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ABSTRACT

An important and widely noticed trend among health professions and occupations in the 1970s has been the increasingly widespread use of credentialing mechanisms. These mechanisms are intended to ensure that health services are provided adequately and with at least a minimum degree of competence. This report is intended to enhance and broaden knowledge of health professions credentialing. It is based on information obtained from more than 40 health certifying agencies. The report is divided into six chapters. Chapter 1 introduces the concepts of licensing and certifying and provides general background for the report, while chapter 2 discusses current problems of concern to all regulators, such as personal qualification requirements for would-be practitioners, test construction and validation techniques, and continuing competency programs. Chapter 3 focuses on current activities of licensing and certifying bodies and their regulatory activities in the various states. Chapter 4 highlights recent federal, state, and private legal challenges to regulatory practices which are alleged to restrict competition unfairly in the health sector and also includes a brief summary of important relevant concepts. Chapter 5 constitutes a minor feasibility study to identify areas of jurisdictional overlap between health occupations and suggests the extent to which scopes of practice could be modified. Finally, chapter 6 points to significant trends and indicates possible areas for further inquiry. (KC)

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# PERSPECTIVES ON HEALTH OCCUPATIONAL CREDENTIALING

***A Report of THE NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES***

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# FOREWORD

This report represents and describes efforts undertaken in the private sector. Certification is the [illegible] complement to licensure, and the National Commission for [illegible] Certifying Agencies is itself a wholly private organization composed primarily of certifying board members

Yet, this report reflects also considerable, perhaps exemplary cooperation between government and private enterprise. Federal support has been instrumental in assuring that this message of certification is sufficiently comprehensive, informative and distributed. At a time when public regulatory programs, and especially those of the Federal Government, have come under increasing fire, it is only fair that government be lauded for support that bolsters private efforts and promotes both greater sharing of information and stronger links between private programs and the public interest.

In particular, we are grateful for the personal attention and support, in the preparation of this document and in the formative work of the Commission, to the Division of Associated Health Professions of the Bureau of Health Professions (formerly, Division of Health Manpower). Thomas D. Leatch, currently Acting Director of the Bureau, and Robert M. Tennant, Ph.D. Chief of the Health Personnel Standards Branch in the Division, have been enormously helpful and generous with their time, and they have our thanks.

Dennis E. Falk
Neil W. Pfeiffer
David Bowen

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# PREFACE

Few frontiers of health policy pose such complex and far-flung problems for the 1980s as the field of health occupational credentialing. There is wide agreement that the public should be protected from incompetent practitioners acting under the guise of competence, that to assure competence some appropriate measures of qualification should be applied to health professionals, that there are credentialing roles to be performed in both the public and private sectors, and that health care delivery is too dynamic, too important, and too awesome to consumers for health professions to be either utterly unregulated or burdened with inflexible, stifling requirements. But, although these broad goals are virtually unchallenged, their attainment is frustrated by a combination of factors that includes difficulties in achieving a correspondence between training and practice, and diffusion of responsibility among all levels of government, professional entities and private watchdog groups.

As the introduction to this report relates, these problems themselves spawned the National Commission for Health Certifying Agencies - a non-profit organization in the private sector with responsibility for assuring that the state-of-the-practice in health occupational certification approaches the state-of-the-art. Although private certification probably will never and should never supplant public licensure as a means of protecting the public, neither can licensing authorities be expected to oversee and coordinate national activities in the certification sphere.

The Commission therefore takes very seriously its obligation to help assure the public that professionals certified in Commission-sanctioned programs are acting within demonstrated ranges of competence. This obligation is fulfilled through a number of Commission processes, including the development of standards as described in the appendix.

Also to meet this central obligation, the Commission has embarked on a research program designed to provide insight into, and comprehensive perspectives on, health occupations certification. This report represents the initial efforts of the Commission, which was chartered in 1977, to compile information on certification across occupations and jurisdictions and to monitor relevant developments. Although not intended

as an encyclopedia of certification, it reviews most of the pressing concerns, from the disparities between licensure and certification to the need to develop mechanisms for assuring continuing competence.

* * * *

The authors gratefully acknowledge the assistance of Patricia Dankmyer, Nancy Graham and Vanita Snow in preparing this manuscript.

Chapter One

# INTRODUCTION

An important and widely noticed trend among health professions and occupations in the 1970s has been the increasingly widespread use of credentialing mechanisms. These mechanisms are intended to offer assurance that health services are provided adequately and with at least a minimum degree of competence.

Due to the complexity of health care organization and regulation in this country, the credentialing process now involves a multitude of actors, including the Federal Government, State regulatory agencies and private professional associations and certifying organizations. As is the case with most dynamic processes in an ever-changing system, the roles and interrelationships of the various credentialing bodies are often perplexing and little understood by those who are not experts. In some instances, even the various regulatory actors themselves have demonstrated a less than comprehensive understanding of all the relevant issues. Yet, adequate and rational regulation of health care personnel and measures to guarantee minimally acceptable health services require that decision-makers possess knowledge and understanding of the concurrent and parallel efforts of other regulators in the field.

The Federal Government has played a strong role in the past decade in articulating concerns, stimulating information-gathering and promoting progress involving health occupational credentialing. In 1971, the U.S. Department of Health, Education, and Welfare (DHEW) submitted to the Congress a Report on Licensure and Related Health Personnel Credentialing.(1) The Report focused attention on major problems involved with various credentialing mechanisms and their effects on the health care system and contained several recommendations for appropriate action in the area. In particular, it recommended study of the feasibility of creating a national commission to oversee the certification of selected health professions. In 1973, DHEW issued a follow-up report, Developments in Health Manpower Licensure,(2) which further addressed health credentialing issues. Two years later, the Department established a Subcommittee on Health Manpower Credentialing to develop policy recommendations.

These recommendations were contained in a 1976 draft report, A Proposal for Credentialing Health Manpower, and its 1977 sequel, (3) which recommended that a national certification commission be established to develop, evaluate and monitor national standards for the credentialing of health occupations.

The establishment of the National Commission for Health Certifying Agencies has facilitated the gathering of a considerable amount of data and research material concerning current credentialing mechanisms - both certification and licensure.* This report describes and assesses current licensing and certification practices and updates the DHEW reports noted above.

Too often, certification and licensure are perceived as processes designed to reflect different levels of skill, with the former designed to connote expertise in a given field or specialty, and the latter intended to grant entry into a profession to individuals possessing rudimentary or minimal competence. These perceived differences obscure the common underpinning of these two regulatory mechanisms - namely, agreement that the public has the right to services from qualified practitioners - and at times may lead to situations where certifiers and state licensing authorities regulating in the same occupational field are unaware of each other's requirements. To effect an integrated health professions regulatory policy at the State, federal and private levels requires a more widely shared understanding of alternative approaches to protecting the public.

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* The term "certification," as used throughout this report, denotes a process by which a non-government agency or association grants recognition of competence to an individual who has met certain predetermined qualifications specified by that agency or association. (Thus, the Commission's Executive Council has defined certification as "the awarding by a private agency of a credential and the right to use that credential which attests to the competence of the individual engaged in the relevant scope of practice.") "Licensure" refers in this report to the process by which a government agency authorizes an individual to engage in a given occupation. Although it is recognized that in several instances, jurisdictions have enacted "statutory certification" (or "permissive licensure") requirements which limit use of particular practice titles to qualified persons and, in some cases, define an appropriate scope of practice, such terminology will be consistently subsumed under the term "licensure."

This report is intended to enhance and broaden knowledge of health professions credentialing. It proceeds from the assumptions that certification and licensure are companion fields of concern, and that a greater awareness of the issues discussed in this report should lead toward integration of health credentialing policy on all levels. The report is based in large measure on information obtained from more than 40 health certifying agencies. This information forms a mosaic of agency activity in diverse areas.

Chapter Two, "Background on Issues," discusses current problems of deep concern to all regulators, such as personal qualification requirements for would-be practitioners, test construction and validation techniques and continuing competency programs. Chapter Three, "State of Practice," focuses on current activities of licensing and certifying bodies and their regulatory activities. Chapter Four, "Antitrust - The Legal Dimension," highlights recent Federal, State and private legal challenges to regulatory practices which are alleged to restrict competition unfairly in the health sector and also includes a brief summary of important relevant concepts. Chapter Five, "Scopes of Practice," constitutes a minor feasibility study to identify areas of jurisdictional overlap between health occupations and suggests the extent to which scopes of practice could be modified. Finally, Chapter Six, "Conclusions," points to significant trends and indicates possible areas for further inquiry.

Chapter One

FOOTNOTES

1. 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.: U.S. Government Printing Office, June 1971.

2. U.S. Department of Health, Education, and Welfare. Developments in Health Manpower Licensure: A Follow-up to the 1971 Report on Licensure and Related Health Personnel Credentialing (Prepared by H.S. Cohen and L.H. Miike, DHEW Publication No.4-3101.) Washington, D.C.: U.S. Government Printing Office, June 1973.

3. U.S. Department of Health, Education, and Welfare. Credentialing Health Manpower (DHEW Publication No.(OS) 77-50057.) Washington, D.C.: U.S. Government Printing Office, July 1977.

## Chapter Two

## BACKGROUND ON ISSUES

Increased public demands for the assurance of practicner competence as well as practitioners' interest in professional recognition have greatly contributed to the recent growth in various credentialing mechanisms. Although these mechanisms for recognizing individual professional ability and competence - licensure and certification - incorporate differing objectives, requirements and methods of administration, together they exert an enormous impact on the health care system.

### Licensure

It is variously estimated that at least 100 health occupational groups are now regulated or seeking regulation in at least one State. The recent upsurge in licensing legislation has been dramatic. Currently, approximately 45 different occupations in the health field are regulated, 14 of them in all States.(1) State legislatures routinely consider numerous bills seeking licensure of a variety of health and other occupations during the course of a particular session. This legislative trend has been fueled by the lobbying efforts of State professional associations, which apparently tend to view licensure as a favorable means of enhancing occupational status.

Under a typical licensing statute, the aspiring health practitioner must satisfy certain education and training requirements. In addition, the applicant must successfully complete an examination and possess satisfactory personal characteristics, as defined in the licensing statute. The functions of licensing boards established to administer statutory requirements include determining eligibility of applicants, setting standards of ethical conduct, disciplining unethical and perhaps incompetent practitioners and assessing the qualifications of applicants who possess out-of-state licenses. Licensing boards commonly are composed of members of the regulated occupation who are suggested by leaders of State professional associations for gubernatorial appointment.

In recent years, many State boards have been "opened up" to include the participation of laypersons who theoretically possess a broader perception of public interest needs associated with regulation. However, the number of laypersons mandated to serve on health licensing boards is frequently lower than for other regulated fields; professional associations conceivably are inclined to resist participation by consumers who are perceived as lacking sufficient experience and technical qualifications to make policy determinations affecting practice in demanding and sophisticated health fields.

Licensing mechanisms lately have come under increasing attack. Frequent criticisms are that they artificially impose unduly restrictive licensure qualifications, which serve to deny access to otherwise qualified applicants, and that they comprise a patchwork system of regulation across all States which impedes interstate mobility of practitioners and contributes to confusing variations in levels of competence.

To damper the parade of licensing statutes enacted without sufficient regard to the long-term manpower and health-care quality implications, DHEW in 1971 and again in 1973 urged States and health occupations to adopt a two-year moratorium on further licensing legislation. The stated purpose of this moratorium was to allow for examination of alternative credentialing mechanisms and to reassess the impact of health licensure. Despite the moratorium, in 1972, 62 new licensure bills were introduced in 30 State legislatures, with 11 bills enacted into law.(2) In 1974, 30 new laws were enacted.(3)

Since the moratorium expired, pressure from numerous occupational groups has increased. To respond effectively to such requests, many States have established review processes that require groups seeking licensure to satisfy enumerated criteria. Approaches of this type currently are used in Minnesota and Virginia, among other States.(4) New demands for board accountability and for proof that licensure does assure consumers adequate care have led to the consideration and implementation of alternative methods of regulation in some States. Such methods include consolidation of licensing authority in a central State agency, a stronger emphasis on discipline of irresponsible practitioners and greater reliance on national measures of competence.

## Certification

Unlike licensure, certification is a voluntary (and national) process whereby a nongovernment agency grants recognition of competence to an individual who has met certain predetermined qualifications.(5) Certification currently affects a wide array of health care practitioners. Of the more than 100 health certifying agencies, the Board of Registry of the American Society of Clinical Pathologists alone maintains a registry of more than 200,000 names of practitioners, and the American Registry of Radiologic Technologists certifies over 109,000 radiographers.

Certifying agencies customarily impose education, training and competency requirements on applicants and offer certificants the right to use special professional title designations. While certification is usually not mandated by government, uncertified practitioners may find themselves excluded from some job opportunities where skills exceeding those typically displayed by entry level practitioners are sought by the employer. It may be anticipated that certification will be of increasing importance as a criterion for the payment of health professionals under Federal health care financing programs. A recent and portentous example is the Rural Health Clinic Services Act of 1978,(6) which establishes certification of nurse practitioners and physician assistants as one measure of eligibility for reimbursement under this special program. The role of the National Commission for Health Certifying Agencies in establishing appropriate certification standards should contribute to the trend toward reliance on certification.

## Relationship Between Licensure and Certification

Despite their somewhat divergent regulatory thrusts, certification and licensure continue to evolve in parallel fashion, and a considerable amount of overlap is apparent. Selective incorporation of certification requirements and procedures into licensing statutes and regulations is common. Particularly in areas where the corresponding certification mechanism has been in operation for a considerable period of time, licensing authorities show little difficulty in

accepting certification requirements, which are ostensibly more demanding and rigorous than educational qualifications, as an alternative pathway to meeting licensing requirements.

Frequently, licensing statutes and regulations require that an applicant successfully complete a core curriculum established and approved by the relevant certifying agency.(7) As a practical matter, licensing boards in many instances similarly defer to professional or other private associations in accrediting training programs, due to a lack of financial resources and an inability to regulate effectively those training programs located in other jurisdictions. In such instances, it is necessary to rely on an appropriate agency that is national in scope.

Licensing boards' dependence on certifying agencies is most prevalent in determining qualifications of out-of-state applicants for licensure. In many instances, boards waive requirements that the out-of-state applicant successfully complete a board-administered examination if the individual is certified by a designated certifying agency.(8)

While waivers of State licensing requirements may be viewed as particularized applications of reciprocity and/or endorsement principles, licensing boards also grant certificate holders other significant privileges. For example, in several States, out-of-state speech pathologists and audiologists who are not residents or licensees but who are certified by the American Speech and Hearing Association are permitted to offer professional services under certain circumstances.(9) These and other benefits accorded to certificate holders are not similarly extended to out-of-state licensees seeking admission in the host State and represent at least a tacit acceptance of the viewpoint that a certificate may signify higher levels of skills and knowledge than a license.

## Continuing Competence

Continuing competence encompasses the growing recognition on the part of the public and licensing and certifying agencies that practitioners must keep abreast of advancements in knowledge and technology and periodically reassess areas of possible skill deficiencies. Implicit in the concept is the notion that assurance of competence is not a "one-shot" endeavor but an ongoing process. Increasingly, demonstrations of continuing competence are required as a condition for relicensure or recertification.

There are several different mechanisms currently used in varying degrees to assure currency of practitioner skill and knowledge. By far the most extensively employed is continuing education. As the 1977 DHEW report, Credentialing Health Manpower, indicated, this term is widely confused with continuing competence. The report referred to findings contained in the 1973 study - Developments in Health Manpower Licensure - which criticized widespread reliance on this mechanism to the exclusion of less traditional and didactic modes which more adequately measure job outcomes. Some of these alternative measures identified in the report include peer review through Professional Standards Review Organizations (PSROs), re-examination, self-assessment techniques and supervisory assessment.(10)

Under self-assessment programs, examinations are developed by experts that are designed to elicit information indicating areas of clinical practice in which the practitioner displays weaknesses. Participation is usually voluntary, and practitioners are provided with comprehensive feedback, usually in the form of a computer printout. This feedback includes in-depth treatment of all examination responses and bibliographic references which offer assistance in indicated areas of weaknesses.

Supervisory assessment is accorded by use of practice audits and patient-management problems (PMPs). Practice audits require the individual to answer questionnaires designed to elicit information concerning actual practice and treatment provided patients and consumers as indicated on appropriate records. The responses are then evaluated and critiqued by supervisors who offer guidance to the practitioner in correcting perceived deficiencies. PMPs involve simulated treatment conditions where the test-taker is presented with an undiagnosed patient or undefined condition and must evaluate and propose suitable alternatives for treatment. Responses are reviewed by supervisors or outside experts, and detailed feedback is provided to the practitioner.

Continuing education has been adopted by State licensing boards, professional associations and certifying agencies on a widespread basis. For example, 41 jurisdictions currently impose continuing education requirements on nursing home administrators, and 44 jurisdictions impose similar requirements on optometrists.(11) However, at least two States - Colorado and Florida - have recently enacted legislation reducing the amount of continuing education mandated for certain professions.(12) Continuing education requirements also are being implemented by professional

societies and certifying agencies. Further, some insurance companies require practitioner enrollment in continuing education courses in certain fields as a condition for obtaining current malpractice coverage.

The medical profession has been particularly active in recent years in implementing recertification programs. In March 1973, the membership of the American Board of Medical Specialties (ABMS) passed a resolution urging that voluntary periodic recertification of medical specialists become a standard policy of all member specialty boards. By 1974, all 22 primary and conjoint boards endorsed recertification in principle. By the end of 1978, 15 boards had established dates for recertification, and five boards had actually conducted recertification procedures.(13) Recertification mechanisms of nine boards were approved by ABMS by late 1979.

The key question is whether participation in continuing education programs improves the performance ability of practitioners. Although the system is relatively simple to administer - the agency or organization imposing the requirement merely has to assure that the practitioner has received a predetermined number of Continuing Education Units (CEUs) from an accredited program - frequent criticism points to the lack of evidence that practitioners will be able to pinpoint precise areas of deficiency and select the appropriate course to remedy their shortcomings. More significantly, critics decry the lack of evidence of positive relationship between continuing education courses and continued competence as measured by enhanced levels of practitioners' skill and knowledge. At present, there is little evaluation of these training efforts.

