

Why Establish a Certification System for Professional Counselors? A Rationale

JAMES J. MESSINA

Since 1970 the Department of Health, Education, and Welfare has been investigating the entire field of certification and licensure of health-related professionals. A final report of their findings resulted in the creation of the National Commission of Health Certifying Agencies. HEW studies and the guidelines of the new commission are the background reviewed in this article, providing the rationale for the establishment of national certification procedures by AMHCA.

The American Mental Health Counselors Association has announced the implementation of a national certification program for professional counselors (AMHCA 1979). In establishing a Board of Certified Professional Counselors, the field of counseling has taken a giant step toward its own professionalization. But many counselors are confused. Some wonder what the advantages of certification are over those of licensure. Others are concerned that counselors might be following the lead of other mental health professionals in establishing a "clubby guild system" (Arbuckle 1977). Still others ask, why credential counselors at all? (Gross 1977). The intent of this article is to address some of these questions and to make a case for certification.

Since 1970, the U. S. Department of Health, Education, and Welfare has been investigating professional credentialing in health-related fields (HEW 1971). A final report of its findings (Cohen 1977) recommended instituting a voluntary network of certification. This recommendation has resulted in the establishment of the National Commission for Health Certifying Agencies (Piemme 1977). The research leading to the setting up of this commission and its guidelines for certification bodies (National Commission 1977) was the foundation on which

James J. Messina, the President of AMHCA, 1978-79, is an Associate Professor and Project Director at the Florida Mental Health Institute in Tampa.

the AMHCA credentialing effort is based. The following is a review of the literature related to these efforts. Before we can discuss professional certification, however, we must have a common understanding of profession.

WHAT IS A PROFESSION?

Peterson (1976) defined the conditions that any group must meet if it is truly to be a profession:

1. The objectives of professional work are definite and immediately practical.
2. Educationally communicable techniques for the attainment of these objectives are available.
3. Applications of techniques involve essentially intellectual operations and practitioners exercise responsible discretion in matching techniques to individual problems.
4. Techniques are related to a systematic discipline such as science, theology, or law whose substance is large and complex and hence ordinarily inaccessible to laymen.
5. Members of the profession are organized in some kind of society with rules for membership and exclusion based in part on professional competence.
6. The aims of the professional organization are at least in part altruistic rather than merely self-serving, and entail a code of ethics whose sanctions are also invoked, along with those of competence, in determining membership in the society and therefore legitimate practice of the profession. (Peterson 1976, p. 573)

Sweezy (1974) posited that a profession is characterized as resting on a systematic body of knowledge of substantial intellectual content, which involves the acquisition of skills for application of this knowledge to specific cases, and that it has standards of professional conduct that override goals of personal gain established with its means for the enforcement of standards and the advancement of knowledge.

Credentialing provides the instrument for enforcement of professional standards. Professional counseling has not defined itself as a profession with recognized and measurable competencies. Its efforts in the licensure and certification areas are an attempt to rectify the lack of credentialing procedures. Before this issue can be addressed, it will be necessary to share a common vocabulary.

DEFINITIONS OF TERMS

The following definitions are used by the AMHCA Certification Committee. These were developed by the HEW Subcommittee on Health Manpower Credentialing, chaired by Harris S. Cohen (Cohen 1977).

Credentialing, the accreditation of individuals, is the formal recognition of professional or technical competence. It is a generic term referring to both the process of certification and of licensure.

Licensure is the process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have obtained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Certification or registration is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. Such qualifications may include (a) graduation from an accredited or approved training program; (b) acceptable performance on a qualifying examination or series of examinations, and/or (c) completion of a given amount of work experience.

Cohen (1977) has discussed three possible forms of examination used in issuing credentials:

A *certification examination* (a licensing examination), which is developed and used under private auspices to determine the level of competence of practitioners in a specific occupation. These are, in essence, qualifying examinations concerned primarily with entry into the occupation.

A *proficiency examination*, which is used to determine the level of proficiency of practitioners, with opportunity for those whose competency is based primarily on on-the-job training and experience.

