

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

FLEX
and
SPEX

Information Bulletin

1990

The Federation of State Medical Boards
of the United States, Inc.
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Fort Worth, Texas 76102-7199
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Examination Dates

Registration deadlines are determined by the individual licensing boards. In general, these deadlines are at least 10 weeks prior to each FLEX administration, 6 weeks prior to each SPEX administration.

FLEX Administration Dates

1990 Component 1 (1½ days)
— June 12 & 13 (Morning)
— December 4 & 5 (Morning)
Component 2 (1½ days)
— June 13 (Afternoon) & 14
— December 5 (Afternoon) & 6

1991 Component 1 (1½ days)
— June 11 & 12 (Morning)
— December 3 & 4 (Morning)
Component 2 (1½ days)
— June 12 (Afternoon) & 13
— December 4 (Afternoon) & 5

SPEX Administration Dates

1990	1991
March 15	March 14
June 14	June 13
September 13	September 12
December 6	December 5

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THE FEDERATION LICENSING EXAMINATION (FLEX) and the SPECIAL PURPOSE EXAMINATION (SPEX)

The Federation of State Medical Boards of the United States, Inc., is a non-profit organization that was founded in 1912. Its membership is comprised of the medical licensing boards of all the states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, and includes most of the sixteen separate osteopathic licensing boards in the United States.

In the United States and its territories, licensure to practice medicine is a privilege granted only by the individual licensing boards of the various jurisdictions. All jurisdictions require, as part of their licensing process, successful completion of an examination or other certification demonstrating qualification for licensure.

In 1968, as part of its continuing efforts to promote uniform standards for physician licensing, the Federation introduced the ***F***ederation ***L***icensing ***Ex***amination (FLEX). Through its elected FLEX Board, the Federation offered FLEX to licensing jurisdictions as a high-quality, nationally standardized examination to replace individual licensing board examinations. Currently, all medical licensing jurisdictions in the U.S. as well as the Canadian province of Saskatchewan use FLEX as their own qualifying examination for physician licensure.

In 1988, the Federation introduced the ***S***pecial ***P***urpose ***Ex***amination (SPEX). SPEX is offered for re-examination of **selected physicians** for whom a licensing board determines the need for a current demonstration of medical knowledge — for example, applicants for licensure by endorsement/reciprocity who are some years beyond initial examination, physicians seeking license reinstatement or reactivation after some period of professional inactivity (due to illness, disciplinary action, etc.). Currently, SPEX is routinely administered by several U.S. licensing jurisdictions and administered as needed by other jurisdictions.

ADMINISTRATIVE INFORMATION

Eligibility

Eligibility requirements for admission to FLEX and SPEX are established by the individual licensing boards pursuant to their statutory and regulatory provisions. Individuals wishing to sit for either examination should contact the licensing board from which they plan to seek license to determine their eligibility according to the requirements of the jurisdiction.

Applications and Fees

Applications for FLEX or SPEX must be obtained from the licensing board for which the examination is to be taken. Applications for the examinations are processed and approved by the individual licensing boards, not the Federation.

Examination fees for FLEX and SPEX are established by the individual licensing boards. Information on fees should be sought from the licensing board for which the examination is to be taken.

Administration Centers and Dates

FLEX and SPEX are administered at test centers established by the individual licensing boards. Information on test center locations should be sought from the licensing board for which the examination is to be taken.

FLEX is administered on the same dates in all jurisdictions. SPEX is administered on the same dates in all jurisdictions. Dates for examination administrations are established by the FLEX Board. Dates for examination administrations in the current year are listed on the inside front cover of this *Bulletin*.

FLEX is available to all jurisdictions for administration in June and December of each year, although some jurisdictions may not give the examination twice yearly. SPEX is available to all jurisdictions for administration in March, June, September and December of each year, although some jurisdictions may not give the examination four times yearly. Individuals should contact the licensing board for which the examination is to be taken to confirm the frequency of exam administrations in the jurisdiction.

Administrations may be cancelled or invalidated if satisfactory evidence is received that a break in the security of the examination has occurred. Such administrations may be resched-

uled at such time as the standard testing conditions necessary for meaningful and valid scores can be assured.

Courtesy Candidates

Some licensing boards will allow individuals to sit for FLEX or SPEX in their jurisdiction even though the examination is being taken as part of the licensing process of another jurisdiction. Individuals sitting for an examination in one jurisdiction for purposes of licensure in another jurisdiction are known as courtesy candidates.

Individuals wishing to take FLEX or SPEX as a courtesy candidate must contact the licensing board from which license is being sought. If the boards' regulations permit courtesy candidates arrangements for sitting the examination in another jurisdiction will be made through the licensing board from which license is being sought.

Examinees with Handicaps

Whenever possible and necessary, reasonable accommodations may be made for administration of FLEX or SPEX to examinees with visual or other physical handicaps. Individuals requiring such accommodations must contact the licensing board for which the examination is to be taken, submitting a request together with such documentation as may be required to substantiate the need. Requests for special accommodations should be submitted as early as possible, certainly prior to the jurisdiction's deadline for receipt of applications. Personal appearance before the licensing board may be required.

If approved, special arrangements, procedures and fees, if applicable, will be established and communicated to the examinee by the licensing board.

Information on FLEX eligibility requirements, application deadlines, test center locations, etc. in the various U.S. licensing jurisdictions is published in the Federation's *Exchange,* a yearly survey of all U.S. licensing board requirements for FLEX and physician licensure. See the back cover of this *Bulletin* for information on how to obtain this publication.

THE EXAMINATIONS

Purpose

The purpose of the FLEX Program is to provide a high-quality, objective and standardized examination for use by physician licensing boards as their own qualifying assessment for licensure. The purpose of SPEX is to provide a high-quality, objective and standardized cognitive examination to **assist** licensing jurisdictions in **their** assessement of current competence requisite for general, undifferentiated medical practice by physicians who hold or have held a valid, unrestricted license in a United States or Canadian jurisdiction. Such examinations provide uniform and equitable assessments in terms of content, levels of difficulty, and scoring practices, creating a rational basis for interstate endorsement/reciprocity.

Development of the Examinations

Development of examination materials is accomplished through a network of committees of medical experts, appointed by and working in collaboration with the National Board of Medical Examiners (NBME) at the direction of the Federation's FLEX Board. Members of the committees are selected for their expertise in their respective fields and are drawn from the academic, practice, and licensing communities. All of the test materials used in FLEX and SPEX are owned and copyrighted by the NBME, and any reproduction or distribution of these test materials without the express written authorization of the NBME is prohibited.

Development and regulation of policies and procedures necessary for implementation of FLEX and SPEX are the responsibility of the Federation through its elected FLEX Board. Members of the FLEX Board include highly qualified physicians from the academic and practice communities, all of whom have experience as licensing board members.

Description of FLEX

The FLEX Program consists of two complementary component examinations, each 1½ days in length.

Component 1 of the FLEX Program is de-

signed to evaluate measurable aspects of knowledge and understanding of basic and clinical science principles and mechanisms underlying disease and modes of therapy. This component places special emphasis on fundamental knowledge of the diseases and problems frequently encountered in a supervised setting on an inpatient basis, i.e., knowledge required of a physician assuming clinical responsibilities associated with post-graduate training.

Component 1 consists of approximately 580 multiple-choice questions in 4 books (Books A through D). Each book contains between 135 and 175 questions, with administration times ranging between 2 and 2½ hours per book. Examinees sitting for Component 1 will take the first book (Book A) on the morning of the first day in the three-day administration sequence, Books B and C on the afternoon of the first day, and Book D on the morning of the second day.

Recognizing that knowledge and understanding of the basic sciences and fundamental aspects of patient care in a supervised setting are assessed in Component 1, FLEX **Component 2** is designed to assess the additional knowledge and cognitive abilities required of a physician assuming independent responsibility for the general delivery of medical care to patients. This component focuses on a core of critical abilities and knowledge required for diagnosis and management of selected clinical problems most frequently encountered by the physician licensed for the independent, unrestricted practice of medicine.

Component 2 consists of approximately 700 multiple-choice questions, presented in 5 test books. Test Book E consists entirely of *sets* of questions and *case clusters,* totaling approximately 100 questions. Two hours are allowed for this test book. Each of the remaining 4 test books (F, G, H, I) contains 135-175 multiple-choice questions, and examinees are given 2 or 2½ hours to complete them. Examinees complete Books E and F on the afternoon of the second day of the three-day FLEX sequence. The remaining test books (G, H, and I) are completed the following day.

Assuring that the FLEX Program is comprised of questions at an appropriate level of difficulty increases the reliability of the pass/fail decisions based upon the examination. In order to do so, a modest number of questions for use in future

examinations are included within each component of the FLEX Program for "field testing." This process allows statistical data to be collected in advance to guide selection of appropriate questions for future examinations. Field test questions are not included in the regular scoring process — i.e., these questions do not "count" toward the calculation of final scores for the examinations. Questions included for field testing purposes are distributed throughout various books of the component examinations, and no distinction is apparent between field test questions and those questions to be used in calculating final scores.

Content of FLEX Components

The content of each component of the FLEX Program is organized around a set of cognitive competencies within a clinical context. Questions included in each component reflect evaluative objectives related to major physician tasks, including history taking, performing a physical examination, using laboratory tests and other diagnostic aids, defining problems to establish a diagnosis, and managing therapy. Basic science questions included in Component 1 reflect all the major basic science disciplines (e.g., anatomy, biochemistry, microbiology, pathology, pharmacology, physiology). All major clinical disciplines are reflected in Components 1 and 2 (e.g., family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine and public health, psychiatry, surgery).

Reflecting the competencies they were designed to assess, the questions comprising Components 1 and 2 are devised to test not only the examinee's knowledge, but discrimination, judgment and reasoning. For example, some questions test the examinee's recognition of the similarities and differences among diseases, drugs, and biochemical, physiologic, behavioral, or pathologic processes. Other questions evaluate the examinee's judgment about cause and effect relationships. In addition to single multiple-choice questions, the components include presentation of laboratory situations or clinical problems in narrative, tabular, graphic and/or pictorial form, followed by a set of 2 or 3 questions designed to determine the examinee's knowledge, interpretation, and comprehension of the situation described. The case clusters included in Component 2 provide an additional evaluation of the

examinee's knowledge and strategies in diagnosis and management by presenting medical problems.

About one-fifth of Component 1 is devoted to assessment of fundamental basic science knowledge and understanding. About two-fifths of Component 1 focuses on the direct application of basic science knowledge to mechanisms of disease, integrating clinical and basic science knowledge of specific clinical problems. The remaining two-fifths of Component 1 emphasizes clinical tasks related to diseases and problems frequently encountered in the delivery of medical care to hospitalized patients.

Samples of the array of evaluative objectives and clinical encounters used to build Component 1 are given in the FLEX workbook entitled, *Guidelines, Strategies, and Sample Items*. See the inside back cover of this *Bulletin* for information on how to obtain the workbook.

Component 2 assesses additional knowledge and cognitive abilities in the context of diseases and problems frequently encountered by the physician licensed for the independent, unrestricted practice of medicine. About one-quarter of Component 2 is devoted to clinical encounters in an in-patient setting. The remaining three-quarters of Component 2 focuses on ambulatory encounters.

Samples of the evaluative objectives and clinical encounters used to build Component 2 are given in the FLEX workbook entitled, *Guidelines, Strategies, and Sample Items*. See the inside back cover of this *Bulletin* for information on how to obtain the workbook.

Description and Content of SPEX

SPEX is a one-day examination consisting of approximately 450 multiple-choice questions in 3 books (Books 1 through 3). Each book contains between 135 and 175 questions, with administration times ranging between 2 and 2½ hours per book.

The questions used in SPEX focus on a core of clinical knowledge and relevant, underlying basic science principles deemed necessary to form a reasonable foundation for the safe and effective practice of medicine. SPEX content is intended to reflect the knowledge and cognitive abilities required of all physicians, regardless of specialty practiced. Because FLEX and SPEX

have this principle in common, SPEX content specifications are based, in part, on FLEX content specifications (see above, Content of FLEX Components). The test question pool developed for FLEX is also used to produce SPEX. SPEX questions are specially selected by groups of experts to assess the requisite knowledge base of physicians who are five years or more beyond medical school graduation and are likely to be engaged in the practice of a particular medical specialty. This underlies another basic difference between FLEX and SPEX: currently one-fifth of FLEX Component 1 is devoted to assessment of fundamental basic science knowledge and understanding. This content area is not included in SPEX.

Preparation for the Examinations

As preparation for FLEX or SPEX, a well-planned and comprehensive review is recommended. Up-to-date textbooks, clinical review publications and periodicals are suggested.

Four basic test item types are used for the multiple-choice questions in FLEX Components 1 and 2 and in SPEX. These types are:

— One Best Answer — Single Item
— One Best Answer — Matching Items
— Comparison/Matching Sets
— Multiple True-False Items

FLEX Component 2 also includes the case cluster format. These sets of questions are intended to explore the extent of the examinee's knowledge of clinical situations and to test the ability to bring information from many different clinical and basic science areas to bear upon these situations.

A brief description and sample of each of these test item formats are included on pages 16 to 20 of this *Bulletin.*

The FLEX Board also produces a FLEX workbook, entitled *FLEX Guidelines, Strategies and Sample Items,* that may be purchased from the Federation of State Medical Boards. The workbook contains

— a description and sample of the content guidelines on which the component exams are based
— test-taking suggestions and specific strategies for completing the various

types of multiple-choice questions, including case clusters
— practice samples of Component 1 and Component 2 multiple-choice questions and case clusters, including answer keys

Information on how to obtain the FLEX workbook is shown on the inside back cover of this *Bulletin.*

Taking the Examinations

The examinee should try to answer all of the questions. Because there is no penalty for guessing, an examinee stands to gain from attempting to answer every question.

Special answer sheets are provided for each test book. For each question, one and only one choice should be marked; giving more than one response or no response is treated as a wrong answer. Answers marked on the test book pages, which are not properly marked on the answer sheet, cannot be counted for scoring. Markings on the answer sheets that are not clearly entered or readable by the scoring machine cannot be counted for scoring.

Testing Conditions

Although the Federation is not directly responsible for the selection of test centers, certain policies and procedures have been established for administration of the examination by the individual licensing boards. These procedures are established to assure that no examinee or group of examinees receives, inadvertently or otherwise, unfair advantage on the examination. Efforts are made to assure that the examinations are administered under standard conditions and in conformity with the principles on which the exam and its scoring are founded. If, in spite of these efforts, a situation arises in which the integrity of the examination process is jeopardized, the Federation reserves the right to invalidate all or part of an examination. FLEX and SPEX test centers are visited periodically by members of the Federation who observe and evaluate the facilities and operations of the center.

FLEX and SPEX are proctored examinations. Reference materials (i.e., books, notes, papers, or other sources) are not permitted to be consulted. Examinees are not permitted to bring personal belongings into the seating area of the test-

ing room. Calculators and electronic paging devices are prohibited. Watches with computer or memory capability are not needed and are not permitted. Telephone use during a testing session is prohibited. (Exception may be made, at the discretion of the Chief Proctor, only upon prior arrangement in cases of personal emergencies. However, any authorized telephone call initiated or received by an examinee during a testing session will be monitored to assure that information relating to the examination is neither transmitted nor received by the examinee.) The identity of each examinee is verified before he or she is admitted to the examination room. Seats are assigned at random, and, for FLEX, examinees are moved to different seats at least once during the course of the administration.

Another measure taken to achieve standard administration conditions is the construction of FLEX as a multiple-sequence examination. In a multiple-sequence examination, the questions in each test book are the same for all examinees. However, the test books vary in terms of the sequence in which questions are presented. The different forms are distributed in a manner such that copying answers from another examinee is likely to result in a score that is no better than one would obtain by random guessing.

Irregular Behavior/Invalidation

Irregular behavior, i.e., conduct that subverts or attempts to subvert the examination process, may constitute sufficient cause for a licensing board to terminate or invalidate an examinee's examination and/or license application or to take other appropriate action that may, in some instances, include disqualification for licensure.

Irregular behavior that occurs during an examination includes, but is not limited to, consulting notes or other reference materials during the administration, copying answers from another examinee, permitting one's answers to be copied, or in any way providing or receiving unauthorized information about the examination while it is in progress. Such irregular behavior during the examination may constitute sufficient cause for a licensing board to terminate or invalidate an examinee's participation. Suspected irregular behavior during an examination is normally reported in writing by the Chief Proctor at the testing center in which the conduct was observed.

Upon receipt of information suggesting that irregular behavior has occurred, the licensing boards will evaluate the information and may request a statistical analysis of an examinee's scores. Interpretation and use of such information, and any actions taken on the basis of it, are the responsibility of the licensing board. Records of such actions, however, are retained by the Federation and are communicated to other licensing boards as appropriate.

Other behavior that is considered irregular includes, but is not limited to, falsifying information, impersonating another examinee, or receiving unauthorized information about the content of the examination prior to its administration. The unauthorized reproduction, sale or other distribution of examination materials is not only considered irregular behavior, but may also constitute conduct that is the basis for appropriate legal action. Such actions on the part of individuals that infringe on the legal rights of the NBME, from whom the Federation obtains the test materials, extend beyond the scope of the policies or procedures described here. It should be understood that the NBME can and will take appropriate legal action when it is convinced that the legal rights of the National Board of Medical Examiners have been violated through infringement of the NBME copyright, theft of test materials, sale of test materials, etc. The Federation and the NBME are firmly committed to protecting the integrity of the FLEX and SPEX examinations and will take action appropriate for the fulfillment of this commitment.

All possible efforts are made to assure that FLEX and SPEX are administered under standard conditions and in conformity with the principles on which the examinations and their scoring are founded. Notwithstanding these efforts, situations may occur in which the integrity of the examination process is jeopardized. Under such circumstances, the Federation may invalidate all or part of an examination.

Scoring of the Examinations

Following each administration, completed examination materials are returned by the individual licensing boards to a central scoring location. FLEX answer materials from all licensing boards are scored at one time. SPEX answer materials from all licensing boards are scored at one time.

Raw scores (number of questions answered

correctly) are determined and then converted to scale scores for reporting purposes. The scaling procedure is a conversion process that yields a single two-digit scale score for each of the two component examinations and a single two-digit scale score for SPEX. The scores are truncated to a whole number (i.e., all decimal places are dropped).

Examinees failing to provide responses on each answer sheet for all sections of a FLEX Component examination and/or SPEX examination will not receive a numeric score. An appropriate indication of the incomplete submission of materials will be reported to the licensing board for which the examination was taken and will be maintained within the examinee's record in the Federation's Examination Data Bank.

Passing requirements on the examinations are established by the individual licensing boards, with recommendations from the FLEX Board of the Federation. It is important to remember, however, that scores are calculated in the same manner and at the same time for the entire group of examinees participating in a given FLEX or SPEX administration; scores are **NOT** calculated on an individual state-by-state basis. Accordingly, differences among states in the percentage of examinees who pass the examinations should not be interpreted as meaning that it is easier for an individual to pass the examinations in one state than it is in another.

A score of 75 is the minimum score recommended by the FLEX Board for passing SPEX and each component of FLEX. It should be noted that this figure is **NOT** "75%," but a value on a scale that meets the requirements of licensing board statutes and regulations. Generally, fewer than 75% of the questions need to be answered correctly in order to obtain a score of 75.

