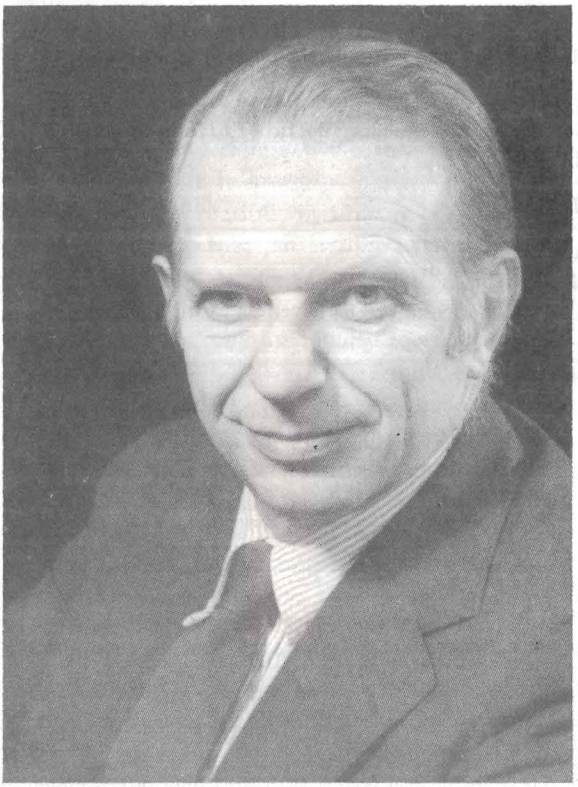
US ISSN 0014-9306

FEDERATION BULLETIN

VOL. 64, No. 6 JUNE 1977



ROBERT A. CHASE, M.D.
President and Director
National Board of Medical Examiners

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Prevention—Halt the input of additional incompetent physicians.

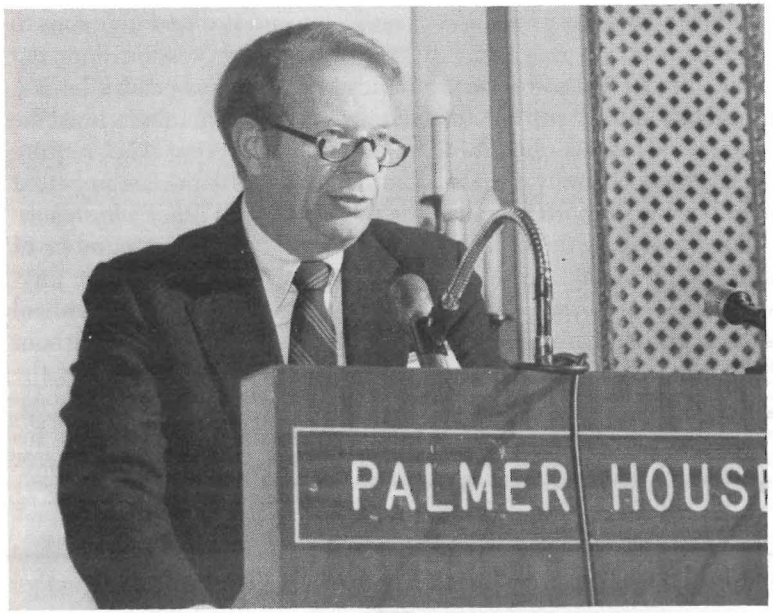
Identification—What are the criteria of competence or incompetence?

Action—Once the incompetent physician is identified, what action is suggested to correct the problem?

Prophylaxis against infusing more incompetent physicians into the practice stream is a shared responsibility with authority vested in three main agencies: 1) educational institutions and their accrediting bodies; 2) licensing and certifying bodies; and 3) the federal establishment.

Education must assume responsibility for awarding the M.D. degree only to individuals who have acquired the competence necessary to move to the next level of medical education. It goes without saying that competence clearly should include a sense of professional ethics.

Licensing organizations must be sure that individuals moving progressively into positions of responsibility for patient care are competent to do so and accrediting agencies must insist that accredited residency programs accept only individuals equipped



Dr. Chase

Robert A. Chase, M.D. has been president and director of the National Board of Medical Examiners since late 1974, when he succeeded John P. Hubbard, M.D., who retired after twenty-five years of service as chief executive of the National Board.

Dr. Chase is widely known and has received international recognition as one of the outstanding specialists in reconstructive surgery of the hand. He is well known, also, for his ability as a medical educator and for his leadership in medical curriculum innovation, as well as the introduction of new techniques in graduate medical education and continuing medical education.

Before joining the National Board, he had been professor and chairman of the Department of Surgery at Stanford University School of Medicine for more than a decade, and had been acting chairman of the Department of Anatomy at Stanford during the preceding year.

A native of Keene, New Hampshire, Dr. Chase is a graduate of the University of New Hampshire *(cum laude)* and Yale University School of Medicine (Alpha Omega Alpha, 1947). His residencies in surgery were at the Yale-New Haven Hospital and the University of Pittsburgh.

Dr. Chase served with the medical corps of the United States Army for eight years (1949-1957), during which he was chief of surgery at Fort Monmouth, New Jersey, chief of the hand surgery section at Valley Forge Army Hospital, Pennsylvania and chief of surgery at the U.S. Army Hospital, Leghorn, Italy. Since 1970, he has been a national consultant in plastic surgery to the Surgeon General, United States Air Force.

He was an associate professor of surgery at Yale prior to assuming the chairmanship at Stanford. While at Yale, the 1962 graduating class voted him the Francis Gilman Blake Award as the outstanding teacher of medical sciences. At Stanford, he was the first Emile Holman Professor of Surgery.

Dr. Chase was plastic surgery consultant at Christian Medical College and Hospital, Vellore, South India early in 1962 and has been a visiting professor in Australia, New Zealand and South Africa.

