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FEBRUARY 1985

JANET DUFFY CARSON, J.D.

"Maintaining the confidence of examinees, as well as the public, in the integrity of the licensing process is vitally important and is a goal that I think can be met. . . ."

IN THIS ISSUE

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CONTENTS

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Cheating on Licensing Examinations — A Legal Perspective

JANET DUFFY CARSON, J.D.

When one hears the word "cheating" in the context of examinations, there is a tendency to think solely or primarily in terms of copying behavior, i.e., one examinee copying the answers of another examinee during the administration of a test. Cheating on examinations is not, however, confined to this type of behavior, and since my comments will not be so confined either, I would like to take a moment at the outset to define the term "cheating" for our purposes.

Dictionaries offer a variety of definitions for the verb "cheat," including "defraud," "deceive," "victimize" and "swindle." There are, however, certain subtle distinctions between the meaning of the word "cheat" and some of its synonyms. "Cheat" implies conducting matters fraudulently, especially for profit to oneself; whereas the term "deceive" suggests deliberately misleading to produce misunderstanding or to prevent someone from knowing the truth; and the word "victimize" has emotional connotations making the cheating seem particularly dastardly because it makes a victim of someone. I mention these nuances not because I assume that everyone has an avid interest in semantics, but rather, because I think that cheating in connection with licensing examinations might be most appropriately described by the combination of these three interpretive definitions: Cheating in connection with licensing examinations is fraudulent conduct which deliberately misleads a licensing board and/or prevents a licensing board from knowing the truth about an individual's ability to meet the requirements for licensure, which conduct is designed to profit the perpetrator and which has the potential of making the public its victim.

While one may assume that those so inclined are always capable of coming up with new and different ways to try to "beat the system," the following are the most obvious types of fraudulent conduct which may be encountered in connection with the licensing examination process: 1) the submission of false credentials and/or false information on applications; 2) the use of an imposter for purposes of taking the examinations; 3) the use of notes, books, or other materials during the

Presented at a symposium on the security of examinations during the annual meeting of the Federation of State Medical Boards, San Antonio, Texas, April 27, 1984.

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Mrs. Carson completed her undergraduate education at Pennsylvania State University, graduating with distinction with a B.A. in political science, and received the J.D. degree from Villanova University School of Law, where she served as the Managing Editor of *The Law Review*.

In her position as Consulting Legal Counsel for the National Board, Mrs. Carson has devoted considerable time and attention to issues related to examination security. These activities have included coordination with law enforcement agencies in investigations relative to breaks in security, cooperation with attorneys prosecuting cases resulting from such investigations, and consultation with a variety of individuals and organizations relative to mechanisms for deterring, detecting, and responding to breaks in security. Mrs. Carson has been called upon to speak and to write about examination security issues on a number of occasions and recently authored an article, "Challenges to the Integrity of the Licensing Examination Process," which was published in *The Bar Examiner*, a publication of the National Conference of Bar Examiners.

administration of the examination; 4) copying behavior; and 5) unauthorized access to secure examination materials.

The first type of fraudulent conduct, the submission of false credentials and/or false information on applications, has recently been the focus of considerable attention in the news media. While this kind of cheating obviously impacts in a very direct way upon the licensure process, that impact is felt in the examination portion of that process only to the extent that individuals who do not, in fact, meet the eligibility requirements for the FLEX, may be admitted to it on the basis of such false documentation. One might hypothesize that this, in turn, may have other implications for the examination process, based on the assumption that those who do not actually possess the education and/or training required to take the FLEX may be more likely to engage in other types of fraudulent behavior, such as copying, in connection with the taking of the examination. At this point in time, however, I am not familiar with

any data or other evidence which would support or refute that assumption.

I am not aware of any instance in recent memory involving the next type of cheating noted, i.e., the use of an imposter for purposes of taking the licensing examination. Hopefully, that does not mean that such conduct is rarely detected, but rather means that such conduct is rarely attempted because of the existence of effective identification processes.

The third type of cheating, i.e., the use of books, notes and other materials by an examinee during the administration of the FLEX, is conduct which is very susceptible to prevention and detection. The effective enforcement of the rule that examinees should not have written materials of any kind at their seats during test administration, except, of course, those examination materials provided by the proctor, should serve to prevent most attempts to engage in this type of cheating. Vigilant proctoring should make it possible to detect the use of any such materials by an examinee who manages to smuggle them into the testing room. It was just such vigilant proctoring in connection with the administration of the June 1983 FLEX in Maine which resulted in the confiscation of certain notes (written on the back of a FLEX identification card) from an examinee, which "crib" notes subsequently provided evidence of a break in the security of a section of that examination. The occurrence of this type of cheating involving use of reference materials during the examination, however, also appears to be fairly rare in practice which, hopefully, indicates that the preventive measures are being effectively enforced.

The types of cheating more commonly encountered are copying behavior and unauthorized access to examination materials. I would like to focus on these two types of conduct, and particularly on unauthorized access to examination materials (often referred to as security breaks), and to examine some of the legal implications of such conduct. An examination of these implications involves consideration of what, if any, action may be pursued by those involved in the medical licensing examination process when confronted with evidence of such conduct and what, if any, criminal prosecutions might be pursued at the federal and/or state level. To be complete, it should also consider the possible exposure of those making decisions and taking action based upon evidence of such conduct.

Copying behavior is the type of cheating which is reported most frequently. This may reflect the fact that examinees are more likely to engage in this type of cheating than others, possibly because it does not necessarily require any advance or sophisticated planning and does not require the expenditure of any money. It may also

reflect the fact that the ability to identify this type of cheating is great because the conduct, of necessity, occurs in the controlled setting of test administrations. Adequate room size, assignment of seats at random, appropriate spacing between seats and vigilant proctoring should operate to deter this type of conduct in most instances and make it detectable in virtually all others.

