TAPPING THE FULL POTENTIAL OF PUBLIC MEMBERS

A Tool Kit for Boards and Community-Based Organizations

- **a publication of a grant project entitled "Strengthening the Community's Voice on California's Health Care Licensing Boards"**

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FOREWORD

This document, *Tapping the Full Potential of Public Members — A Tool Kit for Boards and Community-Based Organizations*, is one product of a grant project called *Strengthening the Community's Voice on California's Health Care Licensing Boards* that was funded by The California Endowment (TCE) in 2008–09.

Individuals who are interested in becoming a member of a California health care licensing board should read this *Tool Kit* in conjunction with *A Guide to California's Health Care Licensing Boards*, which is also a product of the *Strengthening the Community's Voice on California's Health Care Licensing Boards* grant project. That document is intended to acquaint the reader with the responsibilities, governance, and operations of multi-member state boards that license and regulate practitioners who provide direct health care services to Californians. In addition, it describes seventeen California health care licensing boards.

WHO SHOULD USE THE *TOOL KIT*?

It is essential that everyone on a board – licensee and public members alike – has a common understanding and similar expectations about the role and importance of the public member participation.

- **Board members, both public and licensee**: The material in this *Tool Kit* is intended to help newly appointed public members hit the road running by acquiring the perspective and skills to be confident, productive members of the team, remembering their responsibility to represent the public point of view. We hope the *Tool Kit* will also be of use to sitting public members who already have some experience under their belts. Because it is essential that everyone on a board — licensee and public members alike — has a common understanding and similar expectations about the role and importance of the public member participation, we encourage licensee members to read and absorb this document.

- **Board staff:** Board staff also need to embrace the public members' special contributions to the board's work. The staff, and especially the board Chair, can help with the smooth integration of public members into the board's operations.

- **Boards in all professions**: The contents of this *Tool Kit* are relevant to boards in every profession.

- **Community-based organizations:** An important audience for this *Tool Kit* is community-based organizations (CBOs) with a stake in what health care professional licensing boards do and an interest in having an impact on their actions. The *Tool Kit* illuminates board operations and explains why involvement by outside groups can advance their agendas and enrich a board's decision-making.

- **Individuals who think they may want to become a public member of a health professional licensing board**: The candid description of a typical public member's challenges and opportunities should help people considering volunteering for a board appointment to decide whether they really want to make the commitment. This same material should help CBOs and others to vet and select qualified individuals to nominate for public member vacancies.

HOW TO USE THE *TOOL KIT*

Readers will have to apply the information in this *Tool Kit* to their own situation on their own particular board. We hope the material is general enough and comprehensive enough to be applicable, no matter what board. Our goal is to provide practical guidance for how to approach your job.

Read this *Tool Kit* in conjunction with *A Guide to California's Health Care Licensing Boards.* The *Guide* contains detailed information on the responsibilities, governance, operations, and current agendas of California's health professional licensing boards.

A section on actual public member experience in California provides illustrations of how public members have had an impact on their boards' operations and public policy decisions.

WHAT IS INCLUDED IN THE *TOOL KIT* AND WHERE DID IT COME FROM?

The *Tool Kit* begins with a brief historical overview of California's health care professional licensing boards. It goes on to describe why licensing boards are important and how they impact the delivery of health care services to all segments of the population. The next sections address public members: why they are important, challenges they face, and attitudes and techniques that will serve them well during board service and help them be effective representatives of the public interest. A section on actual public member experience in California contains illustrations showing how public members have had an impact on their boards' operations and public policy decisions. The next section discusses why and how community-based organizations (CBOs) can and would want to try to influence board decisions. The *Tool Kit* concludes with a section on why licensing boards benefit from having effective public members and from cultivating strong relationships with CBOs.

The information and advice contained in this *Tool Kit* is derived from more than 20 years of experience working with health care professional licensing boards throughout the country, focusing especially on providing resources and support for their public members. In addition, interviews with public members, board chairs and staff, appointing authorities, and CBOs supplied California-specific content.

EVOLUTION OF LICENSING BOARDS

In the late 1800s, as medicine was becoming more scientific and professionalized, physicians began urging their state legislatures to establish licensing boards composed of physicians, thus giving the profession the legal authority to self-regulate. The statutes that created these boards authorized them to determine educational and other eligibility requirements for earning a license to practice medicine and to discipline licensees who do not meet minimum standards of practice or who engage in unethical or fraudulent conduct. Physicians and their state medical societies contended that such laws were vital to public safety because they combatted quackery and fostered public confidence in medical practice. State legislatures were quick to go along with their requests to create physician licensing boards because they became convinced of the dangers of not regulating medical practice and they knew that legislators did not have the knowledge to determine who is and who is not fit to practice. (California established its medical board in 1876.) Thus did professional self-regulation under color of the law become institutionalized in the United States.

Throughout the 20th century, as other health care professions emerged, state legislatures followed the same pattern. Each new profession came to view licensure as a desired indication of its own professional standing as well as a means of protection for the public. At first, many of the newly licensed professions were placed under the auspices of the medical board; increasingly, they came to have their own boards. In California today, most boards that license health care professionals are located in the state Department of Consumer Affairs. In other states, there are many different types of organizational arrangements, with boards in some states located under a department of public health or an umbrella agency of some kind, or quite often operating as separate, independent agencies reporting to the legislature.

For decades after the first boards were established, they had the public safety role mainly to themselves. But over time, as health care practitioners began to work in hospitals and places other than their own offices or a patient's home, as the professions became increasingly interdependent, and as health care grew more complex, the boards' public safety role increasingly became shared with others – with other state agencies that regulate workplaces, with private accrediting bodies, with federal review entities, and more.

In this dynamic environment, the composition of the boards began to change. In response to increasing public concerns that boards composed entirely of members of the profession were more attuned to the interests of their licensees than to those of the public, legislatures began to authorize the appointment of public members (usually defined no more explicitly than that they

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are not licensed in the profession being regulated) to the boards. Public members, it was widely felt, would shore up public confidence in the boards and would affirm their focus on public protection. Public members would help boards become more accountable, credible, and democratic.

At first, legislatures authorized only one or two public members on boards. In 1961, the California legislature set aside one slot on the then 11-member medical board for a non-physician member, and in subsequent years did the same for other health professional licensing boards. The 1970s saw an acceleration of demands for public accountability, so most states increased the number and proportion of public members. California led the way. In a seminal and widely circulated book on occupational licensure, Ben Shimberg recalled that at a 1977 swearing-in ceremony for newly appointed public members, then-California Governor Jerry Brown called public membership on boards "an idea whose time has come." In his charge to the public members, he added:

> In the name of expertise, specialization and professionalism, a great deal of privilege and restriction and monopoly have grown up. And, it is up to the public member to break down those barriers, to separate privilege from professionalism, to separate quality from restriction, and to ensure that the first order of every profession and of every occupation for which you have responsibility is service to the people.[1]

During the past three decades, California's legislative and executive branches have continued this transformation in the composition of licensing boards in health care and non-health care professions. Today, most of California's non-health care boards consist of a public member majority. Only two health care licensing boards have a public member majority, but the overall percentage of public members on these boards has grown to about 44%. The Schwarzenegger Administration has encouraged this development, calling in 2005 for public member majorities on a number of health care boards, including the Medical Board.