A diplomate of the American Board of Surgery and of the American Board of Plastic Surgery, Dr. Chase has been elected to membership in more than forty professional societies and associations. He is a Fellow of the American College of Surgeons and a member of the American Surgical Association; in both bodies he has served on important committees. In addition, as a member of the American Board of Medical Specialties, he has been a member of the executive committee and chairman of the surgical council. A member of the Institute of Medicine of the National Academy of Science, Chase serves as a member of the executive committee of that prestigious body.

He is a prolific author with a bibliography which includes more than one hundred articles, book chapters and monographs.

Since joining the National Board and moving to Philadelphia, Dr. Chase has kept his hand in the field of surgery, as a professor of surgery at the University of Pennsylvania and as a consultant in surgery at the university hospitals. In addition, he holds staff appointments as attending surgeon at several other well-known hospitals in Philadelphia. RLC

with the knowledge and skills essential to meet patient care responsibilities characteristic within the program.

In 1930, the Federation of State Medical Boards took action to establish its role, and that role has remained unchanged. The Federation deliberately relinquished responsibility and authority for curriculum matters and educational requirements for the M.D. degree to the American Association of Medical Colleges (AAMC) and its Commission on Medical Education, stating: "The Federation regards its proper function as: a) The determination of fitness for the practice of medicine, and b) the enforcement of regulatory measures."

Having assumed that responsibility, the Federation and separate state boards have a capital role in preventing incompetent physicians from entering practice. They find themselves between two conflicting forces as they determine minimum standards for the permit to practice medicine. There are forces favoring more rigorous licensing requirements and equally strong forces urging less rigorous requirements. The field force diagram looks somewhat like this:

Forces Favoring More Rigorous Licensure Requirements	*Forces Favoring Less Rigorous Licensure Requirements*
Physician Groups	Civil Rights Groups
Hospitals	Equal Employment Opportunities Commission
Malpractice Crisis	Foreign Medical Graduates
Federation of State Medical Boards	U.S. Citizens from Foreign Medical Schools
Some State Licensing Boards	Some State Licensing Boards
Consumer Awareness	Consumers in Need Areas
Testing Agencies	Graduate Trainees
HEW	Right to Practice Groups

Forces Favoring More Rigorous Licensure Requirements

Forces favoring more rigorous licensure requirements may have reasons that are self-serving or more nobly, reasons that are in the public interest. Physician groups are regularly suspected of wanting rigorous licensure requirements to keep the numbers and, therefore, competition down. This is clearly enunciated by individuals representing the Federal Trade Commission in public presentations during the past year. For example, Donald Baker, Assistant Attorney General of the Antitrust Division of the Department of Justice, made the following generic comments in a recent talk on antitrust, "Enforcement in the Service Sector":[3]

"Antitrust represents a fundamental commitment to free markets—to individual choice for individual businessmen and for individual consumers.

"The Antitrust Division by filing complaints and indictments serves as an advocate of less protective regulation. Too often government regulations supposedly designed to protect the public are in fact a thinly veiled scheme to protect those who are regulated."

Referring to licensure by state licensing boards whose "proffered purpose is to protect the public from incompetent and unscrupulous practitioners and to promote high standards. The effect is often to minimize competition, stifle innovation and creativity, and control entry and output as effectively as the classic monopolist."

Many medical organizations, such as the American Medical Association (AMA) and now the specialty boards, are taking notice since they are under investigation by the Federal Trade Commission (FTC). The threat, not so thinly veiled, expressed by Baker in the terminal sentence of his paper, reads, "Where we find violations, we shall prosecute. The small case in the small town may deter persons in other small markets. If deterrents do not work, then more suits will be needed, and these will increasingly be felony prosecutions."

I personally hold to the conviction that, generally, physician groups are in fact interested primarily in protecting the public against charlatans.

Hospitals need assurance that staff physicians are qualified, since the responsibility for patient care within the hospital is now legally, at least in part, a hospital responsibility. The malpractice crisis, to the extent that it is due to malpractice based on lack of competence, is a factor favoring stiff requirements for practice.

The Federation of State Medical Boards and selected state boards themselves consider it an obligation to assure physician fitness to practice through strict licensure requirements.

The general consumer public is exerting its influence in favor of stringent licensure requirements. A recent Gallup poll (1975) found the American people to consider professional incompetence as the major factor in the medical liability crisis. Eighty-five per-

cent pointed to stricter requirements and policing of the medical profession as the best solution.

Testing agencies, like the National Board of Medical Examiners, through research are developing methods to improve the objective assessment of important physician characteristics now only measured by imprecise subjective means. The licensing agencies using such methods may more adequately evaluate physicians for licensure.

The Department of Health, Education, and Welfare, through its document, "A Proposal for Credentialing Health Manpower," makes clear its push to improve licensure standards either directly or through the state boards.

Factors Favoring Less Rigorous Licensure Requirements

The recently published Equal Employment Opportunities Commission Guidelines, which have expanded their jurisdiction to encompass certifying and licensing agencies in medicine, may, in their attempt to eliminate adverse impact of tests and examinations on minority groups, threaten the integrity of the private sector licensing and certifying system. Although the primary intent of civil rights groups and the Equal Employment Opportunities Commission is not to diminish the rigor of the licensure process, the results of their current actions may have that effect. The challenge to certifying and licensing agencies to validate examinations if various minority groups perform at unequal levels creates a requirement that organizations cannot afford to cope with financially or in terms of feasibility. This leaves the undesirable alternative of lowering the examination standard to a level which will allow nearly all examinees to pass.

Foreign medical graduates and United States students from foreign medical schools are having difficulty meeting licensure requirements and thus they and their proponents are urging a more lenient standard.

State boards in states where there is a serious physician shortage are likely to want licensure requirements less demanding, as also are pockets of the public in underserved areas.

Fresh new M.D.'s entering graduate training, though admittedly not qualified to practice independently, would like requirements relaxed to allow them to moonlight in practice during training.

And finally, there are some notable individuals who propose that all licensure standards should be abolished with the thought that the market will control the practice. These right to practice advocates seem not to note the successful practice of mystics and other healers who profit from the public's misplaced trust. Offer them the rights of physicians to diagnose, dispense, and operate and the result could be inexcusable irresponsibility and disaster.

