

# FEDERATION BULLETIN

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NATHAN PORTER COLWELL, M.D.  
1870-1936

In appreciation of Dr. Nathan Porter Colwell whose death occurred on January 6, it is fitting that the Federation record its recognition of his important part in the founding of the Federation and his constant efforts to maintain its aims and purposes during the first twenty years of its existence.

As a member of the committee on organization he drew up the constitution and by-laws, and proposed the name "The Federation of State Medical Boards of the United States," which was adopted at the first meeting on Feb. 29, 1912. With the first issue of THE BULLETIN in April 1915 he became the managing editor, and continued in this service until his retirement a few years ago.

During his period of service he exerted a potent influence in shaping the policy of the Federation, and

was largely responsible for establishing THE BULLETIN as an authoritative medium of influence in all matters pertaining to medical licensure.

At the annual session of the Federation, Feb. 16, 1932, an engrossed testimonial was presented to Doctor Colwell, which expressed the acknowledgment of the Federation for his eminent services in the field of medical education and to the cause of medical licensure in fullest measure.

For more than a quarter of a century the editor was privileged the intimate association with this fine cultured gentleman, and his friendship will always be a treasured memory.

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### THE FEDERATION AND ITS DESTINY

As the Federation enters upon its twenty-fifth year, it is well to view in retrospect the reason for its being, as a basis to determine its further destiny.

The Federation was formed in 1912 by a merger of two pre-existing organizations, each having the separate function of the elevation of standards of medical education and improvement in licensure and reciprocity respectively. The principal object of the new Federation was to promote a greater unity of these two functions. This was to be accomplished by annual conferences and through the medium of a monthly bulletin, by developing a sentiment among constituent state boards for greater uniformity in medical practice acts consistent with advancing standards of medical training.

In the succeeding years the Federation has come to recognize more clearly that its function is concerned mainly with the problems of qualifications for practice as they pertain to the different states in this country, as well as interstate endorsement and admission of foreign medical graduates to licensure. This has been made possible only by constant cooperation with the two closely allied agencies, the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges. All this portends that the Federation has an important function in the future development of American medicine. The passive attitude has no place in this program if

the Federation is to measure up to its fullest opportunity and responsibility.

The membership must keep apace not only with the evolutionary changes going on in medical education but equally so with the extension of medical service into many new fields and the varying methods of delivering such service. The demands for medical service in the changing order of society must ever be the guide and the measure of the proper type of training for medical practice.

In this liaison of worthy effort for such high purpose the Federation must recognize its opportunity and assume its fullest responsibility to justify its future destiny.

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### PSYCHIATRY IN THE MEDICAL CURRICULUM

The practice of psychiatry is recognized as a form of medical specialty. In view of the great number of persons with mental diseases, particularly in governmental institutions and special hospitals, there is need for specialized training to assure the best of professional service as well as to further the necessary clinical investigation and research.

While the population of special hospitals for mental diseases parallels that of the colleges and universities in this country, a much larger number of less fully developed cases comes under the observation of the general medical practitioner.

It was a forward step when a plan was instituted recently in several leading medical schools for the professor of psychiatry to select his patients for clinical demonstration from the general medical wards.

The general practitioner if properly trained is best able to recognize the early symptoms of mental diseases as well as the first indications of organic heart disease, metabolic disorders such as diabetes and pernicious anemia, tuberculosis, and many others at a stage at which appropriate treatment will be of greatest avail.

After mental disorders are definitely established the treatment is largely limited to special institutional care.

Psychiatry should therefore have an important place in the medical curriculum and the training of general practitioners.

## DEATH OF DR. COLWELL

**Nathan Porter Colwell** ♂ for many years Secretary of the Council on Medical Education and Hospitals of the American Medical Association, died of cerebral hemorrhage at his home in Wilmette, Ill., January 6, aged 65 years. Dr. Colwell was born in Osceola, Iowa, May 25, 1870, and received his medical degree from Rush Medical College in 1900. He became associate instructor in otology at his alma mater and served at the same time as assistant dean in Rush Medical College.

In 1901 *The Journal* published its first Educational Number, which included a survey of American medical colleges, and in 1903 its first annual State Board Number. Apparently as a



NATHAN PORTER COLWELL, M.D.  
1870-1936

result of these surveys the House of Delegates of the Association was stimulated to the formation of the Council on Medical Education in 1905, and Nathan P. Colwell became its first secretary in 1906. From that time he made numerous contributions to the subject of medical education. As secretary of the Council he bore a large share of the responsibility for direct investigation and report on medical schools, for aiding the trend of discussions at the annual conferences on medical education, and for setting forth clearly the facts in relationship to medical education in the United States. He was also instrumental in organizing the Federation of State Medical Boards of the

United States and drew up its first constitution, which was adopted in 1912. He aided in establishing the monthly bulletin of the federation and served as its managing editor until the time of his retirement as secretary of the Council on Medical Education and Hospitals in 1931. Each of the annual reports on medical education and on hospitals published by the Council on Medical Education and Hospitals during his tenure of office was drawn up under his personal supervision. Moreover, from 1904 to 1915 he compiled the statistics of deaths associated with Fourth of July accidents and did much in the campaign to lower this morbidity and mortality.

From 1913 to 1930 he was a collaborator of the United States Bureau of Education. During the World War his knowledge of medical education was put at the disposal of the United States Army and he served as contract surgeon in the office of the Surgeon General. He was a member of the Institute of Medicine of Chicago and of Alpha Omega Alpha.

During the twenty-five years of his work with the American Medical Association he rendered devoted service at a great sacrifice of his health and leisure. In 1931 he was retired and since that time had been living at home, concerning himself partially with the preparation of a history of medical education. He was an earnest and conscientious worker, devoted to the single purpose of raising standards in medical and hospital care. His temperament was judicial and his mind analytical. To him must be assigned a large portion of the credit for the persistent and steady advances made in medical education in this country during the past quarter century.—*J. A. M. A.*, Jan. 18, 1936.

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### The Aspirant Groups

The increasing number of medical schools and the necessity for highly specialized scientists has led the People's Commissariat for Health to consider the question of organizing aspirant groups in medical institutes. Physicians up to 35 years of age can be enrolled in the aspirant group after they pass examinations in special medical courses, foreign languages and the natural sciences. This course of study is for a three-year period. The first year and a half is devoted to theoretical science related to the specialty taken at the institute. After examinations in practical and theoretical courses, the aspirants pass the second one and one-half years in clinical study. After his thesis has been accepted, the aspirant receives the degree of medical science candidate, if the Supreme Qualification Committee of the People's Commissariat of Health approves him. The Aspirant Institute must help to supplement deficiencies in highly qualified specialists. After graduation their number in the different medical specialties will be markedly increased.—*Moscow Letter*, Oct. 31, 1935.—*J. A. M. A.*, Dec. 21, 1935.

## MEDICAL PRACTICE AND MEDICAL EDUCATION

ALPHONSE M. SCHWITALLA, S.J.  
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ST. LOUIS

This is intended to be, not a paper, but a statement of more or less valid and more or less challengeable deductions from present-day tendencies and phenomena as manifested in schools, social agencies, community life and literature but all bearing upon the relationship of medicine and medical practice on the one hand and medical education on the other. Each statement bears upon a specific and limited phase of that relationship.

The statements are grouped under three main headings:

- I. Trends and phenomena in medicine.
- II. Trends and phenomena in sociology and economics.
- III. Trends and phenomena in education.