In the case of certifying agencies and professional associations in all health fields, more practitioner resistance to rigorous continuing competency programs than to continuing education requirements has been evident. Practitioners may be reluctant to involve themselves with programs that could lead to reductions in their income-earnings or divert substantial periods of time from normal job activities. In addition, concern expressed by senior practitioners as to the consequences of failing to comply with mandatory recertification programs has served as a brake on efforts to develop innovative programs.

Competency Measurement

A pivotal challenge to credentialing mechanisms is that of designating, or designing, appropriate test instruments that effectively measure the skills, knowledge and professional attributes deemed essential for competent practice. Differences of opinion among psychometricians, opposition to such testing excesses as over-interpretation of test results, and sensitivity to equal employment issues are among tensions that have subjected the measurement of job-related competence to growing public controversy.

The Federal Government's articulated concerns involving competency measurement include the need to determine qualifications of health professionals for purposes of reimbursement of services under Medicare and Medicaid and the need to develop appropriate Federal policies to improve the quality and utilization of health care practitioners.(14) Recognition of the importance of these concerns, which are shared not only by disparate Federal agencies but also by States and health care administrators and insurers in the private sector, infuses competency measurement with rising interest on the part of active and aspiring professionals. Previously technical questions loom as potentially political issues.

Individual applicants have expressed concern about whether examinations do in fact measure appropriate skills and knowledge needed for adequate job performance and have demanded that credentialing mechanisms take account of previous training received in settings other than those formally specified in pre-examination requirements. Recent legal challenges to the discriminatory effects of test measurements and allegations addressed to their supposed lack of job-relatedness have become increasingly widespread.

The psychometric community thus is confronted with the need to devise and apply appropriate measurements of competence and interpret test scores in a sound manner that comports with the state-of-the-art. And, in the meantime, the credentialing agencies themselves are faced with the seemingly herculean tasks of defining the domains of subjects to be assessed and implementing testing mechanisms that both assure the public that practitioners are competent and meet such regulatory and legal requirements as Equal Employment Opportunity Commission guidelines.(15)

Types of Examinations

Health occupational credentialing mechanisms usually rely on formal educational curricula as basic requirements. Areas of knowledge, skill and ability deemed essential for competent practice are defined by selected educators and professionals in a particular field and are presented in a written examination that reflects a systematic mode of instruction. Thus, credentialing examinations serve largely to measure the levels of academic performance.

Such traditional testing methods, which employ paper-and-pencil formats (multiple choice, true/false or essay) and/or oral presentations, have been subject to widespread criticism. These measurements are viewed by some as process rather than outcome-oriented in that they focus on education and learning rather than job performance and largely measure one's ability to recognize or recall information rather than the ability to perform one's job at a minimally acceptable level. Traditionally, these examinations generally failed to measure individual traits and characteristics, such as empathy, interpersonal effectiveness or motivation, which are now recognized as important elements of job performance.(16) Nonetheless, few dispute the need to assess relevant scholastic knowledge to assure that health care practitioners have an adequate range and depth of familiarity with current, related theories and facts.

Practical examinations are designed to approximate actual job performance conditions. A variety of currently used techniques include performance tests, in which candidates actually execute a procedure or activity under standard conditions while being observed and evaluated by experts, and simulation techniques, in which actual practice conditions are represented in order to produce and assess applicant behavior. These techniques, however, lack the ease of administration and the cost-effectiveness of paper-and-pencil examinations. Considerable time and expertise needed to develop, administer and evaluate such techniques serve as particularly significant constraints on their more widespread use.(17)

The 1971 DHEW Report on Licensure and Related Health Personnel Credentialing originally endorsed the concept of alternative pathways to credentialing other than the formal education route and urged the development of meaningful examinations to measure non-formal learning and thus facilitate entry into health occupations. The types of measurement recommended include equivalency testing, which is

"designed to equate non-formal learning with learning achieved in academic courses or training programs,"(18) and proficiency testing, which "refers to the measurement of an individual's competency to perform at a certain job level."(19) Under a system of proficiency and equivalency testing, an individual's expertise and skills in the performance of specific tasks as well as prior work experience would be recognized as appropriate qualifications for credentialing.(20) The 1977 DHEW report, Credentialing Health Manpower, suggested that these forms of measurement should be properly considered as complementary mechanisms to assess qualifications of various health personnel and do not diminish the importance of formal education requirements.(21)

Considerable impetus for the use of proficiency and equivalency testing has been supplied by the Federal Government in recent years. The Health Training Improvement Act of 1970 authorized the Health Resources Administration (HRA) to enter into contracts for "developing, demonstrating, or evaluating techniques for appropriate recognition of previously acquired training or experience...."(22) HRA initiatives in this area were reinforced by the Social Security Amendments of 1972, which required development of proficiency examinations in satisfaction of Medicare reimbursement qualification requirements.(23) Under these mandates, HRA in collaboration with professional organizations has designated occupational entry levels suitable for proficiency examination. These include technicians and assistants, for which an associate degree program or its equivalent are considered appropriate, and technologists or therapists, for which a baccalaureate degree is deemed sufficient preparation.(24) The agency has supported proficiency examination programs for occupational, physical and respiratory therapists, radiologic technicians, primary care physician assistants, health educators, health service administrators, and dietitians.(25)

## Examination Development Process

Test development involves a series of discrete but inextricably related tasks. Although procedures vary, the process if done well is frequently time-consuming and may take up to several years. An initial determination that must be made by the organization developing and administering the test concerns the approach to be used in measuring a test-taker's performance. Measurement specialists, in recent years, have identified two different types of measurement that can be applied in test development: norm-referencing and criterion-referencing.

The norm-referencing approach is most useful in assessing a candidate's general knowledge or understanding of the skills or subject area to be measured. Norm-referenced tests are designed to establish an examinee's relative standing in relation to the performance of other examinees. An individual's score is compared with the average performance of an appropriate normative or reference group (typically, all applicants taking the new form of the test). The standard utilized to fail members of the reference group (frequently, anyone scoring more than one standard deviation below the group's mean score) is then applied to all individuals taking the test. By use of this approach, a specified proportion of the candidates are expected to fail the examination regardless of the difficulty level of the examination or the competency level of the candidates.

Items for most norm-referenced tests are selected on the basis of their capability to survey a large area of knowledge. Test preparation requires that a test content outline or "blueprint" be established and that test items reflect the outline. A goal in item selection is to achieve variability in scores. Since the meaningfulness of a norm-referenced score is dependent on the relative position of the score in comparison with other scores, the confidence in the measurement capabilities of the instrument is strengthened if there is more "spread" in the scores.(26) Prototype test items are developed and field-tested by use of sample examinees. Individual items should be discarded if they are too easy or too hard or if individuals of varying levels of ability have similar probabilities of answering them correctly.(27)

Criterion-referenced tests are those which are used to determine an examinee's status with respect to well-defined domains of behavior. Examination preparation begins with defining the abilities to be measured. Thus, a criterion-referenced test is constructed to yield scores that can be directly related to articulated performance standards. Under the criterion-referencing approach, the composition of the test has direct impact on the proportion of candidates who pass or fail the examination.(28)

Before writing items for a criterion-referenced test, it is necessary to identify the specific behavioral domains or abilities to be tested and to establish performance standards for each. A number of methods are available for creating test specifications which adequately describe behavioral domains. For example, the competencies deemed essential for job performance can be determined by a process of expert consensus. If the expert consensus approach is used, however, careful attention should be paid to the method by which experts are

empaneled. As one commentator has indicated, the selective perceptions and beliefs of these judges have a significant impact on resulting test specifications.(29) Another approach is task analysis, which involves observations of actual job performance in order to identify those elements necessary for competent practice.

For each domain included in a criterion-referenced examination, a sufficient number of test items - probably at least 10 to 20 - is needed to assure adequate measurement of competence. An item that would be eliminated from a norm-referenced test because almost all individuals would answer it correctly may be included in a criterion-referenced test if it measures qualifications that have been identified as critical. However, as a practical matter, concern for detailed inclusiveness of competencies within each measured domain may lead to an instrument that is unwieldy in length.

A central concern for competence testing is the method employed for standard-setting. Organizations developing an examination need to decide whether a single pass/fail point should be established or whether separate pass/fail points should be established for each examination sub-part. How to decide where to set the pass/fail level is a complicated question that the Commission is preparing to address through guidelines.

To summarize, there are several major differences between norm-referenced and criterion-referenced tests:

1) Norm-referenced tests are designed to measure general knowledge, while criterion-referenced tests are designed to measure performance in specific areas. Criterion-referencing implies that performance and behavioral domains to be tested are identified before test items are written.

2) Items that do not produce variability among individuals are eliminated from norm-referenced tests, while those that do not fit test specifications are eliminated from criterion-referenced tests.

3) Norm-referenced tests are used to make comparisons among individuals or to select individuals when the number of vacancies is lower than the number of applicants - such as an admissions test. Criterion-referenced tests are quota-free and designed to determine whether individuals have mastered a specific skill or class of behaviors.

Thus, a fixed percentage of examinees regardless of the test difficulty will fail a norm-referenced test, while anywhere from zero to 100 percent of a group can pass a criterion-referenced test.

4) As criterion-referenced tests are more likely to be used to make generalizations, test objectives must be clearly stated, and items must be representative of the domain described in the test objectives.

5) Norm-referenced tests contain less specificity concerning the behaviors a person has to perform than do criterion-referenced tests, which clearly delineate what the examinee can or cannot do.

6) Due to the manner in which items are selected and the way criterion-referenced tests are used, different methods of assessing reliability and validity may be required. Measurement methods devised for criterion-referenced tests are still in a state of development.

Validity and Reliability

According to the American Psychological Association's 1974 Standards for Educational and Psychological Tests, questions of validity are concerned with what conclusions may be properly drawn from a test score and with the usefulness of the measure as a predictor of behavior. As the Standards point out, validity is inferred, not measured, and is judged as adequate, marginal or unsatisfactory.(30)

The simplest method of inferential interpretation of validity is known as "face validity" and involves determinations by experts that the test appears to relate to the performance domain. Face validity is not considered psychometrically acceptable for purposes of drawing inferences.(31) Content validity involves expert consideration and determination that the test content includes a representative sample of significant skills or knowledge specified in the definition of the performance domain. According to the Standards, definitions of the performance domain must be "so carefully detailed that rules for item writing will assure appropriate representation of all the facets of the definition."(32)

Construct validity refers to the "degree to which a test relates to tests of the same competency or tests of different competencies with which it is expected to have a theoretical relationship."(33) A construct is a theoretical idea or hypothesis developed to explain existing data. According to

the Standards, this type of validity is found when one evaluates a test in light of a particular construct and is useful in efforts to improve measures for the scientific study of a construct.(34)

Criterion-related validities, of which there are two types - predictive validity and concurrent validity - involve inferences derived from an individual's test score. Concurrent validity indicates the extent to which a test may be used to estimate an individual's present job performance as measured by a relevant specified criterion. Predictive validity involves the extent to which an individual's future job performance as measured by a specified criterion can be predicted from knowledge of prior test performance and involves a time interval during which experience or training may be applied. Difficulties in applying criterion validation interpretations are due in part to unrealistic or invalid criterion measures and inadequately sized samples.

So-called differential validity refers to the inferences concerning the degree to which different demographic groups perform equally well on a test.

Reliability relates to the accuracy of measurement. Thus, if a group of examinees were administered the same test at two different times, then reliability could be estimated by comparing the two sets of scores. The more consistent the scores, the higher would be the reliability. Estimates of reliability are usually expressed by means of test-retest coefficients of stability, Kuder-Richardson split-half coefficients (KR-20), or standard error of measurement. Coefficients of stability are derived from administration of the same test, or equivalent forms of the test, to the same individuals at two different times and assure that individuals credentialed at different times have demonstrated similar levels of competence. Split-half coefficients indicate the correlation of scores obtained after dividing the test into two equivalent portions. The standard error of measurement is an estimate of how closely test scores approximate a "true" or "perfect" score.(35) There is diversity of opinion about how great reliability need be for a particular examination. But, it is especially important that reliability be great at or near the pass point, where one point either way could determine whether the candidate passes or fails.

Chapter 2

FOOTNOTES*

1. See: 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.: U.S. Government Printing Office, June 1971, p. 43; Developments in Health Manpower Licensure: A Follow-up to the 1971 Report on Licensure and Related Health Personnel Credentialing (Prepared by H.S. Cohen and L.H. Miike, DHEW Publication No. (HRA)74-3101). Washington, D.C.: U.S. Government Printing Printing Office, June 1973, pp. 14-15; State Regulation of Health Manpower (DHEW Publication No.(HRA)77-49). Washington, D.C.: U.S. Government Printing Office, 1977, p. 1.

2. DHEW, Developments in Health Manpower, ibid., pp. 12-13.

3. Hogan, D.B. The Regulation of Psychotherapists: A Study in the Philosophy and Practice of Professional Regulation, Vol. 1. Cambridge, Massachusetts: Ballinger, 1979, p. 242.

4. Minnesota Stat. §214.001 (1976); Virginia Code §54-1.8 (1977).

5. DHEW, Report on Licensure, op.cit., p. 7.

6. P.L. 95-210 (1977), 42 U.S.C. §1395x.

7. See, e.g., Alabama Code §34-19-2 (1978 Cum. Supp.), which requires applicants for a nurse-midwife license to complete successfully an organized program of study and clinical experience recognized by the American College of Nurse-Midwives.

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*These footnotes should not be viewed as including a comprehensive or representative set of references for psychometric issues. The Commission intends to compile such a listing for the lay reader, however, particularly in the area of standard-setting (establishment of cut-off scores).

8. See e.g., Conn. Gen. Stat. Rev., §20-74c (1979 Cum. Supp.), which gives the Commissioner of Health Services discretion to waive an examination and grant a license to an individual certified by the American Occupational Therapy Association; Fla. Stat. Ann., §490.22(1) (1979 Supp.), waiving the State Board of Examiners in Psychology examination (at the Board's discretion) for diplomates of the American Board of Professional Psychology.

9. See, e.g., Ark. Stat. Ann. §72-1809 (1979 Cum. Supp.); Del. Code Ann. tit. 24 §3704.

10. U.S. Department of Health, Education, and Welfare. Credentialing Health Manpower (DHEW Publication No. (OS) 77-50057). Washington, D.C.: U.S. Government Printing Office, July 1977, p. 17.

11. Cf. Vogel, B. "Professional Retraining in Flux" (chart) The New York Times, Sept. 9, 1979 (Special Supplement on Education), p. 3.

12. Ibid.

13. Leymaster, G. and Lloyd, J. "Recertification: History and Present Status." In American Board of Medical Specialties, Conference on Recertification. September 20, 1978, Chicago, Illinois, p. 5.

14. Conant, R. and Hatch, T. "Policies for the Development of Credentialing Mechanisms for Health Personnel: A Progress Report - 1974" The American Journal of Occupational Therapy 28 (May-June):289, 1974.

15. See 42 U.S.C. §2000e et seq.; and 43 Federal Register 38290-38314 (August 25, 1978).

16. Pottinger, P.S. "Competence Assessment: Comments on Current Practices." In Defining and Measuring Competence: New Directions for Experimental Learning, No. 3. P.S. Pottinger and J. Goldsmith, eds. San Francisco, Jossey-Bass, 1979, pp. 30, 32, and 36.

17. Davis, B. "Development of Competency-Based, Career-Entry Examination for Clinical Laboratory Personnel." The American Journal of Medical Technology 44:403, 1978.

18. DHEW, 1971, Report on Licensure, op.cit., p. 53.

19. Ibid.

20. Ibid.

21. DHEW, 1977, Credentialing Health Manpower, op cit., p. 16.

22. 42 U.S.C. §295(h) et seq.

23. 42 U.S.C. §1320a-2.

24. Conant and Hatch, "Policies for the Development of Credentialing Mechanisms," op.cit., p. 291.

25. Ibid., p. 290.

26. Popham, W.J. and Husek, T.R. "Implications of Criterion-Referenced Measurement" Journal of Educational Measurement 6 (Spring 1969), 3.

27. Ibid., p. 6.

28. Ibid., p. 2.

29. Pottinger, "Competence Assessment," op. cit., p. 26.

30. American Psychological Association, Standards for Educational and Psychological Tests, p. 25 (1974).

31. Ibid., p. 26.

32. Ibid., p. 28.

33. Klemp, G. "Identifying, Measuring and Integrating Competence," In Defining and Measuring Competence, op.cit., p. 48.

34. American Psychological Association, Standards, op. cit., pp. 29-30.

35. Cromack, T.R. Characteristics of a Locally Developed Licensure Examination. Paper presented at National Council on Measurement in Education Annual Meeting, San Francisco, April 11, 1979, pp. 5-6.

## Chapter Three

## STATE OF PRACTICE

Information obtained by the Commission points to significant variations in certifying agencies' procedures, requirements and impact on the delivery of health services. Of the 42 different agencies providing information, the numbers of individuals currently holding valid certificates range (where available) from approximately 200 in the case of the Child Health Associate Program to 200,000 in the case of the Board of Registry of the American Society of Clinical Pathologists (hereafter, "Board of Registry"). Also, many of these agencies have established various levels of certification. For example, the Board of Registry conducts certification programs at 16 different professional levels, and the American Nurses' Association certifies 11 different nursing specialties.

Several types of factors are at work in molding the character of certification programs. Variables include the degree of public visibility of practitioners, the extent to which their role is considered important to health, and the demand by individuals in a particular specialty or discipline for official recognition of professional achievement. The funding level of certifying agencies and their administrative history also help determine the nature of examination programs and the qualifications for certification.

To begin to obtain a systematic view of the certification of health professions, this Commission asked certifying agencies for information about agency practices and requirements: in short, the basic method used to gather information was self-reporting. Agencies were asked, for example, whether their examination programs had been found reliable and valid according to each way of determining validity identified in Chapter Two.

Responding agencies, therefore, not only had the opportunity, and the burden, of characterizing their achievements favorably if possible, but also had to structure information without reference to clear guidelines. There is vigorous debate in psychometrics about how criterion-related validity can be established, if at all, just as there is divergence of opinion about whether any known health certification examination is criterion-referenced and whether existing technology is sufficient to construct a truly criterion-referenced test

at all. In this atmosphere of intellectual ferment, it appeared that any precise guidelines for response necessarily would seem to create bias; and so, this initial Commission research effort was aimed at compiling a rough picture of certification activity rather than a scientifically elegant matrix.

