The Walter L. Bierring Lecture

SOMETHING HAPPENED
MAX H. PARROTT, M.D.

Something happened to the community of purpose that our profession must have if it is to remain a real profession. Something bad has happened between those of you who are primarily teachers of medicine and those, like me, who are mainly in patient care. We have been drifting apart, chiefly because we let government, for its own purposes, do things that put us at cross-purposes.

Public-relations expert Walter Johnson predicted some years ago that the practicing professions—along with business and labor—would find themselves pitted against government and education. His prophecy was considered preposterous at the time. Now it is on the verge of becoming true, at least, insofar as you and I are concerned. Yet if medical education and medical practice become polarized, then medicine itself, and the patients it exists for, will be caught in the middle.

In Joseph Heller's novel, Something Happened, the narrator doesn't want to know certain things—doesn't want to know for whom an ambulance is coming. You and I must recognize the disagreeable, and how it developed, because there is an ominous sound in the night that is for all of us.

In tracing the developments, let us first go back in time, back to the aftermath of World War II. The carnage of war was followed by an inevitable sense of guilt and a corresponding concern for life. Threatened by the Cold War and the spread of nuclear knowledge, the belief in life found consolation in the promises of biomedical science and research. Research was encouraged by fresh insights in such areas as genetics and cell structure, and by ample supplies of cash. Grants for research—principally from the National Institutes of Health—were pipelined into the medical schools, constituting one-third of their in-
When Max H. Parrott, M.D., became the 130th president of the American Medical Association during the 1975 AMA Annual Convention in Atlantic City, New Jersey, his inauguration marked the culmination of more than two decades of service to his profession.

Dr. Parrott, who practices obstetrics and gynecology in Portland, Oregon, was active in the affairs of the Multnomah County Medical Society and the Oregon Medical Association (OMA) for many years. A past president of the OMA, he was influential in the establishment of the Oregon Medical Political Action Committee in the early 1960's and was its first chairman.

He was a member of the house of delegates of the American Medical Association from 1961 through 1966 and a member of the AMA Council on Legislation from 1961 to 1965. Elected to membership on the AMA Board of Trustees in 1966, Dr. Parrott was its chairman for two terms (1970-1971 and 1971-1972), continuing on the board until he was elected president-elect at the 1974 Annual Convention of the American Medical Association in Chicago.

A native of Saskatoon, Saskatchewan, Dr. Parrott moved to Oregon as a youth, and he became a naturalized United States citizen. He completed his pre-medical courses at Oregon State College (now Oregon State University), Corvallis, in 1938. Moving to Portland, he earned his M.D. at the University of Oregon Medical School. Immediately following his internship, he entered the United States Army Medical Corps for World War II service.

Working as an anesthesiologist with combat surgical teams, he was attached to the British 8th Army in North Africa during the Tunisian Campaign, later landing with advance troops during the invasion of Sicily in July 1943, and on the Normandy beachhead in June 1944. Dr. Parrott was awarded six battle stars while working with battlefield surgical teams during his distinguished military career.

Following World War II, Max Parrott entered the graduate medical education training program in obstetrics and gynecology at the University of Michigan. He received his Master of Science degree in obstetrics and gynecology from the university in 1949.

Dr. Parrott entered practice in his specialty in Portland, Oregon in 1949 and now practices in a specialty group with four other obstetricians and gynecologists in that city.

He is a diplomate of the American Board of Obstetrics and Gynecology, a member of the American College of Obstetrics and Gynecology and a member of the college committee on gynecological practice. In addition, he holds membership in the Pacific Coast Obstetrical and Gynecological Society and the Pacific Northwest Society of Obstetrics and Gynecology. He is an assistant clinical professor in his specialty at the University of Oregon Medical School.

In addition, Dr. Parrott is active in the Portland Chamber of Commerce, is a Rotarian and a member of the Oregon Blue Shield Board of Directors.

come by 1955. The popular and Congressional rapture for the sciences seemed inexhaustible indeed, particularly after the shock waves from Russia's Sputnik 1 of 1957.

But the passion was bound to cool, as most passions do. It has cooled in the general recent tide of anti-intellectualism, exemplified by the craze for sensationalism and style rather than substance in many activities—by the rash of pseudo-mystical interpretations of the world—and, I might add, by such phenomena as the insinuation of California Congressman John E. Moss last year that the AMA is unfair to chiropractic.

In a hyped-up age that demands instant results, perhaps too much was expected from government-backed health research and from the money put into it. At any rate, it lost a good deal of its charisma. NIH appropriations for medical-school research plateaued in 1966 and then dropped in the wake of a Congressional subcommittee's adverse reports on NIH management of the grants and on their magnitude. Today, the economic recession and budgetary woes enable the government to assume an even tighter, and tougher, stance. And today its grip is tightening on the very classrooms of the medical schools—on its grants for medical training. The move to tie these grants to social purposes—notably, more primary care for the allegedly undercared-for—is questionable even on social grounds. Primary care is already on Stage Center in medical training, accounting for almost 60 percent of last year's new physicians. Geographical gaps in care already are being filled, partly through programs that medical schools started over the years, and through the efforts of the National Health Service Corps, assisted by the AMA. So if the social excuses for playing tough on capitation grants lack validity, what purpose could the government have except a political one—a desire to be master? And if government is to be the master, then the schools will be chattels. And the schools have partly themselves to blame because certainly they have been chattels of the glowing expectations based on federal funds.