### I. TRENDS AND PHENOMENA IN MEDICINE

1. The patient seems to get relatively less of personal attention from the physician today than he received in the past. It is assumed that because medical practice must be more scientific and objective, it must, therefore, become more aloof and more impersonal. The physician is alleged to be more interested in disease processes rather than in the diseased person; disease or disability is treated, so it is said, with little consideration for the luckless patient. The physician takes a physiologic rather than a biologic view of the patient.

Medical education, therefore, must decide whether it desires to progress in the direction of impersonality or whether it will adopt procedures for bringing the patient again into the center of the medical student's interest. Four lines of development which contemplate "the organism as a whole" might be increasingly brought to the attention of the student in medicine.

(a) Human Constitution: While it must be granted that our knowledge of human constitution and of its implications is as yet decidedly fragmentary, still such knowledge as has already been accumulated should be

progressively introduced into medical thought and into medical teaching.

(b) Heredity: The science of heredity is shifting its stresses with bewildering rapidity both with reference to "normal" as well as with reference to pathologic traits. The tendency is still quite general to treat the hereditary factor in medicine as coercive and deterministic, thus losing much of the light which present-day hereditary studies throw upon the modifiability of the organism by the environment. The stimulation of the point of view that hereditary endowment is plastic within limits under the influence of the variegated environment and that, therefore, each patient is unique, is thus lost. Too much of our teaching in medicine is still dominated by the principle of the coercive influence of heredity.

(c) Anthropology: This science which is rapidly developing conclusions of great aid in understanding the organism as a whole, especially grouped disease phenomena, is relatively a neglected discipline in schools of medicine despite the fact that it offers valuable and suggestive points of view in medical integration especially upon the relation of organisms to each other.

(d) Psychology: The thought is "breaking through" that the physical manifestation of disease is only one of its phases and that the physician cannot ignore the other, the psychologic phase. Integration as taught in our schools in the synthesis of symptoms must progressively consider the psychologic phase of the diseased person. The medical schools as a group have reacted favorably in the modification of their ambitions to the educational propaganda but all have not reacted as favorably by the effective modification of their curriculums, thus neglecting to prepare their students for the shifted point of stress in medical practice.

2. *Diagnostics*.—The science of diagnostics, which in its primary concept and in its aims and method should be synthetic, is still said to be too frequently taught to the student as a series of analytic processes. New procedures and methods are alleged to be taught for their own sake without prompt integration into generalized points of view. More specifically attention may be directed to certain areas of interest.

(a) Manual and Inspectional Diagnosis: Suggestions are numerous that manual and inspectional diagnosis is rapidly becoming a lost art; that the young physician has been taught overcaution in relying on

ordinary and established procedures in inspection—palpation, percussion, auscultation—having been taught that these procedures are more personal and, therefore, allegedly less objective than other procedures. Such diagnostic processes are apt to be regarded as crude, antiquated, nonquantitative, vague; obvious symptomatology as manifested in posture, walk, skin color changes, etc., are apt to be ignored to the detriment, so it is said, of the student in the development of “medical judgment.”

(b) *Laboratory Diagnosis*: Laboratory procedures are said to be most responsible for increasing the distance between the patient and the physician. The schools of medicine are accused of fostering this trend by their insistence on the all-importance of the laboratory without enough stress on the purpose of the laboratory; of promoting the student's evaluation of laboratory procedures without adequate teaching concerning their limitations. The thought that laboratory procedures and physical examinations are mutually supplemental is said to be too often ignored. It is feared that thus the physician's personal service as a help to suffering humanity is neglected.

3. *Therapeutics*.—In the field of therapeutics the most striking fact is the extremely rapid multiplication of methods both chemical and physical. The physician is therefore too prone to experiment recklessly with every new drug and instrument even if recommended by irresponsible persons. This fact lays the medical school open to the charge that its teaching has failed to develop the critical faculty in its students. Other phenomena, however, especially those in the background, are not less significant.

(a) *The Disappearance of “Clinical Entities”*: Instead of the former stress on clinical entities, we are in medical practice rapidly progressing toward therapeutic dynamics, combating processes as they manifest themselves rather than the disease. The diseased person is, therefore, apt to be ignored. It is said that the teaching in our schools of medicine is thus becoming more physiological and pathological rather than medical.

(b) *Physical Therapeutics*: The slowness with which physical therapeutics has gained recognition is said to be due to a lack of appreciation of the points of view and conclusions of general physiology. The commercial exploitation of therapeutic apparatus has contributed to the suspicion with which such apparatus is

regarded, and the schools of medicine are said to have done very little to influence such points of view.

(c) *Chemical Therapeutics*: Chemical substances as therapeutic agents, the administration of which conforms most closely to traditional form, is still given ascendancy. Quackery and commercialization, therefore, in other fields are common. It is said by many that schools of medicine have failed to rise to their opportunities. Pluri-potent remedies are in some localities still sometimes preferred to uni-potent ones, proprietary drugs to pharmacopeial compounds because “hit and miss therapeutics” is still the refuge of the ignorant and the inefficient. The confidence in fake and quackery on the part of the public probably reflects the impedence of the medical profession in its efforts to instruct the uninitiated.

4. *Conditions of Practice*.—The conditions under which medical practice today is taking place and for which the medical schools must prepare the physician are extremely numerous and diverse. A few may be singled out:

(a) *Specialism*: Two tendencies are progressively at work:

- (a) The tendency of restoring the practitioner to an honorable place in the practice of medicine, which tendency is due to many factors one of which undoubtedly is the economic situation; and
- (b) The restriction and elevation of the specialist.

The implications for medical education in both of these tendencies is obvious.

(b) *Hospitalization*: Our schools of medicine give the student his clinical experience chiefly in the hospital. In his later practice, the student will encounter hospital, domiciliary and office conditions. Because he has not been taught the practice of medicine under less favorable conditions, the physician is said to be giving a less adequate service to those classes which do not or cannot use the hospital at the time of disease incidence.

(c) *The Auxiliary Professions*: The practice of medicine today is profoundly influenced by progress and development in the professions and quasi-professions ancillary to medicine.

(1) *Nursing*. The nurse is rapidly becoming conscious of an alleged or real dignity as a co-worker of,

rather than of her formerly recognized position as a subordinate to, the physician. She therefore has ambitions for educational development as well as opportunities to fit herself to occupy such a place. In the new relationships, questions arise concerning the centralization of responsibility for the patient.

(2) Hospital administration. The hospital executive, who in days past was so often a physician, is being rapidly displaced today by the nonmedical hospital administrator who propagates the view that the hospital is more than a place in which disease is cured but is rather the community's center for every activity bearing on health or health education.

(3) Dietetics. The dietitian, especially the medical dietitian, is taking over many of the advisory and even therapeutic activities of the physician and makes demands not dissimilar to, though in a different field, those of the nurse.

(4) The medical technologists. The medical technologists, the laboratory technologists, the radiologic and physical therapy technologists, the occupational therapists are all imbued with the ambition of conquering a sector of the field of medicine for their own special and restricted interests.

It is obvious that, if ambitions of the professions ancillary to medicine are realized, medical education must be profoundly modified if the schools are really to prepare the student for the work which he will later be called on to do. In these developments, the physician seems to have stepped out of the central position of dominance and leadership possibly to the ultimate detriment of the nation's health.

5. *Public Health*.—The field of public health also is claiming constantly more attention on the part of medical practitioners and therefore of the schools. The official health agencies are forced sometimes by economics, sometimes by other considerations, to extend their influence beyond the limited fields previously yielded to them and are, therefore, profoundly modifying their relations to the practitioner. Many considerations might here be discussed. To single out several which seem significant:

(a) Nutrition: It is most significant that the field of nutrition and the instruction of the public in nutrition has been so largely dominated by industry, that is, by those agencies and organizations which make it their business to instruct the public on the merits of a par-

ticular food product. This phenomenon has had a profound bearing on the attitude of the public toward medicine. The medical profession has not asserted itself adequately in this propaganda.

