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The Federation: Yesterday, Today and Tomorrow

WILLIAM E. JACOTT, M.D.

It is a very special privilege for me — a great honor — to welcome you to this 1987 Annual Meeting of the Federation of State Medical Boards of the United States and to mark with you the seventy-fifth anniversary of this unique organization. All of us — fellows and friends of the Federation — are here because we share the commitment to public health and safety represented for three-quarters of a century by the Federation and by the men and women who brought it, step by step, to this moment in St. Louis. And we are here because we know the future of that commitment begins today with us and with our service to the American people.

The history of the Federation in our BULLETIN is a superb presentation of our dramatic and interesting past. I have been struck by the similarities between the problems and challenges faced by our predecessors and those by ourselves. Many of today's issues were being discussed in 1912; they differ in degree and complexity, but not substance.

In February 1912, the need for unity and cooperation among the boards spurred the decision of the National Confederation of State Medical Examining and Licensing Boards and of the American Confederation of Reciprocating, Examining, and Licensing Medical Boards to merge their small organizations into this Federation. The names of the Federation's founders are unfamiliar to most of us, but they have our deepest respect. At the height of the Progressive Era in this country (Woodrow Wilson called it the New Day), and with the assistance and encouragement of the AMA, the AAMC, and the Carnegie Foundation they created a more effective instrument to deal with the problems facing medical licensure. They included, among others, Drs. Charles A. Tuttle, of Connecticut; George H. Matson, of Ohio; Arthur B. Brown, of Louisiana; William P. Harlow, of Colorado; Nathan P. Colwell, of Illinois; and Beverly D. Harrison, of Michigan. Dr. Brown was elected first president of the Federation in 1912, and it was Dr. Colwell who suggested the Federation's current name.

In 1913, there were ten member boards. On January 1, 1914, twenty two boards were enrolled
as charter members. For those who want to know if they are on a charter board, these include Arkansas, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

Topics discussed in the Federation’s early meetings are familiar — premedical requirements, internship requirements, examination administration and qualifications, reciprocity, board fees. Also familiar are the subjects of articles in the earliest versions of the Bulletin beginning in 1913 — a model medical practice act, foreign medical graduates seeking licensure in the United States, reporting of disciplinary actions, a national examination, and fraudulent credentials. And though the evolution of the National Board of Medical Examiners can be traced as far back as 1897, much of the discussion and effort related to its creation in 1915 can be seen reflected in the first meetings and publications of the Federation.

A few paragraphs in the July 14, 1913 issues of the ever alert New York Times welcomed the Federation to the national scene by saying that while the state boards would acquire no new power from the Federation, “they will . . . be able to exert much greater influence toward the highly desirable end of securing uniform legislation relative to the public health and safety.”

The Federation had a leader who appreciated that position in the community of medicine and his leadership enhanced the Federation’s ability to meet its obligations. Walter L. Bierring, M.D., president of the Iowa board, was elected to the Federation’s executive committee in 1914. In 1915, he was chosen to replace Otto V. Huffman, of New York, as secretary of the Federation and editor of the Bulletin. He continued in those positions until his death in 1961 at the age of 93. Interestingly enough, he was never president of the Federation, but during his long and remarkable career, he served as president of the AMA, the NBME, and Alpha Omega Alpha, chairman of the American Board of Internal Medicine and the American Board of Preventive Medicine and Public Health. He was a founder of what is now the American Board of Medical Specialties and a regent of the American College of Physicians. A friend of Osler and a student of Pasteur, he was an honorary member of the Royal College of Physicians and the Royal Sanitary Institute of Great Britain. A truly remarkable man and one of the most distinguished, active, and beloved medical leaders of this century. It is no wonder we honor him with our annual banquet and lecture.

Dr. Bierring and the early presidents of the Federation believed in the importance of sound medical education at a time when the quality of medical education was open to question. They also agreed to the need for uniform and nationally accepted examinations. To further these purposes, Dr. Bierring aligned the Federation with the AMA Council on Medical Education, and supported and participated in the creation of the NBME. Reciprocity never became an effective reality in those years despite the widening acceptance of the NBME. The Federation throughout those years played a notable role, but we were limited by inadequate funding, lack of structure, and the absence of a central office and staff.

Between 1940 and 1960, the Federation turned its attention more and more to the issue of the foreign medical graduate. From the arrival of refugee physicians in the 1930s until the founding of the Educational Council for Foreign Medical Graduates, the state boards reacted in a wide variety of ways to the issue. The profession, the states, and the Federation were not prepared to cope with the challenges presented by multiple levels of educational background and by the political, economic, and cultural factors involved. In 1950, the Federation simply approved, in principle, the list of foreign schools published by the AMA’s Council on Medical Education and Hospitals. Further discussions, however, led finally to the development of the Educational Council for Foreign Medical Graduates in 1956, which became the Educational Commission for Foreign Medical Graduates in 1974, an organization in which the Federation played and plays a significant role.

Also in the 1950s, the Federation promoted the idea that boards must be aware of the continuing evolution of medical education. More attention was paid to the quality of graduate medical education and of specialty certification in relation to licensure. In 1956, the Federation established the Examination Institutes to assist member boards in improving the quality of licensure examinations in a rapidly changing world. With that step, it laid the foundation for what was to become the Federation Licensing Examination (FLEX). Also in 1956, the first Guide to the Essentials of a Modern Medical Practice Act was published after four years of study and development. In the 1950s, therefore, the Federation approached a new era in its history. The vigor and potential of its first four decades provided the foundation for the dynamic and aggressive organization that is emerging today.

Shortly after Dr. Bierring died in 1961, with the help of a grant from the AMA, a Federation executive office was established in Fort Worth, Texas. The space was
adjacent to the Texas board, whose secretary, Dr. Mac Crabb, served as secretary of the Federation from 1962 to 1977. In 1966, the Federation was formally incorporated. By 1968, the Examination Institute Committee, guided by such men as Dr. Frederick Merchant and Dr. Ray Casterline, had created FLEX in cooperation with the National Board of Medical Examiners. This remarkable achievement was the culmination of a dream as old as the Federation. Within ten years every state board had adopted the FLEX as its own licensure examination. The FLEX also provided the Federation with a solid financial base with which to address the other challenges before it.

