	ME. REV. STAT. tit. 32, §§6001 <u>et seq.</u> (1979)	29	April 12, 1976
MARYLAND	MD. OCC. & PROF. CODE ANN. §§791 <u>et seq.</u> (1974)	4	July 1, 1972
MISSISSIPPI	MISS. CODE ANN. §§73-38.1 <u>et seq.</u> (Supp. 1978)	23	July 1, 1975
MISSOURI	MO. ANN. STAT. §§345.010 <u>et seq.</u> (1979) (Vernon)	14	September 28, 1973
MONTANA	MONT. REV. CODES ANN. §§66-3901 <u>et seq.</u> (Supp. 1977)	24	1975
NEBRASKA	NEB. REV. STAT. §71-02 (1979)	30	March 20, 1978

TABLE II

continued

State	Legal citation	Order	Effective date
NEW YORK	N.Y. EDUC. LAW §§8200 <u>et seq.</u> (Supp. 1979) (McKinney)	18	April 1, 1976
NORTH CAROLINA	N.C. GEN. STAT. §§90- 292 <u>et seq.</u> (Supp. 1977)	27	October 1, 1975
NORTH DAKOTA	N.D. CENT. CODE §§43-31- 01 <u>et seq.</u> (Supp. 1975)	22	July 1, 1975
OHIO	OHIO REV. CODE ANN. §§4753.13 <u>et seq.</u> (Supp. 1978) (p. 49)	25	September 26, 1975
OKLAHOMA	OKLA. STAT. tit. 59 §§1601 <u>et seq.</u> (1978)	9	January 1974
OREGON	OR. REV. STAT. §§681.205 <u>et seq.</u> (1974)	13	July 1973 (enactment date)
RHODE ISLAND	R.I. GEN. LAWS §5-48 (Supp. 1978)	10	September 1, 1973
SOUTH CAROLINA	S.C. CODE §56-1549.2 (Supp. 1975)	12	January 1, 1974
TENNESSEE	TENN. CODE ANN. §63-1701 <u>et seq.</u> (1976)	8	July 1, 1973
UTAH	UTAH CODE ANN. §58-41-1 <u>et seq.</u> (Supp. 1979)	21	March 1975
VIRGINIA	VA. CODE §54-83.1:5 <u>et seq.</u> (1975)	2	July 1, 1972
WYOMING	WYO. STAT. §33-387 <u>et seq.</u> (Supp. 1975)	19	May 30, 1975

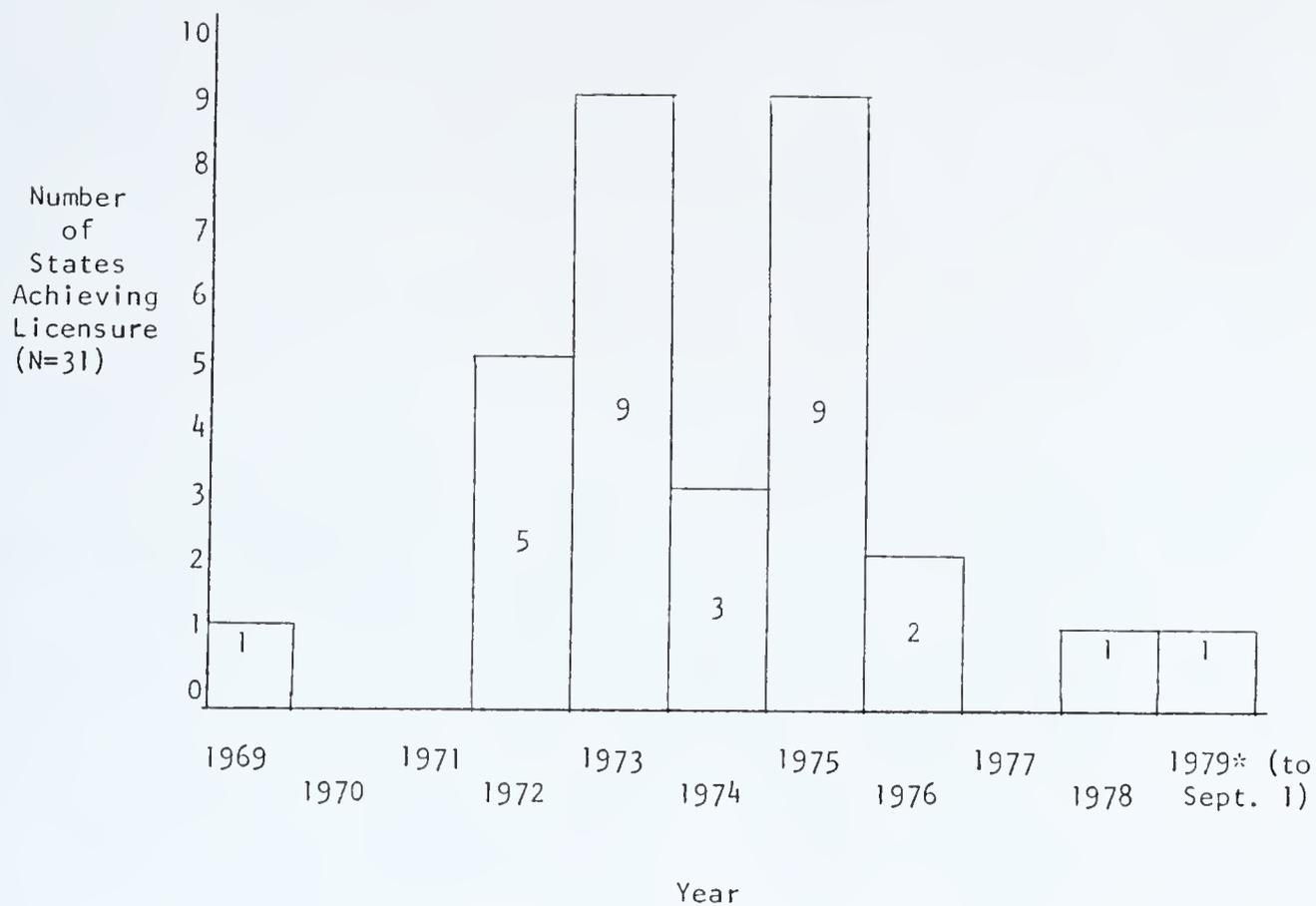


Figure 1 Pattern of statutory enactment, 1969-1979.

Note: *Figure 1 includes the Nevada law which was enacted June 1, 1979. This law has not been included in the comparisons discussed in this chapter.

state licensing agencies, their addresses, and corresponding supervisory authorities. The funding of autonomous and semi-autonomous licensing agencies and the perceptions of agency chairpersons regarding the value of and need for such supervisory authorities will be reviewed in Chapter 5.

The number of individuals serving on state licensing boards varies from state to state, with a range of four members (Nebraska) to ten members (Maryland). It should be remembered, however, that Maryland law mandates two separate licensing boards composed of five members each. California's Examining Committee, with nine members, is the largest single board. Thirteen boards have five members each while 12 boards have seven members each. Generally, four members are needed to establish a quorum to conduct business on boards consisting of seven members and the presence of three members constitutes a quorum on most boards containing five members. Board members are typically appointed by the state governor from a list submitted by the state speech and hearing association. Consequently, a licensee who is not a member of the state association has little, if any, chance of being nominated. Statutory provisions in Indiana, Tennessee, and Louisiana provide for advisors to the board.

The governor shall also appoint two(2) nonvoting advisors to serve for four (4) year terms of office. One of these advisors shall be a member of the hearing aid dealers advisory committee who is a registered hearing aid dealer and the other advisor shall be a licensed physician who is board certified in otolaryngology. IND. CODE ANN. §25-35.6-2-1 (1974) (Burns)

There shall be an advisory council consisting of three members. . . . One (1) member shall be a person licensed to practice medicine or dentistry in the state of Tennessee and who holds certification for the field in which he specialized. . . . One (1) member shall be

TABLE III

LICENSING AGENCIES AND SUPERVISORY AUTHORITIES IN STATES
REGULATING SPEECH PATHOLOGISTS AND AUDIOLOGISTS
(June, 1979)

State	Licensing agency and address	Supervising authority
ALABAMA	Alabama Board of Examiners for Speech Pathology and Audiology P.O. Box 2278 Auburn, Alabama 36830	None
ARKANSAS	Board of Examiners in Speech Pathology and Audiology P.O. Box 5198 Little Rock, Arkansas 72205	None
CALIFORNIA	Speech Pathology and Audiology Examining Committee Board of Medical Quality Assurance 1430 Howe Avenue Sacramento, California 95825	Division of Allied Health Professions Board of Medical Quality Assurance Department of Consumer Affairs
CONNECTICUT	Advisory Council on Speech Pathologists and Audiologists State Department of Health Room 624, R 7051 79 Elm Street Hartford, Connecticut 06115	Department of Health
DELAWARE	State Board of Examiners of Speech Pathology and Audiology Suite 236 Jesse S. Cooper Memorial Building Dover, Delaware 19901	None

TABLE III

continued

State	Licensing agency and address	Supervising authority
FLORIDA	Florida State Advisory Council of Speech Pathology and Audiology Department of Education Teacher Certification Section Room 452 Tallahassee, Florida 32304	Department of Educa- tion
GEORGIA	State Board of Examiners for Speech Pathology and Audiology 166 Pryor Street, S.W. Atlanta, Georgia 30303	State Examining Boards of Georgia--Secretary of State
HAWAII	Board of Speech Pathology and Audiometry Department of Regulatory Agencies 1010 Richards Street Honolulu, Hawaii 96813	Department of Regula- tory Agencies
INDIANA	Indiana Board of Examiners on Speech Pathology and Audiology State Board of Health 1330 W. Michigan Street Indianapolis, Indiana 46206	None
IOWA	Iowa Board of Speech Pathology and Audiometry Examiners State Department of Health Lucas State Office Building Des Moines, Iowa 50319	State Department of Health
KENTUCKY	State Board of Examiners of Speech Pathology and Audiology P.O. Box 456 Frankfort, Kentucky 40601	None

TABLE III

continued

State	Licensing agency and address	Supervising authority
LOUISIANA	Louisiana Board of Examiners for Speech Pathology and Audiology Louisiana State University Medical Center 1100 Florida Avenue, Building 163 New Orleans, Louisiana 70119	Department of Health and Human Resources
MAINE	State Board of Examiners on Speech Pathology and Audiology Department of Human Services Statehouse Augusta, Maine 04333	Commission of Business Regulation, Licensing Bureau
MARYLAND	Board of Examiners for Audiologists; Board of Examiners for Speech Pathologists 301 W. Preston Baltimore, Maryland 21201	State Department of Health and Mental Hygiene
MISSISSIPPI	Mississippi Council of Ad- visors in Speech Pathology and Audiology Mississippi State Board of Health P.O. Box 1700 Jackson, Mississippi 39205	State Board of Health
MISSOURI	Committee of Examiners for Speech Pathology and Audiology The State Board of Registrants for the Healing Arts 3523 North Ten Mile Drive Jefferson City, Missouri 65101	State Board of Healing Arts

TABLE III

continued

State	Licensing agency and address	Supervising authority
MONTANA	Board of Speech Pathologists and Audiologists Department of Professional and Occupational Licensing La Londe Building Helena, Montana 59601	Department of Profes- sional and Occupational Licensing
NEBRASKA	Board of Examiners in Audi- ology and Speech Pathology Bureau of Examining Boards Department of Health P.O. Box 95007 Lincoln, Nebraska 68509	Department of Health
NEW YORK	State Board for Speech Pathology and Audiology State Education Department Division of Professional Licensing Services 99 Washington Avenue Albany, New York 12230	Board of Regents
NORTH CAROLINA	Board of Examiners for Speech and Language Pathologists and Audiologists P.O. Box 5545 Greensboro, North Carolina 27403	None
NORTH DAKOTA	State Board of Examiners of Audiology and Speech Pathology Dakota Clinic Box 6001 Fargo, North Dakota 58102	None

TABLE III

continued

State	Licensing agency and address	Supervising authority
OHIO	Board of Speech Pathology and Audiology Suite 804 79 East State Street Columbus, Ohio 43215	None
OKLAHOMA	State Board of Examiners for Speech Pathology and Audiology P.O. Box 53592 State Capitol Station Oklahoma City, Oklahoma 73105	None
OREGON	State Board of Examiners for Speech Pathology and Audiology 1400 S.W. 5th Avenue Portland, Oregon 97201	Department of Human Resources
RHODE ISLAND	State Board of Examiners for Speech Pathology and Audiology Professional Regulation Department of Health 75 Davis Street Providence, Rhode Island 02908	Department of Health
SOUTH CAROLINA	State Board of Examiners in Speech Pathology and Audiology P.O. Box 11876 Columbia, South Carolina 29211	None
TENNESSEE	State Board of Examiners for Speech Pathology and Audiology Department of Public Health 352 Capitol Hill Building Nashville, Tennessee 37219	None

TABLE III

continued

State	Licensing agency and address	Supervising authority
UTAH	Licensing Committee for Speech Pathology and Audiology c/o Director of Registration Department of Business Regulation 330 E. 400 South Street Salt Lake City, Utah 84111	Department of Business Regulation
VIRGINIA	Virginia Board of Examiners for Audiology and Speech Pathology Virginia Department of Commerce 2 South 9th Street Richmond, Virginia 23219	Department of Commerce
WYOMING	Board of Examiners for Speech Pathology and Audiology Box 4014 Casper, Wyoming 82601	None

a licensed hearing aid dispenser. . . . One member shall be appointed by the governor from the areas of social work, psychology, or special education. The terms of the advisory council members shall be for a period of three (3) years. The duties of the advisory council shall be to assist the board in carrying out the provisions of this chapter and to help in determining the need for expansion or improvement of speech pathology and audiology services in Tennessee. The advisory council will meet concurrently with the board. TENN. CODE ANN. §63-1723 (1976)

Louisiana's physician board member is a nonvoting member and serves in an advisory capacity only.

The majority of states stipulating a provision for consecutive terms as a board member prohibit an individual from serving on the state agency board for more than two consecutive terms. Service requirements for speech pathology and audiology members are mandated under statute in many states, the usual prerequisite being that the speech pathology and audiology members have rendered service in the profession for three to five years previous to appointment. Some state laws require such service to have been performed within the state. "Service" generally includes clinical practice, teaching, or research.

Compensation is, as a rule, not afforded board members. However, many state laws authorize the payment of travel expenses or travel expenses and a modest per diem. Some states apparently view this per diem as a form of compensation, while others explicitly state that board members will receive no compensation but may receive travel expenses and/or per diem. Table IV outlines the specifics of board membership on a state-by-state basis.

Table V examines the composition of state licensing boards. Four states, Florida, Nebraska, Utah, and New York, have licensing agencies composed entirely of speech pathologists and audiologists. New York

TABLE IV
 SELECTED PROVISIONS RELATED TO BOARD MEMBERSHIP ON
 SPEECH PATHOLOGY AND AUDIOLOGY LICENSING BOARDS

State	Total number board members	Total number board advisors	Term of office (years)	Consecutive terms permitted	Service requirements for speech pathologists and audiologists*	Needed for quorum	Compensation
ALABAMA	7	0	3	2	Rendering service at least 5 years prior to appointment	5	No compensation, may be reimbursed for necessary expenses
ARKANSAS	7	0	3	2	Rendering service at least 2 years prior to appointment	4	May receive compensation, shall receive per diem and travel expenses
CALIFORNIA	9	0	4	2	No provision	5	Receive per diem and travel expenses
CONNECTICUT	7	0	3	No provision	Rendering service at least 5 years prior to appointment	4	Members serve without compensation
DELAWARE	5	0	3	2	Rendering service at least 5 years prior to appointment	3	\$20.00/day not to exceed 20 days per year and reimbursement for expenses
FLORIDA	5	0	3	2	Rendering service at least 5 years prior to appointment	3	No compensation, may be reimbursed for traveling expenses
GEORGIA	7	0	3	2	Rendering service at least 3 years prior to appointment	4	No compensation, but receive \$25.00 per diem and expenses
HAWAII	7	0	3	No provision	No provision	4	No compensation, but receive traveling expenses

State	Total number board members	Total number board advisors	Term of office (years)	Consecutive terms permitted	Service requirements for speech pathologists and audiologists:*	Needed for quorum	Compensation
INDIANA	5	2	3	2	Rendering service at least 5 years prior to appointment	3	No compensation, but receive appropriate per diem and travel expenses
IOWA	7	0	No provision	No provision	No provision	No provision	No provision
KENTUCKY	5	0	3	2	No provision	3	No compensation, may receive authorized travel and per diem expenses
LOUISIANA	6	0	3	2	Rendering service at least 5 years prior to appointment	3	No compensation, but may receive per diem and travel expenses
MAINE	7	0	3	2	Engaged full time in practice of speech pathology or audiology at least one year prior to appointment	4	\$25.00 per diem and travel expenses
MARYLAND	10 (2 boards)	0	5	2	Paid work experience for at least 5 years prior to appointment	3	No compensation, but may receive per diem and travel expenses
MISSISSIPPI	5	0	3	2	No provision	3	No compensation, but per diem of \$22.50 plus expenses and travel
MISSOURI	7						see note--Table V

TABLE IV
continued

State	Total number board members	Total number board advisors	Term of office (years)	Consecutive terms permitted	Service requirements for speech pathologists and audiologists*	Needed for quorum	Compensation
MONTANA	5	0	No provision	No provision	No provision	3	\$25.00 per day when attending board meetings plus travel and mileage expenses
NEBRASKA	4	0	3	2	Rendering service at least 3 years prior to appointment	3	Necessary traveling and hotel expenses plus per diem of \$20.00
NEW YORK	7	0	No provision	No provision	Rendering service in the state for at least 5 years prior to appointment	No provision	No provision
NORTH CAROLINA	5	0	5	No provision	Must have at least 5 years paid work experience prior to appointment	No provision	No compensation, but per diem, subsistence, and travel allowance
NORTH DAKOTA	7	0	No provision	No provision	Rendering service for at least 3 years prior to appointment	4	No salary, but per diem and travel expenses for meetings
OKLAHOMA	5	0	3	1	No provision	3	Necessary traveling and subsistence expenses incidental to Board meetings
OHIO	5	0	3	2	Engaged in service for at least 5 years prior to appointment	3	\$15.00 per diem and expenses

State	Total number board members	Total number board advisors	Term of office (years)	Consecutive terms permitted	Service requirements for speech pathologists and audiologists*	Needed for quorum	Compensation
OREGON	7	0	3	Member is eligible for reappointment	No provision	4	Members receive compensation and expenses
RHODE ISLAND	5	0	3	2	Engaged in rendering services for at least 5 years prior to appointment	3	Members shall serve without compensation
SOUTH CAROLINA	7	0	4	No provision	Engaged in rendering services for at least 5 years prior to appointment	No provision	No provision
TENNESSEE	6	3	3	2	Engaged in rendering services for at least 5 years prior to appointment	3	No compensation, but \$25.00 per diem when discharging board duties plus travel and other expenses
UTAH	5	0	No provision	No provision	No provision	No provision	No provision
VIRGINIA	5	0	4	2	Engaged in rendering services for at least 2 years prior to appointment	No provision	No provision

TABLE IV
continued

State	Total number board members	Total number board advisors	Term of office (years)	Consecutive terms permitted	Service requirements for speech pathologists and audiologists*	Needed for quorum	Compensation
WYOMING	5	0	3	2	Engaged in rendering services for at least 5 years prior to appointment	3	No compensation, but per diem for travel expenses

Note: *"Service" includes practice, teaching, or research.

TABLE V
COMPOSITION OF STATE EXAMINING/ADVISORY BOARDS FOR THE
LICENSING OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

Board members	States (N = 30)																														Totals for each membership category		
	AL.	AR.	CA.	CT.	DE.	FL.	GA.	HI.	IL.	IN.	IA.	KY.	LA. ^h	ME.	MD. (A)	MD. (SP)	MS.	MO. ^{**}	MT.	NE.	N.Y.	N.C.	N.D.	OH.	OK.	OR.	R.I.	S.C.	TN.	UT.		VA.	WY.
Speech pathologists	3	2	3	4	2	0	2	2	2	2	1	2	2	1	3	2	2	2	4	2	2	2	2	2	0	3	2	2	2	0	2	2	60
Audiologists	3	2	3	1	2	0	2	2	2	2	1	2	2	3	1	2	2	3	2	3	2	2	2	0	3	1	2	2	0	2	1	54	
Speech pathologist or audiologist	0	1	0	0	5	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	1	5	0	17	
Public member	1	1	3	2	0	0	1	2	0	2	1	0	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	17	
Consumer member	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	1	6	
Otolaryngologist	0	0	0	0	0	1	1	0	0	1	0	1	1	1	1	1	1	0	0	0	0	1	0	1	1	1	1	1	0	1	14		
Physician	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2		
State-certified teacher of speech defective and hard of hearing	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1		
Hearing aid dealer/specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2		
Representative of State Health Office	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1		
Physician or dentist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1		
Unspecified	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2		
Total board members each state	7	7	9	7	5	5	7	7	5	7	5	6	7	5	5	5	5	5	4	7	5	7	5	5	5	7	5	7	5	5	177		

Source: ASHA, 1979b

Note: ^hLouisiana's physician board member is non-voting.

^{**}The Missouri statute makes no provision with regard to the composition of the state agency administering the law. Currently, Missouri Speech and Hearing Association members are placed in seven job categories and one member is chosen from each setting.

law does contain a provision for adding board members who are not speech pathologists or audiologists, but currently the New York State Board for Speech Pathology and Audiology is composed solely of professionals from the disciplines regulated. If nonvoting advisors are excepted, Indiana's Board of Examiners on Speech Pathology and Audiology is likewise comprised exclusively of speech pathologists and audiologists. A number of states such as Nebraska, Alabama, and Delaware have attempted to create a balance between the number of speech pathologists and the number of audiologists serving on the board. Seventeen states have achieved this balance. Arkansas, Indiana, Iowa, and Tennessee have provisions for two speech pathologists and two audiologists to serve on the board, however state law requires that a fifth board position be filled by a professional who is either a speech pathologist or audiologist. Thus an imbalance is created. With regard to states wherein the state statute dictates that a specific number of speech pathologists and a specific number of audiologists will serve, and this number is unequal, all state boards have more speech pathologists serving. The exception to this is Maryland's Board of Examiners for Audiologists. Ostensibly, the rationale for creating a membership disparity in favor of speech pathologists is to provide increased representation for state licensed speech pathologists who outnumber state licensed audiologists in every state. There appears to be some validity for basing the ratio of speech pathology board members to audiology board members on the ratio of state licensed speech pathologists to state licensed audiologists in order to insure adequate representation for licensees.

Public members and consumer members constitute the next largest component of board membership. Eleven state agencies have at least one

public member and six state agencies have at least one consumer member. Only one state, Arkansas, has a statutory provision for both a consumer and a public representative. However, the relatively nonspecific use of the terms "public member" and "consumer member" confound the statistics. For example, the American Speech-Language-Hearing Association (ASHA, 1979b) lists the presence of two public members on the Connecticut Advisory Council on Speech Pathologists and Audiologists. However, the Connecticut statute indicates that the Council will contain "two members of the public, each of whom shall have a communication disorder related to speech or hearing or have a family member with such a disorder" [CONN. GEN. STAT. §20-409 (1975)]. Hence, the two public members are in reality public member consumers. Conversely, state laws such as those operating in Delaware and Montana mandate a consumer representative on the board without defining "consumer." A loose definition of "consumer" could theoretically view a board's consumer representative as a state resident who represents a lay public which is a potential consumer of speech and hearing services.

A review of Table V indicates the representation of medical personnel and hearing aid specialists on a number of state boards. Louisiana law requires the membership of a state-certified teacher of the speech defective and hard of hearing, the South Carolina law mandates inclusion of a representative from the State Health Office, and Georgia and Kentucky include provisions for an unspecified board member.

The duties performed by state licensing boards are many and varied. A perusal of each state statute would be necessary to fully comprehend all the duties performed by each licensing agency, however a compilation of these duties is contained in Table VI. While no single state

TABLE VI

A COMPILATION OF DUTIES TO BE PERFORMED BY LICENSING BOARDS
IN SPEECH PATHOLOGY AND AUDIOLOGY

-
1. Administer, coordinate, enforce licensing law; establish licensing fees; evaluate applicants (e.g., North Carolina)
 2. Adopt rules and regulations, including ethical standards practice (e.g., Arkansas)
 3. Suspend, revoke licenses; license and renew licenses for qualified persons (e.g., Georgia)
 4. Authorize all disbursements necessary to administer licensure law (e.g., Wyoming)
 5. Conduct hearings; keep records and minutes (e.g., Kentucky)
 6. Hire/fire employees; adopt seal (e.g., Louisiana)
 7. Issue subpoenas; administer oaths; examine witnesses; investigate alleged violations (e.g., Wyoming)
 8. Recommend legislation, file with county attorney complaints for prosecution/injunction, and incur necessary expenses (e.g., Montana)
 9. Establish and revise licensure and renewal requirements (e.g., Georgia)
 10. Advise the supervising authority with regard to licensing and educational requirements (several states)
 11. Issue annual list of licensees (e.g., Maryland)
 12. Register persons who apply and are qualified to practice speech pathology and audiology (e.g., Virginia)
 13. Meet at least twice annually (e.g., Maryland)
 14. File annual report (e.g., Florida)
 15. Encourage continuation and improvement of specialized educational courses of training (e.g., Florida)
 16. Rent or purchase space to carry out function (e.g., Oklahoma)
 17. Purchase or rent equipment or facilities necessary to carry out examination of applicants (e.g., Virginia)

TABLE VI
continued

-
18. Contract with testing service (e.g., Georgia)
 19. Prepare and administer examinations (e.g., Georgia)
 20. Supervise examinations (e.g., Kentucky)
 21. Grade licensing examinations (e.g., Connecticut)
 22. Maintain a permanent record of all examination scores (e.g., Hawaii)
 23. Develop standards and methods of documentation and establish procedures for continuing education (e.g., Montana)
-

Source: ASHA, 1979b

licensing board is required to fulfill all the duties specified in this Table, and while some boards may undertake duties not delineated therein, Table VI has used examples from the various states in an attempt to demonstrate the scope of licensing board duties. Chapter 5 will explore the perceived importance of these duties and the time spent in their fulfillment by state boards.

