1 Public Policy and the Professions

In the United States the term *professionalism* has traditionally referred to the provision of expert, high quality service to the consumer—the goal of all occupational groups. Members of the established and aspiring professions in particular are supportive of this definition. In the minds of many citizens today, however, professionalism is a word that connotes elitism, exclusion, and exploitation. Professions are seen as grasping, careless elite groups responsible to no one, rather than altruistic groups of experts whose ethics ensure the quality of their services at a fair price.

The philosophy of professionalism rests on the assumption that in return for a privilege—autonomy from direct societal control—professions will deliver services at prices that do not exploit the privilege of self-regulation. This assumed attribute of professionals most commonly is referred to as a service orientation—a manner of behaving in which dedication to a client's interest takes precedence over personal profit when the two happen to come into conflict (Bledstein, 1976:87). Professions serve the public interest. However, others argue that professionalism results in personal gain for members of an occupation, and thus professionals primarily serve their own self-interest. These two perspectives provide the basis for the societal debate over professionalism.

The Growth of Professionalism in the United States

The degree to which professions serve the public interest is an issue of increasing importance as occupations continue to specialize and professionalize. In recent U.S. history occupations typically have tried to professionalize by developing a full-time occupation, training schools, a national association, legal recognition, and a code of ethics (Wilensky, 1964). A profession is an occupation whose elevated status has been recognized by society, often by licensure laws that grant the privilege of self-regulation. Professions commonly claim possession of certain attributes that mere "occupations" do not possess. These attributes include commitment to the occupation, high educational attainment, and a service orientation. The profession may or may not possess these attri-

butes; what is important is that society believes that the occupation possesses professional attributes.

Today, almost every occupation attempts to attain the label of "professional." Recent articles analyze the professionalization efforts of such diverse groups as personnel managers, occupational therapists, computer programmers, speech pathologists, life underwriters, broadcast newsmen, and conservative rabbis (see Timperly and Osbaldeston, 1975; Bell and Bell, 1972; Nicolais, 1976; Stern and Klock, 1975; Kraft and Weinberg, 1975; Weinthal and O'Keefe, 1974; Zelizer and Zelizer, 1973).

This trend has been identified as a characteristic not only of the United States but of all modern societies. Parsons (1968:536) has written that the development of the professions is probably the most important change that has occurred in the occupational system of modern societies. Goode (1960:902) has suggested that "an industrializing society is a professionalizing society," and the rise of professions in modern societies has led one sociologist to speculate on "The Professionalization of Everyone?" (Wilensky, 1964). Because of the American tradition of limited governmental interference in individual activities and of pluralism in government, the United States in particular among industrialized societies has permitted the development of specialized, expert occupational groupings that have the responsibility for regulating themselves.

Professionalism as a Public-Policy Problem

Until recently the growth of professionalism in the United States has been viewed benignly and has proceeded almost without opposition. Today, however, professionalism has come to be perceived as a public-policy problem by state and federal government.

Since licensing of occupations is a state responsibility and most aspiring professions seek licensing laws, state governments have reason to be concerned about the growth of professionalism. In 1973, it was estimated that the average number of occupations subject to licensure in each state was 39, covering some 307 different occupations (Martin, 1979). State governments are exhibiting more concern over the possible manipulation of self-regulation by the professions, as exhibited by the passage of "sunset" laws in over one-half the states. These laws decree that specified agencies terminate at a particular date unless recreated by new legislation, thus putting the burden of proof for justifying their existence on

the agencies. State governments are also conducting other types of independent inquiries into their licensing systems (Halstead, 1975; Baughcum, 1976). Now many states are requiring the appointment of nonprofessional or lay members to licensing boards; in California, for example, the medical board has one-third lay membership.

Much of the public-policy concern over licensing boards is based on the relationships between professional associations and the state licensing boards that regulate the professions. Gilb (1966) presents strong anecdotal evidence on the close linkages between professional associations and state licensing boards, and Akers (1968) documents several similar examples in five health professions in Kentucky. State licensure is viewed by some policy-makers as a "political process critical to the organizational autonomy and self-regulation" of professions, "often promoted as a way to enhance the status and the public image of the group . . . [and] the economic benefit that often accompanies licensure" (Cohen, 1973a; Shimberg et al., 1973:13).