For the last three administrations of FLEX, there have been eighty-seven instances in which requests have been presented to the NBME for the conduct of appropriate statistical analysis in connection with proctors' reports of suspected copying behavior. Interestingly, fifty-four of those eighty-seven instances were in connection with the December 1982 FLEX, twenty-eight in connection with the June 1983 FLEX, and only five in connection with the December 1983 FLEX. This trend, if it is one, might be reason for optimism, based on the assumption that increased attention to security and other conditions of test administration over the past year or so has effectively prevented or deterred individuals from engaging in this conduct. A true pessimist would probably not view this decrease in the number of reported incidents of copying behavior so favorably, but rather might argue that all the data indicates is a decrease in the number of incidents observed and reported, and not necessarily the number of incidents of cheating which in fact occurred.

In instances in which there is evidence of copying behavior on FLEX, which in most cases involves documented observations by one and preferably more proctors and the results of statistical analyses which are consistent with those observations, the state board involved will presumably wish to pursue some action against the examinee in question. The nature of that action and the process by which it is taken may vary somewhat from state to state depending upon existing state statutes and regulations. Since such behavior renders meaningless the measurements that are made for the examinee who copies, it would seem that, at a minimum, every state board should have the authority and ability to invalidate the FLEX scores of individuals whom it has determined have cheated on the test by copying answers.

Looking now at the liability side, what, if any, legal exposure does a state board face in connection with incidents of copying behavior. Obviously, any examinee who has been found by a board to have engaged in such conduct may choose to challenge the action taken by the board and/or the process by which that action was taken. The existence of statutory or regulatory provisions authorizing the state board to take action in response to fraudulent conduct in connection with the licensing examination process, defining the

types of conduct prohibited, and specifying sanctions which may be imposed when the board has found that an individual has engaged in such conduct, provides a good basis for the defense of such a challenge. A defense which can rely upon such a basis for the action taken, and which can establish that the finding made was supported by the evidence presented and that there was compliance with the requirements of due process in reaching that decision is an "odds on favorite" to succeed, even in the unpredictable arena of litigation.

This appears to be a case of saving the worst for last because the final type of cheating to be addressed is unauthorized access to examination materials, be they materials from forthcoming licensing examinations or materials from previously administered examinations. Such conduct has, during the past two years, been the subject of considerable attention and grave concern, and the reason for such concern is, I think, clear to all of you. The medical licensing examinations are designed and developed to sample across multiple content domains measurable aspects of knowledge, skills and/or abilities deemed necessary for the competent practice of medicine. In light of this, if an individual has unauthorized access to test questions in advance of the examination, he or she may be able to demonstrate the knowledge requisite to answer correctly those specific questions, but the scores attained by that individual on the examination may not, in fact, provide true indices of the examinee's knowledge of the broader subject matter being tested by those questions.

The examinations for medical licensure use questions drawn from a pool of previously used items and thus, in addition to the obvious, unfair advantage which an examinee could obtain through unauthorized access to a forthcoming examination, a considerable unfair advantage could also be obtained by an examinee through unauthorized access to previously used test items. Instances of both types of conduct, unfortunately, have been attempted and have occurred recently in connection with FLEX. These recent occurrences involving breaks in the security of examination materials have resulted in considerable efforts to tighten even further the detailed security measures relative to all phases of the examination process and to assure strict compliance with such measures. This type of cheating is particularly difficult to prevent because of the inability, in most cases, to identify at precisely which point or points in the process the access has been obtained. In the absence of such evidence, mechanisms for preventing security breaks must be applied with equal vigor at all stages of the process. The recent security incidents demonstrated that the

security system and/or compliance with it was not without vulnerabilities, and even with the additional efforts being made to enhance that system, it would be naive to assume that the system is fail-safe.

Given that incidents of unauthorized access have occurred and may occur in the future, what, if any, action can be taken against those who participate in such incidents? In those instances in which the identity of a participant is known and that individual is an applicant for licensure, the state board involved might be able to take action to invalidate the scores of the individual on the examination to which he or she had access, and/or to declare the individual ineligible for licensure for a specified period of time or permanently. The ability of a state to take these or other actions in such instances clearly depends, however, upon whether by statute, regulation or other official pronouncement such conduct has been prohibited and whether the state board has the authority to impose sanctions for such conduct.

Another course of action which might be pursued against individuals having unauthorized access to FLEX is one available to the NBME, as the owner of the test materials, under the federal copyright law. As the holder of the copyright in these materials, the NBME has the exclusive rights of reproduction, distribution and display of these test items, and, given appropriate evidence, may pursue a civil action for infringement against one who violates any of these exclusive rights. The federal copyright law additionally provides that an infringement of a copyright willfully and for purposes of commercial advantage or private financial gain is a criminal offense. Recognizing that federal criminal violations might be involved in such conduct and recognizing that criminal prosecutions should operate as a significant deterrent to those who might be tempted to engage in this sort of conduct, the NBME reports incidents involving unauthorized access to examination materials to the Federal Bureau of Investigation and cooperates with it in its investigative efforts. It is and has been gratifying to know that the serious and national implications of this type of conduct are recognized by those FBI agents with whom we have worked in Philadelphia, who are to be commended for their fine efforts in this regard.

In addition to federal investigations and prosecutions, criminal prosecutions at the state level, for example on charges of breaking and entering, theft, and receipt of stolen property, might also provide appropriate avenues for action against identified individuals in cases involving unauthorized access to examinations.