As for other agencies with authority, the federal government, through its Office of Immigration, must not perpetuate a program for physician immigration that invites any physician to immigrate without making certain that he or she is competent to enter the educational continuum with essentially the same prospect of successful completion as that of domestic medical graduates.

What Are the Criteria of Competence or Incompetence?

I have seen no more succinct a definition of competence than that used in the Georgetown University Health Policy Center Model Medical Practice Act. "Competence," says the report, is: "Knowledge, skills, and professional behavior necessary to provide adequate patient care." The generic definition is as simple as the detailed operational component parts of the definition are difficult. Setting standards of acceptable quality of patient care

Dr. Chase

by providers is one of the very complex and difficult tasks of our licensing boards. Identifying the incompetent physician is a responsibility broadly shared among—

Physician peers—via PSRO's, medical care foundations, tissue committees, etc.
Licensing and certifying agencies
Professional organizations
Hospitals
Third-party payers—private and governmental
Testing agencies
Lawyers
Consumers

Again, the same group.

We are all familiar with the methods of identification used to confirm suspicion of incompetence raised on a routine basis. These methods fall roughly into measures of competency or lack of it by peer review, observation of behavior, audit of care—both process and outcome—and examination.

A physician's knowledge and problem-solving skills are measurable by examination. Some exceedingly important skills, including interpersonal skills, are only partially measurable by present methods, but they are becoming more reliably measurable as time passes. How the physician *uses* his knowledge and various skills (commonly referred to as "process") possibly may be evaluated by observation and audit of patient care records. Review of behavior by peers, with the help of consumers, is the only presently available method to look at such characteristics as honesty, motivation, humanism, and various interpersonal skills.

It is encouraging to see that the standards for competence are becoming national, rather than regional or local, just as the locality rule in malpractice has disappeared and just as standards for licensure to practice have become national through the Federation's effort. That national versus local principle is also beginning to apply to state medical practice acts. Following the lead of the Federation's publication of suggestions for standardizing and modernizing state medical practice acts,* several

* *A Guide to the Essentials of a Modern Medical Practice Act.* The Federation of State Medical Boards of the United States. 1970.

agencies have published model medical practice acts to serve as templates for amendments of existing state statutes.

The two model medical practice acts generated by the AMA's Legislative Department, another created by the Georgetown University Health Policy Center, and one developed by the District of Columbia's Committee on Human Resources, have already had an important influence toward standardizing medical practice acts. Forty-one states have enacted amendments to their medical licensing and disciplinary acts in the last two years and many of these legislative initiatives follow the pattern suggested in the model medical practice acts. Yet Holman, in a recent paper, pointed out that although state laws mention some ninety grounds for revocation of license, not one is stated in the same way in every act and not one law mentions them all.

Perhaps most appalling is the fact that professional incompetence is not listed as a basis for disciplinary action in seventeen state laws. There is movement in the right direction, however, since in Derbyshire's report a year earlier, he noted that twenty-eight state laws were silent regarding both malpractice and incompetence.[4] Generally, the model acts have contained recommendations for: 1) improved definitions of criteria for disciplinary action, including incompetence; 2) stiffer penalties for unlicensed practice of medicine; 3) increased powers for the state licensing board and broader representation on the board; and 4) protection of the board and reporting physician against civil and criminal liability unless their action was accompanied by malice. State legislative bodies are being influenced by these recommendations and many more contained within the model acts.

Once the Incompetent Physician Is Identified, What Action Is Suggested?

Taking appropriate action to deal with the incompetent physician is the most trying obligation that we in the profession have. There are frustrating conflicts in taking action against the incompetent physician in today's legislative climate. Nonetheless, state boards and certifying agencies, medical organizations, hospitals, physicians individually and in groups, lawyers, third party carriers (public and private), and consumers all have a responsibility to assure that appropriate action *is* taken. The authority to level sanctions is most explicit in state boards, but important

action can also be taken by hospitals through limitation of privileges, third parties by withholding reimbursement, certifying boards by withholding certification or denial of recertification, and medical organizations by suspension from membership. Sanctions may be scaled all the way from:

Reprimand
Censure
Probation
Suspension from organization membership
Ineligibility for third-party reimbursement
Loss of certification
Loss of privileges
Temporary loss of license
Permanent loss of license
Arrest
Fine
Jail

One of the lessons learned from the medical licensure experience is that when only a severe sanction is available, it will rarely be applied. With a broader spread in the severity of sanctions, there has been less reluctance on the part of boards and organizations to take action. However, we must recognize that there remain many important deterrents to appropriate action against incompetent physicians and further corrective action is badly needed.

The law, so vigorous in protecting the individual physician's constitutional right to practice, makes very difficult the protection of the public against the incompetent physician. The right of the physician reported as incompetent to sue the reporting physician or lay person has, in the view of some, been a major deterrent to responsible reporting. Many states, either spontaneously or following the pattern of the model medical practice acts, have amended medical practice acts to protect reporting individuals with immunity from liability unless reporting or judgment is accompanied by provable malice. Where such immunity or its equivalent exist, the effect appears to have been enormous. For example, the *Medical World News* study, which selected states with 2,000 to 3,000 practicing physicians, noted the number of disciplinary actions reported between 1969 and 1973 to be as follows:

Oklahoma	3
District of Columbia	4
Iowa	10
Kansas	16
Alabama	24
Oregon	60
Arizona	250

Edwin Holman, noting this discrepancy, pointed out that although there are numerous other variables, it is not unreasonable to assume that the fact that Arizona has a law requiring a physician to report incompetent associates and giving him some protective immunity from libel suits, is in part responsible for the higher incidence of disciplinary actions taken.[5] In Arizona, the reporting of complaints quadrupled after enactment of the law, according to Derbyshire's data.[6]

Five hundred physicians surveyed recently by "Impact," however, felt that physicians are reluctant to report incompetence in other physicians because they simply "don't want to get involved." About one-third of the group felt that professional loyalty plays a part and only one in five thought that fear of being sued was a major factor. In fact, fear of being sued is not well founded when one realizes that suits against doctors who step forward and testify occurs only about one-half of one percent of the time. Transposing the Arizona experience, I expect that physicians would be less reluctant to "get involved" if they were required by law to report and that, in addition, they were protected by immunity against even unlikely civil or criminal action.