Thus, in the nearly fifty years since the first public members were invited to serve on California's health care licensing boards, public member numbers have grown to the point where their influence can be profound. From a largely token presence in the beginning, public

[1] Brown, E.G., Jr. Remarks at swearing-in ceremony for new public members of regulatory boards, Sacramento, CA February 4, 1977 .

members have become a substantial force capable of having a significant impact on their boards' effectiveness in addressing public needs and in particular the needs of underserved communities.

WHY BOARDS MATTER

Boards are the only health care regulatory entities that deal with the competence and ethical behavior of *people* as opposed to *institutions*.

Boards matter firstly because they are the only health care regulatory entities that deal with the competence and ethical behavior of *people* as opposed to *institutions*. While in recent years much attention has been focused on the need to improve *systems* in order to make health care delivery safer and of higher quality, the fact is that systems are always composed of individual practitioners, and as a leader in the system safety movement has stated, "failure to monitor and address health practitioner competency issues is in itself a systems failure."[2] By establishing minimum acceptable standards of practice for all types of health care practitioners, boards play the key role of providing a safety net to protect the public health and safety. No other regulatory system plays that role with regard to doctors, nurses, pharmacists, physical and occupational therapists, and all other types of health care practitioners.

Second, regulatory boards establish health care policy when they implement laws enacted by legislatures. More often than not, state legislatures cast laws related to health care delivery in the broadest of terms, leaving it to professional licensing boards to develop rules and regulations to implement the laws. Thus, health professional licensing boards have an enormous impact on policy as a result of their rulemaking activities. Legislatures in different states may pass very similar laws which are then converted into very different policies, depending on the specific content of the implementing regulations. Nowhere is this more apparent than in implementing so-called "scope of practice" laws that define the practice authority for particular professions (laws that determine who can do what to whom, in what locations, and under what conditions). For example, one state legislature (not California) recently expanded the scope of practice for psychologists to allow licensed psychologists who demonstrate the necessary competencies to prescribe certain classes of medications. The legislation directed the state's board of medicine and board of psychology to jointly develop and publish a regulation specifying how psychologists wishing to earn prescriptive authority should demonstrate their competence in this area. The medical board (which had opposed enactment of the legislation in the first place) dragged its feet on the implementing regulations in order to stall implementation of the legislation. In another example, similar laws granting prescriptive authority and otherwise

[2] Letter from Dr. Lucian Leape to David Swankin, President, Citizen Advocacy Center (CAC), April 2000.

expanding the scope of practice of advanced nurse practitioners have resulted in very different outcomes in different states, depending on the implementing regulations agreed to by the boards of nursing and medicine. In addition, California's Board of Pharmacy is developing rules in early 2009 to implement a 2007 law requiring pharmacists to use a standardized "patient-centered" label on all prescriptions dispensed after January 1, 2011. The law gives the Board of Pharmacy enormous discretion:

- How will the rule accommodate consumers for whom English is a second language, if they speak it at all?

- What will the requirements for "plain language" and "patient-centered" look like?

- Will they ensure that complicated medical terms are readily understandable by consumers with limited education and limited reading ability?

Virtually every health professional licensing board finds itself at one time or another responsible for developing regulations that implement newly enacted legislation. By doing so, boards engage in *legislative* activity which can have just as potent an effect on public policy as the original lawmaking activity in the legislature. It is an awesome and challenging responsibility for the boards to develop regulations consistent with the intent of the legislation and in the interests of public health and safety.

Licensing boards monitor the performance of licensees primarily by responding to complaints. Increasingly, boards are choosing to be proactive as well as reactive in exercising their monitoring responsibilities. As an example, the California Board of Podiatric Medicine requires podiatrists to show that they are up-to-date with the latest standards of practice (currently competent) as a condition of renewing their licenses. Most other boards do not have such a requirement, although many are exploring how they might do so.

Licensing board actions have an impact on access to care and the cost of care.

In addition to safety, licensing board actions have an impact on access to care and the cost of care. In keeping with marketplace logic, setting extremely high standards for entry into a profession reduces access and raises costs by restricting the number of available practitioners. Several licensing boards struggle to find the right balance between standards that protect patient safety and standards that are unnecessarily restrictive. In acupuncture, for example, the board tries to find the right balance between the ancient Eastern tradition of preparing for practice through apprenticeship and the Western tradition of academic preparation. In other fields, such as

nursing and pharmacy, the boards regulate several levels or categories of practice, each with different entry requirements.

Boards enter into public policy-making in additional ways. An example is linguistic and cultural competence. Some boards collect data showing which licensees' offices provide services in languages other than English. The Medical Board of California sponsors a student loan repayment program for newly licensed physicians who agree to practice in underserved areas. Many boards produce public information materials in multiple languages.

These are but a few examples of why boards have an impact on the safety, accessibility, and cost of health care and why, therefore, CBOs and other advocacy groups have a stake in their operations and decision-making. Professional associations pay close attention to what is on the licensing boards' agendas and make sure to try to influence the outcome. Board actions more accurately reflect the interests and needs of the entire population when groups representing the public, rather than the profession, also participate in the process. (Refer to the *Guide*, especially the sections entitled, "Board Responsibilities" and "Board Actions That Have Impacted Access, Quality, and Cost of Care" for more about why licensing boards matter. See also an appendix to this *Tool Kit* consisting of the chapter entitled "How the Regulatory System Works" from Ben Shimberg's seminal book *Occupational Licensing: A Public Perspective.***)**

WHY PUBLIC MEMBERS MATTER

Individuals who have served as public members on one or more of California's health professional licensing boards tell us they believe most of their fellow board members – licensees and public members — genuinely want to live up to their oath to protect the public health and safety. Public members see themselves as part of a team that is striving to fulfill its public protection mandate. They are, nevertheless, sensitive to the fact that as public members, they have been put on boards to make a distinctive contribution; to enrich their board's deliberations and decision-making so that the results reflect the interests of the entire public, not just those of the regulated profession.

Most of the public policy issues that come before boards originate from the legislature or the regulated profession. Public members generally bring a different perspective on issues, or raise subjects that licensee members wouldn't advance and maybe wouldn't even think of. A well-functioning board operates as a team; it works together, but its outcome is enriched

Public members generally bring a different perspective on issues.

because its members approach the board's business from different starting points.