Disciplinary action reports, published in the Bulletin since 1915, were entered in a centralized file in 1963 and a separate monthly listing was begun in 1970. These efforts led to the establishment of our sophisticated computerized Physician Disciplinary Data Bank. Also in the early years of this decade, Federation publications were rapidly enhanced as the Bulletin, the mainstay of Federation communication, was joined by the FSMB Newsletter, the FSMB Handbook, the Exchange, a thoroughly revised and effective Guide to The Essentials of a Modern Medical Practice Act, and the Model for the Preparation of a Guidebook on Medical Discipline.

This brings us to today. Our founders would be amazed and pleased at our current status. Many of the goals have been achieved and implemented. The stature and visibility of our Federation has had significant alteration bringing us to the table at the same level with the other big players in the house of medicine.

I needn't remind most of you about our progress, but a review on this 75th Anniversary is appropriate. The new FLEX exam has reached state-of-the-art in evaluation for licensure. Under the direction of the FLEX Board and with the cooperation of the National Board of Medical Examiners, this new examination has become a valid and valuable tool as one of the standards for licensure.

The computerized disciplinary data bank has become a sophisticated, accurate, and rapid method to track disciplinary action throughout all of our licensure jurisdictions. Whether we are interested in one individual or a group of individuals belonging to a large organization, the DDB can screen in a fast and efficient manner. Truly this has become one of the most important functions of our Federation. We look forward to further developments in the partnership with the AMA as we bid to become the national clearing house under the new federal legislation. To illustrate that point, it gives me great pleasure to read the following letter:

Dear Bill:

On behalf of the American Medical Association, it is my pleasure to congratulate you upon the 75th anniversary of the Federation of State Medical Boards. Our profession has come a long way since 1912, when the National Confederation of State Medical Boards joined the American Confederation of Reciprocal Examining and Licensing Boards to form the FSMB.

Today, nowhere else on earth are the standards of excellence in medicine as rigorous as they are in the United States. I have a deep sense of satisfaction knowing that the AMA and the FSMB will work hand in glove to keep it that way.

Once again, my warmest wishes and gratitude for a job well done.

Sincerely,

James H. Sammons, M.D.
Executive Vice President
American Medical Association

Today we are recognized as a national authority and resource on medical licensure and discipline. We are called upon to participate in discussions and deliberations with other professional organizations. We are asked to testify before the Congress or present background information in their deliberations. We answer inquiries and provide information to the press on an almost daily basis. We have established good communications with our member boards in an attempt to respond rapidly to their many inquiries and concerns. We maintain direct or indirect liaison with nearly all of the recognized medical organizations both public and private. We respond to a variety of requests to participate in programs which allow us to spread the gospel according to the Federation. And finally we respond in an appropriate and caring way to the many inquiries from the public.

Thus today we can be proud of our Federation and its accomplishments. There are many other aspects I could present but I have only illustrated the most significant.

Now what about the future? Maintaining our current progressive and proactive posture will be a significant challenge. I firmly believe the profession should play the major role in the licensure and disciplinary process, sharing the responsibility with our public participants and the capable men and women who staff our organizations and boards. This responsibility cannot be diverted to public officials or large boards with no professional representation or to private entrepreneurs acting as brokers for the state or federal government.

Through the disciplinary data bank communication between the Federation and the individual member boards has been greatly enhanced. This line of communication will become even closer in the future. Eventually each board will be directly tied to the Federation office with a com-
puter terminal. This will allow direct access to disciplinary and other data plus the development of an electronic mail system where important information can be transmitted hourly among the Federation member boards and other appropriate organizations.

I regret I have only visited a few of our member boards during this year as president. I believe it would be important to augment our electronic connections with personal communications. This is already being done by our chief executive officer and his staff. I would challenge the leadership of the Federation to explore the development of a system of more direct and personal interaction. The FLEX Transitional Task Force was a good example of this type of mechanism. I am certain the officers and directors of the Federation will respond to this challenge.

As I view the licensure process throughout the United States, it is clear that the individual boards are involved with a variety of issues. The issues are well known but the sources of pressures and problems are mixed, varied and complex. These issues deal with maintaining our standards for licensure as they apply to eligibility to sit for licensure examinations. Recent questions about the equivalency of one examination as compared to another has raised a number of concerns, some to the level of legislative initiatives in a few of our states. With all of this debate and rhetoric, I predict that people will begin to seriously consider a single route to licensure. This will require careful and thoughtful study and a spirit of cooperation which should include all appropriate parties and organizations. All aspects of this dramatic change including the academic and legal use of the various examinations for licensure, eligibility for graduate medical education and academic achievement should be considered. This is my personal opinion about the future after serving as your president this past year.

The words of Dr. Bierring remain as relevant today as they were when he said them many years ago, "If ever there was a time when the Federation was needed, it is the present. The Federation, with its stability and high purpose, constitutes the main bulwark on which we can depend to preserve the better ideals of medical training and qualifications. The Federation has a definite function and duty in the molding of public and professional opinion, and furthermore to constitute a guarantee for better trained physicians for this and future generations."

It is fitting to close with a statement written by F. W. Peabody in 1927. This statement on "The care of the patient" and published in JAMA illustrates the objective which we all are seeking in our various roles and activities. "The practice of medicine in its broadest sense includes the whole relationship of the physician with his or her patient. The treatment of the disease may be entirely impersonal; the care of the patient must be completely personal. Time, sympathy and understanding must be lavishly dispensed. But the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine — the secret of the care of the patient."

Happy 75th Anniversary to All!
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The Role of Impaired Physician Programs

C. RICHARD MCKINLEY, M.D.

I am honored to be asked to speak to the members and guests of the Federation of State Medical Boards on a subject of both personal affection and concern. I feel I must early on ask to speak off the record for in that way I feel I may more effectively relate to you personally. I feel the need to qualify; to tell you who and what I am, for in that way we may reach some mutual understanding about this fascinating complex subject.