Reporting of Scores

FLEX scores are reported directly to the individual licensing boards approximately seven to eight weeks following each administration. SPEX scores are reported directly to the individual licensing boards approximately four to six weeks following each administration. The licensing boards will then report exam results to their own examinees at some subsequent time. Please note that the individual licensing boards maintain FLEX and SPEX score records for their respective ex-

aminees, and scores are reported to examinees only by the licensing board for which the examination is taken. The Federation does not report scores directly to examinees.

The Federation maintains a computerized data bank of all FLEX and SPEX scores to facilitate reciprocity among jurisdictions. The Federation reserves the right to provide certified transcripts of scores to its member licensing boards as it deems appropriate. Also, for a fee, examinees may request that a certified transcript of their FLEX and/or SPEX scores be forwarded to other licensing boards from which they are seeking licensure and/or to other appropriate credentialing agencies or organizations.

Score Rechecks

The scoring and reporting techniques developed by the NBME and approved by the FLEX Board use a variety of checks and verification procedures. The FLEX Board is confident that the scores reported for each candidate are accurate reflections of the answers marked on the answer sheets turned in by that examinee. If an examinee has serious concern that the scores reported may be in error, the examinee may request a manual rescoring. However, a considerable amount of time is required to rescore the examination by hand and to compare the results with the scores calculated by computer.

Examinees wishing to have a score recheck performed must direct their request to the licensing board for which the examination was taken. If it approves the request, the licensing board will forward the request to the Federation. The Federation assesses a charge for rescoring, payable in advance to the Federation through the licensing board for which the examination was taken.

Re-examination Procedures

Re-examination eligibility and procedures for unsuccessful examinees are established by the individual licensing boards, pursuant to the boards' statutes and regulations. For FLEX, some boards require passage of both components within a single sitting — i.e., if one component is failed, both must be retaken. Other boards have established component sequence requirements — i.e., Component 1 must be passed before a passing score on Component 2 can be ac-

cepted. Examinees should consult the licensing board from which license is being sought for that board's re-examination procedures.

NOTE: Passing FLEX scores achieved through separate component administrations may not be acceptable, even for later endorsement/reciprocity, to those licensing boards that require completion of FLEX within a single administration. Retake of both components may be required for fulfillment of these boards' examination requirements for licensure.

NOTE: The FLEX Board considers the latest scores achieved by an examinee to be the "official scores" for the respective examination and has made recommendations to this effect to the individual licensing boards. For FLEX Board purposes, then, scores achieved through FLEX re-examination replace earlier FLEX scores, and SPEX re-examination scores replace earlier SPEX scores. However, the individual licensing boards are ultimately responsible for determining what scores within an examinee's history meet the board's examination requirements for licensure. Because this is so, certified transcripts of FLEX and/or SPEX scores provided to licensing boards by the Federation currently list all FLEX and/or SPEX scores achieved by a given examinee.

INQUIRIES

The Executive Director of the FLEX Board and the Federation staff in Fort Worth, Texas, are available to answer questions and/or to assist in interpretation of information concerning FLEX and SPEX. Inquiries should be directed to:

Executive Director of the FLEX Board
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, TX 76102-7199
(817) 335-1141

MULTIPLE-CHOICE ITEM TYPES USED IN FLEX AND SPEX

One Best Answer — Single Item

This is the traditional, most frequently used multiple-choice format. It consists of a statement or question followed by four or five options. In FLEX and SPEX examinations, the options in this

item type are always lettered (i.e., A, B, C, D, E). The examinee is required to select the best answer to the item. Options other than the single best (correct) answer may be partially correct, but there is only one best answer to this item type.

> DIRECTIONS (Item 1): Each of the numbered items or incomplete statements in this section is followed by answers or by completions of the statement. Select the *ONE* lettered answer or completion that is *BEST* in each case and fill in the circle containing the corresponding letter on the answer sheet.

Sample Item 1

1. The most effective treatment for tinea capitis caused by *Trichophyton rubrum* is

   (A) epilation with radiation
   (B) griseofulvin, orally
   (C) antifungal ointment, topically
   (D) amphotericin B, intravenously
   (E) to await spontaneous involution

(answer B)

One Best Answer — Matching Sets

This item type usually consists of a list of entities (e.g., diseases, laboratory data) followed by several phrases or statements. As in the one best answer — single item type, there is one best answer. Options other than the correct answer may be partially correct. Examinees may also encounter pictorial materials (e.g., graphs, labeled photographs) that comprise the list of entities.

> DIRECTIONS (Items 2-3): Each group of items in this section consists of lettered headings followed by a set of numbered words or phrases. For each numbered word or phrase, select the *ONE* lettered heading that is most closely associated with it and fill in the circle containing the corresponding letter on the answer sheet. Each lettered heading may be selected once, more than once, or not at all.

(***NOTE:*** Occasionally FLEX and SPEX include sets of matching items that require a one-to-one match, i.e., each lettered heading should be selected only once. Special directions to cover this situation appear within the individual set of items in the test book. Unless you encounter such special

instructions, assume that each lettered heading may be selected once, more than once, or not at all.)

Sample Items 2-3
(A) Phenytoin
(B) Phenobarbital
(C) Valproic acid
(D) Diazepam
(E) Acetazolamide

2. Hepatitis is a potentially serious side effect

(answer C)

3. Hypertrophy of the gums is a common adverse effect

(answer A)

Comparison/Matching Sets

This item type consists of two entities (A) and (B), followed by (C) Both and (D) Neither. Examinees are required to decide whether an item is associated with the first entity only, the second entity only, both entities, or neither entity. As in the one best answer — matching type, the list of entities may include diseases, laboratory data, etc.

DIRECTIONS (Items 4-5): Each group of items in this section consists of lettered headings followed by a set of numbered words or phrases. For each numbered word or phrase, fill in the circle on the answer sheet containing

A if the item is associated with (A) *only,*
B if the item is associated with (B) *only,*
C if the item is associated with *both* (A) *and* (B),
D if the item is associated with *neither* (A) *nor* (B).

Sample Items 4-5
(A) L-dopa
(B) Dopamine
(C) Both
(D) Neither

4. Prescribed for the relief of tremor and rigidity

(answer A)

5. Fail(s) to cross the blood-brain barrier

(answer B)

Multiple True-False Questions

This item type consists of a statement or question followed by four numbered options. The examinee is required to determine whether each of the options is correct or incorrect. Responses are recorded according to a pattern of responses (repeated at the top of each page of this item type) that permits five combinations of responses. You must mark only one answer on the answer sheet.

DIRECTIONS (Item 6): For each of the items in this section, ONE or MORE of the numbered options is correct. On the answer sheet fill in the circle containing

A if only *1, 2, and 3* are correct,
B if only *1 and 3* are correct,
C if only *2 and 4* are correct,
D if only *4* is correct,
E if *all* are correct.

FOR EACH ITEM
FILL IN ONLY ONE CIRCLE
ON YOUR ANSWER SHEET

At the top of each subsequent page containing this item type, the following summary will appear:

DIRECTIONS SUMMARIZED

A	B	C	D	E
1, 2, 3 only	1, 3 only	2, 4 only	4 only	All are correct

Sample Item 6

6. Contraindications to radical mastectomy for carcinoma of the breast include
   (1) hepatic metastases
   (2) "inflammatory" cancer
   (3) edema of the ipsilateral arm
   (4) spread of the tumor to the ipsilateral supraclavicular nodes

   (answer E [all are correct])

CASE CLUSTERS USED IN FLEX

The *case cluster* format is used in Book E of FLEX Component 2. Each case cluster opens with a description of a clinical situation. The opening description may include results of physical

examination (e.g., patient's vital signs), results of diagnostic studies (e.g., laboratory findings, radiologic findings), or other information relevant to the case.

The opening description is followed by a series of multiple-choice questions of the standard types used in FLEX, presented in a progression reflecting the manner in which issues might arise in the work-up or management of an actual case. Often, the multiple-choice questions are grouped according to the demands of the physician task. For example, questions relating to history-taking may be presented first, followed by a group of questions about the physical examination, which may be followed by another group of questions pertaining to laboratory studies. Additional case information may be provided between each task-related group of questions.

OTHER PUBLICATIONS CONCERNING FLEX

FLEX Guidelines, Strategies and Sample Component Examination Items

This FLEX workbook contains

- description and sample of the content guidelines on which the FLEX component exams are based
- test-taking suggestions and specific strategies for completing the various types of multiple-choice questions, including case clusters
- practice samples of Component 1 and Component 2 multiple-choice questions and case clusters, including answer keys

Cost of this workbook is $10, payable by MONEY ORDER made to the Federation of State Medical Boards. (Add $3 for shipment to locations outside the U.S., possessions of the U.S., Canada, and Mexico.)

Send request and payment, ATTENTION: GUIDELINES-5, to the Federation of State Medical Boards at the address shown on the front cover of this *Bulletin*.

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FEDERATION BULLETIN

JUNE 1989



Dr. Bernard W. Neal, president of the Medical Council of Australia and the Medical Board of Victoria (at left) and Dr. Anthony J. Cortese, then president of the Federation of State Medical Boards of the United States and chairman of the Oregon Board of Medical Examiners.

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- Medical Licensure Examinations and State Medical Boards
- The History of Australian Medical Boards
- Reports from the 1989 Federation Annual Meeting

FEDERATION BULLETIN

PUBLISHED MONTHLY BY THE
FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INCORPORATED

VOLUME 76, NUMBER 6 JUNE 1989

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The FEDERATION BULLETIN (**ISSN 0014-9306**) is published monthly by the Federation of State Medical Boards, 2630 West Freeway — Suite 138, Fort Worth, Texas 76102-7199. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Fort Worth, Texas and additional mailing offices. Subscription price $25.00 a year, single copy $2.50. Copyright 1989. The Federation of State Medical Boards of the United States, Inc.

This publication is available in microform through University Microfilms International, 300 North Zeeb Road, Department P.R., Ann Arbor, Michigan 48106.

Postmaster. Send address changes to FEDERATION BULLETIN, 2630 West Freeway, Suite 138, Fort Worth, TX 76102-7199.

Subscriptions and correspondence about subscriptions should be addressed to the Federation of State Medical Boards, 2630 West Freeway — Suite 138, Fort Worth, Texas 76102-7199.

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MEDICAL LICENSURE EXAMINATIONS AND STATE MEDICAL BOARDS 1989

Where Have They Been, Where Are They Going?

JOHN H. MORTON, M.D.

Ever since the states began to license physicians, most state licensure laws have included three requirements:

(1) evidence of good moral character,
(2) graduation from a medical school,
(3) successful completion of a licensure examination.

There has never been any question about the first requirement, but the application of the other two issues has varied through the years.

At one time many states required graduation from an American or Canadian medical school, but this has changed since World War II. When a significant number of foreign physicians sought licensure in the United States following the war, certain state attorneys indicated that a citizenship requirement for licensure might be unconstitutional, and they advised that the licensure examination be offered to any physician who met the other requirements for independent practice. The problem was compounded when a large number of American citizens began to study medicine at European or Caribbean medical schools. Since only American and Canadian medical schools are regularly inspected and certified by the Liaison Committee on Medical Education, state medical boards have never been entirely comfortable with this situation. While recognizing that many first rate medical schools exist around the world, the medical boards are also aware that a number of inferior schools exist. Nevertheless, today a candidate who meets the state's other requirements may take the examination after graduation from any medical school recognized by the World Health Organization. Since the state license is a broad permit to practice medicine[1] and surgery, the licensure examination has always been a general medical evaluation. However, the form of the examination has changed. When my father took the Mary-

Presented at the Baystate Medical Center, Springfield, Massachusetts, April 1, 1989.

Dr. Morton, who is associate editor of the FEDERATION BULLETIN, is a former member of the New York State Board of Medicine. He is professor of surgery at the University of Rochester Medical Center, Rochester, New York. Morton has been involved with the FLEX program from its early years; following six years as a member of the FLEX Board, he now serves as a consultant to that important body. He is a past president of the Federation of State Medical Boards and a former vice chairman of the National Board of Medical Examiners.

land state board examination about 75 years ago, he was confronted with the following essay question:

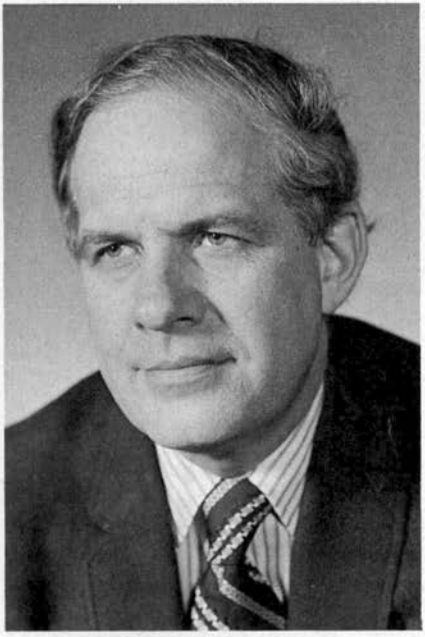
Discuss the management of Rhus toxicodendron poisoning.

My father did not recognize Rhus toxicodendron, but he had studied Greek in college. He knew that "toxico" meant poison and "dendron" meant tree. Therefore, he discussed the use of gastric lavage and emetic agents to deal with ingested berries. When he looked this up later, he was appalled to find that Rhus toxicodendron is poison ivy. Nevertheless, he passed the examination, suggesting that standards on essay examinations may not have been well defined at the time.

From 1915 when the National Board of Medical Examiners first offered its examination, there were two examinations accepted for licensure in most states: the state's own examination and the National Board sequence. When the NBME changed from an essay examination to a multiple choice format in the early 1950s, a number of state medical boards were upset and withdrew recognition of the NBME certificate. After the multiple choice examination had proved its merit, most states once again recognized the National Board examinations. Today they can be used for licensure purposes in every state except Louisiana and Texas.

The state medical board examinations had a different history. Originally each state constructed its own essay examinations, and they varied markedly in quality. For a number of years the Federation of State Medical Boards struggled with this problem, and the development of the Federated Licensing Examination, FLEX, was the result.

When FLEX was offered for the first time in June 1968, approval of this new concept was anything but unanimous; only seven states (Illinois, Maine, Nebraska, New Mexico, Ohio, West Virginia and Wyoming) participated, examining 632 candidates. Oregon joined



Dr. Morton

the program in December 1968. FLEX received a major impetus in 1969 when California, Idaho, Indiana, New York and Utah switched to FLEX in June; Alaska, Connecticut, Massachusetts, Michigan, North Carolina and South Carolina joined the program in December, giving a total of 19 states. By 1974, 51 jurisdictions (48 states, the District of Columbia, the Canal Zone and the province of Saskatchewan) were part of the program, and the last state (Florida) began using FLEX in June 1979. By that time the Virgin Islands, Puerto Rico and Guam were also participating.

The universal acceptance of FLEX so quickly surprised even the members of the FLEX test committee. This feeling was expressed in 1979 at the time Florida entered the program:[1]

> The first FLEX was given in June 1968. At that time not even the most optimistic supporter of uniform state licensure felt that unanimous adoption of the program would be possible in eleven years. On the contrary, many cynics felt that the majority of states would refuse to participate in a truly national program, that the entire concept of FLEX was unrealistic and doomed to failure.

A uniform, reproducible grading system was an important stimulus to the acceptance of FLEX. The FLEX Test Committee initially set 75 as the passing standard for the examination. The number 75 was selected to conform to the passing grade established by tradition and stipulated in some state medical licensure laws. Achieving a 75 does not mean that the candidate has answered three quarters of the items correctly. It is a standard score — consistent from one administration of FLEX to the next — based on the performance of a reference group of examination candidates. The reference group consists of those individuals taking the examination for the first time within one year of graduation from an American or Canadian medical school, and 75 is established as the minimal acceptable performance for this group of individuals.

Standardization is achieved by repeating certain items from one test administration to the next and evaluating reference group performance on these items over several examinations.

When FLEX was first given in 1968, candidates performed poorly on the basic medical science section of the examination. Since all examinees were medical school graduates who had studied basic science several years before taking FLEX, this was not unexpected. To compensate for this the FLEX Weighted Average was developed: the standard 75 grade was calculated by weighing Day I (the basic medical science component) at one-sixth, Day II (the clinical science segment) at two-sixths and Day III (clinical competence) at three-sixths of the total grade. Medical school faculty members were frequently critical of FLEX because of the weighted average, feeling that this understated the importance of a good basic science education. They failed to consider that, in contrast to the National Board examinations, the sole purpose of FLEX is to define a minimal acceptable standard for independent medical practice.

The FLEX Weighted Average was used until June 1985 when the new FLEX was introduced. Several years earlier the FLEX Board decided that a new examination was desirable. The original FLEX was a derivative examination composed entirely of test items which had previously appeared on a National Board examination. This raised the possibility that a candidate might have an unfair advantage, having encountered some of the items previously on a National Board examination or on a subject examination given at the medical school using National Board material. Originally the National Board examinations were designed specifically to offer each state a reasonable alternative to its own examination. After World War II, however, the medical schools paid increasing attention to student performance on Parts I and II. Since that time the National Board examinations have served two disparate purposes: evaluation for licensure and measurement of academic achievement. Both roles are important but they are sometimes mutually incompatible.

The FLEX Board concluded that it was desirable to construct an examination exclusively devoted to licensure purposes, and the new FLEX was developed with this in mind. The examination consists of two components, each of which must be passed separately. Component 1, 1½ days in length, contains approximately 30 percent basic science material. The clinical segment emphasizes in-hospital patient encounters and diagnostic procedures. Component 2 is also 1½ days in length; it stresses ambulatory problems and therapeutic maneuvers.

The item development for the new FLEX is a complex process. First the component committee establishes an examination outline, indicating the material to be covered by the test items and the number of test items to be devoted to each subject. Then individual test committee members develop a series of items to fill the outline. The test committee is a multidisciplinary group which meets to review, discuss and modify the items with an emphasis on clarity and relevance. Particular attention is paid to removing any ambiguity from the item. The component committee then reviews the work of several test committees, further modifying items and selecting those for inclusion on the examination. These items are then introduced into a real FLEX as experimental items which are scored but do not figure in the candidate's grade. After statistical analysis, those items which perform appropriately are placed in the FLEX test item pool for use in future examinations. This careful, multiple phase process assures an examination which is a comprehensive valid measure of cognitive information for the physician entering independent practice.

Over the years there has been a growing interest in the continuing competence of practicing physicians. Most of the medical specialty boards have developed recertification processes, either on a voluntary or a mandatory basis. The state medical boards have become interested in an examination for use by the practicing physician in mid-career, especially if he or she is seeking licensure in a new state. To fill this need the Special Licensing Examination, SPEX, was developed and introduced in 1988. This one day examination is derived from FLEX and emphasizes general clinical competence. It is not a primary licensing examination and should not be used for this purpose. It is designed to evaluate a physician who holds or has held a valid, unrestricted license granted by an American or a Canadian jurisdiction. This requirement assures that the examinee has successfully completed an initial comprehensive licensure examination at some time in the past. During its first year SPEX was used in 18 states, and 146 individuals were examined.