Let's face it:

Federal "grantsmanship" has become the name of the game over the years, with the result that school ties with other funding sources—such as state legislatures, civic groups, alumni, and philanthropists—have, in many cases, been allowed to deteriorate. I am not surprised by the eagerness of the federal govern-
ment to capitalize on the needs and expectations of the schools and play the master. What appalls me is academia's growing consent—or resignation—to the role of chattel. I am well aware that, on many issues, the schools have resisted arbitrary controls. I am aware, for example, that the Association of American Medical Colleges opposed the coupling of basic support for the colleges with mandatory-service obligations for their students. But I am also aware of two tendencies that invite domination. These are the tendencies to minimize it and to rationalize it. Let me discuss each of them in turn.

Domination can be minimized by failing to see its growth over the years, a steady growth that seems almost to have been planned. Many present medical school deans and their colleagues may recall the postwar era as an unfettered golden time—a stable time—which should assure a happy, free-spirited future. However, Rosemary Stevens asserts in her scholarly book, *American Medicine and the Public Interest*, and I quote: "By 1960 the medical schools had become in large part arms or branches of NIH. Their faculties and their interests responded to the availability of an apparently never-ending stream of federal wealth, channeled through a complicated, byzantine system of national peer-review groups and advisory committees." Ms. Stevens further notes that "peer-group definitions of excellence" tended to favor schools doing the most research—Harvard, for example. Favoritism, I should add, is one form of control.

The Comprehensive Health Manpower Training Act of 1971 represents another phase of growing federal domination. It is easy to minimize the import and impact of that legislation, partly because of the recognition it conferred on capitation grants. But what about its requirements for those grants—the requirements that enrollment be continually expanded, and that projects be undertaken in at least three of eight possible areas, such as curriculum change and recruitment of disadvantaged students, according to a plan to be submitted to the Secretary of Health, Education, and Welfare? Regardless of how justifiable any of the requirements were, the fact remains that the schools relinquished part of their internal management to the federal government.

And how much was the sacrifice worth? The ceiling of $5,000 per head per year approved by the Senate was whittled to $2,500 in the act as passed. This shrank to an average of less than $1,600 in what the schools actually got. Some educators, while deploring such current manpower proposals as mandated service, may nevertheless minimize them as isolated ideas. But the history of the past two decades clearly shows that they are part of a trend. And a question we must sternly face is: What is the inevitable outcome of that trend? What is the direction of what British economist Beatrice Webb, advocate of step-by-step Fabian Socialism, called "the inevitability of graduality"?

Next, what about the other tendency that invites federal domination: the tendency to rationalize it? Rationalization consists in accepting the inevitability of an expanded federal role, in according to it as the systematic general solution to the general problems of health care. I submit that this outlook is rationalization, because, deep down, none of us wants to forfeit his freedom, his right to make decisions according to the best dictates of his professional knowledge, experience, and judgment. I know that most of you who are medical teachers feel as strongly about that freedom as I do. And this being so, we should be working together to preserve it. Only by working together can we preserve it. But if other feelings get in the way, the will to work jointly for freedom can languish. And they have got in the way, intensifying the rationalization of growing federal control. Allow me to be frank in saying what these feelings are. One of them is the academic sense of superiority toward us "journeyman" doctors, extending into a conviction that the private sector of medicine is unable to cope with the societal problems of care. Because of the intellectual and personal as well as the financial interface between academia and government, the teacher may feel far closer in spirit to Washington planners than he does to us. The superiority that emanates from the towers and archways of academia is matched by the sense of inferiority that we journeymen tend to have. Working with the sick through a long, pressurized day, we often feel that we are in the furnace room of the human condition as opposed to the ivory tower. Unquestionably, you who are mainly teachers have ideas and concepts that we journeymen should apprehend. But we, in the day-to-day realities of our furnace room, develop perceptions that you should apprehend.

As a member of the gynecologic practice committee of the
American College of Obstetricians and Gynecologists, I am intimate with the differences in outlook. The academic members are far more didactic than we practitioners. For example, they fail to appreciate the pragmatics of the cost-time-yield ratio in patient care—the benefits expected in proportion to the outlay of money and time. And this is ironic, because theoretically the academics are supposed to be more concerned about costs than we are. In our daily practice, we journeymen already are seeing how federal interference in medicine can disrupt patient care.

We have to clutter patient time with masses of federal paperwork based to a large extent on bureaucratic insinuation. We deal directly with ambiguous laws and with the hard, arbitrary regulations that are fabricated from the putty of law. We saw how HEW somehow conceived that the Social Security Act, as amended, would allow largely non-medical panels to review the hospital admissions of Medicare/Medicaid patients. The AMA argued successfully in court that the Utilization Review regulations infringed on the patient's right to care, and HEW then withdrew them. But regulation as a federal way of life—as an insidious force—is a reality that you and I must always reckon with. We must bear it in mind that any law—no matter how purposeful it may be—is merely an enabling act. The regulators activate and steer it.

The Administration talks of de-regulation, in the airlines, the railroads, and other enterprises. How are we physicians—you and I—any less responsible than they are? Yet, the specter of regulation—for all of us—is growing. The Health Planning Act of 1974 has all the potential for bringing on a nightmare of regulation and control from its vast mishmash of authority, divided among several levels of agencies, with the Secretary of HEW standing god-like at the summit. You who are teachers are realizing how this law can interfere with the number and types of physicians you train, the construction of facilities you would need, and so forth. For all of us in the field of medicine, the open-ended Health Planning Act is the most baleful law ever to clear Congress. A major reason it was enacted is that the Comprehensive Health Planning and Regional Medical programs were failing and Congress wanted to cover its mistakes.

Why were those programs failing? One reason is that their often overlapping officialdom had the kind of attitude I alluded to earlier: a disdain for the perceptions and ideas of the practicing professional. Now all of us are stuck with an act whose implementation is likely to compound the errors of RMP and CHP, as well as make plenty of new ones. Great as they are, the dangers of that act cannot be isolated from the dangers of the multipurpose form of National Health Insurance which the AAMC favors and for which the planning act could set the parameters in terms of health services and resources.