Hospitals and medical groups through physician staffs at the local level remain the front line for corrective action to cope with the incompetent physician. A new book which will shortly hit the stands will publicly display an opinion that hospitals are not taking such action, but, in fact, are protecting incompetent physicians by ignoring and justifying medical errors. It is *The Unkindest Cut* by Dr. Marsha Millman.

By contrast, William Mitchell shows evidence of experience in hospital responsibility for disciplining physicians in his practical communication in last month's *Journal of the American Medical Association (JAMA)*, entitled, "How to Deal With Poor Medical Care."[7] I shall not repeat his review and set of sensible suggestions to hospital boards here except to say that I see the same

circle of frustration potentially present for any agency which has as a responsibility and authority the painful problem of dealing with errant, incompetent professional colleagues.

The circle (Figure I) goes somewhat as follows. Recognition of

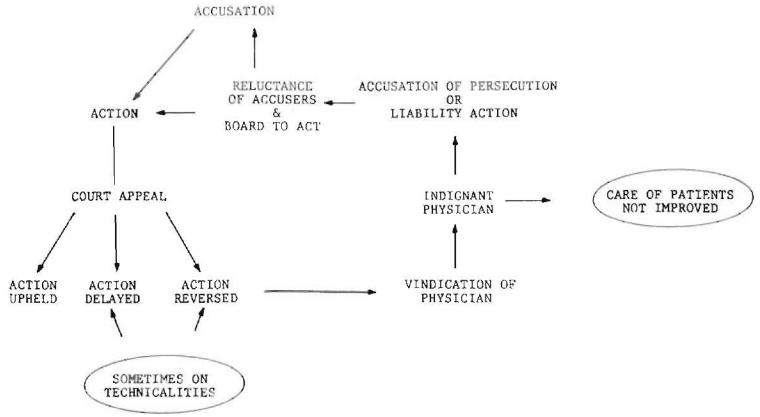


FIGURE I

a possible problem comes through allegation by a responsible, knowledgable person whose observation is direct, not hearsay. Evidence is collected by the board from all sources, including the accused under due process. The accused physician's behavior is evaluated against well-developed criteria available to all physicians. Where justified, action for correction is taken by the Board. There is always the legal right of appeal by the accused physician. Review and appeal may result in the action of the Board being upheld, the action being delayed, or the action being reversed. Reversal and even delay results in apparent vindication of the physician and this gives rise to a whole subset of influences. Delay of action based commonly on legal technicalities is the rule.

Listening recently to an *Audio Digest* family practice tape, I heard Attorney Neil L. Cheyat, distinguished faculty member at Harvard, speaking of the misuse of legal technicalities, say, "I could keep an incompetent physician in practice for years by techniques of delay, technicalities, and the utilization of due process." This conflict between due process to protect the physician versus the morally legitimate removal from practice for the public good is being resolved, at least in some part, by *some*

states through changes in statutes. For example, delay of action can be implemented by a judge who grants a stay order *ex parte* without consideration of the Board's judgment. This allows the physician to continue free of sanctions through all appeals all the way to the Supreme Court. A few states now require a court to hear the state board's side, as well as that of the physician, before a "stay order" is issued. This seems to me to be the least a state legislature could do.

One would expect reversal of board action responsibly taken to be rare. However, Derbyshire's data conflicts with that opinion.[8] In a five-year period to 1974, there were thirty-eight appeals and in ten, or one-quarter of the total, the courts overruled the boards. Most important is that reversal or even delay of action to sanction the physician does nothing to create an incentive for the physician to improve his care of patients. Sadly, it even may reassure other errant physicians. To follow the circle (Figure I) further, reversal or delay with apparent vindication spawns an indignant physician who levels accusations of persecution against the Board and responsible reporting persons. The vicious circle is complete when such accusations result in frustration and reluctance of the Board to go through the painful battle again.

When an authoritative Board acts deliberately, and responsibly bases action on solid nationally standardized criteria and objective incontrovertible evidence, and further provides ample opportunity for the accused to be heard, that Board deserves broad support by the profession. I am concerned that a Board's morale is eroded when legal technicalities appear to vindicate the physician acted against in good conscience by the Board.

I seem to be looking at disciplinary actions, sanctions, and deterrents—all negative terms—when, in fact, one ought also to look at incentive strategies to reward physicians for positive desirable behavior. As a matter of fact, it is questionable whether a deficient, careless, incompetent physician can be made to practice good medicine by an external threat. I like the principle expressed by Kingman Brewster, President of Yale, in his address to the graduating class this year, when he said, "Fear is no substitute for voluntary motivation." Furthermore, the unresponsiveness of the incompetent physician to an external threat may itself be part of his incompetence.

As to controls versus incentives, Clark Havighurst put it well

when he said, "Controls necessarily operate by establishing a minimum level which all providers must meet, and they supply no pressure to exceed that minimum. Incentives, on the other hand, operate on all providers all the time, encourage maximum attention to obtaining improved results even on the part of the very best physicians and hospitals. The pressure is thus for *performance*, not merely *compliance* with minimal standards which, whether set by professional groups themselves or by a government bureau, inevitably linked by the ties of political influence to organized providers, are unlikely to embody very high aspirations."[9]

There are possible actions that might be taken to create incentives for physicians to perform at the highest possible level. For example, in the medical liability insurance coverage area, it has been suggested that there should be incentives favoring excellence in patient care. A reward for avoidance of compensable events might take one of the forms described in Havighurst's *Medical Adversity Insurance*. A system of deductibles which would protect the physician against major financial disaster by having the first 10 percent of any claim up to $50,000 payable by him to the insurer would likely urge good practice. Similarly, an insured physician might be required to pay the first $10,000 of claims in any year and would profit by that amount if he avoided all compensable events. These strategies, augmenting limited self-insurance, might act as an incentive for physicians to do what they are competent to do in a manner that would likely result in the best possible outcome. The obvious disadvantage is the incentive for all physicians to avoid and thus abandon the very patient who may need their services most—the high risk patient.