An *equivalency examination*, which is used to determine the value of experience in nonaccredited education in meeting education requirements under accredited programs.

There is a need for an equitable integration of all three forms of examinations with a certification or licensing process so as to avoid any discriminatory barriers. Now that terms are defined we need a historic perspective in which to place them.

CRITIQUE OF STATE-OF-THE-ART CREDENTIALING

John F. Adkinson (Bureau of Health Resources Development 1975, p. 28) stated:

Health service without competence is basically no health service at all. There is only one way for assuring the general public of competence in the health field, whether referring to health professionals or related allied health personnel, and that is through credentialing or licensing of individual participants. Credentialing encompasses, among other things 1) formal education in an accredited institution, 2) examination by

a duly designated body be it governmental or private in nature, 3) internship, 4) continuing education, 5) renewal of credentials.

Tucker (1975, p. 3) summed up the three reasons for credentialing:

1. To protect the public and provide for quality health care delivery through regulation and control (the degree of which varies depending on the mode of credentialing) of the performance of the practitioners
2. To determine the qualifications for entrance into a profession and
3. To protect the profession and the professionals themselves

Goldberg (1974), however, stated that licensure was not fulfilling the function of protecting the public from unqualified practitioners. He saw it as imposing on health-related personnel unnecessarily difficult requirements, and curtailing the scope and function of such personnel. He concluded that meaningful standards for licensure are not necessarily set, which causes fragmentation of health careers by prohibiting the coordination of interrelated allied health personnel within career lines, and thus contributes to underuse of health manpower through narrow statutory definitions of the scope of functions.

Conant and Hatch (1974) found that attention given to credentialing practices was a result of increased demands for health services, public concern regarding perceived manpower shortages, inefficient use of health manpower, questionable quality of services, and higher costs. Ballanger and Estes (1971) described the disadvantages of licensure. First, licensure provides no real guarantee of the quality or professional acceptance of the group licensed. It is questionable whether substantial quality control can be exerted by an administrative board that has only intermittent contact with the practitioners it licenses. Second, licensure requires a description of the activities and functions of the designated profession. If these are precisely delineated new tasks or responsibilities, they cannot be assumed without a change in the law, which may entail prolonged and costly delays. If they are loosely or vaguely defined, nonuniform interpretation of the bounds of the profession, with consequent legal uncertainties, results. Last, licensure can become a weapon with which a given profession, jealously guarding its boundaries against encroachment, can frustrate reasonable accretion of its preempted duties by other groups over time.

Forgotson and Raumer (1968) warned that professional licensure laws do not often recognize that development of new information renders a person's initial qualifications obsolete unless they are upgraded periodically by continuing education.

In the 1971 HEW report, states were urged to observe a two-year moratorium on the enactment of legislation. The states were also urged to adopt and fully use national examinations for those categories of health personnel for which examinations were available. At the close of

the two-year moratorium, a second report (Cohen & Miike 1973) listed preliminary findings and conclusions since the initial report. As a result, HEW requested an additional two-year moratorium on the establishment of more licensure legislation.

In 1973 certain trends were identified that have a bearing on the national certification and licensure issues (Goldberg 1974). Most new legislation that year did not leave the approval of accreditation of schools up to the various boards. Instead, it deferred such decisions to the national organization of the occupation in question. Some states were concerned with making their educational requirements conform to standards set by professional associations and with the possibility of accepting national examinations in lieu of their own state examinations. Some legislation was proposed to replace the licensure requirement of the state board with certification by some national board or association. States were increasingly accepting national examinations and certification in place of their own work, and some legislation was passed providing for this substitution.

Mehringer's (1975) analysis of the 1974 licensure legislation pointed to a significant result of that year's legislation—Virginia's attempt to coordinate all licensure procedures. The Virginia legislature created a Commission for Professional Occupational Regulation. The Commission evaluates professions and occupations not currently regulated, and determines whether they should be regulated. Through such a commission, Virginia became one of the few states to establish the goal of consistency and cooperation among its regulating boards. (It should be noted that only Virginia allows counselors to be licensed as a result of a public law enacted in 1977.)