The AMA believes in financially comprehensive NHI and has a bill before Congress to provide it. But we reject the idea that the medical-care system has to be overhauled to accommodate the financing. Let us have National Health Insurance, yes, but not a British-style National Health Service, with all of its dreams crumbled by the thumbs of bureaucracy, all of its medical and financial chaos, all of its logjams, all of its demoralization of physicians and patients alike. The most important lesson we journeymen physicians have to impart is that the doctor-patient relationship is as fragile as it is crucial. It can stand no additional strain. Strain is inherent in any program that makes the individual patient a maneuverable mass abstraction, as would be the case, for example, in federal control of residency training. The patient is a victim if residency programs—and the services they furnish—are dismantled, or redistributed, to satisfy some abstract geographical quota. The AMA fought such control in the House of Representatives manpower bill and won. We were not consoled by the provision whereby residency accreditation and allocation would be offered the Coordinating Council on Medical Education, as suggested by the AAMC.

But while we of the AMA have had differences in general outlook, and on specific issues, with you who are medical educators, let me state flatly: We are solidly dedicated to the cause of medical education. That cause is the primary reason why the AMA was founded in 1847 with the help of medical colleges. The Flexner Report of 1910 was one of the finest hours for the AMA, as well as a revolution in medical training, because that report had the collaboration of our Council on Medical Education, which is still a standard-bearer for the best educational standards. As we have told Congress, we want capitation grants to medical schools continued without mandatory payback and service conditions. I suggest, however, that the schools curb their depen-
dence on Washington by further cultivating other sources of money.

The AMA has testified in Congress that it also backs continuation of: Construction loans and grants for medical schools; broad special-project grant authority; loans and scholarships to medical students; start-up and financial distress grants; and assistance for training in family practice, public health, and the allied health professions. Since 1962, the AMA’s Education and Research Foundation has guaranteed more than $66 million in loans to medical students and directly granted some $26 million to medical schools. Let me emphasize, however, that nothing that we do to advance medical education or preserve medical professionalism has any final meaning unless it serves one final end: the care of patients, singly and collectively. That is why the AMA works for better organization of rural care, cooperates with the National Health Service Corps, offers proposals to lift the health levels of Indians and migratory workers, has an NHI bill before Congress, engages in public health education, evaluates drugs, stimulates continuing education. And that is also why you who mainly teach, and those of us who mainly practice, should work together. The patient is the common bond that should unite us. We can cooperate in his behalf and assert our joint ability to advance the health of the nation. Or we can stand apart and let government move between us and over us.

Interviewed about England’s health crisis and the inability of her physicians to cope with it, Dr. Peter J. Banks, former president of both the British and Canadian Medical Associations, said: “There are innumerable royal colleges, some of which are older than the British Medical Association, and each of them feels that it should be the voice of its particular branch of the profession.”

So to ask the ultimate questions:

Is the British experience what we want, with all of its big government, shrunken, divided doctors, and chaos? Is the British experience what we want in the third century of our republic?

ANNUAL REPORT OF FLEX BOARD

Frederick T. Merchant, M.D.

Since the last annual report, the FLEX Board and FLEX Test Committees again have had an interesting and productive year. The FLEX Board met in January, February, and August 1975 and will meet again in January 1976 in Philadelphia as well as during this annual meeting. In addition, a FLEX Workshop is being conducted on January 29. The FLEX Test Committees met in January and August 1975 for purposes of reviewing and approving FLEX examinations administered in December 1974 and June 1975, constructing new examinations, and taking up matters of policy and interest.

C. Allen Payne, M.D., Michigan, was elected to the FLEX Board last year, as you know, with term expiring in 1981, replacing Arthur W. Wright, M.D., who retired from the board. In August, the FLEX Board elected Dr. Payne as Chairman of the Day I FLEX Committee, replacing Dr. Wright.

In addition to Dr. Wright, the following also retired from FLEX Test Committee activity: Roderick Macdonald, M.D., South Carolina, for reasons of health; and Donald L. Brawner, M.D., Oklahoma, and Merritt O. Alcorn, M.D., Indiana, because of retirement from their respective boards. New members who were elected this year to fill vacancies include: Max C. Butler, M.D., Texas, Philip E. Ingaglio, M.D., Pennsylvania, and Edward L. Hollenberg, M.D., Indiana, to the Day I Committee; Frank Adelman, M.D., Oklahoma, to Day II Committee; and Leo W. Lloyd, M.D., Colorado, to the Day III Committee.

As a matter of record, we wish to recognize and acknowledge the excellent work and service of these retiring members from the FLEX Board and FLEX Test Committees in this annual report.

Due to an increasing number of inquiries regarding the examination during this past year and a significant number of administrative matters, the FLEX Board determined that a workshop

Prepared for the annual meeting of the Federation of State Medical Boards of the United States, Chicago, January 31, 1976.

Dr. Merchant is chairman of the FLEX Board and FLEX Test Committees. He is a past president of the Federation and widely known in the medical licensing field.
might well be worthwhile for purposes of a complete review of the administrative aspects of the examination. Many of these matters apparently have arisen as a result of changes in administrative and board personnel over the past eight years. Accordingly, following a discussion with the FLEX Test Committees and with members of the National Board, it was decided to have such a workshop on Thursday, January 29, immediately preceding the regular dates for the annual meeting. It is hoped that this workshop will be beneficial to all who are able to attend.

The new edition of the FLEX Handbook was finalized, printed, and distributed to all state medical boards as well as to others interested in or indirectly involved in the program. It is believed that this updated FLEX Handbook should be most helpful, and some discussion on this will be held at the time of the workshop as well.

