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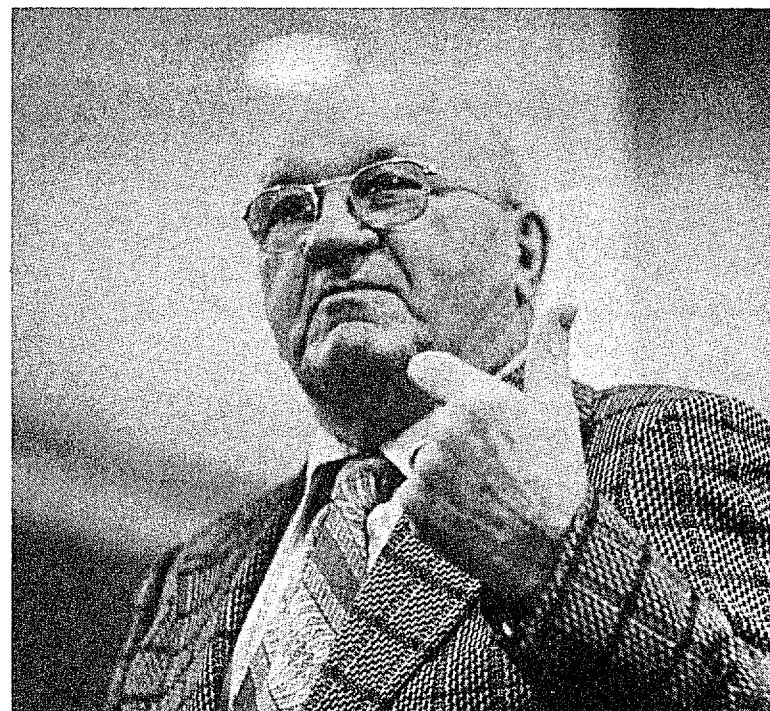
In Memoriam

C. ROBERT STARKS, D.O.

1900-1974

C. Robert Starks, D.O., devoted more than half of the years that he lived serving his profession and the people of his state as a member of The Colorado State Board of Medical Examiners. First appointed to the board in March 1936, Dr. Starks served continuously until his death, October 19, 1974. He had been president of the Colorado medical board since January 1960.

Dr. Starks was born in Cripple Creek, Colorado March 1, 1900. Gold-mining history buffs should immediately recognize Cripple Creek as one of the greatest gold-producing districts in the world. Discovered in Poverty Gulch in 1891, the output of gold



Dr. Starks during 1974 Annual Business Meeting.

from the Cripple Creek region reached its peak in 1900, the year that Dr. Starks was born.

Reared and educated in Cripple Creek and Denver, Dr. Starks attended the University of Colorado, and he earned his D.O. at the Kirksville College of Osteopathy, Kirksville, Missouri.

He had served as chief of staff at Rocky Mountain Hospital and was a past president of the Colorado Osteopathic Association. He was reported to have been a founding member and had been president of the American Academy of Osteopathic Orthopedic Surgeons.

Beyond his practice of orthopedic surgery and involvement in the activities of his profession, Dr. Starks saved some time for community affairs. Long a member of the Kiwanis Club, he was president of the Denver club in 1936, and he was honored as Kiwanian of the Year in 1966. In addition, he was a member of El Jebel Shrine, the Denver Chamber of Commerce and a number of other bodies.

He was widely known throughout the Federation of State Medical Boards, and he attended the annual meetings in Chicago regularly. He had served on many special and standing committees of the Federation and, at the time of his death, was a member of the Articles of Incorporation and By-Laws Committee.

Effective during discussion and debate at annual business sessions of the corporation, his perceptiveness, wisdom and sense of humor will be missed during coming meetings of the Federation. Unquestionably, C. Robert Starks, D.O. will be keenly missed during sessions of The Colorado State Board of Medical Examiners, as well as those fraternal and service organizations to which he had contributed so much.

The BULLETIN is saddened by the death of a friend and loyal member of the Federation. Others will take his place. But another with his sense of loyalty, dedication and enthusiasm will be hard to find.

RLC

CURRENT PROBLEMS AND PROPOSED SOLUTIONS AS RELATED TO THE FOREIGN MEDICAL GRADUATE

WILLIAM D. MAYER, M.D.

When your president, Dr. George Maltby, asked me several months ago if I would participate in this portion of the Federation annual meeting, it was done so in the context of "It might be important for the group to hear about the recommendations of the Goals and Priorities Committee of the National Board of Medical Examiners, particularly as they may impinge upon the foreign medical graduate in the continuum of medical education in the United States." I had just completed the two years of effort that led to the June 1973 publication of the report of the Committee, "Evaluation in the Continuum of Medical Education." Therefore, I indicated I would be delighted to do so.

As the program began to evolve, however, and in December reached a final program phase, I found my topic to be "Current Problems and Proposed Solutions as Related to the Foreign Medical Graduate." Literally translated, I took that to mean, "Tell us what the problems are, then give us the solutions and we will move on to the next topic." Further, I found myself as anchor man on a program in which I was preceded by a truly distinguished group of participants, most of whom I expected would identify many, if not all, of the problems, and also would suggest (or at least imply) some solutions. Given that set of circumstances I could only rationalize my position by assuming 1) that George did not want me to provide an exhaustive summary of possible problems and potential proposed solutions, and 2) that if I repeated comments of previous speakers, I could justify as a medical educator on the pedagogical principle of inculcation. What I *will attempt to do* is to suggest some of the problems

Presented during the 1974 annual meeting, Federation of State Medical Boards of the United States, Chicago, February 1, 1974.