The federal governnent is also showing more inclination to interfere in the previously autonomous functioning of state regulatory boards. For example, the Equal Employment Opportunity Commission (EEOC) has proposed that all licensing, certification and accrediting agencies be required to submit evidence of the validity, relevance and fairness of examinations. The EEOC is attempting to define licensing boards as "employment agencies" because they control entry to the professions (Rose, 1977; Hubbard, 1977).

The Antitrust Division of the U.S. Department of Justice, declaring that state licensing laws "limit competitive freedom, and frequently are used as an affirmative protection by those already permitted into the protected occupation," also intends to be concerned with the professional regulation issue for some time to come (Sims, 1975). The Division has promised to be watchful for attempts of state licensing boards to use regulations as a "convenient cover under which private parties develop, maintain and enforce fundamental competitive restraints . . ." (Wall Street Journal, 1976:4). This view was reflected in a 1977 Supreme Court ruling that struck down legal and ethical bans against the advertising of lawyers' prices and services (*Bates v. State Bar of Arizona*), and the 1975 *Goldfarb v. Virginia State Bar* decision that invalidated minimum fee schedules used by bar associations.

Another federal agency active in the area of professional regulation is the Federal Trade Commission (FTC). In its recent actions,

the FTC attempted to preempt state licensing laws regulating pharmacists, opticians, optometrists, and funeral directors, and began investigations of dental, legal, accounting, real estate, and veterinary services (Clarkson and Muris, 1979). In a statement with far-reaching implications, FTC chairman Michael Pertschuk claimed that "More and more we are discovering that professionals are not markedly different from any other sellers who offer their services in trade" (FTC News, 1979a). The equating of professional services with other occupational services, of course, is a threat to the very concept of professionalism.

Professionalism and the Delivery of Health Services

Because their work is technical and specialized, health occupations are particularly good candidates for professionalization. Their services are also important to the physical and mental well-being of the consumer, facilitating a strong public-interest argument for maintaining minimum quality levels. A rapid increase in professionalizing occupations has in fact been characteristic of the field of health care, for the number of specialized health occupations has continued to multiply with the expansion of health knowledge and technology. Between 1968 and 1977, the number of health occupation job titles grew from 375 to 717 (U.S. DHEW, 1970; 1979). Recent years have seen state government licensure of such groups as acupuncturists, clinical laboratory technicians, emergency medical personnel, physician's assistants, radiology technicians, and medical social workers (U.S. DHEW, 1977; Bernstein, 1977). As a result, the largest single concentration of licensed occupations is in the health industry (White, 1979:14).

In spite of, or perhaps because of, the tremendous growth of professionalism in the field of health, the public spirit of cynicism about professionalism extends into the health professions. The 1970s were a decade in which government expressed increasing distrust of the health professions, as reflected in numerous public policies.

National Standards for Health Occupations

In response to the burgeoning number of new health occupations, the Department of Health, Education and Welfare (DHEW) has proposed that national standards be developed for licensing and certifying health occupations (U.S. DHEW, 1976b). The plan

was issued following DHEW's recommended moratorium on further state licensing of new health occupations between 1971 and 1975. The Department asserts that the issue to license or not to license is settled in state legislatures based upon the political strengths of the participants rather than public need. The proposal recommends a national certification council to oversee private and state organizations in the health occupation licensing field and to move toward national standards for licensing and certification.

Sunset Commissions

Licensing boards for the health professions typically fall under the jurisdiction of state sunset commissions, but so far there is little experience on which to judge their potential impact on the professions. Since sunset laws resulted from the deregulation movement, it is likely that changes, if any, will be in the direction of decreasing professional power. In North Carolina, for instance, the sunset commission staff in 1979 recommended: the abolition of the opticians' licensing board; decreased regulatory powers for the optometry board; less stringent entry restrictions on out-of-state dentists; and lay members on the optometric and dental boards (N.C. Governmental Evaluation Commission, 1979a–c). Most of the proposals have been strenuously opposed by the affected professions, mainly based upon the potential dilution in the quality of care.

State legislatures were beginning to consider or pass laws challenging professionalism in health before sunset commissions existed, and they continue to do so. In the area of dentistry, for instance, 14 states had bills to legalize denturism pending at the end of 1977, and two states had legalized denturism (Abrams, 1978). Denturism involves the sale of dentures by dental lab technicians directly to consumers, and in competition with dentists. Many states are moving more vigirously to investigate consumer complaints of health providers, particularly physicians (MWN, 1974b), and state laws requiring lay membership on professional licensing boards are proliferating. As a final example, the California State Health Department has proposed new rules that would allow physician's assistants, nurse practitioners, and nurse midwives to prescribe medication, order laboratory tests, and determine therapy in the hospital setting without medical supervision (PEN, 1980). The move is strongly opposed by the medical profession.