A total of 15,398 candidates took the complete examination during 1975, with 8,531 at the June examination and 6,867 in December. In addition, 1,155 partial examinations were furnished in June and 1,243 in December. For the period June 1968 through December 1975, the total number of candidates taking the total examination is 71,088, while 13,071 took partial or repeat examinations, at the request of participating boards: a grand total of 84,159 examinations.

The administrative activities of the FLEX Board, through its chairman, continued at a busy pace during the past year with the processing of 769 written communications and the handling of more than 200 telephone calls. In addition to shipping out the FLEX Handbook, numerous memos were also sent to the various state boards and Test Committee members. Since the first of last year 13,571 FLEX Descriptive Booklets, 14,341 Day III examples, and 1,161 out-of-state slips were shipped to the participating state boards.

Dates for future examinations 1976 through 1980 have been established and all dates have been cleared with the AMA to avoid conflict wherever possible. Several inquiries during the year were received relative to possible conflicts and the FLEX Board wants to assure all participating boards that every effort is made in this direction. In the projecting of dates into the future, we have checked with the AMA and other examining organizations to avoid, if at all possible, such conflicts. However, because dates can be changed from time to time, unexpected problems may still arise. The following dates, however, have been cleared and should be satisfactory:

1976—June 15, 16, 17; December 7, 8, 9
1977—June 14, 15, 16; December 6, 7, 8
1978—June 13, 14, 15; December 5, 6, 7
1979—June 12, 13, 14; December 4, 5, 6
1980—June 10, 11, 12; December 9, 10, 11

In 1975, all states except Florida participated in the examination, along with the District of Columbia, the Canadian Province of Saskatchewan, and Puerto Rico. Texas actively joined the program for the December 1975 examination, while Puerto Rico initiated its participation by offering the examination on a voluntary basis in December. The Canal Zone also participated on an individual basis.

Florida has again expressed interest in future participation in the FLEX program, but currently remains handicapped by legislation passed about two years ago relative to review courses and subsequent examinations in a candidate’s own language. This
has created problems, and steps apparently are being made to correct this troublesome situation. General information and the new FLEX Handbook have been furnished to the Florida board for their perusal and ultimate future decision.

During the year the Canal Zone Medical Board expressed interest in making the FLEX examination their official examination toward qualification to licensure. Since prior endorsement policies had not been established, your chairman circulated a memo to all state boards indicating Canal Zone interest, and furnishing also excerpts from their rules and regulations governing examinations. It was requested that all states indicate their position on possible endorsement of a Canal Zone certificate based on the FLEX examination. Thus far approximately half the states have responded. Of these all but one have indicated they would accept for endorsement a Canal Zone license based on the FLEX examination providing, of course, that all other provisions of their state statutes, rules, and regulations would be met by these candidates as well. It is urged at this time that those states not yet responding do so at the earliest possible time following board consideration of the memo request.

The FLEX Board and FLEX Test Committees also took up the matter of the Vietnamese physician since requests had been received relative to making exceptions for these physicians in the matter of acceptance for immediate examination for potential licensure. It was unanimously believed that no exception should be made for these foreign physicians, and that emotional and sympathetic reasons were not sufficient to turn loose unqualified physicians upon the American public. It was believed that these physicians were in no way qualified to practice medicine in the United States, and that practical use of the English language, and knowledge of American ways and disease patterns. Eligibility to sit the examination should in no way be lessened from that required of all other foreign medical graduates. It was further believed that the offering of the FLEX examination at a premature time to these unqualified persons would in no way solve the problem but only create worse problems by their degree of uns success, and departure from an appropriate standard base.

Numerous requests are received throughout the year regard-
formation and interest, the following exceptions (the remaining 18%) are as follows: Arizona, South Dakota, Colorado, and Vermont require a FLEX Weighted Average of 75 but a minimum grade of 60 in the individual subject areas. Oregon and Washington require a FWA 75 with a minimal individual subject level of 70. Delaware requires FWA 75 overall average with a minimum of 70 in the Basic Sciences, 75 in Clinical Science and Clinical Competence. Kentucky requires a FWA 75 overall but a minimal 65 score in the individual day subjects. Virginia requires a FWA of 75 with a minimum score of 65 in the Day I examination.

Acknowledgement is made of the excellent cooperation from the Federation Board of Directors, the Central Office, and the Editor of the Federation Bulletin.

Members of the FLEX Committee this year are: Day I Committee: Drs. C. Allen Payne, Chairman, Michigan; Max C. Butler, Texas; John H. Clark, Utah; Henry G. Cramblett, Ohio; William M. Dabney, Mississippi; James E. Hill, Kansas; Philip E. Ingaglio, Pennsylvania; Elmer G. Linhardt, Maryland; George E. Sullivan, Maine; William J. Morton, Georgia; David W. Wallwork, Massachusetts; and Edward L. Hollenberg, Indiana. Day II Committee: Drs. Lloyd R. Evans, Chairman, Wyoming; Frank Adelman, Oklahoma; R. C. Derbyshire, New Mexico; Bryant L. Galusha, North Carolina; Leo T. Heywood, Nebraska; John M. Irvin, Wisconsin; Gary S. Nye, California; Richard E. C. Miller, Louisiana; John H. Morton, New York; Lawrence Scherr, New York; Clarence B. Trower, Jr., Virginia; and Harold E. Wilkins, California. Day III Committee: Drs. Howard L. Horns, Chairman, Minnesota; Kenneth H. Schnepp, Illinois; Richard E. Flood, West Virginia; and Leo W. Lloyd, Colorado.