A Comparison of Fee Schedules, Renewal Standards, and Continuing Education

As can be seen by observation of Table VII, licensing fees can fluctuate greatly from state to state. While some state variation is inevitable, it should be noted that a speech pathologist or audiologist wishing to renew licensure in Ohio must pay 15 times more than one wishing to renew licensure in Rhode Island. A comparison of initial licensing charges is made difficult by the fact that certain states, for example Florida, include the fee for initial licensure within the amount to be paid for application. The reverse situation, wherein the state may fail to require payment for application because such charges are included in the initial licensing fee, may also be found. In half of the 30 states, the licensing board sets or has input into the setting of some or all of the fees. This would appear to be practical, however, the fact that many licensing boards are operated solely from collected fees makes abuse possible and supervision necessary. There appears to be no relationship between a board's ability to set fees (Table VII) and its inclusion under a supervisory agency (Table III).

TABLE VII
FEES CHARGED FOR LICENSING IN SPEECH PATHOLOGY AND AUDIOLOGY

State	Application	Initial Licensing	Renewal	Delinquency	Replacement	Inactive	Examination	Re-exam	Temporary	Comments
ALABAMA	\$25	\$50 (single or dual)	\$30 (2 yrs.)	10 $\frac{1}{2}$ /month after 30 day grace period, up to double original charge	\$10	\$25/yr.-- 2 yrs. max.	\$25	\$25		
ARKANSAS	up to \$50	up to \$40	up to \$40/yr.	up to \$40						Board sets fees within statutory limits.
CALIFORNIA	\$25 (\$150 limit)	\$50 (\$150 limit)	\$50 (\$150 limit)	\$10				\$15 (\$75 limit)		Application/renewal re-exam fees set by board.
CONNECTICUT		\$25 (\$50 dual)	\$15 with- in one month prior to expiration otherwise --\$20				\$25	\$25	\$25	
DELAWARE	\$25		\$10	\$5	\$5		\$25			Board may set fees.
FLORIDA	\$25	covered by application fee	\$25/yr. (same as dual)			\$10				
GEORGIA	\$70	not to exceed \$100/2 yrs.	\$10	\$20			\$25			Board and Joint Secretary set fees.
HAWAII										Board determines for application, initial licensing, renewal, and late renewal.

TABLE VII
continued

State	Application	Initial licensing	Renewal*	Delinquency	Replacement	Inactive	Examination	Re-exam	Temporary	Comments
INDIANA										
IOWA		\$25	\$25		\$5					Board determines for exam, initial licensing, renewal, and late renewal. Board determines for initial licensing, renewal, and temporary license.
KENTUCKY	\$25	\$50	\$25	\$5-\$10		\$5	\$25			
LOUISIANA	\$50		May not exceed \$50			\$10				Board sets own fees.
MAINE		\$25	\$50/2 yrs.				Up to \$25 (set by board)		\$25	
MARYLAND										
MISSISSIPPI	\$25	\$25	\$25	\$2/mo.						Board sets fees. Registration of aides is \$10.
MISSOURI		\$50	\$25/yr. (same as dual)	\$50 (reinstatement of lapsed license)						Reinstatement of lapsed license is \$50.
MONTANA	\$50-\$100	\$25-\$100	\$25-\$100	10¢/mo. up to twice normal fee			Included in application fee.			Board sets within specified limits.
NEBRASKA		\$75	\$25	\$1	\$2					Certified statement of licensure is \$2.

TABLE VII
continued

State	Application	Initial licensing	Renewal:	Delinquency	Replacement	Inactive	Examination	Re-exam	Temporary	Comments
NEW YORK		\$80	\$30/biennial registration				Included in application Fee of \$80	\$40		
NORTH CAROLINA	\$25	\$25	\$25	\$10			\$25		\$25	
NORTH DAKOTA										
OHIO		\$150 (single or dual)	\$75			\$15/yr.	\$75 nonrefundable			Board sets fees. No fee or combination of fees may exceed \$50 annually.
OKLAHOMA		\$50 max.	\$50 max.	10¢/mo.	\$10 max.	\$10				Board sets fees within statutory limits.
OREGON	\$25	\$25	\$25	\$10		\$10	\$25			Board sets fees.
RHODE ISLAND	\$25	\$5	\$5							
SOUTH CAROLINA	\$25	\$25	\$25	\$25	\$10	\$10				
TENNESSEE	\$50 max.	\$100 max.	\$100 max.	\$100 max.			\$25 max.			
UTAH										
VIRGINIA	\$25		\$15	\$25 up to 30 days-- \$35 after 30 days						Board sets fees.
WYOMING	\$25 \$50 dual	\$50 \$100 dual	\$25 \$50 dual	\$5/mo. \$20 max.		\$10				Presented by board. Fee of \$25 for reciprocal license.

Sources: ASHA, 1975b, "A Review of Audiology State Licensing Bills," 1977

Note: See Table VIII for renewal standards.

Renewal standards are determined to some degree by statute in 25 of the 30 states licensing speech pathologists and audiologists. Table VIII outlines these standards. Usually renewal is not permitted after a five year lapse; however a number of state laws contain more restrictive time limits. In South Carolina, for example, a license may not be renewed if it is more than nine months delinquent. A number of other states require re-examination if a designated time span has elapsed since renewal. Most states allow suspended licenses to be renewed, whereas revoked licenses are generally not renewable. A few states (e.g., Hawaii and Indiana) permit the reinstatement of a revoked license by action of the board and upon payment of renewal and delinquency fees. Although 11 states have some statutory provision for continuing education, in only five states is continuing education currently mandatory for license renewal.

1. The board shall develop standards and methods of documentation and establish procedures for causing individuals who have been licensed to demonstrate continued education before renewing any license more than twice. MONT. REV. CODES ANN. §66-3907 (Supp. 1977)
2. . . . the licenses shall be renewable provided that the licensee verifies having received scheduled graduate level professional training, related clinically to the profession of speech pathology or audiology to the minimum amount of three graduate credit hours or thirty clock hours in face-to-face graduate level instruction, participation and performance completed within each five-year period since the date of initial licensing. UTAH CODE ANN. §58-41-12 (Supp. 1979)
3. Renewals are contingent upon evidence of participation in continuing professional education, such as attending professional meetings and regional inservice programs, as determined by the board. ME. REV. STAT. tit. 32, §6021 (1979)

TABLE VIII

STANDARDS FOR RENEWAL OF LICENSURE AS CONTAINED IN STATE STATUTES
LICENSING SPEECH PATHOLOGISTS AND AUDIOLOGISTS

State	Renewal standards
ALABAMA	License may not be renewed after 2 year lapse.
ARKANSAS	Annual expiration is June 30. No exam necessary for renewal if application is within two years of expiration. No renewal after five years. Suspended licenses may be renewed.
CALIFORNIA	Licenses expire on December 31 of odd-numbered years. License issued after August 31 of odd-numbered year expires at end of next odd-numbered year. Suspended licenses may be renewed. No renewal allowed after 5 year lapse.
CONNECTICUT	Licenses expire on July 31. No renewal allowed after 5 year lapse.
DELAWARE	Expired licenses may be reinstated at the Board's discretion upon payment of renewal and late fees, but a license may not be renewed after a 5 year lapse.
FLORIDA	No provision for renewal standards.
GEORGIA	Annual renewal must be undertaken by December 1 (30 day grace period). No examination is necessary if renewal is within 2 years of lapse. A license may not be renewed after 5 years. A licensee may apply for inactive status for up to 3 years. Reactivation dependent upon payment of a fee and completion of a Board-set refresher course.
HAWAII	Annual renewal by December 31 of each odd-numbered year. It is not necessary for the licensee to take another examination if renewal is sought within 2 years of expiration. Suspended licenses may be renewed. Such is not the case with revoked licenses; however, the Board may later reinstate the license subject to payment of renewal fees. No renewal is permitted after a 5 year lapse.

TABLE VIII

continued

State	Renewal standards
INDIANA	Biennial renewal by December 31 of odd-numbered years. No renewal after 5 year lapse. Suspended licenses may be renewed. Revoked licenses may not be renewed, but the Board may reinstate a license upon payment of regular renewal and late fees.
IOWA	Renewal standards are not specified.
KENTUCKY	Annual renewal by January 30. A 30 day grace period is allowed wherein renewal is \$30. Renewal is \$35 thereafter. A license is not renewable after a 5 year lapse. Suspended licenses may be renewed and upon reinstatement the licensee must pay applicable renewal and late fees. A revoked license is not renewable.
LOUISIANA	Renewal standards are not specified.
MAINE	Biennial renewal by January 1 on at least 30 days' notice from Board. No re-examination necessary if renewal is within two years of expiration. Renewals are contingent upon completion of continuing professional education such as attending professional meetings and regional inservice as specified by the Board. A suspended license may be renewed, a revoked license may not.
MARYLAND	Annual renewal within 30 day grace period. No re-examination necessary if renewal is within 5 years of expiration. No renewal after 5 years, the applicant having to meet existing license requirements.
MISSISSIPPI	Annual renewal by January 1. No renewal examination is necessary if license renewed within two years. Suspended licenses, but not revoked, may be renewed.
MISSOURI	Annual renewal by June 30. Re-examination may be required for reinstatement after a lapse of more than 3 years.

TABLE VIII

continued

State	Renewal standards
MONTANA	Biennial expiration June 30. Renewal may be made 60 days previous. Board may require exam after lapse of 1 year. No renewal after 4 year lapse. Suspended licenses may be renewed. Continuing education to be demonstrated before 3rd renewal.
NEBRASKA	Board may recommend reinstatement when license lapses by failure to renew.
NEW YORK	Renewal standards not specified.
NORTH CAROLINA	Annual renewal with 30 day grace period. No examination required on application for renewal if license had been suspended for failure to renew.
NORTH DAKOTA	Renewal at beginning of each year. Re-examination may not be required if renewal application is made within 2 years of expiration. A suspended license may be renewed.
OHIO	Annual renewal is required. A suspended license may be renewed but a revoked license may not. Renewal of grandfather licenses contingent upon completion of continuing education requirements within six years.
OKLAHOMA	No provision for renewal standards.
OREGON	License may not be renewed after 4 year lapse.
RHODE ISLAND	Annual renewal is required.
SOUTH CAROLINA	License may not be renewed if more than 9 months delinquent.
TENNESSEE	License may not be renewed after 5 year lapse.
UTAH	Renewal contingent upon fulfillment of continuing education requirements.
VIRGINIA	Licenses may not be renewed after 5 year lapse.
WYOMING	Licenses may not be renewed without examination after 5 year lapse.

Source: ASHA, 1979b

4. The board shall provide for the continuing professional education of persons subject to this Chapter by appropriate regulation. GA. CODE §6705(c)(13) (1977)

Iowa also has a mandatory continuing education requirement, with the board determining the number of continuing education hours necessary for licensure renewal. Table IX delineates the statutory provisions relating to continuing education in those states having such provisions, but where continuing education is not currently mandatory for license renewal. The concept of continuing education as it relates to the disciplines of speech pathology and audiology will be discussed more fully in Chapter 5.

Statutory Provisions Related to Grandfathering and Exemptions

Grandfather clauses are contained in all 30 of the state licensing laws; however all such provisions have expired. Table X summarizes these provisions as they are found in state statutes licensing speech pathologists and audiologists. The duration of time allowed for individuals to petition for licensure under such provisions is generally one to three years, with a range of three months (Louisiana) to three years (several states). These clauses serve to "protect the interests of those who are currently engaged in the practice of speech pathology and audiology, as defined in the law, or who have been so engaged during a specified period preceding enactment of a licensure law" ("Summary of 18 State Laws," 1975, p. 101). Applicants securing licensure under such provisions are typically individuals who can give evidence of their active participation in the field on the law's effective date (e.g., Hawaii), or who can document their active participation in the disciplines of speech pathology and/or audiology for a

TABLE IX

STATUTORY PROVISIONS RELATING TO CONTINUING EDUCATION IN STATES
WHERE CONTINUING EDUCATION IS NOT MANDATORY
FOR LICENSE RENEWAL

State	Statutory provision (excerpted)
ARKANSAS	The Board shall require the applicant for license renewal to present evidence of the satisfactory completion of continuing education requirements as determined and published by the Board. ARK. STAT. ANN. §§1819 (1977)
FLORIDA	The council shall do all in its power to encourage the continuation and improvement of specialized educational courses of training to the department [of Education]. FLA. STAT. §468.144(7) (1977)
INDIANA	The board shall, by appropriate regulation, provide for the continuing professional education of persons subject to this article. IND. CODE ANN. §25-35.6-3.9 (1974) (Burns)
MISSISSIPPI	The board shall require the applicant for license renewal to present evidence of the satisfactory completion of continuing education requirements as determined by the board. MISS. CODE ANN. §73-38-33 (Supp. 1978)
MARYLAND	The Board, through rules and regulations, shall require the applicant for license renewal to present evidence of satisfactory completion of continuing education requirements. MD. OCC. & PROF. CODE ANN. §798(c) (1974)
NEBRASKA	The board may contract with institutions of higher learning, professional organizations, or qualified individuals to provide continuing education programs for audiologists and speech pathologists. License fees may be used for such programs. Any funds set aside for the purposes of continuing education may be treated as state funds for the purposes of applying for and accepting any funds made available under federal law on a matching basis for the promulgation and maintenance of programs of continuing education. NEB. REV. STAT. §71-20 (1979)

TABLE IX

continued

State	Statutory provision (excerpted)
NORTH DAKOTA	The board shall require all applicants for license renewal to present evidence of satisfactory completion of continuing education requirements, as determined by the board. Licensing fees shall be used for continuing education. N.D. CENT. CODE §43-37-17 (Supp. 1975)

TABLE X

GRANDFATHER PROVISIONS AS FOUND IN STATE LAWS LICENSING
SPEECH PATHOLOGISTS AND AUDIOLOGISTS

State	Grandfather provision
ALABAMA	Mandatory waiver until November 13, 1976, of examination and educational requirements for applicants who had been actively engaged in practice for two of the preceding five years.
ARKANSAS	Permissive waiver of education, experience, and examination requirements, for persons who were actively engaged in practice on the law's effective date. This applies to applications filed within one year.
CALIFORNIA	Permissive waiver of education and experiential requirements for persons in active practice on effective date, if filed within one year.
CONNECTICUT	<p>Mandatory licensing until July 1, 1974, for</p> <ul style="list-style-type: none"> a) persons who have been in active practice for at least ten years; or b) who are of good moral character and have been in active practice for 30 months during the previous ten years, and, for speech pathologists, meet Dept. of Education certification standards or, for audiologists, hold a bachelor's degree in audiology. <p>Permissive waiver of examination for temporary licensing holders who attain the master's degree by July 1, 1978. Renewable annually until July 1, 1978, without examination for persons applying by July 1, 1974, who:</p> <ul style="list-style-type: none"> a) are of good moral character; b) were employed in the state by a town or regional board of education on January 1, 1974; and c) held a bachelor's degree in speech pathology or audiology.
DELAWARE	<ul style="list-style-type: none"> a) Mandatory waiver, until July 12, 1974, of examination and educational requirements for applicants who were in active practice during any part of the two years preceding the effective date. b) Mandatory waiver of examination and educational requirements for persons certified by ASHA or licensed by a state with equivalent standards.

TABLE X
continued

State	Grandfather provision
FLORIDA	Mandatory waiver of examination and education requirements for applicants filing before the effective date and persons with state speech/hearing teaching credentials who were certified or actively teaching as of July 9, 1969.
GEORGIA	<ul style="list-style-type: none"> a) Permissive waiver for one year after effective date of examination for persons meeting educational and experience requirements. b) Permissive grant of licensure, for one year after effective date, to persons with a baccalaureate degree in speech pathology or audiology who, on the effective date, had been engaged in active full-time practice for the two previous years, or part-time practice of at least 15 hours weekly during the previous five years. c) Permissive grant of licensure for persons currently certified by the State Department of Education.
HAWAII	Mandatory waiver of examination and ASHA eligibility for persons actually engaged in practice on the effective date.
INDIANA	Mandatory grant of licensure, for applications within three years, for persons with at least a bachelor's degree in speech pathology or audiology who, on the effective date, were actively engaged in practice in the state, or had been so engaged for one of the previous five years. Also permissive grant of licensure to any person certified as clinically competent by a nationally recognized association for speech and hearing.
IOWA	Permissive grant of license for persons who, on July 1, 1976, were ASHA certified or held Department of Public Instruction certificates or statements of professional recognition as speech/hearing clinicians. Permissive waiver of any requirements except examination for person with five years of professional experience by July 1, 1976. Mandatory waiver of exam until July 1, 1977, for persons meeting all other licensing requirements but exam.

TABLE X
continued

State	Grandfather provision
KENTUCKY	Until June 16, 1974, permissive waiver of educational requirements and exam for applicants actively engaged in practice on the effective date. Permissive waiver of exam to persons who have passed the ASHA certification exam, and permissive waiver of all/part of exam for persons whom the Board finds have demonstrated competence in those areas.
LOUISIANA	Until April 1, 1973, mandatory waiver of exam and education requirements for persons with a baccalaureate degree in speech pathology/audiology/equivalent who were actively engaged in practice on the law's effective date. Mandatory waiver of exam and education requirements for persons certified by the State Board of Education as teachers of the speech defective and hard of hearing.
MAINE	For 180 days after effective date, mandatory grant of licensure to persons with credentials equivalent to ASHA certification or speech pathologists with a current State Department of Educational and Cultural Services certificate who have been engaged in private practice (120 hours per year outside school employment) for at least 2 years.
MARYLAND	Permissive grant of licensure to persons who are actively engaged in practice in the state on the effective date.
MISSISSIPPI	Mandatory waiver of education and experience for persons actually engaged in practice on the effective date. Such persons must meet waived licensure requirements by five years after the effective date.
MISSOURI	Until September 28, 1974, permissive grant of licensure for persons actively engaged in practice in the state on the effective date. Mandatory grant of licensure to pre-June 1970 college graduates who majored in and taught speech pathology or audiology in a public school or accredited clinic for two years, in this state or any other recognized state.

TABLE X

continued

State	Grandfather provision
MONTANA	Permissive waiver of exam for applicants who had been actively engaged in practice on the effective date. Mandatory licensing prior to July 1, 1976, on payment of fees for persons submitting affidavits that they meet current academic, supervised clinical practicum and post-classroom sponsored employment requirements of ASHA. Provisional licensing, prior to July 1, 1976, for applicants with a bachelor's degree in speech pathology or audiology, with 175 clock hours of clinical practicum, and at least one academic year's experience working in the state. See law for additional details.
NEBRASKA	Permissive waiver of educational requirements and exam for applicants filing within one year of effective date who hold at least a bachelor's degree with a major (as defined by the board) in speech pathology or audiology.
NEW YORK	Within 18 months of effective date, mandatory grant of licensure for persons regularly employed in teaching or working as a speech pathologist/audiologist who have been in practice in the state for two years and hold ASHA certification or equivalent.
NORTH CAROLINA	Mandatory waiver of examination and educational requirements for applicants actively engaged in practice on October 1, 1975, upon sufficient application made by February 28, 1978.
NORTH DAKOTA	Mandatory licensing of persons actually or previously engaged in practice in the state, upon proof of bona fide practice in accord with Board regulations for applications filed within three years of the licensing law's effective date.
OHIO	For one year after the effective date, mandatory grant of licensure to persons who, on effective date, had at least a bachelor's degree in speech pathology/audiology from an accredited college or university, or who was employed as a speech pathologist/audiologist for at least nine months during the three years prior to the effective date. Persons receiving "grandfather" licenses must meet continuing education requirements within six years for renewal (see law for specific requirements).

TABLE X

continued

State	Grandfather provision
OKLAHOMA	Mandatory waiver of examination requirement for one year after effective date for applicants meeting educational and experiential requirements.
OREGON	Permissive waiver until July 3, 1974, of examination and educational requirements for applicants qualified who are engaged actively in practice on July 3, 1973.
RHODE ISLAND	Mandatory waiver of educational and examination requirements for six months following enactment for persons holding a bachelor's degree with at least 30 semester hours in audiology or speech pathology, who have been rendering service for one year within the previous five years.
SOUTH CAROLINA	Permissive waiver of examination and educational requirements for persons who, on effective date, are actively engaged in practice and have been so for a period of three years within the five years preceding their application.
TENNESSEE	Mandatory waiver of examination and educational requirements for persons actively engaged in practice for at least six months during the two years prior to enactment. Expired July 1, 1975.
UTAH	Mandatory waiver of educational, clinical training, and examination requirements for persons holding the CCC or who have been engaged for three of the four years preceding enactment in active practice. Expires six months after effective date.
VIRGINIA	Waiver of examination and educational requirements for six months after effective date for persons who either (a) have been engaged in independent practice of audiology or speech pathology for at least two of the past five years, or (b) hold a bachelor's degree with at least 30 semester hours in speech pathology or audiology and have been practicing for at least one year within the past five, or (c) hold a current certificate from the State Board of Education in speech and hearing disorders.

TABLE X
continued

State	Grandfather provision
WYOMING	Mandatory waiver of examination and educational requirements for two years after effective date for persons holding at least a bachelor's degree in speech pathology or audiology who have been actively engaged in practice during at least one of the preceding five years.

Source: ASHA, 1979b

period of time preceding statutory enactment. For example, Alabama law stipulates that the applicant must have been in active practice for two of the five years prior to the law's effective date. Maine's requirements in this regard are somewhat more definitive, the applicant being required to have engaged in private practice outside school employment for a minimum of 120 hours per year during the previous two years.

While some states (e.g., South Carolina) waive licensure requirements solely on the basis of practice within the field for a particular period of time, other states do not totally eliminate educational requirements. Nebraska, for example, lowers but does not eliminate the educational requirements for those who wish to be grandfathered. Such individuals are required to hold at least a bachelor's degree with a major in speech pathology or audiology. Virginia's statute permits applicants to be grandfathered solely on the basis of experience or, with a less restrictive experience requirement, primarily on the basis of educational achievement. Examination requirements are usually waived for grandfathered individuals, however a few states (e.g., Oklahoma) make the waiver of examination contingent upon the fulfillment of educational and/or experiential requirements.

Two states, Ohio and Mississippi, place renewal stipulations upon licenses obtained via grandfather exemptions. Ohio law mandates that a license obtained by exemption shall not be renewed six years after its initial issuance unless certain continuing education prerequisites have been met. Such individuals must give evidence of a bachelor's degree with a major in the area of licensure or have completed at least 18 semester hours of academic credit or its equivalent. Moreover, the

successful completion of at least 150 clock hours of supervised clinical experience is also required. Mississippi's statute gives grandfathered persons five years to complete the licensure requirements which were waived. These waived requirements include a master's degree or its equivalent, the completion of required clinical and employment experience, and the passing of an examination.

There appears to be a trend toward the inclusion of more restrictive grandfather provisions in state laws licensing speech pathologists and audiologists. Whereas five of the initial six states to secure licensing legislation have laws which contain provisions to permit exemption solely on the basis of experience in the field, three of the last six states to enact licensing laws do not allow grandfather exemptions only on the basis of experience previous to enactment. Of the three states allowing exemption purely on experiential grounds, Ohio, as previously mentioned, requires significant continuing education to keep the license in force. Thus, in four of the last six states to obtain licensure, an individual who has no qualifications other than pre-legislation experience cannot obtain and keep a state license. As states have refined their legislative attempts, and as the professions have matured, it has become apparent to state associations that giving "blanket" concessions to individuals currently practicing in the field is not mandatory from either a legalistic or pragmatic point of view to secure passage of a licensing bill. Furthermore, these same associations have come to reflect upon the detrimental long-term effects which can accrue to the profession because of these concessions.

Exemptions, sometimes referred to as exclusions, are a requisite portion of every state licensing law. Table XI contains a compilation

of exemptions excerpted from speech pathology and audiology licensing statutes. While no state statute provides for all the exemptions delineated in Table XI, such a compilation is valuable in that it provides an overview of the type of exclusions found in the 30 state licensing laws.

