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Medical education in this country goes back a long way, to a period before there was a United States; when this land was mostly unexplored and unsettled; and when its inhabited sections were colonies of the British crown.

Medical teaching in the colonial period was by apprenticeship. A young man would attach himself to a practicing physician who would teach his pupil all that he knew. Compared with today's physician, of course, in view of the advances in medicine through the intervening years, such a man's store of knowledge was pitifully small. Only that fact made the apprenticeship system work at all. When the physician thought his apprentice was ready to go out on his own, he would give him a certificate. That certificate was not only evidence of his competence, but was also the only license he needed to practice anywhere in the colonies.

Many men, fortunately, having completed their apprenticeships, were not satisfied that they knew everything they needed to know to be competent physicians. Those who had such a feeling of inadequacy would travel to Europe to complete and augment their medical studies. Two such early Colonial physicians—John Morgan and William Shippen—finished their studies in Edinburgh, Scotland. When they returned, they established the first school of medicine in this country in the College of Philadelphia in 1765. That school is still graduating physicians as the University of Pennsylvania School of Medicine.

The second medical school in the Colonies was at King's College in New York City. Its faculty was installed two years after the Philadelphia school opened its doors.

By the last decade of the 1700's, after the Colonies had become the United States of America, there were ten medical schools in the fledgling country. Those schools, however, were by no means the only source of medical degrees. There was a proliferation of diploma mills and so-called "lecture schools," from many of which medical degrees could simply be purchased by anyone who could meet the price. In the early 1800's fewer than one out of ten physicians practicing in the United States was the graduate of a medical school. More than eight out of ten had never attended a lecture in a school of medicine.

The first major step in bringing order out of medical educational chaos was taken in 1847 with the founding of the American Medical Association. It was established at a meeting in Philadelphia of physicians from 22 states, assembled at the call of Dr. Nathan Smith Davis of New York. If 22 states do not appear to constitute wide representation, it should be remembered that in 1847 the nation had only 29 states, James Polk, the 11th president, was in office... the first U. S. postage stamp had just been printed... and across the Atlantic in England, Charles Dickens was writing *David Copperfield*.

The year after it was founded, the American Medical Association established a Committee on Medical Education, whose designation was later changed to the Council on Medical Education. The Council suggested some rather startling innovations for the middle of the 19th Century. It advocated that before entering medical school, students should have at least some high school preparation. It recommended that medical schools have regular curricula divided into grades. It urged the separation of education and licensing. At
that time, the medical diploma—even one purchased from a privately owned diploma mill—was also a license to practice. In this connection, the Council requested that the AMA’s member state societies set up boards of examiners for medical graduates and that they petition state legislatures to establish legal examinations to be passed by a candidate before he would be allowed to practice medicine.

A few years later, Dr. Davis, who had founded the AMA, introduced the first graded curriculum at the Northwestern University Medical School. Another important step in bringing quality to medical education, was taken in 1890 when the Association of American Medical Colleges was formed among reputable schools.

The first true university orientation of medical education followed with the Johns Hopkins University Medical School. It required a full college education before entrance. And it had a four-year graded curriculum, with careful student selection, bedside study of patients and eventually, laboratory work by the students.

As the 19th Century drew to a close, profit-making private schools continued to flourish. But the reputable, competent medical schools were gaining prominence. Also gaining were state medical licensing laws. By 1900, because of persistent requests by the AMA and those reputable medical schools, 26 states required an examination for a medical license.

Early in this century the AAMC clamped down on its members. Each one was required to withdraw from the association if it did not demand at least a high school education as a prerequisite for enrollment in medical school.

The AAMC and the AMA’s Council on Medical Education still serve today as the focal point for information about medical schools and medical education, and jointly accredit medical college curricula.

Two years after the tightening of standards by the AAMC, the two groups working together, surveyed existing medical schools and classified them as “A”—acceptable . . . as “B”—doubtful . . . or as “C”—unacceptable. The list and classifications were published in the Journal of the American Medical Association for the world to see. The AMA subsequently went to the Carnegie Foundation for the Advancement of Teaching and requested a detailed study of the status of America’s medical education. The survey was requested from the foundation in order to do away with any charges that the AMA itself was prejudiced for or against any school.

The study was made under the direction of Abraham Flexner, biologist and staff member of the foundation. The results, published in 1910, are still known as the ”Flexner Report.” His findings mobilized both the medical profession and the public for an all-out assault on inferior medical schools. Of the schools then existing, one out of five closed within four years. And very shortly, the death knell of the other inferior schools rang loud and clear when state licensing boards agreed to accept for examination only the graduates of medical schools approved by the AMA’s Council on Medical Education.

Today, thanks in great part to continuing efforts of the AMA and the AAMC, the United States is the world center of medical education. Whereas American physicians once traveled to Europe for the best in education, foreign students and physicians by the thousands now come to this country to take advantage of our medical schools and of our postgraduate educational programs.

There are 88 medical schools in the United States, all but one of which are fully accredited. That one admitted its first students in the fall of 1964 and will be eligible for accreditation when its first class graduates in the spring of 1968. The schools are located in
40 states, the District of Columbia, and Puerto Rico. In the academic year 1965-1966, they graduated nearly 7,600 physicians.