The actions which might be taken in response to incidents involving unauthorized access to examination materials, referred to above, assume that the identity of one or more of the individuals involved is known. This is, unfortunately, not always or, in fact, usually, the case. An example of this is the security break which occurred in Michigan in connection with the December 1982 FLEX. In that instance, it was discovered on the morning of the administration of Day 1 that some person or persons had broken into the locked room in which the test materials had been stored, and had removed materials for Day 2 and Day 3. Notwithstanding a full investigation by the Michigan state police, the individuals who stole these materials were never identified. Such situations involving evidence of a break in security, but little or no evidence as to the identity of those who gained access to the materials or the extent of the distribution of those materials, are extremely frustrating. Another example of this was the incident which occurred in connection with the administration of the June 1983 FLEX in Maine to which reference was made previously. In that instance, while evidence was obtained that one identified individual had had prior access to Section I of that examination, no specific information has been obtained as to the identity of the person or persons from whom that examinee received the materials or as to the identity of other recipients of the materials.

Certainly we can all agree that the privilege of the practice of medicine should not be granted to any individual on the basis of scores the individual achieved on the requisite licensing examination by virtue of his or her prior access to that examination. However, where the evidence available indicates only that there was a break in security and that some unknown number of unidentified examinees may have had access to test materials in advance of the examinations' administration, none of the options for action appear particularly attractive. For example, the option which will assure that no invalid scores will be released, i.e., the refusal to score the examination, will also adversely affect presumably large numbers of innocent examinees. On the other hand, the option which will assure that no innocent examinees will be adversely affected, i.e., the reporting of scores for all examinees except those for whom there is substantive evidence of advance access, may also permit some unknown number of examinees to receive invalid passing scores on the examination by virtue of their advance, but undetected, access to the examination.

There are legal vulnerabilities implicit in any such decision-making which requires the balancing of interests, with the interests of the individual examinees on the one hand and those of the public as the recipients of health care on the other. There is never a guarantee

that a lawsuit will not result from the decisions ultimately made in such instances. While certainly even the successful defense of a lawsuit is time-consuming and costly, the avoidance of such litigation cannot be a goal which overrides the very vital role and responsibility of those charged with assuring the competency of individuals licensed to practice medicine and of those involved in the licensing examination process. It is possible and prudent, however, to minimize the legal risks of such "tough" decisions by assuring that examinees have been advised of actions which can or may be taken under certain circumstances and by assuring that all reasonable efforts have been made to prevent such an occurrence.

This discussion cannot be concluded without making note of the fact that while each instance of cheating is serious and while recent years have seen an increased number of instances of cheating on licensing examinations, "serious" and "increased" do not necessarily mean "pervasive." There are, obviously, many, many examinees who are totally innocent of any cheating. Maintaining the confidence of such individuals, as well as the public, in the integrity of the licensing process is vitally important and is a goal that I think can be met by the continuation of the efforts already being made to deter cheating, to detect it when it does occur, and to take effective and appropriate action in response to it.

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Doctor Frankenstein's Brain

RICHARD J. FEINSTEIN, M.D.

Mary Shelley's classic horror story, *Frankenstein*, was published in 1818. It told of a scientist, Victor Frankenstein, who tried to create a living being for the benefit of humanity and science. He assembled parts from dead bodies and amalgamated the best to form his creature.

In one dramatic portion of the story, he dispatches his assistant Igor to gain entry into another scientist's laboratory to obtain a brain for the creature. Igor is directed to obtain the brain of a recently deceased genius so that the new creature will be good and intelligent. In his haste to please his master, Igor drops the glass jar containing the genius brain. Fearful of repercussions, he unknowingly takes a glass jar containing the brain of a criminal instead.

It is not far-fetched to believe that there are such things as criminal brains or genius brains. Most people do possess a brain which determines, to a great degree, what form their life will take. It seems that both genetic and environmental factors affect us, and our choice of career and lifestyle is determined by the nature of our brain and by what educational and other life experiences we are exposed to.

Dr. Feinstein

It is not always clear why individuals choose to become physicians, instead of choosing some other occupation. When I was young, I must have been presumptuous enough to believe that my level of intelligence and integrity would allow me to succeed as a physician. It was particularly audacious of me to make those presumptions because I came from an uneducated working class

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family who believed that medical doctors were very special people.

Before I even began my first year of medical school, I began to receive the socialization that accompanies a medical career. When people found out that I was to enter medical school, some immediately became more respectful and attentive, and a few even confided in me secrets about their mental or physical condition. The very fact that I was to become a medical doctor, although unproven in any objective way to them, was reason enough for them to make judgements about my intelligence and integrity. All doctors, they supposed, possess a doctor's brain, and are always decent and intelligent men and women.

Let us suppose that in his haste to obtain another brain for Victor Frankenstein, Igor had taken a glass jar with a doctor's brain. Let us also suppose that this brain had been successfully implanted in the new creature who was then brought to life. If the laboratory jar had truly contained the brain of a mature, properly educated and experienced medical doctor, then we could make some assumptions about the then creature's behavior.

Our newly created Dr. Frankenstein would probably be quite intelligent and extremely compulsive and hard working. His mind would possess a great many facts, acquired through many years of medical education and practice, about anatomy, physiology and all the other sciences a physician is required to know.

Our doctor would behave in a fairly predictable way, and although he might wear a stethoscope around his neck or have one sticking out from his suit jacket pocket, most people would have no trouble identifying him as a physician. He would be clean shaven, properly groomed and dressed, and would converse in an intelligent manner about a variety of subjects, including medicine.

When faced with a crisis, in a medical situation or not, he could be relied upon to remain cool and make the proper decisions to restore calm and bring matters under control. He would be rather independent, but would join groups and attend meetings when he perceived a direct benefit to himself or his patients.

He would be an honest person, although he would exceed the speed limit whenever possible to do so and not get caught, and he would aggressively seek out ways to avoid paying his income tax. He would sometimes submit to pressure from patients who wanted to be hospitalized or receive injections or treatments which were not really necessary, although in general he maintained excellent control of his patients and office staff.

He would never knowingly supply a drug addict with controlled drugs or allow himself to become part of any illegal or immoral activity. He would always practice medicine in the most professional and competent way possible.