First of all, despite my identification in the meeting program as a representative, I do not represent the Hazelden Foundation. With Hazelden, I identify not so much as a giver but as recipient. I continue to receive from Hazelden much more than I will ever be able to give. While I do not speak for or from Hazelden, much of what and who I am owe to that institution.

I was admitted to inpatient treatment at Hazelden for inpatient alcoholism in January of 1980. Before that time I represented what may be termed "the loyal opposition" as an active alcoholic impaired physician in the private group practice of urology. I was also serving the last half of my term as president of the Minnesota Urological Society.

Today, as a urologist in solo private practice and in recovery, I still represent to many "the problem" even though I have now been working in the solution for over six years. As an alcoholic, solidly in recovery, I still remain "impaired" to many and I can accept this limitation. In fact, my letterhead, "C. Richard McKinley, M.D., Ltd." feels comfortably human.

When I attend, as I do several times a week, a mutual-help recovery group and just say "I'm Dick, I'm an alcoholic" I feel even more at ease. But I digress from my role here.

My assigned topic is the role of "The Impaired Physicians Program" under the larger subject heading "Identifying Problem Physicians, Channels of Information." I have a handout which I hope will be useful entitled, "Directory of Committees and State Organizations for Impaired Physicians." One striking thing about this array of organizations is the rich variety of names of those committees in place at the state medical society level for addressing this disease or illness or malady or affliction which is alcoholism and other chemical dependency. Their variety alone speaks somewhat to how these physicians are perceived by themselves or their state society.

These are only the ones visible at the state society level. The remainder of programs, committees, groups and organizations, like the subsurface of an iceberg, is even larger. There is hardly a hospital, federal program, military branch, government service, large county society, specialty organization, large clinic or amalgam of physicians which does not have a branch directed to recognize, address and guide toward change physician members found to be impaired.

Here I must hasten to add that I am addressing that area of impairment which deals with alcohol and other drug addiction. Many, if not most of these organizations and groups, also come face to face with those among us who may be physically, psychologically, or organically impaired by stroke, senility, emotional instability or social disruption of some nature. These other areas of impairment are often more...
readily recognizable and well defined and accepted as medical diseases or illnesses and come under physician care and, therefore, diagnosis and supervised treatment earlier.

Here in Minnesota, we have a wide variety available from which to draw examples. I can best speak from personal experience, although attending the 7th American Medical Association (AMA) National Conference on the Impaired Physician in Chicago in April of 1986 gave me an opportunity to see that this variety also exists across the nation.

There exists at the Minnesota State Medical Society level the Committee on Impaired Physicians which until fairly recently was responsible to the Interspecialty Council of the State Society. I served on the Interspecialty Council as a steering committee member. Later, the Committee on Impaired Physicians was made directly responsible to the executive committee of the state medical society.

Currently, the Committee on Impaired Physicians, by informal arrangement or agreement, first shares information received about possible drug or chemical dependency in a physician with Physicians Serving Physicians, a nonprofit organization of physicians in recovery and physicians with alcoholism or other chemical dependency in their immediate families. I am a member of Physicians Serving Physicians, and its immediate past president. Physicians Serving Physicians (PSP), organized in 1981, has as its executive director a certified chemical dependency counselor. PSP solicits contributions from its members and has received them as well from hospital staffs, the Physicians Philanthropic Society of the Minnesota Medical Association, Minnesota Medical Insurance Exchange, and county organizations. Members of Physicians Serving Physicians come from all over the state and include nearly every specialty in medicine.

When PSP learns of a physician with possible chemical dependency, it convenes a panel of three member physicians to carry out discrete, respectful inquiry among family members, close physician acquaintances, and aware hospital staff members, often other members of PSP, since we now number some 130 doctors. Many times the name comes directly to us through a call from a concerned family member or friend, a patient, a medical colleague or partner.

We, in Physicians Serving Physicians, are trained in intervention, an act of “tough love” aimed at raising the “bottom” so as to create a situation in which the drug dependent person can hear face-to-face a detailed account of his/her observed addictive behavior as accurately documented or witnessed by as many people as we feel are required. This is a gentle but very firm confrontation designed to break through the denial and self-delusion that are hallmarks of this disease.

The next step in the intervention is obtaining a commitment on the part of the alcoholic or drug dependent person to be admitted for evaluation and treatment at a chemical dependency treatment center. At this stage, there is no need to force the person to agree to the diagnosis of alcoholism or addiction. That will occur during treatment.

In Minnesota, the Land of 10,000 Treatment Centers, it is not hard to find a good facility to refer to. Following treatment, Physicians Serving Physicians offers support for the treated physician at our monthly meetings, as advocates for entry into recovery.

A support group meeting weekly in the form of a Twelve Step mutual-help group and composed primarily of physicians and dentists has grown up in the Twin Cities as an independent anonymous group. This group also includes medical students, interns and residents, retired physicians, unemployed doctors, as well as those in private or government practice. They are physician specialists, generalists, veterinarians, doctoral level nurses and psychologists. There are similar meetings of doctors in recovery groups in many cities nationwide.

In August of 1985 in Minnesota, amendments to the Medical Practice Act, which require reporting of impaired physicians by professionals became law.

Agreements between the Minnesota Medical Association, Physicians Serving Physicians, and the Minnesota State Board of Medical Examiners are in place and cooperation has begun. Information flows between the Minnesota Medical Association Committee on Impaired Physicians, and the Minnesota State Board of Medical Examiners. Channels of communication are open and information not only regarding identifying problem physicians but information about intervention, treatment, recovery, and monitoring progress is being shared.

Trust is being developed at all levels through personal contact and working together. My attitude toward the Minnesota State Board of Medical Examiners has become transformed because I now know and have worked with several of these individuals personally. Knowing Mel and Bill, and getting to know Dr. Thompson, and having them know me over time builds trust. We can cooperate. That is what has happened in Minnesota. That is what we are like now.

Thus far this talk has been personal, anecdotal and possibly provincial. I wish to maintain that personal touch but go now to some observations for the record, some things that may apply to you all.
and your state boards.

This is material derived not only from my personal feelings and observations, but includes much which has come from information gathered from others at three of the seven national conferences on the impaired physician held by the AMA, at many educational meetings sponsored by doctors in recovery, the most recent in Texas in April of 1986, as well as rather extensive reading in the field and personal contact with people in recovery, both in the profession and in general.