Fifteen additional medical schools are now in various stages of development. A few have already accepted their first students, and the rest will begin accepting students in the years from 1967 to 1970. When their full enrollments are attained, the new schools will add more than 1,000 medical students, which means, within a very few years, 1,000 additional physician graduates every year. A further expansion of these figures is due in the near future.

The academic year ending in 1966 saw nearly 10,000 interns being trained in 772 hospitals around the country. There are some 5,000 approved residency programs in almost 1,300 hospitals, in which 32,000 men and women are taking their last formal educational step before entering practice.

The AMA has also recently established a mechanism for the accreditation of continuing education programs, through which practicing physicians may refresh their basic medical knowledge and remain abreast of modern scientific advances. It is estimated that there were about 175,000 physician registrations at formal continuing education courses in the United States during the 1965-66 academic year.

The AMA's interest in education is not limited to the preparation and continuing education of physicians. The Council on Medical Education also evaluates training and educational programs—some of which are in colleges and universities—relating to health professions and occupations that are important to medicine. The goal is to help provide a continuing supply of well-qualified people in these fields.

Beginning as early as the 1930's, the Council developed minimum training essentials for medical technologists, occupational therapists and physical therapists. These essentials form the base for evaluating and accrediting educational programs in those fields. Training essentials and approval procedures have been developed since that time for medical record librarians, x-ray technicians, medical record technicans, inhalation therapists and cytotechnologists. In each career area, the essentials are under continuing study by the Council and the collaborating professional group. At the present time, there are about 2,000 approved educational programs in the eight allied fields, with a current enrollment of more than 16,000 persons.

It is interesting to speculate as to where we would be right now, had there not been an AMA a century ago to take hold of medical education and guide it toward the standards of excellence that all of us take for granted today. Because of those high standards in medical education, developed through many years, the best doctors who have ever lived on earth are practicing today. The best medical care that has ever in history been available to people is available to them today. And because those standards will not just remain high, but will continue to be lifted, tomorrow's physician and tomorrow's medical care will be still better and more effective.

A number of particularly important steps are now in the planning or implementational stage which will help assure the continuation of improvement in both the quality of medical education and in the quantity of students for whom it is available. I would like to discuss four of these.

First, the expansion of existing schools, which is a companion move to the establishment of the 15 new medical schools which I mentioned earlier. Virtually all existing medical schools are increasing their enrollment or making concrete plans for an increase in the near future. One important impetus for expansion is federal legislation, notably the Health Professions Educational Assistance Act of 1963 and the amend-
ments made to it in 1965. These laws provide financial support for medical schools to expand, replace or improve existing physical facilities. Under the regulations of the laws, a school can qualify for a two-to-one federal matching ratio if it agrees to increase the size of its incoming class by either 20 students or 20 per cent of the largest freshman class in the five previous years, whichever is greater. The increase must come within three years after completion of construction and the larger class size must be maintained for at least 10 years. There are, of course, other provisions of the laws, but those are the most significant for our discussion today.

With the plans now under way, it is expected that by 1972 there will be an increase in medical school enrollments of 1,900 students. This is in existing schools, and is in addition to the expansion of enrollment which will be made possible by the opening of new schools. This expansion could of course, be inhibited seriously if matching federal construction funds become less available because of an escalating war, or for other budgetary reasons.

Such an increase in enrollment, unfortunately, does not necessarily mean a corresponding increase in physician graduates because of student attrition which has ranged between 5 per cent and 13 per cent since 1949. However, there is reason to believe the attrition rate will decline since, historically, medical student attrition has been inversely proportional to the size of the pool of applicants for medical school enrollment. With the applicant pool increasing in size and the ratio of applicant-to-acceptance rising, the attrition rate may reasonably be expected to drop. All of these factors seem to forecast a total United States graduating class of 8,000 M.D. physicians by 1970 and 10,000 by 1975.

A second significant movement in medical education is the apparent swing toward more flexibility in medical school curricula. Previous to this time, all medical students have taken virtually the same courses in a given school, without regard to difference in pre-medical background or ultimate objective of private practice, academic research or other ambition. For students in their junior and senior years, there has been a noticeable trend toward allowing more elective courses. This trend is expected to expand to the freshmen and sophomore students, depending upon the quality of the educational background they bring to medical school and upon their ability to comprehend and apply what they have learned. A facet of the possible curriculum change is seen as the establishment of multiple-track curricula, allowing faster movement for some students and permitting various students to aim their educational effort in different directions; for example, toward private practice or toward research.

One hope of all of us who are concerned with the number and quality of physician graduates is the possible tendency toward interdigitation of medical school and pre-medical education in order to shorten the total educational span and to produce physicians in somewhat less time, without any sacrifice of quality; in fact, with an increase in the quality of education granted. Such a program might also one day apply to the graduate end of medical education in the implementation of recommendations of the Millis Commission that “the internship, as a separate and distinct portion of medical education, be abandoned; and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole.”