## Certification Eligibility Requirements

Certifying processes examined in this study impose a wide and varied range of requirements on applicants. In the overwhelming majority of cases for which information was obtained, completion of formal education or other training programs is a necessary but not sufficient condition for certification. In most instances, the applicant also must obtain a stated amount of work experience or complete an internship or practicum in the relevant discipline or specialty. These requirements of demonstrated clinical experience represent widespread certifying agency acceptance of the notion that merely academic or didactic education prerequisites, by themselves, are insufficient to assure practitioner proficiency.

In general, the higher the occupational level, the greater is the amount of education required. At the technician or assistant level, a high school diploma or associate degree, in addition to other prerequisites, is required in most instances. At the technologist level, undergraduate degree requirements are frequently imposed. (This is not universally true, however; in the case of the American Cardiology Technologist Association, for example, applicants only must have received high school diplomas.) In contrast, at the specialist level, post-undergraduate degree requirements are frequently evident. Thus, clinical specialists in medical-surgical nursing or psychiatric and mental health nursing certified by the American Nurses' Association, and specialists in hematology or immunology certified by the Board of Registry, must possess master's degrees. For many of the dental-related certifying agencies, such as the American Board of Prosthodontics and the American Board of Oral and Maxilliofacial Surgery, as well as for other mechanisms to regulate independent professions, such as the National Board of Chiropractic Examiners, the American Board of Psychological Hypnosis, and the American Board of Ophthalmology, applicants must possess doctoral degrees. (See Table 1: Certification Eligibility Requirements, pp. 32-50.)

In occasional cases, certifying agencies appear quite flexible in their requirements and permit applicants to substitute greater amounts of work experience or successful completion of training programs for degree requirements. To illustrate, a technician in a given occupation might satisfy certification requirements by possessing a high school diploma and engaging in two years of relevant work experience, or alternatively, possessing an associate degree and engaging in one year of practical experience. Similarly, a technologist with a baccalaureate degree might meet agency requirements by either successfully completing an approved training program or engaging in one year of practical experience. The concept of alternative pathways to achieving certification, through which individuals who have obtained a skill or knowledge outside the formal educational setting are evaluated, has become increasingly favored. Agencies instituting such requirements have exhibited an imaginative mix of alternatives in structuring their certification programs. (See Table 1.)

Several certifying agencies, including the Board of Registry, the National Registry of Emergency Medical Technicians, the National Board for Respiratory Therapy, the American Medical Record Association, the National Certification Agency for Medical Laboratory Personnel, the American Registry of Allied Health Science and the American Nurses' Association, conduct numerous certifying programs, thereby granting official recognition to practitioners in different specialty areas. These agencies have policies permitting an applicant previously certified at an entry or intermediate level of an occupation, who desires to become certified at a higher level, to apply appropriate requirements fulfilled for the lower-level certification in partial satisfaction of requirements for advanced level certification. As an example, a candidate for Board of Registry certification as a technologist in immunology may substitute his or her previous training as a certified medical technologist for one year of required clinical laboratory experience, out of the two years normally required of technologists in immunology.

A large number of organizations condition award of a certificate on graduation from an accredited training program. Although several agencies have implemented an accreditation program, many rely on the American Medical Association (AMA) or the American Dental Association's (ADA) activities in this area. Thus, the Board of Registry requires graduation from programs accredited by the AMA's Commission of Allied Health Education and Accreditation (CAHEA) for many of its certification programs. Other

agencies which require graduation from an AMA-accredited program include the National Board for Respiratory Therapy and the American Medical Record Association. Organizations which require study in ADA-approved programs include the American Board of Prosthodontics, the American Board of Periodontology and the American Board of Pedodontics. (See Table 1.)

In addition to education requirements, approximately one-fourth of the organizations providing information to the Commission have indicated that applicants must complete an internship or practicum program to be certified. Less rigidly, the Registry of Medical Therapists and Specialists and the American Board of Ophthalmology currently recommend but do not require such programs. The programs range in duration from 100 hours for paramedics certified by the National Registry of Emergency Medical Technicians to three years for individuals certified by the American Society of Ocularists. In some instances, internship or practicum requirements are built into the formal education program established for potential certificants. (See Table 1.)

Of the certifying agencies from which information was received, all but five - viz., the American Association of Music Therapy, the American Board of Psychological Hypnosis, the Association for the Administration of Volunteer Services, the American Board of Clinical Hypnosis and the American Academy of Gnathologic Orthopedics - offer or soon will offer traditional pencil-and-paper written limited response examinations (usually of the multiple-choice variety) as part of their examination processes. Sixteen organizations administer oral examinations, and six require essay-type responses in examinations. Practical and equivalency testing is currently conducted by 15 organizations. In addition to these testing procedures and formats, various alternatives currently employed include: clinical simulations involving patient-management problems (National Board for Respiratory Therapy and the National Commission on Certification of Physician's Assistants); submission of reports on individual projects (the American Board of Dental Public Health); presentation and analysis of patient treatments (American Board of Prosthodontics, the American Academy of Gnathologic Orthopedics and the American Board of Pedodontics); development of individual portfolios (Association for the Administration of Volunteer Services); and site visits (American Board of Pedodontics). (See Table 1.)

Most organizations supplying information to the Commission about certification requirements also report that they impose requirements for the maintenance of certification. These requirements for the most part do not appear very burdensome to the certificant and usually entail periodic payment of fees and reporting of background information and experience for inclusion in national registries or for other purposes.

Recertification

Currently, recertification efforts by certifying agencies are increasing and varied. Information obtained by the Commission indicates that out of 42 organizations, 13 have recertification mechanisms in current operation, and four plan to implement such mechanisms in the near future. These requirements vary both in terms of the designated time periods within which recertification must be achieved and the mechanisms by which a certificant is obliged to update skills and replenish knowledge.

Although the emphasis on continuing competence is recent - with most affected certifying agencies implementing recertification programs within the past two to three years - it is interesting that several organizations have had such programs in operation for considerable lengths of time. The American Board of Dental Public Health, the American Dietetic Association and the Joint Commission on Allied Health Personnel in Ophthalmology report initiating such programs in 1952, 1969 and 1971, respectively. (See Table 2: Recertification, pp. 51-54.)

Development of appropriate recertification mechanisms appears to be a significant concern of many organizations, as considerable efforts have been undertaken to attempt alternative approaches. The Board of Registry, for example, announced in 1977 a program designed to provide reliable information about the state-of-the-art in both laboratory practice and assessment mechanisms. Under the program, the Board now is surveying certificants to measure techniques and procedures used by laboratory workers. Analysis of data in upcoming months will help to establish objectives and priorities in developing appropriate systems of competence evaluation. Several other agencies, including the National Commission on Certification of Physician's Assistants, the National Registry of Emergency Medical Technicians, the American Society of Podiatric Assistants, and the Registry of

Medical Rehabilitation Therapists and Specialists, also report plans to conduct experimental studies to determine the feasibility of recertification programs for particular specialty areas.

Periods of recertification for individual certificants range from annual (the American Board of Dental Public Health and the Joint Commission of Allied Health Personnel in Ophthalmology) to six years (National Commission on Certification of Physician's Assistants). The mode is five years. (See Table 2.)

Continuing education comprises the most widespread mechanism of recertification. Twelve of the 17 organizations that have implemented or are on the verge of implementing recertification programs have indicated that participation in continuing education is needed for either complete or partial fulfillment of requirements. Of these 12 organizations, ten have instituted mechanisms to evaluate and approve continuing education courses, and one relies on evaluations of the companion professional society.

Other types of mechanisms are being used, however. Two organizations (the Association for the Administration of Volunteer Services and the American Registry of Allied Health Science) report planned use of self-assessment techniques, and three organizations (the American Board of Dental Public Health, the American Nurses' Association, or ANA, and the Registry of Medical Rehabilitation Therapists and Specialists) currently make use of practice audits in assessing continued competence of practitioners. In addition, the ANA and the American Surgical Trade Foundation currently re-administer certification examinations for partial satisfaction of their recertification requirements, and the American Registry of Allied Health Science plans to develop a recertification examination for initial use in 1980 to accompany re-administration of entry-level examinations. (See Table 2.)

A particularly ambitious recertification program has been developed by the American College of Nursing Home Administrators. This program, which will be implemented in 1980, requires completion of computer simulations concerning the management of nursing home operations and includes a peer assessment of individual performance. Additional requirements include continuing education and community or civic activity.

## Coordination of Licensure with Certification

Besides exercising similar functions as observed in Chapter 2, certification and licensure frequently maintain complementary or even interdependent relationships. State agencies in many cases require as a condition of licensure or State recognition that the applicant successfully complete an examination developed and administered by a certifying agency. All jurisdictions except Alabama and Delaware, for example, either require or accept satisfactory performance on ADA examinations in fulfillment of licensing requirements for dentists and dental hygienists. All jurisdictions except Connecticut, the District of Columbia and South Carolina require chiropractors to complete successfully an examination developed by the National Board of Chiropractic Examiners. The examination of the National Registry of Emergency Medical Technicians is relied on by 22 jurisdictions, and that of the National Commission on Certification of Physician's Assistants by 14 jurisdictions. Georgia imposes requirements of examinations developed by the American Society for Microbiology, the National Certification Agency for Medical Laboratory Personnel and the American Board for Certification in Orthotics and Prosthetics for designated occupational groups. Similarly, Colorado requires completion of the Child Health Associate programs examination for one to be licensed in this field; medical technologists in New York must complete an examination developed by the New York State Registry of Medical Technicians; and Texas requires completion of the Association for the Administration of Volunteer Services examination for licensure in certain occupational areas.

## Test Construction Practices and Procedures

Thirty-seven certifying organizations summarized for the Commission current efforts to identify requisite skills, knowledge, abilities and other characteristics associated with effective job performance for purposes of test design and construction. In most cases, analyses are undertaken in-house for this purpose by officials of the certifying agency, academicians from the professional schools responsible for practitioner training and practitioners themselves. Under this process, definitions of an appropriate performance domain are arrived at by consensus. Another common practice involves analyses of survey instruments and questionnaires disseminated to practitioners and individual or institutional employers. Several organizations also report use of interviewing techniques and in-depth scientific studies of practitioners' job roles and functions, and expert judgments. (Agencies' testing practices are shown in Table 3: Test Construction Practices and Procedures, pp. 55-62.)

Only a few of the organizations which employ the expert consensus approach make use of outside services of test development companies or psychometricians to aid in the delineation of job tasks. And, of the eight agencies indicating use of outside expert assistance at this stage of the test design process, seven employ assessment techniques other than, or in addition to, expert consensus. (See Table 3.) However, many certifying agencies have on staff individuals with considerable expertise in test development techniques.

After this initial outline or blueprint stage is completed, the actual examination item-writing process appears to be fairly uniform for all certifying organizations. Typically, certifying agency directors and officers develop individual test items, or, as an alternative, examining or standards committees are formed. Individual test items for determining the competence of practitioners are generated and revised, modified or discarded as appropriate. Thirteen certifying agencies also report that assistance from outside testing agencies or experts is provided. Such assistance normally includes editing of developed questions, further review of individual test items for possible inclusion in the examination and structuring of appropriate test formats. (See Table 3.)

Of the 31 organizations providing descriptions of the pass point-setting procedures for recent examinations, 14 said they made use of a norm-referencing methodology (usually one standard deviation below the mean score of the reference group), 15 said they employed a criterion-referencing approach, and two organizations related that they made use of each of these techniques for different certification programs. Two additional organizations, and some of those purportedly using norm or criterion-referencing for other examinations, administer practical, oral or essay examinations with an absolute cut-off score, whereby experts administering the examination usually determine whether the candidate has passed. (See Table 3.)

For the 19 organizations providing information about pass-fail ratios for examinees over the last three years for which such information was available, wide fluctuations are revealed in several instances. To illustrate, in the case of the American Medical Record Association's examinations for medical record administrators, failure rates ranged from a low of nine percent in October 1976 to a high of 50 percent for the May 1978 examination. Similarly, the Association reported fluctuations between a 27 percent failure rate for

the April 1976 examination to 43 percent for the 1978 examination. (The Association has attributed these disparities to the fact that the April and May examinations typically include a high percentage of "repeaters.") Another example concerns the composite failure rates for the American Board of Certification in Orthotics and Prosthetics' examination in prosthetics (including written, oral and clinical components) which fluctuated between 22 percent, in 1978, and 60 percent, in 1977. Although the failure rates for the written components of the Board's examinations varied only slightly - as would be expected of norm-referenced tests - apparently significant variations were reported in the oral and clinical components, which were of the pass/fail nature. For most organizations, however, less dramatic changes in pass/fail ratios over time were revealed, with variations below five percent reported generally.

In assessing changes in pass-fail ratios for criterion-referenced tests, fluctuations in failure rates over time is not necessarily a sign of a poor testing system. Such a fluctuation could be quite proper if it paralleled variations in training, which would be reflected in the overall preparedness of test-takers at a given time, and/or if it paralleled developments in how actual jobs were performed, which should be reflected in the composition of the test items taken as a whole. For norm-referenced tests, however, such fluctuation would be difficult to defend, because it would mostly indicate year-to-year change in the opinion of the test administrators, before tests were scored, about how large a number of test-takers should be passed - an opinion that must be somewhat arbitrary and could be based on such presumably irrelevant factors as conditions in the job market.

As for validity, content validity was the only type for which more than half of the organizations supplying such information indicated demonstration for their examinations. Content validity was claimed by 25 out of 27 organizations. The remaining types of validities established and the number of certifying organizations which have reported establishing them is as follows: construct validity - 12; predictive validity - 4 (with two other agencies currently conducting studies in the area and another organization having been unsuccessful in attempting to establish this type of validity); concurrent validity - 4 (with two organizations planning further studies); and differential validity - 6. In addition, 21 of these 27 organizations indicated that measures of reliability have been determined for certification examinations. (See Table 3.)

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p.50)

| AGENCY | FORMAL EDUCATION * | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Academy of Gnathologic Orthopedics | | Attendance at 3-3 day training sessions | Presentation of 5 completed cases (over about 3 yrs.) | | E, analysis of 5 treated orthopedic cases |
| American Association for Music Therapy | UG or MA (AAMT approved program) | | | 1 yr. (included in formal education curr.) | |
| | | | 8 years | | |
| American Boards of Clinical Hypnosis | PhD | Post-doctorate training in clinical hypnosis + 3 years supervised practice | 2 years | | Or, E |
| American Board of Dental Public Health | MA | Council on Dental Education/ADA - approved program (1 year) | 4 years | | Or, WLR submission of written reports on program projects |
| American Board of Opthalmology | PhD | Board-approved residency training program ( 3 years) | | 1 year (recommended; mandatory after 7/1/81) | Or, WLR |
| American Board of Oral and Maxillofacial Surgery | PhD | Board-approved training program (3 years) | 1 year | | Or, WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Board of Orthodontics | MA | | 5 years | 2 years | Pra, Or, WLR, E |
| American Board for Certification in Orthotics and Prosthetics | UG or AA (in some circumstances) | Educational Accreditation Commission-accredited training program | 1-4 years | | Pra, Or, WLR |
| American Board of Pedodontics | UG or MA | Council on Dental Education/ADA-approved program (2 years) | 3 years | 2 years | Pra, Pro, Or WLR case histories, clinical site visit |
| American Board of Periodontology | PhD | Commission on Accreditation of Dental and Dental Auxiliary Education Programs-accredited program | 2 years | | Or, WLR case reports |
| American Board of Prosthodontics | PhD | 2 years in ADA-approved program | 5 years | | Pra, WLR, Or presentation & treatment of a patient |
| American Board of Psychological Hypnosis | PhD | 2 specialty training courses (60 hours) | 5 years | 2 years | Pro, Or |
| American Cardiology Technologist Association | HS | | 2 years | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American College of Nursing Home Administrators[1] | UG | Participation in continuing education programs | 2 years + state licensure | | Pra, Pro, Equ, Or, WLR |
| American Corrective Therapy Association | UG | Clinical training | | 400 hours | Or, WLR |
| American Dental Association | | | | | |
| 1.Dentist | PhD | | | | WLR |
| 2.Dental Hygienist | AA | | | | WLR |
| American Dietetic Association | UG | | 3 years | 6-12 months | WLR |
| American Medical Record Association | | | | | |
| 1. Accredited Record Technician | AA (AMRA - AMA-accredited program) | | | Practice in a health care facility (incorporated in AA or UG curriculum) | WLR |
| 2. Registered Record Administrator | UG (AMRA - AMA-accredited program) | | | | |

