

The Early Development of Medical Licensing Laws in the United States, 1875-1900*

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The condition of the American medical profession at the close of the Civil War was, in almost every particular, significantly different from that which obtains today. The profession was, throughout the country, unlicensed and anyone who had the inclination to set himself up as a physician could do so, the exigencies of the market alone determining who would prove successful in the field and who not. Medical schools abounded, the great bulk of which were privately owned and operated and the prospective student could gain admission to even the best of them without great difficulty. With free entry into the profession possible and education in medicine cheap and readily available, large numbers of men entered practice. Indeed in 1860 the census data indicate that the country possessed over 55,000 physicians, or 175 per 100,000 population, almost certainly the highest number of doctors per capita of any nation in the world.¹

Competition resulted not only in a proliferation of medical personnel but in the growth of heterodox theories arising in opposition to standard medical therapeutics. Regular medicine in the early nineteenth century relied heavily on symptomatic treatment, consisting, in the main, of bloodletting, blistering, and the administration of massive doses of compounds of mercury, antimony, and other mineral poisons as purgatives and emetics, followed by arsenical compounds thought to act as tonics. The therapeutic regimen thus developed came to be known as "heroic therapy" and certainly killed large numbers of patients unfortunate enough to undergo treatment at the hands of its practitioners. Two sects—eclecticism and homeopathy—successfully competed with regular medicine and were, between 1830 and 1850, in great part responsible for the repeal of medical licensing laws which remained as legacies of the Colonial period and the earliest years of the Republic.²

Eclecticism's principal theoretician was Samuel Thomson, originally a New Hampshire farmer, who developed and patented a system of medicine

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in 1813 relying exclusively on botanical remedies, steam baths, and rest. He completely repudiated the therapeutic arsenal of heroic medicine, attacking bleeding, blistering, and the administration of mineral poisons as "instruments of death," and injected much common sense into the care of the sick and ailing. Most importantly, he provided an alternative to regular therapy easily understood and eventually widely employed by the American public.³

An even greater threat to orthodox medicine was homeopathy, created by Samuel Hahnemann, a German physician possessed of a formal and rigorous medical education. Hahnemann's researches led him to conclude that the most efficacious remedy for any ailment consisted in the administration of a drug which, when tested in a healthy person, induced those symptoms most closely approximating the symptomology of the disease. This law, *similia similibus curantur*, was the foundation-stone of homeopathic therapeutics. Equally revolutionary was the homeopathic theory of optimal dosage. Regular physicians had prided themselves on the strength and quantity of medication administered, many believing that if ten grains of a substance were thought beneficial, one hundred would likely prove ten times more effective. Hahnemann, on the other hand, argued that extremely attenuated and minute doses were far preferable to stronger ones, indeed, the more attenuated, the better. He went so far as to recommend dilutions to the one-decillionth of a drop of the original medication. Perhaps the most significant contribution of homeopathy, however, and that which in turn contributed heavily to its popularity among the public after its introduction in America in 1825, was its stress on the natural healing powers of the organism itself. Homeopathic physicians were strong proponents of fresh air, sunshine, bed rest, proper diet, and personal hygiene for recuperation in an age when regular medicine regarded these as of little or no value.

By the 1870's, homeopathy, emphasizing minute doses of medication and the recuperative energies of nature, and eclecticism, relying on botanical and herbal remedies, had substantially altered regular medical therapeutics, lessening its dependence on large doses of metallic medicines and bloodletting and adding to its *materia medica* a host of new botanical drugs. The two sects had firmly established themselves as competing systems of medicine, with homeopathy especially popular in the large urban areas of the east and eclecticism concentrated in the midwest and south. Of the 62,000 physicians practicing in 1870, estimates place the number of homeopaths and eclectics at approximately 8,000, with homeopaths accounting for about two-thirds this number.⁴ American Medical Association statistics on medical schools and graduates for 1880 show that of the 100 medical schools in operation in that year, fourteen taught homeopathic medicine, graduating twelve percent of all new physicians, while nine schools taught eclecticism, from which close to six percent of all graduates issued.⁵ For orthodox practitioners, homeopa-

thy and eclecticism represented significant competing forces in medicine. Despite continual denunciations in regular medical journals and medical societies that these sects were pure quackery, they continued to be supported by the public who persisted in channeling fees to heterodox practitioners which, in their absence, might well have ended up in the pockets of regular physicians.

The economic condition of the profession being what it was in the 1870's, with no restrictions on entry into the field, a host of competing medical schools eager to graduate doctors in greater numbers, and heterodox medicine contending for the patient's dollar, regular physicians increasingly felt the need to effectively organize. Their goal was to enlist the support of government as a means of regulating the number and qualifications of physicians. The aims of orthodox medicine and its most effective and tireless spokesman, the American Medical Association, were threefold: (1) the establishment of medical licensing laws in the various states to restrict entry into the profession and thus secure a more stable economic climate for physicians than that which obtained under uninhibited competition; (2) the destruction of the proprietary medical school and its replacement with fewer, non-profit institutions of learning, providing extensive and thorough training in medicine with a longer required period of study to a smaller and more select student body; (3) the elimination of heterodox medical sects as unwelcome and competitive forces within the profession.