Mention of educational recommendations brings up the third significant movement I wish to mention: namely, national studies which have been made and are being made with respect to medical education.
There are four that are of most importance. First, the Citizens Commission on Graduate Medical Education, established in 1963 by the American Medical Association's Board of Trustees and known generally as the Millis Commission after its chairman, John S. Millis, Ph.D., president of Western Reserve University. Second, the Ad Hoc Committee on Education for Family Practice appointed in 1964 by the AMA Council on Medical Education. Third, the National Commission on Community Health Services, established in 1962 by the National Health Council and the American Public Health Association. Fourth and final, "Planning for Medical Progress through Education," the report of a group commissioned in 1964 by the Association of American Medical Colleges, and headed by Lowell T. Coggeshall, M.D., vice president of the University of Chicago.

A great many important and far-reaching proposals and conclusions came from these six study sources, regarding over-all medical education, curriculum flexibility, postgraduate training and all of the other facets. Most significant, perhaps, is that three of them—the Millis Commission, the Ad Hoc Committee and the National Commission on Community Health—urged the increased development of the general, family physician.

Although their proposed titles for this man varied from primary physician to family physician to personal physician, his objectives were the same in all three reports: to be a specialist—to be trained, certified and recognized by his fellows as a specialist—in family medical care. Whatever his title, it is to this man that the patient would first come, as his family doctor. And it is he who, whenever desirable or necessary, would then summon any consulting specialist needed. Some medical schools are already looking toward the implementation of this idea.

Fourth, and last of the major steps I want to cover is the medical schools' apparently increasing awareness of their public and community responsibilities. Heretofore, their primary and, we can almost say their exclusive, interest has been focused on the internal problems of educating physicians. Now, however, they are wisely beginning to turn their vision outward, to see the health care needs of their community and of their nation.

Again, important impetus has come through federal legislation, notably the regional medical programs arising from the Heart Disease, Cancer and Stroke legislation which is realistically involving medical schools in the problems of regional medical needs and is bringing medical schools into conferences on this subject with the leaders both of the community and of the government.

I have not called these significant movements to the attention of this distinguished federation merely as a matter of information. There is much you can do and, in fact, much you must do in order to help these trends continue and to make them effective for improved medical care.

There is going to be more of a need for flexibility in state boards of licensure to meet the needs for new kinds of physicians practicing a new kind of medical care. The present implementation of medical practice acts in many states may make it difficult to carry out experimentation in the field of medical education, either undergraduate or graduate.

For example, there are states where, because of failure to meet certain rigid and specific requirements, a license to practice could not be granted to a physician who had graduated from a multiple-track school . . . from a school where a real interdigitation of medical and pre-medical education has taken place . . . from a medical education in which the total span had been fewer years than tradition has demanded . . . or
where the physician, ready to enter practice, has not had the year of internship.

Where such laws exist, and are inflexible, there will soon be a vital need for modification ... modification that can ultimately be brought about most effectively under the leadership of state boards of licensure, in cooperation with medical schools, associations of organized medicine and all other elements of medical science and medical education in their combined desire to provide the best possible care for the people of our nation under constantly changing conditions.

SUGGESTIONS FOR THE FUTURE

GEORGE H. LACE, M.D.

I spent considerable time and effort on research and preparation of a speech for this, my final appearance as President of the Federation, but I'm not going to give it. I've been told that the best way for a retiring President to bow out is to avoid saying anything controversial but I believe the work of this organization is too important to allow me to take the easy way out.

Instead of just listening to me, I want you to think with me. Ask yourself the very questions I propound and answer these questions as you believe they should be answered. I want you to question the statements that I make. I want you to be as analytical here today as you would be of a patient who appeared before you with a serious illness. By this, I do not mean the Federation is ill; in fact, I believe that it is very healthy. But, I do believe that it is time for each and every member to examine the Federation closely and to define clearly objectives toward which we all are striving. Then we will be in a position to merit the full cooperation of each and every member board so that these objectives can be attained as swiftly as possible.

It is said the past is prologued. Therefore, we should analyze the past and our progress to date. Turning first to the development of the organization we have to recognize that the Honorable Walter Bierring, who founded the Federation, attained an eminent status in the field of medical education and was able to develop the standing of the Federation to a point where it was recognized by the universities and the educators throughout the United States. This led to the develop-

* Presidential Address.

Presented at the Annual Meeting of the Federation of State Medical Boards of the United States, Chicago, February 12, 1967.
ment of reciprocity between the states. The efforts of Dr. Crabb, Dr. Jervey and the late Dr. Bierring, and others within the Federation improved the acceptance of reciprocity and efforts are being made to continue the improvement.

Let us now talk about the problems of licensing doctors. The National Board of Medical Examiners is recognized by many states and its examinations are accepted by many as a means of licensing; but is this enough? I don't think so!

The Federation established the Examination Institute in 1958 and has spent numerous hours in the attempt to develop a bank of questions which would be available to the various state boards for their use. The primary intent of this procedure was to standardize the level of the examinations to be given by the state boards and thus enable a doctor to be recognized on the same basis in any state.

There have been many other qualifying examinations developed over a period of years, such as those for the requirements of the Educational Council for Foreign Medical Graduates and the Basic Sciences. The progress of the ECFMG, in order to determine the qualifications of doctors who are graduates of foreign schools, has been comparatively swift and at the present time these examinations are good practical tools to determine the minimum qualifications of individuals preliminary to their taking the state examinations for licensure.