ASHA (1973a) writes that

the term exclusion is commonly used in discussing licensing but it is often initially misunderstood by many professionals. The exclusion clause delineates (1) those persons who will not be required to have a license in order to practice, or (2) those job settings in which an individual will not be required to have a license in order to practice. "Exclusion" does not mean that the person delineated may not get a license if he so wishes and if he is qualified for licensure according to the provisions of the bill. (p. 16)

While the wording of exemption clauses varies from state to state, and while the precise interpretations of such provisions ultimately lie with state licensing agencies, certain generalizations can be made. Exemptions are stipulated in every licensing law for individuals pursuing a course of study leading to a degree in speech pathology or audiology. Many states provide separate exemptions for students studying speech pathology and for students studying audiology, and the majority of statutes stipulate that such persons must be designated by an appropriate title such as "speech pathology intern" or "audiology trainee." Twenty-three state laws contain provisions affirming that nothing within the speech pathology and audiology licensing law is to be construed as restricting or preventing individuals licensed in the state by other licensing laws from engaging in the profession or occupation for which they are licensed. While such a statement may serve to pacify potential opposition to a licensing bill, it does little in itself to demarcate boundaries of practice (see ASHA's criticism of

TABLE XI

A COMPILATION OF EXEMPTIONS FROM STATE LICENSING LAWS
IN SPEECH PATHOLOGY AND AUDIOLOGY

-
1. Persons acting within the scope of any other profession or occupation for which they are licensed in the state (e.g., Montana)
 2. Speech and hearing specialists credentialed by State Board of Education and practicing solely in the schools (e.g., Oregon)
 3. Students or trainees pursuing a course of study at an accredited institution of higher learning or working in a recognized center; interns or fellows acquiring necessary clinical experience (e.g., Louisiana)
 4. Physician or surgeon in the practice of medicine (e.g., Arkansas)
 5. Supportive personnel directly supervised and controlled by a licensee (e.g., Virginia)
 6. Laryngectomees rendering guidance and instruction to patients who are under the supervision of a licensee or a physician (e.g., Florida)
 7. Persons who consult, disseminate research findings, and offer lectures (e.g., Connecticut)
 8. Nurses and others engaged in screening and audiometric testing under the supervision of a licensed physician, surgeon, or audiologist (e.g., Connecticut)
 9. Hearing aid dealers for testing hearing and other procedures used solely for the fitting and selling of hearing aids (e.g., North Dakota)
 10. Trained technicians performing audiometric screening in industrial settings, supervised by a physician (e.g., South Carolina)
 11. Persons holding Class A certificate from Conference of Executives of American Schools for the Deaf performing functions for which qualified (e.g., Oregon)
 12. Hearing screening programs conducted under public or charitable auspices (e.g., Oklahoma)
 13. Registered or licensed nurses within the scope of their profession, so long as no representation as speech pathologist or audiologist (e.g., Ohio)

TABLE XI

continued

-
14. Persons counseling or instructing laryngectomees (e.g., North Carolina)
 15. Qualified non-resident practitioners who provide services no more than seven days a year, in cooperation with a licensed speech pathologist or audiologist, or for 30 days if the non-resident holds ASHA-certification or a license from a state with equivalent standards (e.g., Alabama)
 16. Within the scope of their employment, employees of federal, state, county, or municipal agencies or chartered educational institutions (e.g., Missouri)
-

Source: ASHA, 1979b

Florida law as one primarily of title protection, with practice being defined only as it relates to title, page 150 of this text). Specific exemptions for individuals practicing in tangential professions are contained in all the laws. Most state laws specifically exempt physicians, although a number of state statutes mention physicians only with regard to screening and audiometric testing (e.g., Connecticut, Kentucky). Five state laws, those in Montana, New York, Oregon, Rhode Island, and Virginia, do not specifically delineate exemptions for physicians. However, all five of these state statutes include provisions designed to prevent individuals from being restricted in the practice of their licensed profession. Missouri's statute is the only one of the 30 state laws which does not specifically include hearing aid dealers/sellers/fitters within its list of exemptions. Twenty-five state laws provide exemptions for federal employees, and 28 state statutes exempt state employees in general or persons holding credentials or certification from a particular state department. Such exemptions are almost always limited to practice within the confines and jurisdiction of federal or state employment. Approximately two-thirds of the state statutes contain exemptions for limited practice (generally 5-30 days a year) for qualified nonresident practitioners. A number of states also provide exemptions with special guidelines for interim practice and supportive personnel. Provisions relating to these items will be discussed in the next section of this text.

Licensure Requirements in Reference to Interim Practice,
Trainees, Supportive Personnel, and Reciprocal Licensing

Interim practice, or the exercise of one's profession in the time intervening between application and board action or between application

and examination, is provided for in 19 state laws. The majority of state statutes containing such stipulations allow individuals holding a current license from another state or ASHA certification to practice until disposition of their application by the board (e.g., Montana, South Carolina) or for a certain specified length of time (e.g., California, Hawaii). Several states (e.g., Nebraska, North Carolina) issue temporary licenses which expire on, or soon after, the date of the next scheduled examination. Table XII, column two, compares state law interim practice provisions.

As noted in the previous section of this text, all of the state licensing laws under consideration include exemptions for students in training (interns, trainees). In addition, a number of state laws contain provisions which specify more completely the conditions under which a trainee and his/her supervisor must operate. Some states, for example Alabama, Ohio, and Utah, require that trainees preregister with the state board prior to obtaining the professional experience required for licensure. Seven states (Iowa, Maine, Maryland, Mississippi, North Carolina, South Carolina, and Virginia) issue or may issue temporary/provisional licenses to those acquiring professional experience required for licensure. In all instances, trainees must be supervised by a licensed (certified) individual. Tennessee law stipulates that licensed individuals may supervise no more than three unlicensed trainees at any one time; however such determinations are generally delegated to the board for inclusion in its rules and regulations. Table XII, column three, examines state licensing law provisions relating to trainees.

TABLE XII

A COMPARISON OF SPECIAL PROVISIONS RELATING TO INTERIM PRACTICE,
TRAINEES, SUPPORTIVE PERSONNEL AND RECIPROCAL LICENSING

State	Interim practice	Trainees	Supportive personnel	Reciprocal licensing
ALABAMA	Persons with ASHA certification or state license may practice in interim between application and Board action.	Persons must register with Board within 30 days of starting to acquire the required professional experience.	May be established by regulation.	None. Licenses are granted without examination to any person certified by ASHA.
ARKANSAS	Persons with ASHA certification or state license may practice in the interim between application and Board action.	No provision	No provision	Permissive waiver of examination for applicants ASHA certified or licensed in a state with equivalent standards.
CALIFORNIA	Persons licensed in another state may practice up to 90 days after submitting application.	Board may determine number of trainees to be supervised by one licensed (or equivalent) practitioner.	Supervisors must register aides and are responsible for them. Licensing agency determines number of aides one licensee can supervise.	None
CONNECTICUT	No provision	No provision	No provision	Permissive licensing without examination for persons licensed in a state with equivalent standards or holding a certificate from a nationally recognized speech pathology/audiology organization.
DELAWARE	Applicants with ASHA certification, its equivalent, or a state license may practice in interim between application and Board action.	No provision	Board may establish minimum qualifications for speech pathology/audiology aides supervised by licensee. A hearing aid dealer cannot be an audiology aide.	Mandatory waiver of examination and educational requirements for persons licensed in state with equivalent standards or certified by ASHA.
FLORIDA	No provision	Fees may be charged for services by a student, intern, or trainee in a qualified program only if service is part of required clinical practicum and the trainee receives no part of fees.	Board may establish uniform standards for speech pathology/audiology aides who work under the supervision of a licensee. Such standards shall be less than those set for a licensee.	Mandatory waiver of exam and educational requirements for persons licensed in state with equal standards or ASHA certified.

TABLE XII
continued

State	Interim practice	Trainees	Supportive personnel	Reciprocal Licensing
GEORGIA	Mandatory temporary, non-renewable license of one year for persons meeting all requirements for licensure but examination.	No provision	Board may establish minimum requirements for speech pathology/audiology aides who work directly under a licensee.	Permissive grant of license to persons currently licensed in a state or country with basically equivalent standards or certified by ASHA.
HAWAII	Persons ASHA certified or licensed in another state as a speech pathologist or audiologist may practice for 90 days after application.	No provision	No provision	Permissive grant of license to persons licensed in another state which maintains equivalent professional standards.
INDIANA	No provision	No provision	Board may establish minimum qualifications for speech pathology/audiology aides who work under direct licensee supervision.	Permissive grant of licensure to persons licensed in another state with equivalent standards or ASHA certified.
IOWA	No provision. Temporary permits available for up to three months' practice in state by qualified non-resident.	One year, once renewable, temporary clinical license available for persons meeting all licensure requirements except clinical experience. Supervision by licensee.	Board may establish standards for non-professional persons supervised by licensees. They are exempt from licensure, but must be designated by appropriate titles.	Permissive waiver of examination for persons with licensure or certification from states with basically equivalent standards.
KENTUCKY	Persons with ASHA certification or other state license may practice pending disposition of application.	No provision	Board may set uniform minimum standards, less than those for licensees, for speech pathology/audiology aides who work under supervision of licensee.	Permissive grant of license to persons licensed in states with equivalent standards, or ASHA certified.
LOUISIANA	No provision	Persons fulfilling professional experience requirements need not be licensed, but this does not relieve supervisor of responsibility for services rendered to client.	No provision	Permissive waiver of examination for persons licensed or certified in another state with equivalent standards or with ASHA certification.

TABLE XII

continued

State	Interim practice	Trainees	Supportive personnel	Reciprocal licensing
MAINE	Practice permitted during interim between application and Board action for persons ASHA certified or with licensure from state with equivalent standards.	One year, once renewable temporary license for persons meeting all licensure requirements except professional employment. Supervision of licensee or ASHA certification holder necessary.	Board may establish minimum qualifications for speech pathology aides working under the supervision of a licensed speech pathologist. Such requirements must be less than those for either licensure or school personnel certification.	Permissive grant of licensure to persons licensed in another U.S. jurisdiction with equivalent professional standards. Mandatory waiver for those ASHA certified.
MARYLAND	Practice permitted during interim between application and Board action if applicant was authorized to practice in former residence.	One year, once renewable temporary license to all persons meeting all licensure requirements except professional experience and examination. Supervision by licensee necessary.	No provision	Permissive grant of licensure for persons ASHA certified or licensed in another state with equivalent standards. No examination is required.
MISSISSIPPI	Practice permitted during interim between application and Board action for persons ASHA certified or licensed in another state.	One year, once renewable temporary license for persons acquiring professional experience under supervision of licensee or ASHA certified practitioner.	Board sets minimum qualifications for the registration of speech pathology/audiology aides working under supervision of licensee who registers the aides. Qualifications for aides may not require bachelor's degree.	Permissive waiver of examination for persons licensed in state with equivalent standards. Waiver for persons certified by ASHA.
MISSOURI	No provision	Exemption for persons obtaining professional experience under the supervision of a licensee. Supervisor must be licensed, if a charge is made for trainee's services.	Committee may set minimum requirements for speech pathology/audiology aides who work under direct supervision of licensee.	Mandatory grant of licensure to persons licensed in a state with equivalent standards or to persons certified by ASHA.
MONTANA	Persons with ASHA certification or equivalent or state license may practice in interim between application and Board action.	Provisional licensing, prior to July 1, 1976, for applicants with a bachelor's degree in speech pathology or audiology, with 175 clock hours of clinical practicum and at least one academic year's experience working in state. See law for details.	Speech pathology and audiology aides work under the direct supervision of licensed professionals and meet the minimum qualifications set by the Board. Provisionally licensed persons who fail to obtain licensure within the allotted six years may nevertheless work as speech pathology/audiology aides.	Mandatory waiver of exam and licensing for applicants licensed in another state with equivalent standards or ASHA certified.

TABLE XII

continued

State	Interim practice	Trainees	Supportive personnel	Reciprocal licensing
NEBRASKA	A temporary license granted to new residents who meet all requirements for licensure except passage of an examination. Temporary license expires on date of next exam.	No provision	No provision	Permissive waiver of exam for persons licensed by another state or certified by a national professional accrediting organization with requirements equivalent to Nebraska.
NEW YORK	No provision	Exemption for clinical or academic practice under supervision of a licensee in a Department of Education-registered school program or ASHA certified center or clinic. See interim practice.	No provision	No provision
NORTH CAROLINA	A non-renewable temporary license granted which is valid for eight weeks after next exam. Applicant must meet educational requirements for license and be supervised by licensee during period.	No provision	No provision	Permissive waiver of all requirements (except fees) for those holding current license or certificate in status having equivalent standards. Waiver of exam for ASHA certified individuals.
NORTH DAKOTA	Board may issue a temporary permit for up to a year for those furnishing the Board with satisfactory evidence of their qualifications. Practice permitted during interim between application and Board action for persons ASHA certified or licensed in another state.	No provision	No provision	Permissive waiver of exam and grant of licensure to persons licensed in another state with equivalent professional standards. Mandatory grant of licensure for persons currently certified or licensed in a state with equivalent standards.
OHIO		Persons acquiring necessary clinical experience must register with Board and may not represent themselves to public as speech pathologists/audiologists.	Board sets qualifications for those working under direct supervision of licensee. Standards must be less than those for licensure as a speech pathologist or audiologist.	

TABLE XII
continued

State	Interim practice	Trainees	Supportive personnel	Reciprocal licensing
OKLAHOMA	No provision	No provision	Exemptions for supervised student interns or trainees are provided. Also exempt are persons not eligible for a license practicing while employed and supervised by a licensee.	The Board shall waive the exam and grant a license to persons currently licensed in a state or country whose requirements for licensure are essentially equivalent to Oklahoma's. The same applies to those certified by ASHA.
OREGON	Persons certified by ASHA or licensed in another state may practice in interim between application and Board action.	Trainees must be clearly designated by a title indicating their status.	Aides meeting qualifications set by Board must work directly under supervision of a licensee.	Mandatory waiver of examination and educational requirements for persons licensed in a state with equivalent standards and persons certified by ASHA.
RHODE ISLAND	No provision	No provision	Board sets qualifications for aides. Aides are supervised by licensee. Board must establish special exam and educational requirements to issue special limited licenses for person claiming expertise with laryngeal impairment and laryngectomies.	Waiver of examination for persons certified by ASHA or licensed in a state with equivalent standards.
SOUTH CAROLINA	Person licensed in another state may practice pending disposition of his/her application.	Provisional licenses may be provided to persons fulfilling their clinical fellowship year.	No provision	Permissive waiver of examination for persons certified by ASHA or licensed in another state.
TENNESSEE	Applicant certified by ASHA or licensed in another state may practice unlicensed pending disposition of application.	Licensed persons may supervise no more than three unlicensed trainees at any one time.	Board may establish minimum qualifications for aides which must be less than those for licensee. Aides must be supervised by a licensee.	Examination requirement waived for persons licensed in another state with equivalent standards.

TABLE XII
continued

State	Interim practice	Trainees	Supportive personnel	Reciprocal licensing
UTAH	No provision	Trainees must preregister with Board and be directly supervised by person certified by ASHA.	Board may establish minimum qualifications for aides which must be less than required for licensure. Aides must be supervised by a licensee.	Licensure extended to persons licensed in another state with equivalent standards which offers reciprocal licensing to persons licensed in Utah.
VIRGINIA	Persons meeting educational requirements may receive temporary license to practice pending examination and issuance of regular license.	Persons engaged in Clinical Fellowship Year may receive temporary license.	Supportive personnel directly supervised and controlled by a licensee are exempt from licensure.	Permissive waiver of examination for persons licensed in another state with equivalent standards or certified by ASHA.
WYOMING	No provision	No provision	Aides must meet minimum qualifications set by Board and work under direct supervision of a licensee. Board has also set rules for registration of all aides.	Permissive waiver of exam for persons licensed in another state with equivalent standards or certified by a nationally recognized association for speech and hearing.

Source: ASHA, 1979b

Supportive personnel is another area of concern receiving attention in many licensing statutes. Twenty state laws contain sections dealing with this element of licensing. Where provisions do exist, state licensing agencies are generally required or, more often, permitted to establish relevant qualifications. Nicolais (1976) writes:

Some licensure boards have encountered difficulties in defining the qualifications and role of supportive personnel (aides). The majority of licensure laws that make provision for aides generally define an aide as a person who possesses qualifications less than those required of the full-fledged professional and require that the aide work under direct supervision of a licensee. Since it is the board's responsibility to establish qualifications for aides, board members in various states have conducted lengthy discussions on what ought to be the educational and/or training requirements for aides. The result has been that the qualifications for aides vary from state to state. In addition, the language in the bill that mandates "direct supervision" has, in some cases, imposed on licensees an unrealistic and time-consuming administrative responsibility. (p. 26)

State licensure provisions related to supportive personnel are capsulized in Table XII, column four.

Reciprocity stipulations are contained in all state laws with the exception of those in Alabama, California, and New York. While Alabama does not maintain reciprocal agreements with other states, licenses are granted without examination to individuals certified by ASHA. Reciprocity provisions typically follow one of three patterns:

1. Reciprocity is mandatory for persons licensed in states with equivalent standards or persons holding ASHA certification (e.g., Oregon, Florida, Montana).
2. Reciprocity is permissive such that the board may withhold reciprocity if an individual does not adequately meet the standards established by law and the regulations promulgated by the board (e.g., Arkansas, Wyoming, Georgia).

3. Reciprocity is mandatory for ASHA certified individuals but permissive (discretionary) for licensees from other states who do not hold ASHA certification (e.g., Maine, Mississippi, Hawaii).

A permissive or mandatory waiver of licensure requirements is granted to individuals certified by ASHA in all states with reciprocity provisions except Iowa, North Dakota, Ohio, Tennessee, and Utah. In three states (Connecticut, Nebraska, Wyoming) reciprocity is not granted to ASHA certified practitioners per se but rather to anyone certified

1. as clinically competent by a nationally recognized association for speech and hearing in the area for which such person is applying for license. WYO. STAT. §33-398(c) (Supp. 1975)
2. by a nationwide professional accrediting organization, recognized as such by the board, if such licensure or certification is equivalent to the requirements of this act. NEB. REV. STAT. §71-162(19) (1979)
3. from a national professional organization, approved by the commissioner, in speech pathology or audiology. CONN. GEN. STAT. §20-411(b) (1975)

Provisions related to reciprocity can be found in Table XII, column five.

Requirements for Licensure and the Compatibility of State Prerequisites with ASHA Certification Requirements

In an earlier portion of this text it was noted that eligibility for licensure could be determined on the basis of personal, educational, experience, and examination qualifications (see page 77 of this text). As is true with respect to licensing in most professions, personal qualifications are relatively unimportant in determining the eligibility of applicants for licensure in speech pathology and audiology. Nineteen of the 30 state licensing laws specify that the

applicant must be of good moral character. However, this requirement is generally disregarded unless the licensing agency receives evidence which would cause it to suspect that an applicant might be in violation of this qualification. Age is a requirement for licensing in only two states, New York and Tennessee. New York law stipulates a minimum age of 21 years, while Tennessee's statute mandates that a licensee must be 18 years of age or older. Several states stipulate that the applicant must be a United States citizen or be in the process of acquiring citizenship (e.g., Utah, Indiana), but such requirements are the exception rather than the rule.

The majority of state laws, as can be seen in Table XIII, publish educational and experience requirements which are in conformity with ASHA's guidelines for obtaining the Certificates of Clinical Competence (CCC). Eighteen states maintain education and experience standards which are essentially equivalent to those currently required by ASHA for the CCC. Such requirements are outlined in Requirements for the Certificates of Clinical Competence (ASHA, 1973b). Among the most important of these are

1. that the applicant submit evidence of the completion of 60 semester hours of academic credit accumulated from accredited colleges or universities;
2. that 12 of these 60 semester hours be obtained in courses related to normal development and use of speech, language, and hearing;
3. that 30 of these 60 semester hours be in courses that provide information concerning communication disorders and information relative to and training in evaluation and management of speech, language, and hearing disorders;

TABLE XIII

COMPATIBILITY OF STATE LICENSING REQUIREMENTS WITH ASHA'S
REQUIREMENTS FOR THE CERTIFICATE OF CLINICAL COMPETENCE

State	Compatible with CCC	Not compatible with CCC	Consistent with pre-1973 ASHA requirements	Comments
ALABAMA	X			
ARKANSAS	X			
CALIFORNIA		X		Requires 275 hours of supervised clinical experience compared to ASHA's 300 hours. Course requirements are less specific.
CONNECTICUT	X			Licensure requirements include the master's degree, practicum, examination, and Clinical Fellowship Year requirements. Required course work not prescribed.
DELAWARE			X	
FLORIDA			X	
GEORGIA			X	
HAWAII	X			Licensure standards include evidence of eligibility for ASHA certification.
INDIANA	X			
IOWA		X		Master's degree is required, but coursework is not specified. Clinical practicum is 275 hours.
KENTUCKY	X			Clinical experience requirement is, however, 275 hours.
LOUISIANA			X	
MAINE	X			Clinical experience requirement is, however, 275 hours.
MARYLAND	X			Board prescribes educational, clinical experience, and employment requirements based on appropriate national standards.
MISSISSIPPI	X			Board of Health prescribes requirements for educational, clinical experience and employment, based on appropriate national standards.

TABLE XIII

continued

State	Compatible with CCC	Not compatible with CCC	Consistent with pre-1973 ASHA requirements	Comments
MISSOURI	X			Clinical practicum requirement is, however, only 275 hours.
MONTANA	X			<ul style="list-style-type: none"> a) Applicants must meet the current academic, supervised clinical practicum, and post classroom sponsored employment requirements of ASHA. b) If applicant fails examination twice, he/she cannot retake until two years of additional experience or training has been completed. c) Board may grant license to person without all formal requirements in unusual or special circumstances, case-by-case.
NEBRASKA	X			
NEW YORK	X			Requirements are established by regulations of Commissioner of Education.
NORTH CAROLINA	X			
NORTH DAKOTA	X			Requirements prescribed by Board are based on appropriate national standards.
OHIO	X			
OKLAHOMA			X	
OREGON			X	
RHODE ISLAND			X	
SOUTH CAROLINA			X	
TENNESSEE	X			Requirements are fixed by rules of the Board; current requirements are equivalent, except 275 hours of practicum, compared with ASHA's 300.

TABLE XIII

continued

State	Compatible with CCC	Not compatible with CCC	Consistent with pre-1973 ASHA requirements	Comments
UTAH		X		Variations in required course work and clinical experience. Licensing committee requires practical examination.
VIRGINIA			X	
WYOMING	X			Eligibility for licensure established by regulations of board; current requirements are equivalent to CCC.

Source: ASHA, 1979b

4. that at least 24 of these 30 semester hours be in courses in the applicant's professional area, with no less than 6 semester hours in audiology (for applicant requesting certification in speech pathology) or speech pathology (for applicant requesting certification in audiology);
5. that 30 of the total 60 semester hours be in courses that are acceptable toward a graduate degree at the institution where they are taken;
6. that the applicant complete a minimum of 300 clock hours of supervised clinical experience with individuals manifesting a variety of speech, language, and hearing problems;
7. that the applicant obtain the equivalent of nine (9) months of full-time professional experience (Clinical Fellowship Year) in which actual clinical work has been successfully completed in the applicant's area of requested certification (p. XXI).

Nine state statutes, all of which were enacted prior to April 1974, have education and experience qualifications which are consistent with those published by ASHA prior to 1973. Basic education and experience differences relative to those noted above are

1. that 18 (rather than 12) of the required 60 semester hours be obtained in courses providing fundamental information related to normal development and use of speech, hearing, and language;
2. that the applicant receive a minimum of 42 semester hours (rather than 30) in courses that provide information relative to the management of speech, hearing, and language disorders and that provide information supplementary to these fields;
3. that 30 of these 42 semester hours (rather than 30 of the total 60 semester hours) be in courses acceptable toward a graduate degree at the institution where they are taken;
4. that the applicant submit evidence of 275 clock hours (rather than 300) of supervised clinical experience with persons manifesting a variety of speech, language, and hearing problems (ASHA, 1972, p. 1).

ASHA believes that the education and experience requirements in Iowa, California, and Utah deviate sufficiently from ASHA standards as to make licensing requirements in these states incompatible with ASHA's pre or post 1973 qualifications for certification.

Provisions for the administration of an examination are contained in every statute. This examination is often identical to or equivalent with ASHA's national examination. Most states, however, waive the examination requirement for individuals having a current license from a state with equivalent standards. In a like manner, the majority of state laws provide a mandatory or permissive waiver of examination requirements for holders of ASHA's CCC. Six states, New York, Iowa, California, North Dakota, Ohio, and Utah, have laws containing no such waiver provision. Tennessee law provides a permissive waiver for applicants who have passed a comparable exam.

Supplementary Licensing Provisions

A number of states have incorporated special features into their laws which attempt to clarify possible ambiguities and/or to define terminology more precisely. The term "Certified Hearing Aid Audiologist" is a case in point. In 1970, the United States Patent Office granted to the National Hearing Aid Society (NHAS) a collective membership mark which included the phrase "Certified Hearing Aid Audiologist." ASHA, in the belief that NHAS use of this term misled the public, petitioned the Patent Office's Trademark Trial and Appeal Board seeking cancellation of this membership mark after suggestions to NHAS that they voluntarily drop this mark failed ("Dealer Group Quiet," 1978, p. 561).

In an attempt to avoid a hostile reaction to state licensing bills by powerful state hearing aid associations, some state laws specifically assured hearing aid dealers the use of this term. Tennessee is a representative example.

A person who has been certified by the National Hearing Aid Society may use the title of "certified hearing aid audiologist." Additionally, licensed hearing aid dispensers may employ and use such terms as "hearing aid center," "hearing aid clinic," or any similar title or description of services so long as the word "aid" is incorporated in any such title or description of service, and insofar as such terms do not connote qualifications or education for which the hearing aid dispenser does not have valid credentials, or do not imply rehabilitative or professional services which the hearing aid dispenser is not qualified to offer. (ASHA, 1979b, Tennessee Summary, p. 4)

Other states' provisions are less specific, stipulating that under state law an individual is deemed to be an audiologist if he provides such services to the public under any title incorporating the terms audiology, audiologist, audiological, hearing specialist, etc.

The role of a licensed audiologist with regard to the dispensing of hearing aids is a question which is specifically addressed in about one-third of the state laws licensing speech pathologists and audiologists. Such provisions typically assert that individuals dispensing, repairing, fitting, selling, or altering hearing aids must be licensed as hearing aid dealers. Hence, the respective roles of audiologists and hearing aid dealers are more clearly defined and professional overlap is avoided.

Finally, nine state statutes provide disclaimers of medical practice. These disclaimers, generally inserted into state licensing laws in deference to powerful physician lobbies, basically state that speech pathologists and audiologists are not permitted to practice medicine,

surgery, or other healing arts. Furthermore, a number of state disclaimers (e.g., North Carolina, Maryland) delineate specific acts to be considered as unethical or unprofessional. Such acts include false representation that medical services will be used or available, false representation that a physician's services are employed or used routinely, or use of the term "doctor" to apply to anyone involved in services except for a licensed physician.

Enforcement of Licensing Provisions: Revocation, Suspension, and Penalties

Justifications for revoking or suspending licensure are summarized in Table XIV. As noted in Table VIII, suspended licenses are typically renewable whereas revoked licenses, except under special circumstances, are not. The penalties for infractions of the law, like the justifications for revocation and suspension, are fairly consistent from state to state. Violations are customarily viewed as misdemeanors, with punishment consisting of a fine not in excess of \$1,000 and/or incarceration for a period of time not to exceed six months. Penalties for violation of speech pathology and audiology licensing laws are not specified in Georgia, Iowa, or Nebraska licensing statutes. Table XV designates penalties for violation of state laws licensing speech pathologists and audiologists for those states having penalties delineated within their licensing statutes.

