

# FEDERATION BULLETIN

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## FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

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WALTER L. BIERRING, M.D., EDITOR, STATE OFFICE BLDG.,  
DES MOINES, IOWA

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## SPECIALTY BOARD CERTIFICATION AND MEDICAL PRACTICE

In this issue appears an interesting discussion by a leading dermatologist, under the title of "Evolution, Revolution and Board Certification, 1932-1954." It presents the remarkable evolutionary changes in medical progress with the development of specialty certifying boards and their effect on modern medical practice.

Since the first specialty board in ophthalmology was organized in 1916 and particularly since the formation of the Advisory Board of Medical Specialties in February 1934, eighteen certifying boards in the different specialties have been established.

The Advisory Board comprises in its membership two representatives, each from the Federation of State Medical Boards, Association of American Medical Colleges, American Hospital Association, National Board of Medical Examiners and the eighteen certifying specialty boards. This Board supervises the standards and policies of the different certifying boards and determines the establishment of additional specialty boards.

Among the far reaching changes in medicine in the past forty years, which in part can be credited to specialty boards are (1) detection of minimal signs of diseases; (2) ramifications of diseases more clearly defined; (3) many patients salvaged from category of incurables, which were due to the development of (a) new methods of diagnosis; (b) better prevention of disease; and (c) more rational and often specific therapy.

It is to the credit of physicians that they have been willing to undergo the additional training required in order to qualify for special recognition. There is general recognition that the specialist has influenced a higher grade of medical and surgical service which has had its definite effect on the quality of general medical practice. It is suggested that the time is appropriate to banish the idea that specialists are primarily consultants and can do their most effective work if they supervise the care of the patient. As the patient is usually referred by the attending physician, the conference that results in regard to diagnosis and treatment will be of mutual benefit. In the years from 1943 to 1950 more than 25,000 physicians were certified as specialists, so that at present from one-third to one-half of all physicians in active practice are specialists, all of which has profoundly influenced modern medical practice.

The increase in group practice is influencing the number of specialists in small centers and the thought is expressed, if specialist medical care is more evenly distributed there will result a higher grade of general practice and the demand for state medicine will be definitely reduced.

## FIFTY-FIRST ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE

**Palmer House, Chicago, Feb. 5-8, 1955**

*All meetings are open to physicians and others interested in medical education and licensure.*

### SCHEDULE OF MEETINGS

SATURDAY, FEB. 5, 9 A. M.-5 P. M.  
GRAND BALL ROOM

**Council on Medical Education and Hospitals, American Medical Association**

SUNDAY, FEB. 6, 9 A. M.-12:15 P. M.  
RED LACQUER ROOM

**Advisory Board for Medical Specialties**  
Open Meeting

2 P. M.-5 P. M., RED LACQUER ROOM

**Federation of State Medical Boards of the United States**  
Reports of Officers  
Annual Congress on Medical Education and Licensure

8 P. M.-10 P. M., ROOM 14

**Federation of State Medical Boards of the United States**  
Annual Congress on Medical Education and Licensure

MONDAY, FEB. 7, 9 A. M.-5 P. M.  
RED LACQUER ROOM

**Council on Medical Education and Hospitals, American Medical Association**

5:30 P. M.-7 P. M., ROOM 14

Reception for Registrants of the Congress by the American Medical Association

7 P. M., CRYSTAL ROOM

**Federation of State Medical Boards of the United States**  
Annual Subscription Dinner

TUESDAY, FEB. 8, 9 A. M.-12:15 P. M.  
RED LACQUER ROOM

**Federation of State Medical Boards of the United States**  
Annual Congress on Medical Education and Licensure

12:30 P. M.-4 P. M., CRYSTAL ROOM  
 FEDERATION SUBSCRIPTION LUNCHEON  
 Business Session

FEB. 5-8, 8 A. M.-5 P. M.  
 ROOM 15

HEADQUARTERS  
 American Medical Association Press  
 SATURDAY, 9 A. M.  
 GRAND BALL ROOM

**Council on Medical Education and Hospitals, American Medical Association**

*Potential Use of Television in Postgraduate Medical Education*  
 DOUGLAS D. VOLLAN, M.D., *Presiding*

8:00 a. m. REGISTRATION

9:00 a. m. OPENING REMARKS

JOHN W. CLINE, M.D., Member of the Council on Medical Education and Hospitals, American Medical Association and Past President of the American Medical Association

9:10 a. m. SYMPOSIUM: EDUCATIONAL POTENTIAL OF TELEVISION IN POSTGRADUATE MEDICAL EDUCATION

*What Has Television Done for General Education?*

GARNET P. GARRISON, Director of Television, University of Michigan

*Medical Television to Date*

RALPH P. CREER, Secretary of Committee on Medical Motion Pictures, American Medical Association

*Television at Medical Society Meetings*

G. FRED ROLL, Director of Public Relations, Smith, Kline & French Laboratories, Philadelphia, Pennsylvania

*A Closed Circuit Postgraduate Program*

ARTHUR L. HOLLEB, M.D., Formerly Medical Producer-Director of Color Television for the American Cancer Society

*An Open Circuit Postgraduate Program*

ROBERT S. WARNER, M.D., Assistant Medical Director, American Heart Association, New York City, formerly Director of Postgraduate Medical Education, University of Utah College of Medicine

*The Medical Center as a Focus of Postgraduate Television*

DAVID S. RUHE, M.D., Director, Audio-Visual Instruction, University of Kansas Medical Center

*Future Prospects; Controlled Open Circuit Television*

FRANK WARREN, M.D., New York University Post-Graduate Medical School and Chairman, Subcommittee on Television, Albert Einstein College of Medicine

GENERAL DISCUSSION

SATURDAY, 2 P. M.  
 GRAND BALL ROOM

**Council on Medical Education and Hospitals, American Medical Association**

DOUGLAS D. VOLLAN, M.D., *Presiding*

2:00 p. m. *Putting Television to Work in Postgraduate Medical Education*

*Color vs. Black and White; Demonstration and Discussion*

*Moderator:* DAVID S. RUHE, M.D., Director, Department of Audio-Visual Education, University of Kansas Medical Center

ROBERT H. JOHNSTON, Midwest District Manager, General Precision Laboratory, Inc., Chicago

RALPH S. YEANDLE, Manager of Product Planning, Industrial Electronics Section, General Electric Company, Syracuse, New York

*Kinescopes, Films and Live Presentations; Demonstration and Discussion*

*Moderator:* J. EDWIN FOSTER, Director, Medical Audio-Visual Institute, Association of American Medical Colleges, Chicago

ROBERT B. HUDSON, Program Coordinator, Educational Television and Radio Center, Ann Arbor, Michigan

RALPH P. CREER, Secretary, Committee on Medical Motion Pictures, American Medical Association

*Closed, Open and Controlled Open Circuit Production; Demonstration and Discussion*

*Moderator:* FRANK WARREN, M.D., New York University Post-Graduate School of Medicine and Chairman, Subcommittee on Television, Albert Einstein College of Medicine

LESLIE E. FLORY, Ph.D., RCA Laboratories, Princeton, New Jersey  
 LYNN POOLE, Producer of Johns Hopkins Science Review, Johns Hopkins University  
 PIETER E. VAN BEEK, Assistant to the President, Zenith Radio Corporation, Chicago  
 WILLIAM J. McDONELL, Regional Manager, Federal Communications Commission, Chicago

*Costs and Financing of Postgraduate Medical Television; Discussion*

*Moderator:* JOHN Z. BOWERS, M.D., Dean, University of Utah College of Medicine

I. KEITH TYLER, Director, Institute for Education by Radio-Television, Ohio State University  
 NEIL J. MURPHY, Controller, NBC Stations WNBQ and WMAQ, Chicago

5:00 p. m. *Summing Up*

W. CLARKE WESCOE, M.D., Dean and Director, University of Kansas Medical Center

5:15 p. m. *Visit to Television Broadcasting Studios*

SUNDAY, 9 A. M.