Other incentives for optimal behavior of physicians take the form of recognition by honor, award, and direct financial rewards. There are subtle perverse incentives to misbehave by over-utilization in our uncontrolled fee for service system and a similar perverse incentive to under-utilize in the pre-pay system. An organizational strategy properly balancing the incentive to over-utilize versus the incentive to under-utilize is probably some form of controlled fee for service system. Some system must be devised to prevent providers from the present possibility that they may carry out marginal, inappropriate, unnecessary, and even harmful procedures for profit.

Another strategy with a positive influence on physician behavior is that generally called the "sick physician plan." The Minnesota State Medical Association, for example, has a plan to identify physicians needing help to overcome problems which result in substandard performance in practice.

Early this month, the State of Washington Medical Association implemented, through its Professional Problems of Physicians Committee, a non-coercive system of peer aid to disabled and thereby incompetent physicians.

Informants, including family or other physicians, have available a hot line phone number which is open twenty-four hours a day. A committee physician will collect information and if intervention is warranted, case managers—physicians from a distant area—arrange to call upon the physician. They will bring the physician's attention to the visibility of his problem and the concern of family, friends, and colleagues. In addition, they attempt to persuade the physician to seek help and they follow up to see if the physician responds. If the system fails, the original informant is so notified and the informant may choose to seek help through the coercive route. The physician who refuses this opportunity for self help will likely be dealt with through the control mechanisms about which I have spoken. Other states, including New York, have initiated non-coercive systems which give the errant physician insight into his own problem and an opportunity to "heal himself."

Summary and Review

By studying the impact of initiatives already being taken to cope with the incompetent physician, it is possible to make some sensible predictions on the outcome of those initiatives.

In the area of prevention, medical schools have responded to the need through such measures as maintaining the same standards for graduation, while revising admissions standards to respond to the public's need for a better balanced group of graduates in terms of sex and racial or ethnic minorities. There has been a positive response to the sense of need for reemphasis on ethics when one notes that seventy medical schools now have ethics courses within the curriculum. Schools, admittedly under some pressure, have placed greater emphasis on generic medical education with new emphasis on primary care.

To the Federation's described role in standardizing and maintaining rigor in licensure must be added a new and highly relevant initiative. It seems likely that the Federation of State Medical Boards will assume responsibility for a requirement that all newly emerging physicians show evidence of measurable competencies to assume patient care responsibility characteristic of that in residency training by passing a standardized comprehensive qualifying examination for entry into such training. This will help to set a common single standard for entry into graduate education for foreign and domestic physicians alike. This promises to eliminate some substandard physicians now entering the practice of medicine in this country. The Federation will, should it assume that responsibility, take one more step toward fulfilling even more comprehensively its avowed responsibility, "the determination of fitness (of individual physicians) for the practice of medicine."

The federal government, through Public Law No. 94-484, the Health Professions Educational Assistance Act of 1976, has set new rigorous (perhaps too rigorous) requirements for the entry of alien physicians. In time, a just system to equilibrate requirements for foreign and domestic graduates will emerge and it will likely diminish the possibility of introducing significant numbers of foreign graduates who are, subsequent to admission, unable to meet licensure requirements.

The National Board of Medical Examiners must insist on high standards in testing methodology and must broaden the important physician competencies that reliably may be measured. Part of the maintenance of high standards of reliability is threatened by any break in security of examinations prior to the administration for certification and licensure. Sadly, the National Board is, of necessity, investing considerable effort and money in security maintenance to cope with forces with felonious intent which threaten test security.

Identification of the incompetent physician is more legitimate and simpler as standardized criteria develop. Several ad hoc groups and the AMA have generated model medical practice acts which serve as a template for individual state legislatures to use in amending and updating their own statutes to adhere more closely to a national standard. Many states have already responded by making changes and I expect all states will do so in due

time. The acts make it possible under the law more effectively to identify and discipline the incompetent physician.

The framework for action to deal effectively with the incompetent physician now exists and that framework is being improved. Incentives to remain competent and sanctions against incompetence are emerging and yet there still remain disincentives which deter physicians from taking action and there are perverse incentives to maltreat for profit—a major form of incompetence. The medical profession will need help if it is to take the lead in minimizing the misuse of legal technicalities or other strategies that work to keep the incompetent physician, or for that matter, the unlicensed and even non-physician, in the practice of medicine.

In my view, there *must* remain a solid resistance on the part of a responsible profession to any attempt to erode the standards for the permit to practice medicine. No matter how noble the social purpose, these threats to rigorous standards must be vigorously countered—a justified position in support of the public's right to protect itself against incompetent providers.

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REPORT OF FEDERATION REPRESENTATIVE TO THE FEDERATION OF ASSOCIATIONS OF HEALTH REGULATORY BOARDS (FAHRB)

KENNETH H. SCHNEPP, M.D.

The Federation of Associations of Health Regulatory Boards (FAHRB) was formed in 1973 to serve as the national coordinating body for matters of mutual concern to the state regulatory boards in the various health sciences. The member organizations of FAHRB are: American Association of Dental Examiners; American Association of State Psychology Boards; American Association of Veterinary State Boards; Council of State Boards of Nursing; Federation of Podiatry Boards; Federation of State Chiropractic Examining Boards; International Association of Boards of Examiners in Optometry; National Association of Boards of Pharmacy; and The Federation of State Medical Boards of the United States.