Here are some of the things public members tell us about how they view themselves:

> "My role is to think like a client would, to ask the questions a client would ask."
>
> "The public member role is to protect the interests of the public and present a public-oriented point of view."
>
> "When it comes to discipline, I try to think of what the public would expect the board to do."
>
> "Many times I raise something that hasn't been thought about by licensee board members."
>
> "Our role may not be different when it comes to disciplinary cases, but there are differences on public policy issues."
>
> "The board wasn't used to having a public member like me. Nor are the professional organizations that are closely associated with the board. They don't necessarily appreciate everything I say. It has taken the board time to see me as a colleague."

All board members must act in a fair and diligent manner, upholding the rights of the individuals and at the same time recognizing the interests of the broader public.

CHALLENGES PUBLIC MEMBERS FACE

All board members — licensee and public — face significant challenges in carrying out their board responsibilities. They must learn the complex laws, procedures, and operations of their boards. When making decisions concerning the licensure and/or discipline of individual licensees, they must ensure that they act in a fair and diligent manner, upholding the rights of individuals and at the same time recognizing the interests of the broader public. In their fiduciary role, they must also ensure that the board is operating efficiently and effectively and is addressing key issues involving licensees and the people they serve. In their work with one another, staff, legislators, other state officials, licensees, and stakeholder organizations, they must communicate clearly and crisply across a range of controversial matters. And they must confront these challenges as volunteers with limited time and resources available to them.

Licensee and public board members also face their own distinctive challenges. Licensee members, who bring to their role knowledge of the technical and clinical issues related to their profession, must learn to put that knowledge in perspective. They must draw on it when relevant, but not allow it to obscure their broader public responsibility. They must learn how to look beyond their familiar professional roles and culture, reinforced through years of schooling and practice, and to act in ways that assure an often skeptical public that they are focused on what is best for it, not the profession. In this context, they must also learn and take to heart the complementary role that public members can play, a role that enhances the overall effectiveness and credibility of the boards.

The public members' challenges are different. To effectively participate in the board's business, they must attain a certain minimum level of understanding of technical and clinical issues without feeling that they must in any way match the licensee members' expertise about the profession being regulated. They must recognize that, aside from their individual qualifications, they have been appointed to a board precisely because they are *not* members of the profession. They must then learn how best to draw on this non-professional or public status to contribute to the public mission of the board. In their quest to become effective public members, they must learn how to tap into the concerns raised by CBOs and patient groups, and to examine how well the board addresses these concerns. They have to develop the skills that enable them to integrate a public-oriented perspective into board deliberations.

As part of this learning process, they must recognize that they serve as a logical connection with CBOs that have an interest in issues that lie within the domain of boards. For those public members who are nominated by CBOs, this is clear from the outset. For other public members, this connection may well be something that they need to examine and become more comfortable with. In both cases, they must learn to play a balancing act, recognizing that while they can serve as an important voice for their community, their primary obligation as board members is to focus on the broad public interest.

So, from their different starting points, both public and licensee members need to make adjustments as they zero in on the public protection mandate of their boards. Their success as a board will in large part turn on how well they learn to work together, drawing on one another's distinctive orientations.

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BEING AN EFFECTIVE PUBLIC MEMBER

A board member's prior experience can have a significant bearing on how quickly and how well he or she adapts to board responsibilities. Those who have "boardsmanship" skills gained from serving in civic, educational, benevolent, or other organizations have valuable preparation for the give and take of licensing board deliberations. Those who have a track record in consumer and/or public advocacy have the advantage of knowing how to articulate concerns in public forums. Those who come from a CBO or otherwise have an awareness of the health care concerns of diverse populations will have a special sensitivity to the ways in which boards relate to and can address these concerns.

Whatever their prior experiences, public members must be ready to make a full commitment to the continuous learning that is key to fulfilling their distinctive responsibility as a public board member. It is helpful, we have learned, to approach that responsibility in three different respects.

1. ***Developing and maintaining connections with community-based organizations.***
   California's wide range of CBOs concentrate on particular health care issues, geographic areas, and/or ethnic groups. In such a large and culturally diverse state (where Latinos, Asians, African-Americans, and other non-Anglo populations account for more than 50% of the population), these CBOs present board members with a prime opportunity to stay attuned to vulnerabilities in the health care system that boards are in a position to address.

   For public members who seek to play a proactive role in applying a broad and client-sensitive perspective, staying in touch with CBOs can be an especially valuable way of remaining informed about health care realities. By attending CBO meetings, giving them reports on board developments, encouraging them to attend board meetings, offering them an open invitation to express concerns, and otherwise maintaining open lines of communication, public members can be conduits for valuable intelligence-gathering for boards and in so doing can help keep the entire board focused on its public mission.

   It is helpful to think of such public member links with CBOs as a complement to the ongoing connections that licensee members have with their professional worlds. Through professional practice, membership and involvement in professional associations, ongoing efforts to enhance their professional knowledge and skills, and/or social interactions with colleagues, licensee members stay attuned to the dynamics of professional practice and to issues of special concern to the profession, even without consciously seeking to do so. Licensee members draw on these connections in various ways when they perform their

board roles. Public members can do the same, albeit with a different set of connections. Together, these diverse sources of input can make for a more balanced board that is responsive to contemporary health care realities.

2. ***Asking big-picture questions.***

All board members have the same basic responsibilities in their policy-making, rulemaking, and board management roles, as well as when reviewing cases involving the licensure and/or discipline of individual licensees. But there are some important differences in how public and licensee members perform these responsibilities. For instance, licensee members can draw on their professional expertise to make judgments on the clinical issues presented in a health care policy matter. Experienced public members often emphasize the importance of respecting that professional knowledge and not trying to act as amateur clinicians.

At the same time, public members note that frequently what seems on the surface to be a matter calling only for clinical expertise is in fact one where a broader perspective can bring valuable, even critical considerations to the fore. For instance, in a discussion of the adequacy of the testing associated with a licensure exam, a board member might well ask about what, if any, attention is devoted to testing for an applicant's cultural competence. If this matter is not addressed in the testing process, it is reasonable to ask why and to ask what may be done about it. In this and many other aspects of a board's deliberations, public members have the opportunity to raise questions and offer perspectives that licensee members may be less likely to raise.

What seems on the surface to be a matter calling only for clinical expertise is in fact one where a broader perspective can bring valuable, even critical considerations to the fore.

The key here is for public members to develop the readiness and know-how to step back, take a look at the big picture, and ask how and why things are the way they are. This is a difficult, time-consuming process but also one that can make the role much more interesting and rewarding. Public members who play this role must maintain a heightened sense of curiosity, gathering information on an ongoing basis from board staff members, from other board members, from literature on the performance of licensure boards, and from attendance at meetings and conferences (such as the annual meeting of the Citizen Advocacy Center). And as they assemble information, they must sift it and analyze it to determine what issues warrant heightened attention by the board, why they call for attention, and how they might be addressed.