RED LACQUER ROOM

**Advisory Board for Medical Specialties**

ROBERT A. MOORE, M.D., *Presiding*

9:00 a. m. *Address of the President*

ROBERT A. MOORE, M.D., President, Advisory Board for Medical Specialties; Vice Chancellor, Schools of the Health Profession, University of Pittsburgh

9:30 a. m. *Some Problems in Residency Training for Graduates of Medical Schools Outside the United States and Canada*

CURTISS B. HICKCOX, M.D., Secretary, American Board of Anesthesiology, Hartford, Conn. Representative of Council on Medical Education and Hospitals

Discussion opened by STILES D. EZELL, M.D., Secretary, New York Board of Medical Examiners

10:30 a. m. *The Use of Formal Didactic Training in Graduate Medical Education*

GEORGE MORRIS PIERSOL, M.D., Dean, University of Pennsylvania Graduate School of Medicine

WILLIAM L. BENEDICT, M.D., Secretary, American Academy of Ophthalmology and Otolaryngology, Rochester, Minn.

Discussion opened by R. D. PRUITT, M.D., Assistant Director, Mayo Foundation for Medical Education and Research, and JAMES THEODORE HOWELL, M.D., Administrative Assistant, Henry Ford Hospital, Detroit

SUNDAY, 2 P. M.

RED LACQUER ROOM

**Federation of State Medical Boards of the United States**

ELMER W. SCHNOOR, M.D., *Presiding*

2:00 p. m. ROLL CALL OF MEMBER BOARDS AND ASSOCIATE MEMBERS

*Report of the President*

ELMER W. SCHNOOR, M.D., President, Michigan Board of Registration in Medicine, Grand Rapids

*Report of the President-Elect*

M. H. CRABB, M.D., Secretary, Texas Board of Medical Examiners, Fort Worth

*Report of the Secretary-Treasurer and Editor of the Federation Bulletin*

WALTER L. BIERRING, M.D., Des Moines, Iowa

3:00 p. m. APPOINTMENT OF COMMITTEES

3:15 p. m. *Panel Discussion: Essentials of a Modern Medical Practice Act. Report of the Study Committee*

*Moderator:* BRUCE UNDERWOOD, M.D., Chairman of Study Committee; Secretary, Kentucky State Board of Health, Louisville

WALTER E. VEST, M.D., Past Chairman, Medical Licensing Board of West Virginia, Huntington

S. M. POINDEXTER, M.D., Chairman, Idaho Board of Medicine, Boise

CREIGHTON BARKER, M.D., Secretary, Connecticut Medical Examining Board, New Haven

HOMER L. PEARSON, M.D., Secretary, Florida Board of Medical Examiners, Miami

GEORGE R. BUCK, M.D., President, Colorado Board of Medical Examiners, Denver

*General Discussion*

SUNDAY, 8 P. M.

ROOM 14

**Federation of State Medical Boards of the United States**

ELMER W. SCHNOOR, M.D., Presiding

8:00 p. m. *Panel Discussion: The Problem of Foreign Medical Graduates*

ELMER W. SCHNOOR, M.D.

STILES D. EZELL, M.D., Secretary, New York Board of Medical Examiners, Albany

WALTER L. BIERRING, M.D., Secretary-Treasurer, Federation of State Medical Boards of the United States, Des Moines

*General Discussion*

MONDAY, 9 A. M.

RED LACQUER ROOM

**Council on Medical Education and Hospitals, American Medical Association**

H. G. WEISKOTTEN, M.D., Presiding

8:00 a. m. REGISTRATION

9:00 a. m. *Address of the Chairman*

H. G. WEISKOTTEN, M.D., Chairman, Council on Medical Education and Hospitals, American Medical Association

9:30 a. m. *Symposium: Legal Medicine in Undergraduate Medical Education*

*Preliminary Remarks*

LOUIS J. REGAN, M.D., LL.B., Professor of Legal Medicine, College of Medical Evangelists; Clinical Professor of Forensic Medicine, University of Southern California School of Medicine; Member Committee on Medicolegal Problems, American Medical Association; Past President, American Academy of Forensic Sciences

*Physician and the Law*

GEORGE E. HALL, J.D., Staff Associate, Law Department, American Medical Association

Discussion to be opened by FRED E. INBAU, B.S., LL.M., Professor of Law, School of Law, Northwestern University; President-Elect, American Academy of Forensic Sciences

*Physician and the Patient*

LOUIS J. REGAN, M.D., LL.B.

Discussion to be opened by EDWIN J. HOLMAN, LL.B., Staff Associate, Law Department, American Medical Association

*Scientific Medicolegal Investigation*

ALAN R. MORITZ, M.D., Professor of Pathology, Western Reserve University School of Medicine; Chairman, Committee on Medicolegal Problems, American Medical Association

Discussion to be opened by SAMUEL A. LEVINSON, M.D., Professor of Clinical Pathology, University of Illinois College of Medicine; Past President, American Academy of Forensic Sciences

MONDAY, 2 P. M.

RED LACQUER ROOM

**Council on Medical Education and Hospitals, American Medical Association**

HARVEY B. STONE, M.D., Presiding

2:00 p. m. *An Experiment in Making the Hospital a Graduate Medical Center—A Preliminary Report*

HAROLD JEGHERS, M.D., Professor of Medicine, Director, Department of Medicine, Georgetown University Medical Center; JOHN BUTLER, M.D., Director of Medical Education, St. Mary's Hospital, Rochester, N. Y., and JOHN O'BRIEN, M.D., Director of Medical Education, Mercy Hospital, Buffalo, New York

2:30 p. m. *The Future Status of the Internship (Symposium)*

*Moderator:* FRANKLIN D. MURPHY, M.D., Chancellor, University of Kansas; Member, Council on Medical Education and Hospitals

*Does the Internship Have a Place in Modern Medical Education?*

EDWARD H. LEVEROOS, M.D., Director, Division of Hospitals and Graduate Education, Council on Medical Education and Hospitals, American Medical Association

THE PROS AND CONS

*The Medical School.* JOHN MCK. MITCHELL, M.D., Dean and Professor of Pediatrics, University of Pennsylvania School of Medicine

*The Non-Affiliated Hospital.* FORD K. HICK, M.D., Professor of Medicine, University of Illinois College of Medicine

*The State Licensing Board.* STILES D. EZELL, M.D., Secretary, New York Board of Medical Examiners

*The Specialty Board.* DAVID A. BOYD JR., M.D., Secretary, American Board of Psychiatry and Neurology

*The General Practitioner.* W. B. HILDEBRAND, M.D., President, American Academy of General Practice

*General Discussion*

MONDAY, 5:30 P. M.