What further changes can be anticipated in the future? One suggestion under active consideration is the development of a computer-based examination. Superficially this idea sounds attractive. The computer can handle information in a manner similar to a real clinical problem. If the examinee starts along the wrong path, further information can allow him or her to reconsider and evaluate the situation correctly. The computer program is able to complicate the problem after therapy is undertaken, once again mimicking the clinical sit-

uation. There is no need for a five-response multiple choice item — the candidate can be given free rein. Theoretically at least the examinee is not bound to a rigid examination schedule — he or she can take the examination at any suitable time. Unfortunately, there are problems with this scenario. Construction of a good computer-based examination is expensive. The development of a problem with branching logic based on the examinee's initial responses is difficult and time-consuming. If the examination is taken at a time and place of the examinee's choice, the state medical board will be confronted with a question — are two examinations involving different problems taken on different days at different sites truly equivalent? The unsuccessful candidate will certainly doubt this and will assuredly find a lawyer willing to challenge the result. With examinations given at different times a potential problem exists with examination security. The growing sophistication of computer hackers in breaking into computer programs adds another source of concern. It may well be that the computer, although an ideal teaching tool, is not an acceptable instrument for use by the state medical boards.

At present there is major interest in moving to a single examination pathway to licensure. For many years[2] state medical board members have been concerned that two separate licensure examinations were inappropriate. They believed that the two systems could not really be equal. They also felt that an unsuccessful FLEX candidate who had not been eligible for the National Board sequence might argue that other candidates who had encountered test items previously while in medical school had an unfair advantage. This second objection was more significant for the original FLEX with test items derived from the National Board pool. The problem was at least partially obviated by the development of the new FLEX with its test items constructed specifically for use on FLEX. A single examination pathway would put this concern to rest, and a task force has been tackling this issue for over a year. In February 1989 they released a position paper "a proposal for A Single Examination For Medical Licensure." This proposal involves a three-part examination system:

Step 1 — based on NBME Part I and offered to candidates who have completed the medical school basic science curriculum,

Step 2 — based on NBME Part II and offered to candidates who are completing their medical school clinical science experience,

Step 3 — based on FLEX and offered to candidates who have

received their medical school diplomas.

If this program comes to fruition, it would provide a single examination system applicable to all candidates. All three steps of the program would be made available to osteopathic medical students and to graduates of schools of osteopathic medicine in the United States. Steps 1 and 2 could be taken by foreign medical students as part of the medical science requirements for certification by the Educational Commission for Foreign Medical Graduates. These individuals would then become eligible for Step 3 after completing any required residency education. It is hoped that the examinations will be of such quality that they will be acceptable to all American medical licensing jurisdictions.

Many people who have been impressed with the development of FLEX have unrealistic expectations of the licensure examination. The examination is a measure at one point in time which tests knowledge, not behavior. Successful completion of FLEX does not assure the appropriate use of knowledge and does not predict future performance.

Failure to understand these limitations has led to several misuses of the examination. Some residency program directors use examination performance, especially on the NBME sequence, in screening residency applications. The fact that examinations lack predictive validity makes examination results a poor device for selecting house officers. Medical schools and hospitals are wont to suggest that excellent performance on the examinations by students or residents offers evidence of the quality of the program they administer. Examinations are a measure of individual performance, and they should not be used to measure a program. Certain state officials have recommended periodic examinations during a physician's career as a solution to the malpractice crisis. Most malpractice actions arise more from problems in the doctor-patient relationship than from gaps in the physician's knowledge. Periodic reexamination will not change this situation or improve the behavior of an arrogant physician.

In addition to its role in granting the initial license to practice medicine, the medical board in most states is also responsible for physician discipline. This role is a difficult and time-consuming one, and the board is frequently hampered by lack of legal expertise and of fiscal independence. Under the circumstances the boards have sometimes been derelict in carrying out this major responsibility. However, most of the boards are given increasing priority to this important task, and disciplinary efforts are improving.

At the present time some politicians are attempting to increase the control of medical practice by

extending the authority of the government, working through the state medical boards. The state medical board, consisting of practicing physicians and interested public members, is not an appropriate agency to determine physician distribution within the state, set physician fees, determine physician call schedules or control physician working hours. Whether regulations of this type are directed to residents in training or to physicians in independent practice, the state medical board lacks the expertise and the wisdom to deal with these thorny issues.

Some economists who espouse the free-market philosophy believe that there is no place for medical licensure or licensure examinations. They suggest that any individual should be allowed to practice medicine at his or her discretion, and they believe that the incompetent person would not be able to maintain a practice. Most patients and most physicians would not agree with this attitude. With reference to licensing examinations most informed physicians would agree with Maloney's[3] observations concerning SESAP, the self-assessment program of the American College of Surgeons:

> SESAP II makes no pretense of measuring clinical competence. . . . It is probable that the outcome of the treatment of surgical disease depends not so much on the surgeon's possession of . . . knowledge but on his ability to take a good history, perform a thorough physical examination, and exercise technical facility in the operating room . . . SESAP II makes only one assumption: given two surgeons of equal intellectual capacity, experience, and technical skill, the more knowledgeable surgeon will provide better patient care. Until a valid measure of clinical competence is developed, this assumption alone justifies the effort on the part of the surgeon to evaluate and expand his own knowledge.

The advocates of FLEX as a licensure examination make a similar claim about its role and its limitations.

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The History of Australian Medical Boards

BERNARD W. NEAL, M.B., B.S. (Melb.)
M.D. (Melb.), F.R.A.C.P., DIP. ED. (Monash)

"The prevailing vice of drunkenness among the lower orders," as Louisa Anne Meredith put it, was such a problem in Van Diemens Land that Sir John Franklin proposed in 1837 that all assigned persons should wear a distinguishing patch on their clothes to distinguish them from free settlers. Sir George Gipps, Governor of New South Wales, rejected the idea. Other distinctions were however to be made, for in that same year of 1837, the Legislative Council (as we've heard) passed the first Act in this country regulating the practice of medicine, a major effect of which was to distinguish on the basis of their background between persons following a similar occupation. The underlying idea was expressed very colourfully by Dr. Fullerton in the Queensland Legislative Council in 1861 — "It was the duty of Parliament" he said "to protect the public from quacks and unskilful vendors of medicine who were more injurious to the community than robbers and assassins."

This idea underlies all the Acts to govern the practice of medicine that have subsequently been passed in all the states and territories. In my brief time I shall touch on the origins of these acts and on some of their more significant and interesting amendments. In doing so, I have been greatly helped by colleagues and Registrars in all the Boards and I have leaned greatly on Mr. Eric Hilder's "One Hundred and Twenty Years of Medical Registration in New South Wales 1838-1958" and Dr. Ross Patrick's forthcoming book "Health and Medicine in Queensland." Mr. Hilder held office as the very respected secretary of the New South Wales Board for many years — unlike his predecessor Mr. William Baker, of whom history records: "Mr. William Baker, clerk of the Board, being absent from this meeting without leave and having in the course of last year been absent two out of four ordinary meetings, the Board are of opinion that his services should be dispensed with."

Apart from the need to prevent infection from incoming vessels, the great stimulus to the introduction of Medical Acts was the Act of the English Parliament in the 6th and 7th years of the reign of King William IV providing for the attendance and remuneration of medical witnesses at Coroner's Courts. A similar Act was passed

Dr. Neal is president of the Medical Board of Victoria, Australia, which has its headquarters in Melbourne and of the Medical Council of Australia.

This is the third in a series of four articles that have been adapted from presentations that were made at the Sequicentenary Meeting of the Medical Council of Tasmania at the University of Tasmania, Australia, in Hobart, December 5, 1987.

Dr. Neal attended the 1989 annual meeting of the Federation of State Medical Boards of the United States in Chicago in late April. Additional information about the recent visit of this distinguished Australian physician to the United States and to the Federation Annual Meeting will appear in subsequent numbers of the BULLETIN.

in New South Wales in 1838 — on the 13th June to be precise — in which the term "legally qualified medical practitioner" was used for the first time but not defined. This was remedied on the 12th October 1838 when another Act created the New South Wales Medical Board. This Act (of only three sections) was extended on the 23rd August, 1844 to include the Port Phillip District. Meanwhile in Britain the first Bill for the registration of medical practitioners had been introduced in 1840, but it was not until 1858 that the Medical Registration Act establishing the General Medical Council was passed.

Prior to the extension to Port Phillip of the New South Wales Act a group of "physicians, surgeons and surgeon apothecaries, actually practising in the town of Melbourne in the district of Port Phillip, had petitioned Sir George Gipps for "the Establishment of a Branch Medical Board at Melbourne." The grounds were the very reasonable ones that "much inconvenience delay and even risk has been incurred in the transmission of the necessary documents to Sydney." The first register of the Port Phillip Medical Board was published in January 1845 and contained 25 names. They seem to have been an active lot and in 1846 formed the Port Phillip Medical Association (PPMA) — antedating both the British and American Medical Associations, and in 1847 the PPMA petitioned the Commons for a Medical Registration Bill. It was not, however, until 18th June 1862 that the first Victorian Medical Practitioners Act was passed, Victoria having come into existence as a separate colony in July 1851.

The year 1844 had been an active year. On the 23rd August, as I have said, the New South Wales

Act was extended to the Port Phillip District, and on the 3rd September, just eleven days later, the Legislative Council of her Majesty's Province of South Australia and its Dependencies passed the Ordinance establishing the Medical Board of South Australia. The Ordinance had but five sections — and two of them dealt with money. The fee for a post mortem was set at two guineas, whilst that for the registration certificate was one guinea — to be paid to the President of the Board who was required to pay it over to "The Colonial Treasurer, on behalf of Her Majesty, for the Public uses of the Province and support of the Government thereof." It was not until the radically new Act of 1983 that the Board gained the financial autonomy it now enjoys.

The South Australian Ordinance used similar terminology to the New South Wales Act of 1838 in listing the medical qualifications required to be deemed a legally qualifed medical practitioner. The New South Wales words were "a Doctor or Bachelor of Medicine of some University, or a Physician or Surgeon, licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland, or a member of the Company of Apothecaries of London." The South Australia Ordinance added the words "or Dublin." A year later — on the 27th October 1845 — the New South Wales Act followed South Australia's lead by recognising "Members or Licentiates of the Apothecaries Hall of Dublin."

This was not to be the last time the New South Wales Act had to be amended to include Irish graduates. More than 100 years later in 1958 the question arose as to the status of Irish graduates registered under a section of the Act referring to the "British Empire." Legally the Republic of Ireland had not been a part of the British Empire since 1949 but apparently unaware of this, the Board had registered some 42 graduates from the Republic. The matter was resolved by the speedy passage of a Bill which amended the Act by the odd device of stating that "the British Empire includes the Republic of Ireland for the purposes of this Act" — Humpty Dumpty would have approved.

Other geo-political problems affecting the registration of overseas graduates have impinged on the activities of the Boards right from the beginning. For instance the 1915 New South Wales amendment bringing in the principle of reciprocity was careful to exclude graduates of German or Austrian Medical Schools. The wording of the reciprocity proviso is a gem of legal tortuosity:

"Provided that no person shall be deemed to be a legally qualified medical practitioner or entitled to be registered as such under the provisions of subsection (1)(b) of this section by virtue of a diploma, degree or license, en-

titling him to practise medicine in the country to which the University, College or other body therein mentioned belongs unless it be made to appear to the Board that by the laws or regulations in that behalf in force in such country the right to practise medicine therein is granted to persons who are registered in this State as legally qualified medical practitioners under this Act by virtue of their being so registered and without further examination or in the absence of such proof unless he passes the examination prescribed by the Senate of the University of Sydney." In other words we will only register yours if you register ours!

Queensland almost from the beginning has had its own ideas about overseas graduates. Moreton Bay had become a Colony under the name of Queensland on 10th December 1859 and existing New South Wales laws applied in the new Colony. Acting under the New South Wales legislation the Queensland Governor-in-Council appointed a Medical Board on 18th February 1860, the President being Dr. George Fullerton (from whom I have already quoted) and who was at the time also a member of the Legislative Council. In this capacity he introduced the first Queensland Bill dealing with health and extending the power of the Medical Board. The Board already had a rule requiring foreign graduates to hold what was called a "States Examination" certificate, but the Board now made use of a list obtained from the General Medical Council which included many European and American medical degrees.

The Board stood firm in its adherence to this list despite strong challenge from disappointed applicants, notably a certain William Smith and Ernest Wuth. The aggrieved doctors took their cases to the Attorney General and to the Supreme Court as well as petitioning Parliament, with the result that an amending Bill was introduced. It was alleged that the Board was "obstructive" and that the real reason for refusing Smith registration was that he practised Homeopathy (the stated reason being that the Pennsylvania College of Homeopathic medicine was not on the Board's list). The Bill had the dangerous provision for the Governor-in-Council to overrule the Medical Board — it was defeated only on the casting vote of the President of the Legislative Council, and it was not until 1867 that a new Medical Act was passed.

Spirited conflict broke out again in Queensland in 1909. The Medical Board and the Queensland Branch of the British Medical Association formed a deputation to the Minister seeking amendments to the old 1867 Act. A bill was subsequently introduced into the Parliament which, according to the *Australasian Medical Gazette*, made the legislators (by re-

cognising "grossly ignorant and incompetent quacks") "accomplices in the act of murder of innocent victims." Members of the Medical Board threatened to resign and members of the BMA pledged not to accept appointment if they did so. The doctors won the day, but still had to wait until 1925 for their desired amendments.

By 1861 Acts or Boards were in place in all the States except Western Australia (Tasmania 1837, New South Wales 1838, Victoria 1844 [1861], South Australia 1844, and Queensland 1859 [1861]. The first Western Australian Act was passed in 1894. At the Board's fifth meeting on 5th June 1895 a "letter was received from the Premier which stated that the government considered that the funds needed for carrying out the Act should be provided by fees received in the administration of the Act," and the Board has had financial autonomy ever since. As early as 3rd July, 1895 the Board claimed to have "completely stopped the inflow of quacks to the Colony and has also purged the newspapers of all quack advertisements" — something of an over-statement as later the same year, the Board took legal action against newspapers for printing both quack and medical advertisements — and lost!

The last two Boards were not established until well into the twentieth century — that of the Australian Capital Territory (ACT) in 1930 and that of the Northern Territory (NT) in 1935.

The first of the fifteen names entered on the ACT register on the 5th of November 1930 was that of John Howard Cumpston, who was also the first Director-General of Health in Canberra and the first Chairman of the ACT Board. Until 1975 the Director-General was ex-officio Chairman of the Board. The ACT ordinance, like most State Acts, contains detailed regulations regarding advertising; it also has the interesting provision that "a body corporate shall not advertise that it will provide a medical service whether through a medical practitioner or otherwise."

The first five names were entered on the Northern Territory Register on the 8th August 1933, and again the first name was that of the Chairman of the Board, in this case Dr. Cecil Cook. Dr. Cook remained on the Register for 50 years until his death in 1985. The second name on the Register was that of Dr. Clyde Fenton, of "Flying Doctor" fame, and the eighth, entered on the 17th of January 1938, is that of Sydney Lance Townsend, whose address was then Tennant Creek. Sir Lance, who was such a central figure in the Foreign Practitioners Qualifications Committee (FPQC) and later in the Australian Medical Examining Council, retained his Northern Territory registration for 45 years until his death in 1983.

All the Acts have been subject to numerous amendments, many of which have been of far-reaching significance. For instance, in 1900 a New South Wales amendment gave the Board power to remove a name for "infamous conduct in a professional respect." The Queensland Medical Act of 1939 established the Director-General of Health as ex-officio President of the Medical Board, made hospital service compulsory for new graduates, and, well ahead of other States, established a specialist register. Perhaps the most significant Victorian amendments have been: in 1970 the establishment of the FPQC, in 1973 the establishment of the Hospitals Accreditation Committee, and in 1980 the introduction of Annual Reports to the Parliament.

Mr. Chairman, many other threads could be followed through these Acts — what persons sit on a Board? who appoints them? on what basis? for how long? for what fees? how is the Board staffed? what are its procedures? what are its disciplinary powers? how does it deal with complaints? how is it financed? This short list alone would provide an agenda for a long time for the new Uniformity Committee of the Australian Medical Council. But as its members propose new and better Acts to guide us in the governance of the medical profession, may they be ever mindful of the rich heritage we have received from the labours of so many over the past 150 years.

Many and varied were the reasons advanced to dispute Boards' rulings. For example, a Mr. Kenny of Campbelltown declared to the New South Wales Board in 1839 that he had lost his papers "by the upsetting of a boat on the river Ganges when proceeding to Calcutta to join his Regiment in the Nagpore Station." He was duly registered, as was Mr. William Houston, who in 1842 attested that his testimonials of qualification had been lost by the burning of the emigrant Ship Indianna of which he was Surgeon Superintendent. Less fortunate was a Mr. Alexander McDonald of Goulburne, who in 1849 submitted a Diploma from the Andersonian University of Glasgow. This was refused, but three months later Mr. McDonald appeared again, this time claiming that he had a Diploma from the Royal College of Surgeons in Dublin, but had unfortunately lost it!

Report of the President

ANTHONY J. CORTESE, D.O.

It is my pleasure to provide this presidential report to you. For me, it has been a very rewarding year. For the Federation, I hope you will agree with me after reading this report, it has been a very successful year.

I would like to present the goals and tasks of the Federation to you to point out what we have accomplished during the past one to five years.

Goal I: To assist the member boards and the people of the jurisdictions they serve in assuring the fundamental professional qualifications of licensed physicians.

How did we do? We have continued to provide a good, valid FLEX examination through the efforts of our FLEX Board. In addition, we now offer the SPEX examination to help facilitate endorsement and reciprocity. Our Legislative and Legal Advisory Committee is now in the process, through a federal grant, of developing a document outlining the elements of a modern state medical board. To address the concerns of the foreign medical graduate, among other things, we were leaders in the Task Force to Study Pathways to Licensure.

Goal II: To act as the national clearinghouse and resource center on all aspects of medical licensure and discipline for the member boards and, as appropriate, for other interested and/or affected parties.

How did we do? We have continued to keep and improve the only physician's disciplinary data bank that will go back before 1989. I urge all of you at this meeting to visit the demonstration on how the Federation does a disciplinary search. I am sure you will be impressed with the speed and accuracy of the process. We also have provided advice and counsel to the national government's data bank.

Goal III: To provide appropriate forums and publications on medical licensure, discipline, and related issues.

How did we do? This program you are attending, the business meeting, committee meetings, publications, and legislative reports will attest to the quality of our effort.

Goal IV: To represent and promote the interest of the member boards and the people of the jurisdictions they serve in and/or before appropriate local, state, regional, national and international bodies affected by or affecting medical boards and/or

Presented at the annual business meeting of the Federation of State Medical Boards of the United States, April 29, 1989, Chicago, Illinois.

Anthony J. Cortese, D.O., Portland, Oregon, served as president of the Federation of State Medical Boards of the United States from the conclusion of the 1988 annual meeting through the 1989 Federation Annual Meeting.