There has been no further analysis by the Department of Health, Education, and Welfare of manpower licensure legislation activities for the years since 1974; however, the early trends identified a need for closer coordination and consistency among the regulatory boards, and for the identification of national-level standards, especially in the examinations of such professions. Also recommended was research into alternate forms of credentialing other than licensure.

INSTITUTIONAL LICENSURE: AN ALTERNATIVE?

An alternate form of credentialing, institutional licensure, was investigated by Starrer, Rose, and Saltzberg (1976). In this process, the institution would establish a committee to define jobs within the institution, set standards required to fill those jobs, develop entry evaluation procedures, evaluate candidates for employment, develop performance evaluation procedures, set standards for maintenance of and promotions in job status, evaluate employees periodically, issue certificates of

job status of employees, and establish educational and training requirements necessary to meet standards for entry, maintenance, and promotion. The committee created to fulfill these tasks could be adapted within existing institutional committee structure, but would include an expert (or a consultant to the committee) in functional task analysis, and would require necessary clerical staff to maintain records. The institution would submit its procedures and ratings to a state monitor composed of the state licensing board and representatives from various health disciplines. The duties of the state monitor would be to establish minimum standards for utility and validity of the processes for use by the committees, approve the processes adopted by each committee, issue certificates of process-approved-status to institutions that meet minimum standards, approve certificates of job status granted to individuals employed within the institution, and make recommendations to the department of education in regard to health-related formal education programs in the state.

The conclusion of the Starrer et al. report was, although it seemed feasible to employ institutional licensure, that the political realities were such that it would be impossible to recommend a national adoption of such a model. Tucker (1975) concurred in his report, where he stated, "Although theoretically feasible it was concluded that the numerous political, technical and social problems which are identified cannot be surmounted to make implementation of institutional licensure feasible" (p. iii). With this alternative discounted, another type of national initiative in credentialing was needed.

ADVANTAGE OF NATIONAL CERTIFICATION PROCESSES

Sweezy (1974) stated that a system of certification that is voluntary is compatible with three important philosophical premises:

1. Certification is a validation of individuals' capacities and must be consistent with the concepts of individual freedom embodied in our national tradition and law.
2. Egalitarian societies reached their necessary balance and control by successive undercontrolling the actions, rather than over controls applied by authoritarian societies. Voluntary action by associated citizens is always preferable to compulsory action if the public interest is adequately protected.
3. The classic law of conservation, which holds that the best solution to a problem is that which requires the least force. (Sweezy 1974, p. 28)

Certification provides evidence of a level of competence defined by the profession as a national standard for practitioners of occupations. Sweezy pointed out that "reliance upon educational records confuses evidence of scholastic performance with job skill. Scholastic credentials attest to performance of a number of separate units of education,

but they are not necessarily evidence of an integrated mastery of a complex set of knowledges and skills," and that "the educational credential progressively loses its relevance as time elapses after graduation. It does not match certification and capability to attest to the maintenance of continuing competence after completion of formal accredited educational programs" (p. 31).

Sweezy found that licensure is limited in value in that it defines a minimum level of competence rather than the highest level of competence possessed by the licensed, and that it has been adopted in some occupations as a vehicle for restricting entry mobility to protect the economic interest of licensed resident practitioners. On the other hand, he observed that certification systems are capable of showing both the breadth and depth of competence, differing from the minimum levels established by a state as requirements for licensing. Certification is also capable of doing so without geographic limitations.

Movement from one locale to another for personal preference or labor market efficiency, which is essential in a free labor market, is restricted when prospective employers have no readily available means for establishing the type and level of occupational competence. The rigidity of licensure can impair the ability of the labor market to meet the changing demands of the health-care delivery system. Lack of uniform licensing requirements and the ever-present possibility of uncoordinated changes between states create a tenuous basis for acceptance of the licensure mode of credentialing as conducive to a free, open labor market. Sweezy (1974) concluded that a national certification system makes more uniform and credible information available to a prospective employer.