What kinds of questions might public members raise as they step back and take this big-picture view? Below we list a number of such questions in eight key areas. Our listing is not meant to be exhaustive but rather illustrative of ways that public members can draw on their broader perspective to raise questions vital to the boards' performance. The particular questions appropriate to particular boards will vary, depending on conditions and circumstances. But the general thrust of them is the same in that they reflect a mindset that the boards are intended to serve as consumer protection agencies. This is a mindset considerably different than the more professional mindset that has typically been associated with boards. What this means in practice is illustrated below:

Licensing

- How well does your board's licensure exam assess the skills that the licensee will be expected to perform? Does it address the potential licensee's cultural competence in dealing with clients?

- Does your board restrict entry to the profession in ways that may unnecessarily limit access to services? Are its rules on reciprocity fair to licensees from other states who seek to be licensed in your state? Are requirements placed on graduates of foreign schools or training programs consistent with the need to protect the public, or are they so extreme as to unnecessarily exclude qualified practitioners?

Rulemaking

- Does your board receive input from citizens and citizen groups when developing rules and regulations?

- What steps has your board taken to assure that the rulemaking record includes comments from citizen groups?

- Is your board doing as much as it could or should to see that office-based surgery is as safe as hospital-based surgery? Are there any available data that have bearing on this question?

Continuing Competence

- Does your board require licensees to demonstrate their competence in any way after initial licensure?

- Do the content and implementation of your board's continuing competence requirements give you confidence that licensees remain competent in their field?

- What steps does your board take to monitor continuing education programs? What evidence is there to support their effectiveness?

- Are your board's efforts on continuing competence in line with the public's expectations in this vital area? Are there recent surveys that are pertinent? If not, might such a survey be warranted?

- Is your board aware of the adequacy of hospital credentialing and privileging practices? Does it serve in any way as a "bully pulpit" to draw attention to the vital role such practices can play?

Discipline

- Is your board taking a consumer protection attitude toward complaints? Does your board provide consumers with sufficient information about how and where they might make complaints to the board? How difficult is the complaint process? Are complainants kept informed during the process? What happens when complainants have limited English language proficiency? Does your board refer complainants whose issue is outside your jurisdiction to other sources of help?

- Does your board have sufficient authority and resources to investigate complaints adequately? How adequately is it able to address cases involving questionable competence?

- Does your board have close working relationships with other state agencies that investigate health care workplaces? How much and what kind of information is shared?

- Does your board analyze trends in complaints and in disciplinary actions to identify opportunities for more proactive, preventive approaches that can reduce the need for discipline?

- Is your board attuned to the movement to reduce medical errors? Does it work with hospitals and other workplaces to lend support to initiatives aimed at finding the causes of medical errors and taking preventive actions?

- Does your board have a good working relationship with its attorneys? Are they involved in developing cases from the investigative stage onward?

- Does your board have a good system for prioritizing complaints, so that the most serious allegations have the highest priority for rapid investigation? Does your board adhere to a reasonable timeline when dealing with complaints?

Impairment Programs

- If your board has a program for licensees who suffer from alcohol or drug dependency, do you know how it works? Does the program have adequate mechanisms in place to ensure its accountability to the board? Do you receive any data on the performance of the program? Can you be assured that the program provides adequate protection to the public?

- Have any inquiries or audits into the performance of the program been conducted in recent times? Should they be?

Board Management

- Does your chair enable all board members to play an active role in board deliberations? Does he/she recognize and tap into the distinctive role that public members can play?

- Are the public members on your board given leadership opportunities? Do they chair important board committees?

- Does your board work effectively as a team? What are its strengths and weaknesses?

- When was the last time your board had a retreat to examine substantive and process issues?

Educational Outreach / Transparency

- How does the public know what your board is doing and how well it is doing?

- Is your board's Web site consumer friendly? Just what information is on it? Are disciplinary actions posted on a licensee's "profile?" Can visitors to the site sort through licensees by ZIP code? By language spoken? Are there any steps that can be taken to see that it becomes a more useful tool for consumers?

- How and how well does your board explain to the public what the profession does and distinguish between various types of practitioners within the profession (*e.g.*, within nursing; occupational therapy vs. physical therapy; psychiatrist vs. psychologist, etc). Does the board seek out consumer feedback and/or advice on how the board can communicate more effectively with the public?

Involving Outside Groups

- How if at all does your board relate to CBOs and other groups external to the profession? What opportunities exist for developing closer and more effective relationships with them? Are there certain types of venues that could be exploited to more fully gain the attention of CBOs?

- How and how well does your board reach out to and inform seldom-heard groups? Is your board sufficiently informed of the challenges involved in reaching these groups? Is it adequately attuned to the linguistic and cultural challenges of communicating with some of these groups? What kind of proactive efforts can reasonably be undertaken?

The Office of the Inspector General of the U.S. Department of Health and Human Services developed a useful checklist by which a complaint process might be evaluated. Boards might benefit from examining their own complaint process and determining how well their program measures up against the following key elements:

Element	Characteristics of an Effective Complaint Process
1. Accessibility	**Complainants are aware of the system and find it easy to use.**
2. Investigative capacity	**Appropriate experts, resources, and methods are available to assess complaints and determine if they are part of an underlying pattern.**
3. Interventions and follow-through	**Substantiated complaints result in appropriate corrective action. Monitoring assures compliance.**
4. Quality improvement orientation	**Complaints guide quality improvement efforts.**
5. Responsiveness	**Responses to complainants are regular, substantive, and clear.**
6. Timeliness	**Each step is completed within an established, reasonable timeframe, and mechanisms exist to deal with emergent complaints in an expedited manner.**
7. Objectivity	**The review process is unbiased, balancing the rights of each party.**
8. Public accountability	**Complaint information is made available to the public.**

*3. **Thinking strategically about agenda-setting.***

As public members quickly discover, the time and resources available to boards are strictly limited. Board meetings tend to be tightly packed, with minimal opportunity for "big picture" discussions. Public members who seek to work effectively with board colleagues will hardly endear themselves if they slow down board meetings by posing too many questions or not choosing their questions carefully.

Public members must be ready to take an initiative to impact the board's agenda – to get the board to address a set of important questions.

Yet, effective public board members will not be content to just quietly blend in. At some point, they must be ready to take an initiative to impact the board's agenda — to get the board to address a set of important questions. The key is to do so strategically and to do enough prior research to be able to present a cogent, persuasive case, supported by evidence and/or logic. The questions should be important ones related to the board's public protection mission. Drawing on input received from CBOs can be extremely helpful in making one's case.

When budget constraints are cited as reasons for not being able to address an issue, public members should be prepared to suggest minimal-cost options for taking action and for drawing wider attention to the issue of concern. In certain cases, it may be appropriate to make the case for seeking financial support though a legislative appropriation.