ROOM 14

**Council on Medical Education and Hospitals, American Medical Association**

*Reception for Registrants of the Congress by the American Medical Association*

7:00 P. M., CRYSTAL ROOM

**Federation of State Medical Boards of the United States**

FEDERATION SUBSCRIPTION DINNER

ELMER W. SCHNOOR, M.D., Toastmaster

*The Responsibility of Licensing Authorities to Medical Education*

DONALD G. ANDERSON, M.D., Dean, University of Rochester School of Medicine and Dentistry; formerly Secretary of the Council on Medical Education and Hospitals, American Medical Association

TUESDAY, 9 A. M.

RED LACQUER ROOM

**Federation of State Medical Boards of the United States**

ELMER W. SCHNOOR, M.D., Presiding

9:00 a. m. *Address of the President*

ELMER W. SCHNOOR, M.D.

9:30 a. m. *The Evaluation of Foreign Medical Graduates for Licensure*

A. C. FURSTENBERG, M.D., Dean, University of Michigan Medical School

10:00 a. m. *Postgraduate Training of Foreign Medical Students*

ROBERT BOGGS, M.D., Dean, New York University Post-Graduate Medical School

10:30 a. m. *Panel Discussion: Proposed Program for the Evaluation of Graduates of Foreign Medical Schools*

*Moderator:* STILES D. EZELL, M.D., New York Board of Medical Examiners

WALTER S. WIGGINS, M.D., Associate Secretary, Council on Medical Education and Hospitals, American Medical Association

DEAN F. SMILEY, M.D., Secretary, Association of American Medical Colleges

EDWIN L. CROSBY, M.D., Director, American Hospital Association

WALTER L. BIERRING, M.D., Secretary-Treasurer, Federation of State Medical Boards of the United States

TUESDAY, 12:30 P. M.

CRYSTAL ROOM

**Federation of State Medical Boards of the United States**

ELMER W. SCHNOOR, M.D., Presiding

12:30 p. m. FEDERATION SUBSCRIPTION LUNCHEON

1:30 p. m. GENERAL SESSION

Reports of Committees: Executive, Resolutions, Nominations and Miscellaneous

2:00 p. m. CONSIDERATION OF REPORT OF COOPERATING COMMITTEE ON GRADUATES OF FOREIGN MEDICAL SCHOOLS

NEW AND UNFINISHED BUSINESS

ELECTION OF OFFICERS

INSTALLATION OF PRESIDENT-ELECT

M. H. CRABB, M.D., Secretary, Texas Board of Medical Examiners

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**Illinois**

**Dr. Kirschbaum Goes to Texas.**—Dr. Arthur Kirschbaum has resigned as professor and head of the department of anatomy, University of Illinois College of Medicine, to become head of the anatomy department at Baylor University College of Medicine, Houston, and fill a similar position in the College of Dentistry of the University of Texas.

## EVOLUTION, REVOLUTION, AND BOARD CERTIFICATION—1932 TO 1954

### CHAIRMAN'S ADDRESS

*George M. Lewis, M.D., New York*

Evolution plays an important role in medicine as in all other phases of life; however, changes in the medical field during the past 30 years have been so profound and so far reaching as to be revolutionary in scope. In many directions this has made available methods for detection of minimal evidence of disease, the ramifications of disease processes have been more clearly defined, and many patients have been salvaged from the category of incurable. The development of new methods of diagnosis, better means for prevention of disease, and of more rational, and often specific, therapeutic procedures poses a challenge to the medical profession. Translation of these modern and continuing advances in knowledge to practical application has not always followed closely, since this is dependent mainly on the availability of physicians with long-term, graduate education leading to the development of special skills and of mature judgment. There is, moreover, often a variation in the quality of medical care depending on the density or sparseness of population, on economic factors, and particularly on the educational status of a community. This problem of providing for more even distribution of superior medical care is a major one in medicine today. With these thoughts in mind it is of importance to trace the growth of specialization and the influence exerted by the specialty boards.

#### PUBLIC ATTITUDE TOWARD SPECIALIZATION

The general public today is much more enlightened in regard to progress in medicine than their counterpart of three decades ago. This is largely because of informative material in newspapers, magazines, radio, and television.

From the Department of Medicine (Dermatology) New York Hospital and Cornell University Medical College.

Read before the Section on Dermatology and Syphilology at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 24, 1954.

Reprinted from J. A. M. A. (Sept. 11) 1954, p. 111.

Some of the material is prepared and disseminated by the medical profession and by medical agencies, but much is the work of lay workers, some of whom devote their professional careers to this field. Cancer, heart disease, and diabetes have been widely discussed. This has resulted in a trend toward self-diagnosis and a desire to share in the decision regarding therapy. The logic of certain diagnostic or therapeutic measures may be perfectly apparent to the physician, but he may meet resistance from a patient unless the measures conform to the information the patient obtains from his favorite columnist. Most patients do not look for miracles from a physician, but they do expect honesty, frankness, and a modicum of skill. Furthermore, they expect fewer mistakes in diagnosis and faster results from therapy if they consult someone who is devoting his entire energies to a particular field. Thirty years ago the desire for specialist care was less apparent than now and was satisfied by comparatively few specialists. While specialists at that time were consulted directly by patients, they were also utilized as consultants by general practitioners to assist in the diagnosis of obscure diseases and in the treatment of patients with unusual or recalcitrant disorders. This approach was helpful only to a small percentage of the general public and, while of help in cases of great complexity, could in no sense be considered a definitive and permanent solution. There has been a gradual realization that in medicine, as in other human endeavors, increasing knowledge must lead to particularization of effort. No lawyer or engineer today could hope to master all the ramifications of his field. The same holds true for a physician.