This paper will concern itself with the activities of organized medicine up to the beginning of the twentieth century, when the first of these goals had been achieved and by which time the groundwork for the other two had been laid.

The American Medical Association (AMA) was established as a permanent national organization at Philadelphia in 1847 at a convention attended by some 230 delegates representing more than forty medical societies and twenty-eight schools.⁶ From its inception, one of its primary aims was the upgrading of medical education and a concomitant reduction in the number of physicians. Its committee on raising medical standards reported at its first meeting that "the large number of Medical Colleges throughout the country, and the facility with which the degree is obtained, have exerted a most pernicious influence" on the profession.⁷ With the object of ameliorating this situation, recommendations were carried calling for a specified minimum preliminary education as a prerequisite for admission to a medical college, a lengthening of the period of study for graduation from a medical school, including compulsory clinical instruction at a hospital prior to the issuance of a diploma, and professional participation in some licensing scheme for physicians.⁸ Indeed, so important was the issue of education considered by the AMA that one of its first acts was the establishment of a Committee on

Medical Education which was to remain in existence for fifty-seven years, until replaced in 1904 by the Council on Medical Education, with greatly expanded powers to investigate and recommend improvements in medical training.⁹ Resolutions similar to those made in 1847 issued forth at all subsequent meetings of the Association and enormous energy was expended in the attempt to implement them.¹⁰ But, despite the priority accorded this question, it soon became apparent that the organization did not possess the strength necessary to accomplish these objectives without governmental involvement.

Although propaganda for these reforms most often stressed the selfless goal of raising the quality of medical care offered the public, some pronouncements were more candid in announcing the reasons for supporting more stringent educational requirements. Thus, the committee on educational standards reporting to the Philadelphia meeting in 1847 observed:

The very large number of physicians in the United States, a number far larger in proportion to its population than in any other country perhaps of which we have a correct knowledge, has frequently been the subject of remark. To relieve the diseases of something more than twenty millions of people, we have an army of Doctors amounting by a recent computation to forty thousand, which allows one to about every five hundred inhabitants. And if we add to the 40,000 the long list of irregular practitioners who swarm like locusts in every part of the country, the proportion of patients will be still further reduced. No wonder, then, that the profession of medicine has measurably ceased to occupy the elevated position which once it did; no wonder that the merest pittance in the way of remuneration is scantily doled out even to the most industrious in our ranks,—and no wonder that the intention, at one time correct and honest, will occasionally succumb to the cravings of hard necessity.¹¹

To which incorrect or dishonest acts physicians' cravings have occasionally forced them to succumb we are not informed, although the hypocrisy of demanding the institution of impossibly high educational standards¹² for all future members of the profession might possibly be regarded as one.

Dr. Stanford Chaillé, Professor of Physiology and Anatomy at the University of Louisiana, was no less open in offering the reasons for his support of rigorous educational prerequisites for practice. "The profession has good reason to urge that the number [of medical graduates] is large enough to diminish the profits of its individual members," he writes, "and that if educational requirements were higher, there would be fewer doctors and larger profits for the diminished number."¹³ But Dr. Chaillé was somewhat pessimistic about the possibility of instituting the necessary reforms which, he correctly concluded, could only come about through the passage of restrictive legislation, since the public would be unlikely to agree that "the

freedom lost will be more than compensated for by the benefits gained.”¹⁴

The solution to raising educational standards was eventually to be found not through appeals to medical schools, most of which were profit-making and therefore in competition with each other, but through legislative intervention and then only through the reintroduction of licensing laws in the various states. At its Cincinnati meeting in 1867, the AMA endorsed a resolution urging “upon the members of the profession in the different States to use all their influence in securing such immediate and positive legislation as will require all persons, whether graduates or not, desiring to practice medicine, to be examined by a State Board of Medical Examiners, in order to become licensed for that purpose,” and further recommending that “said board be selected from members of the State Medical Society, who are not at the same time members of college faculties.”¹⁵ Thus began a campaign to invoke the aid of the respective state legislatures to achieve the goal of limiting the production of medical doctors in the United States through establishing medical examining boards as the only portal of entry into the profession.