Sunset Legislation

Sunset laws, which now exist in 31 states, serve to terminate state laws or state agencies on a specific date unless the state legislature undertakes steps to reenact them. Data relative to such

TABLE XIV

GROUNDS FOR LICENSE REVOCATION/SUSPENSION CONTAINED WITHIN STATE
LAWS LICENSING SPEECH PATHOLOGISTS AND AUDIOLOGISTS

State	Grounds for license revocation/suspension
ALABAMA	Conviction of federal felony directly bearing on professional qualifications; fraud or deceit in professional services; aiding or abetting persons illegally representing themselves to be speech pathologists or audiologists; unprofessional conduct as defined by Board; fraud or deception in application or examination; grossly negligent practice; willful violation of licensing law or regulations.
ARKANSAS	Unprofessional conduct, including: fraud, misrepresentation or concealment of material facts in obtaining a license; violating Board rules on professional conduct or code of ethics; conviction of a federal felony directly bearing on professional qualifications; violating the licensing law or Board rules or orders.
CALIFORNIA	Unprofessional conduct endangering public health, welfare, or safety. Conviction of felony or crime of moral turpitude.
CONNECTICUT	Fraud, misrepresentation or concealment of material facts in obtaining a license; violating professional conduct guidelines or code of ethics established by the Department of Health, or licensing law or regulations; conviction of a felony or crime of moral turpitude.
DELAWARE	Unprofessional conduct, including: fraud, misrepresentation or concealment of material facts in obtaining a license. Violation of the licensing law or of Board rules, orders, or regulations, including its code of ethics.
FLORIDA	Violation of licensing law, order, rule or regulation; conviction of a federal felony; fraud, misrepresentation or concealment of material facts in licensure dealings; gross professional misconduct.
GEORGIA	Felony conviction, or conviction elsewhere of a crime which would be a felony in Georgia; fraud or deceit in connection with professional services or in licensing application or examination; aiding or abetting an unlicensed person in illegal practice of speech pathology

TABLE XIV

continued

State	Grounds for license revocation/suspension
GEORGIA continued	or audiology; unprofessional conduct, as defined by Board, or violation of Board-published code of ethics; gross professional negligence; willful violation of licensing law or regulations.
HAWAII	Unprofessional conduct which has endangered, or is likely to endanger, public health, safety or welfare. Such conduct includes obtaining licensure through fraud, misrepresentation or concealment of material facts; violation of Board defined code of ethics or rules of professional conduct; or violation of the licensing law or any lawful Board order, rule, or regulation.
INDIANA	Unprofessional conduct which has endangered, or is likely to endanger, public health, safety, and welfare including fraud, misrepresentation or concealment of material facts in obtaining a license; violation of Board-set code of ethics or rules of professional conduct; felony conviction for acts directly bearing on fitness to serve the public; violation of licensing law or lawful Board order, regulation, or rule.
KENTUCKY	Unprofessional conduct which has endangered, or is likely to endanger, public health, safety or welfare. This includes fraud, misrepresentation or concealment of material facts in obtaining a license; violation of Board-set rules of professional conduct or code of ethics; violation of licensing law or lawful board order, rule or regulation; or conviction of a felony or crime of moral turpitude. A person whose license has been revoked may apply one year later for reinstatement. Board may require examination and may reject such applications.
LOUISIANA	Felony conviction or conviction elsewhere of crime which would be a felony in Louisiana; obtaining a license by fraud, misrepresentation or concealment of material facts; fraud or deceit in professional services or unprofessional conduct as defined in Board rules/code of ethics; violation of licensing law or lawful Board order, rules, or regulations.

TABLE XIV

continued

State	Grounds for license revocation/suspension
MAINE	Obtaining a license by fraud, misrepresentation or concealment of material facts; unprofessional conduct, as defined in Board rules/code of ethics; violation of licensing law or lawful Board order, rule or regulation; conviction of a felony which the Board finds to have a direct bearing on fitness to serve.
MARYLAND	Conviction of an offense involving moral turpitude; fraud or deceit in securing a license or in professional services; violation of licensing law or lawful Board order, rule or regulation; unprofessional conduct, as by Board rule/code of ethics, including obtaining any fee by fraud or misrepresentation, directly or indirectly employing any unlicensed or suspended person for speech pathology or audiology services, using false or misleading advertising or other representation, allowing use of license by others, falsely representing that the services of a physician are used or available, or inaccurately using "Doctor" or like words.
MISSISSIPPI	Unprofessional conduct which has endangered, or is likely to endanger, public health, safety or welfare. This includes obtaining a license by fraud, misrepresentation or concealment of material facts; felony conviction which Board finds to bear directly on ability to serve the public; violation of Board order, regulation or rule on professional conduct or of licensing law. The Board may grant or deny application for reinstatement after one year and may require examination.
MISSOURI	Felony conviction, if the crime would be a felony in Missouri; obtaining licensure by fraud, misrepresentation or concealment of material fact; fraud or deceit in professional services; unprofessional conduct as defined in committee rules/code of ethics; violation of licensure law or lawful committee order, rule or regulation.
MONTANA	Unprofessional conduct which has endangered, or is likely to endanger, public health, safety or welfare. Includes obtaining a license by fraud, misrepresentation or concealment of material facts; unethical conduct which includes obtaining any fee by fraud or misrepresentation; direct or indirect employment of

TABLE XIV

continued

State	Grounds for license revocation/suspension
MONTANA continued	person with suspended license or unlicensed person (except supervised aides); use of misleading, deceptive or untruthful advertising, promotional material, testimonial, guarantees, or the like; violating the licensing act or Board orders or rules; conviction of a felony or crime of moral turpitude.
NEBRASKA	License revoked if not renewed 30 days after expiration.
NEW YORK	Not specified
NORTH CAROLINA	Fraud or deceit, either on the Board in securing a license, or in connection with professional services; unprofessional conduct including obtaining any fee by fraud or misrepresentation; direct or indirect employment of suspended or unregistered speech pathologist/audiologist; use of misleading, deceptive, or untruthful advertising, promotional material, testimonial, guarantees, or the like; falsely representing that physician services will be employed or using the term "doctor" in reference to anyone involved in service other than a licensed physician; or falsely implying that physician services are routinely used in practice.
NORTH DAKOTA	Unprofessional conduct including obtaining a license by fraud, misrepresentation or concealment of material facts; violation of Board-set ethical code; conviction in federal or state court of offense determined by Board to have a direct bearing on ability to practice unless found under state law to be sufficiently rehabilitated; violation of licensing law or Board order, rule or regulation.
OHIO	Conviction of a felony, or a misdemeanor involving moral turpitude; violation of licensing law or Board rule or order; obtaining a license or other Board action by fraud, misrepresentation or concealment of material facts; gross professional misconduct.
OKLAHOMA	Fraud or deceit in connection with professional services; aiding or abetting an unlicensed person to practice illegally; violation of Board's code of ethics or unprofessional conduct as defined by Board; use of fraud or deception in obtaining a license; gross negligence in practice of profession; willful violation of any provision of Act.

TABLE XIV

continued

State	Grounds for license revocation/suspension
OREGON	The obtaining of a license or any fee by fraud or misrepresentation; employing directly or indirectly any suspended or unlicensed person to perform any work covered in this chapter unless that person assumes the legal status of a supervised aide; permitting another to use one's license; violation of the code of ethics adopted and published by the Board; violation of any lawful order or rule of the Board or of any provisions of licensing law; representing that the services or advice of a person licensed to practice medicine will be used or made available in the practice of speech pathology or audiology if that is not true, or using the word "doctor" or "professor" or other like words, abbreviations or symbols inaccurately; using or causing or promoting the use of any advertising matter, promotional literature, testimony, guarantee, warranty, label, brand, insignia, or any other representation, however disseminated or published, which is misleading, deceiving, improbable, or untruthful.
RHODE ISLAND	Obtaining a license by means of fraud, misrepresentation, or concealment of material facts; fraud or deceit in connection with professional services rendered; unprofessional conduct as defined by Board; violation of any rule of Board or provision of licensure law.
SOUTH CAROLINA	Obtaining a license by means of fraud, misrepresentation, or concealment of material facts; fraud or deceit in connection with services rendered; unprofessional conduct as defined by Board; violation of Board's code of ethics, rules and regulations, or any provision of licensure law.
TENNESSEE	Obtaining a license by fraud, misrepresentation or concealment of material facts; violation of ethical standards or any rule adopted by Board; violation of any provision of licensing law.
UTAH	Failure to maintain the standards and intent of licensure laws; unprofessional conduct, such as obtaining a license through fraud, being convicted of a felony, violating any rule adopted by the Board or any provision of the licensure law; failure to maintain a level of professional practice consistent with all

TABLE XIV

continued

State	Grounds for license revocation/suspension
UTAH continued	requirements by which a license is achieved; practicing in an unprofessional manner or environment or using substandard facilities or equipment; treating any disorder for which licensee lacks the necessary training and experience.
VIRGINIA	Specified in General Administrative Agencies Act
WYOMING	Obtaining a license by fraud, misrepresentation or concealment of material facts; unprofessional conduct or violation of code of ethics, as defined by Board; violating any provisions of licensure law; conviction of a felony, if act for which convicted is found by Board to bear on the felon's trustworthiness to serve the public.

Source: ASHA, 1979b

TABLE XV
PENALTIES FOR VIOLATION OF STATE STATUTES LICENSING
SPEECH PATHOLOGISTS AND AUDIOLOGISTS

State	Penalties for violation
ALABAMA	Misdemeanor, subject to fine between \$100 and \$500
ARKANSAS	Misdemeanor, subject to fine of up to \$1,000 or six months' imprisonment
CALIFORNIA	Misdemeanor, subject to fine up to \$1,000, or six months' imprisonment, or both
CONNECTICUT	Class B misdemeanor
DELAWARE	Fine up to \$500, up to 90 days imprisonment, or both
FLORIDA	Second degree misdemeanor
GEORGIA	Not specified
HAWAII	Petty misdemeanor, subject to a fine of up to \$1,000
INDIANA	Misdemeanor, subject to fine up to \$1,000, six months' imprisonment, or both
IOWA	Not specified
KENTUCKY	Misdemeanor, subject to fine up to \$1,000, six months' imprisonment, or both
LOUISIANA	Misdemeanor, subject for each offense to up to six months' imprisonment, fine between \$100 and 1,000, or both
MAINE	Subject to fine up to \$500, three months' imprisonment, or both
MARYLAND	Misdemeanor, subject to fine up to \$500, ninety days' imprisonment, or both
MISSISSIPPI	Misdemeanor, subject to \$1,000 fine, six months' imprisonment, or both
MISSOURI	Misdemeanor, punished as provided by law
MONTANA	Fine up to \$500, six months' imprisonment in county jail, or both

TABLE XV

continued

State	Penalties for violation
NEBRASKA	Not specified
NEW YORK	Class A misdemeanor
NORTH CAROLINA	Misdemeanor, subject to fine between \$100 and \$500, up to six months' imprisonment, or both
NORTH DAKOTA	Class A misdemeanor
OHIO	Minor misdemeanor
OKLAHOMA	District court may order injunction or restraint of activities in violation of act upon application by Board, Attorney General, or local district attorney. Unlicensed practice is a misdemeanor, subject to a fine up to \$500 or up to six months in jail, or both. Each day of violation is a separate offense.
OREGON	Misdemeanor (applicable only to prohibited acts)
RHODE ISLAND	For violation of any provision of this law, misdemeanor punishable by a fine of up to \$1,000 and/or up to six months in jail
SOUTH CAROLINA	Misdemeanor, punishable by a fine of up to \$1,000 and/or up to six months in jail
TENNESSEE	Misdemeanor, punishable by up to six months in jail, and/or a fine up to \$1,000. Board may petition any circuit or chancery court having jurisdiction to enjoin any person violating the licensing law; all district attorneys general required to assist Board in any suit for injunction or prosecution.
UTAH	For violation of any provision of this act, a misdemeanor
VIRGINIA	Penalties for violation of statutory provisions are found in General Administrative Agencies Act.
WYOMING	Misdemeanor, subject to fine of up to \$100 and/or up to six months in jail

Source: ASHA, 1979b

statutes in states licensing speech pathologists and audiologists is presented in Table XVI. Such legislation is relatively new, with Colorado being the first state to enact sunset review in 1975. The impetus for this type of legislation has been provided to a large extent by Common Cause, and it has grown in popularity since its 1975 inception primarily because it serves to reflect contemporary public and legislative attitudes toward government.

The sunset concept combines two important attitudes in one legislative item. The first is the public's disenchantment with government in general. . . .

Second, similar to the public frustration with government at all levels, is the attitude of legislators that they have almost no control over agencies that the legislature has created. The budget procedures available to the state legislatures are almost always too cumbersome for periodic and systematic review. Oversight of programs often involves only the really controversial agencies and often excludes less controversial or small agencies or departments. ("Legal Developments -- Antitrust and Sunset Laws," 1979, p. 9)

Ten principles to be used in evaluating sunset legislation have been promulgated by Common Cause. These principles are:

1. The programs or agencies covered under the law should automatically terminate on a certain date, unless affirmatively recreated by law. Common Cause's emphasis here is most important. It is not the goal to terminate agencies. Rather, automatic termination is seen as the only method to assure that meaningful legislative oversight will occur. Legislatures now have oversight powers but these are used haphazardly. Common Cause feels that only a fixed date for termination will force legislative oversight.
2. Termination should be periodic (e.g., every six or eight years, in order to institutionalize the process of reevaluation).
3. Introduction of the sunset mechanism will be a learning process and should be phased in gradually, beginning with those programs to which the process lends itself most readily.

TABLE XVI

SUNSET TERMINATION DATA FOR STATES LICENSING
SPEECH PATHOLOGISTS AND AUDIOLOGISTS

State	Date law approved	Termination cycle	Reviewing organization	Type of review	Special features	Date for speech pathology/audiology/licensing board termination
ALABAMA	August 24, 1976	Four years	Select Joint Committee	Analysis by Department of Examiners of Public Accounts	Agency to prepare zero-based budget	October 1, 1981
ARKANSAS	February 3, 1977	Six years (one time only)	Joint Interim Committees	Performance Audit by Division of Legislative Audit		June 30, 1983
CALIFORNIA	None					
CONNECTICUT	June 2, 1977	Five years	Legislative Program Review and Investigation Committee	Performance Audit		July 1, 1982
DELAWARE	None					
FLORIDA	January 16, 1976	Six years	Select Committee			July 1, 1982
GEORGIA	1977	Six years	State Auditor	Performance Audit		July 1, 1984
HAWAII	1977	Six years	Legislative Auditor (not required)	Department of Regulatory Agencies prepares an impact statement		December 31, 1981
INDIANA				Each agency, legislative council and governor files report two years before termination		June 30, 1981
IOWA	1978	Six years	Legislative Oversight Bureau	Performance Audit and Program Evaluation		

TABLE XVI
continued

State	Date law approved	Termination cycle	Reviewing organization	Type of review	Special features	Date for speech pathology/audiology licensing board termination
KENTUCKY	None					
LOUISIANA	July 1, 1979	Four years	Standing Committee and Joint Committee on Legislative Oversight	Zero-based budget and evaluation	Study initiated two years prior to termination date	July 1, 1982
MAINE	1977	Ten years	Legislative Finance Office	Performance Audit	Also covers agency rules	Board is not covered by sunset act
MARYLAND	1978	Six years	Department of Fiscal Services			July 1, 1983
MISSISSIPPI	1978	Eight years	Committee may ask Committee on Performance Evaluation for an evaluation		Lieutenant Governor and Speaker of House assign units to committees	July 1, 1980
MISSOURI	None					
MONTANA	1977	Six years	Legislative Audit Committee	Performance Audit		July 1, 1981
NEBRASKA	May 16, 1977	Six years	Legislative Council	Performance Audit		July 1, 1984
NEW YORK	None					
NORTH CAROLINA	June 23, 1977	Six years	Governmental Evaluation Committee	Agency self-study and performance evaluations		July 1, 1983

continued

State	Date law approved	Termination cycle	Reviewing organization	Type of review	Special features	Date for speech pathology/audiology licensing board termination
NORTH DAKOTA	None					
OHIO	None					
OKLAHOMA	March 10, 1978	Six years	Joint Committee of Legislative Council	Agency self-study	Zero-based budget review	July 1, 1982
OREGON	1977	Eight years	Interim Committee			July 1, 1986
RHODE ISLAND	May 13, 1977	Five years	Oversight Commission	Auditor general conducts zero-based budget review and evaluation		Board is not covered by sunset act
SOUTH CAROLINA	July, 1978	Five years	Legislative Audit Council			January 1, 1980
TENNESSEE	May 26, 1977	Six years	Comptroller/Joint Evaluation Committee	Statutory criteria		June 30, 1983
UTAH	1977	Six years	Study Committee, Legislative Auditor General	Performance Audit		
VIRGINIA	None					
WYOMING	None					

Source: ASHA, 1979c

4. Programs and agencies in the same policy area should be reviewed simultaneously in order to encourage consolidation and responsible pruning.
5. Consideration of the legislation must be preceded by competent and thorough preliminary studies.
6. Existing bodies should undertake the preliminary evaluative work, but their evaluative capacities must be strengthened, for example, staffs of standing legislative committees should be increased to include oversight and evaluation personnel.
7. Substantial legislative committee reorganization is a prerequisite to effective sunset oversight.
8. Sunset proposals should establish general criteria to guide the review and evaluation process.
9. Safeguards should be built into the sunset mechanism to guard against arbitrary termination and to provide for outstanding agency obligations and displaced personnel.
10. Public participation -- public access to information, public hearings, etc. -- is an essential part of the sunset process. ("Legal Developments -- Antitrust and Sunset Laws," 1979, p. 9)

Sunset review can focus upon the quality and quantity of service rendered to the public, upon fiscal considerations, upon compliance with state laws, or upon several of these areas. Georgia's State Board of Examiners in Speech Pathology and Audiology was the first speech pathology/audiology state licensing agency to undergo sunset review, with major areas of the audit including statutes, rules and regulations, the activities of licensing, complaint handling, financial management, and administration. In an attempt to assess compliance with statutory mandates and to determine areas of weakness, the State Auditor's Office undoubtedly asked many questions such as those listed below, which are from the Florida law.

1. Would the absence of regulation significantly harm or endanger public health, safety, or welfare?
2. Is there a reasonable relationship between the exercise of the state's police power and the protection of the public health, safety, and welfare?
3. Is there another less restrictive method of regulation which could adequately protect the public?
4. Does the regulation have the effect of directly or indirectly increasing the costs of goods or devices involved, and, if so, to what degree?
5. Is the increase in costs more harmful to the public than the harm which could result from the absence of regulation?
6. Are all the facets of the regulatory process designed solely for the purpose to have as a primary effect the protection of the public? (ASHA, 1979c, p. 1)

After conducting interviews, assessing the results of questionnaires, and examining license and permit files and other Board documents, the Georgia State Auditor's Office delineated areas in which it felt improvements were necessary. Several of their recommendations are listed below.

1. An examination should be made of the feasibility of combining the operations of the State Board of Examiners for Speech Pathology and Audiology and the State Board of Hearing Aid Dealers and Dispensers. . . .
2. Areas were noted where the Board had not fulfilled its regulatory responsibilities. The Board has not established a program of continuing education as required. . . .
3. Complaint handling procedures need to be more assertive to insure that complaints address all the violations, that disciplinary action is taken when necessary and that complaints are handled in a timely manner.

4. Three of the seven authorized Board members' terms have expired as of June 1977. New Board members should be appointed as soon as possible to meet legislative requirements.
5. Audiometers used by audiologists are not required to be calibrated annually. . . .
6. The license renewal period should be changed from annual to biennial. . . .
7. The Board exceeded its budget allocation by 280% in fiscal year 1976 and 180% in fiscal year 1977. . . . Consideration should be given to having this Board be self-sustaining in that it should generate revenues to cover incurred expenses. . . . (ASHA, 1979a, p. 5)

Chapter 4 has attempted to demonstrate similarities and differences in the 30 state laws licensing speech pathologists and audiologists. While statutory requirements provide the parameters in which state licensing agencies must operate, much of the decision making which ultimately determines the application of the laws and influences the future direction of the professions resides in the personnel comprising state boards. How these individuals interact, how they perceive the responsibilities with which they have been invested, how they establish priorities for these responsibilities, and how they believe these responsibilities should be executed are critical questions to be answered if state licensing is to be studied in its entirety. Chapter 5 will analyze a number of the operational aspects of these licensing agencies to examine the extent to which such boards are carrying out both the spirit and the letter of the law. Furthermore, the attitudes of agency chairpersons with regard to salient questions perplexing the disciplines will be analyzed in the belief that such attitudes proffered by such individuals will, en masse, form the resolutions to these questions.

CHAPTER 5

AN ASSESSMENT OF THE PRACTICES, PROBLEMS, AND PERCEPTIONS OF AGENCIES LICENSING SPEECH PATHOLOGISTS AND AUDIOLOGISTS

As noted at the conclusion of Chapter 4, viewing the evolution of regulation within a profession and contemplating differences and similarities in existing state statutes is insufficient to fully comprehend credentialing. Laws can be interpreted differently. Laws can conflict with other laws. Laws are perceived as being just or unjust, and laws can create greater problems than the ones they were established to remedy.

To adequately understand regulation, it is necessary to look beyond the laws themselves to the manner in which these laws are executed by the individuals responsible for their execution. In the disciplines of speech pathology and audiology, the 31 state regulatory agencies provide the "front line" enforcement of the law. It is to these agencies, then, that one must look to obtain answers to questions regarding the interpretation of the law, the operation of the law, and the flexibility of the present law in the face of future professional developments.

Purposes

The general purposes of this study are

1. to analyze and draw conclusions from data received from speech pathology and audiology state licensing board chairpersons relative to administration of state laws regulating speech pathologists and audiologists,

2. to analyze and draw conclusions from data received from speech pathology and audiology state licensing board chairpersons relative to their opinions and beliefs concerning current controversial questions in the area of professional regulation,
3. to analyze and draw conclusions from data received from speech pathology and audiology state licensing board chairpersons relative to changes in board operation in the event of a given circumstance.

Specific areas of inquiry include

1. board membership criteria and board composition;
2. board establishment, maintenance, and interboard relations;
3. board financing;
4. board autonomy;
5. board duties and the priority of these duties;
6. examination administration and information dissemination;
7. board public relations;
8. enforcement (suspension, revocation);
9. continuing education;
10. advertising, antitrust;
11. infringement by other licensing boards;
12. termination of the board via sunset legislation;
13. specialty certification/licensing.

Procedures

In order to collect data pursuant to the purposes of this study, a 39 item questionnaire was constructed and sent to the licensing board chairperson in each of the 30 states currently licensing speech

pathologists and audiologists.¹ A copy of the questionnaire and the accompanying explanatory letter are contained in Appendix A. Thirty-one questionnaires were mailed, with the chairperson of the Maryland Board of Examiners for Audiologists and the chairperson of the Maryland Board of Examiners for Speech Pathologists each receiving a separate questionnaire. Agency chairpersons not responding within three weeks of the stated deadline for return of the questionnaire were prompted via a telephone call. A second copy of the questionnaire was sent to those individuals who could not be reached by telephone. A return of 21 questionnaires (67.7%) was deemed necessary to undertake this study.

Results and Discussion

Twenty-four agency chairpersons (77.4%) returned wholly or partially completed questionnaires. A list of the licensing agencies represented by the responding chairpersons may be found in Appendix B.

In reporting and analyzing the data contained within the questionnaires, it was necessary to make a distinction between factual information supplied by the informant with regard to such things as board composition, policy, or operational procedure and opinions and beliefs of the informant which did not necessarily reflect those of the board. In fairness to the respondents, therefore, the names of individual

¹The chairperson of the Nevada Board of Examiners for Audiology and Speech Pathology was not included in this inquiry. The Nevada Board was not appointed in time to be included in this survey.

chairpersons have not been used in this report. Moreover, in responses requiring the informant to express personal preference rather than board position, care has been taken not only to avoid the coupling of a response with an individual, but also to avoid the coupling of a response with a particular state board.

It should be noted that responses from the former chairperson of the Connecticut Advisory Council on Speech Pathology and Audiology have been included in this study despite the dissolution of this Council in January 1979. The termination of the Connecticut licensing agency was prompted by a reorganization of the state government at that time, and it is possible that a licensing agency with "board" status may be created in the near future by the legislative process.

Responses to 36 questions were examined for this study. Two questions (numbers 17 and 34) were deleted from the analysis because the questions were perceived as being ambiguous by respondents. One question (number 33) was omitted from analysis due to a lack of information on the part of respondents regarding the subject matter of the question. Questions have been grouped under general topic headings to facilitate presentation of results.

Board Establishment and Maintenance, Membership, Composition, and Inter-board Relations. Analysis of Questions 7, 1, 2, 3, 4, 6, 5, 8, 9, and 35

In an attempt to partially examine the relationship between ASHA and the state boards, respondents were asked the following:

7. Which of the statements below best typifies your feelings with regard to ASHA's role in establishing and maintaining your state licensing board? (23 responses)

- | | |
|-------------------|--|
| <u>0 (0%)</u> | 1. ASHA was instrumental in helping us to establish our board and has been very valuable in providing us with information relative to maintaining/improving our board. |
| <u>8 (34.8%)</u> | 2. ASHA was instrumental in helping us to establish our board, but has played a relatively minor role (or no role) relative to maintaining/improving our board. |
| <u>3 (13.0%)</u> | 3. ASHA was not instrumental in helping us to establish our board, but has been valuable in providing information relative to maintaining/improving our board. |
| <u>12 (52.2%)</u> | 4. ASHA was not instrumental in helping us to establish our board and has played a relatively minor role (or no role) relative to maintaining/improving our board. |

The number and percentage of informants answering in each category are delineated to the left of each of the four possible answers. As can be observed, more than half of the responses indicated that ASHA's services were not utilized to a significant degree during the formation of the board and are not presently used in maintaining/improving the board. Two of these respondents did note, however, that ASHA offered information when requested during construction of the state's licensing bill. The chairperson of a southern state noted, "ASHA has constantly been ready and quite willing to help, but we have carefully and purposely avoided even the appearance of dictation or even guidance from a private professional association." Only one negative comment was issued, that from the chairperson of a northeastern state who indicated that "even when direct requests for assistance were made, no assistance was forthcoming." Informants who indicated that ASHA had been instrumental in helping to establish the board or has been valuable in maintaining/improving the board were of the opinion by more than a two-to-one margin that ASHA's help had come during establishment of the board

and is not an important factor in maintaining or improving the board. Thus, while 47.8% of those replying disclosed that ASHA had proven helpful, only 13.0% of the respondents viewed ASHA's value in this regard as existing beyond the period of board formation.