We again acknowledge and express our appreciation to the NBME Staff for their continued and valuable assistance and cooperation in the management of the FLEX program: Drs. Robert A. Chase, President and Director; David E. Smith, Vice-President and Director Department of Undergraduate Medical Evaluation; William B. Kennedy, Associate Director Department of Undergraduate Medical Evaluation; and Charles F. Schumacher and Paul R. Kelley, Jr., Director and Associate Director respectively, Division of Psychometrics, as well as members of their respective staffs.
LEO T. HEYWOOD, M.D.—ACCOUCHEUR EXTRAORDINAIRE! (HE DELIVERED . . . FLEX)

A resolution introduced by the New York board during the 1956 annual business meeting of the Federation concluded:

"... now, therefore be it
Resolved, That a permanent committee of five members of the Federation be appointed to develop and activate examination institutes in the major branches of medicine covered in licensure examinations for the purpose of creating uniformity in content and quality in these examinations. . . ."

That resolution was adopted and referred to the board of directors for implementation and the first permanent committee for the examination institutes was appointed. The historic significance of that action twenty years ago should be evident to those who have followed Federation affairs even for just a short time. For it was that fundamental idea, ultimately modified by other appropriate actions of the membership at subsequent business meetings, that provided the mechanism from which the FLEX program was conceived, developed and has matured.

Under the direction of committee chairman Stiles D. Ezell, M.D., of New York, initially the institutes were popular, well attended and resulted in the development of many test items that were shared by a number of state licensing boards. Later, in 1964, with Andrew M. Gehret, M.D., of Delaware committee chairman, a new direction was taken and George E. Miller, M.D., Director of Research in Medical Education at the University of Illinois College of Medicine, was invited to conduct the eighth institute. Dr. Miller's demonstration of the practical techniques then available for examination excited the interest of many Federation members. However, some saw danger inherent in those devices in that their complex nature could reduce the leverage available to the average medical licensing board in constructing, administering and scoring its own material. Thus, questions were raised and uncertainty prevailed.

A member of the committee from 1957, Leo Heywood became its chairman in 1964. Undoubtedly, his tenure on the committee provided the vantage point needed to view objectively the several sides of the controversial issues in the medical examination and licensure arena. Furthermore, his experience with that committee highlighted what was needed to lay the foundation for the development of the ideas that generated the FLEX concept.

As a direct response to his enthusiastic guidance, direction and leadership, the four other evangelistic members of the committee overcame the obstacles to its conception and were present as Leo Heywood—acoucheur extraordinaire—presided at the birth of FLEX.

Significantly, Leo Heywood's retirement from the FLEX Board coincided with the twentieth anniversary of the appointment of the first permanent committee for the examination institutes in 1956. In recognition of his nearly two decades of outstanding contributions to the unity, solidarity and purpose of the Federation of State Medical Boards, the following resolution was adopted during the January 31, 1976 annual business meeting:

RESOLUTION

WHEREAS, Leo T. Heywood, M.D. was Chairman of the former Examination Institute Committee of the Federation of State Medical Boards of the United States from 1962-1969, and was a continuous member of that Committee from 1957-1973, and
Whereas, During the period of his Chairmanship, the Committee under his progressive, enthusiastic, and far-sighted planning and direction, evolved the concept of the Federation Licensing Examination (FLEX) in 1964 in order to provide examining boards with reliable, valid, and uniform examination administration to candidates seeking licensure to practice Medicine, and

Whereas, His efforts did indeed result in the formation, design and construction of FLEX in 1967, making it possible to offer the examination for the first time in June 1968 to interested medical examination boards, and

Whereas, This work has produced the greatest single contribution of the Federation of State Medical Boards to its member boards, and has enjoyed unprecedented acceptance and success, and

Whereas, Dr. Heywood has continued his interest as a member of the Federation Licensing Examination Board formed in 1973 to replace the Examination Institute Committee, and as a faithful and productive member of the FLEX Test Committees, and

Whereas, Dr. Heywood's term on the FLEX Board expires at this Annual Meeting, ending 18 years of continuous service in the interest of examination procedures,

Therefore Be It Resolved That, Dr. Leo T. Heywood be recognized at this Annual Meeting by all members of the Federation of State Medical Boards for his outstanding contributions, dedication, and invaluable counsel, and

Be It Further Resolved That, Dr. Heywood be awarded an appropriate symbol of this recognition for his contributions to the strength and purpose of the Federation of State Medical Boards and that a copy of this Resolution be forwarded to the Governor of the State of Nebraska and to the Nebraska Board of Examiners in Medicine and Surgery.

AND NOW THERE IS ONLY ONE

During the 1973 Examination Institute, Frederick T. Merchant, M.D., General Chairman of the FLEX program, noted that he expected near-unanimous endorsement of the examination during that year. That goal was almost accomplished. For, at the end of June 1973, the medical boards of Florida and Texas were the only ones not administering FLEX as their licensing examinations.

The exponential growth of FLEX from the June 1968 initial examination through June 1973 triggered such Federation Bulletin editorial headings as: FLEX Approaching Majority (May 1970), FLEX Approaching Maturity (November 1971), Exponential FLEX (September 1972), and FLEX Unanimous Choice—Almost (October 1973).

In a comment on the apparent loss of momentum in the program, in July 1975, the Bulletin featured Unanimity—a Necessity. And, in the Annual Report of the FLEX Board (for 1975) Merchant pointed out that "all states except Florida participated in the examination. . . ." In addition, he called attention to several other medical licensing jurisdictions that had administered FLEX during the year.

Although there is no room for it to show exponential traits, FLEX is almost a unanimous choice and now there is only one state not participating in the program.