Dr. Cortese, who practices obstetrics and gynecology in Portland, has been a member of the Oregon Board of Medical Examiners since 1972, except for a one-year hiatus between 1981 and 1982. He served as chairman of that board for the 1975-1976 term, has held all of the other elective offices on the Oregon board and, once again, is serving as its chairman. He has been active in the widening responsibilities and high quality programs of that board which has remained in the forefront for many years. He was among the founders of the innovative Oregon Foundation for Medical Examiners.

In earlier years, Dr. Cortese practiced his specialty in Chicago and served as a member of the faculty of the Chicago College of Osteopathic Medicine. He is a fellow of the American College of Osteopathic Obstetricians and Gynecologists and was president of that college for the 1970-1971 term. He is a member and vice chairman of the American Osteopathic Board of Obstetrics and Gynecology.

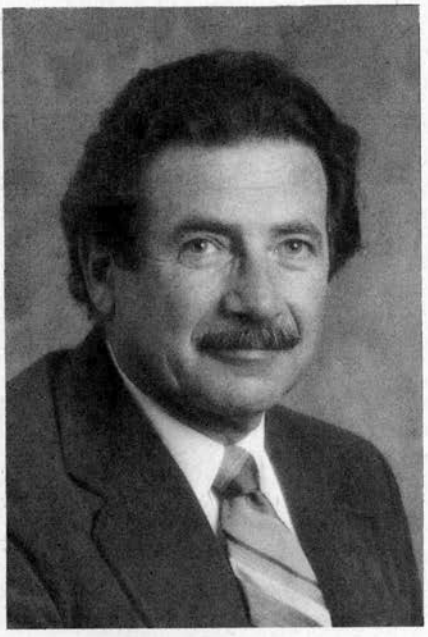
Cortese is a member and past president of the Oregon Osteopathic Association and a member of the American Osteopathic Association. He is also a member of his county medical society, the Oregon Medical Association and the American Medical Association.

Tony has been a member of the Oregon Regional Medical Program Advisory Board, of the Scientific Committee, Oregon Division of the American Cancer Society, and of the Department of Health and Human Services Criteria Committee, Obstetrics and Gynecology, PSRO.

medical licensure and discipline.

How did we do? As you can see by this program, we have been active in federal government activities as well as at AMA and AOA committees. We also represent medical boards at the ACCME, ABMS, ECFMG, and NBME meetings. On the international level, we have attended the meetings of the Federation of Provincial Medical Licensing Authorities of Canada and, through Mr. Dale Breaden, the Australian Medical Council.

I could have presented many more responses to the tasks of the Federation, but I feel the high-



Dr. Cortese

lights above, along with the following reports, will show that this year and the previous five years have marked progressive growth.

COMMITTEE REPORTS

Executive

The Executive Committee met when needed during the year and functioned well in facilitating board meetings and handling pressing issues.

FLEX Board

Chaired by Dr. Henry Cramblett, the FLEX Board has continued to provide a high quality FLEX and, in addition, has begun to offer the SPEX. As was expected, the SPEX is going through the same health growing pains the FLEX went through when it was first offered. Excellent staffing has been provided by Ms. Kathryn Hill.

Program

All members of the Program Committee offered valuable suggestions and many member boards were helpful with recommendations for the program. Special thanks to Illinois for its help and to Ms. Sherry Blanks for staffing and making the Annual Meeting run smoothly.

Legislative and Legal Advisory

Chaired by Dr. Melvin Sigel, the Legislative and Legal Advisory Committee (LLAC) has met four times during the year, revising the MODEL FOR THE PREPARATION OF A GUIDEBOOK ON MEDICAL DISCIPLINE and working on the federal grant project on elements of a modern state medical board.

Long Range Planning

Chaired by Dr. Barbara Schneidman, the Long Range Planning Committee (LRPC) met to consider a variety of specific issues.

Finance and Audit

Chaired by Dr. Donald Kuiper, the Finance and Audit Committee held its annual meeting in January. It will be reporting to you that the Federation's fiscal

condition continues to steadily improve.

Nominating

Chaired by Dr. Howard McQuarrie, the Nominating Committee held its meeting as required by the bylaws and has submitted a report. More names were submitted for each office than the committee could recommend and these were submitted to the president-elect for consideration for committee assignments for the coming year.

Representatives to Other Organizations

Representatives of the Federation to the American Board of Medical Specialties, the Accreditation Council for Continuing Medical Education, the Educational Commission for Foreign Medical Graduates and the National Board of Medical Examiners have attended meetings of those organizations and have filed reports with the Federation.

My Thanks to:

The members of the Board of Directors for their guidance, courtesy, and attendance, and for keeping me in line; to

the staff: Barbara Rains, Linda Marlar, Sherry Blanks, Kate Hill, Kathy Shelton, and all the rest who made this a pleasurable year; and to

Dale Breaden, who, as all of the presidents before me will attest, does it all. Whenever I called, Dale could be counted on to do it, find it, fix it, and most of the time, as you all could tell, write it for me better than I could say it.

And last but not least, I have had the pleasure of serving on the Board of Directors when Dr. Bryant Galusha was president of the Federation, of serving on the search committee when he was hired as executive vice-president of the Federation, and of serving as an officer during the five years he has been executive vice-president. As president, I can not take any credit for any progress made during my tenure in office. I am sure the previous officers will agree with me that all of the credit should go to Dr. Galusha. Traveling around the country attending meetings with him, watching him do his thing and each time come back with new contracts for the Federation, has been one of the greatest educational experiences I have had. I leave this office with a great deal of sorrow for, as all of you know by now, Dr. Galusha has tendered his resignation as of October 1, 1989. A search committee has been formed to find and recommend a person to succeed him as executive vice-president. It is my sincere hope that this search committee will be as fortunate and successful as the one that found Dr. Galusha five years ago.

2810 S.E. Steele Street
Portland, Oregon 97202

Report of the Executive Vice President

BRYANT L. GALUSHA, M.D.

Two close friends who recently retired as chief executive officers of health care organizations told me that their last annual reports were the most difficult they ever prepared. Since both friends were eminently successful, I have the feeling that their difficulty lay fundamentally in the pain of saying goodbye. And this is certainly my situation because what I have to report to you regarding our Federation is good and most encouraging news. Indeed, the past year, by virtually any measure, has been another eventful and highly successful period for our Federation.

For the past five years I have promised you a brief annual EVP report and I confess I have not kept that promise very well — I shall today. I will limit my comments to five specific topics and a brief concluding remark. I chose this format in order to allow time for any questions you may have of me.

But allow me to preface my remarks by telling you of the great pleasure it has been for me over the past year to work with your distinguished board of directors and President Anthony Cortese. I believe this is the finest and strongest board the Federation has ever had, and I must tell you that is saying a very great deal, indeed, because you have been well served by many fine boards over the past years. It has really been a joy working with Tony Cortese. We have had many good times together and have seen many good things accomplished (Tony, my friend, thank you, and ladies and gentlemen of the board, thank you!).

Single Examination for Medical Licensure

Let me begin my formal report to you by commenting on *A single examination for medical licensure*. Its time has come! As Brother George would say, "Read my lips — its time has come." I wholeheartedly support the proposal for a single examination for medical licensure as presented by the task force to study pathways to licensure. This proposal represents a win-win-win situation. A win for maintaining high examination standards and, therefore, a win for the public, a win situation for the NBME and the academic community, and a win situation for the FSMB and the

Presented at the annual business meeting of the Federation of State Medical Boards of the United States, Chicago, Illinois, April 29, 1989.

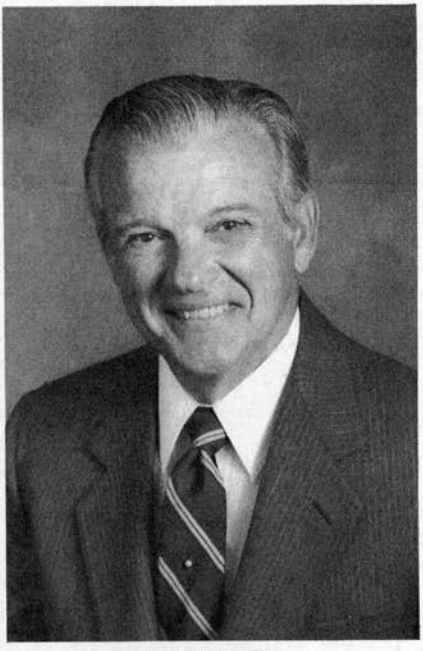
Dr. Galusha is executive vice president of the Federation of State Medical Boards of the United States. Recently, he submitted his resignation from that position, effective later this year. He devoted many years to directing the medical education programs at a large teaching hospital (Charlotte Memorial, Charlotte, North Carolina), served a dozen years as a member of an active state medical licensing and disciplinary board (North Carolina), participated in the FLEX program for fifteen years (member of test committees and the FLEX Board), was elected president of the Federation and served from 1981 to 1982, and in 1983 was elected a member of the executive board of the National Board of Medical Examiners.

His contributions during the five years of his executive vice presidency of the Federation have been legion. — Ed.

licensing community. It neutralizes charges of discrimination and may finally rid us of the pejorative phrase "separate but equal." This proposal represents a long-term goal of our Federation — a single examination for medical licensure with the licensing community being a major player. I urge all of you to support this proposal with vigor and work individually and collectively for its early implementation. Its time has come!

Federation's Physician Disciplinary Data Bank

I know that many of you are understandably concerned and somewhat confused about the future of the Federation's Physician Disciplinary Data Bank in view of the movement of the federal government into the arena of data gathering that the Federation has demonstrated can serve the public and the profession well, if sensibly and thoughtfully done. I can tell you that there is no way of predicting the ultimate outcome of the federal government's effort. It is my sincere hope that the government's National Practitioner Data Bank will be successful. In fact, as a member of the Technical Advisory Committee for UNISYS, the contracted bank operator, and as a member of the Secretary of the Department of Health and Human Services' Advisory Committee, I am committed to giving my best effort to that goal. However, I must say, in my view the National Practitioner Data Bank is significantly underfunded and faces a host of other formidable problems that can be overcome only by a most dedicated effort. Only time will tell if the required effort will be forthcoming. If the diverse and



Dr. Galusha

complex elements of government involved in shaping and operation of the National Practitioner Data Bank can be effectively coordinated, if adequate funding is made available in these crucial formative years and if the focus and purpose of the National Practitioner Data Bank remains consistent with the original intent of Congress and is not allowed to become a tool of an Orwellian "Big Brother" — then and only then will it approach the effectiveness that the Federation's Disciplinary Data Bank has already achieved.

It goes without saying that we must not only maintain our preeminent Disciplinary Data Bank, but we must continue its development and enhancement as the state-of-the-art system. My message to you is to continue your superb cooperation with the Federation's Data Bank program.

Also, you should know that the Direct Access System (DAS) for the Federation's Disciplinary Data Bank is now a reality. Under a federal (HRSA) contract award and with the participation of the Texas, Illinois, Georgia, and Ohio Boards, a year long project of pilot testing and consequent refinement has resulted in the development of a viable Direct Access System that will be made available, in stages, to Federation members over the coming year. I do hope you had the opportunity to see and actually try the Direct Access System during our demonstrations at this meeting. If you did, I believe you will agree that the Direct Access System is a major enhancement to our Disciplinary Data Bank program.

Troubling Proposed Federal Legislation

We have confronted and undoubtedly will continue to confront troubling proposed federal legislation regarding medical licensure. I use the word "troubling" not simply for what the legislation itself addresses, but for what it implies for the future.

Last year I reported to you that Andrew Watry, executive director of the Georgia Board, and I testified before Representative Henry A. Waxman's Subcommittee on Health and Environment

of the House Committee on Energy and Commerce in opposition to two bills designed to deny states the right to differentiate between United States and foreign medical graduates in setting requirements for licensure of physicians already licensed in another state. In our testimony (published in the FEDERATION BULLETIN, April 1988) we stress two main themes: the rights of the state and the real possibility that the proposed legislation may well result in reducing standards to the lowest common denominator.

Although people knowledgable about the Washington scene advised us that the congressional hearing went well and that these bills had little or no chance of success, nonetheless, I was surprised to learn three months after the hearing that Congressman Waxman intended to present an amendment to Title VII of the Public Health Service Act which would implement, in effect, the features of the more far reaching of the two bills, namely that of Mr. Jim Bates, Democrat from California. At that point, your Federation immediately undertook an effort to inform all boards whose states had representatives on the Subcommittee on Health and the full Committee on Energy and Commerce of the nature of this legislation. We encouraged those boards to contact their representatives directly as soon as possible to let them know of their state board's reaction to this misguided legislation. The response to this effort by member boards was immediate and impressively effective. The amendment, which was originally to be presented to Mr. Waxman's Subcommittee on Health, was withheld and later when Mr. Waxman introduced the amendment for Mr. Bates at the full Committee of Energy and Commerce, it was not adopted. Instead, the Committee agreed to call upon the General Accounting Office to conduct a study "For the purpose of determining the practicies and policies of the state in licensing by endorsement physicians who are graduates of schools of medicine located in countries other than the United States." This study by the GAO began in late December and the final report must be submitted to congress in September of this year.

For your information and as a possible future reference source, you will find enclosed in your agenda books:

1) A copy of the Bates bill, H.R. 3241, entitled "Equal Opportunity for Medical Licensure and Reciprocity Act of 1987,"
2) A copy of "Potential Amendment to Waxman 142 (Title VII Bill),
3) Amendment to H.R. 4983 offered by Mr. Waxman on behalf of Mr. Bates, and
4) A copy of the legislation (S. 2889) authorizing the GAO study and prescribing its scope.

Also, I have included a few selected letters representative of our total effort. (I wish I had recordings of all the personal contacts made by telephone.)

The most positive side of this story for me, and I hope for you, is that we now have tangible evidence that the members of this Federation, well informed and unified, can make a difference. You can be assured that this collective effort will be repeatedly called upon in the future since the prospect of national medical licensure is simply irresistable to many in the Congress and the federal government.

Status of National Office

In the operation of our National Office, emphasis has been placed on professionalism, quality, and responsiveness. Our staff, the lifeblood of our organization, again has enlarged the past year and now numbers sixteen full time and two full time equivalents. Although each staff member fulfills a special role with special skills, they function as a team in a most effective manner. I am proud of them all.

A good staff, to be maximally productive, requires good technical support and that has been provided. All of our work stations are designed and equipped to promote efficient operations. During the past year we have invested an additional $200,000.00 to further enhance our computer capabilities — our National Office has become, in effect, a computer center. With the addition in the past month of a state-of-the-art desk top publishing system, we are no longer simply a quasi-publisher. We have become a publishing house, as you will soon see.

Obviously, with this expansion of the Federation's staff and technology and the increasing overall activity of the Federation, we must be prepared to again expand the size of our National Office. In that context, the Board recently approved an option for additional space contiguous to our present office. Last month, that option was exercised and will provide the required expansion space. (This represents nearly doubling the size of our National Office during the past four years.)

The bottom line is that we have developed and maintained a modern National Office that is prepared to meet the Federation's needs for the present and the immediate future. I want to take this opportunity to thank those of you who have visited the office and have observed its efficient operations first hand.

Financial Status

The progress I have been discussing in this report would not have been possible without adequate financial resources. Although we have been successful during the past five years in attracting significant federal contract awards and have enjoyed increasing revenues from the

operation of the Disciplinary Data Bank, the FLEX program remains the financial motor of our organization.

In a few moments you will hear from our treasurer, Dr. Kuiper, of the sound financial position of our Federation. Clearly, our financial status enables us to move ahead, continuing the progress we have made to date and the pursuit of our overall goals.

Concluding Remarks

As I mentioned, the past year has been another eventful and highly successful period for our Federation. Today the importance of our work is better understood and more appreciated than ever before in this history of the Federation. Our work has meaning — significant meaning. *Together* we have addressed the major problems of medical licensure and discipline with conviction and determination and the positive results have attracted nationwide attention. Common purpose and solid unity, I believe, have been key elements of our success. Our efforts to advance medical licensure and discipline have not been hobbled by vested interests, turf conflicts, arbitrary divisions, parochialism, or ego and status plays. We have focused on well defined goals with concentrated effort. Common sense, an outcome orientation, and a full plate have permitted us no time for Brownian movement, redundancies, or the continual reinvention of the wheel — activities that, from my vantage point, are becoming the nemesis of several notable national organizations. Our Federation is a vital organization with a recognized vital role in the health care system of this country. I have been honored to have worked with you in reaching this point. I can tell you with the deepest sincerity that my past five years with the Federation have been a grand and enriching personal experience.

I would like to share with you a noteworthy observation. Never, not one single time during my tenure as executive vice president, have any of you — the board of directors, state board members, state board staff, or friends of the Federation — failed to respond to a request I made on behalf of the Federation. I am certain that few, if any, EVPs could make this claim. I hasten to add that requests I have made of Larry Dixon and Tony Cortese, among others, for strokes on the first tee have been refused since these gentlemen somehow failed to grasp that these requests were directly related to the overall welfare of the Federation — not to mention to its executive vice president!

And finally, I must tell you something important in the history of our Federation. I and several others present today appreciate a fact that I want all to know and appreciate. The notable growth and success of our orga-

nization, in which we have all played a role during the past few years, has been in many ways built on the firm foundation structured by my predecessor, Dr. Harold E. Jervey, Jr. Harold should be proud of his good work and I do hope he is proud of ours.

2630 West Freeway — Suite 138
Fort Worth, Texas 76102-7199

COURT DECISIONS

PSYCHIATRIST'S LICENSE SUSPENDED FOR NEGLIGENCE*

A three-year suspension of a psychiatrist for inadequate evaluation of patients seeking gender reassignment surgery was not excessive, a New York appellate court ruled.

The Office of Professional Medical Conduct charged the psychiatrist with gross negligence and gross incompetence on the basis of his approval of five patients for gender reassignment surgery. The Office contended that his psychiatric examinations failed to meet acceptable medical standards in that his histories did not refer to the patients' emotional and behavioral needs, failed to document their emotional states and previous psychological problems, and failed to describe their personality makeup. He allegedly diagnosed transsexualism and recommended gender reassignment surgery without adequate evaluations and failed to provide necessary postoperative care, contributing to one patient's suicide.

A hearing committee found that the psychiatrist was not responsible for the patient's suicide but that he was guilty of gross negligence in recommending him for gender reassignment in light of his suicidal tendencies. The committee found that he was guilty of negligence on more than one occasion with respect to all five patients. The Board of Regents imposed a three-year suspension on the psychiatrist, the last two years to be stayed, and placed him on probation for three years. The Board also ordered him to undergo a continuing education program in general psychiatry and medical ethics, and directed random review of his office and patient and hospital records by the Department of Health. The Commissioner of Education issued an order enacting the Board's vote.

On appeal, the psychiatrist contended, among other things, that the findings of guilt were not supported by substantial evidence. He cited the testimony of four psychiatrists on his behalf. The court said that the Board's determination was based on a massive amount of testimony presented at the hearing. The court said that the record showed substantial evidence to support the determination and that it was not arbitrary, capricious, or unreasonable.