Dr. Mayer is dean of the medical school, University of Missouri-Columbia. He was one of several asked to make more than one presentation during the 1974 annual meeting, and complete biographical background material regarding Dr. Mayer was printed with his article in the August 1974 issue of the BULLETIN.

and some of the proposed solutions and trust that those which were missed by me and my colleagues can be picked up in the discussion.

If you really want a thorough and complete discussion of the problems and solutions, I would suggest that you capture a copy of the final report of the Bureau of Health Resources Development, *Foreign Medical Graduates and Physician Manpower in the United States*.*

Clearly, the nature of the problem and the proposed solutions are dependent upon who you are and the nature of your frame of reference. I have seen very few problems which so clearly epitomized Saxe's "Six Men of Indostan," "To learning much inclined, who went to see the elephant (though all of them were blind), that each by observation might satisfy his mind."

Is the problem:

1) That we are depriving many countries around the world of their needed medical manpower?

Or is it the converse:

2) That we are failing to meet our international obligations through the development of training programs both here in the United States and abroad, specifically designed to meet the special health problems of given foreign nations?

Or is it:

3) That we are permitting poorly qualified individuals to participate in our health care system either in supervised or unsupervised settings?

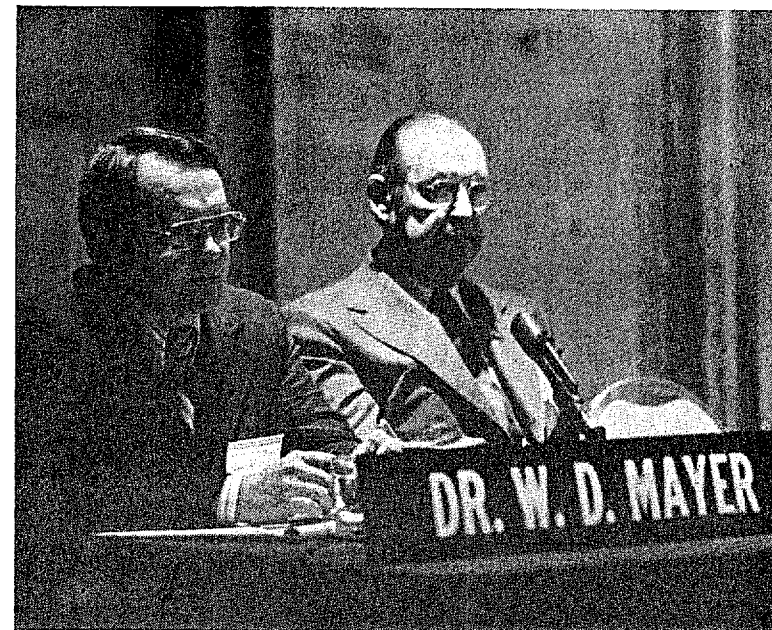
Or is it:

4) That we are in danger of creating an excess of physicians in this country through a marked expansion of our own medical school output coupled with easy access of foreign medical graduates to the United States?

Or is it:

5) That we are unable to develop adequate methods of providing health care in many of our private and public institu-

* DHEW Publication No. (HRA) 74-30. Bureau of Health Resources Development, Division of Manpower Intelligence, Office of International Health Manpower Studies, Public Health Service, Health Resources Administration, United States Department of Health, Education and Welfare, February 1974.



Dr. Mayer (at left) and Dr. Kenneth Schnepf during 1974 annual meeting.

tions and therefore must rely on foreign medical graduates to serve these purposes?

Or is it:

6) That we are unable to provide qualified United States citizens with sufficient entering places in undergraduate medical education in this country, thereby forcing many of them to seek their medical education abroad?

Or is the problem:

7) That we have developed a system of health care and health education in this country which is so pluralistic and so complex that we can't develop solutions even when we have identified the problems?

In regard to this latter issue, did you ever stop to think of all of the organizations potentially involved? The following list, though far from complete, at least gives you some feel for the multiple involvements.

1) The individual state licensure boards,



Dr. Mayer (speaking) and (from left) Drs. Robert Weiss and John Mather.

2) The individual state legislatures, which have established such boards and have enacted laws pertaining to their operations,

3) The Federation of State Medical Boards,

4) The FLEX Board,

5) The Educational Council for Foreign Medical Graduates (ECFMG),

6) The Commission on Foreign Medical Graduates (CFMG),

7) The individual hospitals accepting FMG's as employees or in training programs,

8) The Joint Commission on Accreditation of Hospitals (JCAH),

9) The American Hospital Association,

10) The individual internship and residency programs,

11) The residency review committees,

12) The Liaison Committee on Medical Education,

13) The Liaison Committee on Graduate Medical Education,

14) The Coordinating Council on Medical Education,

15) The American Medical Association,

16) The Association of American Medical Colleges,

17) The twenty-two specialty boards,

18) The American Board of Medical Specialties (ABMS),

19) The United States Department of State,

20) The Department of Labor,

21) The Department of Health, Education and Welfare and its various component parts,

22) The Department of Justice (Immigration and Naturalization Service),

23) The National Board of Medical Examiners.

This is not a complete list, but it does suggest that there may be a few problems of overlapping responsibilities and authority which will tend to inhibit clear and easy solutions, even if some concurrence can be reached by the same groups on the definition of the problem.