At the request of Dr. Morton and Dr. Crabb, I represented our Federation at the 3rd FAHRB Forum held in Chicago September 17-19, 1976. I was aware of FAHRB but that was about all, and, in fact, had some mental reservations concerning the propriety of our Federation acting as one of the sponsors. I can assure you that after attending this Forum and meeting with the directors twice, my earlier misgivings provide to be unfounded.

The program was good and was primarily devoted to the problems of regulation, discipline and the proper management of regulatory board hearings. These were accomplished by the workshop method with a subsequent panel discussion.

Of particular interest was the presentation of Mr. Winston Dean, representing the Office of Policy Development and Planning, Office of the Assistant Secretary, Department of HEW. He discussed "A Proposal for Credentialing Health Manpower," originally published in June 1976. As you may recall, this pro-

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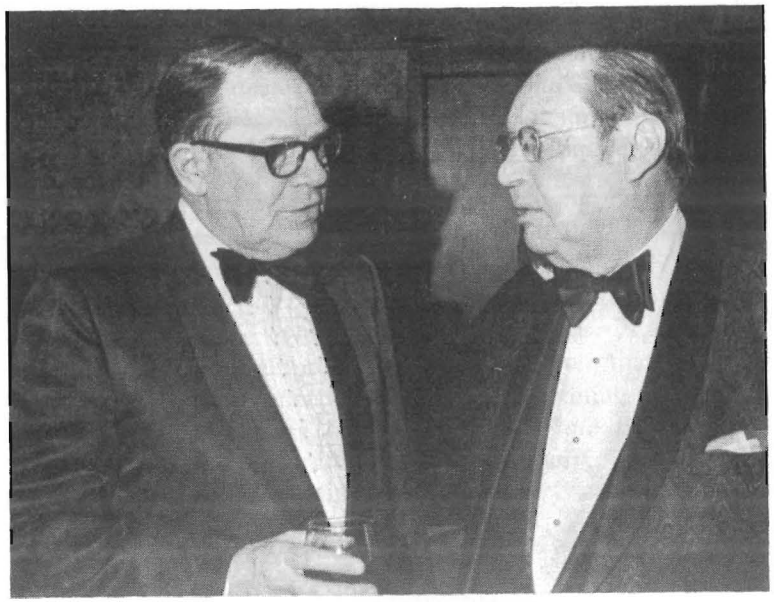
Prepared for the annual business meeting of the Federation of State Medical Boards of the United States, Chicago, January 29, 1977.

Dr. Schnepp is a member of the Board of Directors of the Federation of State Medical Boards and a former member of the Medical Examining Committee of the State of Illinois.



Dr. Schnepp (at right) and Howard L. Horns, M.D.

posed a broadly representative National Certification Council which would lay down rules and regulations for all types of accreditation, certification, and licensure. All regulatory boards in all professions and in all states would be required to comply with these regulations. In the event of noncompliance by any state, enforcement was simple; in reply to a direct question, Mr. Dean made it quite clear—all federal funds would be withheld from that state.

Dr. Casterline followed with a rebuttal emphasizing state's rights and the importance of local control over licensure.

The real chiller was a paper by Bruce M. Chadwick, Deputy Assistant Director, Division of Special Projects, Federal Trade Commission. The speaker told us we were using accreditation, certification, and licensure to limit entry into various fields, to establish monopolies, and to increase costs while offering less service. He attacked the universal professional bans on advertising as reducing competition and concealing charlatans.

It was an experience to listen to this!

I learned enough from my contact with this Forum to conclude that FAHRB is a most worthwhile organization and is doing a

splendid job in coordinating the fight against bureaucratic takeover of the professions. Our Federation should take an active interest in FAHRB and solidly support it.

It might be mentioned that the 4th FAHRB Forum is scheduled for September 16-18, 1977, to be held in the International Hotel, New Orleans.

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COURT DECISIONS

The following Capsule Reviews are reprinted from several issues of Volumes 33 and 34 of *The Citation.*[*]

Osteopath's License Suspended . . . The state board of osteopathic examiners is responsible for determining the standards of practice for members of its profession and in the absence of proof that the standards were arbitrarily or capriciously applied, the board's action will stand, an Arizona appellate court ruled. The court found the evidence sustained the board's suspension of an osteopath for unprofessional conduct and that an order requiring him to take specified postgraduate training was not unconstitutionally indefinite.—*Huls v. Arizona State Board of Osteopathic Examiners in Medicine and Surgery,* 547 P.2d 507 (Ariz.Ct. of App., March 30, 1976)

Dentist's License Suspended . . . A dentist who obtained morphine sulfate by writing prescriptions for persons for whom the medication was not intended or used was suspended from the practice of dentistry for six months by the state Board of Dental Examiners. The Board found that the dentist had committed felonies and thereby was guilty of "conduct of a nature to bring discredit upon the dental profession." On review, a Florida appellate court found that the dentist was only guilty of misconduct where, although he circumvented proper procedure for obtaining the drug, he did so only as a means of obtaining small quantities so that he would not have to store it in the office beyond the end of the day. Sending the case back to the Board, the court said that discipline in excess of a public reprimand and license suspension for 30 days would be excessive.—*Richardson v. Florida State Board of Dentistry,* 326 So. 2d 231 (Fla.Dist.Ct. of App., Feb. 5, 1976)

Bar Examination Not Discriminatory . . . A black citizen who failed to pass the Virginia bar examination brought an action against the state Board of Bar Examiners and its members, al-

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[*] *The Citation* is prepared by the Office of the General Counsel, American Medical Association.

leging that racially discriminatory practices in design, administration, or scoring of the examination deprived black applicants of an equal opportunity to become practicing attorneys in the state. The court found that the test validation principles developed under Title VII of the Civil Rights Act did not apply to professional licensing examinations. The court said that the Equal Employment Opportunity Commission guidelines in that area were designed to measure ability to perform certain limited functions or operate particular machinery, while the bar examination served a much broader purpose. States have a compelling interest in the practice of professions, with a broad power to establish standards for licensing practitioners and regulating the practice of professions as part of their power to protect the public health, safety, and other valid interests, the court said.—*Woodard v. Virginia Board of Bar Examiners*, 420 S.Supp. 211 (D.C., Va., Sept. 9, 1976)

Nurse Denied License . . . A nurse who passed a national licensing examination in the District of Columbia was not entitled to an order compelling New York officials to grant her a nursing license, a New York appellate court ruled.