#### RESPONSE OF PHYSICIANS

While at first specialist care in medicine was considered useful only in cases of severe, disabling, or life threatening illness and injury, it has become apparent that other less vital, but frequently troublesome, disorders also yield more readily to the expert approach. Physicians, aware of their deficiencies, have increasingly sought and obtained the necessary instruction so that they might become proficient in a limited field of medicine. It is of interest to

note the gradual evolutionary tendency to numerical and percentage increase of specialists in the United States during the years 1923 to 1943 (table 1). The pattern was one of gradual expansion, with approximately 1,250 new specialists each year. In sharp contrast, during the seven years between 1944 and 1950, inclusive, over 25,000 specialists were approved as competent by the various boards. This meant that about 3,500 physicians were admitted each year to specialist category, or at approximately three times the former rate. The reasons for this extraordinary condition are various. It is true that the general public has demanded better medical care, not only as individuals, but also through interest in hospital centers. Even in a small community there is increasingly

TABLE 1.—Approximate Number of New Specialists of All Categories Per Year from 1923 to 1954

Period	No. of Yr.	No. of New Specialists	No. per Yr.
1923-1931.....	8	10,400	1,300
1931-1943.....	12	15,000	1,250
1943-1950....	7	25,000	3,560
1950-1954.....	4	5,000	1,250
Total or average 1923-1954.....	31	55,400	1,800

critical appraisal of the credentials of physicians. Physicians who served in the Armed Forces during the second world war were encouraged to seek additional training, either by refresher courses or in long-term training programs, by the government policy of monetary support (G. I. Bill of Rights). They had observed that the armed forces stressed specialist care of patients and could visualize the advantages, not only in pay, but also in the more rapid cure and over-all satisfaction from more knowledgeable handling of the injured and the ill. The overwhelming demand for graduate training might be considered revolutionary, since it was a mass movement in the sense that Webster defines revolution as a "total or radical change." Since 1950 there has been a return to a gradual increase in specialists at the level of approximately 1,250 per year, although the time interval is too

short to establish that this is a definite trend. At this time there are approximately 155,000 physicians in active practice in the United States, this being about three-fourths of all registered physicians. Over 65,000 physicians are practicing a specialty, and most of these are certified as competent by one of the specialty boards. In addition there are 20,000 physicians who are "interested in a specialty." Approximately 70,000 physicians are in general practice.

#### DISTRIBUTION OF CERTIFIED SPECIALISTS IN DERMATOLOGY

It was not too long ago that specialists were to be found in only the larger cities. This is no longer true, and there are few, if any, cities in which specialists of all categories are not to be found. There are 43 cities in the United States in which five or more certified dermatologists are practicing (table 2). Only 31 cities were in this category in 1947. These 43 cities have a total population of 33,747,868 (1950 census) and support 812 certified dermatologists or 1 dermatologist to 41,561 persons. The remaining 116,949,493 persons in the United States have access, sometimes remote, to 526 certified dermatologists or 1 dermatologist to 222,337 persons. This obviously represents inadequate coverage if the same standards of dermatological care are to prevail in all sections of the country. In a paper read before the Section on Dermatology and Syphilology in 1948<sup>1</sup> analysis was made of the distribution of dermatologists in the United States. It is of interest to compare the statistics at that time with those of five years later, and to note a substantial increase in all sections of the country. The increase from 852 dermatologists in 1948 to 1,338 in 1953 is 57%. The total number of specialists who had been certified in dermatology by Dec. 31, 1953 was 1,573. The difference between this and 1,338 represents diplomates who were not reported in private practice in the United States in the 1953 edition of the "Directory

1. Seneear, F. E.; Lewis, G. M., and Cormia, F. E.: Present Status of Dermatologic Training in the United States, Arch. Dermat. & Syph. 60: 475 (Oct.) 1949.



of Medical Specialists." Whereas in 1948 there were eight states with no dermatologist, today only one state, Wyoming, is without such representation. When the in-

TABLE 2.—Distribution of Dermatologists in Cities with Over Five Certified Specialists (1953)

City	No. of Certified Specialists	Population (1950)	Per Capita Distribution
New York .....	237	7,835,099	1:33,059
Chicago.....	56	3,606,435	1:64,400
Philadelphia ...	43	2,064,794	1:48,018
Los Angeles.....	42	1,936,607	1:47,300
Boston.....	28	790,363	1:28,245
Washington, D. C. .	28	797,670	1:28,488
Detroit.....	22	1,838,517	1:83,568
Cleveland.....	22	905,636	1:41,165
San Francisco....	22	760,733	1:34,579
St. Louis.....	17	852,623	1:50,154
Pittsburgh.....	16	678,763	1:42,110
Cincinnati.....	15	500,510	1:33,367
Newark, N. J.....	15	437,857	1:29,190
Houston, Texas ...	14	594,321	1:42,451
Baltimore.....	14	940,205	1:67,157
New Orleans....	14	567,257	1:40,518
Denver.....	12	412,856	1:34,404
Buffalo.....	11	377,393	1:52,490
San Diego, Calif....	11	321,485	1:29,220
Milwaukee .....	10	632,651	1:63,265
Dallas, Texas. .	10	432,927	1:43,292
Seattle.....	10	462,440	1:46,244
Minneapolis .....	10	517,277	1:51,727
Oklahoma City. .	10	242,450	1:24,245
Oakland, Calif. ...	10	350,576	1:35,057
Miami, Fla.....	8	246,983	1:30,872
Indianapolis.....	8	424,683	1:53,085
Paterson, N. J....	8	139,423	1:17,427
Omaha.....	7	247,408	1:35,344
Portland, Ore....	7	371,011	1:53,001
Atlanta, Ga .....	7	327,090	1:46,727
Phoenix, Ariz. . . .	7	105,442	1:15,063
San Antonio, Texas....	7	406,511	1:58,115
Kansas City, Mo. ....	6	453,290	1:75,548
St. Paul.....	6	309,474	1:51,579
Albany, N. Y .....	6	134,995	1:22,499
Long Beach, Calif....	6	244,072	1:40,678
Syracuse, N. Y.....	5	220,067	1:44,013
Birmingham, Ala ....	5	298,720	1:59,744
New Haven, Conn....	5	168,344	1:32,668
Wichita, Kan.....	5	166,306	1:33,261
Elizabeth, N. J....	5	112,675	1:22,535
Dayton, Ohio. . . .	5	243,108	1:48,621
Total....	812	33,747,868	1:41,561

dividual states were surveyed, it was noted that in 1948, only two states and the District of Columbia had a per capita distribution of more than 1:100,000. In table 3

TABLE 3.—Distribution of Dermatologists by State and Geographic Divisions (1953)

Section and State	No. of Certified Specialists	State Population (1950)	Per Capita Distribution
<b>New England</b>			
Maine .....	1	913,774	1:913,774
New Hampshire ..	3	533,242	1:177,747
Vermont. . . . .	2	377,747	1:188,873
Massachusetts	51	4,690,514	1:91,968
Connecticut .. .	27	2,007,280	1:74,346
Rhode Island.. .	6	791,896	1:131,982
Total. . . . .	90	9,314,453	1:103,493
<b>Middle Atlantic</b>			
New York .....	319	14,880,192	1:46,489
Pennsylvania .. .	97	10,498,012	1:108,226
New Jersey . . .	65	4,835,329	1:74,389
Total. . . . .	481	30,163,533	1:62,710
<b>South Atlantic</b>			
Delaware .....	3	313,085	1:106,028
Maryland.....	15	2,343,001	1:156,200
District of Columbia ...	28	802,178	1:28,649
West Virginia.....	5	2,006,552	1:401,110
Virginia .....	15	3,318,680	1:221,245
North Carolina....	15	4,061,929	1:270,795
South Carolina ...	6	2,117,027	1:352,837
Georgia ... ..	12	3,444,578	1:287,048
Florida... ..	21	2,771,305	1:131,966
Total .....	120	21,182,335	1:176,519
<b>East North Central</b>			
Wisconsin .....	17	3,434,575	1:202,033
Michigan .. . . .	37	6,371,766	1:172,209
Illinois.....	82	8,712,176	1:106,246
Indiana.. . . .	19	3,934,224	1:207,064
Ohio.....	65	7,946,627	1:122,255
Total .....	220	30,399,368	1:138,178
<b>East South Central</b>			
Kentucky.... . .	6	2,944,806	1:490,801
Tennessee ... .	13	3,291,713	1:253,209
Mississippi .. . .	3	2,178,914	1:726,304
Alabama.....	9	3,061,743	1:340,193
Total .....	31	11,477,181	1:370,231
<b>West North Central</b>			
Minnesota ... . .	22	2,982,483	1:135,567
Iowa .....	10	2,621,073	1:262,107
Missouri.....	31	3,954,653	1:127,569
North Dakota ...	2	619,636	1:309,818
South Dakota... .	2	652,740	1:326,370
Nebraska .. . . .	8	1,325,510	1:165,633
Kansas .. . . .	14	1,905,299	1:136,092
Total....	89	14,061,394	1:157,993