Obviously, the context in which one phrases the problem has very clear implications for its solution. Admitting, as in the case of "The Six Men of Indostan," that each of us by nature of our backgrounds, current positions, current frames of reference, are biased and therefore professionally blind, let me suggest a context for "the problem." It is admittedly quite incomplete and fails to touch many of the key issues. Hopefully, however, it might provide some insight to the other five blind men, just as this blind man has already received insight from those who have gone before me on the program, and anticipates receiving further insight from those who will follow.

What I intend to do is to assume I am the one blind man from Indostan to approach the elephant from the world of medical education and my role is to develop the biases that come from reviewing the elephant from that perspective.

Taking that position, I approach the elephant with the following assumptions:

1) That the United States has developed the best medical educational program of any country in the world.

2) That we have achieved this position:

a) By linking our medical educational efforts to the university,

b) By building our clinical education on top of a strong biomedical science base,

c) By providing graded clinical responsibility through carefully structured individualized instruction in the clinical years,

d) Through carefully established graduate training programs beyond the M.D. degree leading to certification in twenty-two specialties, ranging from Family Practice to Colon and Rectal Surgery,

e) By establishing carefully monitored national accreditation programs at the undergraduate, graduate and continuing medical education levels, thereby assuring at least some degree of quality as a result of the educational effort,

f) By carefully monitoring evaluation and certification of individuals participating in accredited educational programs, and

g) By increasing acknowledgement of the need to recertify individuals throughout their lifetime of practice.

3) That we are willing to, and in the process of, continuing to assure improved quality in our evaluation procedures throughout the continuum of medical education, from the time of entrance into medical school until departure from practice (through death or retirement), in order to enhance the quality of medical care in this country.

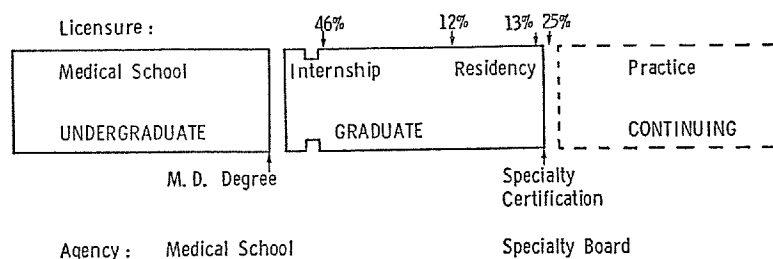


Figure 1

What does the system look like presently? Figure 1 is a schematic presentation which may help to focus our thinking. For purposes of simplification we have divided the periods of education into the undergraduate experience, graduate medical educational experience and the continuing medical educational experience, starting respectively in medical school, internship-residency and throughout the period of practice. The accreditation of the quality of the educational experience is carried out by the Liaison Committee on Medical Education at the undergraduate

level, by the internship review and the multiple residency review committees at the graduate level (now with the Liaison Committee on Graduate Medical Education overseeing the process), and the continuing educational programs, by the AMA accreditation process. And as most of you in this room know, the establishment of a formal Liaison Committee on Continuing Medical Education has been proposed, all of them, in turn, answering to the Coordinating Council on Medical Education (CCME). The efforts of these bodies are to assure that the quality of the educational process at each level meets appropriate standards.

The individual physician is monitored with varying degrees of sophistication throughout his undergraduate and graduate medical educational program by the respective faculties. Having met the standards established by the medical schools at the undergraduate level, the physician is granted the M.D. degree, and having met the standards established by the specialty boards, is granted specialty certification. Further assurance to the public of quality control is provided by the individual state medical boards through licensure to practice. The Levit, Sabshin, and Mueller sub-study of the Goals and Priorities Committee demonstrated (at least for the group graduated in 1960) licensure occurred at the 46 percent level by the end of the first year after graduation, with an additional 12 percent in the period of two to three years post-graduation, 13 percent four to five years post-graduation and 25 percent at the five plus years level, as depicted in Figure 1. For those of you who can quickly add, there were 4 percent of those in the cohort for whom no licensure was ever identified.

Then, this is our system, with the public having the assurance of competency to practice by those individuals who have successfully completed an accredited undergraduate medical school program with the granting of the M.D. degree, an accredited graduate medical education program with specialty certification, and, finally, licensure by the individual state.

This is, in fact, the route that the majority of United States medical graduates now take. The tracking study of the 1960 graduates by Levit, et al. (noted above) demonstrated that 99 percent completed at least two years of additional training be-

yond the M.D. degree, 86 percent completed residency training and entered the specialty certification process and 73 percent were board certified (at least by September 1972). Those individuals limiting their practice to family practice or general practice were excluded from that study since no specialty boards were available to them at that time. We have assumed that from the time of origin of the American Board of Family Practice those entering that specialty will follow similar patterns. A recent survey of the graduates of our four year School of Medicine (University of Missouri-Columbia) since its initiation in 1956 revealed similar statistical patterns. Of those now in practice, 85 percent completed residency training and 58 percent were certified. Of those still in training, 97 percent indicated their intent to complete residency training and 82 percent their intent to achieve board certification.

Given my first assumption, "That the United States has developed the best medical educational program of any country in the world," and given the myriad of individuals, groups and organizations which have been involved in achieving that status, the problem then becomes—how do we sustain and enhance that educational process and how does the foreign medical graduate fit into it?