Let us reflect together on these things. First and primary is the certain knowledge that alcoholism and chemical dependency untreated is a chronic, progressive, relapsing, ultimately fatal situation, characterized in the individual by loss of control and denial of the disease. With that goes acceptance of the fact that physicians are probably as prone to this disease as the general population.

Next is factual evidence that with early recognition, prompt treatment, continued care, and sensible monitoring, recovery is not only probable but predictable, and that physicians in recovery can become what has been termed “weller than well.” In other words, these men and women are capable of functioning in all areas of their lives at a level greater than they ever before experienced. This includes the practice of medicine in its broadest and deepest sense.

Next, there is polarization of feelings about this whole subject, both in public and in the house of healing that is medicine today. There is still unrest and distrust. There are divisive camps which claim on the one hand that we bury our mistakes, protect our own and cover up for our ignorant, look away from the unethical, and hide our sick colleagues.

Then, too, there is the faction which cries that we are on a witch hunt and just want to rid the ranks of competitors, weed out the bad apples, and that our primary purpose is to punish or banish or sacrifice the weak or less conventional ones to keep our own noses clean and our organizational system intact.

We must speak firmly and forthrightly to both camps from a position of integrity with responsible and responsive caring. We know that the practice of healing arts that we all envision as good is good, and, in the main, is healthy, and that the future, though clouded, will get better.

Can we trust each other? Can impaired physicians in recovery trust their state boards? Can state boards trust their state impaired physicians committees? Can we trust the recovery process? Can we set limits in order to protect colleagues and patients while stopping short of revenge and punishment? There must be mutual trust of each other, a spirit of cooperation and open communication. There must be the recognition of self, not only as healer but as sufferer.

We are prone to become patients by virtue of illness. The need for protection of public and patients as our position dictates includes treating physicians as we treat others, as valuable, vulnerable, potentially ill, worthy of treatment and capable of recovery. This requires work on our part: time and attention, but also trust that all, with care and with skill, will be well.

We now come to what has been done by organized medicine. How have we responded thus far? Much pioneer work has been done and we are rapidly gaining in knowledge and information.

In 1972, the AMA Council on Mental Health issued a landmark report entitled, “The Sick Physician.” This was published in the Journal of the American Medical Association, February 1973. Several quotations from that report have been widely used. I would like to share two of them:

“Accountability to the public through assurance of competent care to patients by physicians and other health professionals is a paramount responsibility for organized medicine.”

Then the report acknowledged

“...a physician’s ethical responsibility to take cognizance of a colleague’s inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependence...”

and goes on to state that failing recognition and acceptance on the physician’s part

“It becomes essentially the responsibility of his colleagues to make that assessment for him and to advise him whether he should obtain treatment and curtail or suspend his practice.”

In 1975 and subsequently, at approximately two-year intervals, the AMA has sponsored a national conference on the impaired physician. The last conference was in Chicago in April of 1986 which I attended along with many of you. The impact or message of that conference was one of hope for the family of medicine. Besides addressing medical student, resident and minority issues, there was talk of prevention, if not primary then certainly secondary prevention, by early recognition of prodromes of unhealthy dependencies and intense attention to changes which may head off the late consequences which you deal with in your work. Great emphasis was put on the success of well organized, adequately funded, knowledgeably supported and professionally staffed programs.

Some budgets were impressive: New York with over $350,000; California with $465,
000; New Jersey at $237,000; Florida, $150,000. In Minnesota, the amount is under $75,000. Pouring money on a problem does not alone necessarily solve the problem, but it is much better than ignoring troubling issues, and it certainly clarifies accountability.

In our sister state of Wisconsin, formal agreement exists between the state society and the state board of medical examiners. The Wisconsin committee on impaired physicians seeks to rehabilitate doctors while the examining board serves to discipline doctors. By formal agreement there was formed an intermediary coordinating council composed of members of each body which hears of and deals with the problems of physicians who fail to respond to help from the Statewide Impaired Physicians Program. If persuasion fails, the case is referred to the state board for discipline.

I believe that there can be a graduated and individualized response to deal with each unique situation. Each state program should include certain basic key elements.

I have addressed thus far some of them. These were well covered in a series of six articles by Dr. David Canavan of New Jersey, made available at the conference and now obtainable from the AMA. These elements are first, the area of education and prevention; second, the process of identification of impairment in an individual; third, the ability to confront or intervene; next, treatment referral options; effective monitoring, and last, aftercare with support groups and advocacy.

If these elements are covered in your states, you may be certain that, as the programs grow, and they will, that the problem will come under control if trust can exist between the separate organizations which serve the entire physician population.

The board of medical examiners who are responsible to the public can be trusted to insist on the responsible behavior of the physicians who have been granted the privilege to practice.

The physicians who compose the state medical society and who look to their society for leadership, can trust it to provide support services and sufficient savvy to improve the status of medical care, as well as educate their constituents about problems.

Monitoring aftercare, advocacy and re-entry are key in preservation of the natural resource that is the trained professional. That a physician in recovery is capable of good medical practice is an established fact. You may wish to modify rigid, inflexible monitoring procedures or beef them up. You may well want to advocate for a stronger state program, linking with, and even including on your boards, doctors in recovery.

You may wish to meet and work with mutual-help support groups in general and may even want to participate in some of these open meetings yourself as a concerned, caring outsider to understand personally the beauty of recovery and sobriety.

Trust that many recovering physicians can measurably help their impaired fellows. Trust that most state societies want high standards of practice instead of the covering up of problems, and trust that state boards are pledged to consider the physician returning to practice; reasonably monitoring his recovery and working for him and his patient's best interests, instead of lifting his license or binding him to a punitive surveillance for a protracted period. Reflect on these things. Then will your communities and states face chemical dependency and impairment in a manner which makes each segment co-creators in an evolutionary process for good.

You have tremendous clout; a lot of power. A very close friend of mine says "Recovery is doing the next right thing."