There is the danger of developing overqualifications for certification, which can operate to deny significant segments of our society access to a certified occupation. Excessive educational requirements are the most common type of qualification that can be discriminatory against socially and economically disadvantaged segments of our society (Sweezy 1974).

Another potentially undesirable effect would be the growth of an attitude among the professional groups that they have been somehow endowed with a higher status in the social system (Sweezy 1974). The assumption of a mystique or aura of this sort can destroy good working relationships within the health-care system. The real needs of individuals to advance in self-esteem and self-actualization can be met if a certification system emphasizes progressive growth of a person's command of a real body of special knowledge, skill, or art, and gears this recognition to career development and mobility.

Certification of professionals is affected by a number of influences arising from laws, regulations, and other functions of authority

(Sweezy 1974). These influences are liability for malpractice, eligibility for reimbursement of payment for services, corporate taxation of citizens under law, possible affects of antitrust statutes under the feasibility of a national voluntary system, and collective bargaining and rights of employees.

The liability of an institution for the actions of persons permitted to practice their occupation within its facilities was greatly extended by the decision of *Darling v. Charlestown Community Memorial Hospital* (Illinois) (Sweezy 1974). The doctrine adopted in this case has since been followed in some other state jurisdictions. The primary effect was to hold the institution accountable for the competent performance of all persons permitted to use its facilities in the treatment of patients. It can be strongly inferred, therefore, that the administrators and others employing or granting staff privileges to health-related personnel must be able to ascertain that professional employees do, in fact, have sufficient competence to perform the functions permitted or delegated to them. Certification on a national level makes this task much easier without restricting the geographic mobility of the professionals involved. Another landmark decision relevant to credentialing was handed down in the *Griggs v. Duke Electric Power Company* (Sweezy 1974). The key aspect of this decision was its requirement that test questions used in employment practices must be directly related to the duties of the position for which the test is being used, that is, "job-related." Otherwise, the test was ruled to be discriminatory. If this rule of fairness and relevance is applied to certification it would lead toward greater emphasis on specifically practical, as distinguished from generally intellectual, qualifying criterion standards. The issue of practical criteria and standards for certification leads to larger questions of training and testing for these standards.

A major philosophical question concerns the close ties between accreditation of training and certification. That is, is certification for initial entry into the occupation redundant and should certification be more appropriately used to attest to continuing competence?

There are individuals who, although they have not taken traditional academic training, have acquired the skills necessary to meet maximum standards of competency. Licensure has often acted as a professional roadblock to these individuals. This has been a concern for groups creating a national certification and has provided the impetus for the development of proficiency examinations (Selden 1971). A certification system must protect the interest of those in the society who cannot or do not follow a conventional pattern in obtaining their qualifying knowledge and skills. A practitioner who has achieved adequate levels of competency by nonconventional routes is entitled to the same opportunities for continued employment and updating of capabilities

as one who has the more traditional background (Sweezy 1974). If the certification process is to operate as the public-spirited gatekeeper for a profession, it must have adequate mechanisms for recognizing and dealing with both conventionally and nonconventionally trained personnel.

A balanced assessment of the kinds of accountability, and the need to have a responsive organizational apparatus, leads to the conclusion that other interested parties, including the general public, must have more than token representation or a limited advisory role in the management of a national certification system (Sweezy 1974). Sweezy pointed out that organizations that accredit educational and training programs must not be permitted solely to perform the certification that practitioners can apply the knowledge and skills taught in those programs. Unless this separation is maintained, a definite conflict of interest is created. Such a conflict can be avoided by placing the certification process under the control of an organization or apparatus that can independently represent the public interest. This should be an organization not subject to domination by special interests of educational, economic, medical, or consumer groups. Many hold that the function of certification is to attest to the continued professional qualification of practitioners. Future procedures can validate or challenge certification standards and make it especially urgent that provisions for maintaining professional quality be incorporated into the certification process.