A preliminary examination which is used by 24 states as a means of determining the qualifications of individuals for licensure, is a basic science examination. While in most states this is conducted by boards, separate and distinct from the boards of medical examiners, there are a few states which have combined the function of the two. The Basic Science Examining Boards have performed a much needed function in determining the qualifications of M.D.'s and other individuals applying for licensure to practice medicine and surgery, and these boards have performed a good service in this field. While performing this service, however, they have imposed a difficult burden upon many fully qualified doctors when they seek licensure and this problem is being studied by many of the examining boards to determine whether or not this obstacle can be removed.

Now let's discuss the field of disciplinary action, the second function of the Medical Boards. There is an analysis by the American Medical Association's Committee on Medical Discipline which points out the fact there is much need for improvement within this field. The American Medical Association has, over a period of years, compiled information on individuals who have encountered disciplinary problems and through its Department of Investigation has assisted the various boards by passing on this information. Several years ago, as an outgrowth of discussion among the various member boards at meetings here, it was determined that a central clearing house within our own organization was needed, an arrangement wherein the possibility of individual board members being sued for disseminating information to people outside their own board would be avoided. There was established a central office wherein information was to be assembled concerning each and every doctor who had any disciplinary action taken against him, and the various boards were requested to forward information to this office. Dr. Crabb has been the Secretary in charge of this office and in the short time it has been in existence it has been able to coordinate information received from the various boards and to furnish this information to the inquiring boards and thus establish a desired service. This service is most valuable. Have you availed yourself of it?

The third function of the boards is to prevent the practice of medicine by lay persons or by persons be-
yond the scope of their licenses. This has been a problem of communication primarily between the various boards, the individual state medical societies, the county societies, and state agencies. A number of the law enforcement agencies throughout the country are not conversant with the function played by the medical boards. The boards, in turn, are perhaps frequently loathe to make inquiries of law enforcement agencies concerning activities of their licentiates either in their own or in other states. Is this problem caused by an erroneous idea that a doctor is not subject to the laws of the state or fear of the board becoming involved with the law enforcement agencies? Or, is it a reluctance on the part of the boards to direct inquiries to law enforcement agencies because they haven’t learned to communicate with them? The Oregon Board, for a number of years, has followed the practice of directing letters of inquiry to the police departments, sheriffs’ offices, or other agencies of the area involved concerning any applicant for licensure. If other boards have not been doing this they should be!

I am sorry to report this but, as a result of these inquiries, we have discovered applicants who have been guilty of attempted suicide, those who have been found comatose from taking barbiturates, some who have been arrested upon several occasions for driving under the influence of liquor or being drunk on the street. In one case we discovered a doctor who was arrested and charged with assault with a deadly weapon—he plunged a knife in the abdomen of a rival suitor. In this field the AMA Department of Investigation has developed information concerning lay individuals who have attempted to practice medicine or promote quackery in the various fields. In recent years, the Narcotics Bureau and the Pure Food and Drug Administration have been conducting investigations into activities of individuals associated with the medical field. These agencies have proved to be of invaluable assistance to us and we have helped them to implement their programs. They will be more valuable in the future.

Let us pause to reflect a minute. I have attempted to point out where we are at the present time. We have started out crawling, we perhaps are walking at the present time, and it is high time to start running. But will we be running blindly or shall we actually know our objectives and purposes and run, like Roger Bannister, to the finish line?

In 1864 the fastest time ever established for running the mile was four minutes 59.3 seconds—and it was assumed that this record would probably not ever be beaten. Then in 1945—79 years later—the mile was run in four minutes 1.3 seconds, but it was still assumed that no one could ever run the mile in four minutes or less. It was not until 1954 that Roger Bannister ran the mile in four minutes—and that was 90 years since the four minutes 59.3 seconds record! Now here is what I want to illustrate—because everyone assumed it couldn’t be done, it was not done for 90 years. Yet, since Roger Bannister ran it in four minutes his record was broken 20 times in the next ten years! So, who is to say that what I propose can’t be done? What I will propose today may seem impossible to the weak-hearted just because it hasn’t been done before.

In my talk to you this afternoon I have been building up to a proposal which requires action now! Here it is:

I recommend that the Federation establish in the central office a certification board whose responsibility would be to maintain a central file of information on every person who has applied or is applying for medical licensure.

Why do I recommend this? Because it would relieve the various state boards of much of the cost in
time and money required to make an adequate investigation of the applicant for licensure. It would also relieve the applicant of much of the present cost of obtaining his license to practice, and it would lend some real uniformity for licensure throughout the country.

Obviously, the investigation of the Central Board would have to be sufficiently thorough to assure each state board that the information furnished is reliable and that the report is fair and unbiased.

How could this be done? By requiring each applicant for licensure to file the necessary material and certifications with the Central Board for use by the state board to which he is applying and for use of other state boards to which he might be applying in the future. This Central Certification Board could use a standard form, designed and approved by the state boards, containing all the information considered necessary by them. For example, the certification could state:

Applicant ............................................
Address ............................................