If indeed recovery is doing the next right thing, I feel strongly that those among us here who are informed, and indeed transformed, may go out from here and do the next right thing, for doing the next right thing in each of your constituencies is far more up to you to do than it is to me. I wish you well in your recovery.

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Six Nestors and Miss Wombacher

TRIBUTES TO THE PAST BY
DRS. WALTER L. BIERRING AND RAY L. CASTERLINE
EDITED WITH AN INTRODUCTION BY DALE G. BREADEN

Part I of this article appeared in the July 1987 number of the BULLETIN

PART II

Beverly Drake Harison, M.D.
[1855-1924]

During the lifetime of Dr. Beverly D. Harison, he was often referred to as the Father of Medical Legislation. A record of his accomplishments in promoting better regulatory measures for the practice of medicine tells the story of medical licensure as it developed during the thirty-five years preceding his death in 1924.

Although born in the United States at Canton, New York, May 8, 1855, he received his academic and medical education in Canadian institutions. He attended Bishop's College School, Lennoxville, Quebec; A.B. Trinity College, Toronto; M.D., University of Toronto, 1882; A.M. Hon., University of Michigan, 1910. In 1888, after several years of practice in the Province of Ontario, he moved to Sault Ste. Marie, Michigan, where he remained until 1906 when he located in Detroit.

Dr. Harison was the first and only Secretary of the Michigan State Board of Registration in Medicine, created in 1889. Thirty-five years as Secretary and Executive Officer was a record unequalled at that time in the United States.

* * *

Michigan at this time had a more advanced and practical method of recognizing and listing colleges than any other state in this country. Furthermore, its standards of licensure were on a higher plane and served as a model for other states, as well as national organizations concerned with medical education and licensure. The Michigan Board was also a pioneer in medical reciprocity, Dr. Harison signing the first reciprocity agreement with the Wisconsin Board in 1901.

Dr. Harison was the organizer and Secretary of the American Confederation of the Reciprocating Examining and Licensing Medical Boards. The outstanding contribution of the American Confederation was the adoption and promotion of the principles involving reciprocal relations between states which are fundamental today.

Dr. Harison was a committee of one from the American Confederation that met with representatives of the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, and the National Confederation of State Examining Boards in Chicago, February 12, 1912, at which conference it was decided to have one organization of State examining boards. A sub-committee was appointed consisting of Dr. Harison and Dr. N. P. Colwell to draft a constitution and by-laws for the “Federation of State Medical Boards of the United States” which was definitely organized on February 29, 1912.

Dr. Harison attended every meeting of the Federation from the organization including the one in February, 1924. He frequently contributed to the program, and as a member and Chairman of the Committee on Standardization of Medical Schools, he rendered most efficient service.

He can rightly be classed as one of the founders of our Federation, bringing to it the valuable experience gained in the American Confederation and giving to the new organization the same enthusiastic support that he gave to the old. To the extent that the aims and purposes of the Federation are expressed in the present American standards of medical licensure, they constitute an enduring monument for Beverly D. Harison.

(WLB)

David A. Strickler, M.D.
[1859-1941]

Dr. Strickler had the unique distinction of serving the Federation as its President for a period of nine years. During the first twelve years of the Federation, there were but two Presidents — Dr. Charles H. Cook of Massachusetts, the first President, holding office from 1913 to 1916, and Dr. Strickler from 1916 to 1925. The successful development of the Federation during this early period was largely due to the conservative leadership, good judgment and executive ability of its first two Presidents.

He likewise had an unusual record as a State Board Examiner, being a member of the Colorado State Board of Medical Examiners for a quarter of a century, from 1902 to 1927, and Secretary-Treasurer of the Board during the last sixteen years of this period. He was a Federation member of the National Board of Medical Examiners from 1919 to 1930. While confining his professional practice largely to the field of ophthalmology, he gained a wide experience in matters of examination procedure and was recognized as an authority in medical licensure and qualifying methods pertaining to the general practice of medicine.

Dr. Strickler graduated in medicine from the Hahnemann
Medical College of Philadelphia in 1881. Following a number of years of practice and graduate study he came to Denver in 1895, becoming Denver's pioneer eye specialist, and for more than four decades practiced his chosen specialty. He was a member of the American Academy of Ophthalmology and Otolaryngology, a Fellow of the American College of Surgery, and held a certificate from the American Board of Otolaryngology.

The untiring efforts of Dr. David A. Strickler in guiding the Federation during the critical period of organization, together with the memory of his fine leadership and generous personality will ever remain among the treasured traditions of the Federation.

(WLB)

Harold Rypins, M.D. [1892-1939]

On August 25, 1939, the youngest past president of the Federation, Dr. Harold Rypins, succumbed to [a] coronary thrombosis. In the brief span of less than forty-seven years was crowded a life of service to medicine and human welfare far beyond the measure of time that it represents.

He was born in Evansville, Indiana, on December 21, 1892, the son of Rabbi Isaac L. Rypins and Esther Franklin Rypins. He attended the University of Minnesota, . . . [and] matriculated at Harvard Medical School where he received his medical degree in 1919. After completing his internship at Mt. Sinai Hospital, New York City, he returned to Minneapolis to engage in private practice and research. In 1923, he was invited to assume the office of the Secretary of the New York Board of Medical Examiners. In connection with this office, he acted as Secretary of the Grievance Committee of the State Medical Society of New York from 1926 to 1939. As a representative of the New York Board, Dr. Rypins attended the annual Congress on Medical Education and Licensure for the first time in 1924, and became a potent influence in advancing the higher purposes of the Federation. His first paper, presented to the Federation in February, 1927, was entitled "Administering the Law Against Illegal Practitioners," and reflected his experience . . . in composing the New York Medical Practice Act of 1926. His qualities of leadership were recognized by the Federation in his election as Vice-President in 1928, and President-Elect in 1930, when he was just thirty-eight years of age. He served as President in 1931. In 1932 he was nominated by the Federation for membership on the National Board of Medical Examiners and was re-elected for a second six-year term in 1938.

Dr. Rypins was named as a representative of the Federation on the Advisory Board of Medical Specialties organized in 1934, and also on the Commission on Graduate Medical Education organized in 1937.