Events in Alabama were to prove just how effective a well-organized state association could be in achieving its political goals. There, Dr. Jerome Cochran was successful in forging one of the most powerful state medical societies in the country in the space of only four years and of placing the regulation of medical practice under the complete control of Alabama’s organized physicians. In 1873, Cochran molded the remains of the Medical Association of the State of Alabama, shattered by the Civil War, into a cohesive and politically effective state guild having as its objective ultimate administrative control over all public health matters in the state. In writing of his purpose in reorganizing the Association, Cochran underscored the political nature of the organization:

It is well that we should understand that the *primary and principal* object of the Association is *not* the cultivation of the *science and art* of medicine. Truly, that is not a matter to be neglected, and we hope to accomplish much in this line. But it is not this that we have chiefly at heart. We will appreciate most adequately the real character of the Association if we regard it as a *medical legislature*, having for its *highest function* the *governmental direction of the medical profession of the State*, while its other functions, *important as they are, in themselves, are, in comparison with this, of quite subordinate rank.*¹⁶

After thus organizing the profession, Cochran was able, in 1873, to promote the election of physicians to near-majorities in both houses of the state legislature. Cochran himself was elected State Senator and there led the profession’s forces in passing legislation which soon made the Alabama Medical Association an arm of the state government, with power to regulate

the practice of medicine and to administer public health affairs. County medical societies were empowered to act both as local boards of health and, after the passage of Alabama's medical practice act in 1877, as local medical examining boards. On the state level, the legislative body of the Association also acted as the State Board of Health, with the Board of Censors of the Association exercising the functions of the State Board of Medical Examiners. Thus, the state organization was empowered by the legislature not only to administer the health laws of Alabama but to make rules and regulations respecting questions of public health having the force of law and to have final control over entry into the medical profession in the state.¹⁷

The powers granted by the state government to the profession in Alabama fired the imaginations of representatives of organized medicine in the other states and at the national level and soon became the paradigm against which all other state legislation was measured. One historian of the period notes that "as the leadership of the AMA devised its strategy for organizational expansion it drew confidence and hope from the example of the Alabama society," and the secretary of the AMA and editor of its journal, referred to the Alabama organization as the best in the world and, in terms of its structure and function, one which other states should seek to duplicate.¹⁸

The AMA was eager to aid state societies in formulating and enacting medical legislation and in strengthening governmental agencies charged with their enforcement. This was especially true of state licensing laws, which occupied much of the attention of organized medicine between 1880 and 1900. Even before the passage of Alabama's medical practice act in 1877, both California and Texas—in 1876—had created state boards of examiners to pass on the credentials of prospective practitioners and to issue licenses.¹⁹ The Texas law made examination compulsory for all applicants,²⁰ while California's medical practice act was more typical of early legislation in requiring an examination only of those not possessing a diploma from some legally chartered medical college.²¹ Although the provisions of the Texas act were sufficiently far-reaching to effectively limit the number of new physicians entering the state—each district court was empowered to appoint an examining board composed of three physicians "of known ability" to examine all candidates who had not previously practiced in the state—examining boards were prohibited from testing in the area of therapeutics.²² As result of this provision, which secured protection for proponents of heterodox schools of medicine, regular physicians regarded the Texas law as a weak one, and it eventually fell into disuse when, in some districts, homeopaths were appointed to the boards and regular physicians refused to serve with them.

The question of cooperation with members of the irregular sects was of vital importance to regular practitioners, who were forbidden by the code of ethics of the AMA from dealing in any professional capacity with heterodox

practitioners.²³ Indeed, it was one of the ultimate goals of organized medicine to eventually eliminate these sects entirely. However, despite regular medicine's commitment to this end, temporary compromise became inevitable if the state legislatures were to be persuaded to institute medical licensing laws of any severity. As early as 1884, the *Journal of the American Medical Association (JAMA)* published a lengthy letter from the chairman of the legislative committee of the Iowa State Medical Society, calling for medical practice acts which would exempt therapeutics from the list of subjects in which new applicants would be examined in the interests of securing effective legislation. "That this scheme," wrote Dr. James Hibbard,

embraces no therapeutic doctrine will be distasteful to many excellent physicians, but it is believed that the sober second thought of all classes will recognize that there is little risk in trusting the medication of the ailing to the judgment of any one who is completely master of the [other] departments of medical science. . . . And moreover, it must be an apparent verity to the most obtuse that while regular physicians, eclectics, homeopaths, etc., have their present standing among the people, no one of the schools can reasonably hope to have its peculiar views of therapeutics recognized by an authority that has the power to cause their general adoption to the exclusion of others, . . .²⁴