In a sense, this was one of the key questions addressed by the Committee on Goals and Priorities of the National Board. In part, their recommendations were as follows (see Figure 2):

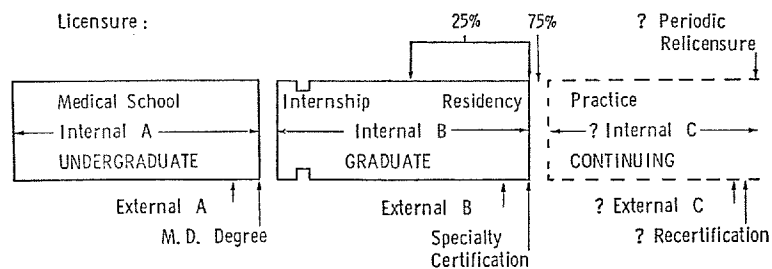


Figure 2

1) That a comprehensive qualifying evaluation (Qualifying A) be required at the interface of undergraduate/graduate medical education to assure that individuals are competent to assume responsibility for patient care under supervision.

a) That this evaluation include both an external examination (External A) and an internal assessment (Internal A) by the medical school of the individual's competency to assume patient care under supervision,

b) That the NBME in association with the FSMB develop the external examination (External A),

c) That the medical schools and their accrediting agencies undertake a major effort in improving the capability for ongoing intramural assessment of the knowledge, skills, attitudes and behavioral characteristics of their students (i.e. enhance their capabilities to accomplish Internal A),

d) That this comprehensive evaluation (both External and Internal) provide the legal basis for the state medical boards to grant a permit to practice in a supervised setting,

e) That all medical school graduates, United States and foreign, be permitted to enter graduate medical education involving patient care only upon meeting these evaluation procedures at a level acceptable to the state medical boards.

2) That a comprehensive qualifying evaluation be required at the completion of graduate medical education to assure that individuals are competent to assume independent responsibility for patient care.

a) That this evaluation include both an external examination (External B or specialty board) and an internal assessment (Internal B) by the institution responsible for the graduate medical education of the individual's competency to assume independent responsibility for patient care.

b) That the individual specialty boards, in cooperation with each other, and, as is deemed appropriate, with the National Board of Medical Examiners, continue to improve their capacity for the development of qualifying specialty exams.

c) That graduate medical institutions and their accrediting agencies undertake a major effort in improving the ongoing intramural assessment (i.e. Internal B) or performance of their trainees.

d) That state medical boards, based on specialty board certification, the graduate medical institution's verification of competence, and *additional requirements which would be determined by the individual states*, grant full and unrestricted

license to practice. You will note from the tracking study that at least 75 percent of the 1960 graduates could have achieved licensure through this route.

e) That for the limited number of individuals not seeking or achieving specialty board certification, full and unrestricted licensure might, at the option of the individual state, be provided on the basis of: satisfactory completion of Qualifying A, graduate medical institution verification of competence at the completion of a minimum of two years of graduate training, and such other additional requirements as would be determined by the individual states. We are estimating that 25 percent of United States medical school graduates will receive licensure via this pathway.

In Figure 2, I have suggested options for recertification and relicensure throughout the continuum of practice. I will not comment further on that issue, for, obviously, that is a major topic in and of itself.

What then are the implications of this suggested enhancement of the evaluation continuum to foreign medical graduates?

1) Obviously, the FMS (Foreign Medical Student) who enters the mainstream of United States undergraduate medical education through the COTRANS Program would simply be incorporated into the process with all of its checks and balances. Clearly, this raises the issue of the expansion of the COTRANS Program and how that might be accomplished.

2) For the individual FMG entering the graduate phase of the continuum, a minimum requirement would be the satisfactory completion of the External A examination, as would be the case for his United States medical school graduate (USMG) counterpart.

a) This raises, however, the very real question, under the proposed scheme, of what degree of assurance state licensure boards would have that Internal A would be met? Clearly, in the instance of the USMG, there would be full assurance of the academic integrity of the medical schools of this country, their willingness to certify that Internal A has been carried out and that the individual is ready to assume patient care responsibilities under supervision, and finally, the backing of the Liaison Committee on Medical Education and the Coordinat-

ing Council on Medical Education that, in fact, the educational process is sound.

b) Obviously, the Committee found no easy answer to this difficult question. It would be inappropriate, if not impossible, to extend our accreditation procedures to medical schools throughout the world. The Committee did state, however, that there should be developed "methods to evaluate English language capability and the potential for adapting to, and benefiting from, the United States medical education and health care environment. This assessment should be a prerequisite for Qualifying A for FMG's who are foreign nationals."

c) Although the Committee did not lay out specific suggestions in this regard, it would appear that three basic routes (or modifications thereof) could be developed.

1. The development of an evaluation instrument measuring some of these characteristics as a prerequisite to taking the External A examination.

2. The establishment of training programs in United States medical schools which would be related to these characteristics for FMG's who have successfully passed External A. One group has in fact suggested that FMG's should be required to satisfactorily complete one year of such an accredited program prior to entrance into graduate medical education. Presumably, this would then assure the equivalent of the Internal A evaluation of the USMG.

3. A third possibility is for this responsibility to be assumed as an initial component of the graduate experience, presumably following satisfactory completion of External A.

As some of you may not be aware, the *Essentials of Approved Residencies* contain a statement on: *Special Requirements for Programs of International Educational Exchange in Medicine*, which states briefly as follows:

"In addition to the foregoing requirements for all residents, those programs which accept graduates of foreign medical schools should contain certain special additional features which are essential to the effective education and training of such individuals.

"a) An orientation program for the foreign medical graduate should include thorough familiarization with patterns of American hospital and clinical practice, organizational responsibilities of hospital personnel, legal as well as moral and ethical concepts of physician-patient relationships and the varying patterns of graduate medical education which lead to competence in practice.