Possible threats to the effectiveness of certification detailed by Sweezy (1974) include, first, the jurisdictional disputes among certifying bodies applying different competence standards in the same occupational field and contesting the control of overlapping functions in emerging occupational roles; second, the pressure for state licensure; third, the potential use of proficiency examinations as a competing system to certification; and fourth, the number of noncertified persons working in the field. These problems must be addressed in the establishment of a national certification system so that it is clear to the professionals involved that there is not a desire to create conflict for their professional identity.

Sweezy found that role definition is still a major process underway in the community of health and manpower. Some factors evidencing this state of flux were competition between occupations, competition between spokespersons for the same occupation, competition with external forces for control of the occupational field, changes in techniques of health care, and changes in the structure of the health delivery organizations.

An advantage that certification has, in contrast to licensure, is one of flexibility. Certification can adapt more readily to changes in technology and delivery systems, and can redefine the knowledge and skills

required accordingly. Licensure, on the other hand, is seen (Sweezy 1974) as freezing the professional's scope of duties in statute or regulation, and intruding the "heavy hand of government" into the credentialing process.

TOWARD A NATIONAL VOLUNTARY CERTIFICATION SYSTEM

The most recent HEW report (Cohen 1977), in reviewing previous studies, concluded that they demonstrated that state licensure of health-related occupations had evolved into a system of varying requirements, responsibilities, and controls that tended, in many instances, to impede effective use 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 tended to emphasize formal education and other requirements for entry into a profession, but devoted less attention to assuring the continued competence of those who are licensed. In some cases, the involvement of a professional association in the activities of a licensure board raised questions about the independence and objectivity of the boards. In this regard, other studies had confirmed that formal disciplinary procedures available to boards are not often used except in cases of blatant misconduct. This 1977 HEW report pointed out that legislatures are frequently the setting for intense political battles over the issue of "to license or not to license" with decisions made—not on the basis of an objective assessment about whether an occupation should be licensed—on the basis of the relative political strengths of the participants. This report concluded that the certificate alternative should be further developed and that the institutional licensure approach, because of the intense controversy that it generated, should not receive their further consideration.

In this report (Cohen 1977), the U. S. Public Health Service endorsed the approach of a national certification system as a viable alternative to state licensure of allied health occupations not presently licensed by states. They also recommended that a National Commission for Health Certifying Agencies be developed to provide a forum for a new level of dialogue among professional organizations, certifying agencies, employers, consumer representatives, and governmental agencies (state and federal). By insuring the participation of a variety of interests, policy decisions would more adequately reflect the public interest and, therefore, promote public accountability in the certification process. It was hoped that the commission would convene ad hoc working groups to develop national standards for allied health personnel (Samuels 1976). The working groups would consist of functionally related clusters of health professionals whose responsibilities bring them into di-

rect contact with one another. In this way, standards for a given health-related profession would be developed primarily by the profession itself with important contributions from related occupational categories.

The report recommended that national standards for the credentialing of selected health occupations be developed and continually evaluated. Standards should be uniformly applied, and therefore these standards should address not only examinations but training requirements for practice, continued competencies, recertification, and disciplinary functions. Moreover, these standards should be continually evaluated for validity and relevance. The report also pointed out that it is critical that the employer representatives participate fully in the process to ensure that the standards developed are practicable and responsive to the unique characteristics of certain regions or facilities without compromising quality services. The report states firmly that licensure is presently, and will continue to be, a function of the state government. What is recommended is the development of a set of uniform standards for health-related personnel, which would assist states in formulating compatible licensure programs where licensure is the appropriate mode of credentialing.

The HEW report (Cohen 1977) set up criteria for future state licensure decisions, and suggested how the public could be effectively protected by means other than licensure. A recommendation was to expand membership on boards to include effective representation of consumers and other functionally related health professionals.