Finally, the court said that the punishment was not excessive. In light of the sensitive nature of gender reassignment surgery,

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The Citation, Volume 59, Number 2, May 1, 1989. Prepared by the Office of the General Counsel of the American Medical Association. Copyright 1989, American Medical Association.

which could lead to subsequent mental and emotional problems, the court found that the psychiatrist's punishment was not excessive. — *Reisner v. Board of Regents of the State of New York*, 535 N.Y.S.2d 197 (N.Y.Sup.Ct., App. Div., Nov. 23, 1988)

SUSPENSION OF MD'S LICENSE REVERSED*

An order suspending a psysician's license for one year should be reversed, the highest court of New York ruled.

The physician, a native of India, was licensed to practice medicine in New Jersey, New York, and Pennsylvania. On about 12 occasions from 1976 to 1979, at the request of a friend who was a life insurance salesman, the physician performed physical examinations for clients of the salesman. The salesman had befriended the physician when the physician arrived in the U.S. and had been helpful in various personal and business matters because of his better command of English and familiarity with American customs.

After an informal hearing, the physician was charged with filing nine false certifications for medical examinations not performed. He claimed that the salesman had helped him fill out the forms and conceded that he may have given him blank forms or forms for patients he did not examine to sign. On his attorney's advice he decided not to contest the charges but to accept a three months' suspension of his license, restitution to the insurance company of $180, and a fine of $2,500. Proceedings were commenced in Pennsylvania based on the New Jersey suspension, and he was given a private letter of reprimand for a technical violation of the Medical Practice Act.

About five years after the New Jersey proceedings the state of New York began administrative proceedings based solely on the New Jersey consent order. Although a hearing committee recommended that the charges be dismissed, the Board of Regents found him guilty of willfully and knowingly filing false medical reports and suspended his license for one year. The suspension was stayed subject to probation. An appellate court affirmed.

On further appeal, the highest court of New York said that the issue of whether he committed knowing and willful misconduct was not actually litigated in the New Jersey action. The physician should have been allowed to deny those charges in the New York action. New York authorities had not allowed him to contest the charges based on the theory that he was estopped from doing so because of the New Jersey consent order. — *Halyalkar v. Board of Regents of State of New York*, 532 N.Y.S.2d 85, 527 N.E.2d 1222 (N.Y.Ct. of App., July 7, 1988)

FEDERATION NEWS

RESOLUTIONS ADOPTED AT 1989 ANNUAL BUSINESS MEETING

Most member boards were represented at the Saturday, April 29, 1989 Annual Meeting of the Federation of State Medical Boards at the Westin Hotel in Chicago. The annual business session featured reports from the elected officers, the executive vice president, committee chairpeople and others, including Federation representatives to other organizations.

Several of these reports appear in this number of the BULLETIN and others will be printed in coming numbers. The resolutions committee, under the chairmanship of Lawrence L. Hirsch, M.D., of Illinois, and consisting, also, of Eugenia K. Dorson of Virginia and W. Earle Riley, M.D., of Alabama, met the day prior to the annual business meeting in a public hearing to review the four resolutions that had been submitted.

Resolutions 89-1 and 89-4 had been submitted by the New Jersey State Board of Medical Examiners and the Federation Legislative and Legal Advisory Committee. Resolutions 89-2 and 89-3 were submitted by the Federation Long Range Planning Committee. Each was slightly modified during the meeting of the Resolutions Committee. All were adopted by the Federation in the form submitted by the committee, as follows:

Substitute Resolution 89-1

Presented by: New Jersey State Board of Medical Examiners and Legislative and Legal Advisory Committee

Subject: Federal Legislation on Confidentiality of Drug and Alcohol Patient Records

Whereas, State licensing boards have the responsibility of protecting the health, safety and welfare of the public;

Whereas, Physician impairment as the result of substance or alcohol abuse is a prime concern of licensing boards;

Whereas, Federal statutes mandating the confidentiality of drug and alcohol patient records may serve to inhibit or preclude the detection and identification of impaired physicians, thereby preventing state licensing boards from taking appropriate action to protect the public and ensure the integrity of the medical professions; now be it

Resolved, That the Federation seek an amendment to federal confidentiality statutes to provide for access of state licensing boards to appropriate information needed by the boards in carrying out their mandate to protect the public health, safety, and welfare in re-

lation to physician licensure and/or discipline.

Substitute Resolution 89-2

Presented by: Long Range Planning Committee

Subject: Single Examination for Medical Licensure

Whereas, The Federation of State Medical Boards of the United States recognizes that there should be a single examination for medical licensure in the various states for all medical graduates who meet the qualifying requirements established by those States;

Whereas, The experience and skill of the Federation of State Medical Boards of the United States and of the National Board of Medical Examiners, demonstrated through development and successful use of the Federation Licensing Examination and the NBME examination sequence, offer unique potential for achieving a single examination to replace the current dual examination system; and

Whereas, The Federation of State Medical Boards of the United States, the National Board of Medical Examiners, and the nation's other leading organizations in medicine and medical education have been and continue to be actively engaged in conversation exploring the development of a single examination for medical licensure; therefore be it

Resolved, That the Federation of State Medical Boards of the United States reaffirms its commitment to establish a single examination for medical licensure in collaboration with other concerned organizations; and be it further

Resolved, That the document entitled "A Proposal for a Single Examination for Medical Licensure" is an official Federation position paper.

Substitute Resolution 89-3

Presented by: Long Range Planning Committee

Subject: Candidate Receptions

Whereas, Elected leadership positions are of primary importance in assuring that the goals and objectives of the Federation of State Medical Boards are accomplished;

Whereas, Some qualified individuals may be discouraged from seeking such positions and be unwilling or unable to incur expenses as a result of campaign activities, such as individual campaign receptions;

Whereas, Member boards of the Federation of State Medical Boards have limited funds, staff, and resources to expend to support election of their nominees; and,

Whereas, It is in the best interests of the Federation and each state board to foster full participation in a democratic electoral process and to accept candidates on the basis of merit and abilities; now be it

Resolved, That the Federation

of State Medical Boards of the United States shall conduct as a regular part of its Annual Meeting an official Candidates' Reception to allow delegates and others to become acquainted with the candidates for election to Federation positions at a single social event.

Substitute Resolution 89-4

Presented by: New Jersey State Board of Medical Examiners and Legislative and Legal Advisory Committee

Subject: Federal/state agency pronouncements accompanying rejections of claims for health insurance coverage

Whereas, Certain state and federal programs provide some level of health care insurance coverage to defined categories of persons in the various states; and

Whereas, Health care costs have risen significantly as a result of development of more sophisticated and expensive technology for delivery of health care, and as a result of improved access to health care for persons previously unable to afford it without subsidy; and

Whereas, As a result of the increased costs to the government insurance programs, restrictions have been enacted in order to more equitably allocate the limited funds available irrespective of actual medical need for a given service to a patient; and

Whereas, As a result of the independent social goal of enhancing quality of medical care, certain government programs are expected to notify state licensing agencies when inappropriate medical care comes to the attention of the government insurance programs so that the licensing boards may investigate the need for possible disciplinary action against those physicians; and

Whereas, Certain government insurance programs are now informing insured patients under the rubric of "criterias and guidelines" that certain medical care was not medically necessary or reasonable, implying a moral or professional dereliction of duty by the treating physician; and

Whereas, In fact the basis for the denial may have been simply the need to restrict access to the program's limited funds rather than the denigration of reputation of the treating physician, thus triggering an inappropriate and unnecessary investigation of the physician by the state licensing board (and unwittingly creating suspicion and hostility in the physician-patient relationship); now be it

Resolved, That the Federation petition congress to clearly separate issues of fiscal restraint from those of medical incompetence.



1713 F

DEPARTMENT: Office of the Attorney General

STATE OF MINNESOTA

OFFICE MEMORANDUM

DATE: July 12, 1990

TO: H. LEONARD BOCHE
Board of Medical Examiners

FROM: MARTHA J. CASSERLY
Special Assistant Attorney General
525 Park Street, Suite 500 (55103)

PHONE: 296-6839

SUBJECT: In the Matter of the Adopted Rule Relating to Examinations

The above-referenced rule has been approved as to its legality by the Attorney General on July 10, 1990.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

MJC:sc

Enclosures

cc: William Brown, Chief Judge (memo only)
MaryAnn Hruby " "
John Breviu

MJC

RULE REVIEW CHECKLIST
(Health)

File No. 1713 — Docket No. 05-0009.0480

DATE RECEIVED 6-27-90 — ADOPTED W/O HEARING X

REVIEW DATE 7-6-90 — EMERGENCY RULE _____

DUE DATE 7-11-90 — TO REVISOR ON 6-27-90

REVISOR APPROVED 7-2-90

APPROVED 7-10-90 mjc — REVISOR DISAPPROVED _____

DISAPPROVED _____ — FILED W/SEC. OF STATE 7/10/90

WITHDRAWN _____ — RETURNED TO AGENCY 7/12/90

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)
Nov 13, 1989 Date published in State Register
_____ Comments

_____ Petition for Adoption of a Rule (if applicable)

✓ Board's Authorizing Resolution
Jan 21, 1989 Date adopted

✓ Proposed Rule
✓ Revisor's Certificate

_____ Notice of Intent to Adopt Rule
147.01 sub 3 Statutory Authority 147.03(c) 147.02 sub (c)
NA Small Business Statement
NA Expenditure of public money statement
April 2, 1990 Signature

✓ ✓ Statement of Need and Reasonableness (if applicable)
NA Small Business Statement
NA Fees - § 16A.128

_____ Affidavit of Mailing Notice of Intent to Adopt Rule
April 16, 1990 Date (30)/25 days before adoption
indicates Notice attached is attached
_____ Copy of rule or summary attached

✓ Publication in State Register
April 16, 1990 Date (30)/25 days before adoption

✓ 180-day deadline from:
NA Effective date of law requiring rule amendment (14.12) (both rules)
✓ end of comment period (§ 14.26) (rules without hearing)
_____ effective date of statutory authority (§ 14.29) (emergency rules)

✓ Resolution Adopting
June 9, 1990 Date adopted

✓ Findings of Fact, Conclusions & Order Adopting
June 19, 1990 Date

✓ Written requests, submissions or comments

✓ Declaration of attorney
John A. Brevik Name of SAAG representing agency

NA Notice of Submission to Atty. Gen. (if applicable)

NA Aff. of Mailing Notice to Atty. Gen. (if applicable)

Board of Medical Examiners

Adopted Permanent Rules Relating to Examinations

Rules as Adopted

5600.0400 EXAMINATION RETAKING, PASSING SCORES, AND SITTINGS.

Subpart 1. **Federation licensing examination passing scores.** For examinations taken before June 1, 1985, a Federation Licensing Examination weighted average score of 75.0 shall be the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States. The latest weighted average score shall be the only weighted average score considered by the board. For examinations taken after June 1, 1985, the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States shall be a score of 75.0 on each component of the examination. The latest score for each component shall be the only one considered by the board except as provided in subpart 4.

Subp. 2. **Examination sittings.** Except as provided in subpart 4, each administration of the Federation Licensing Examination constitutes a sitting by the applicant whether the applicant takes one or more examination components in the examination administration. An applicant may take the number of sittings allowed in items A and B.

A. After June 1, 1985, an applicant who has not received a passing score on one or both components of the Federation Licensing Examination, may complete up to five sittings of the examination before January 1, 1991, to obtain a passing score on both components of the examination. No additional sittings for the Federation Licensing Examination are permitted by the board after January 1, 1991, if the applicant has had three or more sittings as of January 1, 1991. After January 1, 1991, an applicant may take the Federation Licensing Examination components in separate sittings subject to subpart 3.

B. After January 1, 1991, an applicant not receiving

a passing score on each component of the Federation Licensing Examination within three sittings shall not be eligible for licensure by the board nor permitted additional examination sittings.

Subp. 3. **Retaking of examinations.** An applicant who did not receive a passing weighted average score before June 1, 1985, must retake the entire Federation Licensing Examination.

An applicant who did not receive a passing score of 75.0 on a component of the Federation Licensing Examination after June 1, 1985, may either retake the entire examination and obtain passing scores on both components or retake the examination component for which the applicant did not receive a passing score and obtain a passing score on that examination component.

Subp. 4. **Licensure eligibility exception.** Applicants who were not eligible for licensure after June 1, 1985, because their Federation Licensing Examination passing scores were obtained in two but not more than five separate sittings may apply to the board after July 1, 1990, for licensure without retaking and passing an additional component or components of the Federation Licensing Examination.

The application shall be on forms prepared by the board and shall include the information required in part 5600.0200, subpart 2, items A to E, together with the fees described in part 5600.2500.

5600.0600 LICENSE BY RECIPROCITY TO PRACTICE MEDICINE AND SURGERY.

Subpart 1. **Who may apply.** An application for a license to practice medicine and surgery by reciprocity without a written examination according to Minnesota Statutes, section 147.03, may be made by an applicant having a valid license to practice issued by the proper agency in another state who has received a passing score from the Federation of State Medical Boards of the United States pursuant to part 5600.0400 or who has passed a licensing examination of another state with a grade average score of 75 or higher.

[For text of subp 2, see M.R.]

Subp. 3. [See Repealer.]

REPEALER. Minnesota Rules, part 5600.0600, subpart 3, is repealed.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

JUL 10 1990

Joan Anderson Growe

Secretary of State

2:35pm

APPROVED AS TO FORM AND LEGALITY

July 10 1990

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY M T Cassedy

SPECIAL ASSISTANT ATTORNEY GENERAL

147.01 subd 3

.... The board shall have authority to adopt rules as may be found necessary to carry out the purposes of this Chapter.

147.02 sub 1. (c)

... The board shall by rule determine what constitutes a passing score in the examination

147.03 (c) (1988)

... The board, at its discretion, may establish by rule passing grade levels higher than those determined by an examining board or agency or may require the applicant to be examined in subjects not previously covered in an examination.

Boards authority Res - Jan 21, 1989

Notice to Solicitals Nov 13, 1989

I suppose it is O.K to have the Boards resolution and then solicitate opinion Boards' resolution was over a before the Notice of Intent

DEPARTMENT : ATTORNEY GENERAL - Health

STATE OF MINNESOTA

Office Memorandum

DATE : June 26, 1990

TO : PATRICIA NOLTE
Legal Assistant

FROM : JOHN A. BREVIU
Special Assistant
Attorney General

PHONE : Examination Rules

SUBJECT : In the Matter of the Proposed Adoption of Rules of the Minnesota Board of Medical Examiners Relating to Examinations

Enclosed for your review, pursuant to Minn. Stat. § 14.26 (1988) and Minn. Rules pt. 2010.0300 (1989), are the following documents to support the above-referenced rules:

1. Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Relating to Licensing and Examinations;

2. Certificate Of Board's Authorizing Resolution;

3. Rules as proposed with a certificate of approval as to form by the Revisor of Statutes attached;

4. Notice Of Intent To Adopt Rules Without A Public Hearing (as mailed);

5. Statement Of Need And Reasonableness (as submitted to LCAR);

6. Affidavit Of Mailing The Notice Of Intent To Adopt Rules Without A Public Hearing;

7. Notice Of Intent To Adopt Rules Without A Public Hearing (as published in the State Register);

8. Rules as adopted (original and three copies);

9. Certificate Of Board's Resolution Adopting Rules;

10. Findings Of Fact, Conclusions, And Order Adopting Rules Without A Public Hearing;

11. Declaration Of Counsel.

JAB:lb
Enclosures

or spouse must complete the following tasks within 30 days of the financial interview or other authorized request:

A. complete and sign a financial information or authorization form;

B. apply for insurance or other benefits for which an applicant, resident, or spouse of an applicant or resident may be eligible;

C. complete assignment of benefits forms required by third-party payers;

D. sign authorizations for release of medical records; and

E. provide verification of information given on financial disclosure forms.

~~Failure to comply with items A to E results in a determination that the applicant or resident can pay the full cost of care.~~ Providing false information relating to items A to E results in disqualification of an application for admission or in discharge of a resident under part 9050.0200 [Emergency], item E. The maintenance charge must be redetermined or the application for admission must be reinstated or the discharge proceeding discontinued if the applicant, resident, or spouse takes the required action.

Official Notices

Pursuant to the provisions of Minnesota Statutes §14.10, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Board of Animal Health

Notice of Board Meeting

A meeting of the Board of Animal Health has been scheduled for Friday, December 15, 1989 at the Board offices at 9:30 a.m. The Board offices are located at 90 W. Plato Blvd., St. Paul, MN 55107.

Information about this meeting may be obtained by calling the Board offices at 612-296-5000.

Dated: 3 November 1989

Eugene H. Kirchoff
Accounting Supervisor

Minnesota State Arts Board

Notice of Board Meeting

A meeting of the Minnesota State Arts Board will take place at 9:30 a.m. on Thursday, November 16, 1989 at the Arts Board offices, 432 Summit Avenue in Saint Paul. The public is invited to attend. Open meeting law guidelines will be in effect.

Agenda items will include reports on future folk arts programming initiatives, board and staff attendance at the annual meeting of the National Assembly of State Arts Agencies, and review of September Career Opportunity Grant awards.

For more information on this meeting or other programs, contact the Arts Board at 432 Summit Avenue, Saint Paul, MN 55102.

Board of Medical Examiners

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Relating to Licensing and Examinations

NOTICE IS HEREBY GIVEN that the Minnesota Board of Medical Examiners (hereinafter "Board") is seeking information or opinions from sources outside the Board in preparing to propose the adoption of the rules relating to Licensing and Examination. The adoption of the rules is authorized by *Minnesota Statutes* § 147.01, Subdivision 3, which permits the Board to adopt rules as may be necessary to carry out the purposes of Chapter 147.

The Board requests information and opinions concerning the subject matter of the rules. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Ave. W., #106
St. Paul, MN 55114-1080

Oral statements will be received during regular business hours over the telephone at 612-642-0538 and in person at the above address.

All statements of information and opinions shall be accepted until December 1, 1990. Any written material received by the Board shall become part of the rulemaking record to be submitted to the Attorney General or administrative law judge in the event that the rules are adopted.

Dated: 2 November 1989

H. Leonard Boche
Executive Director

Department of Public Safety

Driver and Vehicle Services

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Amendments to Rules Governing License Revocation for Alcohol and Controlled Substance Related Incidents

NOTICE IS HEREBY GIVEN that the State Department of Public Safety is seeking information or opinions from sources outside the agency in preparing to propose the amendments to the rules governing license revocation for alcohol and controlled substance related incidents.

The adoption of the rules is authorized by *Minnesota Statutes*, sections 169.128 and 171.165, subdivision 5. Section 169.128 permits the agency to adopt rules governing chemical tests for intoxication and drivers under the influence of alcohol or controlled substance. Section 171.165, subdivision 5, requires the agency to adopt rules to administer the disqualification of commercial vehicle drivers and the issuance of class C licenses to those disqualified drivers so eligible.

The State Department of Public Safety requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Katherine Burke Moore
Department of Public Safety
211 Transportation Building
St. Paul, MN 55155

Oral statements will be received during regular business hours over the telephone at (612) 297-5755 and in person at the above address.

Any written material received by the State Department of Public Safety shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule amendments are adopted.

Paul J. Tschida, Commissioner
Department of Public Safety

Another related Public Safety OFFICIAL NOTICE appears on page 1190.