"b) While the ECFMG resources described in section 6, "Selection of Residents," are intended to provide reasonable assurance regarding the medical qualifications of foreign medical school graduates, many such individuals have deficits in background education and experience not ordinarily found in graduates of United States or Canadian medical schools. Special educational activities should be designed to correct these deficits in the area of professional medical knowledge and, in some cases, in the use of the English language.

"c) Effective participation in the medical management of patients is impossible without an appropriate degree of appreciation by the foreign trained physicians of the cultural backgrounds of their patients. Such appreciation is unlikely to develop in the absence of carefully planned and conscientiously conducted programs of contact with a wide cross-section of American family life and of other non-medical activities characteristic of the American way of life."

Obviously, this component of the *Essentials* has not been vigorously pursued in the accreditation process. But it does represent another route for assurance of Internal A.

I have not dealt with the issue of the foreign medical graduate coming to the United States "fully trained" and desirous of entering unrestricted practice without additional education in the United States system. I have done this intentionally, for as you recall, I initially defined myself as the blind man from Indostan whose obligation on this issue was medical education.

In summary, let me share with you a personal bias, and a bias that I think evolved for the entire Committee on Goals and Priorities out of its firm belief that the level of medical education and the quality of medical care desired by the people of the United States can be achieved only by a meaningful cooperative

effort of those involved in education, accreditation, certification, and licensure.

This bias implies that individual state medical boards and the Federation of State Medical Boards cannot alone provide those assurances. Similarly, neither can the individual medical schools of this country, the Association of American Medical Colleges or the Liaison Committee on Medical Education. Neither can the individual specialty boards, the American Board of Medical Specialties or the Liaison Committee on Graduate Medical Education. And neither can the National Board of Medical Examiners that is working directly or indirectly with all of these groups.

However, working toward a common goal in a cooperative fashion, I feel the assurances of quality in medical education and the high level of quality medical care desired by the American public can be met. We simply must reach common understanding about those goals and how to achieve them.

I submit that if we can achieve assurance of quality education for United States medical graduates and foreign graduates alike, many of the issues which have been described as "problems of the foreign medical graduate" will be significantly simplified and the solutions to those issues will become more readily apparent.

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FEDERATION BULLETIN, VOLUME 61 (1974)

ANNUAL REPORT OF THE EDITOR

"... the BULLETIN is the official voice of the Federation of State Medical Boards. Clearly, the policies of that corporate entity must be reflected in the overall editorial policy of the periodical..."

With just such a *cliche*, the Editor neared the conclusion of his Annual Report on the 1973 Volume of the FEDERATION BULLETIN.¹ Although once fresh and forceful, the expression appeared to have lost some of its zest and seemed to be less timely than when used in earlier similar reports.

Yet, in leafing through the pages of the twelve numbers of Volume 61 (1974), it becomes obvious that the *cliche*, though stereotyped, continues appropriate and is far from trite.

The GAP Report

Reaction to the recommendations set forth by the Goals and Priorities Committee of the National Board of Medical Examiners, *Evaluation in the Continuum of Medical Education*,² was given substantial space and coverage in the early 1974 issues of the BULLETIN.

During the year, the position of the Federation regarding several of the important recommendations highlighted in the "GAP (or G&P) Report" began to emerge. In articles and editorials such as *Perspectives on Qualifying B*,³ *The State Medical Boards Approach the GAP*⁴ and *Qualifying A—And FLEX, Too?*⁵ the stance of the BULLETIN, reflecting that of the Federation of State Medical Boards, moved from reflex reaction to the expression of a reasonable alternative to full implementation of several of the recommendations which had troubled members of many state medical licensing boards.

Medical Education and Health Manpower Bills, S-3585, et al

Medical education and health manpower bills that were introduced in the United States Senate as well as the House of Rep-

¹Prepared for the annual business meeting, Federation of State Medical Boards, Chicago, January 31, 1975.

representatives, during the 93rd Congress, received considerable coverage in the late 1974 numbers of the BULLETIN. Those bills contained provisions calling for national licensure and relicensure of physicians and dentists, government regulation of graduate medical education and mandated federal service for many, if not most medical school graduates within six months of initial licensure. As proposed, the required service would have been at the pleasure of the Secretary of Health, Education and Welfare, in an area designated by the Secretary and, most likely, as a member of the National Health Service Corps.

Strong opposition to those bills was expressed by individual members of state medical boards and by the Federation. Dr. Robert C. Derbyshire's article, *On Indentured Servitude and the Bureaucrats—Some Comments on S-3585*,⁶ was written for publication in the BULLETIN following his appearance (as an individual and by invitation) before Senator Kennedy's Subcommittee on Health. In that article, he succinctly summarized the far-reaching provisions of Senate Bill 3585 and clearly pointed out the profound effect that bill could have had upon medical students, graduate medical education and the practice of medicine.

Derbyshire's article was followed by President Howard L. Horns' message on *Relicensure and Recertification*⁷ and editorial comment which pointed out the resolute action of the FLEX Board and committees urging all states to consider a FLEX Weighted Average score of 75 as the minimal acceptable medical licensing examination standard.⁸

The editorial, *S-3585, Prescription for a Nightmare*,⁹ and another presidential message pressed for immediate action by members of medical licensing boards in every jurisdiction. They were urged to make their views known and to bring to the attention of their senators and congressmen the efforts of the Federation toward improving medical licensure standards and facilitating movement of physicians from one area to another by enhancing interstate endorsement of licenses to practice medicine.