In the five-year survey of medical schools of the United States and Canada, 1930-1935, conducted under the auspices of the Council on Medical Education and Hospitals of the American Medical Association, and Association of American Medical Colleges, Dr. Rypins cooperated in inspection visits on behalf of the Federation. When the Advisory Council on Medical Education was organized in 1939, Dr. Rypins represented the Federation.

As a medical teacher, he served as lecturer and associate in medicine at Albany Medical College from 1926 to 1937 and as assistant professor since that year.

Aside from publishing a large number of articles on medical education, licensure procedure and related subjects, he was the author of Medical State Board Examinations, which passed through four editions.

Of Dr. Rypins it may be said that he gave the best of his talents to every cause he championed. A former teacher, Professor Joseph Warren Beach of the University of Minnesota, expressed this tribute: "Matchless in courage, loyalty, intellect, ability and charm."

(WLB)

Mary Wombacher [1886-1970]

When Mary Wombacher died August 6, 1970, the brief news story reporting her death indicated that she had lived in Des Moines for more than sixty of her eighty-four years. Miss Wombacher apparently never married and the newspaper account concluded with the terse statement: There are no immediate survivors.

* * *

Although few among the "old hands" at Federation annual meetings would remember [Miss Wombacher's] name, some may recall her record of fifty-seven years of service to medical licensure, as secretary to the late Walter L. Bierring, M.D., from 1904 until 1961. . . . In that capacity, reportedly she attended the Chicago meetings with regularity for a number of years. With her position in life now delineated, Mary Wombacher's name may hold more meaning, particularly for veterans of annual meetings longer ago than they may care to recall. However, even younger (and older) neophytes within the organization should pause and take note.

* * *

Now, none can know to what degree her "woman's touch" may have modified, even if only slightly, the Bierring influence on medical examining and licensing which exists yet today. There are many sayings, too familiar to repeat here, having to do with . . . the support of a loyal and effective secretary. Miss Wombacher's service to Dr. Bierring extended
from well before the frequently-quoted Flexner report through decades that saw momentous changes in all aspects of medicine. And those were the decades of his editorship of the Federation Bulletin, as well as his service as Secretary of the Federation of State Medical Boards.

...And in the implementation of the Bierring approach to many of the problems of those days, one can assume that the faithful secretary played a significant role.

In recording such suppositions, if they are valid, then this elderly [lady] could claim all who are involved in medical examining and licensing as her survivors.

Now that Miss Wombacher has gone on to her reward, hopefully her destination will be the same as that of the man she served as secretary for so many years. A firm belief in the “hereafter” can allow one to envision Walter L. Bierring yet hard at work straightening out some of the problems of licensure, wherever he may be. And there, too, he will need a secretary as faithful as Miss Wombacher — for eternity.

Thus, in honoring the memory of this woman who was known only to the “older hands” at Federation meetings, the Bulletin will be listed among her survivors, along with each Federation member. For the Bierring influence, yet found in many spheres of Federation activities, likely implemented initially by this faithful secretary, can be presumed to have been honed to perfection with her “woman’s touch.” And this heritage, though not classed as “immediate,” without question qualifies as a survivor. (RLC)

Observations on the American Malpractice Dilemma

SANFORD M. LEWIS, M.D.

If infectious disease is caused by micro-organisms, psychogenic syndromes by unresolved emotional conflict and iatrogenic disorders by physicians or their drugs, one wonders if lexicologists can provide a term to deal with the malaise which erupts when one vast societal thrust impacts negatively upon another.

The malpractice morass which so drastically compromises the quality of medical practice nationally has stimulated a diversity of therapeutic responses which were characteristic of an era when science could hope only to ameliorate symptoms while accomplishing little toward identification and removal of cause. The several states continue to aim numerous legislative weapons at varying apparent faults. Results are indifferent since root causes, for the most part, remain incompletely perceived.

The formula of patient plus physician versus disease weights the scale toward mutual benefit. When perverted to patient versus physician versus disease, it invites disaster. Inherent in the equation, as I see it, is the fundamental nidus for constructive change.

That key is the psychology of the adversary role. “Combat” is the energizing spark in the Anglo-Saxon system of jurisprudence. It is the “kiss of death” for the doctor-patient relationship. Since the current basis for dealing with “malpractice” is rooted in conventional legal doctrine, we are witnessing the preservation of juridical process at the cost of aborting the healing symbiosis. In the familiar debate, for instance, about reliance on balanced panel to replace jury, we are advised that the “right” of jury trial must not be diminished nor must the aggrieved be denied access to his “day in court.” The imperatives of legal doctrine come thus into sharp confrontation with the primacy of positive transference which represents the bedrock for effective healing. Since the latter is inherent in human experience which transcends political system, a question arises as to whether the former cannot be modified through innovative and compassionate legislative action.

Once we postulate the “given” that physician and patient must not be placed in an adversary posture, then perhaps we have taken
the major step in developing new constructs for dealing with the problem of professional failure. Certainly, one must anticipate great reluctance, particularly among attorneys, to permit any significant breach in the traditional mode. It is likely that considerations of personal gain are perhaps not as large a factor as deep reverence for the system which has, for the most part, served us well. If that system is truly the great humanistic instrument it was designed to be, it will have flexibility for change in the service of humanistic goals.

When the patient has truly been injured through error, he must be recompensed. Perhaps he should be "made whole" even in the absence of error (no-fault). The extent of that recovery must be reasonable and its reckoning insulated from the vagaries of traditional adversary process. The physician, in a civil exercise, must not be perceived by himself and others as "criminal" in the interests of generating large awards. His patients must not suffer anti-therapeutic doubts and fears stimulated by ubiquitous headlines. Doctors must be free again, for the benefit of the entire community, to pursue the innovative and sometimes inspired medicine which precipitated American healing arts to a position of world supremacy — now seriously threatened by the necessity for regressive defensive practice. Richer and more frequent awards benefit very few. The involution of the healer and the image of the healer, and the fearful constriction of his art presages substantial loss for many more.