A major recommendation of this report was that effective competency measures need to be promoted and adopted to determine the qualifications of health personnel. Special attention should be given to further development of proficiency and equivalency measures for appropriate categories of health personnel. The 1977 HEW report urged that individuals in the health-related fields be assessed by their actual competence as well as by their formal educational achievement.

The issues of what constitutes competence and of the testing and measurement of competence to perform in a given job setting are not simple or noncontroversial matters. Little can be done without a careful and systematic analysis of the relevant occupational role and the development of criterion measures (Boyd & Shimberg 1971). The use of proficiency and equivalency examinations offers a potentially important complementary mechanism to measure the qualifications of various health-related professions.

The Cohen (1977) report also recommended that additional study and training for the professional are the best mechanisms to ensure continued competence, and should be supported as high priority by professional associations. Certifying bodies should work closely with

educators and institutions to develop appropriate programs to upgrade knowledge and skills of health-related personnel on a continuing basis.

The key recommendations of the 1977 HEW report were:

1. A national voluntary system for allied health certification should be established.
2. National standards for the credentialing of health occupations should be developed and continually evaluated.
3. Criteria should be set up for future state licensure decisions.
4. Licensure procedures should be improved in the states.
5. Competency measurements should be developed.
6. Continued competency of the professionals should be encouraged and certified.

NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES

In 1977 the National Commission for Health Certifying Agencies was announced (Piemme 1977). This marked the formation of a group of 65 national organizations representing health certifying agencies, health professional associations, societies, and state licensing and regulatory bodies. It was a sign of a national initiative for the support of national certification efforts for health-related professionals. The purposes of this voluntary, nongovernmental organization are:

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. establish performance standards for existing certifying bodies and to monitor their implementation through the determinations of criteria, policies and roles for certifying systems which are responsive to the needs of the health care system
4. to advise on the need for standards and processes in the establishment of a new certifying system for both emerging and existing health occupations
5. to recommend methods for assuring competency after initial certification
6. to encourage voluntary participation of health related organizations in this commission
7. to maintain and publish a register of organizations which participate in and meet the current and continuing standards of the commission
8. to recognize certifying agencies for outstanding contribution to the certification process
9. to encourage and facilitate the development of common and/or collaborative examinations programs within a profession
10. to study test construction and validation practices
11. to investigate cost saving procedures to collect, analyze and disseminate information to the membership regarding certification technology and its effects on standards to be met by health personnel
12. to conduct educational programs designed to acquaint member organizations, educators, health professionals and the general public with issues relating to the certification process

13. to collect and disseminate information relative to the functions and accomplishments of the national commission on voluntary certification process. (Piemme 1977, p. 3)

It is this National Commission for Health Certifying Agencies to which any national-level board for certification must apply for membership if it hopes for its certification procedures to gain national recognition. This is a process of validating certification procedures and ensuring that they provide a professional service in the public interest.

The National Commission standards were the guidelines (National Commission 1977) followed in the development of the procedures for the certification of professional counselors. The American Mental Health Counselors Association Certification Committee made every effort to ensure that this newly established certification process would meet the approval of the new commission.

AMHCA'S EFFORTS

The Board of Directors of AMHCA decided in March 1978 (AMHCA 1978) that national certification of professional counselors was to be their top priority for the next two years. They chose certification over licensure because they were aware of the findings of the HEW-sponsored studies and of the perils of the state-by-state effort needed to license counselors. The Board recognized that certification, with a national standard of performance and a national examination, would also complement the efforts in states to assist counselors to be licensed.

The Board of Professional Counselors established by AMHCA will become an autonomous entity by January, 1982. This will help meet the guidelines of the National Commission for Health Certifying Agencies (1977), which require that all certifying agencies be separate from the organizations of the professionals they certify.

The formation of the Board and establishment of procedures for certification of professional counselors are major steps in the professionalization of the field of counseling, a field that will surely receive close scrutiny in the next decade.