Some five years later, one of the country's foremost medical men, Sir William Osler, at that time Professor of Medicine at Johns Hopkins University, wrote in the *JAMA* that all physicians, whether regular, eclectic, or homeopathic, stand equal in the eyes of the law and that "if we wish legislation for the protection of the public, we have got to ask for it together, not singly."²⁵ The *Journal*, unswerving to the last, editorially took exception to Professor Osler's suggestion that therapeutics and *materia medica* either be omitted from licensing examinations or that applicants be given the choice of which system they wished to be tested in. "No student," the editorial commented, "of any one of these pathys or isms should receive a license to practice unless he is also possessed of a good knowledge of regular therapeutics as practiced by more than nine-tenths of the medical men of Europe and America."²⁶ But despite the unrelenting attitude of the national association, state societies quickly found it prudent to reconcile themselves to cooperation with homeopaths and eclectics in supporting the establishment of licensing boards on which irregulars were represented in minority capacities or, where this was not possible, in the creation of multiple boards, with homeopathic and eclectic physicians empowered to license their own practitioners.²⁷ Thus, when the California medical practice act of 1876 was amended in 1878 to allow the state's Homeopathic Society and its Eclectic Medical Society to appoint their own medical examining boards to examine and license,²⁸ regular practitioners were forced to temporarily acquiesce in the change.

In some states, physicians were unsuccessful in lobbying the legislature for a state board of examiners and had to rest content with a registration law for doctors. By 1890, twenty-eight states and territories had enacted this kind of legislation. Most often these laws called for practitioners to register with either the medical society or some specified government official in the county in which the physician was practicing, with the added requirement that practitioners present evidence that they were graduates of some medical school. A viscéé diploma then served as a license to practice in the state. The primary purpose of such legislation was to eliminate itinerant physicians and traveling irregulars from competing with the established practitioners of an area and to insure that settled physicians possessed a minimum of formal training. However, these statutes, especially the overwhelming number which were passed before 1884, were seldom enforced with any vigor and tended to be easily evaded. For example, the effects of the Ohio law of 1868, the first of these statutes enacted, was described in 1885 by the secretary of the Ohio State Medical Society in the following terms:

[The] law required that doctors should have a diploma; but practitioners of ten years' standing were exempted, and those of less than that time were given five years to obtain a diploma. Efforts have been made here to enforce this law, but it has been found impossible to prove before a court that the accused did *not* have a diploma, the legal assumption being that he did; so the law has proved useless, and all manner of quacks flourish on our soil.²⁹

The Nebraska registration act of 1881, which required practitioners to register with the county clerk, presenting evidence of having obtained a diploma from a legally chartered medical college, or evidence of ten years' practice, proved no less enforceable. "The law, as it now exists," noted the secretary of the Nebraska State Medical Society four years after its enactment,

is inoperative, because any infringement upon it becomes a criminal offense, the common law providing that, in such cases, the defendant shall be faced by the witnesses of the prosecution. To procure witnesses from distances, the places where bogus diplomas are manufactured, as, for an example, Philadelphia, Cincinnati and St. Louis would involve a cost to which neither individuals nor societies are equal; therefore, the failure of a law otherwise good enough.³⁰

The *Philadelphia Medical Times* gave voice to the profession's dissatisfaction with registration laws, especially as they operated in Pennsylvania and New York, in an editorial published in 1883:

Registration laws, primarily intended for the protection of the profession, seem particularly liable to fall short of their intended objects, not so much because of defective construction, as of unfaithful interpreta-

tion; indeed, unless definite and comprehensive in expression, and fully sustained by public opinion, they may be made in practice to sanction and perpetuate the very evils they were intended to correct. It has been more than once asserted, by those fully qualified to judge, that in the neighboring State of New York the medical profession has really lost, by the Registration Act, more than it has gained. At the last meeting of the State Society of New York, it was mentioned as a fact, by one of its members, that an Indian medicine-man had driven into Rochester, in war-paint and feathers, though engaged in the peaceful art of selling patent medicine, and, having gone to the Prothonotary's office and paid the registration fee, he had obtained a certificate as a physician, with full authority to practice under the law.

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Much disappointment has been expressed by physicians in Pennsylvania, as well as in New York, at the operation of the Registration act, it being claimed that the practical result is that, instead of elevating the profession above irregulars and charlatans, it has degraded the regular practitioner to the level of any one who can register under the act, however unworthy he may be to be in the ranks of the medical profession.³¹

Registration laws were clearly not the answer to limiting the supply of doctors, especially since their enforcement was not popular with the public. As a result, organized physicians worked tirelessly to substitute more rigorous statutes creating medical examining boards in each of the states. The state societies ideally sought legislation which set up single boards, the membership of which was selected from nominees submitted by the state medical associations. Additionally, they lobbied to make examinations mandatory for all prospective practitioners, to have the language of the statute define the practice of medicine as broadly as possible so as to include all attempts at healing, whether for compensation or not, and whether through the administration of drugs or not, and, finally, to encompass within the purview of the statutory authority of the state boards the power to refuse or revoke licenses for "dishonorable" or "unprofessional" conduct, thus effectively legislating the code of ethics of the AMA.³² Most importantly, the state societies and the national association sought medical licensing legislation which established as a precondition for examination by the state boards of examiners, graduation from an approved medical institution. Once this last requirement was legislated, it would then become possible to limit the number of medical schools by appealing to the various state boards to deny recognition to graduates of those colleges falling below the standards set by the American Medical Association or some other equally harsh accrediting organization.