[1]To be implemented

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION* |
|---|---|---|---|---|---|
| American Medical Technologists | | | | | |
| 1. Medical Technician/ Medical Laboratory Technician (MLT) | AA in medical technology or 60 hours required courses | or graduate of medical laboratory school + accredited by Accrediting Bureau of Health Education Schools | 6 months | | WLR |
| 2. Medical Technologist | UG with required courses | | 1 year | | WLR |
| | | graduate of professional school | 4 years | | WLR |
| | | or | | | |
| | | MLT certification | 3 years | | WLR |
| American Nurses' Association | | | | | |
| 1. Nursing of the Child/Adolescent | | | Practice of nursing of child/ adolescent- 2 of last 3 years | | WLR |
| 2. Pediatric Nurse Practitioners | | Approved program, submission of case studies and references | | | WLR |
| 3. Medical-Surgical Nurse | | | 2 years of practice in specialty area out of last 3 years 16 hrs/wk in direct patient care | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Nurses' Association (cont) | | | | | |
| 4. Clinical Specialist in Medical-Surgical Nursing | MA w/concentration in nursing | | 1 year medical-surgical nursing exp. 4 hrs/wk in direct patient care | | WLR |
| 5. Psychiatric and Mental Health Nurse | | | 2 years exp. in last 4 yrs., direct nursing care for 4 hrs/wk | | WLR |
| 6. Clinical Specialist in Psychiatric and Mental Health | MA w/concentration in specialty area | | 2 yrs (with 8 hrs/wk of direct patient care) or 4 yrs (with 4 hrs/wk of direct patient care) + exp. in 2 different treatment modalities + supervised practice for 1 year + current access to supervision or consultation | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Nurses' Association (cont) | | | | | |
| 7. Adult and Family Nurse Practitioner | UG or MA meeting ANA guidelines | Approved program | | | WLR |
| 8. School Nurse Practitioner | UG or MA meeting ANA guidelines | Approved program | | | WLR |
| 9. Gerontological Nursing | | Approved program, documentation of case studies, continuing education | | | WLR |
| 10. Nursing Administration | | | Currently licensed RN; 24 mo. exp. in last 5 yrs in nursing admin. posit. current holder of middle manag. or exec. posit. documentation of respons. | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Nurses' Association (cont)<br><br>11. Nursing Administration - Advanced | MA | | Currently licensed as RN; 36 months exp. in last 5 yrs. in ex. level nursing admin. posit. current holder of ex. nursing position | | WLR |
| American Registry of Allied Health Science (Formerly American Association of Medical Personnel)<br><br>1. Medical Technologist | UG in Medical Technology or Clinical Science | | | 1 year | WLR |
| | | AAMP-approved training school | 4 years | 1 year | WLR |
| | | | 7 years (10 yrs. as of 1981) | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Registry of Allied Health Science (Formerly American Association of Medical Personnel-cont) | | | | | |
| 2. Medical Laboratory Technician | AA in Medical Technique | | | 1 year | WLR |
| | | AAMP-approved Hospital Training Course | | | WLR |
| | | | 3 years (5 years as of 1981) | | WLR |
| 3. Medical Assistant Medical Secretary Dental Assistant Nursing Aide | UG or | AAMP-approved professional school | 1 year (nursing aide) 2 years (medical or dental assistant) 3 years (medical secretary) | | WLR |
| American Registry of Diagnostic Medical Sonographers | AA | 2 years in allied health program | 1 year | | Pra, Or WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| American Society for Microbiology | UG or MA | | 1-4 years | | WLR |
| American Society of Ocularists | HS | | 5 years | 3 years under supervision of a certified member | Pra, Pro, WLR, Or, E |
| American Society of Podiatric Assistants | | | 1 year | | WLR |
| American Surgical Trade Foundation | HS | Minimum of 40 hours formal training | 2 years | | Pra, Pro, WLR |
| Association for the Administration of Volunteer Services | | Applicant may engage in any learning experience designed to meet performance criteria | | | Portfolio development |
| Association of Surgical Technologists | AA or UG | On-the-job training programs<br>Formal hospital programs in surgical technology<br>Vocational-technical programs | | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION * | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program: | | | | | |
| Certified Laboratory Assistant (CLA) | HS | CAHEA[1] -accredited lab. asst. program or military med. lab. spec. | | | WLR |
| | | or | 3 years | | WLR |
| | | or<br>Basic military medical lab. course | 1 year | | WLR |
| Cytotechnologist (CT) | AA<br>or<br>30 hrs. from college or univ. | Completion of CAHEA[1] accredited CT program (1 year) | | | WLR + visual compone |
| Histologic Technician (HT) | HS | | 2 years | | Pra, WLR |
| | or<br>AA or 60 hrs. from college or univ. | | 1 year | | Pra, WLR |
| | | Completion of CAHEA[1] accredited HT program | | | Pra, WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program | | | | | |
| Histotechnologist (HTL) | UG | | 1 year | | Pra, WLR (in Aug. 1980) |
| | | Completion of CAHEA[1] + accredited Histologic Technician program | | | Pra, WLR (in Aug. 1980) |
| Medical Laboratory Technician (MLT) | AA degree from a CAHEA[1] accredited med. tech. program | | | | WLR |
| | | | 5 years | | WLR |
| | | or | | | |
| | AA | Graduation from military med. lab. spec. program | | | WLR |
| | | or | | | |
| | AA | CLA certification | | | WLR |
| | | or | | | |
| | AA | Completion of CAHEA[1] accredited program | 1 year | | WLR |
| | or | or | | | |
| | 30 hrs. from college or university | Completion of CAHEA[1] accredited MLT-C program | | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program<br><br>Medical Technologist (MT) | | | | | |
| | UG w/req. courses | Completion of CAHEA[1] accredited MT program | | | WLR |
| | | MLT certificate | 3 years | | WLR |
| | | CLA certificate | 4 years | | WLR |
| | | | 5 years | | WLR |
| Specialist in Blood Banking (SBB) | UG w/req. courses | MT certificate + CAHEA[1] accredited SBB program (1 year) | | | Pra, WLR |
| | | CAHEA[1] accredited SBB program | 1 year | | Pra, WLR |
| | | | 5 years | | Pra, WLR |
| | MA/PhD in Immunohematology or related areas | | 3 years | | Pra, WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program | | | | | |
| Specialist in Chemistry (SC) | UG | MT or other appropriate certificate | 5 years | | WLR, E |
| | MA | | 4 years | | WLR, E |
| | PhD | | 2 years | | WLR, E |
| Specialist in Hematology (SH) | SAME AS SPECIALIST IN CHEMISTRY | | | | |
| Specialist in Immunology (SI) (to be implemented in Aug. 1981) | SAME AS SPECIALIST IN CHEMISTRY | | | | |
| Specialist in Microbiology (SM) | SAME AS SPECIALIST IN CHEMISTRY | | | | |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program | | | | | |
| Technologist in Chemistry (C) | UG w/req. courses | | 1 year | | WLR |
| Technologist in Hematology (H) | UG | MT certificate | 1 year | | WLR |
| | or | | | | |
| | UG w/req. courses | | 2 years | | WLR |
| Technologist in Immunology (I) | UG | MT certificate | 1 year | | WLR (in Aug. 1980) |
| | or | | | | |
| | UG w/req. courses | | 2 years | | WLR (in Aug. 1980) |
| Technologist in Microbiology (M) (to be offered in 1980) | UG w/req. courses | | 1 year | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| Board of Registry American Society of Clinical Pathologists<br><br>Certification Program<br><br>Technologist in Nuclear Medicine (NM) | | | | | |
| | HS | CAHEA[1] -accredited NM program | 6 years | | WLR |
| | AA in basic sciences or 60 hrs. w/req. courses | CAHEA[1] -accredited NM program | 3 years | | WLR |
| | UG w/req. courses | CAHEA[1] -accredited NM program | 2 years | | WLR |
| | | MT or RT(ARRT)[1] certificate | 1 year | | WLR |
| Child Health Associate Program | UG Child Health Associate Degree | 2 year program | | 1 year | WLR |
| | MA Child Health Associate Degree (either degree is recommended) | | | | |
| Council on Certification of Nurse Anesthetists | UG or MA program in Nursing or Anesthesia - accredited by AANA | Completion of an accredited program 2 years + current state licensure as registered professional nurse | | Included in education program | WLR |

[1]RT(ARRT) - Radiologic Technologist, American Registry of Radiologic Technologists

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION * | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| International Association of Trichologists | | | 100 hours | | Pra, WLR, E |
| Joint Commission on Allied Health Personnel in Ophthalmology (JCAHOP)<br>1. Ophthalmic Assistant | HS | Approved institutional or home study course (1 year or less) | | At least 1 yr. under supervisory Ophthalmologist | WLR |
| 2. Ophthalmic Technician | HS | 2 year accredited education and training program<br>— or —<br>Ophthalmic Assistant certification + 18 credit hours of continuing education from JCAHOP-approved program | 3 years | | Pra, Or. WLR |
| National Association for Practical Nurse Education and Service | UG | State licensure as a practical nurse | 1 year | | Pro, WLR |
| National Board of Chiropractic Examiners | PhD | | | Included in formal education | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| National Board for Respiratory Therapy | | | | | |
| 1. Respiratory Therapists | 62 hours college or university credit | 2 years in AMA-accredited respiratory therapist school | 1 year | | WLR, CS |
| 2. Respiratory Therapy Technician | | 1 year in AMA-accredited therapist technician school | 1 year | | WLR |
| National Certification Agency for Medical Laboratory Personnel | | | | | |
| 1. Clinical Laboratory Scientist | UG (clinical laboratory sciences program | | | | WLR |
| | UG w/36 hrs. of req. courses | completion of clinical laboratory program recognized by the federal government | 2 years | | WLR |
| | 60 semester hrs. of college course work + 36 hrs. of required courses | | 10 years | | WLR |
| 2. Clinical Laboratory Technician | | Graduation from program accredited by agencies recognized by the U.S. Office of Education or the Council on Postsecondary Accreditation | | | |
| | | or Certificate of military laboratory experience | | | |
| | | | 4 years | | |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS (see key p. 50)

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| National Commission on Certification of Physician's Assistants | | Accredited program or program within a nationally accredited school of medicine or nursing that trains pediatric or family nurse practitioners | | | Pra, Pro, WLR, CS (patient-management problems) |
| | HS | | 4 years | | |
| National Registry of Emergency Medical Technicians<br>1. EMT-Ambulance | | 81 hours minimum National Standard EMT-A curriculum | 6 months | | Pra, WLR |
| 2. EMT-Paramedic | | 400 hours of National Standard EMT-P curriculum; certification as EMT-Ambulance | 6 months | 100 hours | Pra, WLR |
| New York State Registry for Medical Technologist<br>1. Medical Technologist | UG w/ required courses | | | | WLR |
| 2. Medical Technician | — or — AA or 60 semester hrs. from an accredited school offering courses in Medical Technology | | | | WLR |

Table 1: CERTIFICATION ELIGIBILITY REQUIREMENTS

| AGENCY | FORMAL EDUCATION* | OTHER TRAINING PROGRAM | WORK EXPERIENCE | INTERNSHIP OR PRACTICUM | EXAMINATION** |
|---|---|---|---|---|---|
| New York State Registry for Medical Technologist (cont.)<br>3. Clinical Laboratory Trainee | HS | Laboratory traineeship in an accredited clinical laboratory | | | WLR |
| Nuclear Medicine Technology Certification Board | HS | Graduation from Joint Review Committee for Educational Programs in Nuclear Medicine Technology (JRCNMT) accredited school | 6 years | | WLR |
| | — or — | | | | |
| | UG or AA w/req. courses or certificate in Medical Technology, Radiologic Technology, or an RN certificate | | 3 years | | WLR |
| Registry of Medical Rehabilitation Therapists and Specialists | UG w/req. courses | Clinical training program | 1 year | 4 months | WLR (being developed) |
| | — or — | — or — | | | |
| | MA w/req. courses | Clinical training program | 6 months | 4 months | WLR (being developed) |

Key

* HS - High School Diploma
UG - Undergraduate Degree
AA - Associate Degree
MA - Master's Degree
PhD - Doctorate Degree

[1]CAHEA - Commission on Allied Health Education and Accreditation of the American Medical Association

** Pra - Practical
Pro - Proficiency
Equ - Equivalency
Or - Oral
WLR - Written Limited Response (multiple choice, true/false)
E - Essay
CS - Clinical Simulation

Table 2: RECERTIFICATION (see key p. 53)

| AGENCY | RECERT. (X=REQUIRED) | HOW OFTEN | YEAR INITIATED | MECHANISM* | RECERT. IN SPECIALTY AREAS |
|---|---|---|---|---|---|
| American Board for Certification in Orthotics and Prosthetics | (3) | | | | |
| American Board of Dental Public Health | X | Yearly | 1952 | CE, PA | |
| American Board of Periodontology | X | Every 3 years | 1975 | CE | |
| American College of Nursing Home Administrators | X | Every 4 years | 1980 | CE, WE, CS | |
| American Dietetic Association | X | Every 5 years | 1969 | CE | |
| American Medical Record Association | (2) | | | | |
| American Medical Technologists | X (4) | Every 5 years | 1980 | (2) | |
| American Nurses' Association | X | Every 5 years | 1975 | CE, PA, RE(1) | X |

Table 2: RECERTIFICATION (see key p. 53)

| AGENCY | RECERT. (X=REQUIRED) | HOW OFTEN | YEAR INITIATED | MECHANISM* | RECERT. IN SPECIALTY AREAS |
|---|---|---|---|---|---|
| American Registry of Allied Health Science (formerly American Association for Medical Personnel) | X (4) | Every 5 years | 1980 | RE, DE, SA | |
| American Society of Ocularists | X (4) | | 1973 | CE | |
| American Society of Podiatric Assistants | X | Every 2 years | 1976 | CE | (3) |
| American Surgical Trade Foundation | X | Every 5 years | 1977 | CE, DE | |
| Association for the Administration of Volunteer Services | X | (2) | 1979 | SA | |
| Association of Surgical Technologists | X | Every 3 years | 1977 | CE | |
| Board of Registry-American Society of Clinical Pathologists (all certification programs) | (3) | | | | |

Table 2: RECERTIFICATION

| AGENCY | RECERT. (X=REQUIRED) | HOW OFTEN | YEAR INITIATED | MECHANISM* | RECERT. IN SPECIALTY AREAS |
|---|---|---|---|---|---|
| Joint Commission on Allied Health Personnel in Ophthalmology | X | Every year | 1971 | CE | |
| National Certification Agency for Medical Laboratory Personnel | X (4) | Every 4 years | 1978 | (2) | (2) |
| National Commission on Certification of Physician's Assistants | X | Reregistration- every 2 years Recertification- every 6 years | 1977 | CE, RE(3), DE(3) | (3) |
| National Registry of Emergency Medical Technicians | X | Every 2 years | 1972 | CE | (3) |
| Registry of Medical Rehabilitation Therapists and Specialists | X (4) | (4) | 1976 | PA | (3) |

Key

* CE - Continuing Education
RE - Re-administration of Entry Examination
DE - Development of Recertification Examination
PA - Practice Audit
SA - Self-Assessment
WE - Work Experience
CS - Computer Simulation

(1) Optional
(2) To be determined
(3) Under study
(4) To be implemented

Table 2(a): RECERTIFICATION

Agencies with No Recertification Program

American Academy of Gnathologic Orthopedics
American Association for Music Therapy
American Boards of Clinical Hypnosis
American Board of Ophthalmology
American Board of Oral and Maxilliofacial Surgery
American Board of Orthodontics
American Board of Pedodontics
American Board of Prosthodontics
American Board of Psychological Hypnosis
American Cardiology Technologists Association
American Corrective Therapy Association
American Dental Association
American Registry of Diagnostic Medical Sonographers
American Society for Microbiology
Child Health Associate Program
Council on Certification of Nurse Anesthetists
International Association of Trichologists
National Asscciation for Practical Nurse Education and Service
National Board of Chiropractic Examiners
National Board for Respiratory Therapy
New York State Registry of Medical Technologists
Nuclear Medicine Technology Certification Board

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| American Boards of Clinical Hypnosis | A | IH | Vote of Board committee members | | |
| American Board of Dental Public Health | A | IH | Cr | | |
| American Board of Oral and Maxilliofacial Surgery | G[1] | IH | Nr | Con | |
| American Board of Orthodontics | A[1] | IH | Cr | Con, Pre, Cnt | |
| American Board for Certification in Orthotics and Prosthetics | A, B, C, G[1] | IH, OC | Cr - Oral<br>Nr - Written | Cst, Dif | Yes |
| American Board of Pedodontics | A | IH | Nr | | |
| American Board of Periodontilogy | A | IH | | | |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| American Board of Psychological Hypnosis | B | IH | Cr | | |
| American Cardiology Technologists Association | A | IH | Cr | Con, Cst, Pre, Cnt, Df | Yes |
| American College of Nursing Home Administrators | B[1] | IH, OC | Nr | Con, Cst, Pre[4], Cnt[4], Dif | Yes |
| American Corrective Therapy Association | A | IH | Cr | Con, Cst | |
| American Dental Association | | | | | |
| 1. Dentist | A | IH | Nr | Con | Yes |
| 2. Dental Hygienist | A | IH | Nr | Con | Yes |
| American Dietetic Association | A | IH, OC | Cr | Con | Yes |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| American Medical Record Association | G[1] | IH. OC | Cr | Con | Yes |
| American Medical Technologists | C | IH | Cr | Con, Cst, Cnt[2] | Yes |
| American Nurses' Association (all examinations) | A | IH, OC | Nr | Con, Cst, Cnt | Yes |
| American Registry of Allied Health Science (formerly American Association of Medical Personnel) | A | IH | Cr | Con, Cst | |
| American Registry of Diagnostic Medical Sonographers | A | IH | Cr | | |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| American Society for Microbiology | A | IH | Nr | | Yes |
| American Society of Ocularists | A | IH | Nr (for WLR) | Con, Cst, Pre Cnt | |
| American Society of Podiatric Assistants | B | IH | Cr | | |
| American Surgical Trade Foundation | A | IH | | | |
| Association of Surgical Technologists | B | IH | Cr | Con, Cst | Yes |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| Board of Registry-American Society of Clinical Pathologists (all examinations) | A, D | IH | Nr-for all written limited response exams and cytotechnologist visual component Cr-for all practical exams & essay component of the exams for Specialist in Hematology, Specialist in Microbiology & Specialist in Chemistry | Con, Cst | Yes |
| Child Health Associate Program | F | IH | Cr | | |
| Council on Certification of Nurse Anesthetists | A | IH, OC | Cr | Con | Yes |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| International Association of Trichologists | A | IH | | Con | |
| Joint Commission on Allied Health Personnel in Ophthalmology | A, C | IH | | Con | Yes |
| National Association for Practical Nurse Education and Service | A | IH, OC | Cr | Con | Yes |
| National Board of Chiropractic Examiners | A | IH | Nr | Con | Yes |
| National Board for Respiratory Therapy[3] | D[1], E[1], F[1] | IH, OC | Cr | Con, Pre[4] | Yes |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES
(see key p. 62)

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| National Certification Agency for Medical Laboratory Personnel | A | IH, OC | Cr | Con | Yes |
| National Commission on Certification of Physician's Assistants | A, B, C | IH, OC | Nr | Con, Cst, Dif | Yes |
| National Registry of Emergency Medical Technologists[3] | B, E[1] | IH, OC | Cr, Nr | Con, Cst | Yes |
| New York State Registry of Medical Technologists | A | IH | | Con, Cst, Pre, Cnt, Dir | Yes |

Table 3: TEST CONSTRUCTION PRACTICES AND PROCEDURES

| AGENCY | HOW PERFORMANCE DOMAIN IS DEFINED* | DEVELOPMENT OF TEST ITEMS** | HOW PASS/FAIL SCORES ARE DETERMINED*** | TYPES OF VALIDITY ESTABLISHED FOR EXAMINATIONS# | RELIABILITY ESTABLISHED FOR EXAMINATIONS |
|---|---|---|---|---|---|
| Nuclear Medicine Technology Certification Board | A, B | IH, OC | Nr | Con, Dif | Yes |
| Registry of Medical Rehabilitation Therapists and Specialists | A | IH, OC | Cr | Con | |

Key

* A - Expert Consensus
B - Survey of practitioners
C - Survey of employers
D - Survey of hospitals
E - Interviews with practitioners
F - Interviews with employers
G - Study of practitioners' job functions

** IH - In-house
OC - Outside consultant

*** Cr - Criterion referencing
Nr - Norm referencing

1 - Services of outside consultant are employed
2 - Planned
3 - Two different types of examinations administered
4 - Under study

# Con - Content validity
Cst - Construct validity
Pre - Predictive validity
Cnt - Concurrent validity
Dif - Differential validity

## Chapter Four

## ANTITRUST - THE LEGAL DIMENSION

For a period of more than 50 years following their enactment, the Federal antitrust laws were considered to have little or no direct application to health professions. As a result, any anticompetitive and monopolistic activities in the health field went virtually unchecked, with successful legal challenges mounted only rarely. Recently, however, government agencies and aggrieved private parties have turned to these statutes as a means of providing appropriate forms of relief. Of particular importance are United States Supreme Court decisions within the past several years that have greatly expanded the potential scope and effectiveness of the Federal antitrust laws.