This is where boardsmanship skills come to the fore. Public members must become skilled enough to know how and when to get their concerns on the board's agenda and to press for them to be constructively addressed. And while public members will want to raise issues in a civil manner and strive for good working relationships with other board members, they must also recognize that there are likely to be times when dissent is unavoidable. They must not allow the understandable desire for consensus on a board to prevent them from going against the grain and raising issues that they see as vital to the public interest.

Public members must become skilled enough to know how and when to get their concerns on the board's agenda and to press for them to be constructively addressed.

In this context, skilled board chairs who are open to the potential contributions of public members can make a big difference. They will recognize that public members approach their role from a somewhat different vantage point than licensee members and from time to time public members could well generate some controversy as they ask the board to focus on why things are the way they are and/or how they could be different. Enlightened board chairs will recognize the value of such input and not allow the quest for board harmony to snuff it out. They will recognize that public members help boards avoid the trap of operating in professional silos, removed from the experiences and concerns of the wider public.

More than one public member told us that the professional association's presence at meetings can be intrusive, interrupting the flow and occasionally creating an environment of dissension between the licensee members and the public members. This is another area where an alert and skilled board chair can maintain decorum and reinforce rather than undermine the value of the public member's contributions.

Finally, as they seek to carry out a proactive, agenda-setting role, public members must remain aware that a reactive role is also important. They must stay attuned to the full range of board actions and inquiries, including the work of the various board committees and subcommittees, and keep their antennae up for situations when a broader, public voice is important. There are times when licensee members may not recognize the

implications of certain actions for access, cost, or the even quality of care. Public members need not always feel that they must have the answers to what should be done in such cases. But they can ask hard questions and call for a clear and strong rationale to back up board decisions, particularly those decisions that may be perceived to advance the interests of licensed professionals over those of the patients they serve.

PUBLIC MEMBERS IN ACTION: ILLUSTRATIONS OF WAYS PUBLIC MEMBERS HAVE MADE A DIFFERENCE

By definition, licensee and public members come to a board with different preparation and life experiences. Their contributions to the board's deliberations are complementary — licensees bring technical expertise and familiarity with professional practice, while public members contribute a broader, consumer perspective and sensitivity to the implications of board decisions for members of the public, including members of culturally diverse communities.

By bringing something extra to boards that were once composed entirely of members of the profession, public members can make distinctive contributions which add to the overall effectiveness of boards. By injecting a consumer or client perspective into the conversation, public members can help licensee members appreciate the issues, concerns, and sensitivities of the broader public and help keep the board's focus on its statutory mission.

1. Their Contribution to Board Business

"Strong public members alter the context of the conversation," one public member told us. "An absence of public members would change the dynamic." Beyond context and dynamic, public members are able to make important, tangible differences in the way boards do business, the priorities they pursue, and their understanding of the changing scope of their mission in our rapidly evolving health care environment.

"Strong public members alter the context of the conversation. An absence of public members would change the dynamic."

Possessing neither the licensee members' professional habits of thought nor the board staff's managerial mindset, public members are well-positioned to help their boards step back and look at the "big picture." For example, among her accomplishments during her tenure, one public member convinced her board to conduct a "pattern analysis" of disciplinary activity so the board could assess whether it was handling the highest priority cases first. For the first time, this board was able to document how many of its disciplinary actions involved quality of care issues, how many were merely affirmations of actions taken in another jurisdiction, how many involved under-treatment of

pain, and so on. This gave the board evidence against which to adjust its disciplinary case priorities and to identify preemptive strategies the board could pursue to prevent the most common infractions from recurring in the future. Another public member recalled convincing her board that it was important to enact policies and priorities that distinguish between ethics transgressions and practice errors.

Other public members tell us they convinced their boards to reexamine time-tested routines and procedures. For example, one public member proposed that his board conduct routine reviews of its regulations, rules and disciplinary guidelines. Another convinced her board of the importance of measuring the outcomes and impacts of their actions (although it did not have the data or resources to do so in a comprehensive way). Another promoted better communication with the public through educational outreach to cultivate consumer awareness of what the board does and how to access it. Public members view outreach to community-based and patient advocacy organizations as a fruitful way to improve the boards' understanding of the realities of healthcare delivery from the point of view of diverse population groups.

There are many more examples of ways in which public members can strengthen their boards by raising issues and concerns and introducing agenda items that licensee members are unlikely to think of or embrace. Examples include exploring ways licensure boards can meet the needs of culturally diverse and underserved populations by, for example, helping practitioners pay off school loans in return for practicing in remote areas. It is typically a public member rather than a licensee member who is the strongest advocate for comprehensive disclosure of information — including disciplinary information — about practitioners on the board's Web site. Public members tend to be more sensitive about making sure the board's materials are printed in multiple languages and are written in a culturally sensitive manner.

It is typically a public member rather than a licensee member who is the strongest advocate for comprehensive disclosure of information.

Often, it is a public member who initiates or sees to fruition board policies that promote cultural competence among the licensed profession. One public member who was told she didn't have the requisite technical expertise nevertheless insisted on reviewing the licensure examination, not to second-guess clinical questions, but to see if there were any questions related to cultural competence and other consumer-oriented considerations. Other public members have worked with their boards to require licensees to provide consumer information to their patients and to provide it in readily comprehensible language.

Public members are able to bring a dispassionate perspective to discussions about the degree of education or other preparation needed to qualify for professional licensure. Because of this, they can be influential in helping boards find a reasonable balance between establishing standards high enough to protect patient safety and establishing standards so high that they unnecessarily limit the number of people who can enter the profession, thus reducing access and raising the costs of care.

In another area that has profound implications for access to affordable health care, public members (rather than members of the profession) are likely to be more open to taking a fresh look at the use of practitioner extenders (such as dental hygienists, pharmacy technicians, nurse aides, etc.) and to expanding professional scopes of practice so that, for example, advanced practice nurses or psychologists can prescribe or administer medications. A former public member related that because of his lack of professional affiliation, he was able to contribute constructively to a highly political scope of practice dispute over which of two professions is qualified to use general anesthesia.

2. Their Effect on Board Credibility

By their very presence, public members lend an air of legitimacy to boards and help the public gain confidence that boards are focused on the people's business rather than the interests of the profession being regulated. But this is only the beginning. When they effectively represent the public interest and contribute to the board's mission, public members can enhance public confidence in the board and in the regulatory process.

A former public member of a California licensing board was an instrumental player in the board's efforts to improve its program for chemically dependent practitioners and, when these efforts were unsuccessful, to terminate the program and go back to the drawing boards. In another example of an initiative intended to bolster public perceptions of the regulatory process, a public member devised a plan to facilitate public testimony at board meetings by informing members of the public what is and is not permitted during the public comment period.

In the context of the board's very important discipline function, the presence and vigilance of public members can serve to keep licensee members from — either deliberately or inadvertently — favoring colleagues who come before the board, or recommending lenient treatment for violations of the practice act. One public member told us his greatest contributions were behind closed doors in executive session when the board was discussing whether to take disciplinary action. Speaking from the public's point of view, he felt he was

able on important occasions to convince other board members to take disciplinary action when their initial inclination had been to go lightly or overlook an infraction.