(b) Epidemiology: The epidemiologists of today must necessarily be quite differently prepared than they were two decades ago. Their police powers are relatively less important and their technical qualifications are necessarily more exacting.

(c) Vital Statistics: The field of vital statistics, growing as it is with constantly accelerating velocity, will claim increasing attention on the part of the schools because of the vast import of the conclusions which are being reached.

6. *Preventive Medicine*.—Preventive medicine is focusing in its endeavors on many interests which at one time were regarded as quite foreign to the physician. Recreational facilities, physical education and home economics are being more and more integrated into programs for disease prevention. It may be questioned whether medical education is prepared to correlate its activities with the many social endeavors in these various fields and whether it has or can modify the curriculum in such a way as to afford the student a basic understanding of the importance of these social processes.

7. *Dentistry*.—After the frustrated efforts of a minority in dentistry to have dentistry recognized as a branch of medicine, in a restricted sense to be sure, the dental profession is today striving more and more for the assimilation of dental points of view by medicine. The validity of the claim must probably be allowed. We must find more space and time in the curriculum for the teaching of these points of view.

## II. TRENDS AND PHENOMENA IN SOCIOLOGY AND ECONOMICS

More pronounced than the changes in medicine itself are the changes in the economic and sociologic environment within which the practitioner is exercising his art. It would seem a truism to say that the medical school must modify its objective to prepare the student for his professional work in this changed environment. The question must be faced whether our medical schools can or should interest themselves in preparing physicians who (a) will acquiesce in these trends and subordinate themselves and their practice to the social

trends, or (b) will direct these trends into channels of thought suggested by the personal character of medical service rather than by group considerations.

In other words: Is it the function of the medical school to develop medical servants to social convictions or to develop medical guides and leaders of popular thought? Or still in a third way: Must the medical schools by reason of changed social conditions abandon:

1. *The Place of the Physician in Society.*—Traditionally the physician occupied a preferential place of honor and privilege in society; today this is less true; he is frequently salaried, is frequently dominated even in his professional work by nonprofessional authority and insidious antiprofessional influence. His professional judgment is being increasingly coerced by financial and economic considerations; even his personal relationship to his patient has not only been called into question but its new definitions have been attenuated to a mere nullity. Many even within the profession have doubted whether the noncommercial, noncompetitive dignity of the physician can be maintained in the future quite as generally as it has been in the past.

2. *Ethics of Medical Practice.*—Not only applications but all the fundamental traditional principles themselves of ethical medical practice are today controverted. If the physician finds some comfort for his professional failure in the new concept of "diffused responsibility" he can do so only by gaging his practice by new standards which approximate those of social service-giving institutions rather than by those of personal service-giving individuals. Altruistic idealism must thus be either redefined or discarded.

3. *The Socializing Tendency.*—It is apparently true that each day more physicians are entering into paid employment. The physician thus enters into multilateral contracts, sometimes expressed, sometimes implied, which are quite different from the former simple bilateral contracts implied in individual practice.

4. *Contract Practice.*—In addition to employment contracts, physicians enter into many other forms of contract practice. The ethics of these procedures as such are not questioned but the safeguards through which adequate and responsible medical practice may be insured to the people as a whole have either not been worked out or if elaborated have by no means found universal acceptance.

5. *Group Practice.*—The growth of group practice is recognized. The dangers to proper medical care of the individual are questioned by many and ethical relations in this respect have thus far failed to secure universal approval.

6. *Clinic Practice.*—With respect to clinic practice, many diverse tendencies are gaining momentum. On the one hand, organized medicine is complaining of the growth of clinical abuse. It is pointing out that the physician is not remunerated for his services. On the other hand, organized medicine has pointed out that the development of pay clinics is enabling groups to enter into competition with the individual physician and is enabling institutions to practice medicine in such a way as to deprive the individual physician of patients on whom he has a legitimate claim.

7. *The Physician in "Social Legislation."*—Social legislation implying a large volume of medical and hospital practice is today impending, not only on the part of the states but also on the part of the federal government. The place of the physician in such legislation has not as yet been well defined nor have the implications of such legislation for the physician been given adequate attention. It is apparent that the physician has been asked repeatedly to give his services at a remuneration considerably below that which he would normally have a right to expect. Furthermore, if health insurance and forms of unemployment insurance become general, the physician will probably be placed in a subordinate position.

8. *Lay Domination Over Medicine.*—Any number of social trends are working toward a subordination of the physician to lay control. As long as this is merely administrative, there can be no reasonable complaint. It is clear, however, that in many of these trends the dictation of lay groups in matters that are purely medical can hardly be avoided. The effect on the nation's health becomes a matter of serious concern.

### III. TRENDS AND PHENOMENA IN EDUCATION

In the field of general education also changes have been taking place and a redistribution of stresses has been effected. Some of these changes and stresses have significance for medical education.

1. *Objectives.*—The importance of objectives and the study of the relation between educational objectives on

the one hand and educational processes and methods on the other, and the relation of all of these to educational administration have at last forged their way into the foreground of interest. It may be questioned whether the school of medicine has learned to use its educational objective as the norm for its education processes, methods and administration. Each school has an individuality and it is obviously important to maintain this individuality within the broad general frame work of "the school of medicine."

2. *Premedical Education.*—Two judgments are passed on today's premedical education. Some groups regard it as entirely inadequate to serve as a basis for a superstructure of medical education, while other groups regard premedical education as entirely too technical. It was the intention of those who planned the prerequisites for the medical curriculum to demand of the student of medicine a prerequisite of broad culture. Instead, the premedical studies have become in the strict sense of the word prerequisites to specialized medical study and therefore have been viewed from the practical rather than from the cultural angle.

3. *The Curriculum.*—In the field of education, considerable attention has been devoted to the study of course sequences. Apparently much of this knowledge has not as yet penetrated into the medical school and therefore the medical curriculum is still characterized too frequently by incoordination, disorder and a lack of unity. Ineffective repetition, vagueness of purpose, unjustified anticipation of clinical studies and other similar phenomena are not rare. Rigorous uniformity in all schools should not be demanded but it should be possible to define what is meant by a basic minimal curriculum as a starting point for all schools and as a standard of reference for wisely initiated variation.

4. *Correlation.*—By reason of the failure of schools of medicine to clearly define their objectives in medical teaching, correlation is as yet inadequate. The tendency to teach not only subjects which are of immediate practical importance to the future practitioner of medicine, but to introduce unrelated and unutilizable information into the curriculum, is certainly to be deplored in view of the shortness of the time available for such studies. The integration of the basic sciences into the medical curriculum is incomplete.

5. *Teaching Technic.*—Relatively little planned experimentation in teaching technic has thus far taken

place in schools of medicine. The different courses on account of their specialized character can probably be best taught by different methods. Even the availability of such general methods as the lecture, quiz, conference, demonstration, the clinical conference, laboratory and their usefulness in the hands of different instructors under different circumstances has not been consciously or intensively studied.

6. *Intravocational Guidance.*—In the general field of education, the aims and methods of personnel guidance have undergone great development. There is need for personnel activity within the field of medical education. It cannot be assumed that the growth of the medical student can take place entirely spontaneously and by self-direction. Guidance is needed not only with respect to the assimilation of knowledge but also with respect to personality problems and the future exercise of professional activity.