TABLE 3.—*Distribution of Dermatologists by State and Geographic Divisions (1953)—Continued*

Section and State	No. of Certified Specialists	State Population (1950)	Per Capita Distribution
<b>West South Central</b>			
Oklahoma.....	13	2,283,851	1:171,796
Arkansas.....	4	1,909,511	1:477,627
Texas.....	60	7,711,194	1:128,519
Louisiana...	15	2,683,516	1:178,901
Total....	92	14,587,572	1:158,617
<b>Mountain</b>			
Montana.....	1	591,024	1:591,024
Idaho.....	1	588,637	1:588,637
Wyoming...	.	290,529	.....
Nevada.....	3	160,088	1: 53,361
Utah.....	5	688,862	1:137,772
Colorado.....	15	1,325,089	1: 88,339
Arizona.....	9	749,587	1: 83,287
New Mexico....	4	681,187	1:170,296
Total....	38	5,074,998	1:133,552
<b>Pacific</b>			
Washington...	18	2,378,963	1:132,164
Oregon.....	9	1,521,341	1:169,037
California....	150	10,586,323	1: 70,574
Total.....	177	14,486,627	1: 81,844
Total for United States.....	1,338	150,697,361	1:112,629

it will be noted that eight states and the District of Columbia now enjoy this advantage. On the other side of the ledger, there are 18 states in which the per capita distribution is less than 1:200,000, and it is in these states that the problem of providing adequate dermatological care is obviously the most pressing.

From a consideration of data it would appear that a dermatologist will survive economically if he receives support from other physicians in a community of from 30,000 to 40,000 population and in many instances in even smaller centers. The patient with a recalcitrant or disabling dermatosis may travel a considerable distance for help, and patients tend to gravitate to a large center of population. These are factors that have not been considered, since they do not lend themselves to accurate analysis. It is of interest that on many hospital staffs and in large group clinics there is need for at least one dermatologist to each 40 physicians. This same ratio holds true when the number of certified dermatologists is divided into the total number of specialists certified by all the boards.

#### ROLE OF THE SPECIALTY BOARDS

It might be appropriate to discuss briefly the specialty boards. How did they come into being? What was their purpose? What have they accomplished? Prior to formation of the certifying boards in the various specialties, there was no recognized standard to ensure the public that claims to special knowledge by a physician were legitimate. The licensing requirements by the states demanded only the minimal knowledge that graduates of first-class medical schools usually had no difficulty in demonstrating; however, there was no provision to test the particular knowledge and judgment of persons who were purportedly medical specialists. With the increasing numbers of physicians specializing in the various medical fields, the desirability for some regulatory scheme became self-evident. Since there was no mechanism available through existing organizations, it is to the credit of specialists within the medical profession that they established voluntary examining bodies in their own fields. It should be emphasized that this whole movement was and is independent and self-motivated, being established and perpetuated within the medical profession itself, and it has not been controlled by the state, by universities, or by any preexisting lay or medical organization.

*Development.*—The first specialty certifying board was the American Board of Ophthalmology, which was created in 1916. The next two boards were the American Board of Otolaryngology and the American Board of Obstetrics and Gynecology, established in 1924 and 1930, respectively. The fourth board was the American Board of Dermatology and Syphilology, founded in 1932. These four boards, together with the Association of American Medical Colleges, the American Hospital Association, the Federation of State Medical Boards of the U. S. A., and the National Board of Medical Examiners joined together to form the Advisory Board for Medical Specialties on Feb. 11, 1934. Since then, 14 other specialty boards have been organized and have been admitted to membership in the advisory board. In addition, there are nine sub-specialty boards. The advisory board, as its name implies, is a loosely knit body,

with no power to make decisions binding on its individual members. It holds an annual meeting at which timely topics currently of interest to specialists are discussed. It also has the authority to admit to membership new specialty boards if such are deemed necessary. The Council on Medical Education and Hospitals of the American Medical Association has cooperated wholeheartedly with both the advisory board and individual boards, to their great benefit.

The various boards began as independent units and have so remained. It will help to understand the functioning of a board if it is kept in mind that it is comparable to a judicial organization. The board is composed of members designated from sponsoring societies. Once elected, the members are responsible only to their own consciences. This independence is highly desirable and obviates the possibility that a board might become a political football. It should be stated that, since the members of a board have the confidence of sponsoring societies and since no individual member has more than executive power, no fear need be felt that board decisions will be biased or discriminatory. The boards have found it advisable to insist on certain basic and minimal training requirements that candidates for the examination must satisfy. Since conditions of practice in the different specialties often present problems peculiar to that group, it is not surprising that individual boards exercise considerable variations in their activities. Moore<sup>2</sup> recently reviewed some of the discrepancies in requirements and in the functioning of the boards. These variations in individual boards are minor, are usually based on sound reasoning, and represent the judgment of thoughtful men.

*Professional Standards.*—The boards were established to determine competence of candidates. In exercising their right to establish the “ground rules” under which they could operate, they have also become a potent force in raising professional standards. For instance, at times the minimal standards established by a board were higher than existed in an institution undertaking to provide

2. Moore, R A Variations on a Theme, J. A. M. A. 154:1216 (April 3) 1954.

graduate training. This resulted either in withholding approval of the institution or in deficiencies being remedied. At times, also, this led to criticism of the boards as interfering with the function of an educational body. This would be true if the boards made ironclad rules with conformity to a pattern as requisite to approval. The American Board of Dermatology and Syphilology, like most, if not all other boards, allows great latitude in the performance of an institution, while requiring that graduate students in that institution be given the opportunity to learn all phases of the specialty. One can see how misunderstandings and nonconformity to regulations can result in friction. The very nature of an examining body indicates that not all candidates will be found qualified. Not all those rejected accept the decision of the board as equitable. Chiefs of hospitals that have been refused approval as adequate for graduate training seldom believe the decision is motivated by clear thinking. And heaven help the board with the temerity to remove from the approved list an institution that had previously qualified! In spite of these and many other difficulties, the vision of those responsible for the formation and conduct of the boards has been amply demonstrated.