Accountability is not forgotten in this conception. Indeed the responsibility for intra-professional discipline increases markedly. The surveillance of qualified "others" continues to be valid and the right of the complainant to fair hearing remains intact. The substance of critical review and reasonable recompense must certainly be preserved. It is the form which requires fresh design. If "doctor-father-friend" is to retain full powers for healing, his judgment must not be in the gladiator's arena nor before the "peers" who need him to be so very much more than "peer." The means are available to judge and, if necessary, debit the man. We can do this, if we set our minds to it, without depreciating the idea (image-magic) and the zeal (creativity) of the healer.

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EDITORIAL

On the Science of Cheating

A previous article in the Bulletin reviewed the thoughts of poets from the sixteenth, seventeenth and eighteenth centuries about medical licensing examinations. These authors also expressed opinions about several other subjects which interest the boards. For instance, cheating to obtain a medical license was rampant, and an extensive literature exists on the subject.

Thomas Paine expressed the credo of the cheater in any age:

These are the times that try men's souls.
We'll need to cheat to reach our goals
And place our names upon the roles.

Many candidates were realistic about their inability to pass FLEX honestly. John Heywood discussed this in a well-known passage:

A penny for your thought;
My chance to pass is naught Unless the FLEX is bought.

A careful survey of the field demonstrated that his price was much too low to attract attention.

Robert Burton reported that a candidate might be forced into a life of crime to obtain the necessary funds for a bribe:

Rob Peter to pay Paul.
I can not pass the FLEX at all Unless before the testing date Paul supplies the answers straight.

Apparently Paul was a pseudonym. Despite vigorous efforts the state medical board was never able to identify and prosecute this individual.

It was cheaper to steal the questions directly, as reported by John Vanbrugh:

He laughs best that laughs last.
I stole the questions, and I passed.

Alexander Pope also extolled the virtues of advance information:

Fools rush in where angels fear to tread.
A good crib sheet will bring you out ahead.

As usual, William Shakespeare had a succinct comment:

And all our yesterdays have lighted fools The way to get around the rules.

Paying a governmental employee to obtain a license was another approach, one discussed by John Donne:

License my roving hands, and let them go.
A healthy bribe my gratitude will show.
It is not clear whether the roving hands were interested in attractive nurses or large fees.

Cheating was so prevalent that its practitioners formed their own clubs and lobbying groups, as reported by Burton:

Birds of a feather will gather together.
Now let us all greet the others who cheat.

Burton also offered the following rationalization from a candidate embarking on a career of fraud:

When they are in Rome, they do there as they see done.
Why should I be honest? I'd be the only one.

There were several ways to become a successful practitioner as reported by Francis Bacon in a verse where his rhyme scheme failed:

Reading maketh a full man;
Conference a ready man;
Writing an exact man;
And cheating a rich man.

The International Rimers Guild gave him very low marks for this effort.

Edmund Burke was probably not correct when he suggested that cheating was a new phenomenon in his time:

But the age of chivalry is gone. We all cheat from dusk to dawn.

Fortunately, however, even in that era there were honest physicians. John Milton expressed the opinion of a conscientious examinee who resented a fellow candidate's efforts to copy his answer sheet:

Look homeward, Angel now or look towards Ruth
I've worked too hard to learn the truth
To share with anyone, Forsooth!

The comment by Oliver Goldsmith was more self-seeking; it is believed to represent the sentiment of a rejected suitor:

When lovely woman stoops to cheat,
I hope she's caught. That would be neat.

Finally, Ben Jonson quoted one candidate who was justifiably proud of herself:

I have it here in black and white.
I've studied hard both day and night.
The challenge of the boards I'll face
And answer well without disgrace.

The board was undoubtedly pleased to be able to award her an unlimited license to practice medicine and surgery.

JHM

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FOREIGN MEDICAL SCHOOL GRADUATE GETS INJUNCTION TO STOP DEPORTATION*

An alien graduate of a foreign medical school was entitled to a preliminary injunction enjoining her deportation until she could apply for legalization or have administrative review of her interim application for legalization, a federal trial court in New York ruled.

The physician had entered the United States in July 1973; trained as an intern through June 1974; and completed a residency in psychiatry and child psychiatry in 1979. She was employed as a staff psychiatrist at a children's center and as a consulting child and adolescent psychiatrist for another organization. The physician was granted a nonimmigrant H-1 temporary worker of distinguished merit status in July 1979, which was effective to June 1980.

She received extensions but was found deportable at a hearing in May 1985; an appeal was dismissed by the Board of Immigration Appeals in July 1986.

In November 1986, the Immigration Reform and Control Act of 1986 was signed into law. The act provided for legalization of aliens who entered the United States before January 1, 1982. An alien admitted as a nonimmigrant, as was the physician, was eligible for legalization if she was in unlawful status before January 1, 1982, and the government knew of her status as of that date.

The physician could not formally apply for legalization under the act until a date to be determined in 1987, but an interim procedure was provided for aliens apprehended prior to the former application period. The physician made an interim application on November 10, 1986; this was denied, and she was ordered to report for deportation on November 25.

The physician applied for a preliminary injunction, and the court issued a temporary restraining order preventing deportation pending a final determination on her application. The court found that the physician had shown the prospect of irreparable harm, as her deportation would make her ineligible for any subsequent application for legalization. She had lived in the United States for 13 years, and her skills as a child psychiatrist were in great demand. Thus, her deportation would involve hardships for her community as well. Therefore, the court found that the physician had satisfied the required showing for preliminary injunctive relief. — Kalaw v. Ferro, 651 F.Supp. 1163 (D.C., N.Y., Jan. 13, 1987)
BOARD OF NURSING HAS AUTHORITY TO ESTABLISH STANDARDS FOR PROGRAMS*

The statutory provision granting the Board of Nursing authority to establish standards for nursing education programs was not unconstitutional as an unlawful delegation of legislative power, the North Dakota Supreme Court ruled.

Hospitals that operated nursing schools brought an action against the board and its members, challenging the constitutional validity of rules promulgated by the board. The trial court certified questions to the supreme court as to establishment of standards and educational requirements for entry into the nursing programs and whether the board had usurped legislative power in passing administrative rules.

The hospitals contended that the board had been given unlimited power by the legislature to establish standards and educational requirements for entry into the nursing programs and whether the board had usurped legislative power in passing administrative rules.