7. *Teacher Preparation.*—Considerable demand has developed from teachers of medical subjects for some expert and formal instruction in teaching technic, classroom and school administration, etc.

8. *School Administration.*—In schools of medicine we may still find, perhaps to an unnecessary extent, apprenticeship in administration. Administrators of such schools are chosen apparently without reference to their knowledge of the general field of education and sometimes even without reference to their technical preparation in their respective specialties. Hence, the schools all too frequently fail to use such commonly known technics as those for the testing of student capacity or student achievement, the aptitudes for specialization, etc.

9. *Auxiliary Professions.*—It is obvious that the educational status of auxiliary professions must profoundly affect medical education. There must be some relationship between the education of the co-worker of the physician and the education of the prospective physician; if for no other reason, then surely because standards of medical practice cannot be maintained on a high level if the standards of practice in auxiliary professions are on a relatively lower level. The patient cannot be properly cared for if he is exposed to inefficient and efficient, intelligent and unintelligent, skilful and unskilful procedures from different persons at the same time.

# ANNUAL CONGRESS ON MEDICAL EDUCATION, MEDICAL LICENSURE AND HOSPITALS

## Program of Meetings to be held in Chicago, February 17 and 18

The thirty-second Annual Congress of the Council on Medical Education and Hospitals of the American Medical Association will be held at the Palmer House, Chicago, February 17 and 18. The Federation of State Medical Boards of the United States will participate in the congress. The program follows:

MONDAY, FEBRUARY 17, 10 A. M.

RAY LYMAN WILBUR, M.D., Presiding

*Report of the Council on Medical Education and Hospitals*

Ray Lyman Wilbur, M.D., LL.D., Chairman, Stanford University, Calif.

*The Accrediting of Higher Institutions*

George F. Zook, Ph.D., President, American Council on Education, Washington, D. C.

*Discussion:* George A. Works, Ed.D., Chicago.

*Consistency Versus Chaos in Medical Education and Licensure*

Walter L. Bierring, M.D., Secretary, The Federation of State Medical Boards of the United States, Des Moines, Iowa.

*Discussion:* James N. Baker, M.D., Montgomery, Ala.

*The State University and Professional Education*

Arthur C. Willard, S.B., LL.D., President, University of Illinois, Urbana.

*Discussion:* Eugene A. Gilmore, LL.B., LL.D., Iowa City.

Red Lacquer Room

MONDAY, FEBRUARY 17, 2 P. M.

MERRITTE W. IRELAND, M.D., Presiding

*The Personality of the Teacher*

James S. McLester, M.D., President, American Medical Association, Birmingham, Ala.

*Discussion:* Charles F. Martin, M.D., Montreal, Quebec.

*Scope and Objectives of the Undergraduate Teaching of Obstetrics*

George W. Kosmak, M.D., New York.

Charles B. Reed, M.D., Associate Professor of Obstetrics, Northwestern University Medical School, Chicago.

Robert T. Riley, M.D., Director, State of Maryland Department of Health, Baltimore.

*Discussion:* Fred L. Adair, M.D., Chicago; Paul Titus, M.D., Pittsburgh; Waller S. Leathers, M.D., LL.D., Nashville.

Red Lacquer Room

TUESDAY, FEBRUARY 18, 9:30 A. M.

REGINALD FITZ, M.D., Presiding

*What Is the Social Objective of the Young Physician?*

Nathan B. Van Etten, M.D., Speaker, House of Delegates, American Medical Association, New York.

*Discussion:* Roscoe L. Sensenich, M.D., South Bend, Ind.

*Some Observations on the Social Background of Medical Practice in Great Britain*

Richard E. Scammon, Ph.D., LL.D., Distinguished Service Professor in the Graduate Faculty of the University of Minnesota, Minneapolis.

*Discussion:* Wilburt C. Davison, M.D., Durham, N. C.

*Instruction of Students and Interns in the Legal, Social and Economic Influences Affecting Medical Practice*

Stanhope Bayne-Jones, M.D., Dean, Yale University School of Medicine, New Haven, Conn.

*Discussion:* Rev. Alphonse M. Schwitalla, S.J., Ph.D., St. Louis.

*Can the Present Medical Curriculum Achieve the Proper Aims of Medical Education?*

Langley Porter, M.D., Dean, University of California Medical School, San Francisco.

*Discussion:* John Wyckoff, M.D., New York.

Red Lacquer Room

TUESDAY, FEBRUARY 18, 2 P. M.

FRED MOORE, M.D., Presiding

*Swans Sing Before They Die*

Elias P. Lyon, M.D., LL.D., Dean, University of Minnesota Medical School, Minneapolis.

*Function of the Hospital in the Training of Interns and Residents*

J. A. Curran, M.D., Executive Secretary, New York Committee on the Study of Hospital Internships and Residencies, New York.

*Discussion:* Harvey Agnew, M.D., Toronto, Ontario.

*The Laboratory of Pathology in the Small Hospital*

Howard T. Karsner, M.D., Professor of Pathology, Director of the Institute of Pathology, Western Reserve University and the University Hospitals, Cleveland.

*Discussion:* A. S. Giordano, M.D., South Bend, Ind.

*Newer Points of View Concerning the Use of the Outpatient Department in Medical Education*

W. McKim Marriott, M.D., Dean, Washington University School of Medicine, St. Louis.

*Discussion:* Robert W. Keeton, M.D., Chicago.

Red Lacquer Room

## THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

TUESDAY, FEBRUARY 18, 9:30 A. M.

IRVIN D. METZGER, M.D., Presiding

*The Federation and the Survey of Medical Schools*

William D. Cutter, M.D., Secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago.

*The Two-Year Medical School*

George M. Williamson, M.D., Secretary, North Dakota State Board of Medical Examiners, Grand Forks.

Benjamin J. Lawrence, M.D., Secretary, North Carolina Board of Medical Examiners, Raleigh.

*Comments on National Board Examinations*

J. Stewart Rodman, M.D., Medical Secretary, National Board of Medical Examiners, Philadelphia.

Everett S. Elwood, Executive Secretary, National Board of Medical Examiners, Philadelphia.

*Final Objective*

Harold Rypins, M.D., Secretary, Board of Medical Examiners of the State of New York, Albany.

*Discussion:* John H. J. Upham, M.D., Columbus; Willard C. Rappleye, M.D., New York.

Room Fourteen

TUESDAY, FEBRUARY 18, 1.30 P. M.

IRVIN D. METZGER, M.D., Presiding

*Narcotic Legislation*

William C. Woodward, M.D., LL.D., Director, Bureau of Legal Medicine, American Medical Association, Chicago.

*Enforcement Procedure*

Thomas J. Crowe, M.D., Secretary, Texas State Board of Medical Examiners, Dallas.

Herbert M. Platter, M.D., Secretary, Ohio State Medical Board, Columbus.

*Aggressive Versus Passive Attitudes of State Board Members*

Arthur C. Morgan, M.D., Member, Pennsylvania State Board of Medical Education and Licensure, Philadelphia.

*Foreign Medical Credentials*

Charles B. Pinkham, M.D., Secretary, California Board of Medical Examiners, San Francisco.

*Experience with Basic Science Law in Nebraska*

Henry J. Lehnhoff, M.D., Secretary, Nebraska Board of Examiners in Medicine, Lincoln.

*The Importance of Introducing Psychiatry as a Requirement for Licensure*

Franklin G. Ebaugh, M.D., Director, Division of Psychiatric Education, The National Committee for Mental Hygiene, and Director, University of Colorado Psychopathic Hospital, Denver.