Finally, the BULLETIN carried the *Federation Position Paper* directing attention to the policy stand taken by the Federation of State Medical Boards regarding Senate Bill 3585 and other similar legislative, administrative and regulatory proposals.¹⁰

Thus, during 1974, as the official voice of the Federation, the BULLETIN clearly reflected the policies of that corporate entity editorially in its reaction to two superficially different, yet related issues, each threatening to encroach upon one or more of the functions traditionally regulated by state medical licensing boards.

Physiognomy and Viscera

In an earlier report,¹¹ the Editor commented upon certain characteristic signs and symptoms of aging that had become evident in the *outward appearance*, the *physiognomy* of the BULLETIN. Taking courage from the ready recognition of the change in character produced by the skilled hands of plastic surgeons in many an "old girl" age fifty-eight, the Editor introduced the current front outer cover format with the January 1971 issue—Volume 58, Number 1. Obviously, the "face-lifting" was a success.

While considering changes in the format of the *inner parts*, the *viscera* of the BULLETIN, the Editor reverted to a habit pattern established and maintained during the many years he devoted to the active practice of internal medicine: *First*, take a history.

Delving into the past, the Editor learned that Dr. Walter L. Bierring was *not* the father and first editor of the FEDERATION BULLETIN (despite the many pages that have been written giving him credit for siring the periodical)! The Federation was organized February 29, 1912. It was not until the following year that the periodical was created by action of the organization. Known as the *Quarterly*, the first four issues of Volume One were published in October 1913, January, April and October 1914. Dr. Otto V. Hoffman, secretary-treasurer of the Federation, was the first editor, and it was in late 1914 that Dr. Bierring, then secretary-treasurer, succeeded Dr. Hoffman as editor.

The minutes of the third annual meeting of the Federation, February 17, 1915, show the motion that authorized the executive committee to publish a monthly bulletin in place of the *Quarterly*. The first issue of the *Monthly Bulletin* (that's the name it carried) was published in April 1915.

In the September 1916 issue—*Monthly Bulletin* 2, Number 6 (volume and issue numbering was not rectified until much lat-

er)—there was an announcement that the first examination of the National Board of Medical Examiners would be held in Washington, D.C., October 16 to 21, 1916. Since the first class of applicants was not expected to exceed twenty or twenty-five, it was predicted that the first examination would be completed in six days and ". . . thereafter no doubt (would) be lengthened to eight or ten days . . ."(!). But, enough of such delving into the personal and family history of the Federation and the BULLETIN.

After the history? Logically, examination. Inspection of the type page format of recent volumes of the BULLETIN shows a measurement of 20 x 38 picas (one pica = 1/6 inch). And that concludes the examination.

With the January 1975 issue, the dimensions have been increased to 24 x 40 picas, thus increasing the amount of text per page by approximately 20 percent. Such a change in type page dimensions is both economically and ecologically sound. For, not only will there be some reduction in the cost of producing the BULLETIN, but each issue will require 20 percent less paper.

Returning to the history, briefly, the type page measurement of *Monthly Bulletin* 2 (September) 1916 was 25 x 40 picas, a striking coincidence.

While discussing the physiognomy and viscera—the physical characteristics—of the periodical, the time seems right to acknowledge again the assistance of The Ovid Bell Press, Inc., Fulton, Missouri, in the production of the BULLETIN. The effectiveness of Mr. Ovid H. Bell, president of the firm, and his staff in maintaining a high degree of professionalism in printing is evident in this periodical and in the many other medical and trade journals and books they produce. The proposal they submitted to print the BULLETIN in 1975 was accepted, and the contract was renewed for another year.

Helping Hands

For many years, the uninterrupted publication of the BULLETIN was made possible by the continued support of the American Medical Association. The confidence expressed by the Board of Trustees in providing ongoing financial assistance to the BULLETIN has become even more meaningful in recent years, during which AMA resources have dwindled.

In addition, administrative and professional staff members of various divisions and departments at AMA have been helpful in establishing and maintaining communication with the BULLETIN. Being adequately informed about decisions and actions at AMA allows prompt reporting of those particularly effecting medical licensure.

Associate Editor John H. Morton, M.D. (*JHM*) has provided a "change of pace" from the Editor's regular stride with timely special articles, reports and editorials. Dr. Morton's assistance and support is gratefully acknowledged, as is that of the members of the BULLETIN Editorial Advisory Board, Drs. Leo T. Heywood, Harold E. Jervy, Jr. and George L. Maltby.

Management and subscription business activities remain a function of the central office of the Federation of State Medical Boards, guided by Federation Secretary M. H. Crabb, M.D. The ready assistance of Dr. Crabb and his staff is acknowledged with gratitude.

Feed the BULLETIN

The FEDERATION BULLETIN can serve as a reliable source of information regarding medical licensure and discipline and as an outlet for news items about jurisdictional licensing boards and their members only to the extent that member medical boards address such material (printed, typed, scrawled or photographic) to the Editor. So, keep those photos and news tidbits coming!

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WHAT'S WRONG WITH QUALIFYING B?

In discussions of the NBME's GAP Report, the Federation has rejected out of hand the concept of Qualifying B, a license for independent practice based on a specialty board certificate. It would be wise to document just why this suggestion is unpalatable.

The first reason is a small legalistic one. The state licensing boards are a part of the state government responsible directly to the governor and the state legislature. The specialty boards are independent free-standing organizations responsible only indirectly to the specialty societies which sponsor them. For the state medical board to delegate its licensing authority to a non-governmental agency over which it had no control would be a questionable abrogation of power.