Regional Transit Board

Public Hearing on Metro Mobility

The Regional Transit Board will hold a public hearing on Monday, December 4, 1989 at 4:00 p.m. on the 1st floor Mears Park Centre, 230 E. 5th Street, St. Paul, MN 55101 on the provision of Metro Mobility services. This hearing is held pursuant to *Minnesota Statute* 473.386 section d. Interested persons are encouraged to attend this hearing and offer public comment. Please call Mary Fitzgerald, board secretary, if you wish to speak at the public hearing or if you need an interpreter. You may also sign up at the hearing. The Regional Transit Board offices are located on the 7th floor of Mears Park Centre, 230 E. 5th Street, St. Paul, MN. 55101, telephone: 292-8789.

Michael Ehrlichmann
Chairman

CERTIFICATE OF THE

MINNESOTA BOARD OF

MEDICAL EXAMINERS

AUTHORIZING RESOLUTION

I, Stephen P. Kelley, J.D., do hereby certify that I am a member and the president of the Minnesota Board of Medical Examiners (hereinafter "Board"), a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the Board duly and properly called and held on the 21st day of January, 1989, that a quorum was present, and that a majority of those present voted for the resolution which has not been rescinded or modified:

RESOLVED, that H. Leonard Boche, Executive Director of the Board, is hereby granted the authority and directed to sign and give the Notice of the Board's Intent to Adopt a Rule Amendment Without a Public Hearing governing administrative procedures, i.e., Flex exam, prorating annual registration fees, and timing of reports of Continuing Medical Education, to all persons who have registered their names with the Board for that purpose, to publish the notice and rule amendment in the State Register, and to perform any and all acts incidental thereto.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 21st day of January, 1989.

Stephen P. Kelley

STEPHEN P. KELLEY, J.D.
President

Attest by one other Board Member

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Adoption of Rules of the Minnesota Board of Medical Examiners Relating to Examinations

STATEMENT OF NEED AND REASONABLENESS

Pursuant to Minn. Stat. § 14.23 (1988), the Minnesota Board of Medical Examiners (hereinafter "Board") hereby affirmatively presents the need for and facts establishing the reasonableness of proposed rule amendments, Minn. Rules pts. 5600.0400 and 5600.0600, subps. 1 and 3 relating to examination of physicians.

In order to adopt the proposed rules and amendments, the Board must show that it has complied with all procedural and substantive requirements for rulemaking. These requirements are as follows: 1) there is statutory authority to adopt the rules; 2) the rules are needed; 3) the rules are reasonable; 4) all necessary procedural steps have been taken; and 5) any additional requirements imposed by law have been satisfied. This Statement demonstrates that the Board has met these requirements.

1. STATUTORY AUTHORITY

The statutory authority of the Board to adopt these rules is as follows: Minn. Stat. § 147.02, subd. 1(c)(1988) authorizes the Board to determine what constitutes a passing score for the Federation of State Medical Boards' examination. Minn. Stat. § 147.03(c) (1988) authorizes the Board to establish passing grade levels higher than those determined by another state's examining Board or agency for licensure by endorsement or reciprocity. Minn. Stat. § 147.01, subd. 3 (1988) authorizes the Board to adopt rules as may be necessary to carry out the purposes of Minn. Stat. §§ 147.01 to 147.33.

2. STATEMENT OF NEED

There are five basic reasons for the amendments to Minn. Rules pts. 5600.0400 and 5600.0600, subp. 1 and repeal of Minnesota Rules pt. 5600.0600, subp. 3. They are:

1. To incorporate the change made in the passing score for the Federation Licensing Examination (hereinafter "FLEX Examination") by the Federation of State Medical Boards in June 1985 which makes the minimum passing score 75 on each component of the examination rather than a minimum FLEX weighted average score of 75;

2. To establish specific standards for the retaking of and number of sittings permitted with the FLEX Examination in light of the changes made by the Federation of State Medical Boards involving passing scores for the FLEX Examination;

3. To correct an inconsistency between Minn. Rules, pts. 5600.0400 and 5600.0600, subp. 3 (5600.0400 permits retaking portions of the FLEX Examination and 5600.0600, subp. 3 requires the entire examination be repeated if any part is failed) which has the effect of denying eligibility to applicants who had obtained passing scores of 75 on each component of the examination in two but not more than five separate sittings after June 1, 1985;

4. To repeal Minn. Rules pt. 5600.0600, subp. 3, in order to prevent a conflict of interpretation between part 5600.0600, subpart 3 and the amended version of proposed part 5600.0400 regarding the standards for passing scores, examination retaking and examination sittings for the FLEX Examination.

5. To establish under Minn. Rules pt. 5600.0600, subp. 1 clear eligibility standards for applicants seeking licensure by reciprocity regarding passing scores on the FLEX exam or exams of other state agencies or boards.

The Federation of State Medical Boards changed their policy and procedures in June 1985 on the FLEX Examination from a three component exam (one component per day) requiring a minimum weighted average score of 75 to a two component examination (one component per one and a half days) with a minimum score of 75 on each component. It is necessary that Minn. Rules pts. 5600.0400 and 5600.0600, subps. 1 and 3, be changed to accommodate the new scoring required by the Federation of State Medical Boards.

The FLEX Examination is a nationally recognized examination used to measure the skills necessary for a physician to operate in contemporary society. The Board believes the continued use of the FLEX Examination will serve the Minnesota public by assuring the Board has a means to measure the competency of physicians prior to licensure and that the physicians will be versed in modern medical techniques and advances as reflected in the continually revised content of the examination.

Because Minn. Rules pts. 5600.0400 and 5600.0600, subp. 3 both contain references to a FLEX weighted average score, it is necessary the rules be revised and/or repealed in order to adjust to the change in scoring (minimum component scores of 75) as directed by the Federation of State Medical Boards.

It is also necessary to revise Minn. Rules pts. 5600.0400 and 5600.0600, subp. 3 in order to remove the inconsistent language of the rules. Part 5600.0400 reads "If an applicant falls below a weighted average grade of 75, it shall constitute a failure. In order to be eligible for licensure, the applicant may repeat those parts of the examination on which he received a grade of less than 75 or may repeat the entire examination." Part 5600.0600, subpart 3 reads in part: "If the applicant fails the examination, he or she shall repeat the entire examination."

Because of the confusion concerning the retaking of portions of the FLEX Examination, coupled with the Board's policy of requiring the FLEX Examination be taken in one sitting (examination administration), applicants are being denied eligibility for licensure based on the failure to take the exam in one sitting rather than having failing scores. The Board seeks to change the rule to remove the inconsistent language and to correct the restrictive and negative impact the rules and policy have caused on applicants receiving passing scores in separate examination sittings after 1985.

The Board also sees the need to provide clear and consistent standards for applicants to follow in order to assure compliance with the rules. The specific standards regarding passing examination scores, test retaking and number of examination sittings permitted found in proposed Minn. Rules pt. 5600.0400 would address this informational need and insure applications for licensure are properly completed. The repeal of Minn. Rules pt. 5600.0600, subp. 3 removes redundant language which is outdated and in conflict with proposed part 5600.0400. The amendments to part 5600.0600, subpart 1. clarifies what passing scores are required for applicants seeking licensure by reciprocity and effectively replaces Minn. Rules pt. 5600.0600, subp. 3.

3. STATEMENT OF REASONABLENESS

On January 21, 1989, the Board approved a resolution authorizing the Executive Director of the Board, H. Leonard Boche, to sign and give the Notice of the Board's Intent to Adopt a Rule Amendment Without a Public Hearing governing the FLEX Examination and Licensing Registration and Renewal and approved a draft of the proposed rule subject to changes required by the Revisor's Office. On November 13, 1989, the Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules

Relating to Licensing and Examinations was published in the State Register.

The following are the Proposed Permanent Rules Relating to Examinations.

5600.0400 ~~GRADES~~ EXAMINATION RETAKING, PASSING SCORES, AND SITTINGS.

~~A weighted average grade of 75 shall be the passing grade on all examinations prepared and graded by the Federation of State Medical Board of the United States. If an applicant falls below a weighted average grade of 75, it shall constitute a failure. In order to be eligible for licensure, the applicant may repeat those parts of the examination on which he received a grade less than 75 or may repeat the entire examination. The latest grade received shall be the only one considered by the Board.~~

Subpart 1. Federation licensing examination passing scores. For examinations taken before June 1, 1985, a Federation Licensing Examination weighted average score of 75.0 shall be the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States. The latest weighted average score shall be the only weighted average score considered by the Board. For examinations taken after June 1, 1985, the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States shall be a score of 75.0 on each component of the examination. The latest score for each component shall be the only one considered by the Board except as provided in a subpart 4.

The practice of medicine is dynamic and subject to constant advances. In order to adequately measure the competency of physicians, the Federation of State Medical Boards developed a new FLEX examination

which was first used in June 1985. With the new examination came a new scoring requirement. The FLEX Examination prior to June of 1985 required there be a minimum FLEX weighted average score of 75.0. The new FLEX Examination requires there be a minimum score of 75.0 for each component of the examination.

The FLEX Examination has broad acceptance across the United States. The Board recognizes the continued use of the FLEX Examination, in its new format, serves the interests of the Minnesota public by providing the Board a means to evaluate the competence of a physician before licensure. Since the examination is regularly updated, advances in medical science would be reflected in the examination and thus necessarily part of an applicant's educational background.

It is reasonable and necessary that the Board amend Minn. Rules pt. 5600.0400 to accommodate the changes made in the scoring of the FLEX Examination made by the Federation of State Medical Boards. The passing score of 75.0 on each component of the FLEX Examination is a requirement that is reasonably attainable and sufficiently high to assure only competent individuals will pass the examination and are licensed to practice medicine in Minnesota. The use of the passing score of 75.0 on each component of the FLEX Examination provides Minnesota with medical standards equivalent to most other states and thus will assist in processing reciprocity applications.

The language of Minn. Rules pt. 5600.0400, subpart 1 is also necessary for the understanding of Minn. Rules pt. 5600.0400, subp. 4. Because subpart 4. provides for licensure eligibility when passing component scores were received in separate sittings, it is necessary the component scores be clearly defined so subpart 4. is properly interpreted and applied.

With Minn. Rules pt. 5600.0400, subp. 1, applicants for licensure in Minnesota are made clearly aware of the examination scoring standards used by Minnesota for licensure. This will prevent unintended submission of unacceptable credentials materials by applicants which had occurred after June 1, 1985.

The last sentence of Minn. Rules pt. 5600.0400, subp. 1 makes the Board's rules consistent with the Federation of State Medical Board's policy of accepting only the latest FLEX score for evaluation purposes.

Subpart 2. Examination sittings. Except as provided in subpart 4., each administration of the Federation Licensing Examination constitutes a sitting by the applicant whether the applicant takes one or more examination components in the examination administration. An applicant may take the number of sittings allowed in items A and B.

A. After June 1, 1985, an applicant who has not received a passing score on one or both components of the Federation Licensing Examination, may complete up to five sittings of the examination before January 1, 1991, to obtain a passing score on both components of the examination. No additional sittings for the Federation Licensing Examination are permitted by the Board after January 1, 1991, if the applicant has had three or more sittings as of January 1, 1991. After January 1, 1991 an applicant may take the Federation Licensing Examination components in separate sittings subject to the provisions of subpart 3.

B. After January 1, 1991, an applicant not receiving a passing score on each component of the Federation Licensing Examination within three sittings shall not be eligible for licensure by the Board nor permitted additional examination sittings.

Minn. Rules pt. 5600.0400, subp. 2 is necessary to establish standards for the number of examination sittings allowed for an applicant

to obtain a passing score or scores on the FLEX Examination. Such standards are necessary because the Federation of State Medical Boards does not recommend any set number of sittings and leaves such standards to the state medical Boards.

Under the previous language of Minn. Rules pt. 5600.0400, there was no limit on the number of examination sittings allowed before denial of eligibility for taking the examination or for eligibility for the licensure. The language of Minn. Rules pt. 5600.0600, subp. 3 did specify that a passing FLEX weighted average score of 75.0 had to be obtained in not more than five sittings in licensure by reciprocity cases. Part 5600.0600, subpart 3 also required that the FLEX Examination be retaken in its entirety if a component was failed and therefore precluded any passing scores taken in separate sittings of the examination if one portion of the exam was failed. Further confusion existed between Minn. Rules pts. 5600.0400 and 5600.0600, subp. 3 since part 5600.0400 allowed for the retaking of a part of the examination or the entire examination.

The Board determined that one standard for examination sittings was necessary and that such a standard needed to comport with the change in the passing score for the FLEX Examination. Minn. Rules pt. 5600.0400, subp. 2(A) and (B) makes consistent what has been the standard since June 1985 and sets a new standard starting January 1, 1991.

Subpart 2(A) of part 5600.0400 uses the same standard of examination sittings as was allowed under Minn. Rules pt. 5600.0600, subp. 3, (that being five sittings), but indicates that component scores will be used after 1985 rather than a FLEX weighted average score. This rule provision is necessary to provide a transition between the old and new rules without changing the number of sittings previously accepted by

the Board. Subpart 2(B) of part 5600.0400 sets a new standard of three examination sittings to obtain a passing FLEX Examination score starting on January 1, 1991. By setting a new standard the Board makes clear what is required for licensure and ends the confusion caused in the previous rules.

Because Minn. Rules pt. 5600.0600, subp. 3 stated that failure of any part of the FLEX Examination required the entire exam be repeated, the old standard of five sittings was predicated on the whole examination being taken in one sitting rather than exam components in separate sittings. Minn. Rules pt. 5600.0400, subp. 2(A) still allows the five sittings during the transition period prior to January 1, 1991, but does not require that the entire exam be retaken in order to obtain an acceptable score. Prior to June 1985, the Federation of State Medical Boards issued a FLEX weighted average as the official score on the exam. Thus failure to obtain a FLEX weighted average score of 75 meant failure of the entire exam. After June 1985, the FLEX exam was changed and the test results were issued as component scores not a FLEX weighted average. This resulted in the requirement of a score of at least 75 on each component. Part 5600.0400, subpart 2(A) allows applicants who took the test after June 1985 and failed a component to retake just the component within a five sitting limit prior to January 1, 1991. Individuals who did not receive a passing FLEX weighted average score of 75 in one sitting prior to 1985 are also allowed the retake the entire test within the five sitting limit prior to January 1, 1991.

The Board always advised applicants to complete any remaining examination sittings as soon as possible in order to avoid being caught in any future rule changes. Most inquiries to the Board have been by applicants needing to retake a component rather than the entire FLEX Examination, thus this provision allows such applicants the opportunity

to complete the exam without the cost of retaking the whole examination which has deterred some individuals from proceeding with a licensure application. There will be at least one examination sitting opportunity prior to January 1, 1991.

The Board wished to act as quickly as possible to have the new standard of three examination sittings in place to avoid any further confusion by applicants planning on taking or retaking the FLEX Examination. The new standard is based on applicants being able to retake components of the FLEX Examination rather than the entire examination as required before by Minn. Rules pt. 5600.0600, subp. 3. Because it is more difficult to retake an entire examination than just a component, the Board had allowed more opportunities for applicants to obtain passing scores on the FLEX Examination. The change from five examination sittings permitted to three examination sittings is a matter of comparability. With a greater chance of successfully completing a component of the FLEX Examination, less opportunities for retaking the exam should be provided in order for the standards to be comparable. If the Board were to retain the five examination sitting standard, any passing score may reflect that the applicant has learned how to take the examination rather than proving the applicant is competent to practice medicine. A competent medical graduate will have ample opportunity to prove his or her ability over the course of three examination sittings, especially if only one component is involved. It is reasonable to believe that if an applicant cannot obtain passing component scores in three examination sittings, the applicant should not be permitted to practice medicine.

There are 24 states which allow candidates to sit for the FLEX examination three times without restrictions. Of those states, 21 require at least one year of additional training before additional

retakes are allowed. Three states have just a three sitting limit. There are 10 states with a two sitting limit with a third sitting allowed after a year's training. One state has a four sitting limit if done within two years. There are two states with a five sitting limit. One state allows six sittings within a three year period. There were eight states with no limits on sittings. One state had no limits if done within five years. One state indicated the limit could be set at the discretion of its Board. There were two states that did not provide information. [See in attachments 1989-1990 Federation of State Medical Board of the United States EXCHANGE, Section 1: FLEX and M.D. Licensing requirements. page 21].

The setting of a limit on the number of times a person may take a licensure exam is not unusual. The National Board of Medical Examiners allows applicants to take its examination three times. A fourth opportunity to take the exam is conditioned on approval of a petition requesting such a retaking. Thus the three examination sitting limit is used by a majority of the State Licensing Boards and the National Board of Medical Examiners as a standard for the number of examination sittings applicants are permitted for licensure purposes.

Subpart 3. Retaking of examinations. An applicant who did not receive a passing weighted average score before June 1, 1985, must retake the entire Federation Licensing Examination. An applicant who did not receive a passing score of 75 on a component of the Federation Licensing Examination after June 1, 1985 may either retake the entire examination and obtain passing scores on both components or retake the examination component for which the applicant did not receive a passing score and obtain a passing score on that examination component.

Minn. Rules pt. 5600.0400, subp. 3 is necessary in order to recognize the change from a FLEX weighted average scoring system to the

component scoring system utilized by the Federation of State Medical Boards after June 1, 1985. With the changes in scoring systems, the manner of examination retaking was also effectively changed after June 1, 1985. Subpart 3 makes clear that exam retaking before June 1, 1985 required the entire exam had to be taken over. As noted earlier in subpart 1, only the latest FLEX weighted average score is accepted by the Board. After June 1, 1985, the FLEX exam could be taken in components. This language is necessary to clarify that scores received prior to June 1, 1985 could not be averaged with scores after June 1, 1985 since the whole exam had to be taken or retaken prior to June 1985 and thus was not a component score.

The rule further clarifies that after June 1, 1985 retaking an examination component would be allowable rather than having applicants retake the entire FLEX Examination. This language is necessary to accommodate the exception established in Minn. Rules pt. 5600.0400, subp. 4 in which passing scores were received when applicants retook components in separate sittings rather than the entire examination after June 1, 1985.

The recognition by the Board of the option to take or retake only a component of the FLEX exam will bring it in line with most other states. Only Guam, Arizona, Louisiana and New Hampshire require that the entire examination be retaken each time.

Subpart 4. Licensure eligibility exception. Applicants who were not eligible for licensure after June 1, 1985, because their Federation Licensing Examination passing scores were obtained in two but not more than five separate sittings may apply to the Board after July 1, 1990, for licensure without retaking and passing an additional component or components of the Federation Licensing Examination.

The application shall be on forms prepared by the Board and shall include the information required in part 5600.0200, subp. 2, items A to E, together with the fees described in part 5600.2500.

The Board determined it was necessary and reasonable that licensure applicants be evaluated based on passing scores rather than the manner in which the FLEX Examination was taken after June 1, 1985 when the scoring changed from a FLEX weighted average score to component scoring. Because Minn. Rules pts. 5600.0400 and 5600.0600, subp. 3 did not take into account the changes in the scoring of the FLEX Examination after June 1, 1985, the impact of the existing rules was to deny applicants eligibility for licensure based on improperly taking the exam (taking or retaking exam components rather than the entire exam) even though passing scores were received within the sitting limitations used by the Board (not more than five separate exam sittings).