*Discussion* John R. Neal, M.D., Springfield, Ill.; J. Earl McIntyre, M.D., Lansing, Mich.; Roy B. Harrison, M.D., New Orleans.

EXECUTIVE SESSION.

Room Fourteen

**Federation Dinner**

The annual dinner of the Federation of State Medical Boards of the United States will be held Monday, February 17, at 6.30 at the Palmer House. All attending the congress are invited.

## PROGRAM

*Address. The Responsibility of a University in Medical Training*

Eugene A. Gilmore, LL.B., LL.D., President, State University of Iowa, Iowa City.

*Address. The Art of Medicine*

Irvin D. Metzger, M.D., President, The Federation of State Medical Boards of the United States, Pittsburgh.

*Round Table Discussion—State Board Problems.***Reduced Railway Fares**

Reduced railway fares will be in effect for those who attend the congress. In some cases excursion rates are offered. In most instances the reduced rate will be on the certificate plan. Those planning to attend the congress should make inquiry of the railroad ticket agent before purchasing transportation to Chicago.

**FROM OUR EXCHANGES****TOO MANY DOCTORS IN THE ARGENTINE**

Dr. Rafael Bullrich, dean of the medical faculty of Buenos Aires, in his address at the inauguration of the new session (*Semana Médica*, April 11) states that the Argentine Republic, with a population of 12,000,000, has a yearly output from her medical schools of 600 new doctors, while Belgium, whose population is but slightly less, thinks that her output of 300 is too great. He calls for united action of the medical faculties of the Republic with the idea of limiting the number of entrants and raising and equalizing the standard of knowledge demanded from candidates for degrees in medicine and dentistry. Soviet Russia, he declares, in endeavoring to recruit the medical profession from the ranks of the manual worker, and in doing all in its power to prevent the doctor's son from following in his father's footsteps, is shamefully lowering the cultural level of the new race of doctors and is destroying tradition, which is one of the greatest forces in a nation's historical unity.—*Brit. M. J.*, Sept. 21, 1935.

**THE HISTORY OF MEDICAL EDUCATION  
IN THE UNITED KINGDOM**

In his opening address to the 142d session of the General Council for Medical Education and Registration, the president, Sir Norman Walker, surveyed the history of medical education and legislation in the United Kingdom. During the early years of the nineteenth century many efforts were made to secure better regulation of the practice of medicine, for it had become evident that something different from the limited rights conferred on universities and medical corporations was required. The medical act of 1858 resulted in the establishment of a council with rather vague and undefined powers. The council first settled who was to come on the register by virtue of his existing qualifications or appointments. It next made arrangements for the production of the British Pharmacopoeia, asked all teaching bodies for a statement of their requirements from candidates for qualification, and erected a committee on education. It laid down that four years must be spent in professional studies, that the licensing bodies would do well to encourage students to study natural science before their strictly medical course, and that both the first and the

final examination should be partly written and partly oral, and, so far as practical, clinical. The act of 1886 established several new principles. No one could today be registered who had not passed a qualifying examination in medicine, surgery and midwifery, and the system of approximately decennial inspection of examinations, which it introduced, had been of equal value to the council and to the public. In the General Medical Council every licensing body had a representative to contribute his share to every change in medical education. The council's duty was to ensure "that the standard required from candidates at the qualifying examinations shall be such as sufficiently to guarantee the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery." The elasticity of the system was one of its strongest characteristics. The council placed efficiency before uniformity.—London Letter, Nov. 30, 1935.—*J. A. M. A.*, Jan. 4, 1936.

#### MEETING OF THE GERMAN LAY PRACTITIONERS

The tendency under the present régime in Germany to promote the cause of the so-called *heilpraktiker*, or the nature-cure practitioners, has been frequently mentioned in recent letters. The "Heilpraktikerbund Deutschlands, Reichsverband in München" held recently in Frankfort-on-Main a session to which all the district leaders of the reich and the directors of the professional schools of the league were invited. About 200 representatives attended. This league was created in 1933 by the federal ministry of the interior and was assigned the task of cleansing the league, which consisted of twenty-three former associations of *heilpraktiker* and numbered 5,700 members, of all unsavory elements. The league is endeavoring to perform the task assigned to it and, it is asserted, has launched a bitter fight against quackery. From 1,500 to 2,000 former *heilpraktiker* have already been eliminated, and the management of the league has stated that about 1,500 more members will be removed. Those members thus eliminated are for the most part *heilpraktiker* who have refused to appear before a commission of the aforementioned league and submit to an examination as to their knowledge of the theory and practice of the principles of healing advocated by the league. To what extent these *heilpraktiker* differ from quacks, in a scientific and medical sense, is not clear. In any event, the opposition of licensed physicians to these lay practitioners is great. On the other hand, the *heilpraktiker* are endeavoring to do all in their power

to prove to the government authorities, who are well disposed toward them, the serious nature of their activities. It is of interest that the director of the league, a government appointee, spoke at this meeting on "The Interests of the Heilpraktiker Profession"; the director of the federal professional school of the league discussed the continuation courses to be given next winter, and the leader of the press and propaganda presented the aims and tasks of the propaganda of the league. It is evident that the *heilpraktiker* will exert themselves to the utmost to gain the same rank and prestige enjoyed by regularly licensed physicians.—Berlin Letter, Oct. 21, 1935.—*J. A. M. A.*, Dec. 21, 1935.

#### NEW PHYSICIANS MUST SERVE BULGARIAN RURAL DISTRICTS

The government has ordered that every medical student, when qualified to practice, must serve for two years in the provinces at a fixed salary paid by the state before he may establish a private practice in the locality of his choice. He may accept no fees during his novitiate and his patients will receive treatment free of charge.

The authorities of the commune to which he is sent will provide him with lodgings and the state will pay his traveling expenses in addition to his salary of \$25 a month. This salary may seem incredibly low, but it corresponds with the general standard. Only twenty-four Bulgarian officials, including the ministers, receive more than \$125 a month.—*New York Times*.

#### NEWS ITEMS

**License Revoked.**—The Arizona State Board of Medical Examiners reports the license of Dr. Claude E. Duvall, Tucson, revoked, December 3, for violation of the Harrison Narcotic Act.

**Personal.**—Dr. Frederick T. van Beuren has been made associate dean of Columbia University College of Physicians and Surgeons, New York, succeeding Dr. Edward Cathcart, resigned.

**Illegal Practitioner Jailed.**—William Griffin, St. Louis Negro and self styled "herb doctor," was recently found guilty of practicing medicine without a license. He was sentenced to serve ninety days in the workhouse. The complaint against him was made by a Negro woman after Griffin had treated her daughter with salves and medicines for a stomach ailment.

**West Virginia Revocation.**—The West Virginia Public Health Council, on October 29, revoked the license of Dr. Chester Arthur Hutchinson, formerly of Appalachia, Va.

Dr. Hutchinson is now serving a twenty-year sentence in the penitentiary at Richmond, Va., having been found guilty of murder in the first degree (THE BULLETIN, March 1935, p. 89).

**State Board Appointments.**—Gov. George H. Earle of Pennsylvania has announced the following appointments to the State Board of Medical Education and Licensure: Drs. William Cullen Bryant of Pittsburgh and Domer S. Newill of Connellsville, succeeding Drs. Harry W. Albertson and Charles J. Hemminger, whose terms expired, and Dr. George W. Hartman of Harrisburg to fill the vacancy caused by the death of the late Dr. Clarence Bartlett.