In another context the title of this comment is appropriate, too. For, now there is only one of the five members of the "original FLEX committee" remaining as a member of the FLEX Board. Leo T. Heywood, M.D., of Nebraska, who was chairman of the committee at the beginning of the program, retired from the board at the 1976 annual business meeting. Arthur W. Wright, M.D., of New York, retired at the 1975 meeting. Lall G. Montgomery, M.D., of Indiana, left the program at the end of 1973 due to poor health. Ray L. Casterline, M.D., of Oregon, resigned from the program in early 1973 to join the organization now known as the Educational Commission for Foreign Medical Graduates.

Frederick T. Merchant, M.D., of Ohio, long the general chairman of the FLEX program, remains the only one and is scheduled to retire from the FLEX Board at the 1978 annual business meeting.

As Casterline, Montgomery, Wright and Heywood stepped aside, the infusion of "new blood" from the selection and/or election of new members maintained strength and continuity in the program. However, in the case of Merchant, in addition to his chairmanship of the test committees, the program and the FLEX Board, for many years he has assumed responsibility for
duties that normally would have been performed by an executive director of a program such as FLEX. Thus, Merchant is the only one and is the FLEX Board member with the greatest expertise in the operation of FLEX.

Therefore, with Fred Merchant's retirement from the FLEX Board scheduled to take place in less than two years, the Federation cannot wait long before reaching a decision regarding the position of executive director of the FLEX program.

RLC

BOUND VOLUMES OF
FEDERATION BULLETIN

Bound copies of Volume 62 (1975) of the Federation Bulletin are available for purchase at the Central Office of the Federation. Since fewer "over-run" copies of certain issues of Volume 62 were available for binding, prospective buyers should communicate promptly with the Central Office. Bound copies of several earlier volumes, however, remain available. The cost of current and earlier bound volumes of the Bulletin remains $5.00 per copy.

To submit orders (and for additional information) write directly to M. H. Crabb, M.D., Secretary, Federation of State Medical Boards of the United States, Inc., 1612 Summit Avenue—Suite 308, Fort Worth, Texas 76102.

Court Decisions

CHIROPRACTOR NOT AUTHORIZED TO PERFORM PHYSICAL EXAMINATIONS*

The state department of transportation was not authorized to amend its regulations to permit chiropractors to give physical examinations, a Pennsylvania appellate court ruled.

The Pennsylvania Chiropractic Society petitioned the state department of transportation for a change in its regulations to permit chiropractors to give physical examinations to applicants for certain operators’ licenses. After a hearing, the petition was denied. The Chiropractic Society appealed.

Affirming the decision of the transportation department, the court said that the practice of chiropractic was limited to the relationship between the articulations of the vertebral column, as well as other articulations, and the nervous system. To permit chiropractors to perform general diagnostic examinations would expand the scope of chiropractic beyond its statutory limits, the court said.

The department authorized only physicians and osteopaths to perform physical examinations, and it had properly denied the petition, the court concluded.—Commonwealth of Pennsylvania, Department of Transportation Hearing Board v. Pennsylvania Chiropractic Society, 349 A.2d 509 (Pa. Commonwealth Ct., Jan. 2, 1976)

ACTIVITIES OF THE NATIONAL BOARD OF MEDICAL EXAMINERS—1975: A REPORT TO THE FEDERATION

JOHN H. MORTON, M.D.

The National Board of Medical Examiners (NBME) is increasingly involved in evaluation at all levels in the medical field, preparing examinations for medical students, for specialty board physicians, for assistants to the primary care physician. However, the main interest and function of the board remains the evaluation of candidates for licensure either through the National Board’s own examinations or through FLEX. Despite requests for help from many quarters, the development of high quality examinations for primary licensure remains the board’s first priority.

Important personnel changes have occurred at the board. 1975 was the first year under the direction of Robert A. Chase, M.D., the new president of the board. Dr. Chase has already shown a major interest in the Federation and its activities. It is anticipated that under his leadership the National Board will continue to work closely with the various state medical boards. John S. Millis, Ph.D. assumed the role of chairman of the NBME at its annual meeting in March, 1975. At that time Lloyd R. Evans, M.D. was elected to the NBME’s Executive Committee. Drs. Frederick T. Merchant and Robert C. Derbyshire have retired from the Executive Committee, but Dr. Evans and I express the Federation’s point of view at NBME Executive Committee meetings.

During the year the Advisory Committee on Undergraduate Medical Evaluation (ACUME), which is charged with the development of a Comprehensive Qualifying Examination (CQE), has been busy. Edmund D. Pellegrino, M.D., is the chairman of the committee, and I represent the Federation in its activities. In 1974 the ACUME met with a Federation subcommittee to discuss this examination. In 1975 the committee met with a number of other groups and collected other opinions about a CQE. At the present time the committee has begun to develop the prototype of such an examination. Once the prototype examination has been developed, it will be tested for reliability and validity before it is offered as a possible link in the chain between medical school and postgraduate training. Until the CQE has achieved a measure of acceptance, the traditional Parts I, II and III of the National Board examinations will be continued as before.

The National Board, despite its many activities, is faced in 1976 with inflationary pressures. Personnel costs, travel costs and printing costs have all risen rapidly in the last several years. In order to balance income against expenses, NBME is evaluating carefully the costs of all its examinations including the three parts of the National Board examination and FLEX. In 1975 the board raised the charge to undergraduate medical students for the NBME series of examinations for the first time in many years. In carrying out its expanded research activities, the board has been successful in obtaining external funding to cover some of the costs involved. Nevertheless, further adjustments are inevitable in the near future.

The board has become increasingly concerned about cheating during its examinations. There have been more cases brought to the Board’s attention each year, and reports of irregularities in FLEX have been front page news. It would be well for the Federation and the NBME to discuss the issue of cheating together and establish a common approach to this serious problem.