The second point, which concerns the purpose of a state license and a specialty board certificate, is more substantial. The state originally issued licenses to practice medicine to assure its citizens that medical practitioners possessed at least minimally acceptable competence. The job of the state licensing board remains unchanged, to assure that all physicians in practice satisfy minimum basic standards. The initial purpose of the specialty boards was to assure the public that a practitioner possessed an unusual degree of knowledge and skill in one particular branch of medicine. Although it could be argued that the specialty boards have moved in the direction of basic competence, a move which has sparked the development of certain subspecialty boards, the specialty boards nevertheless remain concerned with one facet of the medical spectrum. To equate minimal competence to practice with unusual ability in a narrow field is illogical.

The third argument, which concerns the character of a medical license, is basic. Medical licenses at present convey broad powers to practice. The limitations which narrow a physician's field of activity come from other sources—hospital staff regulations, workmen's compensation regulations, referral practices within the profession, to name a few. A broad license should be

based on credentials which are equally broad. A license to practice medicine based solely on a certificate of special competence in diagnostic radiology, for instance, is ridiculous on its face.

The fourth concern grows out of number three and is equally fundamental. If a license were based on a specialty board certificate, the powers it conferred would have to be appropriately drawn. It might be reasonably simple to define the practice and the limits of diagnostic radiology in legal terms, although even here a troublesome gray zone would exist. It would be exceedingly difficult to define similar standards and limits in internal medicine or in general surgery, for example. Defining the limits either too broadly or too narrowly would create difficult problems both for the physician and the authorities charged with enforcement.

The fifth item is a small but natural corollary of the fourth. There are still certain physicians who desire to satisfy minimum requirements and begin medical practice. These doctors, who do not wish to do hospital work, feel no compulsion to go through a long postgraduate training program. There is no persuasive evidence that these physicians are not safe practitioners. There is persuasive evidence that they fill a need in the community. If they satisfy basic minimum standards, why should these physicians be forced into a kind of training which will prepare them for a different career?

The GAP Committee recommended Qualifying B because in fact most physicians today complete training for board qualification. The committee reasoned that, this being the fact, board certification should become the standard for independent practice. In making this recommendation, they conveniently overlooked the high failure rate which remains characteristic of many specialty boards, boards which are justifiably committed to excellence rather than minimum competence.

In solving the theoretical problem that no physician actually practices "medicine and surgery" any longer, the GAP Committee raised a number of problems which are hard to resolve. It seems clear that the solution posed in this instance is worse than the situation which the committee wished to rectify.

JHM

HEALTH MANPOWER LEGISLATION— REQUIEM AND REVIVAL

The medical education and health manpower bills that were introduced in the United States Senate and House of Representatives during the 93rd Congress (S-3585, et al) could have had far reaching effects upon medical students, graduate medical education and the practice of medicine.

However, the bills which passed after long debate, first on the floor of the Senate and later in the House, each had been altered significantly by amendments. Thus, they were referred to a Senate-House joint conference committee during the closing days of the 93rd Congress.

The conferees apparently were not able to reach agreement. So, the proposed medical education and health manpower legislation was not reported out of that committee before the concluding sessions of "the 93rd."

The amendments had deleted some of the provisions of those bills that were strongly opposed by members of many licensing boards and by the Federation of State Medical Boards. Nonetheless, there has been no indication of the form in which the proposed legislation might have emerged following the compromises that are expected to occur during the deliberation of joint conference committees.

This *requiem* is written in expectation of a *revival* of interest in legislative proposals effecting medical education and health manpower during the early months of the 94th Congress. For, although the conferees could not reach agreement and the proposed legislation appears moribund, the issue is far from dead. Therefore, it is anticipated that revival will be accomplished without resurrection, heavily underscoring the wisdom of the "... development of a Washington presence ..." proposed by Federation President Howard L. Horns, M.D.¹

The Long Range Planning Committee has recommended that consideration be given to having Federation representation in Washington, D.C., and the Board of Directors approved that

recommendation in principle during its recent meeting in Portland, Oregon.

None can disagree with the importance of keeping the Federation advised of impending administrative and legislative action. The need is obvious. Time is of the essence. A decision should be reached during the 1975 annual meeting.

RLC

BOUND VOLUMES OF FEDERATION BULLETIN

The Central Office of the Federation will have bound copies of Volume 61 (1974) of the BULLETIN available for distribution soon. With a limited number of "over-run" copies available for binding, those interested in obtaining bound volumes should communicate promptly with the Central Office. Bound copies of several earlier volumes remain available, and the *cost* of current and earlier volumes *remains* at pre-inflationary levels: Five dollars.

Orders should be submitted directly to M. H. Crabb, M.D., Secretary, Federation of State Medical Boards of the United States, Inc., Suite 304—1612 Summit Avenue, Fort Worth, Texas 76102.

1. Horns, Howard L. President's Message. FEDERATION BULLETIN 61:349 (October) 1974.

Federation News:

PROPOSED AMENDMENTS TO CORPORATE DOCUMENTS TO BE CONSIDERED DURING 1975 FEDERATION ANNUAL MEETING

During the February 1974 annual business meeting, a proposed amendment to change the corporate by-laws (Chapter X, Sections A and F) was referred to the Federation Articles of Incorporation and By-Laws Committee. In resolution format, the proposal recommending that a *Program Committee* be added to the standing committees of the Federation was printed in the November FEDERATION BULLETIN.*

Any proposed amendment of the Federation Articles of Incorporation or By-Laws must be mailed by the secretary to each member medical board at least two months before the meeting at which any proposed change is to be considered.