**Fined for Recording Blood Pressure on Boardwalk.**—Harry Forman, who operated a stand on the boardwalk at Atlantic City, N. J., where he made blood pressure readings, was arraigned in district court, October 23, before Judge W. Lindley Jeffers, who fined him \$200 but suspended the fine. Forman was investigated by the state medical board and the Atlantic County Medical Society after protests were received from about 175 physicians who visited Atlantic City at the annual session of the American Medical Association last June, it was said. Forman contended that he was not practicing medicine but that his machine was similar to a weight machine. The *New York State Journal of Medicine* printed in its November 15 issue a letter from the president of the Taylor Instrument Companies, Rochester, N. Y., deploring misuse of instruments produced solely for the medical profession. The letter requested that the company be given any information concerning the way these instruments are procured for unethical purposes so that steps may be taken to prevent continuance of the practice.

**"Bone-Setter" Pleads Guilty.**—Peter D. Heppner, 51 year old farmer of Butterfield, Minn., pleaded guilty to a charge of practicing healing without a basic science certificate, on October 15, in the district court at Fairmont, Minn. Since 1922 Heppner has represented himself as a "bone-setter." He has no medical education whatsoever and has been engaged in farming for the past thirty years. In 1934, following an investigation conducted by the Minnesota board of medical examiners, Heppner was warned to discontinue the practice of healing. Subsequently, he attempted to secure a license from the medical board to practice massage. He was unable to qualify and was denied the right to take the examination. The recent investigation disclosed that Heppner was operating two days weekly in a hotel at Fairmont. In his room were found numerous bottles, ointments, a cupping and bleeding apparatus and a device for giving electrical treatments. Heppner's patients paid him \$1 for each treatment by leaving the money on the dresser in his room. In this manner, Heppner thought that he was immune from prosecution. Following a hearing, he was sentenced to a term of three months in the Martin County jail. He was ordered to refrain from practicing healing in any manner in the state of Minnesota and was placed on probation. He was warned that unless he complied with the laws of the state in every respect, he would be committed to the county jail.

## A SURVEY OF LEGISLATION OF INTEREST TO PHYSICIANS CONSIDERED BY STATE LEGISLATURES FROM JAN. 1 TO NOV. 1, 1935

T. V. McDAVITT

Bureau of Legal Medicine and Legislation, American Medical Association  
CHICAGO

### INTRODUCTION

This survey discusses briefly those proposals considered by the various state legislatures from Jan. 1 to Nov. 1, 1935,<sup>1</sup> deemed to be of the most interest to the medical profession. The amount of detailed discussion of laws and bills varies according to the relative interest of the subject matter to the profession. Thus, for instance, legislation relating to medical or cult licensure and rights is discussed purposely in more detail than is legislation relating to dentists, nurses or pharmacists.

### I. LEGISLATION RELATING TO LICENSES TO PRACTICE THE HEALING ART

#### A. LEGISLATION AFFECTING APPLICANTS FOR ANY FORM OF LICENSE

**CONDITIONS PRECEDENT TO EXAMINATION BY "PROFESSIONAL" BOARDS.**—*Knowledge of the Basic Sciences.*—A basic science law was enacted in Iowa.<sup>2</sup> All applicants for licenses to practice any form of the healing art are to be required to demonstrate to an impartial board of examiners a comprehensive knowledge of anatomy, physiology, chemistry, pathology, bacteriology and hygiene, before presenting themselves to their respective licensing boards. Basic science bills, or bills

Reprinted from the *American Medical Association Bulletin*, November 1935, pp. 121-143.

<sup>1</sup> During the period in question forty-four state legislatures [of all the states except Kentucky, Louisiana, Mississippi and Virginia] met in regular sessions, the legislatures of Colorado, Georgia, Illinois, Kentucky, Mississippi, Nebraska, New Jersey, Ohio, Oregon, Rhode Island, and Tennessee met in one special session; the legislatures of Idaho and Texas met in two special sessions, and the legislature of Louisiana met in three special sessions. At present writing all regular sessions are adjourned but special sessions continue in Colorado, Illinois, Mississippi, Nebraska, Ohio, Oregon and Texas. A special session is called in Minnesota to convene December 2.

<sup>2</sup> Ia., Acts, 1935, c. 17.

similar in theory if not in name, were considered and killed by the legislatures of seven other states.<sup>3</sup> An unsuccessful attempt was made in Washington<sup>4</sup> to repeal the existing basic science law and to enact in its place a greatly emasculated basic science bill. A Wisconsin bill,<sup>5</sup> which was killed, proposed to exempt applicants for licenses to practice chiropractic from the provisions of the Wisconsin basic science act.

**CORPORATIONS AS PRACTITIONERS.**—Laws were enacted in Alabama,<sup>6</sup> California,<sup>7</sup> Illinois<sup>8</sup> and Maryland<sup>9</sup> authorizing the formation of corporations to provide on a "nonprofit" basis "hospital care" to their members or subscribers. The Alabama law authorizes such corporations to provide "hospital care" but not "medical or surgical services." The California law permits such corporations to furnish "maintenance and care in a hospital, nursing care, drugs, medicines, physiotherapy, transportation, material appliances, and their upkeep." The extent of the services which may be rendered by the corporations contemplated by the new Illinois<sup>8</sup> and Maryland<sup>9</sup> laws may conceivably include the services of licensed physicians. Bills quite similar in purpose to the laws just discussed were killed in California,<sup>10</sup> Georgia,<sup>11</sup> Kansas,<sup>12</sup> Oklahoma<sup>13</sup> and Washington.<sup>14</sup>

An Illinois bill,<sup>15</sup> which was killed, proposed so to amend the medical practice act as to permit corporations to practice medicine.

#### B. CHANGES IN MEDICAL PRACTICE ACTS AFFECTING NONSECTARIAN PRACTITIONERS

**BOARDS OF MEDICAL EXAMINERS.**—*Appointment of Members.*—A law was enacted in Connecticut<sup>16</sup> which apparently eliminates the Connecticut eclectic medical

3. Calif., A. 1552; Colo., H. 634; Kan., S. 31; Mont., S. 119; Nev., A. 261, S. 57; Okla., S. 285; R. I., H. 708.

4. Wash., H. 178.

5. Wis., A. 421.

6. Ala., Laws, 1935, c. ??, approved September 14, introduced as H. 769.

7. Calif., Laws, 1935, c. 386.

8. Ill., Laws, 1935, p. 621.

9. Md., Laws, 1935, c. 476.

10. Calif., S. 471, S. 473, S. 474, A. 1887, A. 2309.

11. Ga., S. 197, H. 291, H. 918.

12. Kan., S. 454.

13. Okla., H. 207.

14. Wash., H. 492.

15. Ill., H. 425.

16. Conn., Laws, 1935, c. 250.

examining board but continues both the Connecticut medical examining board and the homeopathic medical examining board. The governor is to appoint the members of the boards but he selects annually for membership on the respective boards the physicians nominated by the medical society affected. Four Tennessee bills,<sup>17</sup> all of which were killed, proposed that members of the board of medical examiners be appointed by the governor from a list of names submitted by the Tennessee State Medical Association. Under the present law, no such restriction on the governor's choice exists.

*Composite Membership.*—A new Arizona law<sup>18</sup> provides that four members of the board shall be graduates of schools recognized by the Association of American Medical Colleges and one member a graduate of a recognized school of osteopathy. The prior law required two members to be "allopaths," one member a homeopath, one member an eclectic, and one member an osteopath. Two unsuccessful Tennessee bills<sup>19</sup> proposed to eliminate the provision in the present Tennessee medical practice act requiring that the board consist of "four representatives from the regular school, one from eclectic, and one from the homeopathic school of medicine," and merely to require that board members be graduates of "an acceptable or class 'A' medical school classified as such by the Council on Medical Education and Hospitals" (presumably of the American Medical Association).