The credentials of the above named applicant have been examined and the board finds as follows:
1. Graduated from ............. Medical School at .......... (medical school) (place)
on .......... (date)
2. Completed ...... years of internship at .......... as of .......... (date)
3. Completed ...... years of residency in .......... as of .......... (date)
4. Consultation with the professors at the Medical School, Hospital Chiefs of staff, Departments of Residencies and other authorities including Medical Societies, Narcotic Bureaus, law enforcement agencies, etc., as indicated, disclose the following:
   (a) Addiction to narcotics ...... (No) (Yes)
   (b) Misuse of amphetamines, barbiturates, or other drugs ...... (No) (Yes)
   (c) Habitual and/or excessive use of alcohol ...... (No) (Yes)
   (d) Any noteworthy infractions of the law ...... (No) (Yes)
   (e) General moral character appears to be: (Satisfactory) (Unsatisfactory)

What would be the result of this? When a local doctor applies to any state board for licensure, that board could obtain the necessary information to make an intelligent determination much quicker and with less effort and less cost than at present—especially if the applicant is from another state.

Please understand. This control board would be purely a reporting agency—it would make no determination or even any recommendation. The function of deciding whether or not the candidate is acceptable would remain with the state boards, as it now is and this as it should be.

Gentlemen, you may consider this proposal as a rather radical departure from the present approach to licensure, and, frankly, I hope you do! I also hope you will see the merit in this approach and that your incoming President will see fit to set up a committee to study the proposal, and, hopefully, to arrange for its implementation.

I wish Dr. McMahon the best of luck and I assure him that I will be available to aid him in any manner that I can. I thank all of you for your help during the past year and particularly my thanks to the members of the Executive Committee for the many hours they have spent in helping me to accomplish the work that we have done during my term of office. I am grateful to the members of the Federation for their help and suggestions. Let's hope those suggestions and the proposal I have made will be implemented in the near future.
EDITORIALS

On “Grandfather Clauses” and Standards

The champions of basic science laws use as one of their most telling arguments the point that they have raised standards for licensure. This they claim despite the numerous “grandfather clauses” in the laws, the apparent inability of the states to agree upon what subjects constitute the basic sciences, and the famous incongruity in one law which exempts candidates from taking basic science examinations if they had service in World War II or if they were in school in 1939.

To the above we have an interesting incident to add. Our attention was recently directed to a candidate for licensure whose acceptance for endorsement was contingent upon his passing the basic science examination. But alas, our poor candidate, having foolishly burned his bridges behind him by selling his home and office in his original state, failed the Basic Science examination. Fortunately he was saved from total ruin by obtaining a job in a state hospital, a regular license not being required for such work.

But there may yet be a happy ending to our tale as, undaunted by his original reverses, our candidate, after waiting two years, found that he was eligible for a basic science certificate by waiver because of a “grandfather clause” in the law. Despite his previous failure in the examination, he was granted a certificate by waiver, thus forcibly calling attention to another absurdity of the basic science laws. If he was considered unfit to obtain a license to practice after he had failed the examinations, by what stretch of the imagination could the passage of two years render him fit? One might assume that he had obtained additional training in the basic sciences but this is doubtful.

The moral to our story is obvious. Either proof of proficiency in the basic sciences is necessary to practice medicine or it is not. The mere passage of time does not make a candidate proficient nor diminish the importance of the basic sciences to clinical competence. So let’s talk less about elevation of standards and recognize the situation as it is—political expediency.

Fame Is Fleeting

Our distinguished dinner companion at the recent Federation banquet pointed out that, although the principal event of the evening was the Walter L. Bierring Lecture, no direct reference was made to the great man who was being memorialized. No doubt this was due to the assumption of both the president of the Federation and the Bierring lecturer that the name was so well known that it was unnecessary to identify Dr. Bierring to the audience.

Although Dr. Bierring’s name still lives with most of the older members of the Federation, we were disconcerted when we heard a new member refer to him as “a man named Bierring, whoever he was.” Therefore with no thought of rebuke to anyone, we shall identify Walter L. Bierring to the new members of the Federation and pay brief tribute to him as is our wont periodically.

In praising a man of such varied talents as Dr. Bierring it is difficult to know where to begin. For our present purpose it is perhaps best to identify him with the Federation first. Dr. Bierring was the founder of the Federation and its guiding spirit for many years. The first editor of the BULLETIN was Otto V. Huffman, M.D., of Albany, New York, who served from April to August 1915 when Dr. Bierring assumed the position and held it continuously until February 1960. Born in 1868 and dying in 1961 with mind still active at the age of 93, he lived through one of the
most exciting periods of medicine and savored every moment of it. Trained by Koch, Billroth, Pasteur, Metchnikoff and Roux, he had several successful careers, having taught pathology and bacteriology for 11 years, engaged in the practice of internal medicine for two decades, finally establishing a third career as director of the Iowa State Department of Health. During all of these years he worked constantly to raise the standards of medical education and practice, was one of the founders of the National Board of Medical Examiners, and for long was secretary of Alpha Omega Alpha and editor of The Pharos. He was president of the American Medical Association in 1934-35.

The Bierring Lectureship was established several years before his death and many of us remember the modesty with which Dr. Bierring received the many well deserved tributes from several different lecturers.

Despite his many accomplishments fame seems to be fleeting for Dr. Bierring. This situation must not be allowed to exist and the Federation will continue to revere him; his place in history must be emphasized to succeeding generations of Federation members.

Another Service of the AMA

We recently received a valuable volume from the AMA, entitled Disciplinary Digest. Published by the Law Division, it is a compilation of court decisions pertaining to disciplinary actions of state boards of medical examiners.