The several standing committees will hold meetings during the late afternoon of the first day of the 1975 meeting, Thursday, January 30, 1975. During those committee meetings and the annual business meeting the following day, any member of the Federation is given time to be heard. Thus, at those meetings of the various standing and special committees and the FLEX Board, each member of the Federation has the opportunity to make known his views on the proposed amendments to the corporate documents noted in this article as well as a number of other important matters.

Additional proposals to amend the Federation Articles of Incorporation and By-Laws were mailed to all member medical boards November 30, 1974. That *was* two months prior to the meeting, but it was too late to meet the press deadline for inclusion in the December BULLETIN.

Amendment to Articles of Incorporation

The first, proposing amendment of the Articles of Incorporation, would add a new Section D to Article III, which sets forth the objects and purposes of the corporation:

* FEDERATION BULLETIN 61:389 (November) 1974.

SECTION D. *To obtain and disseminate information regarding proposed legislative and administrative actions affecting healing arts licensure.*

Such a proposal *might* seem to be implicit in Section A of the same article. But *proposed* Section D extends the purposes of the Federation from the somewhat restrictive verbiage expressed in Section A, "*To keep itself and its members informed . . .*" to encompass an almost unlimited audience.

Restricted only by the language of Article IV, Section A, ". . . no substantial part of the activities or funds of the corporation shall be devoted to carrying on propaganda or otherwise attempting to influence legislation . . .," addition of the proposed Section D to the "objects and purposes" of the corporation would authorize the Federation (as a body and through the BULLETIN) to *obtain and disseminate* information about legislative *and* administrative proposals affecting healing arts licensure to anyone having an interest in such lore.

Amendments to By-Laws

Although seemingly clear when adopted in February 1970, the sections of the chapters of the by-laws relating to the election of officers, filling of vacancies and the rights and duties of the officers of the Federation are in need of clarification.

Thus, several amendments to the by-laws have been proposed. The present language of the pertinent sections of Chapters III and IV is followed by the proposed amendments which would replace the present sections.

Chapter III Election of Officers

Section A. *The Election of Officers*—The election of all officers shall be by a majority vote of the Member Medical Boards present and voting. The voting members of the corporation at the annual session shall elect a President-elect, who is the First Vice-President and a 2nd Vice-President, Secretary, Treasurer, and one Member to the Board of Directors annually. The offices of Secretary and Treasurer may be elected as one office.

Section A. *The Election of Officers*—The election of all officers shall be by a majority vote of the Member Medical

Boards present and voting. The voting members of the corporation at the annual session shall elect a President-elect, a Vice-President, Secretary, Treasurer, and one Member to the Board of Directors annually. The offices of Secretary and Treasurer may be elected as one office.

Section D. *Vacancies*—If before the expiration of the term of office for which he was elected, the President or President-elect dies, resigns, is removed or otherwise becomes disqualified, the 2nd Vice-President shall succeed to that office vacated with all the prerogatives and duties pertaining to the office as though he had originally been elected and serve for the duration of the unexpired term.

A vacancy created by death, resignation, removal or other disqualification of the 2nd Vice-President, Secretary, Treasurer, or an elected Member of the Board of Directors or a vacancy in a contingency not here provided shall be filled by appointment of the President, subject to the approval of the Board of Directors, until the next annual session at which time, if necessary, the voting members shall elect for the unexpired portion of the term.

Section D. *Vacancies*—If before the expiration of the term of office for which he was elected, the President dies, resigns, is removed or otherwise becomes disqualified, the President-elect shall succeed to the office vacated with all the prerogatives and duties pertaining to the office as though he had originally been elected and serve for the duration of the unexpired term.

A vacancy created by death, resignation, removal or other disqualification of the President-elect, Vice-President, Secretary, Treasurer, or an elected Member of the Board of Directors or a vacancy in a contingency not here provided shall be filled by appointment of the President, subject to the approval of the Board of Directors, until the next annual session at which time, if necessary, the voting members shall elect for the unexpired portion of the term.

Chapter IV Rights and Duties of Officers

Section B. *President-elect and First Vice President*—The President-elect and First Vice President shall assist the President in

the discharge of his duties and shall officiate for the President during his absence or at his request.

Section B. *President-elect*—The President-elect shall assist the President in the discharge of his duties and shall officiate for the President during his absence or at his request.

Section C. *2nd Vice-President*—The 2nd Vice-President shall assist the President and the President-elect and the Board of Directors in the discharge of their duties.

Section C. *Vice-President*—The Vice-President shall assist the President and the President-elect and the Board of Directors in the discharge of their duties.

These amendments, calling for deletion of former sections and substitution of new sections, obviously have been designed to create for the two positions titles more clearly setting forth their status: *President-elect* and *Vice-President*.

The BULLETIN supports adoption of the several proposed amendments to the Federation Articles of Incorporation and By-Laws, as they have been cited above.

Although the proposals to amend the by-laws, in part, clarify the status of the officers of the corporation, more significantly, they recommend the addition of a *program committee*. All have the strong backing of the board of directors and the BULLETIN.

And the Board, as well as the BULLETIN, urge adoption of the proposed addition of a new Section D to Article III, authorizing more substantial efforts toward obtaining and disseminating information affecting healing arts licensure to an *almost* unlimited audience. Obviously, adoption of the amendment would give broad discretionary authority to the Board and, through the Board, to the BULLETIN. But, in times such as these when legislative and administrative actions can affect healing arts licensure almost instantaneously, “spreading the word” frequently cannot await the approval of the membership at the next annual meeting.

RLC

THE FEDERATION OF STATE MEDICAL
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INCORPORATED

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1974

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