For years, the State University of New York had recognized the national examination given by the National League for Nursing. However, in July, 1974, the University administered a different test in New York and refused to recognize the examination passed by the nurse in June, 1974. She then brought an action to compel New York officials to issue her a license as a registered professional nurse. A trial court dismissed the suit, and she appealed.

On appeal, the New York court ruled that the officials had not acted arbitrarily in refusing to recognize the test. The New York officials switched tests because they felt that the examination was not secure. The officials' decision to give a different test for licensing purposes was not arbitrary, the court said. It could not substitute its judgment for that of the administrative officials, the court concluded. The trial court's judgment was affirmed.—*Smith v. University of the State of New York*, 373 N.Y.S.2d 896 (N.Y.Sup.Ct., App.Div., Oct. 23, 1975)

Federation News:

FEDERATION PRESIDENT WILKINS ANNOUNCES MEMBERSHIP OF FIVE STANDING COMMITTEES AND REPRESENTATIVES TO SEVERAL ORGANIZATIONS

President Harold E. Wilkins, M.D. recently announced the appointment of a number of members to five standing committees of the Federation of State Medical Boards, as well as the election of other members to represent the Federation on the boards of several other organizations.

ARTICLES OF INCORPORATION AND BYLAWS COMMITTEE

Elmer G. Linhardt, M.D., Annapolis, former secretary of the Maryland Board of Medical Examiners, will continue as chairman of the Federation Articles of Incorporation and Bylaws Committee.

Dr. Linhardt

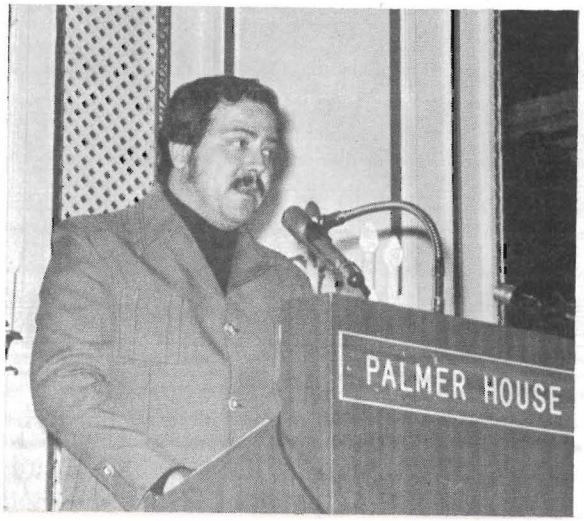
The other members of the committee are Thomas J. Sinatra, M.D., Brooklyn, vice-chairman of the New York Board; Russell O. Sather, M.D., Crookston, president of the Minnesota board; Charles B. Odom, M.D., New Orleans, president of the Louisiana

Dr. Sinatra (at right) and Jackson W. Riddle, M.D., former executive secretary of the New York board.

board; and Richard C. Lyons, M.D., Erie, chairman of the Pennsylvania board.

LEGISLATIVE ADVISORY COMMITTEE

R. C. Derbyshire, M.D., Santa Fe, secretary-treasurer of the



Dr. Godinez

New Mexico Board of Medical Examiners, and a past-president of the Federation, was appointed chairman of the Federation Legislative Advisory Committee.

Richard E. Flood, M.D., Weirton, a member of the West Virginia Medical Licensing Board, and president-elect of the Federation, is a member of that committee; as are Carlos D. Godinez, M.D., McAllen, a member of the Texas board; Howard L. Horns, M.D., Minneapolis, a consultant to the Minnesota board and a past president of the Federation; and Edgar W. Young, Jr., M.D., Oklahoma City, secretary-treasurer of the Oklahoma Board of Medical Examiners.

PROFESSIONAL RELATIONS COMMITTEE

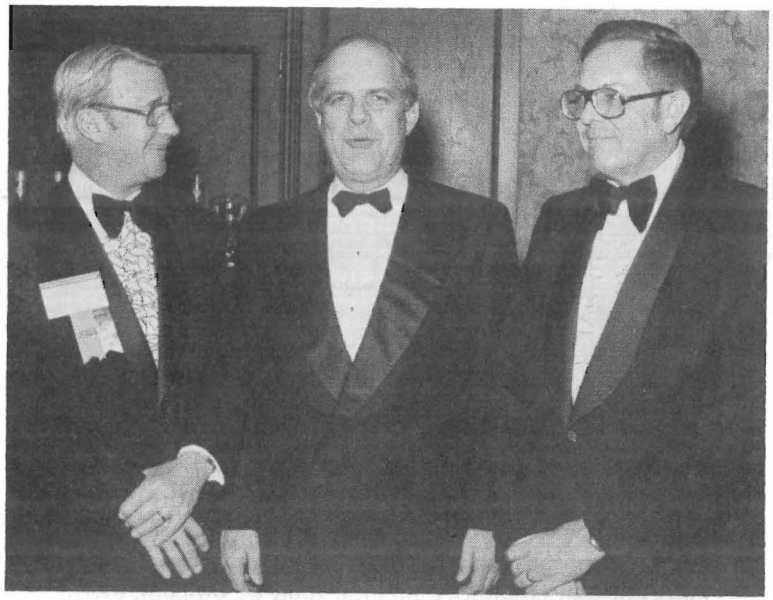
Clarence B. Trower, Jr., M.D., Norfolk, assistant secretary-treasurer of the Virginia State Board of Medicine, was appointed chairman of the Federation Professional Relations Committee (formerly, the Public Relations Committee).