The antitrust laws were "designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade,"(1) and they "reflect a legislative judgment that ultimately competition will not only produce lower prices, but also better goods and services."(2) Thus, these laws rest on free market concepts contrasting sharply against a pro-regulatory approach, although agencies enforcing antitrust laws often are perceived as regulators due to their symbolic role as instruments of government intervention. Antitrust statutes of recent relevance to health professions are the Sherman Antitrust Act of 1888 and Section 5 of the Federal Trade Commission (FTC) Act of 1914 (as amended in 1938).

As courts and regulatory bodies, as well as the Congress, have embarked on a gradual overhaul of the antitrust rules among professionals, several complicated policy and legal questions have emerged. For example, should professional activity be subject to the same rigorous treatment under antitrust law as that accorded business and commercial activities? Second, does the Federal Government have the constitutional right to wield its antitrust club against one side or the other in a purely local dispute? Third, can antitrust laws effectively limit the basic right to petition or influence government? Fourth, if a State regulates a profession or activity, can the Federal Government step in to strike down specific State regulations on the ground that they violate Federal antitrust law? Fifth, do the antitrust laws have application to the certification of health professions? Sixth, should the Federal Trade Commision serve as a regulator, or de-regulator, or only as an investigator of the

health professions, or should it instead be totally uninvolved? Seventh, do the States, as well as the Federal Government, have a role in enforcing antitrust principles?

These difficult questions are in the foreground of health manpower policy, partially obscured, perhaps, only from an historical perspective that does not recognize their relevance to issues of the supply, distribution and credentialing of health care practitioners. Moreover, these are only some of the troublesome antitrust problems facing the health care community at large. But, they are among the most important, and this chapter discusses them in the order in which they are listed in the previous paragraph.

## Scope of the Antitrust Acts

The Sherman Act seeks to prevent those business practices which result in market control and substantially lessen competition. Section 1 of the Act focuses on restrictive agreements ("...every contract, combination...or conspiracy in restraint of trade or commerce...is hereby declared to be illegal," 15 U.S.C. Sec. 1) including, for example, agreements among competitors to fix prices, restrict output, divide markets or exclude other competitors. Section 2 of the Act prohibits monopolization or attempts to monopolize. The mere existence of monopoly power is not in itself a violation of this section. Instead, the Act serves to prohibit practices which lead to the seizure and exercise of monopoly power.

Section 5 of the FTC Act prohibits "unfair methods of competition." It has been interpreted also to prohibit conduct which in its incipiency threatens to bring about an antitrust violation(3) or conflicts with the basic policies of the antitrust laws while falling short of any specific violation.(4)

### Trade or Commerce

For a considerable period of time, a major impediment to the application of the Sherman Antitrust Act to the health care area was the so-called "learned professions" or "professional" exemption. Under the exemption, anticompetitive activities on the part of professions and professional organizations were not subject to antitrust scrutiny because such activities were not considered "trade or commerce" within the meaning of the Sherman Act. Although the United States Supreme Court never explicitly recognized such an exemption,

several decisions have paid lip-service to the idea that professions should be treated differently from customary business and commercial entities for antitrust purposes.(5)

Recent decisions have made it clear that there is no professional exemption from antitrust laws. In Goldfarb v. Virginia State Bar,(6) the U.S. Supreme Court recently laid to rest any lingering doubt about the existence of a professional exemption. Despite the assertion by a local association that competition is inconsistent with professional practice, the Court found that the challenged activity - setting of minimum legal fees for title-searching services - was tantamount to commercial and business practices. However, while acknowledging that various professional practices are imbued with a "business aspect," the Court cautioned against viewing restraints on competition in professional activities in the same light as restraints on purely commercial activities.(7) Implications of Goldfarb will be discussed in a following section.

Interstate Commerce Requirement

The Federal antitrust laws are limited as part of the Congress' constitutionally derived power to regulate only interstate commerce. If a challenged activity has little or no impact on interstate commerce, jurisdictional challenges to a court's ability to hear the antitrust claim will be upheld.

Supreme Court decisions within the past two decades have substantially broadened the reach of congressional power in regulating interstate commerce. In contrast to earlier cases, which classified activity as either "local" (and therefore beyond congressional purview) or "interstate," these later cases recognized that purely local or intrastate activity might have a substantial impact on interstate commerce and thus become subject to congressional control.

A recent example of this expansive construction of the commerce clause occurred in Goldfarb, where, despite the county bar association's claim that there was no showing that prospective purchasers were discouraged from buying homes and that the effect on interstate commerce of a fee schedule mechanism operating in the county was remote, the Court found that a sufficient relationship with interstate commerce had

been established.* Similarly, in Hospital Building Co. v. Trustees of Rex Hospital,(8) the Court held that a conspiracy to restrain expansion of a 49-bed hospital would unreasonably burden interstate commerce, because these activities could affect purchases of out-of-state medicines and insurance as well as payments of out-of-state lenders and managers.

In the area of medical staff privilege disputes, courts have found sufficient interstate impact where a single physician alleged anticompetitive action. Thus, in an antitrust suit brought against a hospital for restraint of trade in excluding a plaintiff physician from staff membership, the court ruled that the plaintiff could proceed with the suit if he could establish that a significant number of his patients received Medicare or Medicaid benefits even though his and the defendant-hospital's patients were almost all from a certain area in Michigan.(9) At least one commentator, though, has argued that staff privilege disputes do not raise truly antitrust issues and that an allegation of anticompetitive action toward a single physician should be dismissed on jurisdictional grounds because the impact on interstate commerce is too attenuated.(10)

As these cases indicate, the expanded concept of interstate commerce raises the likelihood of successful antitrust actions being brought by the Justice Department or private parties against professional groups. The willingness of courts to find the necessary nexus between the challenged conduct and interstate commerce will assure that this jurisdictional hurdle will be surmounted more easily by plaintiffs in the future than it was in the past.

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*The Court first identified interstate aspects of real estate transactions within the county, including the provision of funds for home mortgage loans which are supplied from outside the State and Federal loan guarantees by Federal agencies located in other jurisdictions; in light of the fact that title searches were required as a condition of making a loan, title examinations were viewed as integral and inseparable parts of interstate real estate transactions, and the Court found that fixed fee schedules of a purely local nature, when applied in connection with legal services furnished in conducting such an examination, sufficiently affected interstate commerce.

## Exemptions

### Political Action Doctrine

It is now well-settled that under the antitrust laws, professional associations that engage in concerted activity against competitors are, in most cases, subject to antitrust suits. However, the judicially created "political action" exemption to the antitrust laws affords some protection to associations and their members when they are exercising their political rights to petition government. Even when these latter efforts are aimed at attaining anticompetitive government decisions, the antitrust laws will not be interposed as a barrier to the right to communicate with public officials.

The political action doctrine was first enunciated by the Supreme Court in Eastern Railroad Presidents Conference v. Noerr Freight(11) and elaborated on in United Mine Workers v. Pennington.(12) In these cases, where the defendants' activities involved lobbying with public officials and engaging in publicity campaigns designed to influence legislation and obtain enforcement of laws that would eliminate competitors, the Court held the Sherman Act inapplicable. The Court's reluctance to apply the Sherman Act was based on constitutional and policy considerations containing the regulation of political activity.

The Noerr holding was qualified by the "sham exception" to the political action doctrine. The Court recognized that in instances when defendant's activities, "ostensibly directed toward influencing governmental action, is a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor,"(13) then the political action doctrine is not available as a defense to a party charged with violating antitrust laws.

In California Motor Transport Co. v. Trucking Unlimited,(14) the Court extended Noerr-Pennington immunity to include some attempts to influence administrative and judicial decisions. However, some plantiffs' access to administrative and judicial processes normally available to competitors was held to fall outside the area of Noerr protection. Thus, by differentiating between the political arena and adjudicatory proceedings, the Court created a dual standard under the sham exception, with a "sham" being easier to demonstrate where attempts are made to affect administrative and judicial decisions than to influence actual legislation.(15)

The Noerr-Pennington doctrine is particularly relevant to health care. One type of anticompetitive activity involving the issue has been the active opposition of State medical societies to Health Maintenance Organizations' license applications before State agencies. Assuming that no abuse of the administrative process is committed, such activity would in all likelihood enjoy immunity from antitrust enforcement.

Other examples of concerted activity involve boycotts whereby local medical society members refuse to accept Medicaid patients unless the State and Federal governments are willing to pay higher fees. Arguably, this type of activity can be protected under the Noerr-Pennington defense as an effort to influence State allocation of Medicaid funds. Although the case law on this issue is inconclusive, several commentators(16) have argued that doctors' Medicaid boycotts should fall within the judicially created consumer exception to the Noerr-Pennington doctrine,(17) which states that the defense is inapplicable when the government is acting in a proprietary capacity as a purchaser of goods and services - a function which includes the setting of Medicaid reimbursement levels.

Generally, it is apparent that broad applications of the Noerr-Pennington doctrine may work to frustrate antitrust enforcement efforts. When confronted with these issues, courts will be asked to weigh carefully the competing economic and political interests in fashioning appropriate judgments and remedies.

State Action Doctrine

In addition to specific industry exemptions from antitrust laws as provided by statutes,(18) regulated industries also enjoy, to some extent, immunity from these laws. This inapplicability of antitrust laws to regulated industries is based in part on a policy determination that unrestricted competition among economic units in the marketplace is incompatible with regulatory initiatives. The interface between antitrust enforcement and Federal regulatory agencies' responsibilities in particular fields has been the subject of much judicial inquiry, with courts' attention to this issue unlikely to diminish. Perhaps even more controversial is the relationship between State agencies and the antitrust laws due to the presence of delicate constitutional issues involving conflicting Federal and State policies.

When confronted with conflicting policies embodied in Federal and State laws, courts usually undertake a "pre-emption" analysis. Under this type of analysis, a Federal law will be determined to supercede, or overshadow, a State law if the Federal law explicitly preempts the State law or if the Federal law authorizes conduct incompatible with the State law. Rather than solely relying on congressional dictates as expressed in a particular statute, it is likely that some courts have engaged in making policy judgments as to which State laws ought to be preempted. As a counter-vailing consideration, these policy judgments are constrained by principles of federalism, which place constitutional limitations on the preemptive power of the Federal Government.

The State action doctrine, shielding State-regulated activity from antitrust attack, can be viewed as a particularized application of preemption analysis. The doctrine was first enunciated in 1948, when the U.S. Supreme Court, in Parker v. Brown,(19) determined that a California raisin marketing program involving raisin growers, marketers and a designated State official acting in concert to regulate raisin production and sale was immune from attack under the antitrust laws, despite its anticompetitive effects. The Court found that the Sherman Act was not intended to prohibit anticompetitive activity by a State, but instead was directed only at private conduct.

While the Court did not define precisely the scope of the exemption, it did enumerate two types of activity which would not be protected: a State's grant of legislative immunity for private antitrust violations, and the entering into anticompetitive agreements by a State and a private party. Parker did not discuss whether a State could delegate its immunity. As one authority has pointed out, this lapse is crucial in the health care area, where regulations are often promulgated by a mixture of State officials and private health care providers.(20)

For a period of 32 years, the Supreme Court failed to clarify many of the issues left unresolved by Parker. But, the Court recently reexamined the state action doctrine in Goldfarb v. Virginia State Bar(21) and perceptibly narrowed the exemption. In Goldfarb, a Sherman Act challenge was undertaken against a county bar association's minimum fee schedule which was enforced by the Virginia State Bar. The county bar claimed that the activities of the State Bar "prompted" it to issue fee schedules, thus triggering an exemption from the Sherman Act under the State action doctrine. The Court, in rejecting the county bar's claim,

indicated that "anticompetitive activities must be compelled by direction of the State acting as a sovereign"(22) in order to be exempted from the antitrust laws. Despite its landmark status, Goldfarb failed to provide clear guidance in interpreting and applying the State action doctrine. Questions about the explicitness of State directives to an agency undertaking anticompetitive activity, such as the question of whether an agency may infer its authority to undertake anticompetitive activities from a general legislative intent in order to satisfy the Goldfarb compulsion test, were left unresolved.

The Court next took up the relationship between State regulation and the antitrust laws in Cantor v. Detroit Edison Co.(23) That case involved a challenge to a utility company's practice of giving away "free" light bulbs to residential users and adding the cost to the overall price customers paid for electricity. The bulb program was included in the utility's schedule of rates and approved by Michigan's Public Service Commission. When a seller of light bulbs brought an antitrust claim that the utility used its monopoly power in the distribution of electricity to restrain competition in the light bulb market, Detroit Edison claimed that it was exempt under the State action doctrine. The Supreme Court denied the utility's claim. Despite technical compulsion by the State as sovereign, it was held that mere acquiescence by the State agency in approving the utility-initiated program was not sufficient State action for antitrust immunity to apply. Thus, Cantor makes it clear that State supervision alone is not sufficient to trigger antitrust immunity, particularly when the State has made no policy determination rejecting competition in furtherance of its regulatory scheme.

An instance where the State action doctrine was successfully asserted occurred in Bates v. State Bar of Arizona,(24) where the U.S. Supreme Court, while striking down a ban on legal advertising on First Amendment grounds, was unanimous in holding that the restraint on attorney advertising imposed by the Arizona Supreme Court did not violate the antitrust laws. The Court, in upholding the State Bar's assertion of State action immunity, reasoned that, unlike in Goldfarb, the challenged activity was explicitly compelled by the State through the Supreme Court of Arizona, "the ultimate body wielding the State's power over the practice of law"(25) pursuant to the State constitution.

The most recent Supreme Court consideration of State action doctrine occurred in City of Lafayette v. Louisiana Power and Light Co.(26) In this case, the Court rejected an argument by municipally owned public utilities that their anticompetitive activities were protected under the State

action doctrine. Four justices indicated that the State action doctrine applies only if such anticompetitive activity has been "authorized or directed"(27) by the State; however, according to this opinion, such authority need not be "specific or detailed" and will be found to exist even "when it is found from the authority given a governmental entity to operate in a particular area that the legislature contemplated the kind of activity complained of."(28) A Federal court of appeals relied on the above language in modifying a lower court's order which enjoined the Texas State Board of Public Accountancy from enforcing a board rule prohibiting competitive bidding.(29) The lower court had concluded that the legislature did not really address the issue and that, in light of the fact that the rule had been approved by a majority of licensees, promulgation of the competitive bidding ban should not be viewed as State action.(30)

Rather than adopting any conclusory test for determining the scope of the State action doctrine, the Supreme Court appears to have applied a case-by-case approach. However, as Goldfarb, Cantor and City of Lafayette indicate, where regulation is undertaken by a private or State political subdivision rather than by the State legislature or a State agency (as in Bates), there will be a greater reluctance to immunize allegedly anticompetitive conduct.

Antitrust and the Credentialing of Health Manpower

Arguments that certifying agencies serve as gatekeepers to the market and thereby insulate certificants from the rigors of competition suggest that these organizations are potential targets of antitrust attack. Antitrust laws may afford an attractive remedy to rejected applicants who can demonstrate unnecessarily restrictive certification requirements.

Thus far, despite the potential application of antitrust laws to this area, few related cases have been reported. Perhaps the most significant case concerning the issue is Veizaga v. National Board for Respiratory Therapy,(31) which involves a class action challenge to the practices and activities of the National Board for Respiratory Therapy, the American Association for Respiratory Therapy and several hospitals in the Chicago area. It was alleged in the case that the defendants had conspired to engage in a concerted refusal to deal by not hiring plaintiffs unless they successfully completed the certification examination. The trial court, in ruling on defendants' challenge that sufficient

impact on interstate commerce had not been demonstrated, refused to dismiss the suit (the court held that a significant interstate nexus exists, because the defendant hospitals advertised for respiratory therapists in nationally circulated periodicals and received applications from out-of-state practitioners, and because the examinations were administered on a national basis).

In reviewing defendants' assertion that certification activities of a professional association could not be considered trade or commerce and thus lay beyond the reach of antitrust laws, the Veizaga court heeded Goldfarb's caution that, although there is no "learned profession" exemption, anticompetitive actions on the part of professional associations should not be viewed in the same light as similar actions affecting purely commercial activity. The court, in allowing plaintiffs to amend their complaint, pointed to the need for further inquiry into the precise nature of the challenged activity and indicated that if it were found to be commercial, more stringent tests under the antitrust laws would be applied than if the activity were viewed as professional.

A judgment has not yet been reached in the Veizaga case. Plaintiffs recently filed a third amended complaint,(32) and a definitive ruling must await further litigation. Any decision in the case may serve as important precedent, indicating the extent to which antitrust law may set limits on the role of certification. Especially significant are issues of the relationship of the certification examination to actual practice skills, and the right of employers to reject routinely employment applications submitted by non-certified individuals.