The issue of appointment to a professional regulatory agency, a topic previously discussed in Chapter 2 (see page 124 of this text), was examined in connection with state agencies licensing speech pathologists and audiologists. As noted in Chapter 2, board members serving on regulatory agencies in many occupations and professions are appointed by the governor from the membership rolls of the state association. A licensed member of the occupation or profession might not, therefore, be considered for board membership if he chooses not to belong to the state association. To probe this question, chairpersons of state agencies licensing speech pathologists and audiologists were asked:

1. If an individual is licensed in speech pathology and/or audiology in your state but is not a member of the state's professional association, are there any means by which the individual can be included in consideration for board membership? (24 responses)
If yes, what are these means by which a person can be considered? (22 responses)

All state agency chairpersons, with the exceptions of those in Florida, Iowa, and Maryland, responded affirmatively. The chairperson of the Iowa Speech Pathologists and Audiologists Examining Board was unsure as to the availability of alternate channels for membership consideration in Iowa. While 87.5% of the responding chairpersons affirmed that other means for consideration are present within their states, further inquiry often failed to elicit other avenues by which a licensed professional who is not a state association member can secure board

nomination. Many informants stated only that membership in the state association is not a prerequisite under law for consideration as a board appointee. While this is undoubtedly true, the more practical question of whether definite procedures are offered to licensees who are not state association members remains largely unanswered. It seems likely that while in some states it is theoretically possible for any licensee to serve on the board, actual practice dictates that board nominees habitually come from the ranks of the state association. A number of replies specified means by which a nonmember of the state association might gain consideration for appointment. Probably the most comprehensive attempt to obtain qualified licensees who are not state association members is carried out in Louisiana. In this state, self-nomination forms are mailed to all licensed speech pathologists and audiologists within the state prior to each board election. Several state chairpersons (e.g., Ohio, Georgia) noted that recommendations for board appointment can be submitted from other organizations, and the reply from Delaware disclosed that this state's association draws from all of the state's licensed members when delivering recommendations to the governor. Other respondents indicated that it was possible for an individual to nominate himself to the governor, and a few replies remarked that "political connections" might prove beneficial in seeking appointment. Despite the abundance of positive responses to the question of availability of alternate means by which a person can be considered for board appointment, it appears that few states are actively soliciting nominations from outside the state association.

In connection with the aforementioned questions, board chairpersons were asked:

2. What, if any, steps have been taken to assure that board membership represents an adequate cross section of professional job settings within the disciplines of speech pathology and audiology? (22 responses)

Responses separated into three categories. The first consisted of those replies which revealed that essentially no steps have been undertaken to assure that board membership represents an adequate cross section of professional job settings within speech pathology and audiology. Seven responses were of this nature. One informant commented that "job setting has not been a consideration although public school people were very paranoid during the 'grandfather period' -- some credentials were marginal even under the liberal grandfather provision." Another chairperson noted that she considers it impossible to achieve a cross section of job settings with only two speech pathologists and two audiologists serving on the board. Two respondents indicated that no steps have been taken due to the fact that professionals within the state do not view job setting representation as a problem. A second grouping of responses was composed of replies from states wherein some informal attempts are currently being employed to assure a degree of job setting equity. The nine responses constituting this category were characterized by phraseology such as "every effort is being made," "members of the board try their best to," and "we attempt to be aware of." The chairperson of a southern state wrote that although nothing related to the question is to be found in statute, nevertheless there is an informal understanding that sex, job setting, geographic location, and professional emphasis are to be considered in recommending

appointments. Another response pointed out that informal consideration of job settings by the executive committee of the state association, the individuals charged with recommending appointees, has seemed to work to everyone's satisfaction. A similar situation exists in a northeastern state where, although nothing official is undertaken, "every effort is made to insure board membership from school, government agencies, and the private sector." Responses from six states evidenced a more formalized approach to the problem. One informant explained that the state association places all members into one of seven job setting classifications and that one licensing agency member is chosen from each setting. This same chairperson indicated, in reference to alternative means by which a licensee can be considered for board membership, that it is not necessary for an individual to be a member of the state association to be considered. This apparent contradiction was not explained. The chairperson of a western state noted that in his state "job settings are represented and so required by the law, and include all major settings of service." It is apparent that, despite unofficial, well-intentioned attempts at insuring some degree of cross sectional representation, few states have established formal mechanisms for this purpose.

Board composition was further explored by obtaining input from licensing agency chairpersons regarding their idealized board composition. Questionnaire recipients were asked:

3. What would be your "idealized" board composition? That is, if board composition were left to your discretion, what idealized composition (not taking into account the personalities or competencies of those currently serving on the board) do you see as best achieving the board's goals and best fulfilling the board's duties? (23 responses)

Thirteen respondents replied to this question by stating that either their idealized board composition is identical to the present composition of their state licensing board, or by specifying particular job settings which they would like to see represented on a board consisting of the same ratio of professionals as is now the case. Respondents in this latter group are apparently satisfied with the degree of representation by the various professions and the public; however feel that idealization could occur if more consideration were given to the job settings from which board members are chosen. One informant replied:

We have been very successful with the present composition (without regard to individual persons). We weren't keen initially about having a physician on the Board, but he has been most helpful, particularly with the medical community and their relationship with hearing aid dealers. We are glad we have several [members] who are from the academic community, since much of our work has to do with evaluation of training of individuals.

Another chairperson, whose response indicated that his idealized board is commensurate with his current board, commented on a board's sex ratio by expressing his feeling that "the sex ratio is not important as long as at least two women or men are appointed." Four chairpersons indicated the need for better lay representation on their boards. Three of these four responses were from states where the lay public is not formally represented on the licensing board, and the fourth response emanated from a state where two public members already occupy board positions. Four questionnaires indicated that the repliers' idealized board composition could best be achieved by increasing the representation of speech pathologists and audiologists on the board. One chairperson revealed that he would remove the audiologist position from his board and substitute another speech pathologist position.

Another expressed the belief that an attorney should occupy a position on his board, while the chairperson of a northeastern state noted that her idealized board would consist of one more speech pathologist or audiologist and one less otolaryngologist. Several informants took issue with the notion of an "idealized board." The presiding officer of one board stated that board composition is relatively unimportant if all members are competent professionals in their respective areas. Another chairperson commented that "the number [and presumably the composition] is not so important as philosophies. Administratively the Board can be 'run' by any reasonably competent person (preferably a paid, non-speech pathology/audiology professional administrator)." The attitudes and opinions of licensing board chairpersons with regard to idealized board composition, as mirrored in their answers to this question, indicate that the problems discussed in Chapter 2 probably do not exist to a significant degree here. There appears to be a general satisfaction with current board composition, and the image of the professional board member fighting fiercely to protect his colleagues from the onslaught of the consumer is nowhere to be seen. In many cases, just the opposite is being observed. A more detailed look at the relationship between the board and the public/consumer will be presented on the following pages.

In an attempt to examine board participation in the public sphere, the following questions were addressed to licensing board chairpersons:

4. Does your board undertake special efforts to obtain public representatives (advocates, consumers, etc.) for participation at legislative hearings or at hearings for proposed rule changes? (22 responses) Have such efforts on the part of your board been successful? (10 responses)

Twelve respondents acknowledged that such efforts have not been undertaken by their boards. Of these 12 responses, six originated from states currently having one or more members of the lay public serving on their licensing board. It is possible that licensing boards in these six states believe that having public representation on the board eliminates the need to actively seek other public participation. Six of the 12 negative responses were obtained from states where the public is not currently represented on the board. One informant in this category replied that although such efforts have not yet commenced in her state, she believes that sunset legislation is requiring that attempts to more fully involve the public begin. She contends that this mandate may well be beneficial. Another chairperson, likewise presiding in a state where special efforts to obtain public representation at legislative hearings have not been initiated, noted that her board has been considering such solicitation of the public for situations requiring board action. Ten chairpersons answered this question by affirming that their board does make special efforts to obtain public representatives for participation at legislative hearings or at hearings for proposed rule changes. The licensing board chairperson of a southern state indicated that her board follows the state administrative code which "requires that all meetings be published in prominent newspapers in the state at least ten days in advance. We have notified interested persons known to us. . . ." Of the ten replies which answered affirmatively, all but two indicated that efforts which the board has initiated have been successful. One dissenter disclosed that his board has been successful at obtaining representatives, but unsuccessful at getting the

desired results. With 54.5% of the respondents indicating that special efforts as previously described have not been made, and with 27.3% of the respondents serving in states with no public board member in addition to their reported lack of effort in seeking public participation outside service on the board, it is apparent that considerable room for improvement exists. The success of those boards that have undertaken such efforts augurs well for boards which wish to pursue greater public representation at all levels.

The question of including lay public appointees on the licensing board was next broached to questionnaire recipients:

6. Do you agree with mandatory inclusion of one or more public representatives on speech pathology/audiology licensing boards? (24 responses)

Seventeen chairpersons agreed that they would favor such inclusion, five disagreed, and two were undecided. Table XVII views response to this question as a function of public representation on the board.

TABLE XVII

RESPONSE TO QUESTION 6 AS A FUNCTION OF
PUBLIC REPRESENTATION ON STATE LICENSING BOARDS

N=22 (2 responses not tabulated)

	Number of affirmative responses to question 6	Number of negative responses to question 6
Number of states having at least one public or consumer board member	10	2
Number of states having no public or consumer board member	7	3

As revealed in Table XVII, only two of the 12 chairpersons serving in states with some lay representation on their licensing boards were against mandatory inclusion of such members. Whether such a reaction represents professional bias, an unpleasant experience with current public members, or an aversion to the word "mandatory" is unknown. Seven of ten responses received from individuals chairing boards in states with no public representation on the board were in favor of such mandatory inclusion. Thus, with 83.3% of the chairpersons from public board member states favoring inclusion, and 70% of the chairpersons from states with no lay board representation favoring inclusion, the public/consumer area will undoubtedly continue to make inroads into board membership. Ultimately, however, state licensing boards will become increasingly interested in the quality rather than quantity of public representation. This aspect will be discussed next.

To assess chairpersons' perceptions regarding the input provided their boards by public representative board members, chairpersons were asked:

5. If your board currently has a public representative(s) serving, do you feel that this member(s) has significantly contributed to the operation of the board or has served in more of an "observer" capacity? (13 responses)

All respondents from states where one or more public members currently serve on the board replied to this question. Eight informants affirmed that their board's public representative(s) significantly contributes. Comments such as, "the individual is very perceptive, asks pertinent questions and contributes relevant information" and "both public members are valuable members and contribute freely" were received. Three informants viewed their public representative(s) in more of an

observer capacity. One chairperson disclosed that his representative "has no idea what is going on." Another reported that the major benefit supplied to the board by her agency's public representatives is the establishment of a quorum when one attends. Otherwise, "they do not contribute much." Two responses indicated a "mixed" opinion. One noted:

We have two public members. Both have attended meetings regularly and commented. One public member is a hearing aid dealer. This has caused considerable controversy. The other is an elementary school teacher. Their presence has assisted in raising the awareness of the speech pathologists and audiologists on the Board, however neither of the public members feels competent to assist in work related aspects of Board function.

The other respondent in this category held different views of the contributions made by each of the board's two public representatives. While the first public member "significantly contributed by virtue of personality and being an advocate (paid) for handicapped," the second member "has chosen to 'go along.'" Consequently, although the majority of respondents expressed the belief that their public representative(s) significantly contributes, a sizable percentage (38.5%) revealed that one or more of their public board members serve in somewhat of an observer capacity. In view of the positive reactions on the part of board chairpersons, as previously documented, toward the mandatory inclusion of public representatives, it is evident that a number of states must place more emphasis on the selection and orientation of public board members. Those responsible for nominating and selecting public representatives must be made aware of the qualifications needed to serve on a given board, and must make their selection accordingly. There appears to be little gained by having a board position occupied

by an observer rather than by a participating member, and even less to be gained by defrauding the public into believing that they are indeed competently represented.

The relationship which exists between state agencies licensing speech pathologists and audiologists, and the contact which a given agency has with boards licensing other professionals within its state, were investigated via responses to several questions. While it was assumed that informal regional meetings of speech pathology and audiology board chairpersons/members were generally accepted and approved by those participating, it was speculated that opinion concerning the formation of a formalized national organization might be somewhat more negative. Consequently, board chairpersons were asked:

8. Are you in favor of the proposed creation of a national organization consisting of licensing board members (or board representatives) from state speech pathology/audiology licensing boards? (24 responses) If not, why? If so, do you have any reservations about such an organization? (5 responses)

Eighteen of the 24 respondents favored the establishment of such an entity. While the majority of those replying in this fashion appeared to have no reservations, a number of affirmative replies were qualified. One chairperson admitted that his "yes" was a weak "yes." A midwestern informant expressed a belief that "such an organization should not be connected with ASHA in any way." However, he continued, such an organization should be open to suggestions from ASHA. A third affirmative replier stated that she fears domination of the organization by large states, and that she views the problems of large states as being different from those of smaller states. Four chairpersons revealed uncertainty regarding this question to the point where they were unable to specify an affirmative or negative answer. One such individual

wrote, "I'm not sure what function they [a national organization] will serve other than information sharing which we have found . . . is not too good." A second indicated that her licensing committee is waiting to review organizational statements regarding the purposes and goals of the proposed organization before deciding to offer support. Two of the 24 responses to this question were negative, with one observing that such a creation "would have no useful purpose other than to share problems, not solutions." The chairperson of a midwestern board revealed a number of reasons for his opposition to the proposed organization, among which are the transient nature and short terms of board members and the poor chance for acceptance by enough states to make such an organization worthwhile. This informant continued by noting that the creation of such an organization, were it to have a chance for survival, should be undertaken by ASHA. The fact that only 8.3% of those responding signified outright disfavor should not be taken as evidence of unmitigated support for creation of the proposed organization. Indeed, 41.6% of the responses tabulated failed to show unqualified support. If a massive undertaking such as the creation of a national organization is going to be successful, the uncertainties of many potential participants must be analyzed and removed. Assuming continuance of current levels of skepticism, the effectiveness of such an organization, although possibly not the eventual creation of such an organization, is seriously in doubt.

Intrastate association with other professional licensing boards was queried next, as questionnaire recipients were asked:

9. Has your state promoted any activities designed to bring together members of different state licensing boards within your state in an effort to designate common problems and discuss possible solutions? (24 responses) If not, do you believe such a meeting would have merit? (16 responses)

A total of eight respondents, or one-third of those answering the initial question, indicated that such activities to encourage communication between professional licensing boards within their states do exist. The chairperson of a northwestern state noted that although a group for this purpose already exists in her state, it is very ineffective. Sixteen informants, or two-thirds of those replying to this question, observed that such activities are not present at this time within their states. When these 16 individuals were asked if they believed that such a meeting of licensing boards within their states would have merit, 11 responded in the affirmative. One informant in this affirmative group suggested that the Association (coalition) of Health Related Professions in his state might serve in such a capacity. State agencies licensing speech pathologists and audiologists exist within a political environment which can either facilitate or hinder the efforts of such agencies in serving their licensees. It may be, in latter cases, that one state licensing agency is powerless to evoke a positive response to change at the legislative level. In such instances, the use of previously established lines of communication between licensing boards within the state can serve to help determine how extensive is the need for change and how widespread is the support for change. The fragmentation of licensing boards that appears to be present within many states effectively eliminates the sharing of information among numerous agencies which exist in the same state, under the same political influences, for the same purposes.

In the realization that friction may occur between licensing agencies within a state which could mitigate against the type of communication previously discussed, the following questions were proffered:

35. Do you feel that other state boards in your state have restricted the ability of speech/language pathologists and/or audiologists to "compete" in serving the communicatively handicapped? (23 responses) If so, which state boards might these be and what problem areas exist? (5 responses)

Eighteen chairpersons reported that they do not know of any instances of restriction by other licensing agencies within their states. Two of these respondents qualified their answers. The presiding officer of a southern licensing board speculated upon the possibility of restriction to his board by the passage of a bill regulating occupational therapists. The other qualified response noted that "the hearing aid dealers' board has insisted that [an] audiologist be licensed as [a] hearing aid dealer in order to dispense hearing aids in _____". Most audiologists have complied because they do not wish to go to court and challenge their board." Five chairpersons replied to this question by affirming that restrictions upon their boards are present. Four of these five individuals indicated areas of conflict or potential conflict with agencies licensing hearing aid dealers and fitters. One respondent stated that the Board of Hearing Aid Dealers and Fitters in her state "places restrictions regarding provision of amplification -- audiologist 'recommends' -- and if language is carefully chosen, few problems arise. Hearing aid banks or loan programs present a real problem where there is currently no assistance for amplification for the elderly." Another revealed that in her state the "hearing aid dealers and fitters board requires that

audiologists apprentice for two years to a hearing aid dealer in order to dispense hearing aids, except under the 'auspices' of a physician." A third replier viewed the fact that the Hearing Aid Dealers and Fitters Board in his state exempts physicians and not audiologists as being restrictive. The single response in this category which did not remark upon difficulties experienced with state boards licensing hearing aid dealers did, nevertheless, note that the observed restriction is also in the area of audiology. This response made reference to a state licensing law's liberal exclusion section which specifically exempts all physicians from the requirements of the speech pathology/audiology statute. Physicians may then, according to this chairperson, "practice audiology in their offices even though not qualified." If a conclusion can be drawn from analysis of reactions to these questions, it is that state licensing agencies regulating speech pathologists and audiologists do not generally see conflict or overlap with other licensing agencies within their states as a major concern. Over 78% of the responding chairpersons perceived no restrictions as being placed on their boards by other state licensing agencies. When friction was noted, it occurred 80% of the time with the state board licensing hearing aid dealers and fitters and invariably came about due to what were perceived as restrictions placed upon the job performance and the job scope of licensed audiologists.

Board Financing and Autonomy. Analysis of Questions 10, 11, 12, 13, 14

Issues related to the financing of state agencies regulating speech pathologists and audiologists can be somewhat complex, and attempting to obtain relevant data via questions requiring a choice

between polarized answers somewhat difficult. The reader is referred to pages 125 and 126 of this text for a general discussion of professional licensing board financing.

Many state licensing boards serving the various professions are financed entirely from fees generated by the licensing boards themselves. To ascertain if such is the case in the professions under consideration, the following question was proposed:

10. Is your licensing board financed solely through the fees which are collected for license application, issuance, and renewal? (24 responses)

Eighteen of the responding individuals reported that the board they represent is financed solely as indicated in the question. It is to be understood that many such boards received an initial "start-up" allocation prior to collection of initial fees. Six respondents stated that their boards are not financed solely via collected fees. The chairperson of the Utah Licensing Committee for Speech Pathology and Audiology disclosed that the amount budgeted by the legislature for operation of his committee is included in the appropriation for the Department of Registration, and is not a line item. The questionnaire respondent from the state of Hawaii noted, in a similar fashion, that her board is a part of the Department of Regulatory Agencies. No specific funding is earmarked for her board. Several other board chairpersons replied in a like manner. Table XVIII lists each state's response to this question.

TABLE XVIII

THE RESPONSES OF STATE LICENSING BOARD CHAIRPERSONS TO QUESTION 10

Question: Is your licensing board financed solely through the fees which are collected for license application, issuance, and renewal?

Responses (N=24)

<u>Yes</u> (18)		<u>No</u> (6)
Arkansas	Maryland (SP)	Connecticut
California	Missouri	Georgia (current allo-
Delaware	Montana	cation \$4800)
Florida	Nebraska	Hawaii
Iowa	North Carolina	New York
Kentucky	Oregon	Ohio
Louisiana	Rhode Island	Utah
Maine	South Carolina	
Maryland (A)	Tennessee	

Regardless of methods implemented for financing a board, it was deemed important to determine the degree of control exercised by a board with regard to its budget. Consequently, questionnaire informants were asked:

11. Does your board have its own budget with board control or is there a hierarchy of control? (24 responses) If the latter is true, does the withdrawal of funds require a special appropriation act by the legislature despite the fact that the legislative appropriation may equal the amount deposited? (11 responses)

Eight chairpersons reported that their board has its own budget, 13 replied that there is a hierarchy of control, and three individuals felt that both answers were appropriate to some degree. While it might be expected that those states with boards which have control of their own budget would generally be those states where licensing agencies have no direct supervisory authority, such is not the case. Four of the eight chairpersons indicating that their board has its own budget serve in states where the board has a supervisory authority (Iowa,

Louisiana, Maine, Nebraska). The reader is referred to Table III, page 175 for a delineation of licensing agencies and corresponding supervisory authorities. Of the 13 responses noting a hierarchy of control, ten were from states with boards having a direct supervisory authority. All three of the informants choosing both answers serve on boards with a direct supervisory authority. A further analysis of this question was deemed inappropriate due to the fact that "hierarchy of control" was not operationally defined. Many respondents, asserting that their board has its own budget, supplied qualifying comments such that it became apparent some degree of external control is exerted similar to that existing in states where board chairpersons perceive a hierarchy of control. Consequently, this question, as worded, was judged to be insensitive to fine gradations of external control. It is apparent, however, that only one-third of those chairpersons who replied to this question consider themselves to be presiding over a board unencumbered by budgetary restrictions imposed at a level above that of the board itself. Only two states, South Carolina and Connecticut, indicated that the withdrawal of funds for board use requires a special appropriation act by the legislature despite the fact that the legislative appropriation may equal the amount deposited.

Since underfunding has been frequently cited as a chronic problem in the efficient operation of state agencies licensing professionals (see page 126 of this text), answers were solicited to the following question:

12. In your opinion, is your licensing board currently underfunded?
(22 responses)

Responding chairpersons clearly indicated that such is not the case. Underfunding is reported to exist in only three states, all of which are regulated by a supervisory authority.

The chairpersons of these three state boards were then asked:

13. If you believe your licensing board to be currently underfunded, in what areas (e.g., distribution of information, enforcement of statutes, make-up and administration of examinations, etc.) do you feel such underfunding has curtailed your services? (3 responses)

The chairperson of a northeastern state noted that underfunding resulted in the inadequate distribution of information by his board. The two remaining replies to this question were somewhat optimistic concerning future funding allocations. The first respondent pointed out that the budgetary process in his state is being changed so that eventually all licensing boards in the state will be self-sufficient. Consequently, this individual expects that underfunding of his board will continue for only the next few years. The second individual replied that his board is "beginning to resolve this problem" and that the state legislature has increased the allotment to his board by 70% since the first biennium (1977-1978). Whatever shortcomings may appear in the operation of those boards licensing speech pathologists and audiologists, it appears, contrary to what is reported with regard to boards licensing other professionals, that underfunding cannot be designated as a major contributing cause for these imperfections.

The issue of autonomy of function versus centralization of function, previously discussed in Chapter 2 (see pages 121-123), was studied to determine whether board chairpersons would prefer more autonomy in board operation or increased centralization to provide economies of scale, increased coordination and reduced duplication of

"routine" tasks. Persons receiving questionnaires were asked:

14. If your board is autonomous (no supervising agency), do you feel that increased centralization would provide more benefits to your board than liabilities? (12 responses) If your board is operating under a basically centralized system, do you believe that more autonomy would better enable your board to perform maximally? (13 responses)

The respondent from only one state agency (Florida) expressed a belief that increased centralization would be advantageous to his licensing board. Eleven chairpersons who believed their boards to be autonomous exhibited no desire to participate in a more centralized system. Seven of the eight chairpersons who earlier reported (question 11) that their board has its own budget with board control were within this group, with the eighth chairperson not responding to this question. Two of the three individuals expressing a belief that their board is underfunded (question 12) also were included within these responses. It is interesting to note that six of the 11 responses currently being discussed originated from licensing boards having supervisory authorities. Whether this indicates that licensing boards having supervisory authorities are as likely to view themselves as having autonomy as are those having no such authorities, is unclear. It may also be true such informants are, in reality, not substantiating their current autonomy but rather stating a desire not to have even more centralization of function inflicted upon them. Be this as it may, it is obvious that those boards with budgetary control are almost unanimously against increased centralization. When chairpersons of boards operating under what they regard as a centralized system were queried in connection with perceived benefits of expanded autonomy, only three of 13 respondents suggested that additional autonomy would be beneficial. Several

of the ten informants who indicated that increased autonomy would not be welcome noted that their boards, while operating within a centralized system, currently have relative autonomy. Hence, from viewing the replies to these two questions, it would appear that chairpersons serving on licensing boards where autonomy is perceived as high generally feel little need for an increase in centralization. Many of those chairpersons serving on boards within a centralized system believe that sufficient autonomy for their boards already exists within the system, demonstrating that "autonomy" and "centralization" may not represent the extreme points on a continuum which some authors would have us believe. Autonomy is relative, and its presence or absence depends to a large extent on one's expectations in a given situation and on one's past experience. The amount of autonomy needed to make one feel autonomous is a function of many diverse factors, and it might be well to heed the advice of one informant who, in discussing the situation in her own state, stressed the need for specificity:

Define autonomous. Certain licensing functions (i.e., the actual issuance of a license) are through a central licensing agency. The only problem this has presented -- so far -- has been when unilateral decisions regarding procedures have been made. There has been an improvement and, perhaps, we can both learn how to make better decisions. When a Central Licensing Division is involved that makes no distinction between a Professional Boxers Board and Speech Pathologists and Audiologists, problems arise. It is necessary to sit down together and work things out -- something which has not yet been effected.

Board Duties. Analysis of Questions 15 and 16

The duties performed by state licensing boards were examined along three dimensions:

1. time spent in fulfillment of duties,
2. perceived importance of duties,
3. ability to complete duties.