The boards have been criticized as responsible for the fostering of monopolistic practices. One of the most frequent sources of dissatisfaction concerns the selection of staff members for a hospital when the institution requires board certification for appointment. This has resulted occasionally in unfair treatment of physicians eminently qualified but who, for one reason or another, have never been certified. No one can deny that a lay board of governors of a hospital might be rightfully impressed by certification as indicating high qualification, and it is true that the onus of proof might well be on a noncertified applicant for a hospital position to demonstrate his competence. However, once competence has been proved, either through long service or otherwise, discrimination against him as noncertified cannot be justified. The board certificate should never be used as a weapon. For details of the everyday functioning of a board, the reader is urged to read the article by Brace-

land and Boyd.<sup>3</sup> Written in a humorous vein, it portrays vividly the active life and the vicissitudes of the secretary and therein the problems, great and small, that confront, and sometimes confound, the members of these organizations. Recent publications by Watson <sup>4</sup> and by Schnabel <sup>5</sup> also are informative.

#### RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

Recent exhaustive surveys both in the field of pre-medical <sup>6</sup> and of medical <sup>7</sup> education indicate a wide divergence in colleges in both content and method. There would appear to be a definite trend toward a "balanced education" and a strong feeling that the physician should have a broad and liberal education with less emphasis on science in the premedical years and with cultural subjects receiving more attention. There is considerable agitation to shorten the total period of education for the physician. No unanimity of opinion appears possible as to just when this retraction in time should occur, except that everyone concerned believes it should happen in some period other than the one in which he is personally interested. Adding to the difficulty is the growing realization that, for a physician to be strongly equipped to take his place in the medical community, long-term graduate training is almost essential. Hospitals and medical colleges offering graduate instruction were unprepared for the heavy demand for specialty training immediately after World War II. This urgent request for instruction became a challenge to institutions that had not heretofore had experience in the field of graduate medicine. This was at a time when the staffs of the undergraduate medical colleges were just recovering from the wartime accelerated program. There was some hostility to the

3. Braceland, F. J., and Boyd, D. A.: Secretary of the Board: Apologia Pro Vita Sua, J. A. M. A. 148: 708 (March 1) 1952.

4. Watson, C. J.: Some Activities and Impacts of the American Board of Internal Medicine, J. A. M. A. 138: 257 (Sept. 25) 1948.

5. Schnabel, T. G.: The American Board of Internal Medicine, J. A. M. A. 152: 1590 (Aug. 22) 1953.

6. Severinghaus, A. E.; Carman, H. J., and Cadbury, W. E.: Preparation for Medical Education in the Liberal Arts College, New York, McGraw-Hill Book Company, Inc., 1953.

7. Detrick, J. E., and Berson, R. C.: Medical Schools in the United States at Mid-Century, New York, McGraw-Hill Book Company, Inc., 1953.

insistence by the boards that appropriate basic science subjects must be taught. Some misunderstandings arose over the implementation of these requirements. The boards were occasionally accused of assuming an unreasonable or dictatorial attitude.<sup>8</sup> In general, however, this and other actions of the boards helped materially to elevate standards and to protect graduate students from being exploited.

*Residencies and Fellowships.*—At this time graduate training programs are centered chiefly around the residency and fellowship, with only a minority of students receiving instruction in so-called postgraduate medical schools. Preceptorship instruction is still considered acceptable as an additional method of learning dermatology and some other specialties. In many instances the residency and fellowship program is under the direction of a medical college, although this is by no means requisite to approval by the Council on Medical Education and Hospitals of the A. M. A. or by many of the boards. It is also true that some hospitals with no medical college affiliations are, nevertheless, able to carry out a satisfactory program, and that their graduates are able to compete favorably with those trained in hospitals closely affiliated with a medical college. Basically, the reasons for existence of a hospital and of a medical college are different. The primary obligations of the former are to the patient, for whom the hospital provides shelter and facilities for care and tries to attract an adequate medical staff. The continuing education of the younger members of the staff is rightfully a secondary consideration. On the other hand, the main function of a medical college should be to select and train medical recruits to be good physicians. Medical colleges try to provide opportunities and sufficient challenging experiences so that their graduates are basically competent physicians. This is becoming more and more difficult. In those fortunate centers where a medical college is coupled with a hospital, the professional staffs are identical, and the preclinical departments of the medical college have the vision, funds, and inclination to cooperate fully, a superior graduate program is

8. Chesney, A. M.: Some Impacts of the Specialty Board Movement on Medical Education, J. A. M. Coll. 23: 83 (March) 1948.

probably in operation. There are too few such loci now available.

If the trend toward specialization continues, as there is every reason to expect it will, the medical colleges cannot evade their responsibility to their own graduates to provide a program and to supervise and instruct in the specialties. It is debatable whether the more general use of the graduate degree, which should indicate ability in teaching or research, will be found desirable. There are, no doubt, many valid reasons, financial and otherwise, for failure of many medical colleges to assume the responsibility to graduate education. With the present reduced demand for graduate training it would seem appropriate for the medical colleges to show a more active interest in this vital problem. In the future they should assume the lead in the specialty movement.

#### ECONOMICS OF SPECIALIZATION

The speciality movement has developed rapidly and spontaneously. It has been erroneously blamed as responsible for some problems, particularly the rising cost of medical care. In most communities the fees charged by specialists, with the exception of those in the surgical fields, are not substantially more than those of general practitioners, although they are necessarily higher than formerly. This fact is not, however, the main cause of hardship. Illness costs more than formerly, chiefly because diagnostic measures are more complicated and, therefore, more expensive, and because the cost of hospitalization has increased enormously. Many modern drugs are expensive. The charge that specialists are responsible for the economic woes of the general public, because patients have to be referred from one kind of specialist to another, has some small basis in fact. This should be offset to some degree by the expected lessening in morbidity through more expert care. It should be emphasized that the physician's fee is actually only a fraction of the total cost of medical care. The rapid growth of group practice is a significant trend, being an answer to the demand for specialist care in smaller communities. The provocative, impatient idealism of Means<sup>9</sup>

9. Means, J. H.: *Doctors, People, and Government*, Boston, Little, Brown & Company, 1953.

raises many questions relating to defects in present day medicine. The role of government looms large in his attempts to point the way to improvement. The majority of physicians apparently feel otherwise.<sup>10</sup> The main economic medical hazard is still the unpredictable catastrophic illness or injury that requires prolonged care and is further complicated by loss of income. This, of course, is not peculiar to specialization. It is an ever-recurring and fortunately rare problem the solution of which offers considerable difficulty. It has been partially solved by prepaid insurance for both medical care and hospitalization. Specialists, as physicians, have in the past cooperated and will always cooperate in such situations with their services donated or at reduced fees when indicated by hardship or distress. The ability to provide adequate specialist care in sparsely populated communities is a difficult problem, but it should not be insurmountable. It is here that planning on a county, state, or national level may be required, if the problem cannot be solved under the auspices of existing organizations.