The arrangement of Disciplinary Digest is orderly; it is divided into three parts, beginning with constitutional considerations, passing to types of offenses and finally to procedural matters. The last section includes practical considerations concerning the hearing, judicial review and evidence. All points throughout the book are profusely illustrated by adequately documented examples. Although many of the cases presented will be familiar to those who have been constant readers of The Citation and the Federation Bulletin, this is the first time that the variety of problems of discipline have been brought together in a single volume.

According to Edwin Holman of the Department of Medical Ethics of the AMA, additional copies of Disciplinary Digest will soon be sent to all board members and also we hope to legal counsellors to the boards. This book should be perused by all people concerned with medical discipline. We wish that it could be also sent to officers of state medical societies. Some of these are all too ready to criticize boards of medical examiners for not revoking the licenses of doctors whom they assume to be guilty of wrong doing; they disregard the fact that adequate proof often cannot be obtained. Even superficial inspection of this excellent volume would impress them with the legal complexities with which boards are all too frequently confronted.

We congratulate the Law Division of the AMA not only for a workmanlike job in preparing Disciplinary Digest but also on the service which it has performed for the state boards. This should prove to be an authoritative reference work for a long time to come and we look forward to the appearance of revised editions when indicated. This tangible evidence of interest of the AMA in our problems is indeed welcome.
PRESIDENT'S PAGE

The 63rd Annual Congress on Medical Education and Licensure was, as usual, a very interesting and informative meeting. Everyone was well rewarded for his efforts in attending, even in the face of the Chicago snowstorm of '67. In fact, the programs of the Council on Medical Education and those of the Federation were so good that there was a "conflict of interest" as to attendance at one of the sessions. This problem is now being resolved—not by down-grading the programs but merely by re-arranging the schedules.

From the standpoint of the Federation the attendance was only fair, 40 member boards out of a possible 52 were represented, and only 114 members out of a membership of 402 were there. This 28 per cent attendance is nothing short of pathetic. The Congress on Medical Education is undoubtedly one of the finest orientation and indoctrination meetings that a board member can attend—here we rub shoulders with the finest in medical education; here we hear of new medical schools and the expansion of existing schools, new teaching techniques, new and improved curricula, experimentation to improve both the quality and quantity of American doctors, and above all, here we meet our fellow board members with whom we can discuss, hot and cold, our many problems and find out how the other boards think and act. This is of mutual help to everyone concerned.

The bad weather may have had something to do with the poor attendance but my contacts indicated that it was a lack of board funds. This is understandable as some of the boards still have an annual renewal fee of $2.00. No one has an inherent right to practice medicine, it is a privilege bestowed upon an individual by the state, and certainly, a renewal fee of at least $10.00 is little enough to pay for this privilege. Every board should have an appropriation in its budget large enough to send its entire membership to the Congress on Medical Education and Licensure. Come to Chicago next February!

Rhett McMahon, M.D.
COURT DECISIONS

Osteopathic Society's Suit for Deletion of "M.D." From Licenses of Osteopathic College Graduates States Cause of Action—A motion by the Commissioner of Education to dismiss a suit against him by the state osteopathic society for an order requiring him to delete "M.D." from the licenses of osteopaths who have received that degree from the California College of Medicine, on the ground that no cause of action was stated, was denied by a New York trial court.

It was alleged that the osteopaths on whose licenses "M.D." was added had never attended the California College of Medicine or taken any courses leading to a medical degree, and that the only medical education they had received was in an accredited school of osteopathy leading to a degree of doctor of osteopathy. It was alleged that the Commissioner, by adding the "M.D." so obtained to the "D.O." already on the osteopaths' licenses, misled the public as to the osteopaths' professional training, and thereby exceeded his statutory authority and acted contrary to the public policy of the state.

It is the public policy of the state, as expressed through legislation, to maintain a distinction between osteopaths and medical doctors who employ different concepts of the art of healing in their practice. Although the California College of Medicine has the right to issue any degree authorized by that state, an "M.D." degree, obtained as those involved here were, would not qualify an applicant to be licensed in New York, nor would a license obtained in any other state on the basis of such a degree be recognized.

The osteopathic society had the necessary standing to bring this suit. It alleged that it was a duly organized membership corporation, made up of a majority of those holding osteopathic licenses and trained in osteopathy, and that it had a vital interest in all matters affecting the osteopathic profession and the public.

The suit was not barred by the statute of limitations. It was brought within the required time after the Commissioner's refusal of the society's demand that "M.D." be stricken from the licenses. Further, the suit was not directed only to licenses already issued, but also to license renewals and licenses to be issued in the future.

BOOK REVIEW


For a man who was so frequently wrong and whose theories on the causes and treatment of disease bordered on cultism, Benjamin Rush occupies an unusually prominent place in American history. His position is truly important as witnessed by the many articles which have been written about him, in addition to his autobiography and his other extensive works. Obviously he must have possessed other attributes which secure his place in history, not the least of which was his part in the American Revolution both as physician and statesman.

Despite the wealth of available material about the life and times of Benjamin Rush, Dr. Binger’s book is the first definitive full scale biography which has appeared. He proves that his subject is worthy of such treatment.