The Federal Trade Commission

The Federal Trade Commission (FTC) has moved vigorously against elements of laws and ethical codes that in the FTC's opinion restrict competition within the health professions. In 1975, the FTC proposed rules that would preempt state pharmacist licensing laws restricting prescription drug price advertising (U.S. FTC, 1975). After extensive hearings, the drug rules were abandoned because of a 1976 U.S. Supreme Court decision (*Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*) that allowed drug price advertising under the first amendment to the U.S. Constitution. Similar FTC proposals were made against restrictions on eyeglass advertising (U.S. FTC, 1976a). After a thorough investigation, the Commission unanimously accepted a trade regulation rule which preempts state laws and private ethical codes that prohibit the advertising of prescription eyewear or eye examinations. Affected by the rule are optometrists, opticians, and ophthalmologists. The rule, which became effective July 3, 1978, also requires that consumers be provided with copies of their prescriptions after they have their eyes examined (Federal Register, 1978).

In addition, the FTC in 1975 filed an antitrust complaint against the American Medical Association (AMA), alleging that advertising restrictions in physicians' codes of ethics illegally restrain competition. In late 1978 an administrative law judge's decision supported the FTC's stance; that decision is now under appeal. A similar complaint against the American Dental Association (ADA) will be settled by the AMA decision (FTC News, 1979b).

A recent FTC staff study has charged that physicians tend to bill more for services covered by Blue Shield insurance in which physicians control administration of the plans, and the staff is pursuing evidence of "concerted efforts among providers to frustrate cost-control initiatives sponsored by insurance companies" (Palmer, 1979:279). In another area, the FTC is investigating claims that some health maintenance organizations have been victimized by anticompetitive conduct of fee-for-service physicians. The FTC has challenged relative value fee schedules on the basis that they are used to fix prices, and in 1976 after FTC action two specialty societies (orthopedic surgeons and obstetrician/gynecologists) agreed to abandon relative value scales. A related consent order barred the American Society of Anesthesiology (ASA) from restraining anesthesiologists from working on a salaried, rather than fee-for-service, basis (Palmer, 1979). Finally in the medical area, the

FTC in 1976 commenced an investigation of the control of the supply of health personnel by organized medicine (Avellone and Moore, 1978).

In the field of dental care, the FTC is investigating restrictions on the ability of nondentists to provide denture care directly to the public, the ability of dental hygienists to offer preventive services directly, and several other controls over less traditional types of dental practice (Daynard et al., 1979). Many of these same issues were raised in a recent report by a Council of State Governments task force on state dental policies, again reflecting substantial pressures to loosen restrictions on professional dental practice (COSG, 1979).

The FTC's venture into the health care industry is likely to continue in the immediate future; indeed, its breadth is expanding. In 1977 the FTC sponsored an exploratory national conference on competition in the health sector (Greenberg, 1978) and in 1979 staff members prepared a wide-ranging review of possible initiatives in health services (U.S. FTC, 1979). Such possibilities include investigations of competition among hospitals, physician opposition to the development of nonphysician providers, the unavailability of third-party reimbursement to nurse-practitioners and other nonphysician providers, and patient access to medical records.

Other Attacks on Professionalism in Health

Several other governmental policies have challenged the assumption that all is right with professionalism. The Professional Standards Review Organization (PSRO) law of 1972 mandates physician review of federally-financed inpatient hospital utilization and is meant as both a cost and quality control measure. The movement to establish PSROs clearly was aided by an expanding distrust of the ability of professionals to police themselves adequately (U.S. DHEW, 1972). The law still recognizes a traditional concept of professionalism, however, as nonprofessionals do not participate in PSRO decisions.

The Justice Department, Department of Labor, General Accounting Office (GAO), and the courts are likely to provide support for the general policy of deregulation and heightened competition among health services providers (Sims, 1978; Shimberg, 1979). Since 1975, for example, the Justice Department has filed antitrust suits against the promulgation of relative value scales by associations of podiatrists, anesthesiologists, radiologists, and other

health professionals. As mentioned earlier, the Supreme Court, in the 1976 Virginia State Board of Pharmacy decision, overturned legal and ethical restrictions on advertising by pharmacists, and similar decisions by lower courts are multiplying.[1] Finally, citing the potential for lower prices and greater accessibility of dental services, a 1980 report by the GAO recommended the removal of state laws inhibiting the use of expanded function dental auxiliaries to fill teeth.