#### RESPONSIBILITIES OF SPECIALISTS

It is to the credit of physicians that they have been willing to undergo the additional training required by the boards in order to qualify for special recognition. This has seldom been an easy assignment. Small wonder, then, that the frequent reaction of a new diplomate is to throw his books into the corner and say that he is through with study forever. He knows, of course, that he has only started on a program that will continue during his professional life. He must either continue to study and become increasingly proficient or he will regress. His duty to himself, to the profession, and to his patients is to come periodically in contact with others in the specialty and to keep abreast of new developments. In addition, there is a debt to the physician's teachers to be repaid. This should take two forms: (1) there should be a personal, professional contribution, by research, by teaching, and by helping to organize or to staff dermatology departments; and (2) there should be support of the activities of his specialty board, the American Academy of Derma-

10. *Doctors, People, and Government*, Book Review, J. A. M. A. 154: 183 (Jan. 9) 1954.

tology and Syphilology, the A. M. A., and other organizations, local, regional, and national in scope. Active participation means regular attendance at meetings, appropriate discussion in the scientific deliberations, and the voicing of suggestions or criticisms when such seem desirable or necessary. Communications are best directed to the secretary of the organization in question. Rumors that are palpably false regarding the activities of a medical organization should be brought to the attention of its officers, so that further harm may be stopped.

#### SPECIALIST MEDICINE IN THE FUTURE

With the gradual reduction in the number of general practitioners there are some communities in which it is difficult to find a "family doctor." It is, therefore, important for each physician, whether specialist or not, to qualify as family doctor. Such a physician must have the confidence of a family that consults him when illness develops. It is more than likely that some physicians will continue to wish to be general practitioners, caring for common disorders and acting as family physicians. From all indications, however, the percentage of such physicians will continue to decline gradually.

The time would seem appropriate to banish the idea that specialists are primarily consultants. Formerly, the specialist was often thought to be a standoffish, cold-fish scientist. Unfortunately, there are still some specialists with a detached and perfunctory attitude of superiority and a lack of appreciation of the finer sensibilities of the patient. For the most part, however, the specialist of today is a realistic, sympathetic practitioner and does his most effective work when he looks after the patient, rather than when he tries to supervise the problem with another physician. At times, consultation between physicians is valuable, but usually this is when the diagnosis is in doubt, when there is some question of medicolegal complications, when long-continued therapy has been ineffectual, or when a decision may determine the life of a patient. The United States is now the most fortunate nation in the world, medically as well as in many other ways; however, there is still room for improvement. It is a matter of record that there are many places in the United States where specialist care of patients is the rule.

Most of the practicing physicians on the staffs of institutions in the larger cities, and in many medium-sized and smaller cities in the United States, confine their practice to a limited field. The success of group practice in many sections of the country is further evidence that care of patients at the specialist level can be accomplished in sparsely settled communities.

So far the demand for specialist care has been mostly from larger centers of population. There is evidence, however, that increasingly the rural population and persons in small towns will insist that they too should be treated by specialists. A patient who recently came 150 miles to New York said he did this because he noted that that was what the physicians in his community did when they required medical attention. This is a period of transition and the change will no doubt require many years. Indications at this time point to eventual universal specialization. As mentioned previously, it would appear from analysis of available statistics that one out of 40 practitioners should be a dermatologist. Since there is no agreement as to how many physicians of all categories are required to provide medical care for the United States, it is obviously impossible to do more than guess at the future dermatological requirements. Nevertheless, it is evident that the saturation point has not nearly been reached. In fact, the number of dermatologists at this time could be probably doubled, provided there was a proportional increase of other specialists. The outlook in the next 30 years could well be 4,000 to 5,000 dermatologists, or even more as the population increases.

The present agitation for the socialization of medicine is mostly due to economic considerations, but the desire of the public to receive not only adequate but superior medical care may be an additional factor. Many persons mistakenly believe that in some magic way the cost will be less and the quality of medical care will improve if the government is in control. It is evident that the present administration is not anxious to venture into the regulatory field, and future administrations will not have the incentive if the public generally receives the superior medical care that is available now for a minority. The chief problem is to provide specialist care in sparsely

settled districts. The great and continuing advances in medicine must become universally and promptly available, which will require a sufficient number of specialists.

#### SUMMARY

From 1943 to 1950 about 25,000 physicians became certified as specialists. The result has been a profound change in medical practice, since from one-third to one-half of all physicians now in active practice are specialists. To judge from a survey of certified dermatologists, the distribution of specialists is still uneven. The highest rate per capita is found in the large centers of population, but increasingly, even in smaller cities and large towns, specialist care may be obtained. It is in the rural communities and in sparsely settled areas that specialists are in short supply. The continued increase in group practice and the large number of rural communities in which a hospital center has been established makes it evident that specialist care will be in time available to all sections of the United States. It is apparent that this major change in medical practice has occurred concurrently with sociologic and economic problems of utmost difficulty to solve. Lack of specialists may be an important factor with the rising cost of medical care as a basis for talk of socialization. It is probable that if specialist medical care was more evenly distributed there would be no appreciable demand for state medicine. The specialty boards as examining agencies have served an invaluable role in setting up standards of proficiency for specialists. Specialists must continue to study in order to keep abreast of current progress and should support the activities of organized medicine. Efforts should be made to shorten the total period of education of the physician. This is increasingly important since the majority of physicians now believe graduate training to be essential in order to prepare for the demands of private practice. The question is raised whether the medical colleges should not more closely integrate and supervise graduate education that should in the near future be considered of equal importance with the basic undergraduate medical course.

66 E. 66th St. (21).

## FROM OUR EXCHANGES

### REGISTRATION OF GERMAN PHYSICIANS

Because a provision in a long-standing treaty with Germany has expired, all physicians, dentists, and veterinarians who are German nationals and have been admitted to the United States for permanent residence now must register with Selective Service under the "Doctor-Draft" act. Germany is one of 18 countries with whom the U. S. has treaties that contain, among other things, a provision for exempting nationals of each country from military service while living in the other country. That provision in the German treaty expired last June 2. Accordingly, Selective Service has directed that affected doctors who had not yet reached their 50th birthday on Jan. 15, 1951, must now go to a local draft board and sign up as special registrants. It was explained that the January, 1951, date is written in the law and that it was deemed applicable in this case. However, German nationals who are now 51 years or older will not be subject for service, just as in the case of any physician, dentist, or veterinarian presently registered under the law. The "Doctor-Draft" act itself expires next June 30. The other 17 countries with whom we have treaties or international agreements containing reciprocal exemption from military service are Argentina, Austria, Costa Rica, China, El Salvador, Estonia, Honduras, Ireland, Italy, Latvia, Liberia, Norway, Paraguay, Siam, Spain, Switzerland, and Yugoslavia. An official estimate of the number of doctors of German origin affected by the new development was not available; however, it is estimated unofficially that the total runs into the thousands.—*J. A. M. A.* (Oct. 30) 1954.