It is no mere coincidence if there is a similarity between the creature's behavior and our own. Our minds and souls have been molded from our first premedical college class when we were seventeen years old. Many of us were molded even before then by a combination of genetic and environmental factors when it was hoped that we would become medical doctors, and we were expected to behave appropriately.

In the premedical curricula at universities and colleges, we spent hours in labs and at libraries with colleagues who had similar interests, goals and intellects. In medical school, not only were we exposed to all the rigorous educational requirements needed to become a medical doctor, but we were also exposed to the personalities and attitudes of our teachers, residents, interns, and other students. We shared on-call duty with them; studied with them; observed them on rounds and at conferences; and we learned as much from those experiences about becoming doctors as we did from memorizing lists of bones and blood vessels.

Medical education is comprised of the myriad of facts necessary to diagnose and treat sick human beings, but it is also comprised of thousands of hours where the student learns how a doctor behaves in the presence of patients, colleagues, and society in general, under all possible situations and circumstances. The very lengthy period required for medical education, whether it is justifiable and necessary for the amount of factual material received and processed, is required to allow young people to become socialized into doctors — to develop doctor's brains.

I am very concerned about people who purport to be medical doctors or who want legal access to the delivery of health care, but who have not been exposed to an educational and social process needed to provide them with a doctor's brain. A few years ago, a physician was found to have used forged credentials to obtain a Florida license, and it was determined that she was not really a physician at all. This occurred only after she had been convicted of rampant insurance fraud and after she had hired an assassin to kill a former physician colleague. Only very rarely do real doctors commit such severe legal and ethical violations because real doctors' brains are generally incapable of such moral and legal transgressions.

I am also concerned about certain foreign medical graduates who have attended off-shore Caribbean medical schools which do not require any premedical education at all. The first and second year students at some of these schools are not exposed to the close supervision by faculty

and house staff that allows for proper socialization. Many students then spend their third and fourth medical school years in preceptorships with solo practitioners at community hospitals in South Florida and elsewhere. They are denied access to the large variety of faculty, interns, residents, other students, and clinical situations which are necessary to provide them with the attitudinal and behavioral mind of the doctor, as well as the purely factual mind.

I am also concerned about other categories of health care providers who fashion themselves as physicians, and who are demanding legislative access to patient care and the right to utilize hospitals. Nurse practitioners, psychologists, chiropractors, and a large number of other types of health workers may possess the factual skills to take care of patients in certain clinical situations, but they may not possess the other skills that are necessary for providing unrestricted and unsupervised medical care to human beings in both in-patient and out-patient settings.

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Foreign Medical Graduates: Credentials and Licensure — III The Missouri Plan

GARY R. CLARK

Soon after the 1983 annual meeting of the Federation of State Medical Boards, the Missouri State Board of Registration for the Healing Arts formed a subcommittee to study issues regarding foreign medical schools and the graduates of those schools. Following the initial deliberations of that special committee, Dr. George Ladyman, its first chairman, wrote to all of the member boards of the Federation. In his letter, Dr. Ladyman outlined the Missouri board's experiences with foreign medical graduates, as well as foreign medical schools. The purpose of his letter was to focus attention on the issues and to attempt to work out a unified approach toward the solution of the widespread concerns.

Thirty-one state boards responded to the Ladyman letter. There was an overwhelming expression of interest in having the various states cooperate in solving the problems that had been described. In most cases, the sentiment was that all states should attempt to work together to resolve the troublesome issues and to cooperate within the overall structure of the Federation of State Medical Boards.

On March 21, 1984, the Missouri Subcommittee on Foreign Medical Schools met in Chicago with the Federation Commission to Evaluate Foreign Medical Schools to present "The Missouri Plan" for consideration by the Commission. The "Plan" calls for incorporating the Commission as a

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Mr. Clark, Douglas N. Cerf, executive director of the Arizona Board of Medical Examiners, and Teresa D. Creef, J.D., general counsel of the Virginia Board of Medical Examiners, all addressed the topic, "Foreign Medical Graduates: Credentials and Licensure, during the April 1984 meeting of executive directors/secretaries, at the annual meeting of the Federation of State Medical Boards of the United States. Mr. Cerf's presentation was printed in the December 1984 number of the BULLETIN and Ms. Creef's in the January 1985 BULLETIN.

Mr. Clark is executive secretary of the Missouri State Board of Registration for the Healing Arts.

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separate legal entity within the structure of the Federation of State Medical Boards. An incorporated Commission could contract with state boards for the purpose of fact-finding in accord with the statutory powers of delegation provided to such boards.

Such a Commission should have its own staff, including separate legal counsel. The staff would

1. Work to prioritize the task of evaluating foreign schools by polling the states for medical schools from which they have graduates licensed, thus creating a master list of foreign medical schools;
2. Coordinate teams for future site visits;
3. Prepare contracts between the states and the Commission; and
4. Investigate funding sources.

Legal counsel could analyze statutory authority at the jurisdictional level in order to properly advise states of changes needed in their legislation for the purpose of delegation.

The Board of Directors of the corporation (the revitalized Commission) would develop standards upon which states could consider the data once collected and presented. This Board should differ in makeup from the Commission as now constituted, being composed of individuals from the Federation of State Medical Boards, other organizations, such as the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the American Osteopathic Association, the federal government and the public at large.

The Missouri board (1) requested that the Federation Commission to Evaluate Foreign Medical Schools recommend to the Federation Board of Directors that the Commission be reorganized and reactivated toward a concerted effort to evaluate foreign medical schools for the purpose of collecting and disseminating information about the quality of medical education provided — for purposes of medical licensure, (2) requested that immediate consideration be given this proposal, (3) requested that if the Commission's decision were favorable to this proposal that the Commission approach the Board of Directors immediately, and (4) offered assistance from the (Missouri) board to facilitate the proposed course of action.