These reforms were accomplished in stages, between 1874, when the first tentative steps at setting up medical examining boards were taken in Kentucky, and 1915, when Alabama, Colorado, and New Mexico remained as

the only jurisdictions not requiring both a diploma in medicine and examination of all applicants as prerequisites for practice. By 1915, only six out of the fifty-one jurisdictions had failed to empower their boards of examiners to refuse recognition of diplomas from "sub-standard" medical schools. During the period between 1874 and 1915, the various state legislatures enacted over 400 statutes relating to medical practice, revising, amending, and supplementing their original medical practice acts to bring them more into line with the wishes of the state societies and the AMA.³³

One of the most effective of these early laws, with respect to reducing the number of physicians in the state, was the medical practice statute passed by Illinois in 1877. The execution of the law devolved upon the state board of health, created by separate enactment, and required that all practitioners henceforth beginning practice in the state either present their diploma from a legally chartered medical institution "in good standing" with the Board, or undertake an examination.³⁴ Under the leadership of Dr. John Rauch, one-time chairman of the AMA's Section on State Medicine, the Illinois Board in 1880 adopted a schedule of minimum requirements which medical schools had to meet, which were enforced beginning in 1883. These requirements, in the words of Dr. Rauch, prescribed

that a medical college, in order to be held in good standing for the admission of its graduates to practice in Illinois, shall exact such a general preliminary education of the intending student before his admission to the lecture-room, as will enable them to comprehend the instruction therein given; and shall issue its diploma conferring the degree of M.D., only upon the completion of such curriculum of study—as to the branches of medical science taught, the duration of the reading, and of lecture-terms, and the amount of practical instruction in hospital and at the bedside—as obtains in the average medical school.³⁵

Illinois thus became the first state to refuse to license graduates in medicine from "inferior" colleges, with its State Board in the enviable position of being able to restrict entry into the profession simply by reassessing the credentials of the various medical schools.

The examinations which prospective Illinois physicians would otherwise have had to undergo appear to have served a similar purpose in discouraging new doctors from entering the state. In 1891, the *JAMA* noted that

the report of the State Board of Health of Illinois for 1889 illustrates the efficacy of its laws for the regulation of medical practice. When the law went into effect there were in the State, engaged in practice, 7,400 persons. Of these 3,600 were graduates of some medical college, while 3,800 were non-graduates. In other words, the graduates constituted only 48 percent of all engaged in practice. On January 1, 1890, the percentage of non-graduates to the whole number was only 9. From 3,800 the number has been reduced to 575. The total number of physicians in the State is less now than it was twelve years ago.³⁶

Nine years after the passage of Illinois' medical practice act, the President of the Detroit Medical and Library Association, the largest local medical society in Michigan, in a spirited plea for the enactment of similar legislation in his own state, attempted a rough estimate of the financial effects of the Illinois statute. Assuming that each of the three thousand physicians who otherwise would have been practicing in Illinois had its law not been enacted would have earned on the average \$2,500 annually, the author calculates that some \$67,500,000 "have been saved" by the reduction in supply in the space of nine years.³⁷ Despite the inducement these figures served to Michigan physicians to lobby more vigorously for equivalent legislation however, they were unsuccessful in gaining an effective law until 1899, twenty-two years after Illinois had passed hers.

The first state to require both a diploma in medicine *and* examination was Florida. In 1889, the State Medical Society was successful in prevailing upon the state legislature to enact a medical practice law which authorized the appointment of medical examining boards for each judicial district to examine all candidates "upon production of a medical diploma from a recognized college."³⁸ Because of sectarian pressure, a state-wide homeopathic board was established at the same time and, by separate legislation ten years later, an eclectic examining board was also created.³⁹ Curiously, the Florida law provided that district examiners, that is, those appointed to examine prospective orthodox practitioners, must themselves have been graduates of "some medical college recognized by the American Medical Association." Inasmuch as the AMA did not begin to classify and recognize medical colleges until 1906, the Florida law seems to have anticipated the activities of the Association in the area of medical education by some seventeen years!⁴⁰

Of the two requirements, physicians—with good reason—held that compulsory examination was a more effective method of limiting the supply of new practitioners than was the requirement that they present evidence of holding an M.D. degree. In the absence of restrictions respecting the proliferation of medical schools, their number had increased from sixty-five in 1860 to seventy-five in 1870, and to 100 in 1880. By 1900, there were 160 medical schools operating in the country, of which twenty-two offered instruction in homeopathic medicine and nine in eclectic medicine.⁴¹ Graduation from a medical college, while it might well improve the technical competence and enhance the qualifications of new practitioners, could not serve as a basis of curtailing their supply, as could mandatory examinations tailored to the number of applicants in any given year. In extolling the benefits of compulsory licensing examinations, physicians openly referred to the importance of curbing competition and establishing a more secure economic environment in which to practice. Thus, Dr. John Roberts, Professor of Anatomy and Surgery at the Philadelphia Polyclinic, in an

address before the Medical Jurisprudence Society in 1884 observed:

Such an examination would weed out and keep out of the profession those persons who, though ignorant of medical science, accept professional duties and emoluments, and thus increase the difficulty of an educated physician gaining a livelihood. There are, undoubtedly, too many physicians for the needs of the closely settled districts. Fewer doctors, and better ones, would be a boon to most sections of the state. The state examination would affect both objects.⁴²

No less candid was Dr. Perry Millard who, in 1887, while first vice-president of the AMA and secretary of the Minnesota State Board of Medical Examiners, announced before the AMA's Section on State Medicine that the medical profession, "the noblest of them all," has been for too long "left to a competition that is intolerable to an educated man." "Had we been alive to our interests," he continued, "our present environment would offer better inducements to the educated masses today. . . . [L]et me insist upon a renewal of our zeal in behalf of our material interests, and cooperate in obtaining at the hands of the legislatures of the different States such regulations of the practice of our profession as will place the standard thereof upon a citadel of greater strength and power."⁴³ Dr. Millard offered Minnesota's medical practice act of 1887 as possibly the best law yet enacted on the subject. Under its provisions every physician commencing the practice of medicine in the state had both to pass an examination offered by the State Board of Medical Examiners and, additionally, to furnish satisfactory evidence of having attended three full courses of lectures of at least six months each in a medical school.⁴⁴ The Board was also empowered, as it had been under an earlier law of 1883, to refuse or revoke certification for "unprofessional or dishonorable conduct." As a result of this law, by 1889 Dr. Millard, by then Acting Assistant Surgeon of the Army, could boast:

Minnesota possesses a smaller ratio of physicians to the population than any State in the Union. Instead of one physician to every 750 inhabitants, the last medical census shows but one to every 1,300. Through the courtesy of the Secretary of the Minnesota Board, I am permitted the first public announcement of these figures. I may state, however, that they are not made public with a view of promoting emigration. It is a pleasure to announce that both the profession and the public are quite uniformly supporting the law.⁴⁵

Why the public should applaud a law which effectively cut the availability of physicians by forty percent in two years we are not told, although it is clear why the remaining practitioners would be delighted with the change. This same specious identification of the profession's interests with those of the public at large reappears throughout Dr. Millard's 1889 address. "The profession is at present awakening to the necessity of efficient medical legislation," he continues:

The fields are fertile and the harvest shall be plentiful; the handwriting is on the wall, and the interpretation is easily read. The people [*sic*] have awakened to the fact that there are twice as many practitioners of medicine in this country as are commensurate with its legitimate wants.⁴⁶

Indeed, Dr. Millard was correct in suggesting that the states were increasingly receptive to enacting medical legislation. By 1887, seventeen states had established medical examining boards, although only six of these had made examination mandatory. A large number of states, however, still operated under registration laws—if they controlled the practice of medicine at all—and these ranged from the unenforceable to a few which were strictly administered. Distressed at the lack of uniformity among the various state laws, the *JAMA*, in an editorial appearing in its issue of December 17, 1887, suggested that

if these efforts to procure legislation for regulating medical education and practice in the several States are to continue, the first and most important object to be accomplished is the framing of a bill based on sound principles of political economy, brief and simple in its details, yet sufficiently comprehensive to establish and secure the practical enforcement of a fair standard of general education before the commencement of medical studies, and a reasonably thorough knowledge of all the recognized branches of medicine, including clinical and practical laboratory work, before receiving a license to practice, by an able committee, appointed by the American Medical Association.⁴⁷

In the following year, a proposal was put forward by Dr. A. Y. P. Garnett, in his Presidential address before the AMA, calling on the Association to appoint standing committees for each state and territory “to attend the sessions of the respective Legislatures and use all honorable means looking to the reduction of the number of medical schools in the United States, and a consequent diminution in the annual number of medical graduates” by the passage of laws appropriate to these purposes. The *JAMA*, although finding the objectives of the proposal commendable, reiterated its suggestion that the first step toward securing the necessary legislation was to prepare a uniform draft law endorsed by the AMA and the state societies, which would then be presented to the legislators of the various states for consideration.⁴⁸ The provisions of this ideal law were revealed in an editorial which appeared in the *JAMA* in the last week of 1887 and deserves extended quotation.

Fair investigation will show that no law can be framed, the execution of which will materially improve the education and usefulness of the medical profession, unless its provisions are such as shall establish and enforce a standard of education as a prerequisite to the study of medicine embracing, in addition to the ordinary elementary branches, at least a thorough knowledge of mathematics, physics, the natural sciences and English literature.