WHY THE INVOLVEMENT OF COMMUNITY-BASED ORGANIZATIONS MATTERS

By weighing in on public policy issues, CBOs can help boards be more relevant and better serve culturally diverse constituencies.

There is a general consensus among regulators that the more information that is available to a licensing board, the better its decision-making will be. This is particularly the case in a state such as California where the majority of the population is comprised of members of diverse minority groups who may make distinct linguistic and cultural demands on the health care delivery system. By making their interests and agendas known to a licensing board and by weighing in on public policy issues, CBOs can help boards be more relevant and better serve culturally diverse constituencies.

Licensing board officials and public members confirm that professional association representatives are regulars at licensing board meetings, but the boards rarely, if ever, see or hear from consumer and community organizations. This means that boards may not be sensitive to grassroots issues, such as difficulties gaining access to affordable care, cultural and language barriers that affect access and quality, the role that race plays in diagnosis and treatment, provider shortages in underserved areas, the need for non-English language interpreters, and so on.

Boards address a number of thorny issues that require a balancing of various interests. By expressing a grassroots perspective, CBOs can help boards strike an appropriate balance. For example, boards often are faced with deciding what qualifications are necessary to safely perform certain clinical tasks. They may be asked to weigh the relative importance of education versus professional experience or on-the-job training. Boards don't want to lower standards; at the same time, they don't want to overestimate what it takes to be a competent, safe practitioner and thereby reduce the availability of health care in certain areas. CBOs can provide data about how such decisions could impact health care in their communities and thereby help boards determine where to draw the line.

CBOs and their members can make their views known to policy-makers — legislators, the Governor, the Department of Consumer Affairs — about community concerns. These outside organizations affect the work and capacity of boards by supporting budget authorizations or enabling legislation affecting powers and authorities, and in other ways.

CBOs that back health care related legislation need to continue to monitor and advocate during the rulemaking and implementation stages to be sure their original goal is met.

Many CBOs advocate or testify before legislative bodies, but rarely at hearings or on bills that have an impact on licensing regulation. Significantly, when legislation is passed that instructs a board to address issues of cultural competence, the licensing board is generally given the responsibility to develop rules to implement the legislation. If the board does an indifferent job, the intent of the legislation can go unfulfilled. Therefore, CBOs that back health care-related legislation need to continue to monitor and advocate during the board's rulemaking and implementation stages to be sure their original goal is met.

Public members who originate from CBOs can impart to the board their on-the-ground understanding of the challenges associated with access to safe, quality, cost-effective health care from the perspective of the patient/consumer. A solid connection to CBOs can give public members added authenticity and heft when they express a consumer perspective during board deliberations.

CBOs stand to benefit from having individuals familiar with the concerns and needs of their members sitting at the policy-making table. Public members stand to benefit from having support for the positions they present to the board. Boards stand to benefit from being better informed about the impact of their decisions on the real-life issues affecting diverse groups among the consuming public.

The authorities who appoint members to licensing boards are interested in receiving nominations of qualified and interested individuals, including from diverse demographic groups. CBOs can screen their staffs and their memberships for individuals qualified to provide a direct, accurate reflection of the issues affecting their communities. Qualities to look for include advocacy experience, some familiarity with government processes, and an understanding of and passion for the issues that need to be addressed. At the same time, it is important to nominate individuals with the temperament and capacity to contribute to the day-to-day, often mundane, board operations.

By nominating public members to serve on boards, CBOs would send a signal that they appreciate the impact board actions have on their constituents and want their concerns represented at the table. Attending board meetings underscores this message and enables community organizations to provide demographic data and perspectives that can help inform board decisions.

Some community organizations already have leadership training programs to prepare their members and staff for positions in advocacy and policy-making settings. Others have résumé banks. Others do not enjoy the resources necessary to spare members or staff to the time-consuming job of a licensing board public member. A promising option may be to pull together one or more coalitions of community-based organizations that would vet and nominate candidates for public member positions.

Also, CBOs can establish a relationship with sitting public members and have some impact on board business pending appointment of their own nominees some time in the future. Since they haven't been involved with boards prior to now, the appearance of community-based organizations could be a game-changer. In the words of one public member, "Knowing there are people out there supporting public members is very helpful. It is good when the real customer shows up at a board meeting."

On a cautionary note, just as licensee members are expected to overcome their socialization as members of their profession and be guided by what they perceive to be the public interest, public members need to guard against thinking of themselves as no more than advocates for the narrower interests of a particular constituency group at the expense of their role as representatives of the larger public. Sometimes it will be more effective for CBOs to advocate from the outside in behalf of their agenda, placing the board's public members in a supporting posture.

Public members need to guard against thinking of themselves as no more than advocates for the narrower interests of a particular constituency group at the expense of their role as representatives of the larger public.

PAYOFFS FROM THE BOARDS' POINT OF VIEW

If public members are qualified, respected and integrated into the board, and if the board has ongoing communication with members of the public through CBO involvement and other means, the board will benefit from having a broader perspective and more complete data before making its decisions. Boards will consider factors they might not otherwise be aware of. With effective public members and outside input, boards can have greater confidence they are addressing issues that really matter to health care consumers.

When decisions and actions are based on input from the public, boards will be in a position to earn greater credibility. Public trust in the regulatory system is fragile when the primary information about boards is communicated in media exposes of medical tragedies, or a board's failure to act or to act appropriately. Boards can earn the public's confidence by being

conscientious about finding out what various communities want and by looking after the broad public interest.

ADDITIONAL RESOURCES

California Department of Consumer Affairs, *California Health Personnel Licensing Policy: Policy and Legal Implications of Health Occupational Licensure* (health career ladder project) Sacramento, CA, June 1979 (available in many California libraries).

Citizen Advocacy Center (CAC), *Public Representation on Health Care Regulatory, Governing, and Oversight Bodies: Strategies for Success*, 1995 (available from CAC, www.cacenter.org).

Schmitt, Kara and Shimberg, Benjamin, *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Council on Licensure and Regulation (CLEAR) 1996, (available from CLEAR, www.clearhq.org).

Shimberg, Benjamin, *Occupational Licensing: A Public Perspective*, Educational Testing Service, Princeton, New Jersey 1980.

APPENDIX

How the Regulatory System Works[3]

Most occupational and professional regulation in the U.S. is conducted under the aegis of state government. Through their understanding of how the regulatory system works and their ability to use the system, occupational groups derive much of their power.

ADMINISTRATIVE AGENCIES: FOURTH BRANCH OF GOVERNMENT?