*Terms of Members.*—The new Arizona law,<sup>18</sup> just referred to, also provides a staggering six year term for members of the board. The prior law provided only for a two year term.

*Board Meetings.*—Laws concerning the time or place of required board meetings were enacted in three states. A new North Carolina law<sup>20</sup> permits the board to meet in whatever city or cities of the state it desires to do so. The prior law required at least one board meeting to be held annually in Raleigh. A law enacted in Oklahoma<sup>21</sup> requires the board to meet on the second Wednesday in June and December, rather than on the

17. Tenn., S. 297, S. 964, H. 458, H. 1325.

18. Ariz., Laws, 1935, c. 99.

19. Tenn., S. 964, H. 1325.

20. N. C., Public Laws, 1935, c. 363.

21. Okla., Laws, 1935, p. 56.

second Tuesday in March and September as the prior law required. A new Oregon law<sup>22</sup> permits the board to hold meetings for examining applicants whenever it deems advisable provided that at least two such meetings are held annually. The prior law required such meetings to be held on the first Tuesday in January and July.

*Miscellaneous.*—A bill enacted in Arkansas<sup>23</sup> requires each of the three medical examining boards in the state and the chiropractic and osteopathic boards to file with the secretary of state a list of all persons licensed within the past twenty years, with information as to addresses and the date and manner in which the licenses were issued, whether by examination, by reciprocity, or by virtue of a diploma. In the future such information must be submitted by the respective boards within a week after the issuance of a license. A new Pennsylvania law<sup>24</sup> designates the licensing agency, formerly known as the *Bureau* of Medical Education and Licensure, as the *Board* of Medical Education and Licensure. A new Wisconsin law<sup>25</sup> authorizes the board to "approve and recognize" professional colleges. Prior to the enactment of this law the board was forced to accept credentials from any professional college maintaining the standard of preliminary education designated in the medical practice act and requiring at least four courses of eight months each. Another Wisconsin bill<sup>26</sup> proposed that the board "investigate complaints of violations of [the medical practice act], notify prosecuting officers, institute prosecutions, and if it so direct, and the court and district attorney consent, its counsel shall assist the district attorney." This bill was killed.

CONDITIONS PRECEDENT TO LICENSURE.—*Educational Qualifications.*—Laws relating to the educational qualifications of applicants for licenses to practice medicine were enacted in Georgia,<sup>27</sup> California,<sup>28</sup> Pennsylvania<sup>29</sup> and Wisconsin.<sup>30</sup> The new Georgia law amends those

22. Ore., Laws, 1935, c. 42.

23. Ark., Acts, 1935, Act. No. 148.

24. Pa., Laws, 1935, c. 417.

25. Wis., Laws, 1935, c. 457.

26. Wis., S. 495.

27. Ga., Acts, 1935, p. 412.

28. Calif., Laws, 1935, c. 670.

29. Pa., Laws, 1935, c. 417.

30. Wis., Laws, 1935, c. 457.

provisions of the medical practice act which required an applicant for a license to be a graduate of a legally incorporated medical college in good standing with the board by permitting graduates of one of the two colleges of medicine now existing in the State of Georgia to qualify also. The new California law authorizes the board of medical examiners to issue a physician's and surgeon's certificate to an applicant who, although failing to furnish documentary evidence satisfactory to the board that he has completed a resident course of instruction fulfilling the requirements of the act, presents a diploma issued to him by a medical school approved by the board and, in addition, files satisfactory documentary evidence of having either completed the fourth year in an approved medical school in the United States or having served at least one year in residence in a hospital in the United States approved by the board for internship. The new Pennsylvania law requires an applicant for a license to be a high school graduate and to have had two years [rather than one year as the prior law required] of college credits in chemistry, biology and physics prior to medical study. The new Wisconsin law<sup>30</sup> requires applicants, among other things, to have a "diploma from a reputable professional college approved and recognized by the board" of medical examiners. Under the prior law apparently the board had no discretion in accepting the credentials of an applicant with respect to professional college studies so long as the professional college maintained a standard of preliminary education designated in the medical practice act and required at least four courses of eight months each.

An unsuccessful Massachusetts bill<sup>31</sup> sought to amend that provision of the medical practice act which requires an applicant, among other things, to have attended courses of instruction for four years of not less than thirty-two school weeks in each year in one or more legally chartered medical schools by permitting an applicant who has attended "courses" which in the opinion of the board are equivalent thereto, to be also eligible for licensure. A Missouri bill,<sup>32</sup> which was likewise killed, proposed to require applicants to be able to read and write in the English language, and to have received

31. Mass., H. 756.

32. Mo., H. 307.

a diploma from some medical college in the United States "prescribed [sic] by the board and/or recognized and approved by the American Medical College Association [sic]." An unsuccessful Ohio bill<sup>33</sup> proposed to require an applicant to have received prior to his admission to medical school either a degree from a reputable college or to have satisfactorily completed at least two full college years in an approved college in premedical subjects. An attempt in Oklahoma<sup>34</sup> to require an applicant to be a graduate of a medical college approved by the Association of American Medical Colleges and the Oklahoma State Board of Medical Examiners was killed. The New Jersey legislature rejected a bill<sup>35</sup> to require the board to examine any applicant who had attended four full courses of lectures for four years in a medical college in good standing, who had completed an internship of eighteen months in an approved hospital in the state and who had served at least fifteen years as a resident member of the staff of an approved hospital. An unsuccessful attempt was made in Georgia<sup>36</sup> to permit the board to prescribe a three year course to be taught in medical schools and to license graduates of such courses "to practice medicine in all its branches," except surgery, and to require of applicants for such a license a preprofessional education equivalent only to graduation from high school.

*Citizenship Requirements.*—Bills relating to the citizenship of applicants for licenses to practice medicine were considered in Connecticut, Florida, Missouri and Pennsylvania, the Pennsylvania bill alone becoming law. The new Pennsylvania law<sup>37</sup> requires "applicants foreign to the territory of the United States" to "present a certificate of United States citizenship or a declaration of intention." The defeated Connecticut bill,<sup>38</sup> just referred to, proposed to eliminate the requirement in the present medical practice act that an applicant be a citizen of the United States. The Florida and Missouri bills<sup>39</sup> proposed to require applicants to be citizens of the United States. The present Florida law requires an applicant to be a citizen or to have declared his inten-

33. O., S. 137.

34. Okla., H. 233.

35. N. J., S. 313.

36. Ga., H. 804.

37. Pa., Laws, 1935, c. 417.

38. Conn., H. 1165.

39. Fla., S. 146; Mo., H. 307.

tion of becoming one while the present Missouri law has no analogous provision.

*Internship Requirements.*—A new Pennsylvania law<sup>40</sup> amended that portion of the medical practice act which required an applicant to have had one year of internship by eliminating the provision in the prior law which required that during that year of internship the applicant must have attended not less than six confinements. An unsuccessful Oklahoma bill<sup>41</sup> proposed to require an internship.

*Fees.*—Bills respecting the fees to be exacted from applicants were considered and killed in two states. An Illinois bill<sup>42</sup> proposed to raise the examination fee to \$20 and to raise the fee for a license without examination to \$50. A Missouri bill<sup>43</sup> proposed to raise the fee to \$25 from \$15.