The law, to be of value, must not only specify plainly the minimum requirements for commencing the study of medicine, but it must provide the tribunal in each State whose duty it shall be to examine and register all persons proposing to commence the study of medicine, and to issue certificates to those only who are found qualified in accordance with the standard given in the law; and no *time* shall be allowed as having been spent in pursuing medical studies until such registration and certificate has been obtained. To accomplish this does not necessitate a multiplication of State Examining Boards. The same Board that decides the qualifications of the students in medicine and awards to them the license to practice, should also examine and decide upon the preliminary qualifications of those proposing to study medicine. If it be said that the requirement compelling every person proposing to study medicine to spend the time and money necessary to demonstrate to a State Board of Examiners his fitness for entering upon the important field of professional study, would deter many from making the attempt, the obvious answer is, so much the better for all the parties interested. . . . It would not only materially lessen the number entering upon the study of medicine and thereby aid in lessening the evil of overcrowding the professional ranks, but it would do it by turning aside the very class whose free admission heretofore has done more to lower the standing and usefulness of the profession than any other influence that could be named.⁴⁹

What the *JAMA* here proposed was nothing short of a license to embark upon the *study* of medicine, a requirement so preposterously out of keeping with the legal protections of the Constitution that had any state attempted to enact this provision in their medical practice acts, it would have certainly been struck down by the courts. Yet, despite the absurdity of the provision, it was included in the proposed draft law published in the *JAMA* two years later. Section three, in part, reads:

All persons hereafter intending to commence the study of medicine in this State shall apply to the State Board of Medical Examiners for an examination and certificate of registration as students of medicine and surgery. It shall be the duty of said Board to personally examine all such applicants in the following branches of general education, viz., English grammar, composition, geography, civil history, arithmetic and algebra, physics and all the natural sciences, and at least one of the following languages, Latin, French, or German, and shall give certificates only to those whose examinations are satisfactory to the Board. And no person shall be credited for any part of the legal period of his medical studies prior to the date of his certificate of preliminary examination.⁵⁰

The authors of this draft law—the Committee on Uniform Medical Legislation, chaired by Dr. Millard—offered no explanation of why a thorough grounding in English grammar, composition, civil history, and a foreign language should be made legal prerequisites for the study of medicine and surgery, but it is obvious that these requirements would have drastically curtailed the number of entrants into medical school and would have reduced the supply of medical graduates to a mere trickle. Nor can there be

any other purpose in stipulating that an applicant would not be credited with having spent any time in the study of medicine until he had *first* received a "certificate of preliminary examination."

This provision of the draft law was removed in the second version of the model act proposed to the Section on State Medicine at the AMA's fortieth annual meeting in June, 1889, despite support for it by no less venerable a figure than Sir William Osler.⁵¹ In its place, it was recommended that only those medical colleges requiring a preliminary examination in the subjects listed in the earlier draft be classified by the State Boards as "in good standing." Additionally, the draft act provided that all applicants present evidence of having studied medicine and surgery for no less than three years, attending "three full courses of medical lectures, of not less than six months' duration each."⁵²

Soon after the AMA's recommended bill appeared, the Illinois State Board of Health adopted the requirement that three years' attendance at lectures would constitute a condition for a college to be recognized as in good standing. However, a concerted attempt by physicians in Missouri in 1891 to convince the state legislature to amend its medical practice act to provide for the three-year standard met with failure. According to the chairman of the Committee on Legislation of the St. Louis Medico-Chirurgical Society, "great efforts were made to carry the bill" and "members of the Legislature were written to from all over the State;" one Senator, he noted, "assured me that his pockets were full of such letters." But, despite such massive lobbying, the proposal was defeated.⁵³ Physicians were more successful in New Jersey and New York. In 1890, both states enacted statutes establishing boards of medical examiners, which were to set examinations for all prospective practitioners, provided that candidates first presented evidence of having a diploma in medicine issued from some medical school requiring a minimum of three years' study, including three courses of lectures in different years.⁵⁴ Additionally, New York's law stipulated that candidates must, previous to having attended medical school, have obtained "a competent common school education." New York thus became the first state to empower its examining board to set pre-professional educational requirements. When, four years later, New Jersey revised its medical practice act, it too added a provision similar to that of New York's law.⁵⁵ A "competent common school education" for purposes of the act was interpreted by the New Jersey State Superintendent of Public Instruction as consisting of an array of subjects startlingly similar to those earlier suggested by the AMA's Committee on Uniform Legislation: orthography, arithmetic, English grammar and composition, geography, history of the United States, algebra, and physics.⁵⁶

So pleased was organized medicine with its recent successes in Illinois, New York, and New Jersey, that the *JAMA* remarked in January, 1892:

Within the last very few years—we might almost with propriety say, within the last very few months—there has been a rustling and a rattling, as of dry bones, indicative of a change of thought, an evolution of sentiment amounting to a tacit demand, that is a sure premonition of a forward movement all along the line. The several State legislatures are, one after another, with reasonable rapidity, enacting laws having for their purpose an elevation of the standard of educational requirements for the privilege and right to practice medicine.