Accrediting practices of private professional associations have also recently been subject to antitrust scrutiny. In United States Dental Institute v. American Association of Orthodontists,(33) a private dental school and individual dentists brought an antitrust suit against an association of orthodontists and the American Dental Association, claiming that the defendants engaged in a boycott prohibited under the Sherman Act. Various challenged activities included preventing State approval of the school and practitioner participation in the school's programs. The defendants were alleged to have issued guidelines for continuing dental education which eliminated the school from the list of accepted institutions and to have issued opinions in which they declared it to be unethical for any practitioner to participate as a faculty member in the school or any other unapproved program. In addition, the defendants were alleged to have refused

acceptance of plaintiffs' advertisements in defendants' publications seeking faculty members and listing available course offerings. The individual dentist-plaintiffs alleged that these restrictive practices prevented them from receiving training and performing orthodontic services and had the effect of preserving orthodontists' special commercial interests.

The defendants moved to dismiss the dental institute's case, arguing in part that a "learned profession exemption" should be applied. The court denied the motion, using language that may reflect the readiness of courts to include credentialing in the scope of activities that are covered by the antitrust laws. If the plantiffs' allegations are true, said the court (and courts, in considering motions to dismiss claims, must accept plantiffs' allegations), then the defendants':

> . . . actions seek to prevent dentists from acquiring the skills necessary to competently service their patients and the full extent of their legal authorization to practice. Even though the professional regulations are not so limited, it is charged that the practice of orthodontia has effectively been restricted to fully certified orthodontist specialists, as a result of defendants' actions. The consequences of this, plantiff allege, have been to protect to protect the orthodontists' monopolistic position which enables them to charge higher rates for their services to the public than the market would otherwise bear. Defendants' actions thus operate on the business and commercial aspects of the dental practice by preserving the orthondontists' special commercial interests.(34)

## Antitrust Activities by the Federal Trade Commission in the Health Field

Despite the paucity of judicial cases dealing with antitrust challenges to the activities of professional organizations, the Federal Trade Commission (FTC) has become extremely active in recent years in combating anticompetitive restraints in the health professions. Much of the recent FTC antitrust activity in the health care field has concerned practices which have tended to restrict the supply of health manpower and deprive consumers of needed information on which to base purchasing decisions.

One of the premier FTC antitrust actions in the health care field was an investigation of the American Medical Association (AMA) and two of its component State and local societies to determine whether they illegally restrained the supply of physicians and medical services through promulgation of principles of medical ethics which limited advertising and solicitation of patients. Following commencement of the AMA case, the FTC initiated an investigation of the American Dental Association (ADA) and component State and local societies amid charges that the ADA's enforcement of its ethical code likewise violated the antitrust laws. Late in 1979, the FTC issued final, but appealable, orders prohibiting enforcement of the AMA and ADA ethical restrictions on advertising.(35)

A related FTC activity against the AMA concerns agency criticism of the Association's role in accrediting medical schools. That Commission's Bureau of Competition staff have urged DHEW to deny recertification of the AMA-related Liaison Committee on Medical Education as the sole government-sanctioned accrediting body for medical schools, because of apparent self-interest involving limits on the number of physicians entering the profession. In response to this criticism, the Commissioner of Education, while failing to deny recertification, did limit the period of recognition to two years rather than four years as had previously been done routinely.(36)

The FTC also is currently investigating whether the Joint Commission on the Accreditation of Hospitals has unfairly acted to exclude licensed clinical psychologists from the staffs of hospitals and psychiatric facilities.(37)

Other relationships in the health care field have been challenged by the FTC. The Commission's Bureau of Competition recently issued results of an investigation into medical participation in the control of Blue Shield and other prepayment plans, declaring that the "structural relationship that exists between physician organizations and most Blue Shield plans raises inherent antitrust and conflict-of-interest problems."(38) The Bureau's staff drafted a proposed rule which would limit physician organizations from participation in and control of such plans. The Bureau has also attacked physician-developed relative value scales as unlawful price-fixing agreements. These scales contain lists of medical procedures, each of which is assigned a unit value to reflect the purported complexity and professional time associated with the procedures. Such guides can be converted into fee schedules by applying an appropriate dollar conversion factor to each category of procedure. In challenging

the use of relative value scales, the Commission has obtained consent orders barring several physician organizations, including the American College of Obstetricians and Gynecologists,(39) the American Academy of orthopedic Surgeons,(40) and the American College of Radiology,(41) from issuing such guides. However, a Federal district court has dismissed a similar U.S. Department of Justice antitrust suit against the American Society of Anesthesiologists for adopting a relative value scale, on the ground that the list comprised a mere guide and did not attain the level of a price-fixing agreement.(42)

The Commission's Bureau of Consumer Protection also has been active in the area, notably in investigating State laws that regulate health professions in a manner viewed by the agency as inimical to consumers' economic interest. Last year, the Commission issued a final rule to preempt State laws prohibiting or restricting the advertising of ophthalmic goods and services.(43) In addition, the Commission's San Francisco Regional Office initiated an investigation of the impact of state dental laws on the supply and interstate mobility of dentists.(44)

These and other activities indicate that the FTC has become a potential thorn in the side of some health care-related organizations. The Commission's vigilance in the enforcement of antitrust principles with respect to health professions has generated considerable controversy and at times may have motivated organizations to reconsider activities subject to potential challenge. The Congress now is considering legislation to curtail FTC authority over the professions.

State Antitrust Developments

Anticompetitive activities in the health area are also subject to the Sherman Antitrust Act's State counterparts. Recently, attorneys general of several jurisdictions have resorted to these State laws to challenge allegedly anticompetitive activities undertaken by health professionals. In New York, the State's attorney general has filed suit against the American Medical Association, the American Hospital Association, the American College of Physicians, the Joint Commission on Accreditation of Hospitals and other organizations, charging them with conspiring to eliminate the chiro- ls practic profession from New York by engaging in a group boycott. Alleged activities include pressuring medical and osteopathic doctors not to refer patients to chiropractors or to accept referrals from them, and refusing to permit hospitaot to honor chiropractors' requests that x-rays be taken on

particular patients.(45) In Arizona, the State's attorney general recently entered into a consent judgment with the Arizona Radiologial Society, under which the latter agreed not to enforce any ethical rule requiring radiologists or nuclear physicians to work on a fee-for-service basis and to refrain from working as salaried employees.(46) Massachusetts' attorney general has obtained a consent decree against a State nurses' association, under which the latter agreed not to publish rate schedules for private day nursing care.(47) These and other recent actions point to significant increases in State antitrust activity in the health care area.

Summary

For a long time, the health care field was shielded from application of antitrust principles. However, recent U.S. Supreme Court decisions have clarified that health and other professions are not exempt from the Federal antitrust laws. Similarly, expanding notions of the Federal Government's power to regulate interstate commerce have assured that many anticompetitive activities in the health care area which were once thought to be beyond the reach of the antitrust laws are now subject to its provisions.

Despite broadened Federal power in the antitrust area, several recognized exemptions may serve to frustrate government efforts to curtail anticompetitive activities in the health field. Under the political action doctrine, associations' lobbying activities with public officials, even when these efforts are aimed at attaining legislation which would eliminate competition, are immune from antitrust attack. A similar exemption applies in the case of attempts to influence administrative and judicial decisions. However, exemptions may be lost and anticompetitive activities found under the antitrust laws if it is determined that an association's exercise of its political right to petition government is a mere "sham" undertaken with the primary aim of directly interfering with a competitor's business or professional activities. Under the State action exemption, meanwhile, anticompetitive activity on the part of State officers, agencies and government entities acting pursuant to a State's explicit authorization is considered immune from antitrust challenge. Thus, anticompetitive activities on the part of a State agency regulating practice in a health care profession under legislative mandate may lie beyond the reach of Federal antitrust laws.(48)

Recent litigation has been focused on the anticompetitive implications associated with private health organizations' certification programs. To illustrate, a challenge to the credentialing practices of respiratory therapists is currently

before a Federal court. In addition, accrediting practices of professional organizations which seek to restrict member participation in teaching and training programs conducted by competing organizations have been subject to recent antitrust attack.

The Federal Trade Commission has been extremely active in combating anticompetitive practices of various health professions. Commission action in 1979 included prohibitions on practices of the American Medical Association and the American Dental Association which the Commission found to restrict the supply of physicians and dentists and related services. Consent orders have been obtained against several physician groups barring the use of relative value scales, which were alleged to be price-fixing agreements. Also, the Commission's Bureau of Competition staff recently completed an investigation of medical participation in the control of Blue Shield and other pre-payment plans and drafted a proposed rule designed to limit such participation. Moreover, activity on the part of State attorneys general in attacking anticompetitive practices of health professions has been increasingly evident in recent months. Given the multi-pronged nature of the antitrust challenge, it is reasonable to assume that health occupational credentialing in the 1980s will be vigorously watched by antitrust authorities.

Chapter Four

Footnotes

1. Northern Pacific Ry. v. United States, 356 U.S. 1, 4 (1958).

2. National Society of Professional Engineers v. United States, 435 U.S. 679, 695 (1978).

3. See, e.g., FTC v. Motion Picture Advertising Service Co., 344 U.S. 392 (1953).

4. See, e.g., Atlantic Refining Co. v. FTC, 331 U.S. 357 (1965); FTC v. Raladam, 283 U.S. 643 (1931).

5. See e.g., United States v. Oregon Medical Society, 343 U.S. 326, 336 (1952); FTC v. Raladam, supra note 4.

6. 421 U.S. 733 (1975).

7. In a portentous footnote, the Court elaborated on the appropriate analysis to be applied to professional activities:

   The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context be treated differently. We intimate no view on any other situation than the one with which we are confronted today. (421 U.S. at 788-89, n.17)

8. 425 U.S. 738 (1976).

9. Zamiri v. William Beaumont Hospital, 420 F. Supp. 875 (E.D. Mich., 1970).

10. Havighurst, Professional Restraints on Innovation in Health Care Financing, 1978 Duke L.J. 303, 367.

11. 365 U.S. 127 (1961).

12. 381 U.S. 657 (1965).

13. 365 U.S. at 144.

14. 404 U.S. 508 (1972).

15. Note, Physician Influence: Applying Noerr-Pennington to the Medical Profession, 1978 Duke L.J. 701, 704.

16. See, e.g., Note, supra note 15, 705-709; Weller, Medicaid Boycotts and Other Maladies from 'Medical Monopolists': An Introduction To Antitrust Litigation and the Health Care Industry, 11 Clearinghouse Rev. 99, 102-103 (1977).

17. See, e.g., George R. Whitten, Jr., Inc. v. Paddock Pool Builders, 424 F. 2d 25, 31-34 (1st Cir.), cert. denied, 404 U.S. 1047 (1972).

18. See, e.g., the McCarran-Ferguson Act, 15 U.S.C. 1011-1015, which confers an exemption from the antitrust laws on those engaged in the "business of insurance" if such business is regulated by State law. Since its enactment in 1943, a vast amount of litigation has attempted to clarify and more precisely delineate the Act's scope. However, in a recent U.S. Supreme Court decision, Group Life and Health Insurance Co. v. Royal Drug Co., Inc., 440 U.S. 205 (1979), it was held that the term "business of insurance" does not apply to agreements between an insurance company and pharmacies to supply prescription drugs at a flat rate to the company's policyholders. The Court distinguished between the "business of insurance," which is exempt from the antitrust laws, and the "business of insurance companies," which is not. The agreements between the insurer and participating pharmacists were perceived as mere arrangements for the purchase of goods and services rather than the spreading and underwriting of a policyholder's risk and were thus not within the ambit of "business of insurance" exemption.

19. 312 U.S. 338.

20. Blumstein and Calvani, State Action as a Shield and a Sword in a Medical Services Antitrust Context: Parker v. Brown in Constitutional Perspective, 1978 Duke L.J. 389, 404.

21. See supra note 6.

22. Id. at 791.

23. 428 U.S. 579 (1976).

24. 433 U.S. 350 (1977).

25. Id. at 360.

26. 435 U.S. 389, 98 S. Ct. 1123 (1978).

27. Id., 96 S. Ct. at 1137.

28. Id., 98 S. Ct. at 1138, quoting City of Lafayette v. Louisiana Power and Light, 532 F.2d at 434 (5th Cir. 1976).

29. United States v. Texas State Board of Public Accountancy, 592 F.2d 919 (5th Cir.), cert. denied, _U. S._, 100 S. Ct. 262 (1979).

30. United States v. Texas State Board of Public Accountancy, 464 F. Supp. 400 (W.D. Tex., 1978).

31. 1977-1 Trade Cases Par. 61,274 (N.D. Ill. 1977).

32. See American Medical News, June 29, 1979, at 6.

33. 396 F. Supp. 565 (N.D. Ill. 1975).

34. Id. at 581.

35. 937 BNA Antitrust and Trade Reg. Rptr. (ATRR) at E-1 (Nov. 1, 1979).

36. Palmer, Antitrust Activities by the Federal Trade Commission in the Health Field - An Address Before a Joint Meeting of the Health and Welfare Committee and the Council on Antitrust and Trade Regulation of the FBA, 37 Federal Bar J. 40, 46 (1978).

37. 802 ATRR at A-6, 7 (Feb. 22, 1977).

38. Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, at 2 (1979).

39. 3 CCH Trade Reg. Rep. Par. 21,171 (Dec. 14, 1976).

40. Id.

41. 3 CCH Trade Reg. Rep. Par. 21,236 (March 1, 1977).

42. United States v. The American Society of Anesthesiologists, 473 F. Supp. 147 (S.D.N.Y.1979).

43. 43 Federal Register 23992 (July 2, 1978).

44. Palmer, supra note 35, at 46.

45. New York v. American Medical Association, No. 79 C1732 (E.D.N.Y., July 2, 1979), see 922 ATRR at D-1, 2 (July 12, 1979).

46. Arizona v. Arizona Radiological Society, No. C388972, (Ariz. Super. Ct., Maricopa Cty., June 1, 1979), see 919 ATRR at D-5, 6 (June 21, 1979).

47. In re Licensed Practical Nurses of Massachusetts, Inc., No. 36800 (Mass. Super. Ct., Suffolk Cty., Aug. 9, 1979), see 929 ATRR at D-9 (Aug. 30, 1979).

48. An important test case concerning this issue may grow out of the FTC's attempt (supra note 42 and accompanying text) to prevent States from prohibiting advertising of eye services.

## Chapter Five

## SCOPES OF PRACTICE

One of the major purposes and effects of public credentialing of the health professions is to delineate the scope of practice of each regulated profession. Typically, such delineation occurs in licensing statutes, rather than in regulations or through certification activities undertaken in the private sector. It may be contended that assignment of scopes of practice to professions comprises the anatomy of licensure, used to carve health services into separate jurisdications and thus to establish interrelationships among the diverse occupational groups.

Delineation of scopes of practice has been an extremely important licensing activity since the origin of licensing laws, but in recent years a new dimension has been added to the importance of this activity. The proliferation of health professions, along with specialization within professions so that different levels of occupational entities have appeared, renders the lines of demarcation between occupational groups necessarily fuzzy and difficult for practitioners, legal authorities and consumers to identify. Moreover, changes within the health care delivery system itself have caused some of the statutory definitions of scopes of practice to become dated and to seem inflexible or even oppressive. Privately, many health licensing experts are heard to say that licensing laws are honored in the breach and that no hospital could adequately function in today's environment without stretching or even ignoring certain aspects of scope-of-practice restrictions. To assure the relevance of licensure to actual practice, it may become necessary to adjust State or other licensing configurations to allow changes to be made in delineations of scopes of practice without lengthy, highly political recourse to State legislatures.

In recognition of the importance of scopes of practice to health occupational credentialing, this Commission, in undertaking the present study, has attempted to develop an approach to the analysis of statutory scopes of practice. Although scopes of practice are not ordinarily perceived as components of certification processes, it is impossible to develop certification policies or to review licensure without considering the importance and difficulty of assigning scopes of practice to each occupational group. Indeed, the identification of functions performed by a group is arguably the first crucial step in the development of a certification process.

The method chosen here for assessing scopes of practice is basically a content analysis of statutory provisions, which allows for comparisons among regulated occupations within States, and for comparisons among States in the regulation of a single occupation. Hypothetically, such an analysis would tend to show:

- specific interprofessional overlap in scopes of practice, and identification of areas of practice not assigned by law, within each State;
- conformity among States in the scope of practice of each profession;
- composite overlaps among States, suggesting which professions tend to perform certain identical functions; and
- vague scopes of practice which could be clarified by regulations, without the necessity of obtaining amendments in legislation.

## Methodology

The method of inquiry undertaken as part of this study comprises a pilot approach to the problem. A single investigator with previous experience working with health occupational licensing laws composed and applied a taxonomy of components of scopes of practice for a particular cluster of professions. The cluster of occupations chosen - medicine, psychology and social work - presumably performs some similar functions in the area of the delivery of mental health services. The source of the text of statutory scopes of practice was Volume II: A Handbook of State Licensure Laws, in The Regulation of Psychotherapists by Daniel B. Hogan (Cambridge, Massachussets: Ballinger Publishing Company, 1979). According to that author, most of these laws as presented in the volume have been updated to 1978.

Several limitations of the approach, as undertaken in embryonic fashion for this study, deserve note. A single investigator was used, so that validity, reliability and freedom from bias have not been demonstrated. Only a few professions involved in mental health care are included; nursing, for example, is not part of this analysis. Therefore, this pilot study hardly represents a definitive analysis of statutory scopes of practice in the mental health field.

With this approach, regardless of the number or talents of investigators, judgment is extremely important in determining which components are present in a particular statutory scope of practice. It is usual for the same or similar words to reappear in different provisions in a different order or with some slight modification. To illustrate, one of the components used here was "remuneration," suggesting that to practice as a member of a particular profession in the licensing State, one must or could charge for services; it is a matter of judgment whether this component is present in a statutory provision that one is engaged in the scope of practice "whether or not remuneration" exists. In such close cases, the operative concept is context: One must analyze phrases within the context in which they appear. In any event, because of these limitations and others, this pilot substudy represents merely an approach to analysis of scopes of practice and is not intended to be definitive.