In order to investigate the first dimension, responses to the following question were requested:

15. With regard to the duties performed by your licensing board, what are the approximate percentages of time spent in discussing or actively pursuing fulfillment of these duties? (22 responses)

Table XIX delineates these percentages on a state-by-state basis and gives a mean percentage of time spent in fulfilling each duty. It is of interest to note that licensing board chairpersons in five states indicated that their boards spend no percentage of time involved with the enforcement of licensing statutes and the investigation of alleged violations. In only two states (Florida and Arkansas) do such activities consume a significant portion of the board's time. As would be expected from the data just presented, little board time is utilized in conducting hearings, suspending, revoking, and restoring licenses. Extreme variation in time apportionment with regard to these two duties is found. While Arkansas' board spends 23% of its time in enforcement and investigation and only 1% in conducting hearings or suspending/revoking/restoring licenses, Oregon's board devotes 3% of its time to the former duty and 40% to the latter. The major percentages of board time, according to respondents, are expended in the promulgation and monitoring of specific board regulations and in the examination or other determination of eligibility for licensure. While

TABLE XIX

PERCENTAGE OF TIME SPENT IN DISCUSSING OR ACTIVELY PURSUING FULFILLMENT OF BOARD DUTIES

Duties	States (N = 22)																						Mean percentage
	AR.	CA.	CT.	DE.	FL.	GA.	HI.	KY.	LA.	ME.	MD.(A)	MD.(SP)	MT.	N.Y.	NE.*	N.C.	OH.**	OR.	R.I.	S.C.	TN.		
enforcing licensing statutes and investigating alleged violations	23	0	5	10	25	5	0	1	10	0	10	5	5	0	5	0	7	5	3	10	5	10	6.5
conducting hearings, suspending, revoking, and restoring licenses	1	0	5	0	10	5	0	2	0	0	5	0	0	5	0	2	5	5	40	5	2.5	5	4.2
promulgating and monitoring specific board regulations	5	0	20	10	20	5	40	1	10	50	5	15	50	15	30	10	2	2	30	5	10	30	16.6
examining or otherwise determining the eligibility of applicants for licensure	25	65	60	70	5	40	50	75	20	20	10	60	25	35	25	80	20	15	10	70	45	20	38.4
completing and maintaining efficiently organized and easily retrievable records	30	10	0	0	5	5	0	1	15	0	0	2	0	0	20	5	20	10	5	0	5	5	6.2
issuing licenses and collecting fees	10	5	0	0	0	20	0	10	20	0	10	1	0	0	0	0	10	8	10	10	20	10	6.5
public relations	1	5	5	0	10	0	0	0	5	10	5	0	0	20	10	0	9	3	0	0	2.5	5	4.1
answering correspondence and disseminating information	5	8	5	10	25	20	10	10	20	10	20	15	15	25	5	5	30	40	2	0	10	15	13.9
other	0	7	0	0	0	0	0	0	0	10	35	2	5	5	0	0	12	0	0	0	0	0	3.5
Total percentage	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.9

Notes: *Nebraska's board had been in operation for only six months at the time percentages were specified.
 **Ohio's Chairperson provided two sets of data, one for the first three years of the board's existence and one for that period of time after the initial three years. Only this second set of percentages was included here.

the mean percentage of time designated for each of these duties represents, to some degree, what might occur on an "idealized" board, the range of percentages for each duty is perhaps more revealing. The fact that several boards spend no time or only 1% of their time in the promulgation and monitoring of specific regulations, while a number of boards utilize from 30 to 50% of their time in completion of this task, dramatically points out the lack of uniformity among boards in time allocation for a given responsibility. This disparity is even more apparent in connection with a board's responsibility for examination or other determination of eligibility for licensure, as a range of 5% to 80% is observed. It is likely that the extreme variation in time apportionment from board to board for the same duty is due to a number of factors. The length of time which the board has been in existence will influence the distribution of percentages. This is illustrated by the fact that the first state board to be organized (Florida) and the last state board to be organized (Nebraska) represent the extremes of 5% and 80% respectively in connection with the board responsibility just discussed. Furthermore, the role which a board's supervisory authority plays can affect the duties a board must perform. Centralization may alleviate the need to spend large amounts of time in record keeping or in issuing licenses and collecting fees. The planning and implementation of special programs such as continuing education may temporarily lessen the amount of time which a board can devote to other considerations. Certainly the number of licensees within a state will help determine where a board concentrates its energy, and statutory differences in terms of basic board responsibilities are important considerations in time allocation. Finally, the intermix

of a number of unique individuals with differing backgrounds and viewpoints regarding board priorities will contribute to a determination of the time which a board is willing to devote to a particular task.

Inquiry was next made into the relationship between the perceived importance of the duties previously specified and the board's ability to fully execute them. Board chairpersons were asked to make judgments in the following manner:

16. Below are listed a number of possible duties to be performed by licensing boards. In column one, please rank the importance of these duties as you view them in carrying out the purposes for which your board exists. Rank the most important duty as number one (1). In column two, please rank the duties in terms of your board's ability to complete them. Rank that duty which you believe is fulfilled to the greatest extent as number one (1). You may, if you believe that several duties are completed to an equal extent, use the same number more than once. (23 responses)

Table XX demonstrates the mean rankings for each duty. The fact that respondents were permitted to use the same ranking for several duties if they so wished precluded the use of sophisticated statistical analysis. Since those individuals who chose to use a particular ranking more than once generally tended to do so with the higher ranks (e.g., rank 1 or rank 2), mean rankings are somewhat elevated from what would have been the case had each ranking been permitted to be used only once.

Inspection of the mean rankings for importance juxtaposed with the mean rankings for completion discloses that state licensing boards consider the examination or other determination of an applicant's eligibility for licensure to be their most important function. It is also that responsibility which they are best able to complete. As previously noted in Table XIX (page 274), licensing boards spend more than twice as much time in fulfilling this duty as in fulfilling any

TABLE XX
 MEAN RANKINGS FOR IMPORTANCE OF DUTIES AND
 BOARD'S ABILITY TO COMPLETE DUTIES

Duties	Mean rankings for importance	Mean rankings for ability to complete
Enforcing licensing statutes and investigating alleged violations	3.35 (3)	4.28 (6)
Conducting hearings, suspending, revoking, and restoring licenses	4.14 (4)	4.47 (7)
Promulgating and monitoring specific board regulations	2.95 (2)	3.05 (3)
Examining or otherwise deter- mining the eligibility of applicants for licensure	1.68 (1)	1.41 (1)
Completing and maintaining efficiently organized and easily retrievable records	5.65 (8)	3.89 (5)
Issuing licenses and collecting fees	4.84 (6)	2.56 (2)
Public relations	5.23 (7)	4.90 (8)
Answering correspondence and disseminating information	4.45 (5)	3.57 (4)
Other	NA	NA

other. Examination of Table XIX also reveals that board chairpersons believe the promulgation and monitoring of specific board regulations is that charge which consumes the next largest quantity of board time. Table XX indicates that this function is ranked second in importance and third in its ability to be adequately completed by the board. Discrepancies in the three dimensions of: time spent in fulfillment of duties, perceived importance of duties, and ability to complete duties, can be discovered by a perusal of Table XIX and Table XX. For example, licensing board chairpersons ranked the enforcement of licensing statutes and the investigation of alleged violations as third in importance for carrying out the purposes which justify the existence of a licensing board. However, the average percentage of time occupied with this responsibility is only 6.5%, and the board's ability to adequately accomplish this incumbency is judged by respondents to be relatively low.

Much the same situation exists relative to conducting hearings, suspending, revoking, and restoring licenses. Public relations is deemed relatively unimportant in relation to the other duties specified, and informants ranked it last in terms of their ability to accomplish tasks of this nature. Despite this, and despite the low percentage of time devoted to this area of board operation, several respondents affirmed its significance. One informant asserted that "boards, especially this one, need to do some public relation work. [The] public, hospital administrators, etc. need to be informed of [the] existence of [the] board, its role, etc. That [is the] greatest criticism since little is done to actually directly protect the consumer." Viewing mean rankings alone does, unfortunately, severely

limit the validity of inferences which can be made with regard to any particular state. The reader is cautioned that, in general, the range of rankings for a particular duty was wide. For example, although the public relations function of the board, as seen in Table XX, is considered to be relatively unimportant and not well accomplished, several state boards ranked their public relations function first or second in one or both categories. Similarly, despite mean rankings which indicate that licensing boards consider the promulgation and monitoring of specific board regulations to be both important and well executed, individual state's rankings placed this board duty as low as seventh in both areas of investigation. Hypothesized reasons for the variability between states were discussed in reference to the last question.

Examination Practices and Information Dissemination. Analysis of Questions 18, 19, 20 and 21

As stated in Chapter 2, the completion of a competency examination is one of the most controversial prerequisites for admission to licensure in a profession. A number of authors have stressed the inadequacy of such tests, and have taken the viewpoint that examinations of this nature restrict entrance to a profession for the individual who is competent but who tests poorly (see pages 80-82). In the disciplines of speech pathology and audiology, an individual wishing to be certified in either of these two areas by the American Speech-Language-Hearing Association must pass a comprehensive examination administered by the American Board of Examiners in Speech Pathology and Audiology (ABESPA). State licensing boards are at liberty to use the results of the ABESPA examination in their deliberations concerning an applicant's

eligibility for licensure, or they may wish to develop their own assessment tool. In an effort to determine how widespread is the use of competency tests developed at the state level, the following questions were submitted to licensing board chairpersons:

18. If your licensing board administers a state examination which may be taken by the applicant in lieu of the national examination for certification, what percentage of those obtaining licensing in your state do so by taking your state examination rather than the national exam? (20 responses) What percentage of those taking your state exam pass? (2 responses)

The respondent from only one state (Utah) gave clear indication that a state examination exists and is being used. This informant stated that both the ABESPA examination and a state practical examination are required of potential licensees. Approximately 80% of those taking the state practical examination are successful. The individuals from three states (Delaware, Kentucky, and Maryland), when asked to designate the percentage of applicants taking their state examination rather than the national test, specified 0%. Whether this indicates the presence of a state examination which no one has ever chosen to take, or rather signifies that no such state test exists, is uncertain. A further complication occurs by virtue of the fact that a number of states offer a "state" examination, but one which is identical to that supplied by ABESPA. One respondent reported that the number of applicants wishing to have the state examination administered is "very low," however he qualified his reply by noting that his state's test and the national examination are actually identical. In any event, responses from state board chairpersons revealed that the vast majority of state boards use the national (ABESPA) examination to assess applicants' qualifications. Two repliers did indicate that one of the priorities of their board

during the next year is to develop an alternate examination.

The subsequent questions, addressed to chairpersons of boards in states administering a state examination, asked:

19. Does your state licensing board make an effort to inform applicants who fail your state licensing exam as to their areas of weakness? (9 responses) How is this accomplished? (2 responses)

Two respondents (Hawaii and Utah) disclosed that their board does attempt to contact examinees regarding noted areas of weakness on the state examination. This is accomplished via a letter issued by the board's executive secretary in Hawaii and by letter or conference in Utah. While the response from the chairperson of Hawaii's Board of Speech Pathology and Audiology to the previous question (question 18) failed to acknowledge the existence of a state examination which differs from that promulgated by ABESPA, the issuance of a letter to examinees in that state strongly suggests the presence of such a state examination. Seven informants stated that no efforts are made as stated in the question. Of these seven negative responses, however, four noted that no state examination is currently administered within the state. Consequently, questionnaire results suggest that a minimum of two states (Utah and Hawaii) and a maximum of five states offer or require an examination developed at the state level. Two states (Utah and Hawaii) advise examinees regarding their areas of weakness on such a test.

While the preceding question (question 19) focused on board communication with a limited population (i.e., applicants) under certain specified conditions (i.e., applicant does poorly on examination), question 20 attempted to examine the more general communication which

a board might wish to facilitate with the public. Those receiving questionnaires were asked:

20. Does your board use any special techniques to facilitate communication with the public (such as 800-number telephone lines)? (24 responses)

Six state board chairpersons, those from California, Florida, Louisiana, New York, North Carolina, and Oregon, responded affirmatively.

Techniques specified include:

1. announcement of board telephone number in state association periodicals (N.Y.),
2. provision of 800 numbers and information services/publications through department of consumer affairs (Ca.),
3. report of board activities at state association meetings and special announcements in state association publications (Fl.),
4. widely published telephone number with 24 hour answering service and employment of a 1/2 time secretary (N.C.),
5. dissemination of public information brochures (La. and Or.).

Two individuals who responded negatively to this question did comment upon the occasional use of a toll free telephone line by the state association and use of an association newsletter to disseminate information. In conclusion, six of 24 respondents indicated the use of special techniques to facilitate communication with the public, and eight of 24 respondents specified a technique or techniques employed. If one perceives licensees within a state to be a board's "public," then the dissemination of information via state association meetings, activities, publications, etc. may suffice. However, if one perceives a board's public as being consumers and potential consumers of speech pathological and audiological services, then apparently little

is being done by state boards to inform the public regarding the nature of services offered by licensees, the credentials which licensees possess, and the existence of a board to which a consumer has recourse if he feels he has been treated unfairly. The facts that so many respondents interpreted "public" as referring to licensed members of the professions within the state, and that many of the communication techniques illustrated would obviously be appropriate only for communicating with fellow professionals, are significant. State licensing boards, perhaps in part because of their newness, apparently are having sufficient difficulties establishing channels of communication with "their own," and true public communication must, therefore, be assigned a low priority.

A final question in the area of public communication and information dissemination dealt with procedures for handling requests by applicants. State licensing board chairpersons were asked to address the following question:

21. Does your licensing board furnish a pamphlet or brochure to an inquiring applicant which explains in "layman's terms" the licensing requirements, procedures, regulations, cost, etc. or does your board send a copy of the applicable portion of the state statute to the applicant? (23 responses)

Only one state board chairperson (Rhode Island) indicated that his board does not furnish a pamphlet or brochure, or provide a copy of the applicable portion of state statute to inquiring applicants. Two informants (Missouri and South Carolina) reported use of a pamphlet or brochure, while six respondents (Arkansas, Connecticut, Hawaii, Maryland[A], Montana, and Utah) noted that they mail a copy of part or all of the state statute. Four presiding officers (California, Louisiana, Nebraska, and Oregon) maintained that their boards provide

both a pamphlet or brochure and a copy of the pertinent section of state statute. Eight responding individuals (Delaware, Florida, Georgia, Kentucky, Maine, New York, North Carolina, and Tennessee) stated that, in addition to sending a copy of the applicable portion of state statute, their boards also respond to correspondence from applicants by providing personal replies and/or enclosing material related to such things as board regulations, fee schedules, application, and continuing education. The chairperson of the Iowa Board of Speech Pathology and Audiology Examiners specified that his board "answers letters of inquiry with appropriate information by return letter. Some handouts are available." The Ohio Board of Speech Pathology and Audiology reported use of pamphlets or brochures, the state statute, and a form for filing application. Of the 23 state boards responding to this question, a total of 19 send a copy of their state statute (or a copy of that section of the law bearing upon the applicant's question), with or without other materials, to inquiring individuals. Certainly this seems a practice that should be adopted by all state licensing boards. Fifteen of the 23 chairpersons indicated that they furnish a pamphlet or brochure, with or without other materials, in their correspondence with applicants. Such explanatory material, relating to board rules and regulations not specified in statute, doubtless proves very valuable to recipients.

Enforcement of the Law: Grievances, Suspensions, Revocations, and Use of a State Attorney. Analysis of Questions 22, 23, and 24

Chapter 4 (page 231) noted that statutory justifications for suspension or revocation of licensure are very similar from state to state.

In an effort to better comprehend the practical aspects of enforcement, state licensing board chairpersons were asked to respond to these questions:

22. What is (are) the primary reason(s) for the revocation of licenses issued by your board? (22 responses) What types of grievances does your board hear? (14 responses) What is being done to insure due process? (13 responses) Do you feel your procedures for policing board regulations and state mandates are sufficient? (19 responses)

Seventeen informants were unable to delineate reasons for license revocation in their states because no license has yet been revoked (with the possible exception of revocation due to nonrenewal of license). Several of these replies reiterated statutory provisions for revocation (see Table XIV, page 232), but no application of these sections of statute has been found necessary by the board. Although the Board of Examiners for Speech and Language Pathologists and Audiologists in North Carolina has not yet revoked a license, its chairperson reported that the board is "considering a revocation now, based upon complaint of sexual assault on a minor child (a patient), which if proven, would be a violation of the Board's Code of Ethics." Another application for revocation in North Carolina was based upon a complaint regarding an alleged forgery of an employer's signature. No hearing was required as the request for board action was withdrawn. Five respondents (California, Georgia, Maryland [SP], Missouri, and Oregon) disclosed that one or more licenses in their states have been revoked. Reasons specified included falsified application for licensure, provision of services without a license, insurance fraud, voluntary surrender of license due to mental illness, an offense of moral turpitude, and working outside the professional area of licensure. Fourteen responding

individuals outlined grievances which have been presented to their board. These grievances are listed below, with a numeral following the grievance indicating that said grievance was specified by more than one chairperson. A number of categories overlap, as it was deemed important to retain the original wording of responses whenever possible.

1. practicing without a license (4)
2. unethical practice/violation of code of ethics (3)
3. presentation of false information on licensure application (3)
4. provision of services by hearing aid dealers for which they were not licensed
5. failure by board to grant license
6. illegal use of term "audiologist" or "speech pathologist"
7. incompetence
8. incompetence (grandfathered in)
9. individual working in another profession providing speech pathological services
10. fee charges
11. moral turpitude
12. request for grandfathering

The problem of establishing due process was commented upon by 13 chairpersons. While the respondent from one northeastern state wrote that she feels nothing is presently being done within her state to insure due process and to adequately locate and serve aggrieved individuals, the majority of replies were more positive. Some noted that a standard procedure for all licensed professions in the state is mandated which consists of board investigation, notification of the accused, legal hearings, board decision (written by legal counsel),

and avenues for appeal. Several replies revealed that investigations are carried out by the board's supervisory authority. One informant indicated that it is often necessary to seek counsel with other professional licensing boards within the state, especially when infringement is implicit in the grievance. Another board chairperson candidly observed that a significant problem in this area is getting the consumer or professional to file or maintain a complaint. In this same line of thought, the chief officer of a western licensing board disclosed that what is being done currently in his state is waiting -- waiting for an incident considered serious enough for someone to raise a formal complaint. This shortage of grievances or formal complaints may be directly related to the lack of public dissemination of information previously discussed in question 20. When queried as to whether procedures for policing board regulations and state mandates are sufficient, nine individuals affirmed that they are, four reported that they probably are, four revealed that insufficient time has elapsed to make a determination or that the opportunity for assessment has not arrived, and two respondents asserted such procedures are not adequate.

To determine the number of license revocations and suspensions which have been brought about through the settlement of grievances, the instigation of due process, and the policing efforts of state boards licensing speech pathologists and audiologists, questionnaire recipients were requested to provide a response to the following:

23. What percentage (or what number) of the licenses which you have issued since your board's inception have been revoked? (23 responses) What percentage (or what number) have been suspended? (23 responses) What is the total number of initial (not renewal) licenses which have been issued by your board? (20 responses)

Table XXI presents the data obtained from responses to these questions. As can be seen, respondents indicated that a total of 15 of the more than 18,050 licenses issued have been suspended or revoked. It is difficult to imagine that the ratio of suspensions/revocations to initial licenses issued represents even an approximation of the number of violations committed which would warrant board action. Several of the reasons for the extremely low percentage of suspensions and revocations have been supplied by informants in answering previous questions. The newness of many boards is undoubtedly a factor, as recently formed licensing boards may be too encumbered with procedural matters to adequately undertake the responsibilities of enforcement. Secondly, as indicated in Table XIX, relatively little of the average board's time is consumed with matters of enforcement. Furthermore, Table XX discloses that many board chairpersons rank the ability of the board to successfully complete duties related to enforcement as low in relation to the importance which they perceive for duties of this nature. The lack of emphasis placed upon public enlightenment by many boards (see question 20) undoubtedly hinders the communication of abuses or violations from the public to the board. The seeming interest on the part of many licensing boards to bring their role to the attention of licensees and potential licensees is meritorious in many respects, however, it is the consumer of services who must ultimately suffer the consequences of professional abuses, and it is the enlightened consumer of services who must ultimately report them.

All state licensing board chairpersons responded affirmatively to the following question:

TABLE XXI

LICENSURE REVOCATIONS AND SUSPENSIONS IN RELATION TO
TOTAL INITIAL LICENSES ISSUED

State	Number of licenses revoked	Number of licenses suspended	Total number of initial licenses issued
ARKANSAS	0	0	--
CALIFORNIA	2	0	4215 (3,676[SP]-539[A])
CONNECTICUT	0	0	900
DELAWARE	0	0	130
FLORIDA	0	0	1029
GEORGIA	5 (approx.)	0	475
HAWAII	0	0	150
IOWA	0	0	400+
KENTUCKY	0	0	285 (225[SP]-60[A])
LOUISIANA	0	0	1050
MAINE	0	0	140
MARYLAND (A)	0	0	--
MARYLAND (SP)	2	3	759
MISSOURI	1	0	795
MONTANA	-	-	332
NEBRASKA	0	0	--
NEW YORK	0	0	2900
NORTH CAROLINA	0	1	850
OHIO	0	0	2427
OREGON	1	0	385
RHODE ISLAND	0	0	--
SOUTH CAROLINA	0	0	315 (approx.)
TENNESSEE	0	0	383 (328[SP]-55[A])
UTAH	0	0	130
TOTALS	11 (.0006%)	4 (.0002%)	18,050+

24. Does your licensing board have access to the use of a state attorney? (24 responses)

When asked if the board had ever needed to use a state attorney's services, all but three respondents (Delaware, Florida, Rhode Island) replied that such a need had arisen. Some of the reasons specified for seeking state legal aid include:

1. to provide legal advice regarding complaints issued to the board,
2. to aid in the drafting of letters and the writing of board decisions,
3. to represent the board in general hearings,
4. to advise concerning board rules and regulations and to advise with regard to administrative procedures that will be upheld by the courts,
5. to interpret sections of state statute,
6. to aid in the development of materials to be used in attempting revisions of the licensing law,
7. to issue reprimands to licensees,
8. to investigate and initiate legal procedures concerning persons practicing without a license,
9. to advise in the event of a lawsuit filed against the board.

Continuing Education. Analysis of Questions 25, 26, 28, 27, and 29

Continuing education has been, and continues to be, one of the most important and controversial issues facing state boards licensing speech pathologists and audiologists. This multifaceted issue is, in reality, a hierarchy of questions. For example:

1. Does continuing education have a place in the disciplines under consideration?
2. If so, is it to be mandatory or voluntary?

3. If mandatory, should it be required for keeping in force ASHA certification, state licensure, or both?
4. If it is to be mandatory for licensure renewal, should the state licensing board assume the responsibility for determination of the amount and content of continuing education required?
5. If the state board undertakes this responsibility, what is a reasonable amount of continuing education to require?

As has been previously pointed out, there is currently no mandatory continuing education requirement for maintenance of the Certificates of Clinical Competence issued by the American Speech-Language-Hearing Association. Likewise, continuing education is not required for license renewal in any state with the exceptions of Georgia, Iowa, Maine, Montana, and Utah. ASHA has for many years debated the question of mandatory continuing education for its certificate holders. In 1972, it endorsed the principle of certification renewal by passing a resolution affirming the Association's responsibility to assure that certified individuals maintain their clinical skills at a level commensurate with current knowledge. In November of 1974, the ASHA Legislative Council gave its approval to the publication of a proposal which outlined suggested criteria to be used for renewal of the Certificates of Clinical Competence. A number of problems delayed publication until 1977, at which time the following proposed statements of principle were issued.

1. Continuing education for the profession is the last but, perhaps, the most significant stage of the certification process that begins with academic and practicum training and proceeds through the Clinical Fellowship Year and the National Examination. Its time frame, however, is unique in that it parallels the individual's entire professional life.

2. Participation in continuing education is viewed as a professional obligation and, hence, mandatory for all persons holding the CCC.
3. The ultimate purpose of continuing education is to improve the quality of services delivered to communicatively handicapped children and adults. . . .
4. Continuing education is dynamically sensitive to the individual's professional competence with specific reference to the prevailing professional atmosphere.
5. Continuing education is an individual educational experience. Hence, viable continuing education programs must emerge out of the expressed needs of members of the profession on local, state, and national levels.
6. Continuing education programs may be sponsored by a broad spectrum of academic institutions, educational and service agencies, and professional organizations.
7. A continuing education program is usually of relatively short duration . . . and may focus content on a narrow subspecialty of the field. . . .
8. Criteria for continuing education program development include accessibility, feasibility, suitability, and accountability.
9. All continuing education programs to be used for certification renewal must have the approval of the responsible ASHA board. ("Proposed Plan of Continuing Education," 1977, p. 611)

Proposed plans for implementing a continuing education program followed these statements; however, internal opposition (see footnote 10, page 29) and determination of the specifics which would make a proposed plan viable have thus far prevented the inauguration of mandatory continuing education for ASHA certification renewal. ASHA is not unique in that it has, for many years, espoused continuing education without having developed and implemented a workable system. Jackson (1977) reported that, while eight nationally recognized organizations in the allied health professions unanimously encouraged continuing education, only

two required it as a condition for membership or registration. Jackson's conclusions were that the majority of the organizations which she studied

1. did not require continuing education as a condition of membership,
2. had a mechanism for accrediting or approving continuing education activities,
3. provided their members with a system of documentation of individual participation in continuing education.
(p. 156)

While the subject of continuing education for certification renewal is certainly one of concern to licensing board chairpersons, the topic of continuing education requirements for state licensure renewal is one of even greater concern. To poll the opinions of licensing board chairpersons in both these areas, the following questions were asked:

25. Do you believe that some type of mandatory continuing education credits should be required to maintain continuing ASHA certification? (22 responses) Do you believe that some type of mandatory continuing education credits should be required for relicensure in your state? (23 responses) If not, would you favor voluntary continuing education with your state licensing board maintaining a register of those submitting valid continuing education credits? (9 responses)

Replies to the initial question reflected the disparity of opinion which has impeded progress toward the promulgation of certification renewal standards. Ten informants indicated that they are in favor of mandatory continuing education credits for maintenance of ASHA certification, while 12 respondents disclosed that they do not favor such requirements. When these same individuals were asked if they favor mandatory continuing education credits as a prerequisite for licensure renewal in their states, 13 answered that they do while ten replied that they do not. All ten chairpersons who answered affirmatively to the initial question, with one exception, answered similarly

to this question. Three respondents who were disinclined toward the establishment of mandatory continuing education obligations for ASHA certification renewal approved of such prerequisites for renewal of licensure in their own states. One replier who declined to answer the initial question regarding ASHA certification responded favorably toward the establishment of mandatory continuing education requirements in his state. The chairpersons of all states currently requiring continuing education for state licensure renewal were for such requirements, and one such individual noted that she would not limit continuing education requisites solely to continuing education units. Of the 65 hours needed over a two year period for relicensure in her state, only 45 fall into a category which would include continuing education units. The ten respondents who were unfavorably disposed toward the use of mandatory continuing education credits for renewal of licensure in their states were then asked if they would favor a program of voluntary continuing education with their board operating a registry. Seven of these ten chairpersons revealed that they would approve of such a voluntary program, two reported that they would not, and one failed to respond. One of the two dissidents expressed his belief that the operation of a voluntary program as specified is a function of the state association, thus disfavor of a voluntary program in this case appears to be more related to the group operating the program than the nature of the program itself. While the instigation of some type of board-controlled program of continuing education for licensure renewal is favored by an overwhelming majority of the participants in this study, mandatory requirements for relicensure are received with somewhat less enthusiasm. Such conservatism is reflective

of a number of widely held beliefs, among which are that

1. the assumption that mandatory continuing education automatically improves an individual's ability to perform his job may be an erroneous one;
2. a professional who is capable of earning an advanced degree is also capable of determining the quantity and specific nature of the continuing education which he needs to fulfill his professional responsibilities. For those few professionals who are not capable of making these decisions independent of state board regulations, mandatory continuing education would be of little benefit anyway;
3. the less that government interferes with the right of a private citizen to pursue the livelihood for which he was prepared, the better. As Becker (1974) asserts, ". . . compulsory continuing education imposes a political structure that is fundamentally alien to the free and motivating organizational structure that has brought forth our accomplishments to the consuming public" (p. 351).