All we were really asking was that the Commission be incorporated so that it could enter into contracts with state boards, much like the contracts that boards have for the preparation of the Federation Licensing Examination. That would address one of the issues raised in several lawsuits wherein plaintiffs have asserted that the Federation cannot act on behalf of state boards.

The medical practice act of Missouri allows the Missouri board to engage the services of special consultants. And I imagine that most states have similar provisions in their statutes. That could solve one problem.

If the Commission were incorporated, it could be adequately and properly funded and staffed to carry out its assigned tasks. The Commission has been active since 1980. But, as has been the case with most of the committees of the Federation, it has functioned to the degree that busy physicians, members of their respective state boards, could give their time — to do yet another task.

We must applaud the efforts of the Commission, insofar as the resources provided allowed it to go. We in Missouri believe that it is time to put some resources into the process and try to move forward. In sum, we are proposing that the Commission to Evaluate Foreign Medical Schools be reorganized and revitalized. For medical boards, state by state across the United States, have the responsibility of making certain that only competent physicians are admitted to the practice of medicine.

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During the late summer and early fall of 1984, the former Federation Commission to Evaluate Foreign Medical Schools was reorganized and reenergized under the chairmanship of Edward A. Wolfson, M.D. Renamed the Federation Commission on Foreign Medical Education, it was given the task of reporting on the educational facilities of foreign medical schools. To implement such a program, the Commission is establishing and will continually update reasonable criteria that could be used by teams of medical educators that may make on-site visits to review the data bases of foreign schools.

An increasing number of states have asked the Commission to act as a *factfinder* regarding the educational standards of foreign medical schools in a way that will assist state licensing boards and the medical schools to fulfill their respective objectives of efficient and competent licensure and medical education.

The revitalized Commission is to be praised for its forthright approach to the important challenge it has been asked to address. All member boards are urged to cooperate and delegate *fact-finding* to the Commission. — Ed.

BOOK REVIEW

Of Foxes and Hen Houses: Licensing and the Health Professions, by Stanley J. Gross. 204 pp. $35.00. Westport, Connecticut. London, England. Quorum Books. 1984.

In 1976 Milton Friedman, participating in a panel discussion at the Congress on Medical Education of the American Medical Association, threw a bombshell into the proceedings when he gave his opinion of licensing. The thrust of his argument was that all forms of licensure were bad and they were originally established by members of trades and professions ostensibly to protect the public but, actually, to protect their own interests. He did not exempt medical licensing from his attack. His answer? The marketplace can decide the matter of competence to practice medicine.

Friedman pointed to the monopoly exercised by the medical profession through licensing, from admission to medical school through authorization to practice the profession. The discussion stimulated by Friedman's presentation was indeed lively and ruffled the feathers of some of the participants. This reviewer conceded that many of Friedman's arguments were convincing but he thought that if medical licensure were immediately discontinued, the public would pay a hideous price while waiting for the marketplace to decide the quality of medical care.

Since 1976 several newspapers with wide circulation have launched vicious attacks upon the medical licensing boards of several states, criticizing them for laxness in discipline and their failure to protect the public against unscrupulous, incompetent physicians. In the December 17, 1984 issue of the *New York Times* an editorial appeared in which the writer claimed that medical self-regulation is a mockery, even though doctors' tolerance of failure damages public health and invites heavy malpractice awards. The writer asks how an alleged 10,000 impostors practice medicine without the public or the profession noticing anything amiss. In a cruel cut, the writer says, "Impostors, because they know their limitations, may be a lesser threat to health than qualified doctors who have slipped into incompetence."

The title of Gross's book, "Of Foxes and Hen Houses" is so arresting that it should arouse wide interest. He states his theme in the preface where he says, "The image of a fox guarding the hen house depicts the situation of professionals charged with regulating themselves to protect the public.

As a consequence of self-regulation they have been able to ignore the substantial amount of evidence that has rejected the assumption that self-regulation has safeguarded the public." He then enlarges upon Friedman's ideas in detail.

Early in the book Gross attacks credentials, saying that if they only informed they would merely pose problems of reliability and validity. But they go further in that they sort people into "valued and not-so-valued categories." He claims that grades do not predict either competence or success in a profession. He also says that licensing by the state, making practice without a license a criminal offense, abuses the public trust.

Gross contends that regulation has two basic characteristics. "First, it assumes vulnerability and helplessness on the part of the public. Second, it poses the problem of who guards the guardian?" Carrying the fox analogy further, he claims that this poses a conflict of interest because professionals have both special competence and their own interests. My answer to the question, who guards the guardian, is the courts. The author overlooks the provisions in all medical practice acts that the individual who is aggrieved by an action of a board can always appeal to the courts which, in many cases, overrule the guardian.

In answer to the question, "Why regulate?" Gross analyses the arguments in favor of licensing such as to protect the public against harm caused by incompetent and unethical practitioners. He concedes that the people have difficulty in protecting themselves. He continues, "The legitimate purposes of licensing are compelling. People indeed have difficulty in protecting themselves. Yet a system that appears to operate to benefit those who serve the public raises questions about whether it can accomplish what its proponents say it can, and if it cannot, about what kind of system, if any, could do so."

The author presents six basic arguments against licensing, some of which are outdated as far as medicine is concerned. For example, he says that licensing agencies may limit the number of entrants into any occupation. To bolster his argument he quotes so-called authorities whose studies were carried out as long ago as fourteen years. Because of a shortage of physicians in the 1960s the federal authorities encouraged medical schools to enlarge their classes and also advocated the creation of more medical schools. The result? There is now a nationwide excess of physicians. Moreover, the author quotes other authorities who blame licensing restrictions for the shortage of medical personnel in rural areas and among the urban poor. The licensing boards do not have the authority to tell physicians where they must practice.