It should also be noted that a different taxonomy could alter the results of the study. This, too, is because different professions have different terms applied to their scope of practice - terms that frequently have similar meanings. For example, although psychologists in North Carolina have a broad and detailed scope of practice, the law does not recognize that they "treat" patients, as do physicians there, or that they help people adjust socially or increase their functional capacity, as do social workers in many states, although North Carolina law does provide that psychologists "assist in . . . . attainment of personal growth." The point is that, from the patient's viewpoint, all these concepts probably appear quite similar in the mental health area and probably could be included in the same scope-of-practice component, although, from a statutory or legal perspective, these concepts appear, at least at first blush, to be quite different.

## Results of Investigation

The aggregate results of the study across all the jurisdictions are shown in Table 4: Components of Statutory Scopes of Practice for Medicine, Psychology and Social Work: 50 States and the District of Columbia, pp. 87-90. It does not reveal where overlaps in scopes of practice occur in particular states. The reader will note that components are grouped into the major categories of entrepreneurship, application of a discipline, evaluation, intervention, counseling, supportive services and a miscellaneous or "other" category.

The table reveals that significant overlap occurs in some components of intervention, in diagnosis, in some entrepreneurial aspects, and, between psychology and social work only, in some of the "other" components. Outside the entrepreneurial aspects, diagnosis, treatment and disease prevention are the only components shared among all three professions. A lack of overlap is particularly apparent within the category of application of a discipline.

Some conclusions may be drawn in the case of each of the occupations. In the profession of medicine, scopes of practice tend to show great uniformity across States. All States license physicians, and only one State does not specify a scope of practice in the licensing law. Five components are listed in the statutes of at least half the States. Further demonstrating the uniformity, only three components are listed in at least five but no more than fifteen States. The most common components are treatment, holding oneself out as a member of the profession, diagnosis, prescription and surgery.

Psychology, on the other hand, shows great diversity among States. Psychologists also are licensed in all States, but only four components (testing of mental and personality characteristics, psychotherapy, application of established principles of perceptions and emotions, and personality counseling or guidance) are listed in the statutes of at least half the jurisdictions specifying a scope of practice. Of the 45 components identified in the study, 17 are listed in the statutes of at least five but no more than 15 jurisdictions.

Social workers are licensed in 21 jurisdictions, all but five of which specify a scope of practice. These scopes of practice tend toward greater uniformity than is found in the psychology statutes but less than is found in the case of medicine. Seven components are listed in the statutes of at least half the jurisdictions specifying a scope of practice, but that number is only nine jurisdictions. Twelve of the 45 components are mentioned in at least two but no more than six of the 17 jurisdictions with a scope of practice.

## Implications

Results of this pilot study raise serious questions about the match between statutory scopes of practice and the realities of professional practice. A threshold problem is the inherent vagueness resulting from the fact that scopes of practice are not chosen from a particular list of discrete functions. Taken at face value, the statutory schemes might

suggest that physicians, unlike psychologists and social workers in many States, do not counsel, conduct research or provide supportive services. Another troublesome problem involves the fact that 17 of the components in the case of psychology, and 12 of the components in the case of social work, are mentioned in the statutues of between 10 and 30 percent of the licensing jurisdictions: This may or may not suggest, for example, that psychologists evaluate personalities, diagnose, and resolve emotional conflicts, or that social workers perform psychotherapy, modify behavior and participate in legislative processes.

The mere existence of these problems leads to the conclusion that, to learn what a health profession does to the exclusion of other professions, one should not look to State practice acts. A nationwide licensing system that authorizes professionals to do different things in different States, when in fact they do largely the same things in all States, contains at least an element of absurdity. Practice acts fail to guide the public or professionals to a knowledge of interprofessional differences in scopes of practice. And, because there does not exist an alternative mechanism for identifying scopes of practice, differences among the myriad of professions are so imprecise as to be mysterious.

Some of this imprecision naturally results from subtle or indiscernible differences in the meanings of words used in the statutes. For example, in the mental health care area, it is not immediately clear what the implications are if a psychologist in a State is authorized to evaluate and classify a personality, but not to make a diagnosis, or if a social worker may counsel individuals short of administering psychotherapy.

Despite the rudimentary nature of this pilot study, it does suggest the possibility of a promising avenue of research. The method can be used to determine overlaps or practice omissions in each State, thus indicating where a State scheme may lack enough coherence that the statutes should be interpreted only very broadly to determine whether a non-physician professional is conducting the unauthorized practice of medicine or if similar statutory violations are taking place. Similarly, the method can be used to identify professions, such as psychology, that clearly lack conformity in scope of practice among States. It also can be used to ascertain which components tend to be listed in scopes of practice of different professions; to illustrate, the fact that all three of these professions are somewhat engaged in diagnosis and treatment suggests that States that prohibit non-physicians from diagnosing and treating are not thereby maintaining a credible prohibition.

However, this method may not be particularly useful in showing where scopes of practice can be adjusted and kept up-to-date through regulation without recourse to legislation. The very imprecision of statutory scopes of practice results in a general inability to learn from the face of the statute just what individuals, whether they be licensed under the statute or prohibited by the statute from engaging in the scope of practice, are prohibited from doing. For example, surely the fact that no statute authorizes psychologists or social workers to maintain an office or place of business, at least as a provision of licensure, does not itself forbid such entrepreneurship. That only psychologists are authorized to apply psychological principles and procedures of understanding and influencing behavior does not prevent social workers from applying the same principles and procedures. Admittedly, regulations can clear up many such ambiguities, but the point is that the legal meaning of scopes of practice as currently written in vague terms do not reveal to any degree of certainty just where courts might permit licensing boards or other regulatory authorities to adjust scopes of practice by permitting psychologists to make diagnoses, social workers to open offices, etc.

Even this cursory, segmented review of statutory scopes of practice thus demonstrates the inherent vagueness of statutory schemes to lay out the scopes of practice of the various health professions. Sophisticated interpretation must be used to apply these scopes of practice to real-life situations, and such interpretation ought to be informed by a familiarity with scopes of practice across States and across professions as well as by a knowledge of the dynamics of health services and interprofessional relations. Increasingly, courts and regulatory bodies may be called on to make judgments about alleged violations of practice acts that prohibit an individual who is not licensed as a member of a particular profession from encroaching on that profession's scope of practice specified in the statute. Our results indicate that the laws are so vague - perhaps in some cases unconstitutionally vague - that a wooden application of such laws would comprise a pathetic and foolish exercise. In the long run, it is to be hoped that new, more flexible mechanisms will be created to respond to the needs of practitioners, employers, consumers and government officials to know, within some degree of comfort, which professions or specialties within professions are qualified and authorized to perform particular functions.

Table 4: COMPONENTS OF STATUTORY SCOPES OF PRACTICE FOR MEDICINE, PSYCHOLOGY AND SOCIAL WORK: 50 States and the District of Columbia

| COMPONENT | MEDICINE: Number of States | PSYCHOLOGY: Number of States | SOCIAL WORK: Number of States |
|---|---|---|---|
| ENTREPRENEURIAL | | | |
| 1. Remuneration | 21 | 20 | 2 |
| 2. Holding self out as member of the profession or expert clinician | 38 | 15 | 5 |
| 3. Professional activity, relationship, or service | 1 | 21 | 13 |
| 4. Offering to treat | 18 | 0 | 0 |
| 5. Offering services | 13 | 9 | 1 |
| 6. Maintaining office or place of business | 13 | 0 | 0 |
| APPLICATION OF A DISCIPLINE | | | |
| 7. Applying recognized principles, methods, procedures of test interpretation | 0 | 7 | 0 |
| 8. Applying established principles of learning motivation, perception, thinking and emotional relationships | 0 | 27 | 0 |
| 9. Applying psychological principles, methods, procedures of understanding, predicting, influencing behavior | 0 | 23 | 0 |
| 10. Applying social work values, principles, techniques | 0 | 0 | 12 |
| 11. Basis of knowledge in human development and behavior | 0 | 2 | 6 |

Table 4: COMPONENTS OF STATUTORY SCOPES OF PRACTICE FOR MEDICINE, PSYCHOLOGY AND SOCIAL WORK: 50 States and the District of Columbia (Continued)

| COMPONENT | MEDICINE: Number of States | PSYCHOLOGY: Number of States | SOCIAL WORK: Number of States |
|---|---|---|---|
| APPLICATION OF A DISCIPLINE (Cont.) | | | |
| 12. Basis of knowledge of social resources or institutions, and how they interact with human development and behavior | 0 | 0 | 10 |
| 13. Using psychosocial methods | 0 | 0 | 2 |
| 14. Involves psychophysiological characteristics, physical dysfunction | 0 | 1 | 0 |
| 15. Within limits of individual competence or preparation, or based on training | 0 | 6 | 0 |
| EVALUATION | | | |
| 16. Measuring or interpreting tests of mental abilities, aptitudes, interests, personality characteristics, etc. | 0 | 42 | 0 |
| 17. Psychological evaluation, personality appraisal or classification | 0 | 10 | 1 |
| 18. Personal or vocational evaluation | 0 | 20 | 0 |
| 19. Diagnosis | 37 | 15 | 2 |
| 20. Interviewing | 0 | 16 | 1 |
| 21. Explaining or interpreting psychosocial aspects | 0 | 0 | 4 |

Table 4: COMPONENTS OF STATUTORY SCOPES OF PRACTICE FOR MEDICINE, PSYCHOLOGY AND SOCIAL WORK: 50 States and the District of Columbia (Continued)

| COMPONENT | MEDICINE: Number of States | PSYCHOLOGY: Number of States | SOCIAL WORK: Number of States |
|---|---|---|---|
| INTERVENTION | | | |
| 22. Psychotherapy | 0 | 30 | 7 |
| 23. Personality readjustment | 0 | 7 | 2 |
| 24. Altering social conditions to enable people to realize potential | 0 | 2 | 12 |
| 25. Treating disease, injuries, etc. | 47 | 8 | 3 |
| 26. Preventing or controlling social problems | 0 | 0 | 1 |
| 27. Prescribing medication | 36 | 0 | 0 |
| 28. Surgery | 28 | 0 | 0 |
| 29. Preventing disease or disorder | 8 | 12 | 2 |
| 30. Modifying, altering, or effecting change in behavior | 0 | 19 | 4 |
| 31. Hypnosis | 2 | 14 | 0 |
| 32. Ameliorating personal problems, etc. | 0 | 14 | 1 |
| 33. Resolving conflicts in emotions or attitudes that interfere with emotional social, or intellectual functioning; effecting change in emotional responses | 0 | 11 | 1 |
| COUNSELING | | | |
| 34. Personality counseling or guidance | 0 | 24 | 1 |
| 35. Counseling individuals, families or groups | 0 | 15 | 10 |

Table 4: COMPONENTS OF STATUTORY SCOPES OF PRACTICE FOR MEDICINE, PSYCHOLOGY AND SOCIAL WORK: 50 States and the District of Columbia (Continued)

| COMPONENT | MEDICINE: Number of States | PSYCHOLOGY: Number of States | SOCIAL WORK: Number of States |
|---|---|---|---|
| COUNSELING (Cont.) | | | |
| 36. Consulting | 0 | 7 | 3 |
| SUPPORTIVE SERVICES | | | |
| 37. Helping individuals, groups or communities adjust socially or enhance or restore their capacity for social functioning, human effectiveness, etc. | 0 | 6 | 13 |
| 38. Helping people obtain services | 0 | 0 | 8 |
| 39. Helping communities or groups provide or improve social and health services | 0 | 0 | 9 |
| OTHER | | | |
| 40. Research | 0 | 20 | 9 |
| 41. Administration | 0 | 0 | 8 |
| 42. Social planning | 0 | 5 | 3 |
| 43. Teaching | 0 | 10 | 7 |
| 44. Participating in legislative processes | 0 | 0 | 2 |
| 45. Human engineering | 0 | 1 | 0 |
| TOTAL: Number of licensing states | 51 | 51 | 21 |

Chapter Six

# CONCLUSIONS

The two major methods of credentialing members of the health occupations in the United States are licensure and certification. This report focuses on certification, which is a topic that is yet to be thoroughly researched and well-understood by regulators, professionals and the public.

Recent decades have seen an increasing demand for licensure on the part of occupational groups. This demand reflects the proliferation of health professions that has accompanied technological developments in the health care sector. It also reflects a sense of the benefits that licensure provides by granting recognition to professionals and providing the public with a feeling of protection. In recent years, certification also has seen an upswing. Although these two credentialing processes are separate, licensing bodies - state agencies or boards - sometimes rely on certifying agencies for demonstrations of the competence of individuals.

Wide variation exists among processes of certification. Some large agencies certify different occupational levels and groupings. These agencies can offer the advantages of career ladders, whereby a practitioner can apply qualifications earned for certification at a lower level toward qualifications for upper level certification. This report both discusses background issues in health occupational credentialing and supplies new information about the particular activities of certifying agencies. Forty-two certification organizations submitted data to the Commission as part of this research effort.

This study reveals that educational requirements remain paramount in certification. But, these requirements have come to include clinical as well as academic or didactic components. Although more education is typically required for higher level credentials, certifying agencies have begun to offer alternative pathways that allow clinical or related experience to be substituted on a limited basis and in some measure for educational requirements. In addition, approximately one-fourth of the certifying agencies supplying information reported that they require an internship or practicum.

Continuing competence is an area of increasing attention and controversy. Seventeen of the 42 agencies are implementing

recertification programs. Most of these programs rely on continuing education to assure continuing competence. But other techniques, from readministration of the entry level examination to development of a recertification examination based on simulation, from self-assessment to practice audit, are being used innovatively.

While practitioners are being exposed to the concept and demands of continuing competence, aspiring practitioners are beginning to gain familiarity with issues in competency measurement. Credentialing examinations are beginning to move away from merely measuring educational advancement to measuring actual clinical capabilities. Almost all of the certifying agencies administer paper-and-pencil tests, mostly multiple choice in format, but many use oral or practical examinations as well, and a few have implemented clinical simulations, submission of reports on individual projects, presentation and analysis of patient treatments, development of individual portfolios, or site visits.

The two major testing approaches now claiming adherents are norm-referencing and criterion-referencing. The latter is theoretically suited to evaluating competence but is extremely difficult to implement. It requires the successful candidate to demonstrate actual job-related competence, whereas norm-referencing imposes only the obligation to score relatively high, as compared with the rest of the examinees, on questions related to a general body of knowledge and chosen largely because they discriminate among applicants. According to the responses of the certifying agencies, norm-referencing and criterion-referencing are equally popular as basic approaches to the setting of pass/fail levels.

Another huge area of testing controversy concerns validity and reliability of tests. Twenty-five agencies stated that they have demonstrated content validity (only two admitted that they had not), which reflects an apparent relationship between the content of the examination and the material on which applicants should be tested. The organizations report much less success on relating test performance to present or prospective job performance. Approximately three-fourths of the agencies supplying information on the issue stated that they had established examination reliability, which embodies the accuracy of measurement.

A different dimension of current activity is that of antitrust law. This important area of legal ferment has a broad but disputed scope. Antitrust law has application to numerous areas of health and professional affairs including

the loss of occupational opportunity to non-certified persons and the intertwined relationships among certifying agencies and other important groups. This report discusses antitrust law in some depth, partly to compensate for the relative lack of attention ordinarily accorded it until now as a consideration of health manpower policy.

The other legal topic addressed in the report is statutory scopes of practice as defined for occupations in State licensing laws. Preliminary evidence is presented to show that these scopes of practice are quite vague and outdated and that they differ markedly among States despite the presumed uniformity of training and competence among members of the same profession in different States. A method used in this report to examine this topic can help to determine overlaps or omissions in scopes of practice within a State, or difference among States in the scope of practice for a single profession. The results indicate that it is difficult to apply State laws to determine whether practitioners are acting within established areas of competence. Similarly, the laws provide relatively little guidance about precisely which activities members of a given occupation are engaged in.

Doubtless the entire area of health certification requires further research to reveal its scope, impact on practitioners, cost implications and relevance to performance. Moreover, it appears clear that far greater communication is needed among regulators and other interested parties in both the public and private sectors about the actual extent of credentialing activity currently taking place. Information of health occupational credentialing policy pertaining to a State or a particular occupational group ought soon to become a phenomenon of the past. And, because the pertinent questions involve lively debate and reflect rapid developments, there is much information to share.

Ultimately, the purpose of certification, like that of licensure, is to assure competence and responsibility and thus an acceptable level of quality in the delivery of health services. It is unfortunate, therefore, that so little attention has been focused on certification in the past. As the 1970s brought recognition of the magnitude of certification problems, so will the 1980s present the opportunity for resolution.

Appendix

THE DEVELOPMENT OF COMMISSION STANDARDS
October 5, 1979

Background

The National Commission for Health Certifying Agencies is primarily a standard-setting organization. The Commission's central mission is to develop and apply standards in the national certification and membership criteria for organizations that certify health professionals. To the extent that these criteria gain acceptance in the certification community and among the public and other interested parties, the Commission will succeed in improving health occupational credentialing.

For these reasons, a large share of effort devoted to date by the Commission has been concentrated in the area of criteria and standards. The bylaws of the Commission require certifying agencies to comply with established criteria as the condition of membership in Category A of the Commission - the category that includes certifying agencies and holds majority voting power in Commission deliberations. The arduous process of developing initial criteria to be used in reviewing membership applications was culminated in December 1978 at the Commission's annual meeting. These criteria are listed at the end of this appendix.

As even a cursory review of these criteria would reveal, the criteria that have been developed are notable for their breadth and difficulty of attainment. These rigorous criteria involve certifying agencies' structure, examination processes, dissemination of information and efforts to keep pace with the latest developments in occupational credentialing. Certifying agencies must be non-governmental and non-profit-making, administratively independent and broadly based with governing board representation from members of the certified profession, interested employers and consumers. The agencies must at least have access to trained and knowledgeable authorities in psychometrics and must be financially secure. Job-relatedness periodic review, adequate security, appropriately established pass/fail levels and reliability as well as validity are all required of certification examinations.

In addition, the criteria require member certifying agencies to make available to the public descriptive materials about their activities and examination structure. Applicants for certification must be furnished with extensive information about the nature of the certification process and qualifications for certification. Discrimination according to age,

sex, race, religion, national origin, disability or marital status is prohibited. Significantly, agencies are further required to establish alternate pathways where appropriate, as an option to strictly educational qualifications, by the beginning of 1982. Confidentiality of results, prompt reporting of decisions, and feedback on areas of deficiency and confidentiality all are considered essential components of Commission-sanctioned certification procedures. And, even the attainment of all these criteria is insufficient, if the applicant agency has not developed or is not developing a program for recertification or continuing competence.

