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Baker: History of Licensure in Occupations in the Health Professions

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HISTORY OF LICENSURE IN **SEVERAL** OCCUPATIONS IN THE HEALTH PROFESSIONS

Shirley A. **Baker**¹

Abstract: The origin of **licensure** in the medical professions is outlined beginning in Europe around the first century with the examination of potential physicians by the most respected physician in the land. Guilds developed and licensing bodies became university medical faculties. Prussia was the first country to require specific courses for license eligibility whereas state control first developed **in** Germany. Americans fluctuated among various licensing methods until the 1700s when state boards were established, Professional standards, including **licensure**, for **allied health** professions have typically followed the lead of physicians. The origins, advantages and disadvantages of **licensure** in several of these occupations are reviewed **also**.

Historians have recorded the revered status of physicians beginning from the first century B.C. in Rome under the reign of Julius **Cesar**. In the book

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of Vendidad, from the Parsis collection of sacred books known as the Avesta, the oldest known set of regulations for physicians (specifically surgeons) is recorded. In 931 **A.D.** the ruler of Arabia required that all potential physicians undergo examination by the most respected physician of the land, Sinan ibn **Thabit** of **Harran (Sigerist, 1935)**.

Licensure of physicians, as a means of protecting the vulnerable public, began in the European Middle Ages **during** a time when crafts and professions of all kinds were organized into guilds. From guilds came strict standards and regulations regarding the quality of professional services. The paramount importance of developing standards for the medical profession was evident to the structured medieval society. Regulated training was designed as the means whereby society considered the physician to be "legal" (**Sigerist, 1935**).

Surgeons were **considered** craftsmen and therefore were allowed to form their own guild. The guild was responsible for governing itself and setting strict standards for its members. In order to practice surgery, a surgeon was required to be a member of the surgeon's guild. Physicians, on the other hand, were not allowed to form a guild due to the generalized nature of their skills. Therefore, "physicians organized, and their licensing body became the medical faculty of the universities" (**Sigerist, 1935, p. 1058**) . The school of Salerno became the first such university to be empowered as a regulatory entity by Norman King Roger in the year 1140. Under the Hohenstaufen ruler Frederick II, very strict detailed laws were established during the period 1231 to 1240. Licenses were issued by the emperor or his representative. Heavy penalties threatened those practicing without a license. Other countries throughout Europe adopted these policies. In addition, physicians were required to renew their license each time they relocated. The

relicensure process involved a presentation of appropriate diplomas held by the physician to the faculty of the local university for approval (Walsh, 1935) . Since many cities in England were not fortunate enough to have a univeristy, a medical society known as the **Royal** College of Physicians was established in London on September 23, 1518. Scotland became a charter member of the college in 1681. Thus, in these two countries, licenses were granted by a medical society rather than a school (**Sigerist**, 1935).

In 1725 Prussia was the first country to require specific academic courses for license eligibility, but the license examination was conducted by a state board of health. After the unification of Germany, responsibility for licensing physicians was returned to the universities so candidates would not have to take two examinations--one from the university and one from the state. Unfortunately, a **law** passed in 1869 required those using the title "physician" to hold a license but allowed anyone else to practice medicine without a license. Austria, on the other hand, combined licensing practices of Prussia and later Germany so that a state official controlled examinations given 'by the university faculty (**Sigerist**, 1935).

Medical practice was controlled in America until after the Revolution. America then repeated the same sequence of events concerning **licensure** that had taken place in Europe during the previous 2,000 years. But, as with other developments in this country, the entire sequence took Americans only 300 years to complete (Sigerist, 1935). State boards of examiners had begun to be appointed by the **1760s** with a state appointed board in New York (**Shryock**, 1967) . Due to increasing demand for physicians during the nineteenth century, medical schools tended to relax standards in order to supply the country with needed physicians. As a result, the university degree could no longer be

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regarded as a symbol of competence. State boards soon became the regulatory agencies. Medical **licensure** statutes in the various states were widely divergent (Derbyshire, 1969). Only with the advent of a **mobile** society did interstate **licensure** conflicts become a seemingly insurmountable problem that still exists.

Origin of Allied Health Professions' Licensure

In the 1930s, other groups of health professionals sought **licensure**. (Dental hygienists established **licensure** in Colorado in 1889). The first medical support groups to obtain **licensure** were nursing and medical technology in 1938. A nursing **licensure** law was first passed in New York to register nurses **to** ensure a standard level of care. The statute was not enforced, though, until 1947. Today, all states require nurses to be licensed in order to practice (Lesnik and Anderson, 1947).

Medical technologists also obtained **licensure** in 1938 in California. Since that time, only four other states (Tennessee, Florida, Hawaii, and Nevada) have passed **licensure** legislation. Most states regulate certain laboratory procedures and/or require **licensure** of the laboratory director (Daley, 1984).

In 1968, radiological technologists and occupational therapists became regulated through **licensure**. Radiological technologists were first licensed by the state of New York. Almost 10 years elapsed before any other states followed with **licensure laws**. The federal government, recognizing the need for regulation of all radiation handling professions, mandated that all states must have **licensure** legislation by January 1, 1985 (Consumer Patient Radiation Health and Safety Act, 1981).

Occupational therapists were first licensed in Puerto Rico in 1968. Not

until 1975 did the continental United States have established **licensure** in the state of Florida and New York. Currently, 27 states and two territories license occupational therapists (Information handouts, American Occupational Therapy Association (**AOTA**), 1985).

California was first to license respiratory therapists in 1982. New Mexico followed in 1984. Today, almost every state in the nation is in some stage of **licensure** consideration (Brown, 1984).

Conclusions and Implications

Proponents of **licensure** in the health professions will list the major advantages as: (a) legal safeguard of the public's interest, (b) formal establishment of the occupation as a profession, and (c) proof of licensee's attainment of a minimum competency level (**Shimberg**, 1981). Opponents to occupational **licensure** propose that **licensure** is merely a means of controlling the job market, thereby raising salaries.

The present system of providing medical care has been so restricted by the intervention of occupational **licensure** that it is almost impossible to demonstrate what things would be like if the free market had been allowed to prevail The customer himself should be the supreme judge of **who** is competent to perform the services he requires. . . . One also receives scant assurance **of** competence under a licensing system. . . . We are never sure that a test has been devised to determine the abilities of individuals to perform certain tasks. (**Barger**, 1975, pp. 197-199)

Kane (1982) argues "that **licensure** examinations should be interpreted as measures of specific abilities that are critical for professional practice . . ." (p. 911).

Wilensky (1964) examined the history of eighteen occupations including dentistry, medicine, nursing, optometry, and pharmacy. He determined that crucial events in the advent of professionalism occurred in the following order:

1. People start working full-time performing groups of related tasks.
2. A training school is established.
3. People with like occupations combine **to** form a professional association.

4. Incessant political agitation requires passage of a **law** to protect job territory and to enforce a code of ethics.

5. A formal code of ethics is developed containing various rules addressing issues surrounding unqualified or unscrupulous practitioners, internal competition, and client protection and service (pp. 142-145).

Licensing is the most restrictive of all forms of regulation. No regulation should **be** more restrictive than what is necessary to protect the public. In many cases, certification or registration are better alternatives (**Shimberg**, 1981).

Disadvantages **of** licensing include limited interstate mobility, high costs of **licensure** administration, limited reciprocity, increased expenses incurred in policing the profession, limited scopes of practice, and restricted entry to jobs and training (**Shimberg**, 1981). The major issue facing licensing boards today is "How do we assure the public of an individual's continued competence?*" Many state legislators **may** be addressing this issue in the months to come.

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