Administrative agencies have been characterized as a "fourth branch of government," existing alongside the legislative, executive, and judicial branches. They affect almost every facet of daily life. They set rates for vital services, including gas, electricity, and telephone. They tell airlines who may pilot their planes, where they may fly, and, until recently, how much they could charge for tickets. They watch over activities that involve our bank deposits, stocks and bonds, even insurance policies. They deal with complaints about unfair labor practices and award compensation to workers who are injured on the job.

The broad scope and power of administrative agencies did not come about by design, but rather evolved out of necessity. As problems of an industrialized, urbanized society grew more complex, the existing machinery of government proved inadequate to meet the problems that arose. Historically, legislative bodies passed laws and relied on the executive branch to see that they were carried out. The courts served as referees when individuals questioned the constitutionality of a law, how it was being interpreted, or the way in which it was being enforced.

But that model failed to take into account the fact that legislators lack the time, the expertise, and often the inclination to deal with complex questions. What kinds of boilers would be acceptable in what kinds of industrial plants? What rates should railroads or truck lines charge? What kind of curriculum should nursing schools offer? Legislators recognized that the best they could do with many questions was to formulate general policies and standards and then turn over to an administrative agency responsibility for working out details. Thus, in theory, at least, regulatory agencies are an extension of the legislature, with power to fill in the details of a law and to make rules that have the force of law.

As autonomous regulatory agencies have evolved, they have developed a uniqueness that many ordinary citizens do not fully understand. While such boards are not part of the legislative branch, they are empowered to promulgate rules that have the force of law. While not formally a part of the executive branch, they implement laws. While not part of the judicial branch, they exercise sanctioning power over individuals similar to those of a court.

[3] An excerpt from ***Occupational Licensing: A Public Perspective*** by Benjamin Shimberg, Center for Occupational and Professional Assessment, Educational Testing Service, Princeton, New Jersey, 1980.

Created on an ad hoc basis to deal with specific problems, administrative agencies enjoy considerable independence. It is not uncommon for them to stand alone, often unattached to any department or other agency of government. Standing alone, they often operate with virtually no oversight.

Such a system would seem to challenge the constitutional principle of separation of powers. Indeed the constitutionality of regulatory agencies has been challenged on numerous occasions, but after much deliberation, the courts have held that such agencies are legal as long as they: 1) restrict themselves to promulgating rules and regulations necessary to fulfill the stated legislative purpose based on standards provided by the legislature, and 2) provide procedural due process for their licensees. Requiring procedural due process is a way of saying that an agency must deal fairly with those it regulates.

A specialized type of law, known as administrative law, has grown up around these regulatory agencies. Administrative law sets forth the ground rules by which administrative agencies must function to insure orderly procedures and equal treatment for all.

President Franklin D. Roosevelt recognized that the uncoordinated growth of federal administrative agencies needed to be brought under control. In 1939, he instructed the attorney general to conduct a study of all existing federal administrative agencies and to propose needed reforms in their procedures. It took seven years to complete this task, and, in 1946, a federal Administrative Procedures Act (APA) was passed. Since then, many states have enacted APAs patterned after the federal APA, setting forth in detail the procedures that agencies must follow in making rules, adjudicating disputes, or dealing with violations of agency rules.

During the New Deal years, when many administrative agencies were created to deal with pressing economic and social problems, former Supreme Court Justice William O. Douglas, then chairman of the Securities and Exchange Commission, foresaw a serious conflict of interest problem. He proposed to President Roosevelt that every regulatory agency be abolished within 10 years of its creation; otherwise, he said, they would be captured by the very industries they were established to regulate.

Douglas's fears were well founded. Many of the agencies were concerned with regulating such complex industries as railroads, banking, and utilities. Experts from those industries were often recruited to serve as regulators. They often brought with them an attitude that held that what was good for their industry was also good for the country. Since most of those who accepted appointment intended to return to the jobs they had left, they usually maintained their business contacts. Thus, friends and associates from the industry had ready access to the regulatory official. They could press their viewpoints not only at the regulator's office, but also on the golf course or at the country club. Non-industry people had no such ready access. Being less familiar with the ways of bureaucracy, the public usually waited for formal hearings to present its arguments. There tended to be little communication between consumer representatives and regulatory officials. Thus, the regulators often had little understanding of the consumer's concerns or of the impact that regulatory actions would have on the public.

Whatever the reasons, the regulatory process was thus frequently "captured" by the people who were supposed to be regulated. Critics of government regulation have noted that regulated industries often become government protectorates, living in a world of assured investment

returns and closed membership and insulated from the spectre of competition. Such an environment, say proponents of deregulation, usually breeds inefficiency and stifles competition.

Many of those who once viewed governmental regulation as an effective way to protect the consumer against the power of vested interest groups are having second thoughts about the whole idea. They now acknowledge that they may have underestimated the role of competition in a free market as a way to assure the public of goods and services at a fair price.

Disillusionment with government regulation seemed to underlie efforts at the national level to deregulate such industries as the airlines and trucking and the emergence of Sunset legislation at the state level. The unique feature of the Sunset approach is the enactment of a law setting termination dates for specified agencies and programs, including occupational licensing boards.

Here is the way Sunset usually works: Prior to the deadline date, data are collected and hearings held to determine whether a need for the agency still exists; whether the activities of the agency are duplicated elsewhere; and whether the agency is operating in an effective manner. Agencies that can demonstrate that they are still needed and that they are doing a good job are given a new lease on life – usually for five or six more years. Those that cannot justify their continued existence are allowed to expire. Leaders of Colorado Common Cause, who thought up the idea, argue that the sun should be allowed to set on agencies whose continued existence could not be justified. Hence, the term "Sunset Legislation"…

THE POWER OF BOARDS

The authority of boards to adopt rules and regulations that have the force of law is undoubtedly the greatest source of a regulatory board's power. This power enables a board to set forth practice and conduct standards to which all practitioners must adhere on pain of disciplinary action. Boards also have authority to evaluate the qualifications of applicants, examine them for competence, investigate complaints, and take disciplinary action where warranted.

As previously noted, most licensing boards in the United States are made up of members of the regulated occupation. Thus, the system is essentially one of self-regulation under the aegis of the state.

At one time it was quite common for licensing laws to stipulate that board members be appointed from lists provided by the professional and trade association subject to regulation. It was felt that such a requirement would insure not only that board members had high professional qualifications, but that they would enjoy the respect and confidence of their fellow practitioners. Even though many states have dropped the requirement that board members be selected from lists of association nominees, the tradition persists in most states. This means that, in practice, the leadership of a trade or professional group determines who gets appointed. It should surprise no one that nominees tend to be individuals who identify strongly with the goals of the association and the occupational group. Indeed, a common criticism of self-regulatory boards is that their members often fail to make a distinction between the goals of a licensing board and those of a professional and trade association. The licensing board is supposed to have as its primary concern the protection of the public, while the association is supposed to advance the interests of its members.