The second count against li-

censing is that it creates a monopoly. This I cannot deny; nor can I deny the claims of economists that this tends to increase the cost of medical care. I can only partially agree with the author's claim that controlling entry is the manipulation of examination pass rates. This has not been true since the firm establishment of FLEX. I cannot deny the contention that the standards in some states are lowered to permit unqualified foreign medical graduates to practice in state hospitals.

The third argument against medical licensure which compares it with private clubs I cannot refute in view of the influence of organized medicine in the appointment of members to licensing boards. On the other hand, I question the fourth claim that licensing restrains innovation and increases the likelihood of malpractice suits.

To the fifth argument against licensure, that boards may be arbitrary in revoking licenses, I repeat, the protection offered by the courts can prevent such actions.

I have no quarrel with the sixth contention, that there is a lack of accountability in that the licensing system has failed to protect the public.

The chapter on the history of licensure is interesting, although the author neglects to mention that Texas passed the first modern medical practice act in 1873. Here Gross describes the successful efforts of the medical profession to eliminate midwives in the United States. He says that this has not improved the quality of obstetrical care and that in other countries the performance of midwives is usually equal to that of physicians and sometimes superior.

Gross expresses concern about the lack of assurance of continued competence of physicians. He seriously questions the value of the corrective action of mandatory continuing medical education. Obviously, he ignores the more than fifty recent articles showing that continuing education does improve patient care and, in many cases, the improvement continues for long periods.

In another chapter, "Licensing Boards and the Regulatory Process," the author discusses the ineffectiveness of public members on medical licensing boards. Governors see these appointments as additional political plums, selecting members without regard to their abilities. This is all too true in some states.

Gross, in brief mention of the Flexner Report, uses a twisted argument. He blames the report for the decline of medical school enrollments and their failure to keep pace with a growing population. In reality, the Flexner Report caused a decline in enrollments by eliminating many diploma mills.

The author goes to great lengths to define competence. He assails the traditional paper and pencil

tests of knowledge, saying that they tap only a very small part of the richness of human behavior. He continues, "Without a clear picture of the objective to be achieved it is not really possible to determine degree of competency of a physician's performance, since it is not known what it is the practitioner should be accomplishing." He makes the well known point that a person who can pass examinations is not necessarily competent to perform certain functions. Quite true. But he ignores the efforts of the National Board of Medical Examiners and other organizations to improve tests of competence.

In summarizing a section on competence, Gross says that licensing agencies do not function to save life and property and that assessment of initial competence relies on invalid criteria. He then states that discipline of errant physicians is confined mostly to prosecuting unlicensed physicians rather than those already licensed. He provides no documentation for this statement which I am sure is untrue.

Until the last chapter, the author bases most of his arguments against licensing upon quotations from other writers. Therefore, one is anxious to learn the opinions of the author and what, if any, procedures he recommends in place of licensure. His recommendations include the following.

First, he recommends the removal of the highly restrictive practice acts and substitution of less restrictive evaluation to give the public increased freedom of choice.

Second, he recommends regulation of procedures, not occupations. He suggests that all specialized competency evaluations should be open to anyone who has relevant training regardless of occupation.

Third, he recommends professional disclosure, pointing to the Supreme Court decision permitting advertising by professionals.

Fourth, he proposes voluntary certification. He admits the drawbacks to this are that it does not prevent uncertified persons from being hired and another weakness is the absence of standards regarding the quality of the credentials issued.

Fifth, he suggests performance-based evaluation of competence. The author says that professional associations will regain credibility to the extent that competency measures predict quality performance. Gross believes that there is a need for potential providers to demonstrate competence without regard to how it is acquired. Competence and education are not equivalent. Is it possible that he advocates a return to the long discredited apprenticeship system of medical education?

Gross foresees no changes in the licensing system in the near future when he says, "Though substantial change appears unlikely at this time — given the en-

trenched power of experts, the tenacity with which experts withhold knowledge, and the increasing complexity of that knowledge — there is reason to believe that the direction for change is through public awareness." His point is that there is a necessity for consumer self-protection by education.

While many of the author's criticisms of licensure are legitimate, his nearest approach to assurance of competence he expresses in general terms. He advocates "Increasing consumer knowledge so that more mutual relationships can develop is the first step in a strategy emphasizing self-protection by the public itself."

The author has appended an extensive bibliography, arranged according to the University of Chicago system; this provides easy reference for the reader. On the whole, the author's style is readable although he employs such barbarisms as "credentialling," "legitimating," and "operationalize."

Despite the use of some dated material, the author presents a thoughtful approach to the still unsolved problem of assessment of competence. The book should give pause to both licensing and certifying authorities even though they might disagree with some of his views.

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Bound Volumes
FEDERATION BULLETIN

Bound copies of Volume 71 (1984) of the FEDERATION BULLETIN will soon be available for purchase at the national office of the Federation of State Medical Boards. Bound copies of several earlier volumes also remain available. The cost of *current* and *earlier* bound volumes is $25.00 per copy.

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Communications

FEDERATION LOGO

To the Editor:

In 1962, when the officers of the Federation of State Medical Boards were planning a ceremony to recognize the 50th anniversary of the organization, they learned that there was no official emblem or unique seal for the Federation. Therefore, an official seal was created and adopted by the Federation at the 1962 annual business meeting.

Perhaps many of the present members of the Federation who were not there for the golden anniversary celebration would like to know what the various portions of the seal represent.

The cogs of the wheel represent the various states (there *are* fifty — I have counted them — Ed.)

The numerals MCMXII show the year the Federation was founded (1912).

The caduceus represents the medical nature of the organization

The colors:

The golden outer rim (with the cogs) indicates that the emblem was created on the golden anniversary of the Federation.

The red of the inner rim, the white of the field and the blue of the caduceus show that the Federation of State Medical Boards is truly *of the United States*.