*Reciprocity.*—The provisions of the California medical practice act relating to the issuance of licenses by reciprocity were amended this year.<sup>44</sup> The prior law required an applicant for a license by reciprocity to have been a resident of the state which issued the certificate used as the basis of application for one year subsequent to the issuance of such certificate. In lieu of this requirement, the new law authorizes the board to accept evidence of two years of licensed practice in another state. A law was enacted in Arkansas<sup>45</sup> authorizing the board of medical examiners to license without examination diplomates of the National Board of Medical Examiners.<sup>46</sup> An unsuccessful Oklahoma bill<sup>47</sup> proposed to require an applicant for a license by reciprocity to be a graduate of a medical school, which, at the time of the applicant's graduation, was recognized by the Association of American Medical Colleges or by the Oklahoma Board of Medical Examiners.

*Special Exemption from Examination.*—The legislature of Arkansas killed two bills<sup>48</sup> to permit the licen-

40. Pa., Laws, 1935, c. 417.

41. Okla., H. 233.

42. Ill., H. 1085.

43. Mo., H. 307.

44. Calif., Laws, 1935, c. 672.

45. Ark., Acts, 1935, Act 165.

46. Strictly speaking, the privilege thus accorded to diplomates of the National Board of Medical Examiners is not based on reciprocity.

47. Okla., H. 233.

48. Ark., S. 107, S. 142.

sure without examination of persons who had been engaged in the practice of medicine for twenty years continuously prior to Jan. 1, 1935.

ANNUAL REGISTRATION.—Laws relating to annual registration were enacted in three states. In Arizona a new law <sup>49</sup> requires licensed physicians to register annually on or before the first day of January with the secretary of the board and at that time to pay a fee of \$3. A new Arkansas law <sup>50</sup> requires eclectic licentiates to register annually with the eclectic medical examining board and to pay a registration fee of \$2. A new California law <sup>51</sup> raises the fee required of physicians in connection with annual registration to \$2 from \$1.

An unsuccessful attempt was made in Illinois <sup>52</sup> to require all persons licensed to practice any form of the healing art to register annually with the director of the Department of Registration and Education and to pay an annual renewal fee of \$1.

Bills proposing to amend provisions in existing laws relating to annual registration were killed in three other states. In Connecticut a bill <sup>53</sup> sought to eliminate the annual fee required in connection with annual registration. Two Florida bills <sup>54</sup> proposed to eliminate the provisions of the medical practice act relative to annual registration. Another Florida bill <sup>55</sup> proposed that after a physician has once registered with the board of medical examiners and paid a fee of \$2, that he need not reregister until such time as he changes his residence or the place in which he carries on the practice of medicine. A North Dakota bill, <sup>56</sup> which would have become law but for the governor's veto, proposed to make it a misdemeanor for a licentiate to fail to pay the required annual reregistration fee.

REVOCATION AND REFUSAL OF LICENSES: *Causes*.—Laws enumerating causes for which licenses may be revoked, suspended or refused, in addition to the causes set forth in the prior laws, were adopted in Connecticut,

49. Ariz., Laws, 1935, c. 99.

50. Ark., Acts, 1935, Act. 25.

51. Calif., Laws, 1935, c. 672.

52. Ill., S. 257.

53. Conn., H. 845.

54. Fla., S. 143, H. 277.

55. Fla., H. 147.

56. N. D., H. 311.

Maine, Oklahoma, Oregon and Pennsylvania. The Connecticut law <sup>57</sup> authorizes the revocation of the license of any practitioner who fails to file a birth certificate as required by law. The new Maine law <sup>58</sup> authorizes the revocation of the license of any licentiate who (1) has been convicted, either within or without the state, of any crime involving moral turpitude or of any crime in the practice of his profession, (2) has been guilty of fraudulent or unprofessional conduct in the practice of his profession, (3) is addicted to the use of narcotics, or (4) has used advertising which the board of medical examiners considers to be deceptive, misleading, extravagant, improbable or unethical. The new Oregon law <sup>59</sup> adds to the conduct enumerated in the prior law which is deemed to be "unprofessional or dishonorable," the "obtaining of any fee through fraud or misrepresentation." The Oregon law also permits the board to suspend licenses as well as to refuse to issue them or to revoke them. The Oklahoma law <sup>60</sup> authorizes the board to revoke the license of any licentiate who has been convicted of any felony in or without the state of Oklahoma. The new Pennsylvania law <sup>61</sup> permits the board to revoke or suspend a license "upon satisfactory proof of grossly unethical practice, of misleading public advertisements, or of any form of pretense which might induce citizens to become a prey to professional exploitation." The governor of California pocket vetoed a bill <sup>62</sup> which would have made the following acts additional causes for the revocation or suspension of licenses: (a) fraudulent representation that a manifestly incurable condition can be cured, (b) advertising that the licentiate will treat syphilis or prostate conditions or prostatic ailments, (c) the execution by a licentiate in his professional capacity of any false certificate and (d) acceptance by a licentiate of employment from persons who directly or indirectly solicit patients.

The legislatures of five states rejected bills on this subject. An Illinois bill <sup>63</sup> proposed to authorize the revocation of the license of any practitioner who knowingly issued "a false certificate to any person to aid such

57. Conn., Laws, 1935, c. 239.

58. Me., Laws, 1935, c. 118.

59. Ore., Laws, 1935, c. 42.

60. Okla., Laws, 1935, p. 56.

61. Pa., Laws, 1935, c. 417.

62. Calif., S. 154.

63. Ill., H. 320.

person to obtain an appointment as a teacher in the schools of the state and showing such person to be free from contagious, infectious and communicable diseases." A Nevada bill <sup>64</sup> would have made "disobedience" rather than "wilful disobedience," of the law or of the rules and regulations of the state board of health a ground for revoking a license. A New York bill <sup>65</sup> would have authorized the revocation of the license of a physician who "has been guilty in any way of unprofessional conduct." A Pennsylvania bill <sup>66</sup> proposed to authorize the revocation or suspension of the license of any practitioner who had "acted as an adjuster of claims arising out of personal injuries who had negotiated for the settlement of any such claims where such claims do not involve injuries to the physician or his family." A Tennessee bill <sup>67</sup> would have denominated as unprofessional conduct and as such grounds for the revocation of a license, "conviction by the Federal Government of the violation of the Harrison Anti-Narcotic Act."

*Procedure.*—A new New York law <sup>68</sup> provides that hearings by the board of regents of the University of the State of New York on disciplinary proceedings, pursuant to the provisions of the medical practice act, may be held by not less than three members of the board of regents but that any decision or determination in such proceedings must be made by the board as a whole.<sup>69</sup>

The legislature of Tennessee killed two bills <sup>70</sup> proposing that no license be revoked until the licentiate had been notified in writing of the charges against him and had been given an opportunity for a full and complete hearing, with the right to be represented by counsel.

*Restoral.*—A new Pennsylvania law <sup>71</sup> provides that when the licensing agency has restored a revoked or suspended license, the name of the licentiate shall be "replaced upon the record in the office of the Superintendent of Public Instruction."

64. Nev., S. 142.

65. N. Y., S. 1667.

66. Pa., H. 1136.

67. Tenn., H. 1325.

68. N. Y., Laws, 1935, c. 612.

69. The reason for this law appears to be as follows: The board of regents sits as a body in exercising its jurisdiction under the medical practice act. It is frequently found inconvenient to get the entire body together at a particular time or place. This law will enable the board of regents to delegate the taking of evidence, at least, to subcommittees which will later report their findings to the entire body. But the entire body must hand down the decision or determination.

70. Tenn., S. 297, H. 458.

71. Pa., Acts, 1935, Act. 269.

(To be continued)