The courts said that because of the nature of the subject matter, the standards provided by the statutes must be broad. If the legislature had specifically set the standards, the flexibility inherent in the board’s rule-making authority would have been lessened, and the hardship of those subjected to it might have been increased without opportunity for further hearing. The court found that the statutory provision was not unconstitutional.

The second question concerned the board’s rule-making power. The court said that it was easy to equate high standards of nursing in the interest of public health with a requirement that persons who trained nurses be qualified under proper authority and that applicants for licensure in nursing receive an appropriate degree before being permitted to take an examination for licensure. The court said that the board had the authority to define a school as “a post secondary educational institution offering transferrable academic credit,” and to exclude diploma nursing schools from operating nursing programs if they did not offer transferrable academic credits.

The court pointed out that medical science is advancing at a rapid rate and the knowledge that nurses must have to give quality nursing service in matters of life and death is increasing, justifying the delegation of standard setting in the statutory provision in question. The court found that the board had not usurped legislative power in determining who might recommend a person to take the test. — Trinity Medical Center v. North Dakota Board of Nursing, 399 N.W.2d 835 (N.D.Sup.Ct., Jan. 8, 1987)

PEdiATRICIAN SUes INSURERS OVER LIABILITY FOR PAYMENT OF MALPRACTICE SETTLEMENT*

A trial court’s statements as to the responsibility of insurers in a malpractice action were insufficient to permit application of the law to the facts of the case, the highest court of the District of Columbia ruled.

A newborn infant had been in an intensive care nursery for about 24 hours when first examined by a pediatrician during daily rounds. The pediatrician saw the infant again the same day, when he was advised that the infant was suffering from acute respiratory distress. He made a diagnosis of bacterial meningitis. After the infant’s mother gave her consent, the pediatrician signed an order transferring him to a children’s hospital.

An action alleging malpractice in the pediatrician’s failure to diagnose the infant’s disease earlier resulted in a settlement. A dispute arose between the hospital’s insurer and the company that insured the pediatrician in his private practice. The pediatrician filed a declaratory judgment action against both insurers to determine which was liable for payment in the settlement agreement.

The hospital’s insurer contended that the pediatrician was acting outside the scope of his employment with the hospital when he attended the infant. The pediatrician’s insurer argued that he was at all times acting as a hospital employee and that their liability, if any, was limited to amounts in excess of the coverage provided by the other insurer. The trial court found that the pediatrician was acting within the scope of coverage of both policies and that the hospital’s policy provided primary coverage.

On appeal by the hospital’s insurer, the court did not have sufficient findings before it to allow application of the law to the facts of the case. The trial court simply stated that the pediatrician was acting within the scope of both policies while caring for the infant. The proposed findings of the pediatrician and his insurer asserted that he was acting solely as a hospital employee. Findings that it was unable to provide an intelligent appellate review on the basis of the trial court’s conclusory findings, the court sent the case back to the trial court with instructions to prepare adequate findings of fact and conclusions of law, accompanied by its reasoning, on the responsibility for liability insurance protection. — United States Fidelity and Guaranty Company v. Kaftarian, 520 A.2d 297 (D. of C. Ct. of App., Jan. 22, 1987)
1987 RECIPIENT OF THE JOHN P. HUBBARD AWARD

Christine McGuire Selected by the National Board of Medical Examiners

G. William Daeschner, Jr., M.D., then chairman of the National Board of Medical Examiners, presented the 1987 John P. Hubbard Award to Christine McGuire during the recent annual meeting of the National Board in Philadelphia.

This award is given annually to an individual who has made significant contributions to the pursuit of excellence in the field of evaluation in medicine.

Christine McGuire currently holds appointment as Professor of Medical Education, Center for Educational Development, University of Illinois at Chicago and Professor of Educational Psychology, College of Education, University of Illinois at Urbana.

The John P. Hubbard Award was established in 1983 by the National Board of Medical Examiners (NBME) in special tribute to John P. Hubbard, M.D., President Emeritus of the Board. Honoring Dr. Hubbard as a principal guiding force of the Board, this award acknowledges his creative and inspired leadership of the National Board during his 25-year tenure as its President. Previous recipients of the award include: Howard S. Barrows, M.D. of Southern Illinois University School of Medicine, George E. Miller, M.D. of the University of Illinois at Chicago, and Stephen Abrahamson, Ph.D. of the University of Southern California School of Medicine.

In introducing Christine McGuire, Dr. F. Marian Bishop, Chairman of the 1987 John P. Hubbard Award Committee, noted that, “Her strength in the field has been acknowledged in so many ways by so many national and international groups that it seems entirely fitting for the National Board to cap that recognition with the 1987 Hubbard Award.”

McGuire received degrees in English, Education and Economics and then joined the faculty of the University of Chicago as an Instructor in Economics, later becoming Chief Examiner and Associate Professor of Social Sciences. In 1961, Christine McGuire was appointed to serve as Assistant Director in the Office of Research in Medical Education and Lecturer in the Department of Preventive Medicine at the University of Chicago College of Medicine.

Christine McGuire is widely recognized for her contributions in the development of patient management simulations in medical evaluation. Christine McGuire’s experience in the field of medical education has included serving as Coordinator for Pilot Studies in Evaluation of Professional Education for the American Heart Association; Project Director for the Orthopaedic Training Study; and as Co-Principal Investigator in the Study of Certification in Child Psychiatry. In addition, she has served as a consultant to the World Health Organization, Association of American Medical Colleges, Committee on Certification in Child Psychiatry and Neurology, and as Director and staff for various medical schools and societies on virtually every continent in the world.

McGuire has an extensive list of invited lectures and addresses and has had numerous papers published on evaluation techniques in medical education.

Christine McGuire’s selection as the recipient of this award followed a call for nominations published widely in the medical press in the fall of 1986. The 1987 John P. Hubbard Award Committee, chaired by Dr. F. Marian Bishop, included as members, Drs. Stephen Abrahamson, Arthur S. Elstein, Richard H. Moy, and Robert W. Prichard.

Christine McGuire receiving 1987 Hubbard Award certificate from Dr. Daeschner.