Members of that committee include John U. Bascom, M.D., Eugene, immediate past chairman of the Oregon Board of Medical Examiners; Raymond C. Grandon, M.D., Harrisburg, a member of the Pennsylvania board; DeWitt E. DeLawter, M.D., Bethesda, president of the Board of Medical Examiners of Maryland; and George P. Taylor, D.O., Sidney, secretary of the Nebraska State Board of Examiners in Medicine and Surgery.

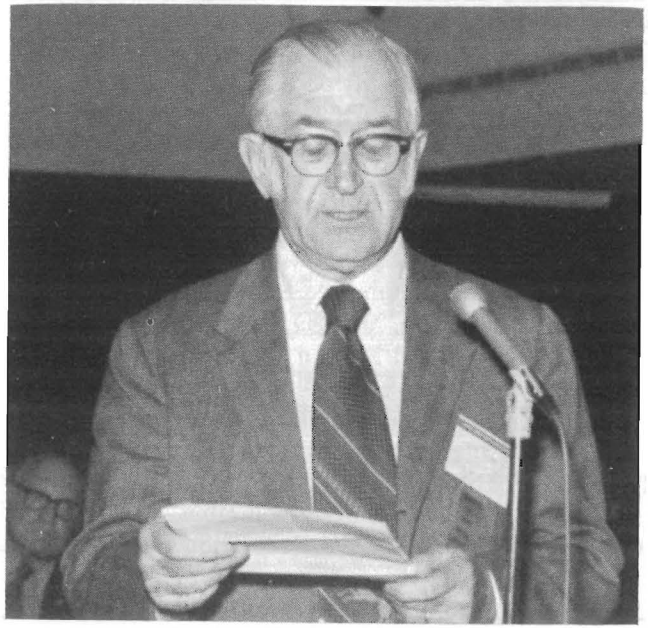
NOMINATING COMMITTEE

Immediate past president John H. Morton, M.D. became chairman of the Nominating Committee of the Federation, succeeding past president Dan A. Nye, M.D. Dr. Nye, Kearney, is a member of the Nebraska board and Morton, Rochester, a member of the New York board.

The other members of that committee are Joseph J. Combs, M.D., Raleigh, former executive secretary of the North Carolina Board of Medical Examiners and a past president of the Federation; Henry G. Cramblett, M.D., Columbus, a member of the Ohio board and a member of the Federation Board of Directors; Howard L. Smith, M.D., Roswell, for many years a member of the New Mexico board; and A. Bryan Spires, Jr., M.D., Austin, secretary-treasurer of the Texas Board of Medical Examiners.



From left: Dr. Nye, Dr. Morton and Dr. Cramblett.



Dr. Combs

GALUSHA AND WILKINS ELECTED TO MEMBERSHIP ON THE NATIONAL BOARD OF MEDICAL EXAMINERS

The Federation Board of Directors elected Bryant L. Galusha, M.D., Charlotte, a member of the North Carolina board, and Harold E. Wilkins, M.D., Downey, president of the Federation and a past president of the California board, to represent the organization on the National Board of Medical Examiners for initial four-year terms ending in 1981. Howard L. Horns, M.D., Minneapolis, was elected to membership in the National Board for a second term, ending in 1981.

Lawrence Scherr, M.D., long a member of the New York State Board for Medicine, continues as a member of the National Board; his first term will expire in 1980. Edgar W. Young, Jr., M.D., Oklahoma City, will complete the unexpired portion of the term of John A. Layne, M.D., Great Falls, Montana during the 1978 annual meeting.

Dr. Young

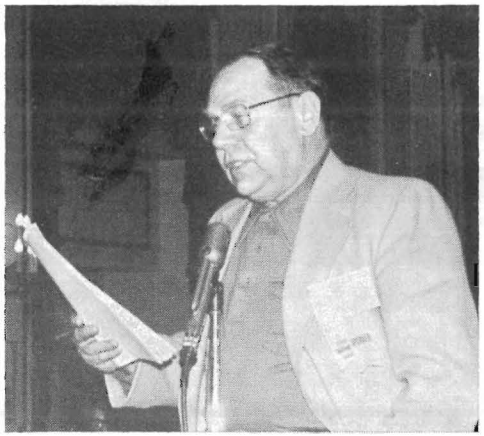
Galusha, Horns, Scherr, Wilkins and Young are official Federation representatives to the National Board of Medical Examiners. However, several other Federation members serve as members-at-large of that prestigious body, each appointed to membership because of his widely recognized expertise in examination, cer-

tification and licensure. Among those "at-large" members are the vice-chairman of the National Board, John H. Morton, M.D. and Lloyd Evans, M.D., Laramie, Wyoming, a member of the NBME Executive Committee.

LIAISON COMMITTEE FOR CONTINUING MEDICAL EDUCATION (LCCME)

R. C. Derbyshire, M.D. was selected to represent the Federation as a member of the LCCME committee appointed to study accreditation procedures for continuing medical education programs.

Howard L. Horns, M.D. continues as the principal Federation representative to the LCCME.



Dr. Horns

AMERICAN BOARD OF MEDICAL SPECIALTIES

Henry G. Cramblett, M.D., John H. Morton, M.D. and R. C. Derbyshire, M.D. continue as Federation representatives on the American Board of Medical Specialties.

During the 1977 annual meeting, the Federation Board of Directors recognized Dr. Morton's outstanding service as a member of the American Board of Medical Specialties by electing him to a third term, which will expire in 1980. In addition, the board elected Dr. Derbyshire as an alternate representative to ABMS for a second term, which will expire in 1980.

Henry G. Cramblett, M.D. will conclude his second term as a

member of the ABMS (representing the Federation of State Medical Boards) in 1980.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

Harold E. Jervey, Jr., M.D., Columbia, long a member of the South Carolina board, a past president and, now, secretary-treasurer of the Federation; and Kenneth H. Schnepp, M.D., Springfield, formerly chairman of the Medical Examining Committee

Dr. Jervey

of the State of Illinois, and a member of the Federation Board of Directors, are serving their second terms as members of the Board of Trustees of the Educational Commission for Foreign Medical Graduates.

RLC

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

Officers and Directors
1977

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