It is this difference in perspectives that may at times give rise to conflicts of interest. From time to time, board members may be faced with decisions, on trade practices for example, that run counter to their own interests and those of fellow practitioners. In subsequent chapters, a number of examples will be given of instances where board decisions seem to have placed the interests of the occupational groups ahead of those of the public. While these examples are important to document the existence of abuse by some boards, it is only fair to say that such instances seem to be the exception rather than the rule.

For readers to understand how even a few boards can use their powers to advance the interests of their own group, they must understand how boards are constituted, what powers they possess, and to whom they are accountable.

When most of the early regulatory boards were established, they were granted a high degree of autonomy. This was clearly an expression of the esteem in which these professions were held and of legislators' confidence in the ability of the professions to regulate themselves in the public interest.

Boards expressed their independence in a variety of ways. Not being responsible to any established department of government, they could locate their offices wherever they pleased. This often turned out to be in the home or place of business of the board's secretary. If a board had a paid executive, clerical staff, or inspectors, the hiring and supervision was conducted by the board. Since continued employment and raises were entirely in the hands of the board, it is understandable why the loyalty of the staff was directed more towards the board and the occupational group than towards the public.

Autonomous boards have tended to be self-contained and self-sufficient units. They process their own paperwork; prepare, administer, and grade their own tests; conduct their own investigations; and frequently hire their own attorneys to prosecute licensees in disciplinary proceedings. Such administrative independence is likely to entail a considerable amount of waste and duplication of effort. Their separate status provides few opportunities to share facilities, staff, equipment, and other resources. As a rule, occupational groups strive to keep their administrative autonomy, arguing that in the long run it is more efficient and less costly than a bureaucratic superagency.

The feeling of independence is further heightened by the fact that most of these autonomous boards are supported by income derived from licensing fees. Unlike other agencies of government, they do not usually have to appear before the legislature to ask for funds or to justify their expenditures. In many states, it has been customary for such boards to deposit their income in separate bank accounts and to use their funds for whatever they perceive to be necessary expenses. Such fiscal independence – like administrative independence – can be a mixed blessing. Boards with a large number of licensees often have excess funds – more than enough to carry out their responsibilities. However, small boards may find that they are underfunded. As a result, the quality of their examinations, investigations, and services to licensees and the public may suffer. Such boards might have been better off under a system where the resources of a state's richer boards are shared with poorer boards.

While administrative and fiscal independence have given rise to questions about the efficiency and effectiveness of autonomous boards, their decision-making authority raised questions about accountability. In theory, autonomous boards are accountable to the legislature, but in practice

legislators have paid them little heed. Unless there are complaints from constituents or members of the occupational group, legislators seldom ask questions about what boards are doing: whether their entry standards are fair; whether rules and regulations are in the public interest; whether the public is being adequately protected by the board's enforcement activities.

If boards are not accountable to the legislature, then to whom are they accountable? One might expect board members to feel themselves accountable to the governor or other executive officials who appointed them. Yet in practice it often does not work that way. Once board members have been confirmed, they are usually insulated from control by the executive during their terms of office.

In one state, the press sought access to certain board records under the Freedom of Information Act. The board refused to make these records available, claiming that the records in question were not covered by the act. The governor disagreed. He asked the board to release the records. When the board refused to comply, he sought an opinion from the attorney general. The latter ruled that the records should be made public. The board continued to refuse to yield the records, so the attorney general sought a court order to force compliance. The court issued such an order, but the board appealed to a higher court. While the appeal dragged on, neither the governor nor the attorney general could do anything further to secure release of the records. Finally the legislature interceded. It passed a law that specifically directed the board to make its records available to the public. The board complied with the legislative directive.

The foregoing incident dramatizes the limited power of governors over board members, once their appointments have been confirmed. In most states, the law allows board members to be removed only for cause – such as nonfeasance or malfeasance, but not for disagreements over policy matters.

The tenuous link between autonomous boards and the governor's office in one state was brought to the author's attention when he was trying to arrange appointments to interview board executives in a large southern state. Unable to find an up-to-date list showing the addresses of various regulatory boards, the author appealed to the governor's office for help. In due course, the governor's legal counsel made a list available. However, in phoning for appointments, the author found that the list was hopelessly out of date. Boards had appointed new secretaries and in several instances had relocated their offices. This experience suggests that either the boards had not bothered to notify the governor's office about the changes or the governor's staff had not considered the information of sufficient importance to update its records. In either case, it is difficult to believe that the governor's office was exercising any meaningful oversight.
If autonomous boards are not being monitored effectively by the legislative or executive branches of government, who is monitoring their activities? It is safe to say that officials of trade and professional associations pay close attention to what boards are doing. Representatives of such groups are frequently present at board meetings and they usually appear at hearings to testify regarding proposed rules.

There is nothing wrong with associations monitoring the activities of boards. That is their job. However, one may ask if it is sound public policy for such associations to “call the shots,” as they often do through their role in the appointive process, through their lobbying capabilities, and through their pervasive presence at rulemaking hearings. By contrast, the public is all but

invisible in such proceedings. Small wonder then that board members may feel that they are more accountable to the professional association than they are to the general public.

LIMITING THE AUTONOMY OF BOARDS

For most of this century, autonomous boards were the primary mechanism for administering licensure laws. Although central agencies were established in New York (1892), Illinois (1917), Washington (1921), Pennsylvania (1923), and California (1929), as late as 1969 the Council of State Governments (1969) could identify only 16 states which had central agencies overseeing some aspect of licensure. By 1980 the balance had tipped. A more recent study by the Council of State Governments (Roederer &, Shimberg, 1980) found that 29 states had some degree of centralization.

It should be noted that bringing autonomous boards together into a single umbrella agency does not necessarily mean that the autonomy of the various boards has been curbed in any significant way. Usually, boards have been centralized as part of a reorganization effort to promote greater efficiency and to enhance the span of control. The central agency is given responsibility for such housekeeping activities as providing space, answering inquiries, collecting fees, processing license renewals and performing other routine chores. Under this arrangement, boards retain their autonomy over such crucial matters as reviewing and approving applications, developing and scoring exams, setting standards for practice and conduct, and disciplining licensees. They usually retain control over their own budgets and the hiring and supervision of staff.

In their study Roederer and Shimberg (1980) tried to ascertain the extent to which central agencies have authority over the boards that fall under their jurisdictions. They developed a survey instrument that presented five models:

> *Model A* describes a state where no central agency exists. Boards are fully autonomous. Twenty-one states fit this model.
>
> *Model B* describes a relationship in which boards are autonomous, but a central agency performs certain routine administrative functions. Six states fit this model.
>
> *Model C*. In this model, boards are essentially autonomous, but a central agency may have authority for such functions as budgetary, personnel, and certain disciplinary activities. Seventeen states fit this model.
>
> *Model D* describes a situation where board actions are subject to review by a central agency. Four states fit this model.
>
> *Model E* describes a structure where the central agency has complete licensure authority. Boards exist only in an advisory capacity. Two states fit this model.