Although some criteria tend to be rather precise, it was recognized early in the formation of the Commission that a system for refining and interpreting membership criteria is necessary. This system is embodied in the Commission's Committee on Standards, one of the few standing committees in the organization. Already this committee has begun to address the most pressing problems in the area of refinement of criteria and has developed its own tentative agenda for 1980.

Because in many instances the state-of-the-practice in certification appears to lag behind the state-of-the-art, and because several goals in health certification clearly will prove difficult to achieve, some of the original membership criteria have been declared from the outset to be "delayed criteria." Such measures need not be complied with by members of the Commission until specified dates, in no case later than January 1, 1982. Delayed criteria include administrative independence, consumer and employer input into the governance of certifying agencies, evidence that pass/fail levels are arrived at in an acceptable manner, and availability of alternate pathways to certification.

The Commission views the setting of standards as the heart of its activities, and therefore it is appropriate that most of the major structures within the Commission participate in some way in the standard-setting process. Typically, this process works as follows. The Membership Committee, which applies criteria to applicant agencies in reviewing applications for Commission membership, comes to an awareness that certain criteria are too vague to apply consistently without refinement of the criteria, or apparently convey different meanings to different individuals. Or, more broadly, the Membership Committee may come to believe that a particular criterion or set of criteria cannot appropriately be applied to a certain class of applicants, such as State agencies, new and evolving certifying agencies or national federations of State boards. In all these cases, the Membership Committee

recommends that the Committee on Standards evaluate the problem and propose some refinement. The Committee on Standards then determines the priority of the problem and places it on the Committee agenda.

In considering all such problems the Standards Committee seeks to obtain wide input into the decision-making process. Leaders in State occupational regulation, health professions education and certification itself serve on the Committee, which is aided by a panel of psychometric experts. Administrative and legal expertise is provided. Once the members of the Committee arrive at a consensus on an approach to the problem, the Committee determines whether the proposed solution appears to require a change in the stated criteria, in the bylaws of the Commission, in formal procedures or in some other mechanism. The Committee's recommendation is then delivered to the appropriate body for re-evaluation and, if appropriate, implementation.

Generally, this recommendation will advance to the Executive Council, which is the governing board of the Commission. The Council is free to modify or reject a Standards Committee recommendation, but the process of sifting and winnowing ideas within the Commission is so pervasive and complex that any arbitrary veto of reasonable Standards Committee proposals is virtually impossible. For example, the chairman of the Standards Committee has served as a member of the Executive Council and consequently is able to participate fully in Council deliberations over standards.

Modifications of bylaws and criteria also is a matter for consideration by the General Assembly of the Commission, which meets annually in December. Sixty percent of the votes in the Assembly are shared equally among Category A members, which are certifying agencies. The remaining 40 percent are shared among Category B members, which are other non-profit organizations with an interest in health occupations certification. General Assembly sessions have reflected the liveliness and importance of issues concerning certification standards. Although committee deliberations in the Commission perhaps tend to be influenced by national leaders whose own expectations for certification are high and whose sensitivity to the public interest is great, the Assembly may be seen theoretically as providing a check on Commission activity through an awareness of certifying agency limitations and resource constraints.

In the current era of ferment over the professions, there is nothing stagnant about health occupational certification. The setting of standards is unlikely to result in any concrete structure in the forseeeable future. The Commission therefore does not envision the development of a single set of standards

that can easily and automatically be applied to certifying agencies. Rather, as the Commission prepares to move beyond its formative stage, it is preparing for constant dynamism in the standard-setting area. The Committee on Standards will not expire after a certain date or once a particular agenda is completed, but instead will serve as a perpetual forum for the consideration of those issues most in need of consideration and as a permanent vehicle to assure that the issues are resolved in the public interest to the benefit of people involved in certification and for the enhancement of certification ideals. Thus, within this Commission, the task of setting and refining standards always will be evolving.

## The Objectives of Standards

Three major tests can fairly be applied to standards adopted by the Commission. Taken together, these tests may be considered to constitute the objectives of Commission standards.

The first test is whether the standard serves the public interest. The vigor with which this test is applied should be evident from an examination of the membership criteria. Certification that is linked to profit-making or subsumed within some broader activity is suspect, because it does not appear to afford the public needed protection and unity of purpose. Employer or supervisor and public input into certifying agency governance is intended as a check to assure that the certification process fits the requirements of health care rather than the narrower design of an occupational group. Validity or job-relatedness in examinations assures that individuals who are certified are competent to deliver particular categories of services rather than merely being members of an established professional monopoly that perpetuates its own entry criteria without regard to changes and needs in health care delivery.

The second test that may fairly be applied to Commission standards is one of universality. Standards should not be so fragmented that each one contains some loophole for the benefit of a particular organization or group. Nor should a standard be so narrow as to be excessively burdensome to a particular class of certifying agencies. In appreciation of these considerations, the original set of Commission criteria are purposefully vague in requiring that particular methods for establishing validity and reliability be used by certifying agencies. Because no known method is universally applicable, member agencies are free to choose among appropriate methods and thereby promote and benefit from innovations in psychometrics. A particularly difficult problem in

universality for the Commission is the identification of proper membership criteria for State agencies that participate in credentialing diverse health occupations. The participation of such State agencies in the Commission offers an unparalleled opportunity to improve symbiosis between licensure and certification, but the entry of State agencies into the Commission - if their credentialing processes do not meet Commission standards applied to private agencies - would allow such State agencies to represent their activities as being Commission- sanctioned and would dilute Commission integrity. This latter issue will be a topic for further consideration at the 1979 General Assembly.

The final test is attainability - whether a particular proposed standard is within the reach of certification. Although the need for assuring continuing competence is widely evidenced, current methods providing such assurance generally have undemonstrated effectiveness, so that at the present time it would be impractical to require certifying agencies to prove that they in fact require actual continuing competence of their certificants. This particular issue is so complex and pressing that it is the theme of the 1979 Educational Conference immediately preceding the General Assembly session. The concept of attainability also requires that standards be applied to new and evolving certifying agencies with considerable flexibility, without thereby making it so easy to become a certifying agency with some degree of Commission approbation that the Commission becomes an agent in the proliferation of professions.

Absent from these objectives is any way of directing Commission activities to benefit certified health professionals without also benefiting the greater public and the community of professions. In a period of increasing doubt about the capacity and vigor of health professions in regulating themselves, the viability of certification depends on great strides in improving techniques of certification to increase job-relatedness, better assure entry-level and continuing competence and enhance the accountability to the public of mechanisms of professionalization. The Commission has no hesitation in inviting observers to measure Commission activicies and standands along these objectives, therefore, rather than along any narrower objectives involving only private economic, political or other social gain. The Commission itself is a test of whether the private sector can be mobilized to regulate professions, with sufficient stringency.

## Early Stages in the Development of Standards

The standard-setting process can best be illustrated by a discussion of actions taken so far, in the initial stages, involving items on the Standards Committee agenda.

It should be noted at the outset that the membership application, containing all the membership criteria, has proved to be so cumbersome to complete that applications have been received by the Commission at a somewhat slower pace than was originally anticipated. However, review of the applications by the Membership Committee is correspondingly difficult and time-consuming, so that it might have been a hardship for that Committee to have been faced with the task of reviewing scores of applications in a single year. As the membership process becomes more stable, of course, the burden on that Committee will be lightened, and there will be sufficient experience in the application process that applicants will enjoy more guidance and precedent in their task. This point is mentioned initially, because the Membership Committee acted with dispatch and foresight in identifying areas in need of Standards Committee consideration.

The Standards Committee convened for the first time on August 21-22, 1979. That meeting may serve as an example of the Committee's procedures and operations. The meeting opened with a brief discussion by the Membership Committee chairman of problems in criteria interpretation that his Committee had been experiencing. These problems had been summarized, and alternative courses of action proposed, in an earlier staff memorandum to the Standards Committee. Also at the beginning of the meeting, the President of the Commission spoke of the Standards Committee as the "heart of the Commission" and compared the importance of standard-setting in the organization to the setting of standards within the Joint Commission on the Accreditation of Hospitals.

The first issue taken up by the Committee was criteria for State members. This issue involves the fact that, under the bylaws as currently written, State agencies that perform a credentialing function can join the Commission only as Category B members, in which case State mechanisms are not subject to the same rigid criteria that are applied to private certifying agencies applying for Category A membership. This discussion began with a general exchange of ideas about the value of Commission membership to State agencies and the potential role of such agencies in the Commission. The Committee decided to recommend that a separate category of membership eventually be created for State agencies that

credential diverse health occupations, and the Committee identified which of the current criteria should be applied to such agencies. This discussion also led to a decision to incorporate discipline (that is, the loss of professional privileges for ethical infractions or incompetence) into the criteria at some point in the future.

Next, the Committee discussed how certification should be defined and whether the Commission should permit Category B members to give special awards for excellence in a profession without having to meet Category A membership criteria. The Committee agreed that such honorific awards, when they are solely that, should not be interfered with by the Commission.

On the topic of transitional membership, including the issue of whether a new category of transitional member should be created in the Commission to include organizations that are merely beginning to develop certification procedures, deliberation led to a conclusion that the Commission should form an affiliate status without voting power for organizations that could not currently meet Commission criteria or for some reason had not yet decided to apply for Commission membership.

Finally, the Committee developed its own agenda for its next meeting, scheduled early in December. Agenda items include:

1. What constitutes a legitimate consumer or public member of a Category A member organization? The criteria require certifying agencies to have input from such consumer or public members into their decision-making processes.

2. What precise standards should be used by the Membership Committee in assessing methods for establishing pass/fail levels on certification examinations?

3. What standards should exist for eligibility of an occupation for Commission membership? For example, it is arguable whether occupations that appear mainly to constitute a skill rather than a profession (e.g., phlebotomists), groups whose work is not necessarily health-related (e.g., morticians) or not legitimized (e.g., faith healers), and segments of fractionated occupations (e.g., psychoanalysts) should be eligible for involvement in the Commission through certifying agencies.

In subsequent meetings, the Committee agreed to discuss issues of administrative independence, the job-relatedness of examinations and recertification.

In acting on the recommendations formulated by the Standards Committee, the Executive Council, meeting on September 14-15, 1979, decided to approve a bylaw amendment that would allow the creation of criteria for all types of members, rather than merely Category A certifying agency members. But, the Council favored proceeding cautiously in the area of relations with State agencies. The Council adopted a definition of certification that would permit certifying agencies to continue to confer honorary awards and approved a bylaw change that would establish an affiliate status in the Commission. These bylaw changes will be submitted to the General Assembly in December. The definition of certification that was decided on by the Executive Council is the "awarding by a private agency of a credential and the right to use that credential, which attests to the competence of the individual engaged in the relevant scope of practice."

In later stages, these actions themselves can be expected to be refined, and the General Assembly will take action on the proposed bylaw changes. The Standards Committee hopes to complete its deliberations on the listed agenda items in 1980, and will continue to seek guidance from the Membership Committee and the Executive Council about which issues are of highest priority. The Committee also intends to assure that its deliberations include as wide a variety of expertise as is possible and appropriate. It has charged the staff to distribute readings and prepare background papers for consideration by the Committee membership before meetings. In these ways, a correspondence between the seriousness of the topics considered and the vigor of Committee inquiry and deliberations will be assured.

Summary

The setting of standards for certification is the major activity of the National Commission for Health Certifying Agencies. In the current period of innovations in psychometrics and doubts about professional regulation, there is nothing easy about establishing standards for certification. The Commission stands for the proposition that certification should be geared to the public interest but oriented primarily to the private sector. Thus, the mission of the certification community in the decade ahead is one of enormous challenge.

Within the Commission, the setting of standards is envisioned as a continual process. Early signs indicate that the development of standards in this case is a process without beginning or end. It is a process notable for the divergence of constituencies, the diversity of issues, the difficulties of resolution but agreement about general goals and their importance.

NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES

## Criteria for Approval of Certifying Agencies

A certifying agency responsible for attesting to the competency of health care practitioners has a responsibility to the individuals desiring certification, to the employers of those individuals, to those agencies that reimburse for the services and to the public. The National Commission for Health Certifying Agencies was formed to identify how those varying responsibilities can be met and to determine if a certifying agency meets those responsibilities. Membership of a certifying agency in the Commission indicates that the certifying agency has been evaluated by the Commission and deemed to meet all of the established criteria. In order to be "approved" for membership in the Commission, a certifying agency* shall meet the following criteria:

1. Purpose of Certifying Agency

    a. shall have as a primary purpose the evaluation of those individuals who wish to enter, continue and/or advance in the health profession, through the certification process, and the issuance of credentials to those individuals who meet the required level of competence.

2. Structure of Certifying Agency

    a. shall be non-governmental;

    b. shall conduct certification activities which are national in scope;

    c. shall be administratively independent° in matters pertaining to certification, except appointment of members of the governing body of the certifying agency. A certifying agency which is not a legal entity in and of itself shall provide proof that the agency's governing body is administratively independent in certification matters from the organization of which it is a part;

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* The term "certifying agency" as used in this document means an independent not-for-profit certifying agency or a not-for-profit association with a certifying component. As of January 1, 1982, the certifying component of a not-for-profit association must be administratively independent.

° Administratively independent means that all policy decisions relating to certification matters are the sole decision of the certifying body and not subject to approval by any other body and that all financial matters related to the operation of the certifying component are segregated from those of the professional associations.

d. shall have a governing body which includes individuals from the discipline being certified. A certifying agency which certifies more than one discipline or more than one level within a discipline shall have representation of each on the governing body;

e. shall require that members of the governing body who represent the certified profession shall be selected by the certified profession or by an association or associations of the certified profession and such selection shall not be subject to approval by any other individual or organization;

f. shall have formal procedures for the selection of members of the governing body which shall prohibit the governing body from selecting its successors;

g. shall provide evidence that the public consumer and the supervising professional and/or employers of the health professional have input into the policies and decisions of the agency, either through membership on the governing body or through formalized procedures as advisors to the governing body. The criterion will be effective January 1, 1981;

h. the certifying body of a professional organization shall be separate from the accrediting body of the professional association.

3. Resources of Certifying Agency

a. shall provide evidence that the agency has the financial resources to properly conduct the certification activities;

b. shall provide evidence that the staff possesses the knowledge and skill necessary to conduct the certification program or has available and makes use of non-staff consultants and professionals to sufficiently supplement staff knowledge and skill.

4. Evaluation Mechanism

a. shall provide evidence that the mechanism used to evaluate individual competence is objective, fair and based on the knowledge and skills needed to function in the health profession;

b. shall have a formal policy of periodic review of evaluation mechanisms and shall provide evidence that the policy is implemented to insure relevance of the mechanism to knowledge and skills needed in the profession;

c. shall provide evidence that appropriate measures are taken to protect the security of all examinations;

d. shall provide evidence that pass/fail levels are established in a manner that is generally accepted in the psychometric community as being fair and reasonable. This criterion will be effective January 1, 1981, after standards have been established.

e. shall provide evidence that the evaluation mechanisms include evidence of attempts to establish both reliability and validity for each form of the examination.

5. Public Information

a. shall publish a document which clearly defines the certification responsibilities of the agency and outlines any other activities of the agency which are not related to certification;

b. shall make available general descriptive materials on the procedures used in test construction and validation and the procedures of administration and reporting of results;

c. shall publish a comprehensive summary or outline of the information, knowledge or functions covered by the test;

d. shall publish at least annually, a summary of certification activities, including number tested, number passing, number failing, number certified and number recertified (if the agency conducts a recertification program).

6. Responsibilities to Applicants for Certification

a. shall not discriminate among applicants as to age, sex, race, religion, national origin, handicap or marital status and shall include a statement of non-discrimination in announcement of the certification program;

b. shall provide all applicants with copies of formalized procedures for application for, and attainment of, certification and shall provide evidence to the Commission that such procedures are uniformly followed and enforced for applicants;

c. shall have a formal policy for the periodic review of application and testing procedures to insure that they are fair and equitable and shall give evidence to the Commission of the implementation of the policy;

d. shall publicize nationally appropriate data concerning the certification program including eligibility requirements for certification, basis of examination, dates and places of examinations;

e. shall provide evidence that competently proctored testing sites are readily acessible in all areas of the nation at least once annually;

f. shall publicize nationally the specific education background or employment background required for certification;

g. shall give evidence that a means exists for individuals who have obtained a skill or knowledge outside the formal educational setting to be evaluated and obtain certification or in the absence of such means, provide reasonable justification for exclusion. These means employed should be consistent with the evaluation standards. This criterion will be effective January 1, 1982;

h. shall provide evidence of uniformly prompt reporting of test results to applicants;

i. shall provide evidence that applicants failing the examination are given information on general areas of deficiency;

j. shall provide evidence that each applicant's test results are held confidential;

k. shall have a formal policy on appeal procedures for applicants questioning examination results and shall publish this information in examination announcements.

7. Responsibilities to the Public and to Employers of Certified Personnel

a. shall strive to insure that the examination adequately measures the knowledge and skill required for entry, maintenance and/or advancement into the profession;

b. shall provide evidence that the agency awards certification only after the skill and knowledge of the individual have been evaluated and determined to be acceptable;

c. shall periodically publish a list of those persons certified by the agency.

8. Recertification*

   a. shall have in existence or shall be in the process of developing a plan for periodic recertification;

   b. shall provide evidence that any recertification program is designed to measure continued competence or to enhance the continued competence of the individual.

9. Responsibilities to Commission

   a. shall provide the Commission on a regular basis with copies of all publications related to the certifying process;

   b. shall advise the Commission of any change in purpose, structure or activities of the certifying agency;

   c. shall advise the Commission of substantive changes in test administration procedures;

   d. shall advise the Commission of any major changes in testing techniques or in the scope or objectives of the test;

   e. shall undergo re-evaluation by the Commission at five-year intervals.

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* In this document the term "recertification" includes periodic renewal or revalidation of certification based on re-examination, continuing education or other methods developed by the certifying agency. This criterion will be effective January 1, 1982.

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