This rule provision provides that applicants would be judged based on their component passing scores received after June 1, 1985 (so long as no more than five examination sittings occurred) and that further retaking of the FLEX Examination in whole or part would not be required for evaluation for licensure.

Beginning July 1, 1990, applicants fitting the above criteria could submit applications with the component passing scores received in two to five sittings and not be denied eligibility for licensure based on scores received in separate sittings. If the applicant's licensure credentials, in addition to the FLEX scores, are complete, then licensure would take place. The burden of additional testing will not serve any purpose with passing scores already available and would perpetuate the unfairness that occurred.

This rule provision clearly identifies which parties are eligible for the exception and the criteria for qualifications under the

exception. This provision does not impair or confuse any future standards created by the earlier subparts of the rule since it only applies to situations already existing between June 1, 1985 and July 1, 1990. Based on the number of inquires (15) received by the Board as of November 1989 regarding this possible exception, the number of potential applicants receiving scores between June 1, 1985 and July 1, 1990 who may use the rule exception is relatively small and will not present a serious impact on the licensing process by a sudden large influx of applications. Therefore, this provision presents no future administrative problems for the Board in taking such corrective action.

5600.0600 LICENSE BY RECIPROCITY TO PRACTICE MEDICINE AND SURGERY

Subpart 1. Who may apply. An application for a license to practice medicine and surgery by reciprocity without a written examination according to Minnesota Statute section 147.03, may be made by ~~a physician--licensed by an accredited state licensing board or agency~~ an applicant having a valid license to practice issued by the proper agency in another state who has received a passing score from the Federation of State Medical Boards pursuant to part 5600.0400 or who has passed a licensing examination of another state with a grade average score of 75 or higher.

The amending language of Minn. Rules pt. 5600.0600, subp. 1 is reasonable and necessary in order to clarify for applicants seeking licensure by reciprocity what the passing score requirements are so they may determine their eligibility status in regard to applying for licensure by reciprocity. This rule provision is also necessary to replace the confusing language of part 5600.0600, subpart 3. which is being repealed.

Because all the standards and requirements for the FLEX Examination will be found under Minn. Rules pt. 5600.0400, the

reference to part 5600.0400 in the rule provides a simple cross-reference. Keeping all the FLEX standards and requirements under one rule provision will avoid the confusion caused when different FLEX standards existed under parts 5600.0400 and 5600.0600, subpart 3.

Likewise, the language regarding the passing score requirement (grade average of 75 or higher) on licensing exams of other states makes clear what score is needed to comport with the eligibility requirements for licensure by reciprocity. The previous rule language under part 5600.0600, subpart 3 was confusing and unworkable. It read in part, "a grade average of 75 on examinations other than FLEX shall be the passing grade on all examinations graded by the Board". Since the Board does not grade any examination this provision was not only confusing but also unenforceable.

By having the score for the FLEX examination and for licensing exams of other states clearly referenced or defined in proposed Minn. Rules pt. 5600.0600, subp. 1, rather than part 5600.0600 subpart 3 applicants can more easily identify and comply with the eligibility requirements for licensure by reciprocity. The subheading "Who may apply" further reinforces the idea that applicants must meet the scoring requirements listed. This may help avoid having applicants inappropriately submit application materials and fees which cannot be processed due to an applicant not having the appropriate FLEX exam or state licensing board score.

REPEALER. Minnesota Rules, Part 5600.0600, subpart 3 is repealed.

The repeal of Minn. Rules pt. 5600.0600, subp. 3. is reasonable and necessary to correct outdated, incorrect and confusing language found in Minn. Rules pt. 5600.0600, subp. 3 concerning the FLEX weighted average score, passing scores for exams other than FLEX, and standards on exam sittings and retakings.

Because the Federation of State Medical Boards changed the scoring of FLEX exams in 1985 from a FLEX weighted average score to component scores, the FLEX weighted average of 75 score under Minn. Rules pt. 5600.0600, subp. 3 is outdated. Minn. Rules pt. 5600.0400 will describe all standards regarding the FLEX Examination including passing scores, exam sittings and exam retakings.

The amended language of Minn. Rules pt. 5600.0600 subp. 1 also replaces Minn. Rules pt. 5600.0600, subp. 3 by clarifying the passing score requirements on the FLEX exam or state licensing board exams needed by applicants attempting to obtain licensure by reciprocity.

4. COMPLIANCE WITH PROCEDURAL RULEMAKING REQUIREMENTS

Minn. Stat. §§ 14.05 to 14.12 and 14.22 to 14.28 specify certain procedures which must be followed when an agency adopts or amends rules. Minn. Stat. §§ 14.05 to 14.12 have been complied with by the Board as noted below. The procedures for adoption of non-controversial rules in Minn. Stat. §§ 14.22 to 14.28 are being followed inasmuch as no public hearing is presently planned and need not be held unless 25 or more persons make a timely written request for a public hearing.

The adoption of these rules will not require the expenditure of public money by local public bodies, nor do the rules have any impact on agricultural land. The adoption of these rules could have negligible effect on small businesses as discussed below. See Minn. Stat. § 14.115.

Pursuant to Minn. Stat. § 14.23, the Board has prepared this Statement of Need and Reasonableness which is available to the public. The Board will publish a Notice of Intent to Adopt Rules Without a Public Hearing in the State Register and mail copies of the notice and proposed rules to persons registered with the Board pursuant to Minn. Stat. §

14.14, subp. 1a. The notice will include the following information: 1) that the public has thirty days in which to submit comments on the proposed and give information pertaining to the manner in which persons may comment; b) that no public hearing will be held pursuant to Minn. Stat. § 14.25 unless 25 or more persons request in writing a public hearing on the proposed rule within the 30 day comment period; 3) that the rule may be modified if modifications are supported by data and the view submitted; and 3) that notice of the date of submission of the proposed rules to the Attorney General for review will be mailed to any persons requesting to receive the notice and give information on how to request the notice.

5. ADDITIONAL REQUIREMENTS

Small Business Considerations

It is the position of the Board that Minn. Stat. § 14.115 (1988) relating to small business considerations in rulemaking does not apply to the rules it promulgates. Minn. Stat. § 14.115, subd. 2 does not apply to "agency rules that do not affect small business directly." The Board's authority relates only to physicians and not to the businesses they operate.

The Board is also exempt from the provisions of Minn. Stat. § 14.115, subd. 7(c) which states that section 14.115 does not apply to "service businesses regulated by government bodies, for standards and cost, such as . . . providers of medical care." Physicians provide medical care and are regulated by the state for standards and cost. The Board regulates physicians for standards. The Minnesota Department of Human Services regulates physicians for costs with respect to the Medicaid system.

However, should these proposed rules be construed as being subject to Minn. Stat. § 14.115, the Board notes below how the five

suggested methods listed for reducing the impact of the rules on small businesses should be applied to the proposed amendments. The five suggested methods enumerated are as follows:

a) the establishment of less stringent compliance or reporting requirements for small business;

b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

c) the consolidation or simplification of compliance or reporting requirements for small businesses;

d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule;

e) the exemption of small businesses from any or all requirements of the rule.

The feasibility of implementing each of the five suggested methods and whether implementing any of the five methods would be consistent with the statutory objectives that are the basis for this rulemaking are considered below.

1. <u>It would not be feasible to incorporate any of the five suggested methods into these proposed rules.</u>

Methods (a) and (c) or subdivision 2 relate to lessening compliance or reporting requirements for small businesses either by (a) establishing less stringent requirements, (b) establishing less stringent schedules or deadlines for compliance with the requirements, or (c) consolidating or simplifying the requirements. Since the Board is not proposing any compliance or reporting requirements for either small or large businesses, it follows that there are no such requirements for the Board to lessen with respect to businesses. If, however, these proposed rules and amendments are viewed as compliance or reporting requirements

for businesses, then the Board finds that it would be unworkable to lessen the requirements for those physicians who practice in solo or clinic settings of fewer than 50 employees, since that would include the vast majority of licensees. Method (d) suggests replacing design or operational standards with performance standards for small businesses. The Board's rules do not propose design or operational standards for small businesses as a replacement for design or operation standards that do not exist. Finally, method (e) suggests exempting small businesses from any or all requirements of the rules. The application of this provision would exempt virtually most licensees from the purview of the rules, a result which would be absurd.

2. Reducing the impact of the proposed rules on small businesses would undermine the objectives of the Minnesota licensing law for physicians.

Pursuant to Minn. Stat. §§ 147.01 et seq., the Board was designated as the agency for establishing requirements for licensure and for adopting standards for disciplinary action to govern the practices or behavior of all physicians. Pursuant to Minn. Stat. § 147.01, subd. 3, the Board is specifically mandated to promulgate rules as may be necessary to carry out the purposes of the Minn. Stat. §§ 147.01 to 147.33. Given these statutory mandates, it is the Board's duty to establish licensure qualifications and disciplinary standards which apply to and govern all applicants and licensees regardless of their practice. As it has been stated above, it is the Board's position that the proposed rules will not affect small businesses and certainly do not have the potential for imposing a greater impact on physicians in solo or small practices than those practices large enough to remove themselves from the definition of small businesses. It has also been explained above that the Board considers it infeasible to implement any of the five suggested

methods enumerated in subdivision 2 of the small business statute. Nonetheless, to the extent that the proposed rules may affect the business operation of a physician or group of physicians and to the extent it may be feasible to implement any of the suggested methods for lessening the impact on small businesses, the Board believes it would be unwise and contrary to the purposes to be served by these rules for the Board to exempt one group of physicians, indeed possibly the vast majority of physicians, from the requirement of these rules. Similarly, the Board believes it would be unwise and contrary to its statutory mandate for the Board to adopt one set of standards for those physicians (which may consist of a nonexistent class) who work in a large business setting and adopt another, less stringent set of standards to be applied to those physicians who practice in a solo or small clinic type of setting. It is the Board's view that these rules must apply equally to all physicians if the public whom they serve is to be adequately protected.

Licensees, regardless of whether they are considered individuals or small businesses, have had and will continue to have an opportunity to participate in the rulemaking process for the proposed rules. The Board has used a very open process to draft these rules. The Board has kept the various associations well informed of the proposed rules as they were developed and has also provided notices and articles in its newsletter about the proposed rules.

LIST OF ATTACHMENTS

1. A copy of the Proposed Rule Relating to Licensing and Examination of Physicians.

2. FLEX and SPEX Information Bulletin 1990 - Prepared by the Federation of State Medical Board of the United States, Inc.

3. FEDERATION BULLETIN - Vol 76. No. 6, June 1989 containing an article by John H. Morton, M.D. titled "Medical Licensure Examinations and State Medical Boards 1989 - Where Have They Been, Where are they Going?"

4. THE EXCHANGE: SECTION 1: FLEX AND M.D. LICENSING REQUIREMENTS 1989-1990 published by the Federation of State Medical Boards of the United States, Inc.

1989-1990 THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

EXCHANGE

SECTION 1: FLEX AND M.D. LICENSING REQUIREMENTS

1 MD

THE EXCHANGE

A publication of the Federation of State Medical Boards of the United States

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ISSN 0888-5648

The 1989/1990 edition of the *Exchange* reflects design and production improvements made possible in part by a project funded under HRSA Contract No. 240-87-0049 between the Federation of State Medical Boards and the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services.

Board of Medical Examiners

Proposed Permanent Rules Relating to Examinations

Rules as Proposed

5600.0400 ~~GRADES~~ EXAMINATION RETAKING, PASSING SCORES, AND SITTINGS.

~~A weighted average grade of 75 shall be the passing grade on all examinations prepared and graded by the Federation of State Medical Boards of the United States. If an applicant falls below a weighted average grade of 75, it shall constitute a failure. In order to be eligible for licensure, the applicant may repeat those parts of the examination on which he received a grade less than 75 or may repeat the entire examination. The latest grade received shall be the only one considered by the board.~~

Subpart 1. **Federation licensing examination passing scores.** For examinations taken before June 1, 1985, a Federation Licensing Examination weighted average score of 75.0 shall be the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States. The latest weighted average score shall be the only weighted average score considered by the board. For examinations taken after June 1, 1985, the passing score on examinations prepared and graded by the Federation of State Medical Boards of the United States shall be a score of 75.0 on each component of the examination. The latest score for each component shall be the only one considered by the board except as provided in subpart 4.

Subp. 2. **Examination sittings.** Except as provided in subpart 4, each administration of the Federation Licensing Examination constitutes a sitting by the applicant whether the applicant takes one or more examination components in the examination administration. An applicant may take the number of sittings allowed in items A and B.

A. After June 1, 1985, an applicant who has not

Approved by Revisor KTH

received a passing score on one or both components of the Federation Licensing Examination, may complete up to five sittings of the examination before January 1, 1991, to obtain a passing score on both components of the examination. No additional sittings for the Federation Licensing Examination are permitted by the board after January 1, 1991, if the applicant has had three or more sittings as of January 1, 1991. After January 1, 1991, an applicant may take the Federation Licensing Examination components in separate sittings subject to subpart 3.

B. After January 1, 1991, an applicant not receiving a passing score on each component of the Federation Licensing Examination within three sittings shall not be eligible for licensure by the board nor permitted additional examination sittings.

Subp. 3. **Retaking of examinations.** An applicant who did not receive a passing weighted average score before June 1, 1985, must retake the entire Federation Licensing Examination.

An applicant who did not receive a passing score of 75.0 on a component of the Federation Licensing Examination after June 1, 1985, may either retake the entire examination and obtain passing scores on both components or retake the examination component for which the applicant did not receive a passing score and obtain a passing score on that examination component.

Subp. 4. **Licensure eligibility exception.** Applicants who were not eligible for licensure after June 1, 1985, because their Federation Licensing Examination passing scores were obtained in two but not more than five separate sittings may apply to the board after July 1, 1990, for licensure without retaking and passing an additional component or components of the Federation Licensing Examination.

The application shall be on forms prepared by the board and shall include the information required in part 5600.0200, subpart 2, items A to E, together with the fees described in part 5600.2500.

5600.0600 LICENSE BY RECIPROCITY TO PRACTICE MEDICINE AND

Approved
by Revisor _____

SURGERY.

Subpart 1. **Who may apply.** An application for a license to practice medicine and surgery by reciprocity without a written examination according to Minnesota Statutes, section 147.03, may be made by ~~a physician licensed by an accredited state licensing board or agency.~~ an applicant having a valid license to practice issued by the proper agency in another state who has received a passing score from the Federation of State Medical Boards of the United States pursuant to part 5600.0400 or who has passed a licensing examination of another state with a grade average score of 75 or higher.

[For text of subp 2, see M.R.]

Subp. 3. [See Repealer.]

REPEALER. Minnesota Rules, part 5600.0600, subpart 3, is repealed.

Approved
by Revisor _____

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Examinations

AGENCY: Board of Medical Examiners

MINNESOTA RULES: Chapter 5600

The attached rules are approved for publication
in the State Register

Kathleen T. Harrington
Assistant Revisor

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the
Proposed Adoption of
Rules of the Minnesota
Board of Medical Examiners
Relating to Examinations

NOTICE OF INTENT TO
ADOPT RULES WITHOUT
A PUBLIC HEARING

(1) Notice is hereby given that the Minnesota Board of Medical Examiners (hereinafter "Board") intends to adopt the above-entitled rules without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minn. Stat. §§ 14.22 to 14.28 (1988). The statutory authority to adopt the rules is Minn. Stat. §§ 147.01, subd. 3, 147.02, subd. 1.(c), and 147.03(c) (1988).

(2) All persons have 30 days in which to submit comment in support of or in opposition to the proposed rules or any part or subpart of the rules. Comment is encouraged.(3) Each comment should identify the portion of the proposed rules addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rules within the 30-day comment period.(4) If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing.(6) Any person requesting a public hearing should state his or her name and address and is encouraged to identify the portion of the proposed

rules addressed, the reason for the request, and any change proposed. (7) If a public hearing is required, the Board will proceed pursuant to Minn. Stat. §§ 14.131 to 14.20 (1988).

(3) Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West
Suite 106
St. Paul, MN 55114
(612)642-0528

(8) The proposed rules may be modified if the modifications are supported by data and views submitted to the Board and do not result in a substantial change in the proposed rules as noticed.

(11) A copy of the proposed rules is attached to this notice.

(12) A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rules and identifies the data and information relied upon to support the proposed rules has been prepared and is available from H. Leonard Boche upon request.

(14) Pursuant to Minn. Stat. § 14.115 the Board's Statement of Need and Reasonableness addresses the effect these rules may have on small businesses.

(9) If no hearing is required, upon adoption of the rules, the rules and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request

notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General or who wish to receive a copy of the adopted rules must submit the written request to H. Leonard Boche.

Date: April 2, 1990

/s/ Leonard Boche

H. Leonard Boche
Executive Director

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Adoption of Rules of the Minnesota Board of Medical Examiners Relating to Examination

AFFIDAVIT OF MAILING THE NOTICE OF AND ORDER FOR HEARING AND CERTIFICATE OF MAILING LIST

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

William Robert Marczewski, being duly sworn says:

I hereby certify that the list of persons and associations who have requested, pursuant to Minn. Stat. 14.14, subd. 1.a, that their names be placed on the Minnesota Board of Medical Examiners rulemaking mailing list is accurate, complete, and current as of this 16th day of April, 1990.

That on the 16th day of April, 1990, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of and Order for Hearing in the above-entitled matter by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid, to all persons and associations on the aforementioned mailing list.

William Robert Marczewski
Medical Regulations Analyst

Subscribed and sworn to before me
this 16th day of April, 1990.

Lois Kauppila

LOIS KAUPPILA
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES APRIL 28, 1992

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Edina, MN 55424

R. Romanathan, M.D.
1669 68th Ave. NE
Fridley, MN 55432

of the date of submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit a written request to the State Board of Electricity.

John D. Quinn
Executive Secretary
State Board of Electricity

Board of Medical Examiners

Proposed Permanent Rules Relating to Examinations

Notice of Intent to Adopt Rules Without a Public Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Board of Medical Examiners (hereinafter "Board") intends to adopt the above-entitled rules without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in *Minnesota Statutes* §§ 14.22 to 14.28 (1988). The statutory authority to adopt the rules is *Minnesota Statutes* §§ 147.01, subd. 3, 147.02, subd. 1.(c), and 147.03(c) (1988).

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rules or any part or subpart of the rules. Comment is encouraged. Each comment should identify the portion of the proposed rules addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rules within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address and is encouraged to identify the portion of the proposed rules addressed, the reason for the request, and any change proposed. If a public hearing is required, the Board will proceed pursuant to *Minnesota Statutes* §§ 14.131 to 14.20 (1988).

Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West
Suite 106
St. Paul, MN 55114
(612) 642-0528

The proposed rules may be modified if the modifications are supported by data and views submitted to the Board and do not result in a substantial change in the proposed rules as noticed.

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A STATEMENT OF NEED AND REASONABLENESS that describes the need for and reasonableness of each provision of the proposed rules and identifies the data and information relied upon to support the proposed rules has been prepared and is available from H. Leonard Boche upon request.

Pursuant to *Minnesota Statutes* § 14.115 the Board's Statement of Need and Reasonableness addresses the effect these rules may have on small businesses.