REFERENCES

- American Mental Health Counselors Association. Minutes of Board of Directors Meeting, 18-19 March 1978. Washington, D. C.: Author, 1978.
- AMHCA Certification Committee. The Board of Certified Professional Counselors Procedures. *AMHCA Journal*, 1979, 1, 23-38.
- Arbuckle, D. S. Counselor licensure: To be or not to be. *Personnel and Guidance Journal*, 1977, 55, 581-585.

- Ballinger, M. D. & Estes, E. H. Licensure or responsible delegation. *New England Journal of Medicine*, 1971, 284, 330-331.
- Boyd, J. L., & Shimberg, B. *Handbook of performance testing. A practical guide for test makers*. Princeton, N. J.: Educational Testing Service, 1971.
- Bureau of Health Resources Development. *Report of the meeting to discuss the feasibility of a national system of certification for allied health personnel*. Springfield, Va.: Author, 1975. (NTIS No. PB-248-860).
- Christ-Janer, A. *Study of accreditation of selected health educational programs*. Washington, D. C.: ASAHP, 1971.
- Cohen, H. S., & Miike, L. H. *Developments in health manpower licensure: A follow up to the 1971 report on licensure and related health personnel credentialing* (DHEW Publication No. (HRA) 74-3101). Washington, D. C.: Government Printing Office, 1973.
- Cohen, H. S., & HEW Subcommittee on Health Manpower Credentialing. *Credentialing health manpower* (DHEW Publication No. (OS) 77-50057). Washington, D.C.: Government Printing Office, 1977.
- Conant, R. M., & Hatch, T. D. Policies for the development of credentialing mechanisms for health personnel, a progress report—1974. *American Journal of Occupational Therapy*, 1974, 28, 289.
- Forgotson, E. H., & Roemer, R. Government licensure and voluntary standards for health personnel and facilities: Their power and limitations in assuring high quality health care. *Medical Care*, 1968, 6, 346.
- Goldberg, I.; Hurley, L.; & Mehringer, A. *Analysis of 1973 state health manpower licensure legislation*. Springfield, Va.: Aspen Systems Corp., 1974. (NTIS No. PB-237-816)
- Gross, S. J. Professional disclosure: An alternative to licensing. *Personnel and Guidance Journal*, 1977, 55, 586-588.
- Mehringer, A.; Hershey, N.; & Kabinow, J. *Analysis of 1974 state health manpower licensure legislation*. Springfield, Va.: Aspen Systems Corp., 1975. (NTIS No. PB-240-665).
- National Commission for Health Certifying Agencies. *Criteria for approval of certifying agencies*. Unpublished text, Washington, D. C., Author, 1977.
- Peterson, D. R. Is psychology a profession. *American Psychologist*, 1976, 31, 572-581.
- Piemme, T. E. Statement to the press. Unpublished manuscript, Washington, D. C., National Commission for Health Certifying Agencies, 1977.
- Samuels, W. M., Proceedings certification conference, Kansas City, Missouri, August 2-5, 1976. Washington, D. C.: National Commission for Health Certifying Agencies, 1976.
- Selden, W. K. (Ed.). *Part One: Working papers SASHEP, accreditation of health educational programs*. Washington, D. C.: ASAHP, 1971.
- Starrer, R. L.; Rose, W. L.; & Saltzberg, E. J. *Alternate regulation of health personnel: Institutional licensure study*. Springfield, Va.: Hospital Educational and Research Foundation of Pennsylvania, July 1976. (NTIS No. PB-262-231).
- Sweezy, E. E. *Feasibility study of a voluntary national certification system for allied health personnel*. Springfield, Va.: Institute of Public Administration, 1974. (NTIS No. HRP-0002053).
- Tucker, W. R. *Credentialing health personnel by licensed hospitals: The report of a study of institutional licensure*. Springfield, Va.: Rush-Presbyterian-St. Luke's Medical Center, 1975. (NTIS No. PB-244-329).
- U. S. Department of Health, Education, and Welfare. *Report on licensure and related health personnel credentialing* (DHEW Publication No. (HSM) 72-11). Washington, D. C.: Government Printing Office, 1971.