However, it is apparent from respondents' comments that more and more states are moving from contemplation to implementation of state-wide continuing education programs. As more states require continuing education for license renewal, more licensees (and thus more ASHA members) will acquiesce to the reality of continuing education. Objection to mandatory continuing education requirements for ASHA certification renewal will become academic, as state licensees will simply use credits obtained for state licensure renewal to satisfy ASHA's demands.

Questionnaire recipients were next asked to react to this question:

26. For licensed practitioners within your state, who do you feel should decide the basic policy regarding continuing education requirements (e.g., ASHA, the state association, your board, the legislature, your supervising agency, etc.)? (23 responses)

Nine board chairpersons specified that the board alone should determine the fundamental policy in connection with continuing education required

for state license renewal. However, four respondents saw this responsibility as belonging to the state association. Two informants asserted that the legislature should make decisions related to the underlying policy, with one replier stating that "no one but the General Assembly can set any policy regarding continuing education for licensees. . . . They made the law and they are the only ones who can amend it." A number of individuals indicated that several groups should share responsibilities in this area or that, while the board has primary responsibility, it should solicit input from other agencies. For example, three board chairpersons expressed the belief that the responsibility for deciding basic policy should rest with both the state association and the board, and two respondents suggested that while it is incumbent upon the board to render decisions in matters of this nature, the board should solicit advice from "all concerned groups" and other "professional organizations." A midwestern respondent observed that his board had wielded the decision making power in the establishment of criteria for continuing education in his state, but that information had been requested from ASHA and input sought from the state association. Another midwestern respondent replied "I would want ASHA to set broad general policies to encourage a national standard. The state association should provide input to the Board. At this point the Board has the responsibility as defined by law." Only one replier made reference to his board's supervisory authority, specifying that the state board licensing speech pathologists and audiologists in his state should control continuing education requirements for its licensees, and the board's supervisory authority should decide basic policy "for overall concepts." While the majority of

informants believe that it is solely or primarily the licensing board's obligation to resolve the question of continuing education within its state, a sentiment with which it is difficult to argue, there appears to be little concern for establishing policies and criteria which will provide consistency from state to state. Board chairpersons have indicated, in response to other questions, a need to disassociate their boards from ASHA and to use ASHA resources only sparingly. It seems unlikely, in the case of a question with this diversity of opinion, that any national standards for certification renewal set forth by ASHA will create a unanimity of continuing education requirements for state licensure. Regional meetings of board members may create some commonality of requirements, but it seems likely that the differences already noted in renewal standards from state to state (see Table VIII, page 197) will become greater with the addition of continuing education mandates.

Just how great a disparity might one expect to find among states with regard to continuing education requirements? To answer this question, board chairpersons were asked to provide input concerning the following question:

28. Defining one (1) continuing education unit as consisting of "ten (10) contact hours of participation in an organized educational experience under responsible sponsorship, capable direction, and qualified instruction" (Asha, September 1977, p. 613), how many units do you feel should be required for license renewal (please indicate the time span between renewals, e.g., 10 units per two years for renewal)? (12 responses)

Many respondents indicated some hesitancy in replying to this question, noting that they are undecided as to specified amounts of continuing education to be required or reporting that their board is currently

contemplating this same question. Below are listed the amounts of continuing education specified by the 12 respondents, progressing from the least amount to the greatest amount. Where biennial or triennial renewals were indicated, units of continuing education were reduced to yearly amounts to facilitate comparison.

1. 5 units per 3 years (1.67 units per year)
2. 4 units per 2 years (2 units per year)
3. 2 units per year
4. 2 units per year
5. 2 units per year
6. 2 units per year
7. 7 units per 3 years (2.33 units per year)
8. 2.5 units per year
9. 8 units per 2 years (4 units per year)
10. 9 units per 2 years (4.5 units per year)
11. 5 units per year
12. 15 units per 3 years (5 units per year)

Although responses to this question were received from only 12 of 31 board chairpersons, nevertheless, were each quantitative opinion presented above to be formally approved by the respective state board, licensees in the state with the greatest amount of continuing education needed for renewal would require three times the amount of those licensees in the state with the least amount of continuing education needed for renewal. It is likely that, had all state board chairpersons responded to this question, the difference noted would have been even greater. Hence, in answer to the question posed earlier

regarding the magnitude of disagreement on the issue of amounts of continuing education to be required, it can be said that the diversity of opinion seems sufficient to assure that an agreement resulting in relatively uniform standards from state to state is unlikely.

As an alternative to fulfilling rigid continuing education prerequisites for renewal of state licensure, it has been suggested by some individuals that an acceptable score on the National Examinations in Speech Pathology and Audiology (NESPA) in the practitioner's area of certification should attest to his continuing proficiency and should act to satisfy continuing education requirements for license renewal. In connection with the renewal of ASHA certification, ASHA's Committee on Continuing Professional Education had the following thoughts:

The national examinations are considered measures of knowledge that serve as the base for the provision of clinical services. The Committee is of the opinion that successful completion of the national examinations would indeed be an indication that an individual has maintained currency in knowledge related to clinical practice and that the national examinations are viable alternatives to measure involvement in continuing professional education. ("Proposed Plan of Continuing Education," 1977, p. 616)

In an effort to determine the reactions of state licensing board chairpersons to such a proposal relative to licensure rather than certification renewal, these individuals were asked:

27. Do you believe that a licensee in your state should be able to exempt himself/herself from the need to acquire continuing education units by resubmitting himself/herself for examination on the National Examination in Speech Pathology and/or the National Examination in Audiology and obtaining an acceptable score? (22 responses)

Reaction to such a proposal was generally negative, with only six of 22 respondents expressing basic approval of such an idea. The chairperson of the Iowa Board of Speech Pathology and Audiology Examiners reported

that an exemption similar to the one proposed above is currently included in his board's continuing education rules, however, other chairpersons expressed doubt that such an exemption would be incorporated in any criteria for continuing education adopted by their boards. One presiding officer commented that the NESPA is "a paper test and is insufficient evidence of clinical competence." Another negative informant added that she believes this examination is not designed to measure professional development. It appears the position that a written examination can adequately assess an individual's professional growth in a practical science is a tenuous one, and one which is likely to be in the minority for some time to come. If one believes that a professional will insure his own continuing education in his own areas of interest, then it is somewhat insulting and contradictory to ask such an individual to submit to continuous national examinations. If one believes that a professional will not insure his own continuing education, it would seem more expedient to focus attention on developing means by which it could be assured that the professional would acquire needed continuing education. Instituting successful completion of a written examination as an alternative does not seem germane to this goal.

In a final attempt to delve into the perplexing questions inherent in the establishment of continuing education, licensing board chairpersons were asked to assess the impact of continuing education upon their boards:

29. Would your present licensing board members be capable of absorbing the responsibilities of monitoring continuing education units and validating such units for license renewal? (23 responses) Would additional board members and/or funding be necessary? (23 responses)

Thirteen of the 23 replies received in answer to the first question revealed a belief that the state licensing board as it currently exists would be able to satisfactorily perform duties related to the board's continuing education responsibilities. All but two of these individuals disclosed that additional board members and/or funding would not be necessary. One of these two repliers noted that his board currently maintains continuing education requirements for state licensees, but that funding may have to be increased if responsibilities are to be met in the future. Ten informants indicated that they do not believe their board could presently assimilate the responsibilities of monitoring continuing education units and validating such units for license renewal. All of these ten respondents reported that additional board members and/or funding would be prerequisite to the successful undertaking of such tasks. On the basis of this question, it would appear that about half of the state boards licensing speech pathologists and audiologists view maintenance of a board regulated continuing education program as having sufficient impact to warrant alteration in board membership, board funding, or both.

Antitrust and Advertising. Analysis of Questions 30, 32, and 31

The application of federal antitrust statutes to occupational and professional licensing is a relatively recent event, and one which carries great import for both ASHA and the various state licensing boards. Codes of ethics which restrict competition will come under increasing federal scrutiny, and repercussions of these new judicial and legislative postures are likely to be felt at the level of state licensing.

Secondary results [of these new judicial decisions] are likely to focus on regulations of licensing boards for both hearing aid dealers and speech-language pathologists and audiologists. Regulations promulgated by those boards which unduly limit entry into the field, restrict advertising or limit competition in other ways may be subject to antitrust attack. However, if these provisions are contained in the actual statute as opposed to a regulation, an antitrust action will probably not be successful because it would be apparent that it is state policy ". . . to displace competition with regulation. . . ." ("Legal Developments -- Antitrust and Sunset Laws," 1979, p. 8)

In order to discover whether state boards licensing speech pathologists and audiologists are evidencing concern in connection with possible antitrust violations, and whether such boards are contemplating the integration of certain questionable regulations into law, responses were invited to the two questions specified below:

30. In an area such as advertising where no statutory provision may exist, will state licensing boards attempt to have existing board regulations inserted into statute in order to avoid antitrust violations? (15 responses) Do you see any particular regulations set forth by your licensing board which you feel might be subject to antitrust attack? (19 responses)

Eight of the 15 individuals providing a reply to the initial question indicated a belief that state licensing boards will engage in such attempts in an effort to forestall conflict with the Federal Trade Commission (FTC). However, only two of these responding chairpersons viewed any regulations issued by their boards as being susceptible to FTC disapproval. The chairperson of a northwestern board noted that the law in his state may need to be legislatively altered, as the current code of ethics opposes advertising. The presiding officer of another northwestern board disclosed that the code of ethics under which licensees in her state operate is modeled after ASHA's code, and board members in her state, as well as those in many other states, will be carefully monitoring the results of recent changes which ASHA

instituted in its code. Seven respondents anticipated few, if any, efforts by state boards to avoid antitrust difficulties in the manner outlined in the first question. It appears that, when confronted by regulations which may be in violation of antitrust rulings, a number of boards are electing to countermand such regulations rather than attempt to have them inserted into law. One chairperson reported "we have done away with all such provisions as recommended by our attorney" and another respondent disclosed "our board has revised our code of ethics statement on advertising in a manner similar to that of ASHA. We believe this statement is consonant with recent court rulings, and so does our attorney." The chairperson of a southern board responded to the question by observing that use of the ASHA issued Certificates of Clinical Competence to grant licensure without examination might elicit an unfavorable response from federal sources. Although more than half of the respondents replying to this question asserted a belief that state licensing boards would undertake to have selected existing board regulations introduced into law for antitrust purposes, evidence to this effect was not forthcoming. When each informant was asked if he recognized any specific board regulations which might be vulnerable to attack, only four affirmative replies were received. Not one of these four replies indicated that integrating a regulation into the licensing law appears to be the method of choice for avoiding possible antitrust difficulties. In the face of concern, state boards appear much more likely to rescind a regulation rather than attempt to continue it under statute.

In an effort to solicit further chairperson input related to antitrust and anticompetition, questionnaire recipients were asked:

32. Do you believe that there are sections of your state law or of regulations set forth by your board which, under present judicial interpretation, have an anticompetitive effect?
(20 responses) What are they and how should they be altered?
(1 response)

While these questions are similar in nature to the preceding one (i.e., Do you see any particular regulations set forth by your licensing board which you feel might be subject to antitrust attack?), they did provide informants an opportunity to comment upon statutory provisions, as well as board regulations, which might be perceived as anticompetitive in nature. Moreover, a distinction was made between "anticompetitive effect," with an emphasis upon statutory provisions and/or board regulations which, because of their possible anticompetitive nature, exert a particular influence upon licensees, and "anticompetitive attack," with an emphasis upon the properties of such provisions and/or regulations which determine the probability that such provisions and/or regulations will come "under fire" from federal sources. Thus, "anticompetitive effect" deals with output while "anticompetitive attack" deals with input. In answer to this question regarding the anticompetitive effect of portions of the state law or of board regulations, only one chairperson replied affirmatively. This individual disclosed that sections of his board's code of ethics dealing with advertising need to be modified. Another respondent, although answering negatively, asserted that the question of anticompetitive provisions or regulations deserves careful study and monitoring. The chairperson of a southern licensing board pointed out that the very

nature of licensure is to limit competition; this is inherent in regulation. The question to be asked, according to this respondent, is "does it unfairly, unreasonably limit it or only sort out competence and add protection to the public it serves." Finally, one informant chose to look at anticompetitive behavior as a recipient, indicating that restrictions placed upon licensed audiologists in his state relative to the dispensing of hearing aids without a hearing aid dispenser's license are most definitely anticompetitive. In summation, it appears that few state licensing boards are actively concerned with regard to antitrust violations. The few boards which evidence concern have already altered offending regulations or are in the process of doing so, and in every case except one this does not appear to involve legislative action.

The question of advertising was next introduced as licensing board chairpersons were asked:

31. Within your state, who should decide the basic policy with respect to advertising (e.g., ASHA, the state association, your licensing board, the legislature, your supervising agency, etc.)? (22 responses) Do you feel that restrictions on advertising should be relaxed? (20 responses)

Eleven informants, or half of those replying to the first question, signified without qualification that the state licensing board should determine advertising policy for licensees within the state. One such respondent succinctly revealed how he arrived at such a conclusion.

ASHA should not decide state policy. [The] state association is unprepared to handle such an issue. [The] licensing board is competent to handle it and the most likely place to do so. [The] legislature would handle only general policy as relates to all licensure -- not to just speech pathology and audiology licensure. [The] supervising agency [is] unlikely to take the responsibility.

Another replier indicated that "rules governing licensees are made by the board subject to review by the legislature and adjudication by the courts," while a third stated that his board "has adopted ASHA's Code of Ethics. Judgments of violations of that Code would be made by the licensing board." Five responding individuals speculated that policy in connection with advertising should not be made unilaterally by the board. The chairperson of a southern board asserted that, while the board should "carry the most weight," ASHA and the state association should be involved. Several other replies were almost identical to this one, with informants either indicating a board determination with association input or specifying joint responsibility for policy formation. The remainder of the responses to the first question disclosed a belief that the state association should formulate basic policy (2), the state legislature should set forth policy in law (2), the licensing authority should specify policy with board input (1), and each individual practitioner should decide his own policy (1). While the majority of board chairpersons polled viewed the board as having total, primary, or joint responsibility for the creation of advertising policy, an undercurrent of opinion exists which gives the licensing board no voice in the determination of such policy. When asked if restrictions on advertising should be relaxed, sentiment was strong in both directions. Nine replies asserted that such restrictions should be relaxed, eight replies expressed a belief that they should not be relaxed, and three responses noted that restrictions on advertising had already been relaxed or that such restrictions do not exist relative to board licensees. A negative respondent wrote,

"[state] rules require that a person conform to the highest professional standards in the community -- which is essentially no restriction if one follows the lawyers' examples." Obviously the issue of restrictions upon advertising is a polarizing one, to a minor extent in relation to the agency responsible for formulating such policy and to a major extent in relation to just what this policy should be. It is likely that continued FTC pressure will bear heavily upon what course of action will be taken by the states; however, such federal involvement is unlikely to alter opinions concerning what, if any, restrictions should be imposed.

Board Termination via Sunset Legislation. Analysis of Question 36

The possibility of termination through sunset review is one which many state licensing boards must examine (see Table XVI, p. 241). Consideration of the manner in which speech pathologists and audiologists would be regulated in the event of board termination, if indeed any regulation were present, is intriguing. Hence, licensing board chairpersons were asked to reflect upon the following hypothetical assumption:

36. Assuming that your state legislature were to terminate your licensing board (under sunset legislation), how would you suggest that the disciplines of speech pathology and audiology best be regulated within your state? (21 responses)

Responses to the preceding question showed interesting variation. Five informants felt that, were their board to be terminated, the state association would be in the best position to assume a regulatory function. One of these five respondents made specific reference to the standards section of his state association, while another replier

disclosed that he is not sure how his state association would undertake the functions vacated by the board. None of the five respondents indicated how regulation would be achieved or what degree of regulation could emanate from an organization without its regulatory powers established and defined in statute. Two individuals looked to ASHA for regulation of state practitioners, with one noting that "the only alternative [to board licensing] is voluntary certification through ABESPA." Three replies specified the use of a state agency in a regulatory capacity, with one respondent expressing a belief that regulation in her state "would be taken over by the Office of Public Instruction for school involvement and dropped for private." A second board chairperson perceived regulation as involving a registration system coordinated by the State Department of Health, and a third replier pointed out that regulation of state practitioners would still be a responsibility of the Department of Regulatory Agencies, only without the presence of a formalized licensing board. The presiding officer of a northern board viewed regulation as operating through "a coalition of 'interested organizations.'" Suggested organizations included OSHA, the organization of directors of university training programs, and the supervisors of school speech and hearing programs. The chairperson of a western licensing board asserted that regulation could best be accomplished by having the disciplines of speech pathology and audiology come "under the licensure of another compatible profession which would accommodate it." Two responding individuals saw no alternative but the inauguration of new licensing legislation resulting in reinstatement of the board, and two informants noted that

if state boards cannot convince legislators as to the efficacy of the board, then perhaps the board's existence as a regulatory agency cannot be justified. Peer pressure by means of a well-publicized committee was offered as a possible regulatory expedient by the chief officer of a midwestern board, and the chairperson of a neighboring state flatly asserted that "at this point there isn't a viable alternative." The respondent from a southern licensing board contested the assumption upon which the question was based.

The assumption is in error. The "sunset commission" is beginning review of our Board and has indicated that they intend to "tighten" our law considerably. They have even suggested that they are considering a proposal to the General Assembly to require that hearing aids be dispensed only under the prescription of an audiologist licensed by our Board. We don't think it will happen easily (without considerable fight from hearing aid dealers) but they are looking for measures to "protect the public" further.

Perhaps the concise reply of the chairperson from a large northern state best conveys the instantaneous, "gut level" response of many chairpersons to this question. When asked to project means for regulating the professions in the event of board termination, this individual simply replied, "God forbid." The diversity of responses to this question indicates not only that measures for regulating speech pathology and audiology might vary greatly from state to state in the event of massive board termination, but also that few respondents, having participated in state control "of one's own by one's own," are willing to retreat to the pre-licensing era of ASHA control. So strong is this sentiment that some informants suggested regulation by state agencies with no speech pathology/audiology representation, one suggested licensure under another profession, and several saw no

alternative but board reinstatement. It is apparent that chairpersons have no desire to relinquish control of state practitioners to ASHA in the event of board termination, even if such state control is "patchwork" and even if such control is exerted primarily by individuals outside the disciplines.

Degree Requirements and Specialty Certification/Licensure. Analysis of Questions 37, 38, and 39

Two areas of professional concern which have thus far received only cursory treatment are the areas of degree requirements and specialty certification/licensure. While the master's degree is required for speech pathology and audiology licensure in all 30 states having obtained licensure as of May 31, 1979, clinicians practicing in school districts are often not required to obtain a state license. Such individuals are issued certification or similar credentials by the state educational agency, with the stipulation that they obtain licensure if they engage in practice outside the public schools. In 1977, the states listed below required public school practitioners to hold a master's degree. As can be noted, a number of these states do not have a state licensing statute.

<u>Speech Pathology</u> (16)		<u>Audiology</u> (6)
Arizona	Kansas	Georgia (effective 1978)
California	Louisiana	Iowa
Colorado	Maryland	Louisiana
Connecticut	Montana	Maryland
Georgia (effective 1978)	Nebraska	Montana
Idaho	Vermont	North Dakota
Illinois	West Virginia	
Iowa	Wisconsin	

While many professionals in the disciplines of speech pathology and audiology have expressed the belief that public school speech and

hearing clinicians should be required to obtain the master's degree, a certain segment of the profession is also of the persuasion that the Ph.D. degree should be a prerequisite for the individual in private practice. To survey the opinions of licensing board chairpersons in connection with these proposed degree requirements, the following questions were asked:

37. Do you favor:

1. that the Ph.D. degree be required for the licensed speech pathologist/audiologist to engage in private practice? (20 responses)
2. that the master's degree be required for practitioners engaged in the practice of speech pathology/audiology in the public schools? (22 responses)

Only four of the 20 respondents replying to the initial question are of the conviction that the Ph.D. degree should be mandatory to engage in private practice. One negative informant stated his feeling that the Ph.D. degree is not a private practice degree, but rather a research degree. He continued by asserting that "Ph.D. training programs lead a person away from, rather than toward, success in private practice. A post-master's degree program aimed at preparation for private practice would be a poor Ph.D. program." Another chairperson disclosed that he favors inauguration of a clinical doctorate, although he did not indicate whether he believes that such a degree should eventually be mandatory for private practice. Unanimity of response was achieved with regard to the second question, as all 22 replies indicated agreement with the statement that the master's degree should be required for individuals practicing in the public schools.

Rapid growth in the disciplines under consideration, along with an outpouring of research data and the societal trend toward specialization of function, has caused observers both within and outside the professions of speech pathology and audiology to question whether it is theoretically possible for a person to be proficient in all areas of practice. Currently, a licensed practitioner is assumed to be competent to diagnose and remediate a variety of disorders. However, knowledge in each area of practice is increasing at such a rate as to make proficiency in a single area a lifetime's work. This is not to imply that many or most licensees currently holding general licenses do not recognize this problem and limit their practice to a specific population or populations. However, in an age of public accountability and public protection, licensing an individual to practice in areas where he is not competent, and then assuming he has the integrity and common sense not to wander into these areas where he has, in fact, a legal right to be, is unacceptable to many. Consequently, questionnaire recipients were provided the following information and asked to express their viewpoint:

38. Dr. Katharine G. Butler, in her Presidential Address (Asha, January 1979, p. 5) states that "in a recent study of Legislative Councilors, I found that a majority of the councilors wished to explore the matter of specialty certification." Which of the following best expresses your view with regard to specialty certification and/or licensing? (20 responses)

- | | |
|----------------|--|
| <u>4 (20%)</u> | 1. I am opposed to both specialty certification and licensing at this time. |
| <u>9 (45%)</u> | 2. I might favor some form of specialty certification under certain conditions, but not specialty licensing. |

- 5 (25%) 3. Rather than specialty certification or licensing, I would tend to favor a voluntary state registration of "specialists" who had met certain education, experience, and/or examination prerequisites.
- 2 (10%) 4. Provided certain conditions were met, I would endorse both specialty certification and specialty licensure.
- 0 (0%) 5. Other (please specify)

The number and percentage of informants answering in each category are delineated to the left of each of the five possible answers. One replying individual indicated both answer 2 and answer 3, and was not included in the tabulation of responses. The spread of responses over the five possible answers is evidence as to the lack of consensus concerning this question. Fifty-five per cent of those replying indicated they might endorse specialty certification or specialty certification and specialty licensing. However, informants were much more inclined to favor specialty certification without specialty licensing. A voluntary system of state registration was not well received, as only one-fourth of those replying reported they could support such a proposal. Few were opposed to all forms of specialty credentialing, including voluntary registration. One such individual noted that hers is a rural state and that "with major problems of geography -- specialty licensing would be madness. In this state, although there is board recognition, there are no specialty laws for physicians and dentists." Results from this limited sampling would seem to indicate sufficient support for the inauguration of limited specialty certification beyond the specialties of speech pathology and audiology already certified. Apparently ASHA has likewise perceived the

presence of such support, as indicated in the following passages from a letter written by ASHA President Norma Rees (November 5, 1979) to the Association's membership.

The proposal to establish a new certificate in language learning disorders is based on the rationale that members of our profession have been involved with language problems for many years and the time is appropriate to make available a form of recognition for such professionals. One only needs peruse the Association's journals and Convention programs to understand the many facets of language disorders with which our profession is concerned. The caseloads of many of our clinicians are filled with children having language learning problems. . . .

Despite the ever-broadening role of speech-language pathologists in the delivery of services to individuals with language disorders that has occurred during the last decade, a growing number of restrictions now are being imposed to alter that role. To a large extent, these restrictions have developed from differing views of the scope of practice defined by the Certificate of Clinical Competence in Speech Pathology. In ASHA's view, a wide spectrum of services to individuals with language disorders fall within that scope. . . . However, administrators who are responsible for the employment of personnel serving children with special needs (particularly personnel in the schools) are confused about the role of speech-language pathologists. . . . Increasingly, therefore, speech-language pathologists have been excluded from participation in programs where they once assumed major responsibilities.¹

At this writing, a decision regarding the proposal to establish a Certificate of Clinical Competence in Language Learning Disorders has not been rendered. Whatever the outcome of current deliberations by ASHA's Legislative Council, it seems likely that specialty certification will be instituted within the next several years.