If no hearing is required, upon adoption of the rules, the rules and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General or who wish to receive a copy of the adopted rules must submit the written request to H. Leonard Boche.

Dated: 2 April 1990

H. Leonard Boche
Executive Director

Rules as Proposed

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~~A weighted average grade of 75 shall be the passing grade on all examinations prepared and graded by the Federation of State Medical Boards of the United States. If an applicant falls below a weighted average grade of 75, it shall constitute a failure. In order to be eligible for licensure, the applicant may repeat those parts of the examination on which he received a grade less than 75 or may repeat the entire examination. The latest grade received shall be the only one considered by the board.~~

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A. After June 1, 1985, an applicant who has not received a passing score on one or both components of the Federation Licensing Examination, may complete up to five sittings of the examination before January 1, 1991, to obtain a passing score on both components of the examination. No additional sittings for the Federation Licensing Examination are permitted by the board after January 1, 1991, if the applicant has had three or more sittings as of January 1, 1991. After January 1, 1991, an applicant may take the Federation Licensing Examination components in separate sittings subject to subpart 3.

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Subpart 1. **Who may apply.** An application for a license to practice medicine and surgery by reciprocity without a written examination according to *Minnesota Statutes*, section 147.03, may be made by ~~a physician licensed by an accredited state licensing board or agency.~~ an applicant having a valid license to practice issued by the proper agency in another state who has received a passing score from the Federation of State Medical Boards of the United States pursuant to part 5600.0400 or who has passed a licensing examination of another state with a grade average score of 75 or higher.

[For text of subp 2, see M.R.]

Subp. 3. [See Repealer.]

REPEALER. *Minnesota Rules*, part 5600.0600, subpart 3, is repealed.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

CERTIFICATE OF THE

MINNESOTA BOARD OF MEDICAL EXAMINERS

RESOLUTION ADOPTING RULES

I, Cassius M.C. Ellis, III, M.D., do hereby certify that I am a member and the president of the Minnesota Board of Medical Examiners (hereinafter "Board"), a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the Board, duly and properly called and held on the 9th day of June, 1990, that a quorum was present, and that a majority of those present voted for the resolution which has not been rescinded or modified:

> RESOLVED, that the rules relating to Examinations are approved and adopted pursuant to authority vested in the Board by Minn. Stat. § 147.01 subd. 3(1988). H. Leonard Boche, Executive Director of the Board, is authorized to sign the findings of fact, conclusions and order adopting the rules and further is authorized to modify the rules if necessary to obtain the approval of the rules by the Attorney General and to perform the necessary acts to provide that the rules shall have the force and effect of law.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 9th day of June, 1990.

Cassius M.C. Ellis, III, M.D.
President

Attest by one other Board member

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the
Rules of the Minnesota
Board of Medical Examiners
Relating to Examinations

FINDINGS OF FACT,
CONCLUSIONS, AND ORDER
ADOPTING RULES WITHOUT
A PUBLIC HEARING

(1) Notice of the Minnesota Board of Medical Examiners (hereinafter "Board") intent to adopt the above-entitled rules was published in the State Register on April 16, 1990, and was sent by United States mail to all persons on the list maintained by the Board pursuant to Minn. Stat. §§ 14.14, subd. 1a and 14.22 on April 16, 1990. (2) The statement of need and reasonableness was prepared before the Notice of Intent to Adopt Rules Without a Public Hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

FINDINGS

(4) 1. All persons were given the opportunity to submit comment on the rules for 30 days after notice of proposed rulemaking. (3) No requests for a public hearing on the rules was received by the Board.

2. One submission commenting on the rules was received by the Board. Sidney P. Abramson, Esquire, submitted comment on behalf of Morris E. Bellis, M.D. The comment indicated that an exception as provided under Minn. Rule pt. 5600.0400 subp. 4 should be granted allowing reciprocity without further examination to applicants who passed the FLEX examination prior to June 1985 in separate sittings using the passing average score from each sitting rather than requiring a FLEX weighted average.

3. The comment submitted by Sidney P. Abramson was considered by the Board. It was not accepted by the Board because it seeks to create a new retroactive licensure standard for individuals who took the FLEX examination prior to June 1985. The Board, under the proposed rules, did not intend to expand licensure to such individuals, but to correct and update the rules to allow for licensure of individuals denied licensure after June 1985 because of changes in the FLEX examination which were not incorporated into the Board rules.

4. (7) No requests for notice of submission to the Attorney General were received by the Board.

CONCLUSIONS

Based on the comments and evidence in the record before the Board, including the statement of need and reasonableness which is incorporated herein as the Board's findings, the Board concludes that the above captioned rules are both (8) needed and reasonable.

NOW, THEREFORE, IT IS HEREBY ORDERED that the rules identified as Minnesota Board of Medical Examiner Rules Relating to the Examinations are adopted this 19th day of June 1990, pursuant to authority vested in the Board by Minn. Stat. § 147.01 subd. 3 (1988). (9)

/s/ Leonard Boche

H. Leonard Boche
Executive Director

ROBINS, KAPLAN, MILLER & CIRESI
ATTORNEYS AT LAW

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DALLAS, TEXAS
MINNEAPOLIS, MINNESOTA
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May 10, 1990

SIDNEY P. ABRAMSON
(612) 349-8202

Mr. H. Leonard Boche
Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, MN 55114-1080

Re: Dr. Morris E. Bellis
Our File No.: 025615-0000

Dear Mr. Boche:

The undersigned represents Dr. Morris Bellis of Norton, Virginia. Dr. Bellis seeks admission to practice medicine in Minnesota. Dr. Bellis was born in Minnesota and received his B.A. at the University of Minnesota. He went on to complete his medical education in Mexico, graduating in December 1978 from Autonomous University of Guadalajara, Mexico. Thereafter, he successfully completed internships and a residency, the latter in a program in Otolaryngology-Head and Neck Surgery at White Memorial Medical Center in Los Angeles, which he completed June 30, 1985. As part of that year of residency, he successfully completed one year of general surgery at the VA facility in Sioux Falls, South Dakota associated with the University of South Dakota School of Medicine in June 1982.

He passed the FLEX exam in 1982, no. 460626005. He is currently licensed in California, Oklahoma, Virginia, and Alaska. He holds staff appointments at hospitals in California and Virginia, and has served as Chief of Surgery in 1988 and 1989 at the Norton, Virginia Community Hospital. This year, he serves as Vice Chairman of the Quality Assurance Committee.

He has published in his special field and has made presentations to professional groups regarding his publications across the country.

Dr. Bellis, however, runs afoul of Minnesota's licensing requirements as they are currently formed and anticipated by the action of the Board of Medical Examiners this year. He has written and provided material to the Board regarding this. In addition, in conjunction with the 30-day comment period currently in process, he has resubmitted his prior correspondence and also offers the record of his prior attempt to be licensed for practice in Fergus Falls, which failed based on the regulations now being revised in Minnesota. His problem lies in the Board's proposal which differentiates between persons completing the FLEX exam prior to June 1, 1985 and those taking the exam subsequent to June 1, 1985. Although he acknowledges that the examination was reconstituted in June 1985, in substance intermeshing basic sciences with various clinical areas of inquiry, he is convinced and has provided documentation for the proposition that the test questions are drawn from the same pool of information, and preparation for taking of the exam has not changed. Therefore, he finds that since he took the examination in components prior to 1982, as was then appropriate, at this time he has exceeded the number of examinations allowed to calculate his score by having each component counted as a test and, therefore, has not passed the test in a fashion now acceptable to the Minnesota Board. In other words, now each component taken counts as a test and he has exceeded the three sittings now allowed by the Board. Furthermore, if he is compelled to take the entire exam he would essentially be forced to abandon his current practice in order to prepare for aspects of the exam which, although certainly appropriately tested, are irrelevant to his specialty and practice.

Dr. Bellis devoutly wants to be licensed in his home state of Minnesota. It appears that his licensure in four other jurisdictions, as well as his credible record of practice and demonstration of no disciplinary procedures pending against him or having been completed against him since he began practice, should in fairness entitle him to admission in Minnesota. Dr. Bellis has retained our office to assist him in his goal of licensure in Minnesota. He asks that the Board consider as part of its new regulations, a reciprocity with other jurisdictions of the United States tempered certainly by a requirement that he be properly licensed in another venue and not be under censure or discipline, and further, that he produce credentials and evidence of successful completion of other state licensure, as well as proof of successful passing of the FLEX exam, as he has to the other four states. Although Dr. Bellis persists in his view that the pre-1985 FLEX exam, which he did pass, was a more difficult test (since the basic science scores of the first day of the three-day exam were reported separately and averaged in with the other scores in obtaining a

final score, while the current test's weighted average provision in the two-day reformulated test melds basic sciences together with clinical concerns, thereby not weighing basic sciences adequately), he feels that at the very least, for those who are now successful practitioners who completed the FLEX prior to 1985, an exception ought be written into the rules consistent with the action of 22 states. He further has in mind that there is an inconsistency between the treatment of United States medical school graduates and off-shore graduates, but vigorously asserts that such prejudice aside, he has completed, as his curriculum vitae suggests, an appropriate and recognized United States internship and residency, and has been licensed by four jurisdictions in the United States, not to mention his successful years of practice.

Dr. Bellis urges the Board to consider his previously-submitted critique of the regulations and to grant to him a license to practice in Minnesota. He continues to offer his availability to the Board for testimony notwithstanding the fact that the Board anticipates no public hearing under its current notice of intent to adopt rules without such hearing.

Very truly yours,

ROBINS, KAPLAN, MILLER & CIRESI

Sidney P. Abramson

SPA/ln
cc: Dr. Morris Bellis


MAY 1990
MN BOARD OF
MED EXAM

Morris E. Bellis, M.D.
EAR, NOSE AND THROAT
100 - 15TH ST.
MEDICAL ARTS BUILDING
NORTON, VIRGINIA 24273

TELEPHONE: (703) 679-0160

MAR 1990
MN BOARD OF
MED EXAM

February 28, 1990

Mr. H. Leonard Boche
Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, Minnesota 55114-1080

Dear Mr. Boche:

I read your letter of 2-20-90 as well as the proposed rules on licensing and examination, dated 11-06-89, sent by Mr. William R. Marczewski under cover letter of 2-16-90.

Concerning the proposed rules on licensing and examination, sub-part 1 states that for examinations taken before 6-01-85, a Federation Licensing Examination weighted average is necessary for licensure. Scores from the FLEX retaken in parts are not recognized or considered for licensing purposes by the Minnesota Board. Yet, sub-part 2 states that each administration of the FLEX constitutes a sitting by the applicant whether the test was taken in parts or in its entirety. I think this is unfair. If the Minnesota Board will not even consider scores from partial retaking of the FLEX prior to 6-01-85 for licensing purposes, then the Board should not charge those applicants who took the FLEX in components prior to 6-01-85 with a sitting for the FLEX. It appears that applicants who took the FLEX prior to 6-01-85 will be charged with sittings on the FLEX in which the scores are not even eligible for consideration for licensure. Under the proposed rules, applicants taking the FLEX after 6-01-85, whether in its entirety or in components, are all granted consideration for licensure and are charged with sittings only on scores eligible for consideration by the Board.

continued.....

Sub-part 2-A, which discusses applicants who have taken the FLEX after 6-01-85, states that applicants not receiving a passing score on one or both components of the FLEX taken after 6-01-85 may have up to five sittings to obtain a passing score before 7-01-90. This is ambiguous to me. It is not clearly stated whether a total of five sittings are permitted after 6-01-85 for all applicants, or whether applicants who took the FLEX prior to 6-01-85 must include their sittings from the "old FLEX" into the total of five sittings on the "new FLEX". Sub-part 2-A does not address how the sittings of those who took the FLEX prior to 6-01-85 will apply to the FLEX after 6-01-85.

Again, it would seem unfair for the Board to charge me with sittings from the FLEX prior to 6-01-85 if the FLEX given after 6-01-85 is so different from the previous FLEX that the Board has deemed it advisable to propose new rules relating to the scoring and licensing under the "new FLEX".

Sub-part 3 states, in part, that an applicant who did not receive a passing weighted average score before 6-01-85 must retake the entire FLEX. It seems that a different standard is being used concerning those who took the FLEX prior to 6-01-85 as compared to those taking the FLEX after 6-01-85. I think that I did pass the FLEX (prior to 6-01-85) and that denial of licensure because I re-took components contradicts the new rule proposals which permit retaking of components after 6-01-85. Furthermore, applicants under the FLEX after 6-01-85 even have their choice of re-taking the examination in its entirety or in components; whereas applicants taking the FLEX prior to 6-01-85 are obligated to retake the entire examination, including components previously passed.

With regard to sub-part 4 lines 24-28, I ask the Board why the group of applicants who took the FLEX between 6-01-85 and 7-01-90, and were not eligible for licensure, have had their licenses put on hold for the last five years until the proposed new rules are adopted? If my understanding is correct, this group of applicants have had their licenses delayed because their scores were in components obtained in two, but not more than five, sittings. This is identical with my retaking of the FLEX prior to 6-01-85 in components. Part 4 seems to me to say that this group cannot be licensed until the proposed new rules are adopted because no provision currently exists for licensure under components.

page 2.....

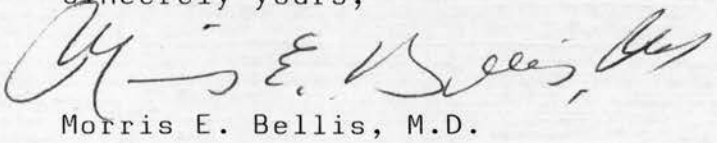
The new rules if adopted will then allow retrograde licensure of this group of people who took the FLEX in components; however, the retrograde licensing stops on 6-01-85. I would ask the Board why not continue the retrograde licensing prior to 6-01-85? I would also ask the Board why this group of applicants is earmarked for special retrograde consideration under the proposed new licensure rules?

In response to the letter from Mr. Boche dated 2-20-90, I would note that had I not contacted the Minnesota Board in December of 1989 because of my interest in obtaining a license in Minnesota, I would not be aware that new rules on licensure were under consideration by the Board. Furthermore, if I had not by chance been in contact with the Board I would not have received the above mentioned letter from Mr. Boche advising me that, according to his interpretation, my last chance of taking the FLEX is in June of 1990.

I would like to remind the Board that the licensing and examination rules are still in the proposal stage. The public commentary time period has not even begun yet. Any subsequent evaluation of the proposed rules following the commentary period is yet to take place. Therefore, how can there be an official cut-off date of 7-01-90 when the rules are still in the proposal stage and have not been properly established according to the adoption procedures.

I would also bring to your attention that it is unrealistic to expect any applicant for licensure in Minnesota to prepare for a comprehensive examination on such short notice. This is especially true for applicants who are currently in private practice. I suggest that the 7-01-90 date not be considered a definitive date for licensing purposes due to the current unestablished status of the proposed rules on licensing and examination.

Sincerely yours,



Morris E. Bellis, M.D.

MEB/ab

Sent via - Federal Express.

Morris E. Bellis, M.D.

EAR, NOSE AND THROAT
100 - 15TH ST.
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TELEPHONE: (703) 679-0160

January 15, 1990

Mr. William Marczewski
Medical Regulation Analyst
Minnesota State Board of Medical Examiners
2700 West University Avenue, Suite 106
St. Paul, Minnesota 55114

Dear Mr. Marczewski:

I understand that the Minnesota State Board of Medical Examiners is in the process of considering changes in the rules regarding licensure of physicians who have taken the FLEX test. Enclosed are rule change proposals which I believe will make the FLEX licensing requirements comparable with licensing through the National Boards.

These proposals are presented to the Minnesota Board in the context of my solo private practice of Ear, Nose and Throat with Facial Plastic Surgery in Norton, Virginia. I have had a successful practice for five years, however, I was born and raised in Minnesota and would like to continue my practice in Minnesota. Currently, I hold licenses to practice in California, Virginia, Oklahoma and Alaska by way of the FLEX taken in 1982.

I think that the new Minnesota Board rules would achieve greater fairness in licensure between those who have taken the Flex and those who have taken the National Boards if the following recommended changes were adopted:

I. The new rule changes should apply to the FLEX taken prior to 1985 because:

A. the FLEX is a standard examination recognized by all fifty state boards

continued.....

MN BOARD OF
MED EXAM
JAN 1990

B. the FLEX has long maintained a uniform knowledge base for the granting of physician licenses

C. the quality of the FLEX examination, as well as the knowledge base, remain unchanged in the post-1985 FLEX as compared to the pre-1985 FLEX examination

1) the "pool" of questions, which is the source of questions asked at the FLEX examination, is unchanged in the pre and post-1985 examinations

2) the "pool" of questions given in the FLEX come from the same "pool" of questions used in the National Board examination which tests U.S. trained medical students

D. the Minnesota Board does not deny licensure to U.S. trained medical graduates on the bases of when they took the National Boards

E. the pre-1985 FLEX was more difficult to pass because the Basic Science scores from Day-1 were reported as a separate score which was averaged in with the other scores in obtaining the final score--since 1985, no reporting is made of how well or how poorly the Basic Science questions are answered

II. A "weighted average" based on the current requirement of retaking the entire FLEX examination is too restrictive and burdensome and should be changed because:

A. U.S. medical students are merely required to take one-day of the National Boards at a sitting. The three parts (days) of the National Boards examination are separated by years of study and preparation. U.S. trained applicants take the National Boards examination while in their medical school training and not years after the tested subjects were studied, whereas FLEX applicants are tested on their entire medical school and internship training in one examination

B. if a "day" of the National Boards is failed, the U.S. applicant is only required to retake the failed day. Previously passed National Board days are recognized as passed and remain on the record as such, with no requirement of retaking all parts of the National Boards (including passed parts)

continued.....

C. some 22 states permit licensure based on partial retaking of the FLEX and combining of scores, according to the 1989-1990 "Exchange" published by The Federation of State Medical Boards:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Kentucky, Maine, Maryland, Michigan, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, Virginia and Wyoming

D. the new concept under consideration by the Minnesota Board permitting retaking of only the failed days of the FLEX should be adopted because:

1) it is consistant with the long established approach of other state boards which permit retaking of only parts of the FLEX, and

2) it is consistant with the approach of the Minnesota Board of permitting U.S. trained applicants to initially take the National Boards in parts and, subsequently, to retake only failed parts

3) the policy of requiring those who have taken the FLEX to take it over in its entirety is inconsistant with its policy relative to the National Boards which is taken in parts

III. concerning those who passed the FLEX prior to 1985 whose licensure in other states is based on combining of scores, Minnesota should apply this method of licensure as well. A rule permitting combining of scores on the FLEX is no different than what is being done currently for those who take the National Boards and fail one or more days

Sincerely yours,

Morris E. Bellis, M.D.

MEB/ab


MN BOARD OF
MED EXAM
JAN 1990

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the
Proposed Adoption of
Rules of the Board of
Medical Examiners Relating
to Examinations

DECLARATION OF COUNSEL

I, John A. Breviu, Assistant Attorney General, do hereby declare that I have examined the above-captioned rules and the supporting rulemaking record and that, based on my examination, the Administrative Procedure Act and Minn. Rules ch. 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0480.

Dated: June 25, 1990.

JOHN A. BREVIU
Assistant Attorney General