In his introduction, Binger says that he started out to tell the story of Rush chronologically but soon found this impossible because of the overlapping of his interests and activities. Therefore he proceeded topically, a happy choice in view of the final result.

Born in Byberry, Pennsylvania, in 1746, Rush was educated at the West Nottingham Academy in New Jersey and at the College of New Jersey later known as Princeton University. After briefly considering the study of law only to discard it, he was apprenticed for five years to Dr. John Redman, one of the famous teachers of Philadelphia. Not satisfied with this training, he then went to Edinburgh where he received his degree in medicine. After the customary grand tour he returned to Philadelphia to begin the practice of medicine. By now he was 23 years of age and the author states that he was “serious, diligent, cultivated and humorless.” Unfortunately the last characteristic remained with him throughout the remainder of his career.

Rush served a term in the Continental Congress and part of his fame in history is due to the fact that he was one of the signers of the Declaration of Independence. He also was an Army doctor but because he unhappily revealed the appalling lack of sanitation and the filthy conditions of the hospitals he soon clashed with the great Dr. Shippen who bested him politically. Whether or not Rush joined the conspiracy of Conway against General George Washington the author does not say. Following a period of medical exile in Princeton, he returned to Philadelphia after the city had been evacuated by the British. He was given the post of Professor of Chemistry at the newly formed medical school which later became the Medical School of the University of Pennsylvania. He soon developed an active if unremunerative practice mainly among the poor and plunged into many civic activities. Due to his uncompromising ideas of right and wrong he soon antagonized many of his colleagues and fellow citizens.

Rush had one theory as to the cause of diseases including those of the mind and body. He thought that “underlying all disease was a predisposing debility—operating on this debility was a stimulus or exciting cause and these together produced excessive action or convulsive excitement in the walls of the blood vessels.” The treatment? Preventing or reducing the exciting cause and lowering the resulting tension which would be accomplished by violent purgation and liberal blood letting.

An excellent account of the horrible epidemics of yellow fever in Philadelphia is given. Throughout these Rush, despite his misguided theories and violent treatment of his poor patients, proved himself a truly dedicated physician who sacrificed his own health for
his patients. Although there were many who disagreed with his therapeutic methods, he had a large number of devoted students who carried his word to the remotest reaches of the 13 states. In spite of his dogmatism he was a shrewd observer and came close to discovering that yellow fever was transmitted by mosquitoes.

Only in the last part of the book does Binger describe Rush's work in psychiatry on which most of his fame rests. This shows remarkable restraint in view of the fact that the author is a psychiatrist himself. Rush's views on the treatment of the mentally ill were far ahead of his time. He did much to correct the frightful abuses to which the miserable "lunatics" were exposed. In the humane care of these poor people he ranked as a pioneer along with Pinel of France.

Carl Binger has created a vivid picture of Benjamin Rush and his times. This biography is written with such skill as to make it an absorbing book which easily transports the reader back to Philadelphia of the 18th Century. Another advantage is the lack of many distracting footnotes which clutter up so many biographies. For the interested reader the bibliography and references are all in the back of the book.

This work should secure Carl Binger's place in the front ranks of medical biographers.—R.C.D.

FEDERATION NEWS

General

Canada. The College of Physicians and Surgeons of the Province of Quebec recently discovered that Indian physicians holding diplomas in ayurvedic medicine were serving as interns or residents in Quebec hospitals. They were also persons who, completed a medical course shorter than the regular one at which candidates obtained a diploma of "Licencié." Aware of the fact that the General Medical Council and the ECFMG do not recognize diplomas granted by schools in ayurvedic medicine and the degrees of "Licencié" granted by a few Indian medical schools, the residency permits granted to Indian graduates who hold non-approved diplomas have been cancelled. Therefore the following are not allowed to serve as interns or residents or fellows in the hospitals of the Province of Quebec: Shashikumar K. Khedkar, Ajit Singh Jamnadas Morpia, Hasu Parikh, Bhanulal M. Nanavaty, Shirish Parikh, Violet Sunder Dass, Ramchandra Devendra Marje. If more information is required Dr. Augustin Roy, Registrar, College of Physicians and Surgeons of Quebec, will be glad to furnish it.

Board Actions, Arrests, Convictions, Fines, Revocations, etc.

California. On February 2, 1967 the license of Russell Theodore Brown, M.D., Vacaville, was revoked because he was convicted of a crime involving moral turpitude.

On February 2, 1967 the license of Howard D. Eaton, M.D., Los Angeles, was revoked because he was found guilty of unprofessional conduct in that he issued false and fictitious prescriptions for narcotics.

On February 4, 1967 the license of Gerald Dale Hensel, M.D., Los Angeles, was placed on probation
for five years because of unprofessional conduct in that he was convicted of offenses involving moral turpitude.

On February 9, 1967 the accusations against George S. Hopkins, M.D., Bell, were dismissed.

On February 2, 1967 the probationary license granted to Roger M. Mitts, M.D., Corona, was terminated and his license revoked because he violated terms of his probationary order of March 25, 1966 in that he passed forged prescriptions for narcotics for self-use.

Florida. On January 14, 1967 the license of Lucian Le Bron Alexander, M.D., Naples, was reinstated and his permission to reapply for a special narcotic tax stamp was granted because of the end of his suspension.