E. C. Swanson, M.D.
220 North Main Street
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Dr. Swanson is a past president of the Federation of State Medical Boards, serving from the 1963 to the 1964 annual business meetings. — Ed.

FINGERPRINTING IS ESSENTIAL

To the Editor:

In the editorial, "Advice from a Caterpillar," October 1984 BULLETIN, signed by JHM (presumably, John H. Morton, M.D.), I take issue with Dr. Morton's statement that the use of photographs and fingerprints to assure proper identification is degrading. I have never heard of an applicant for licensure who objected to submitting photographs.

In regard to fingerprints, New Mexico was one of the first states to require them. Because I thought that some might object to this requirement, I personally interviewed fifty consecutive applicants, asking them if they resented it. Only two objected, one of whom was found to have a criminal record in another state, the other was a chronic complainer about the whole process. Most of the younger applicants said that they had been fingerprinted so often for various reasons that they were used to it.

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Editor's Note: Apparently the statement about fingerprinting in the editorial was ambiguous. My point was that it should not be necessary in a learned profession to take steps of this nature to prevent dishonesty. Obviously, these steps are essential as Dr. Derbyshire indicates. Fingerprinting is "degrading" as far as the profession is concerned; it is essential for identifying the individual examinee.

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OUT-OF-STATE ORTHOPEDIST NOT QUALIFIED TO TESTIFY IN MISS. MALPRACTICE SUIT*

The locality of neighborhood rule for expert witnesses in malpractice cases should be expanded to the whole state and a reasonable distance adjacent to state boundaries, the Mississippi Supreme Court ruled.

The patient, a 61-year-old logger, suffered a wound 16 inches long and 1½ inches deep when a chain saw blade was thrown againse the calf of his left leg. He was taken to a local hospital, where he was treated and admitted. The patient had a high fever and his leg was swollen, although the treating physician found no evidence of infection. A physician called in for consultation the next day agreed with his treatment.

Two days after the accident, the patient was transferred to a Veterans' Administration hospital. A physician there found an infection so extensive that amputation of the leg above the knee was necessary. The patient later required amputation of an additional four inches of his leg and a portion of his buttock. A pathologist examining tissue from the leg wound found marked swelling, various forms of bacteria, and microscopic particles of wood.

The patient brought a malpractice action against the physician who first treated him. At the trial, he called as an expert witness an orthopedic surgeon from another state. The surgeon testified that almost every procedure used by the physician was improper and constituted negligence. The physician and other local physicians testified that the procedures and techniques used were proper and in accordance with the skills and standards of the medical profession. The jury awarded the patient $400,000 in damages.

On appeal, the question was whether or not the locality or neighborhood rule should be applied in qualifying the patient's expert. The court said that Mississippi had followed the locality rule for many years, and that while it should not be abolished it should be extended and expanded. The standard of care should be that degree of skill and diligence practiced by a reasonably careful, skillful, diligent, and prudent practitioner in the state and for a reasonable distance adjacent to state boundaries. The court said that an expert witness who was familiar with the statewide standard of care should not have his testimony exluded because he did not practice in the state.

As to the patient's expert, he

* *The Citation*, Volume 47, Number 4, June 1, 1983. Prepared by the Office of the General Counsel of the American Medical Association.

had never practiced in the state or examined or treated a patient in the state except for examining the patient the night before the trial. He had never been in the hospital or consulted with any physicians in the county and had no knowledge of the manner in which patients had been treated there. The trial court had extended the locality rule to the similar locality rule and permitted him to testify, expressing doubt as to whether he qualified. The Supreme Court found that he did not qualify under the locality rule, the similar locality rule, or the new rule adopted by the court.

Reversing the lower court's decision, the court sent the case back for further proceedings. — *King v. Murphy,* 424 So.2d 547 (Miss. Sup.Ct., Nov. 17, 1982; rehearing denied, Jan. 14, 1983)

INDIANA PHYSICIAN CAN BE SUED IN ILLINOIS COURT*

An Indiana physician who regularly treated Illinois patients solicited by an Indiana hospital was doing business in Illinois for the purposes of jurisdiction in a malpractice action, a federal trial court in Illinois ruled.

A boy who attended an Illinois high school was admitted to the Indiana hospital after the palm of his hand was punctured by a pencil. The physician operated to remove a portion of the pencil from the boy's hand. After the operation, the boy's condition deteriorated, and he died two days after he was transferred to an Illinois hospital.

The boy's mother, an Illinois resident, sued the physician, the hospital, and the school in an Illinois court under the state wrongful death act. The physician and hospital petitioned for removal to the federal court. The hospital moved for transfer to an Indiana district, and the physician moved for dismissal for lack of jurisdiction or for transfer to an Indiana district.

The physician stated that he was an Indiana citizen, licensed to practice in Indiana, and that he treated the boy only in Indiana. He argued that there was no basis for jurisdiction over him in Illinois and that it was precluded by federal due process.

The mother contended that the Illinois Supreme Court had construed the Illinois long-arm statute to assert jurisdiction over nonresident parties whose conduct outside the state produced injury within the state. She also contended that there was jurisdiction over the physician on the theory that he was doing business in Illinois.

The mother alleged that the physician regularly treated Illinois patients directly and through referrals at the hospital, that he was compensated with Illinois public and private funds for treating residents, and that the hospital, as his referral agent, regularly and continuously solicited Illinois patients. She produced copies of hospital advertisements in the Yellow Pages of the Chicago telephone book. The physician admitted treating patients on the hospital's referral.