To celebrate its 60th year the National Board is planning an International Invitational Conference in Philadelphia March 17 and 18, 1976. At this conference there will be speakers from America and abroad discussing changes in medical licensure. Many Federation members should be interested in attending this conference.

At present, the members of the NBME Board of Directors selected by the Federation are Merritt O. Alcorn, M.D., Howard L. Horns, M.D., John A. Layne, M.D., George L. Maltby, M.D. and David W. Wallwork, M.D.*

* See Page 125 this issue, Federation Bulletin.
PRESIDENT MORTON ANNOUNCES MEMBERSHIP OF STANDING COMMITTEES OF FEDERATION

At the Sunday afternoon, February 1, 1976 first meeting of the 1976-1977 board of directors, Federation President John H. Morton, M.D. announced the names of those he had appointed members of standing committees of the corporation. Dr. Morton’s appointments were approved by the board of directors.

Professional Relations Committee

During the 1976 annual business meeting, the Federation of State Medical Boards adopted an amendment to the corporate bylaws changing the name of the Public Relations Committee to the more appropriate Professional Relations Committee. The basis for the change in the name of the committee and the exact language of the amendment to the bylaws will be discussed in articles dealing with the business meeting.

Clarence B. Trower, Jr., M.D., Norfolk, Virginia, a member of the former Public Relations Committee, was named chairman, replacing Bryant L. Galusha, M.D., Charlotte, North Carolina, formerly chairman, who left the committee. Raymond C. Grandon, M.D., Harrisburg, Pennsylvania; James E. Hill, M.D., Arkansas City, Kansas; and A. Bryan Spires, Jr., M.D., Austin, Texas were reappointed members of the committee. George E. Sullivan, M.D., Waterville, Maine is the newly appointed member of the committee.

Legislative Advisory Committee

Jackson W. Riddle, Ph.D., M.D., Albany, New York was appointed chairman of the Legislative Advisory Committee, replacing Charles B. Odom, M.D., New Orleans, Louisiana, who resigned. Mor J. McCarthy, M.D., Kailua, Oahu, Hawaii; Howard L. Smith, M.D., Roswell, New Mexico; and Edgar W. Young, M.D., El Reno, Oklahoma were reappointed members of the committee. Carlos W. Godinez, M.D., McAllen, Texas, formerly a member of the Articles of Incorporation and By-Laws Committee, was appointed to replace Malcolm O. Scramahorn, M.D., Pittsboro, Indiana.

Articles of Incorporation and By-Laws Committee

Elmer G. Linhardt, M.D., Annapolis, Maryland was reappointed chairman of the Articles of Incorporation and By-Laws Committee. Russell O. Sather, M.D., Crookston, Minnesota and George F. Taylor, M.D., Sidney, Nebraska were reappointed members of the committee. Richard C. Lyons, M.D., Erie, Pennsylvania and Thomas J. Sinatra, M.D., Brooklyn, New York were appointed to the committee, replacing John M. Irvin, M.D., Monroe, Wisconsin and Carlos D. Godinez, M.D., McAllen, Texas.

Nominating Committee

As stipulated in the By-Laws, the immediate past president of the Federation becomes the chairman of the Nominating Committee. For the 1976-1977 term, Dan A. Nye, M.D., became chairman of the committee. Federation Past-President Joseph J. Combs, M.D., Raleigh, North Carolina; Lloyd R. Evans, M.D., Laramie, Wyoming; John H. Clark, M.D., Salt Lake City, Utah; and Kenneth H. Schnepp, M.D., Springfield, Illinois were named as the other members of the committee.

Program Committee

During the 1975 annual business meeting, the Federation
adopted an amendment to the By-Laws creating a program committee, consisting of three members: the president, serving as chairman, assisted by the immediate past-president and the president-elect of the corporation.

Dr. John H. Morton is chairman for the 1976-1977 term. Drs. Dan A. Nye and Harold E. Wilkins are the other members of that committee, as provided for in the amended By-Laws.

Editorial Advisory Board

Harold E. Jervey, Jr., M.D., Columbia, South Carolina; Leo T. Heywood, M.D., Omaha, Nebraska; and Harold E. Wilkins, M.D., Downey, California were reappointed members of the Editorial Advisory Board. Dr. Jervey is treasurer of the Federation; Drs. Jervey and Heywood are past-presidents of the corporation; and Dr. Wilkins is president-elect.

SCHERR AND YOUNG ELECTED TO MEMBERSHIP ON THE NATIONAL BOARD OF MEDICAL EXAMINERS

Lawrence Scherr, M.D., Manhasset, New York and Edgar W. Young, Jr., M.D., El Reno, Oklahoma, who had been nominated to represent the Federation of State Medical Boards, were elected to membership during the March 19, 1976 annual meeting of the National Board of Medical Examiners.

Dr. Scherr is a member of the New York State Board for Medicine and has been president of that board. He has been a member of the FLEX Test Committees for a number of years and serves on the Day II (Clinical Sciences) Committee. Dr. Scherr was nominated to replace David W. Wallwork, M.D., former secretary of the Massachusetts Board of Registration in Medicine, whose term on the National Board had expired.

Dr. Young is secretary-treasurer of the Oklahoma State Board of Medical Examiners. He has served on several special and standing committees and is widely known throughout the Federation of State Medical Boards. Dr. Young was nominated to replace John A. Layne, M.D., Great Falls, Montana, a veteran member of the Montana Board of Medical Examiners. Dr. Layne recently had resigned from his membership on the National Board.