On January 14, 1967 the license of Lester Haynes Blackburn, M.D., Sarasota, was reinstated without narcotics privileges.

On January 14, 1967 the license of Kent Palmer Bradley, M.D., was reinstated without narcotics privileges.

On October 29, 1966 the license of John Bayard Britton, M.D., Fernandina Beach, which had been previously suspended for two years was placed on probation because of unprofessional conduct.

On November 3, 1966 the license of Louis Robert Guerrieri, M.D., which had been suspended for two years was placed on a probationary basis without narcotics privileges.

On January 14, 1967 William Alexander Morris, III, M.D., Ft. Lauderdale, was reprimanded for unprofessional conduct.

On November 3, 1966 the license of Alvin John Tight, M.D., Ft. Lauderdale, was placed on probation due to violation of narcotics laws and unprofessional conduct.

Kansas. On January 14, 1967 the license of John A. Billingsley, Jr., M.D., Chanute, was reinstated without narcotics privileges.

On January 14, 1967 the license of Floyd Earl Muck, M.D., Kansas City, was reinstated.

Louisiana. On February 6, 1967 the license of Kerne Maurice Coreil, M.D., was suspended because of mental illness and drug addiction.

Massachusetts. On December 15, 1966 the license of Daniel L. Berni, M.D., was restored.

On January 19, 1967 the license of Joseph Kreplick, M.D., was restored.

Michigan. On January 26, 1967 the temporary license of Wolfgang A. J. Bose, M.D., Boyne City, was revoked because of unprofessional and dishonest conduct; he was convicted of the offense of conspiracy to commit abortion and sentenced to five years with probation and $1,200 costs.

On January 26, 1967 Amleto Gliosci, M.D., Detroit, was reprimanded because he was found guilty of violating residency license restrictions by practicing in an unapproved hospital.

On January 26, 1967 the license of William L. Harrison, M.D., Detroit, was revoked because he was found guilty of unprofessional and dishonest conduct when he was convicted of the criminal offense of conspiracy to commit criminal abortion and sentenced to two and a half to five years in the State Prison.

On January 26, 1967 Rudy G. Hilado, M.D., Detroit was reprimanded because he was found guilty of violating the residency license restrictions by practicing in an unapproved hospital.

On January 28, 1967 Jijibhoy J. Patel, M.D., Royal Oak, was reprimanded because he was found guilty of violating the residency license restrictions by practicing in an unapproved hospital.

Mississippi. On February 18, 1967 William Carlisle
Touchstone, M.D., Forest, was placed on probation because of addiction to narcotics.

New Mexico. On January 30, 1967 the license of Neil C. Terhune, M.D., was revoked because of immoral, dishonorable and unprofessional conduct and conduct unbecoming a physician.

On March 6, 1967 the license of Emmet J. Thorpe, M.D., Roswell, was placed on probation because of unprofessional conduct.

South Dakota. On February 17, 1967 the license of Floyd L. Peninger, M.D., was suspended because of his commitment to a mental institution.

Texas. On January 13, 1967 the license of Lowell Leon Schupback, D.O., Kansas City, Missouri, was cancelled because of violation of his probation.

On January 12, 1967 the license of Clarence Houston Vann, M.D., Carrollton, was cancelled because of his conviction of two felonies.

Virginia. On February 15, 1967 the license of George Hatcher Snead, M.D., Williamsburg, was automatically revoked when he was admitted to a hospital as a drug addict.

On December 12, 1966 the license of W. H. L. Westbrook, Jr., M.D., Williamsburg, was restored on a probationary basis without narcotics permit and contingent upon his remaining at Eastern State Hospital.

Washington. On September 19, 1966 the license of H. Macmillan Rodney, M.D., Spokane, was suspended for one year and one day commencing September 19, 1966 due to unprofessional conduct in that he was convicted of income tax evasion in the U. S. District Court.

Canada, Alberta. On January 13, 1967 the license of Denys Penelope Visser, M.D., Calgary, was placed on probation for one year because she was found guilty of associating her name and practice with one John Visser and the Neuro-Rheumatic Clinic in such a manner as to be misleading to the public and also because she did improperly bill insuring agencies.

Ontario. Jacobus Johannes Du Preez, M.D., Ch.B., Toronto, has served as intern or resident in the following hospitals in Canada and the United States on the basis of reports received and has been refused an enabling certificate by the College of Physicians and Surgeons of Ontario: St. John's General Hospital, St. John's Newfoundland; Joseph Brant Hospital, Burlington, Ontario; R. E. Thomason General Hospital, El Paso, Texas; Suburban Hospital, Bethesda, Maryland. Confidential reports on his performance and behavior should be requested from the above hospitals or the College of Physicians and Surgeons of Ontario.

On January 4, 1967 Lorne Evans Carpenter, M.D., Toronto, was found guilty of infamous, disgraceful and improper conduct and of professional misconduct. Therefore his name has been erased from the Registry of the College of Physicians and Surgeons of Ontario.

The name of Ladislav Joseph Gondor, M.D., Toronto, has been erased from the Registry of the College of Physicians and Surgeons of Ontario because he was found guilty in Criminal Court of a criminal offense committed in connection with the practice of his profession.