The court found that due process precluded jurisdiction over the physician solely on the basis of the long-arm statute. However, the court said that by regularly treating patients solicited by the hospital the physician might be considered to be doing business in Illinois. The hospital and physician argued that they and any Indiana witnesses would be inconvenienced by a trial in an Illinois court. The court pointed out that transfer to Indiana would inconvenience the mother and her witnesses, including those from the school and the hospital where the boy died. The court denied the motions for transfer. — *Lemke v. St. Margaret Hospital,* 552 F.Supp. 833 (D.C., Ill., Dec. 13, 1982)

MD'S LICENSE CAN BE REVOKED FOR CONVICTION OF DRUG LAW VIOLATION*

A jury verdict finding a physician guilty and the judgment of conviction entered thereon constituted a "conviction" under the Alabama Uniform Controlled Substances Act, the Alabama Supreme Court ruled.

After the physician was convicted, the Attorney General filed a complaint with the medical licensure commission, asking it to hold a hearing and enter an order suspending or revoking the physician's license. The physician filed a complaint seeking a declaratory judgment as to the definition of the term "conviction" and seeking a temporary injunction to prevent the Commission from proceeding on the Attorney General's complaint until a ruling was made on the declaratory judgment action.

The trial court granted the injunction but ruled against the physician as to the definition of the term "conviction," issuing an order defining "conviction of a felony," according to the Medical Licensure Commission Act, as a judgment of conviction entered by the trial court.

The physician appealed, contending that the word conviction, as used in the Controlled Substances Act, meant final conviction and that his license could not be suspended or revoked until his conviction could no longer be reversed or set aside on appeal. He was concerned that because the statute did not provide for automatic reinstatement upon reversal of his conviction, such reinstatement would lie within the discretion of the commission.

The supreme court pointed out

that the commission had stated that as a general rule whenever a judicial order was based on a previous order and the previous order was reversed or set aside, the subsequent order based on it would likewise be reversed or set aside. The court pointed to a previous case where the judge stated that reinstatement would be both automatic and retroactive on such reversal. Finding that this was in accordance with the intent of the legislature when it passed the Controlled Substances Act, the court affirmed the trial court's judgment. — *Evers v. Medical Licensure Commission of Alabama,* 421 So.2d 89 (Ala.Sup.Ct., July 23, 1982; as modified, Oct. 22, 1982)

HOSPITAL NOT LIABLE FOR FAILURE TO SUPERVISE MD*

A hospital was not liable for failing to supervise an attending physician in the diagnosis and treatment of a patient, the Mississippi Supreme Court ruled.

The patient was admitted to the hospital on March 4, 1974. He was nauseated, vomiting, and suffered from shortness of breath. The physician's treatment consisted of antibiotics, X-rays, and other drugs. He remained in the hospital for three days, when he was transferred to a second hospital at the insistence of his mother.

The second physician diagnosed his condition as a ruptured appendix requiring immediate surgery. The patient suffered a cardiac arrest while in surgery and died. In her complaint against the first hospital and the first physician, the patient's mother alleged that the physician was negligent in diagnosing and treating her son and that the hospital failed to properly select, train, and supervise the physician.

On appeal from an adverse decision by the trial court, the patient's mother argued that the hospital was liable for negligence in failing to supervise the physician's diagnosis and treatment. The Supreme Court observed that only an individual physician could practice medicine. There was no allegation that hospital employees were negligent in treating the patient, the court said. If the hospital had a duty to second guess a physician's diagnosis and treatment, it would be illegally practicing medicine, the court said. It would not impose that duty.

The trial court's decision was affirmed. — *Porter v. Pandey,* 423 So.2d 126 (Miss.Sup.Ct., Dec. 8, 1982)

* *The Citation*, Volume 47, Number 3, May 15, 1983. Prepared by the Office of the General Counsel of the American Medical Association. Copyright 1983, American Medical Association.

FEDERATION NEWS

BRINDLEY HONORED BY AMERICAN MEDICAL ASSOCIATION

G. Valter Brindley, M.D., a Temple, Texas surgeon and civic leader for many years, has been named to receive the *1985 Distinguished Service Award* of the American Medical Association (AMA).

Dr. Brindley was recently appointed interim executive director of the Texas State Board of Medical Examiners.*

In nominating Dr. Brindley for the award, which is the AMA's highest honor, AMA Board of Trustees Chairman John J. Coury, M.D., noted that "his distinguished career has been characterized by outstanding service to the medical profession and to the compassionate care of his patients. He is a nationally known and respected surgeon; he has served his profession through effective leadership at the local, state, and national levels."

LYONS STEPS DOWN AS CHAIRMAN OF PENNSYLVANIA BOARD

Richard C. Lyons, M.D., of Erie, recently stepped down as active chairman of the Pennsylvania State Board of Medical Education and Licensure. He will continue on the board as *chairman emeritus*.

* Federation Bulletin 71:349 (November) 1984.

Lyons, a urologist, has served as a member of the Pennsylvania board for thirteen years, eight as vice chairman and chairman.

The new chairman is Barbara K. Shore, Ph.D., a public, or lay member who had been vice chairman of the board. Dr. Shore is a professor in the School of Social Work at the University of Pittsburgh. She is the first woman, non-physician to serve as chairman on the Pennsylvania board.

Joseph Marconis, M.D., of Pottsville, is the new vice chairman of the board. Dr. Marconis, a urologist, is a former president of the Urological Association of Pennsylvania.

Dr. Lyons noted that he will continue to urge passage of pending legislation which would help resolve disciplinary problems with physicians in the state. He added that he had testified before the Pennsylvania Senate Professional Licensing Committee to urge passage of legislation giving the board authority for summary suspension of physician licensure. Lyons pointed out that state boards are frequently criticized for not moving fast enough with discipline, "getting a bad apple out of practice." He said that the pending legislation would allow the board to immediately suspend the licenses of such physicians — pending, of course, complete access to due process.

He also recommended the adoption of legislation that would make it a crime for hospitals not to report "impaired physicians" who should not be practicing because of a variety of problems, including aging, alcoholism or neglect.

RLC

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