The other members officially representing the Federation on the National Board are Merritt O. Alcorn, M.D., Madison, Indiana, formerly a member of the Indiana Board of Medical Registration and Examination and, for many years, a member of the FLEX Test Committees;* Howard L. Horns, M.D., Minneapolis, Minnesota, who continues active in the FLEX program as a member of the Day II (Clinical Sciences) Test Committee; and George L. Maltby, M.D., Portland, Maine. Drs. Horns and Maltby are past presidents of the Federation.

In addition, a number of members of the Federation hold “at-large” membership status on the National Board, because of their expertise in matters related to examination and licensure. Among those are John H. Morton, M.D., who was re-elected vice chairman of the National Board; Lloyd R. Evans, M.D., who was re-elected to the executive committee of the National Board, Robert C. Derbyshire, M.D.; Leo T. Heywood, M.D.; and Kenneth H. Schnepp, M.D. Dr. Morton is president of the Federation of State Medical Boards and a member of the Day II (Clinical Sciences) Committee in the FLEX program. Dr. Derbyshire is a past-president of the Federation, a member of the FLEX Day II Committee and secretary-treasurer of the New Mexico Board of Medical Examiners. Formerly, Dr. Derbyshire served two terms as an official Federation representative to the NBME. During that time, he was elected to the NBME Executive Committee. Dr. Evans, Laramie, Wyoming, is chairman of

the FLEX Day II Committee; Dr. Heywood, a member of the Nebraska State Board of Examiners in Medicine and Surgery, is past-president of the Federation and serves on the FLEX Day II Committee, as does Dr. Schnep, who is a member of the board of directors of the Federation and a former member of the Illinois Medical Examining Committee.

WHAT'S NEW WITH THE BOARDS?
NEW ADDRESSES, NEW MEMBERS, NEW OFFICERS
AND RESIGNATIONS, THAT'S WHAT!

California. The California Board of Medical Quality Assurance (formerly, the California Board of Medical Examiners) has moved to: 1430 Howe Avenue, Sacramento, California 95825. The telephone number remains the same: (916) 322-5043.

Florida. The State of Florida Board of Medical Examiners recently held elections to select new officers. Victor J. Martinez, M.D., Tampa, was elected president, succeeding Madison R. Pope, M.D., Plant City. Dr. Martinez had been vice-president of the board. Benjamin M. Cole, M.D., Orlando, who had been secretary of the board, was elected vice-president. Leo Grossman, M.D., Miami Beach, was chosen secretary of the board.

The Florida Board of Osteopathic Medical Examiners has moved to: 315 South Calhoun-Suite 850, Tallahassee, Florida 32304.

Mr. Dennis P. Wittenberg is executive coordinator for the Florida osteopathic board.

Massachusetts. Stuart H. Shapiro, M.D. is the new secretary of the Massachusetts Board of Registration and Discipline in Medicine. Dr. Shapiro succeeds David W. Wallwork, M.D., who was secretary of the former Massachusetts Board of Registration in Medicine, which was abolished December 31, 1975.

Mississippi. The Mississippi State Board of Health, which administers medical licensing activities in that state, recently held elections, selecting new officers. Moncure Dabney, M.D., Crystal Springs, was elected president. Dr. Dabney succeeds S. Lamar Bailey, M.D., Kosciusko, who retired from the board. Wilfred Q. Cole, Jr., M.D., Jackson, was elected vice-president, succeeding George Lamar Arrington, M.D., Meridian, who, also, retired from the board. Alton B. Cobb, M.D., M.P.H., continues as state health officer and executive officer and secretary.

William B. Hunt, M.D., Grenada is a new member of the Mississippi board, replacing Dr. Bailey and Frank W. Bowen, M.D., Carthage is another new member of that board, replacing Dr. Arrington. James O. Gilmore, M.D., Oxford, was appointed to the Mississippi board to replace G. Lacey Biles, M.D., Sumner, who, also, retired from the board.

New Jersey. Irving Plain, M.D., Newark is a new member of the New Jersey State Board of Medical Examiners, replacing Rudolph G. Matlferd, M.D., New Brunswick.

Oklahoma. Frank A. Clingan, M.D., Tulsa, recently was appointed to the State of Oklahoma Board of Medical Examiners, replacing Francis R. First, Jr., M.D., Checotah. Harry B. Tate, M.D., Oklahoma City, was appointed to replace Donald L. Brawner, M.D., Tulsa, who had been president of the board for a number of years. Frank L. Adelman, M.D., Enid, has replaced Dr. Brawner on the FLEX committee. Richard L. Winters, M.D., Poteau, was appointed to replace William A. Matthey, M.D., Lawton, who had been vice-president of the board. The terms of Drs. First, Brawner and Matthey, as members of the Oklahoma board, had expired.

In addition, James W. McDaniel, M.D., Chickasha, was appointed to the Oklahoma board.

Commonwealth of Puerto Rico. Dr. Pablo Luis Morales, Santurce, Puerto Rico, is president of the Commonwealth's Board of Medical Examiners. A recent roster of members of that board included Dr. Jose M. Rigau, Hospital San Carlos, Santurce, Puerto Rico, as a new member of the board. The names of Dr. Jose E. Rechany, Departamento de Salud, Santurce; Dr. Jose Reomeu Garcia, Santurce; and Dr. Egidio S. Colon Rivera, Rio Piedras, had been deleted from the roster printed by the central office of the Federation January 1, 1976.

South Dakota. Robert A. Buchanan, M.D., 700 South Dakota Street, Huron, South Dakota 57350 (telephone (605) 352-6439) has succeeded G. Robert Bartron, M.D., Watertown, as secretary of the South Dakota Board of Medical and Osteopathic Examiners.

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THE FEDERATION OF STATE MEDICAL
BOARDS OF THE UNITED STATES,
INCORPORATED

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1976

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