¹Rees, N. Personal communication. November 5, 1979

Will specialty licensure follow? Although responses to the previous question revealed little enthusiasm for specialty licensure at this time, it should be remembered that national support was likewise weak when Florida, using essentially the same criteria for licensure as required by ASHA for certification, successfully attempted to become the first state to license the specialties of speech pathology and audiology. Is there reason to believe that this pattern should not be repeated? With this question in mind, the chairpersons of state licensing boards were asked:

39. Do you foresee the licensing of specialists in your state within the next decade? (20 responses) Assuming such specialty licensure did occur in your state, do you feel that your licensing board would be able to accommodate such with minor alterations or would specialty licensure result in massive changes in board composition, practice, and/or regulations? (14 responses)

Nineteen of the 20 individuals replying to the first question expressed a belief that the licensing of specialists would not occur within their states during the next ten years. Responses to the second question revealed that informants were evenly divided as to whether minor or massive changes would be required. It appears likely that state certification, or state acceptance of ASHA certification, will predominate during the early years of specialty credentialing. It is not difficult to envision, however, that at some point, through the process of professional identification, a strong cadre of individuals certified in a particular area will come to resent a certification law which regulates the use of their title but does not regulate the practice of their specialty as well. Herein lies the difference between a certification law and a licensure law (see p. 66 of this text). A similar situation to that described above is the counselor/psychologist conflict discussed

by Sweeney and Sturdevant (1974), Cottingham (1978), and others. Counselors, currently offering some services under long established psychology licensure laws, are beginning to realize that as a distinct professional entity they "can work toward identification of the counseling function and service as legally distinct from psychology licensure" (Cottingham, 1978, p. 331). It is certainly not beyond the realm of possibility that, a number of years hence, it will be written that "language pathologists, currently offering some services under long established speech pathology licensure laws, are beginning to realize that as a distinct professional entity they can work toward identification of the language remediation function and service as legally distinct from speech pathology licensure."

Conclusions

The preceding investigation presented a number of questions to the chairpersons of state boards licensing speech pathologists and audiologists. Many of these questions were gleaned from the observations of writers commenting upon certain aspects of general professional licensure as found in Chapter 2. Other questions were specific to the disciplines of speech pathology and audiology, and have only limited applicability to licensure in other professions or occupations. The nature of this survey was such that, while many spheres of concern were explored, an in-depth discussion of any particular area was not undertaken. The lack of published research relating to the numerous problems and issues touched upon herein creates a fertile environment for closer inquiry. Specific suggestions for such inquiry include:

1. analysis of how optional (voluntary) registration affects a state's ability to achieve eventual licensing legislation;
2. analysis of geographic factors in the determination of board composition, policy, and attitude;
3. analysis of problems affecting the board, board priorities, board attitudes, etc. as a function of the board's length of existence;
4. analysis of emerging trends and the projection of future trends (e.g., in board financing and in the assigning of supervisory authorities) as determined from a comparison of states achieving early licensure with those achieving later licensure;
5. analysis and substantiation of boards' areas of weakness as ascertained in this Chapter and promulgation of viable procedures for remediating such weaknesses;
6. analysis of the relationship between boards licensing speech pathologists and audiologists and the national association (ASHA) as opposed to the relationship between other professional licensing boards and their national associations;
7. analysis of the policies, problems, and attitudes of licensing boards in large states versus those in smaller states, and in states with many licensees concentrated primarily in urban areas versus states with fewer licensees located primarily in rural areas.

In addition, many of the questions examined in relative isolation throughout this investigation would benefit from cross-question analysis. For example, is a state which administers its own state licensing examination more likely to demonstrate independence and progressiveness in other areas?

Since conclusions drawn from responses to a particular question or questions are contained within the body of this study, such conclusions will not be reiterated here. A number of generalizations can be made; however, it should be remembered that any generalization may have

little relevance to the responses of a particular licensing board chairperson. Furthermore, a response from one member of a licensing board, albeit the chairperson, does not necessarily represent a consensus of board opinion. Nevertheless, it is believed that responses from state licensing board chairpersons, when viewed as a collectivity, should provide an indication as to general areas of board involvement, general board attitudes, and general board concerns.

If one allows oneself to look for a moment beyond the microcosmic world of the individual question dealing with the individual issue, it is often possible to perceive impressions which are derived from and buttressed by the results of various aspects of one's research. These impressions transcend determinations made or conclusions formed, yet are achieved from subconscious percolation of these very same determinations and conclusions.

One such impression received from an analysis of chairpersons' responses is that state boards licensing speech pathologists and audiologists are composed of well-meaning, overworked professionals (and sometimes public members) who are unabashedly practical and fiercely independent. Time does not permit these individuals the luxury of reflection upon hypothetical situations, evolving trends, or rhetorical questions as they go about the task of fulfilling board responsibilities. Furthermore, while it is true that many professional licensing boards may do nothing more than "incorporate the ethics, standards, and particular interests of private associations into administrative regulations and thus give the status of public law to essentially private rules" (Council of State Governments, 1952, p. 4), state boards regulating the professions in question have shown an

inclination to develop more fully and in other directions. With consideration to the relatively brief existence of most of these licensing boards, accomplishments have been many. This is perhaps partially due to the fact that board members are too busy with a myriad of professional responsibilities to realize that what they must accomplish, in the time which they can allot for such accomplishment, is clearly impossible.

A second impression received from an amalgamation of thoughts relative to board performance is that errors of omission, as opposed to errors of commission, account for the majority of board inadequacies. Again, time limitations, inexperience, and the part-time status of board members may create omissions in areas such as enforcement, information sharing, and construction and implementation of special programs. These types of omissions give the impression of cautiousness and conservatism. However, research such as that summarized in Chapter 2 reveals that acts of commission, e.g., the creation of artificial barriers to licensing and the establishment of excessive obstacles to licensee mobility, are viewed more critically by investigators than are acts of omission.

A third impression is that state boards licensing speech pathologists and audiologists fail in many respects to satisfy the professional licensing board stereotypes presented in Chapter 2. One example of this is the reported lack of speech pathology/audiology licensing board underfunding. This underfunding was a situation which Warnath (1978) and others found to be commonplace among professional licensing boards. Moreover, contrary to assertions by Barron (1966), Gilb

(1966), and Schorr (1977) regarding the tremendous influence which private professional associations have over licensing boards, such does not seem to be the case in the professions under discussion. While it is true that most speech pathology and audiology board members grew together professionally within the confines of ASHA, many board members manifest a conscious desire to demonstrate their board's autonomy from ASHA. Additionally, a number of board members apparently have not forgotten that period of time when ASHA refused to support state licensure (see Chapter 3), and to accuse ASHA of wielding tremendous influence with these individuals relative to state licensure would be ludicrous. Finally, public representation on speech pathology and audiology licensing boards appears to be taking place without the turmoil and "gnashing of teeth" which reportedly has occurred on other professional licensing boards. Whether the humanitarian disposition of the professions under consideration is to blame for failing to uphold the stereotype, or whether the purported hullabaloo had somewhat quieted by the time most licensing boards in these professions had been faced with the question of such representation, is unknown. Whatever the reason(s), the infiltration of the lay public into speech pathology and audiology licensing boards appears to be progressing, although slowly, with the backing of a large majority of board chairpersons.

Ultimately, the question of how to regulate the professions, as pointed out previously, has been given by the state to the professions themselves. The state mandates and monitors, provides structures and strictures, yet only the grossest abuses have been dealt with by termination of a profession's privilege to self-rule. Recent extensive

criticism has prompted a widespread investigation of the practices employed by boards regulating the professions, and the resulting censure has caused a revival of discussion related to regulatory alternatives to licensure. A major purpose of this dissertation was to examine, in the light of literature pertaining to professionalism and general professional regulation, the efficacy of licensing in the professions of speech pathology and audiology. This was accomplished by means of reviewing the history of licensure in these professions, by means of comparing and contrasting state licensing legislation, and by means of analyzing responses to a comprehensive questionnaire dealing with various aspects of licensure. Despite the inadequacies inherent in the licensing process and the abuses to which such a system lends itself, there appears to be no current alternative which provides the benefits of licensure with a lower potential for abuse. It is a credit to the professions of speech pathology and audiology that a careful investigation of licensure in these disciplines serves to reinforce the argument that a profession can, within certain limits, regulate itself to the benefit of all concerned.

APPENDIX A
EXPLANATORY LETTER
AND QUESTIONNAIRE

(Name and Address
of Chairperson)

Dear (Name of Chairperson):

Enclosed is a questionnaire which examines some of the practices, problems, and perceptions of the 30 licensing boards operating in the areas of speech pathology and audiology within the United States. The results of this questionnaire will be analyzed and reported in a doctoral dissertation which is investigating certain aspects of professional licensure in general and licensing of speech pathologists and audiologists in particular. Unlike many studies wherein it is possible to mail several hundred questionnaires while expecting and being satisfied with only a 50 percent reply rate, the fact that the number of questionnaires which can be distributed for this study is limited by the number of licensing boards in our field places an extremely high value upon each questionnaire. Consequently, your input with regard to the operation of (name of state licensing board agency inserted here) and your opinions concerning some of the issues which affect or may ultimately affect the licensing of speech pathologists and audiologists in the state of (name of state) is of great interest to me.

Therefore, I earnestly ask that you take the time necessary to answer this questionnaire and return it to me in the enclosed, postpaid, self-addressed envelope. In the interest of your time, most of the questions can be answered by simply checking "yes" or "no." However, additional space has been provided for any qualifications or expansions which you might care to provide. Your comments will be most appreciated. If you cannot answer a particular question, it would be most helpful if you could briefly specify your reason(s) for not responding to that question (e.g., "no statistics kept in this area," "am not familiar with the concept addressed by the question," "have no opinion in this area," "question is vague," etc.).

May I thank you in advance for your time and effort, and assure you that data obtained from each returned questionnaire will be analyzed and reported in such a way as to assure the anonymity of a particular respondent. If for some reason you are unable to complete this questionnaire, please forward it to another speech pathologist or audiologist who is currently serving on your board. Please return the completed questionnaire by July 13.

Again, my sincere thanks for your help.

Sincerely,

Frederick R. Heitman, M.A., C.C.C.-S.P.

Approved by:

Thomas B. Abbott, Ph.D.
Supervisory Chairperson

QUESTIONNAIRE
Regarding Licensure in
Speech Pathology and Audiology

State of _____

Directions: Please answer the questions as specified below. If for any reason you are not able to answer a question, it would be most helpful if you would indicate your reason for not answering it (e.g., "do not understand question," "am unfamiliar with the concept of _____ as related in the question," "statistics are not kept by our board with regard to _____," etc.)

Questions

1. If an individual is licensed in speech pathology and/or audiology in your state but is not a member of the state's professional association, are there any means by which the individual can be included in consideration for board membership?

Yes _____ No _____

If yes, what are these means by which a person can be considered?

2. What, if any, steps have been taken to assure that board membership represents an adequate cross-section of professional job settings within the disciplines of speech pathology and audiology?

3. What would be your "idealized" board composition? That is, if board composition was left to your discretion, what idealized composition (not taking into account the personalities or competencies of those currently serving on the board) do you see as best achieving the board's goals and best fulfilling the board's duties?

4. Does your board undertake special efforts to obtain public representatives (advocates, consumers, etc.) for participation at legislative hearings or at hearings for proposed rule changes?

Yes _____ No _____

Have such efforts on the part of your board been successful?

Yes _____ No _____

5. If your board currently has a public representative(s) serving, do you feel that this member(s) has significantly contributed to the operation of the board or has served in more of an "observer" capacity?

_____ Significantly contributed

_____ More of observer

Comment:

6. Do you agree with mandatory inclusion of one or more public representatives on speech pathology/audiology licensing boards?

Yes _____ No _____

7. Which of the statements below best typifies your feelings with regard to ASHA's role in establishing and maintaining your state licensing board?

_____ 1. ASHA was instrumental in helping us to establish our board and has been very valuable in providing us with information relative to maintaining/improving our board.

_____ 2. ASHA was instrumental in helping us to establish our board, but has played a relatively minor role (or no role) relative to maintaining/improving our board.

_____ 3. ASHA was not instrumental in helping us to establish our board, but has been valuable in providing information relative to maintaining/improving our board.

_____ 4. ASHA was not instrumental in helping us to establish our board and has played a relatively minor role (or no role) relative to maintaining/improving our board.

8. Are you in favor of the proposed creation of a national organization consisting of licensing board members (or board representatives) from state speech pathology/audiology licensing boards?

Yes _____ No _____

If not, why? If so, do you have any reservations about such an organization?

9. Has your state promoted any activities designed to bring together members of different state licensing boards within your state in an effort to designate common problems and discuss possible solutions?

Yes _____ No _____

If not, do you believe such a meeting would have merit?

Yes _____ No _____

10. Is your licensing board financed solely through the fees which are collected for license application, issuance, and renewal?

Yes _____ No _____

If not, what was the amount that your state legislature budgeted for your board's operation during 1979 (or for fiscal year 1978-79)?

11. Does your board have its own budget with board control or is there a hierarchy of control?

_____ Board has own budget

_____ Hierarchy of control

If the latter is true, does the withdrawal of funds require a special appropriation act by the legislature despite the fact that the legislative appropriation may equal the amount deposited?

Yes _____ No _____

12. In your opinion, is your licensing board currently underfunded?

Yes _____ No _____

13. If you believe your licensing board to be currently underfunded, in what areas (e.g., distribution of information, enforcement of statutes, make-up and administration of examinations, etc.) do you feel such underfunding has curtailed your services?

14. If your board is autonomous (no supervising agency), do you feel that increased centralization would provide more benefits to your board than liabilities?

Yes _____ No _____

If your board is operating under a basically centralized system, do you believe that more autonomy would better enable your board to perform maximally?

Yes _____ No _____

15. With regard to the duties performed by your licensing board, what are the approximate percentages of time spent in discussing or actively pursuing fulfillment of these duties?

- _____ % enforcing licensing statutes and investigating alleged violations
- _____ % conducting hearings, suspending, revoking, and restoring licenses
- _____ % promulgating and monitoring specific board regulations
- _____ % examining or otherwise determining the eligibility of applicants for licensure
- _____ % completing and maintaining efficiently organized and easily retrievable records
- _____ % issuing licenses and collecting fees
- _____ % public relations
- _____ % answering correspondence and disseminating information
- _____ % Other (Please Specify) _____

16. Below are listed a number of possible duties to be performed by licensing boards. In column one, please rank the importance of these duties as you view them in carrying out the purposes for which your board exists. Rank the most important duty as number one (1). In column two, please rank the duties in terms of your board's ability to complete them. Rank that duty which you believe is fulfilled to the greatest extent as number one (1). You may, if you believe that several duties are completed to an equal extent, use the same number more than once.

Col. 1 Col. 2

		1. enforcing licensing statutes and investigating alleged violations
		2. conducting hearings, suspending, revoking, and restoring licenses
		3. promulgating and monitoring specific board regulations
		4. examining or otherwise determining the eligibility of applicants for licensure
		5. completing and maintaining efficiently organized and easily retrievable records
		6. issuing licenses and collecting fees
		7. public relations
		8. answering correspondence and disseminating information
		9. Other (Please Specify) _____

17. Has your state board taken any steps to remove barriers to mobility that are not directly related to competence (e.g., age, residency, citizenship, good moral character)?

Yes _____ No _____

If so, what steps have been taken?

18. If your licensing board administers a state examination which may be taken by the applicant in lieu of the national examination for certification, what percentage of those obtaining licensing in your state do so by taking your state examination rather than the national exam?

_____ %

What percentage of those taking your state exam pass?

_____ %

19. Does your state licensing board make an effort to inform applicants who fail your state licensing exam as to their areas of weakness?

Yes _____ No _____

How is this accomplished?

20. Does your board use any special techniques to facilitate communication with the public (such as 800-number telephone lines)?

Yes _____ No _____

If yes, please state techniques employed.

21. Does your licensing board furnish a pamphlet or brochure to an inquiring applicant which explains in "layman's terms" the licensing requirements, procedures, regulations, cost, etc. or does your board send a copy of the applicable portion of the state statute to the applicant?

_____ Furnish a pamphlet or brochure

_____ Send a copy of applicable portion of statute

_____ Other (Please Specify) _____

22. What is (are) the primary reason(s) for the revocation of licenses issued by your board? What types of grievances does your board hear? What is being done to insure due process? Do you feel your procedures for policing board regulations and state mandates are sufficient?

Primary reasons:

Types of grievances:

What being done:

Procedures sufficient?:

23. What percentage (or what number) of the licenses which you have issued since your board's inception have been revoked? What percentage (or what number) have been suspended? What is the total number of initial (not renewal) licenses which have been issued by your board?

_____ percentage (or number) of licenses revoked

_____ percentage (or number) of licenses suspended

_____ total number of initial licenses issued
(number up until what date? /79)

24. Does your licensing board have access to the use of a state attorney?

Yes _____ No _____

If so, has your board needed to use his/her services?

Yes _____ No _____

For what reason(s)?

25. Do you believe that some type of mandatory continuing education credits should be required to maintain continuing ASHA certification?

Yes _____ No _____

Do you believe that some type of mandatory continuing education credits should be required to be eligible for re-licensure in your state?

Yes _____ No _____

25. (continued)

If not, would you favor voluntary continuing education with your state licensing board maintaining a register of those submitting valid continuing education credits?

Yes _____ No _____

26. For licensed practitioners within your state, who do you feel should decide the basic policy regarding continuing education requirements (e.g., ASHA, the state association, your board, the legislature, your supervising agency, etc.)?

27. Do you believe that a licensee in your state should be able to exempt himself/herself from the need to acquire continuing education units by resubmitting himself/herself for examination on the National Examination in Speech Pathology and/or National Examination in Audiology and obtaining an acceptable score?

Yes _____ No _____

28. Defining one (1) continuing education unit as consisting of "ten (10) contact hours of participation in an organized educational experience under responsible sponsorship, capable direction, and qualified instruction" (Asha, September 1977, p. 613), how many units do you feel should be required for license renewal (please indicate the time span between renewals, i.e., 10 units per two years for renewal)?

_____ units per _____ year(s)

29. Would your present licensing board members be capable of absorbing the responsibilities of monitoring continuing education units and validating such units for license renewal?

Yes _____ No _____

Would additional board members and/or funding be necessary?

Yes _____ No _____

30. In an area such as advertising where no statutory provision may exist, will state licensing boards attempt to have existing board regulations inserted into statutes in order to avoid antitrust violations?

Yes _____ No _____

Do you see any particular regulations set forth by your licensing board which you feel might be subject to antitrust attack?

31. Within your state, who should decide the basic policy with respect to advertising (e.g., ASHA, the state association, your licensing board, the legislature, your supervising agency, etc.)?

Do you feel that restrictions on advertising should be relaxed?

Yes _____ No _____

32. Do you believe that there are sections of your state law or of regulations set forth by your board which, under present judicial interpretation, have an anticompetitive effect?

Yes _____ No _____

What are they and how should they be altered?

33. Perhaps you are aware of the National Commission for Health Certifying Agencies which was established in December, 1977. This Commission is a voluntary, non-governmental organization which grants recognition to certifying agencies in the public interest. At the time of its inception, this Commission was comprised of 65 contributing organizations. Purposes of the Commission include:

1. to promote public health and safety through the certification process,
2. to develop and encourage high standards of professional conduct among certifying agencies,
3. to recommend methods for assuring competency after initial certification,
4. to encourage and facilitate the development of common and/or collaborative programs within a profession.

The American Speech-Language-Hearing Association is currently not a member of this Commission. From your knowledge of this Commission, do you favor ASHA's participation?

Yes _____ No _____

If so, what effect do you envision?

34. Do you believe that the responsibility for accrediting programs in speech pathology/audiology within your state should rest with the state licensing board rather than with ASHA and/or regional accrediting bodies?

Yes _____ No _____

What responsibilities, if any, do you view a state licensing board as having with regard to accreditation?

35. Do you feel that other state boards in your state have restricted the ability of speech/language pathologists and/or audiologists to "compete" in serving the communicatively handicapped?

Yes _____ No _____

If so, which state boards might these be and what problem areas exist?

36. Assuming that your state legislature were to terminate your licensing board (under sunset legislation), how would you suggest that the disciplines of speech pathology and audiology best be regulated within your state?

37. Do you favor:

Yes ___ No ___ that the Ph.D. degree be required for the licensed speech pathologist/audiologist to engage in private practice?

Yes ___ No ___ that the Master's degree be required for practitioners engaged in the practice of speech pathology/audiology in the public schools?

38. Dr. Katharine G. Butler, in her Presidential Address (Asha, January 1979, p. 5) states that "in a recent study of Legislative Councilors, I found that a majority of the councilors wished to explore the matter of specialty certification." Which of the following best expresses your view with regard to specialty certification and/or licensing?

- _____ 1. I am opposed to both specialty certification and licensing at this time.
- _____ 2. I might favor some form of specialty certification under certain conditions, but not specialty licensing.
- _____ 3. Rather than specialty certification or licensing, I would tend to favor a voluntary state registration of "specialists" who had met certain education, experience, and/or examination prerequisites.
- _____ 4. Provided certain conditions were met, I would endorse both specialty certification and specialty licensure.
- _____ 5. Other (Please Specify) _____

39. Do you foresee the licensing of specialists in your state within the next decade?

Yes _____ No _____

Assuming such specialty licensure did occur in your state, do you feel that your licensing board would be able to accommodate such with minor alterations or would specialty licensure result in massive changes in board composition, practice, and/or regulations?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. RESPONDENTS WILL BE NOTIFIED AT THE CONCLUSION OF THIS STUDY WITH RESPECT TO THE AVAILABILITY OF THIS DATA VIA INTERLIBRARY LOAN.

APPENDIX B

STATE LICENSING AGENCIES REPRESENTED BY QUESTIONNAIRE RESPONSES

Questionnaires received from chairpersons of the following state licensing agencies were utilized in this study.

Board of Examiners for Speech Pathology and Audiology P. O. Box 5198 Little Rock, Arkansas 72205	Speech Pathologists & Audiolo- gists Examining Board State Department of Health Lucas State Office Building Des Moines, Iowa 50319
Speech Pathology and Audiology Examining Committee Board of Medical Quality Assurance 1430 Howe Avenue Sacramento, California 95825	Board of Examiners of Speech Pathology & Audiology P. O. Box 456 Frankfort, Kentucky 40601
Advisory Council on Speech Pathology and Audiology State Dept. of Health Room 624, R 7051 79 Elm Street Hartford, Connecticut 06115	Louisiana Board of Examiners for Speech Pathology & Audiology Louisiana State University Medical Center 1100 Florida Avenue, Bldg. 163 New Orleans, Louisiana 70119
State Board of Examiners for Speech Pathology & Audiology Suite 236 Jesse S. Cooper Memorial Bldg. Dover, Delaware 19901	Board of Examiners on Speech Pathology and Audiology Dept. of Human Services Statehouse Augusta, Maine 04333
Department of Education Teacher Certification Section Room 452 Tallahassee, Florida 32304	Board of Examiners in Speech Pathology 301 W. Preston Baltimore, Maryland 21201
Georgia Board of Examiners for Speech Pathology & Audiology 166 Pryor Street, S. W. Atlanta, Georgia 30303	Board of Examiners in Audiology 301 W. Preston Baltimore, Maryland 21201
Board of Speech Pathology & Audiology Department of Regulatory Agencies 1010 Richards Street Honolulu, Hawaii 96813	The State Board of Registrants for the Healing Arts 3523 North Ten Mile Drive Jefferson City, Missouri 65101

APPENDIX B

continued

Board of Speech Pathology &
Audiology
Department of Professional and
Occupational Licensing
LaLonde Building
Helena, Montana 59601

Board of Examiners in Audiology
and Speech Pathology
Bureau of Examining Boards
Department of Health
P. O. Box 95007
Lincoln, Nebraska 68509

State Education Department
Division of Professional
Licensing Services
99 Washington Avenue
Albany, New York 12230

Board of Examiners for Speech and
Language Pathology and Audiology
P. O. Box 5545
Greensboro, North Carolina 27403

Board of Speech Pathology and
Audiology
65 South Front Street
Room 214
Columbus, Ohio 43215

Board of Examiners in Speech
Pathology and Audiology
1400 S.W. 5th Avenue
Portland, Oregon 97201

Board of Examiners in Speech
Pathology and Audiology
Professional Regulation
Department of Health
75 Davis Street
Providence, Rhode Island 02908

South Carolina Board of
Examiners in Speech Pathology
and Audiology
Box 11876
Columbia, South Carolina 29211

State Board of Examiners for
Speech Pathology & Audiology
Department of Public Health
352 Capitol Hill Building
Nashville, Tennessee 37219

Licensing Committee for Speech
Pathology and Audiology
c/o Director of Registration
Dept. of Business Regulation
330 E. 400 South Street
Salt Lake City, Utah 84111

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BIOGRAPHICAL SKETCH

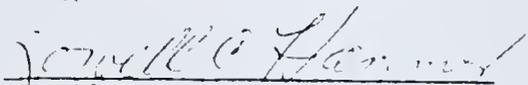
Frederick R. Heitman was born June 28, 1946, in Brooklyn, New York. At the age of six he moved to Plymouth Meeting, Pennsylvania, where he remained until his matriculation at the University of North Carolina (Chapel Hill) in 1964. He was graduated Phi Beta Kappa from this university in June of 1968, with an A.B. degree in Speech Education. He worked as a speech improvement clinician for the Chester School District of Chester, Pennsylvania, and in March of 1969 was married to the former Atha Elaine Mullis. In 1971, he became the speech pathologist for Melmark Home, Inc. of Berwyn, Pennsylvania. He remained in this position until September 1972, at which time he entered the graduate school of the University of Florida in pursuit of the Master of Arts degree in speech pathology. This degree was awarded in August of 1974. Following receipt of this degree, the author commenced doctoral studies at the University of Florida. In June 1975, he returned to the Melmark Home as Chief Speech Pathologist. He held this position until May 1977, at which time he returned to the University of Florida to complete the requirements for the Doctor of Philosophy degree.

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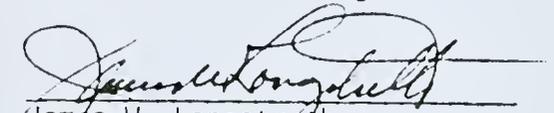
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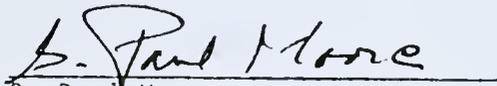
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