### THE KOREAN G. I. BILL

Veterans are eligible for education and training under the Korean G. I. bill if they served in the armed forces after June 27, 1950, had at least 90 days' total service, and were separated under conditions other than dishonorable. The 90 day requirement is waived for veterans discharged because of an actual service-incurred injury or disability. A veteran is entitled to training for one and one-half times the length of the period he spent on active service after June 27, 1950. The maximum is 36 months of training.

Korean G. I. bill students receive a single allowance check each month from the government. With the help of this money, they must meet all their own expenses of training, such as tuition,

fees, books, and supplies. Rates for veterans in school full time are \$110 a month, without dependents; \$135 with one dependent; and \$160 with more than one dependent.

When a veteran applies for training, he must specify the objective he intends to reach and the training program he plans to take that will lead him to his objective. Under the law, a veteran may change his program of training no more than once. Also, the law prohibits him from training for an objective for which he already is qualified by reason of prior training or experience. The matter of stating a proper objective is of utmost importance to all veteran-trainees, including those training in the field of medicine. For a premedical student, the objective would be the profession he is aiming for: physician (M.D.). For a veteran taking his medical internship, the objective also would be physician (M.D.); however, if his total course is for a specific specialty, that specialty becomes his objective: pediatrician, surgeon, and so on. For a veteran taking a residency course leading to certification by a specialty board, the objective would be that specialty for which the board has established standards; examples would be orthopedic surgeon, pathologist, and specialist in physical medicine and rehabilitation. The veteran planning residency training in a field in which specialty board requirements have not been published should inquire at his VA regional office about (1) proper objective to put down and (2) special requirements the residency course must meet.

One item of importance to all Korean G. I. bill veteran-trainees is the monthly G. I. education and training allowance. Premedical students going to school full time obviously will be paid the full-time classroom rate, ranging from \$110 to \$160 a month, depending on dependency status. G. I. interns and residents also will receive the rates paid to classroom students. To be acceptable under the Korean G. I. bill, and therefore to qualify for the full-term training pay, a medical internship course must be accredited and approved by the A. M. A.'s Council on Medical Education and Hospitals, for whatever length the Council has approved for the particular internship course at the particular hospital. No G. I. allowance may be paid to veterans taking nonapproved internships, since nonapproved courses would not be recognized as qualifying a veteran for the practice of the profession.

A medical residency course must meet the following three requirements in order for veterans to draw classroom pay:

1. It must be accredited and approved by the Council on Medical Education and Hospitals of the A. M. A. as a standard residency.
2. It must lead to a certification in accordance with Council standards.
3. The length of the course may not be longer than that prescribed by the specialty board or by the A. M. A. Council.

G. I. allowances may not be paid to veterans enrolled in residencies that do not meet the three requirements. Veterans may obtain information about any phase of medical training under the Korean G. I. bill from their nearest VA office.—*J. A. M. A.* (Oct. 30) 1954.

## NEWS ITEMS

### Alabama

**Narcotic Violation.**—Dr. Felix Jenkins McGraw, 5353 1st Ave., North, Birmingham, pleaded guilty in the U. S. District Court at Birmingham to a charge of violation of the federal narcotic law and on July 15 was sentenced to serve a year and a day, was fined \$100, and was placed on probation for a period of three years to begin at the expiration of the foregoing sentence.

### California

Decisions of the Medical Board. The Board of Medical Examiners reports the following actions:

*Oct. 18, 1954.*

The application for modification or termination of probation for Dr. Henry McNeil Ward, Los Angeles; Dr. John Gordon Rennie, North Hollywood; Dr. Donald F. Predmore, Olive View and Dr. Carl Frederick Larson, Sausalito, were considered, and it was the decision of the board that their narcotic privileges be restored and that the other terms and conditions of their probation remain the same as shown on the previous decision of the board.

*Nov. 29, 1954.*

The license of Dr. Joseph John Salopek, Marysville, was revoked provided however that the effectiveness of the order be stayed until Feb. 24, 1957, until which time respondent is placed on probation to the board on certain terms and conditions.

The license of Dr. Albert F. Stelhorn, Los Angeles, was revoked, the execution of the order being stayed and the respondent placed on probation for a period of five years under certain terms and conditions.

The license of Dr. Martin J. Reimringer, Eldridge, was revoked.

The license of Dr. William B. Strickland, Shasta, was revoked; the execution of the order being stayed until Oct. 13, 1956, until which time respondent is placed on probation under certain terms and conditions.

*Dec. 2, 1954*

The license of Dr. Louis Boonshaft was revoked, execution of the order being stayed and respondent placed upon probation for a period of five years under certain terms and conditions.

The probationary terms as provided in the decision of the board effective as of Aug. 28, 1953, in the matter of Dr. Charles Walter Higgins were modified to the extent that it would again be permissible for him to practice medicine and surgery, all other terms and conditions of the probation remain the same as provided in the original decision.



### Florida

**License Revoked.**—On Nov. 20, the Board of Medical Examiners reports the license of Dr. Abraham Silver was revoked. It was found that medical license No. 5140, issued on Aug. 13, 1952, was obtained through fraud and deceit.

### General

**Survey of Veterans Trained Under Public Law 16.**—A Veterans Administration survey was made to learn what happened to World War II disabled veterans after they finished or stopped training under Public Law 16 and started making their own living. The survey covered a representative sample of disabled World War II veterans throughout the nation who had received Public Law 16 training at some time after the law went into effect in 1943. These veterans, many of them amputees, blinded or with weakened hearts and other serious disabilities, have more than doubled their prewar incomes, so that now they are earning \$400 a year above the national average. Ninety-five out of every 100 of the rehabilitated veterans are employed, and nearly all are using skills they learned while in training. After military service and Public Law 16 training, the weekly pay averaged \$72 for those who had reached the stage of complete rehabilitation. The weekly average for those who had discontinued training before completing their courses was \$66.

The VA report states, as of Oct. 8, that the trained disabled veteran not only has overcome his handicap but has boosted his earning capacity above the national level. Of the employed veterans, 87% reported they were using skills acquired through Public Law 16 training. At the time they started training, their average age of the men was 27.7 years. The median prewar schooling of the veterans was 11.6 years. Twenty-six per cent had never gone beyond grade school; 60% attended high school, and 14% had gone to college. Forty-one per cent of the veterans had orthopedic disabilities, such as arm or leg amputations; 24% had recovered from nervous or mental illnesses; 7% had circulatory and heart conditions; 8% had tuberculosis or other respiratory ailments; the rest had a variety of other service-connected ailments.

The average disabled veteran received 21.3 months of training under Public Law 16. Twenty-four per cent took their training at college; another 24% attended schools below the college level; 41% trained on-the-job, and 11% took their training on-the-farm. More than 602,000 disabled veterans had received training under the program since it began 11 years ago. VA records reveal that two-thirds officially were declared rehabilitated through training, although many of the others are doing work in which the skills acquired through training are used. Among some of the trainees with the highest rates of rehabilitation were electrotypers and stereotypers, with 83%; telephone and telegraph servicemen, 80%; photoengravers, 79%; industrial engineers, 78%; optometrists, 76%; physicians and surgeons, 76%; and dentists 73%..