The Defense of Professionalism

The defense of professionalism has been led by the professions themselves. Their attitude toward the public-policy challenges has been one of reluctant acceptance, at best. The professions generally have rejected the idea that their past actions have not been in the public interest.

The rallying cry of the defenders of professionalism is that the quality of services must be maintained. In the battle over PSRO, many physicians expressed a fear that loss of individual autonomy would destroy the profession. The conservative Council of Medical Staffs said the PSRO law "spells the end of the private practice of medicine as we know it today" (MWN, 1974a:40). Another physician wrote in the *New England Journal of Medicine* that the PSRO law "will have a subtle but profound chilling effect on the honest transfer between patient and doctor. . . . Excellence will inevitably suffer" (LeMaitre, 1974:1323). The American Medical Association, after divisive debate, passed different resolutions supporting PSRO, favoring repeal, and favoring alteration of the law by amendment. Another conservative physician group, the Association of American Physicians and Surgeons, filed suit challenging the PSRO law's constitutionality (MWN, 1974a). All this resistance came in spite of the fact that PSROs will be composed only of practicing physicians. In the end, "The PSRO bill reveals the deep scars inflicted by the medical lobby" (Etzioni, 1974:507).

Medicine's response to the proposed relaxation of advertising restrictions on physicians has been similarly defensive, with an argument based on potential abuses in the quality of care. For instance, the former editor of the *New England Journal of Medicine* wrote that "This intrusion must rank as sheer inanity to anyone who believes that superior medical care and the maintenance of some professional attributes go hand in hand. . . . If the FTC has

its way, and doctors succumb to hucksterism . . . no one need worry any longer about deprofessionalization. The process will have run its full course" (Ingelfinger, 1976:334–5).

In the same vein, the chairman of the Council of Deans of the Association of American Medical Colleges spoke of fears of a "less committed profession and a deterioration in the services we [physicians] offer the public" (Krevans, 1979:345); the AMA president stated that advertising by a professional "is the very antithesis of professionalism" (Reynolds, 1976:37); and numerous other physicians voiced similar opposition (Geist, 1978; Relman, 1978; Avellone and Moore, 1978).

The response by physicians mirrors earlier statements by the professions of pharmacy, optometry and dentistry against advertising. In 1977 the American Dental Association justified its ethical canons against advertising because the ethical code was "the direct result of the ADA's desire to fulfill its public-service responsibilities with reference to the maintenance of sound, qualitative standards of dental practice" (Stock, 1978:1208). Organized pharmacy's ethical restriction on advertising was based squarely on the philosophy of professionalism, reading that "A pharmacist should not solicit professional practice by means of advertising or by methods inconsistent with his opportunity to advance his professional reputation through service to patients and to society" (APA, 1975:2).

A final example of the reaction of the health professions to public policy challenges is their response to DHEW's proposal for a national certification council to oversee health licensing boards. Despite the very mild threat to the current "division of labor" in health, the established health professions responded negatively. In a strongly-worded reaction to the proposal, one organization of health professions contends that the proposed council would subvert professionalism: "There is a tendency in the Proposal to view health care as a series of individual procedures performed by a number of technicians. The adoption of this idea would be disastrous to the American people. They need health care which is a series of interrelated treatments administered under the direction of . . . a professional" (FAHRB, 1976:5).

Summary

Thus in the health field, as in other occupational sectors of society, there is substantial turmoil over public policy toward the profes-

sions, and health professions are under growing pressure to furnish evidence of their commitment to provide quality service at nonexploitative prices. Benign acceptance of professional autonomy has given way to public-policy attacks on the anticompetitive nature of many of the standards developed by the self-regulating professions. Professionals have vigorously responded to the challenges, with the defense of professionalism resting on the argument that the quality of services will suffer if attacks on professionalism succeed. "Quality" takes on a broad and ill-defined meaning in these controversies; it may refer to the degree of respect for the professional, the degree of communication or humanism in the professional-client relation, the technical sophistication of the service, or the actual outcome of the service.

At this time, it is unclear whether public-policy proposals will survive the political resistance of the professions, and the effect of these proposals, particularly on the quality of professional services, is unknown. Debate on professionalism in the academic disciplines is growing, however, and that debate may help to direct future policy.