And with unblushing hypocrisy, it added that these restrictive statutes were not “in a broad sense a system of class legislation, for such Acts are for the common conservation, of the health and lives of all the people.”⁵⁷

Still, it was felt that more effective legislation, accomplished with more dispatch, would be forthcoming if physicians themselves sat as state and national legislators. They had proved their efficacy in acting in the interests of the profession in Alabama in the 1870's and again in Iowa in the late 1890's, where physicians in the state legislature succeeded in enacting a comprehensive medical practice act making both a licensing examination and a medical diploma from a school in good standing mandatory.⁵⁸ The Iowa statute also provided that applicants were required to present evidence of having attended *four* full courses of twenty-six weeks each, thus bettering the period recommended by the AMA for medical study by a full year.⁵⁹ In 1897, when this act was passed, there were six physicians in the Iowa House, including the Speaker, and twice that number in the State Senate.⁶⁰ “About every other time the name of a member of the legislature is used,” observed the Keokuk *Gate City*, “it has the prefix of doctor. In no state in the Union are the doctors so active in politics as in Iowa. Everywhere they are natural politicians, but in Iowa they get more for themselves, while in other states they seem more content to help the other fellow.”⁶¹ The events in Iowa, the *JAMA* commented, “show what the physician can do and we venture to say that legislation other than medical will be safe in having the physician take such a prominent part in it.” Indeed, the *JAMA* went further and recommended the Iowa physicians as examples to be emulated throughout the country. “The example of Iowa physicians should be followed in every state in the Union and then we would hear less of some of these frauds and public nuisances that are so prominent at the present time.”⁶²

This theme of physician-as-legislator was taken up by a number of practitioners, excited by the successes of the profession in Iowa. Dr. John Hamilton, Professor of the Principles of Surgery at Rush Medical College in Chicago, addressed the Illinois State Medical Society on the enormous advantages to be gained by controlling a portion of the state and national legislatures. Noting that physicians had only two ways to be heard in the legislatures of the country, either by sending “friends to represent us,” or by electing physicians, Dr. Hamilton concludes:

Shall the doctor go into politics? you ask. I say yes, if he can personally afford it and is of ripe experience. We may never hope to have correct medical legislation until we are either properly represented in the law-making body, or the community in general shall have elementary knowledge of medicine; the latter is probably not practical in our day, and only the former course is open.⁶³

And, complaining of the fact that only ten physicians sat in Congress in 1897, Dr. Ephraim Cutter offered no less than nineteen reasons why the profession's representation in the Senate and House should be substantially increased. Addressing the Section on State Medicine of the AMA, Dr. Cutter emphasized the "need of physicians awaking to a realizing sense of their National rights and importance as citizens, especially in governmental bodies."⁶⁴ A few of the reasons offered for increasing the profession's membership in Congress are worth quoting since they provide insight into the interests, scope and priorities of organized medicine's political goals at the national level.

8. The effect of physicians in their own department [i.e., in their bureaucratic functions] being ruled over by lay people is embarrassing, harassing, if not paralyzing.
15. Physicians are needed in Congress to put through the department of public health in the cabinet.
16. More physicians are needed in Congress to see that man has his foods protected, as plant and cattle foods are protected.
17. Physicians are needed in Congress to see to other causes that hinder the biologic developments of man. The family is the unit of the nation. If one is sick and feeble the other is so. Grand and noble mothers have made English and Dutch speaking nations great. None are better able to tell how to have healthy families than physicians. If States need such laws, physicians should make them.
19. Finally, physicians are needed in Congress to enforce all that is good in this Section of State Medicine.⁶⁵

The increasing role of physicians in political life and their growing involvement as government functionaries on the Boards of Examiners and Public Health Boards which most states had created by the end of the century had given the profession a taste of political power. Their appetites once whetted, they sought an ever greater expansion of their participation in determining and executing government policy on questions of social health and medical practice. Doctors who had witnessed the intervention of government into these areas beginning in the 1870's had experienced a growing sense of their own importance in shaping public policy and thereby gaining in prestige and wealth. The situation could not but have been productive of a cast of mind eager to further remold the structure of American society to bring it more into line with the wishes of medical practitioners. The Section

on State Medicine, established by the AMA in 1872, gave voice to these wishes by recommending priorities, formulating draft laws, and generally coordinating the efforts of the profession toward "the application of medical knowledge and skill to the benefit of communities,"⁶⁶ not to speak of the benefit of physicians themselves. "The aggregation and concentration of population is productive of danger to life and health, the removal of which is the unquestioned duty of the State," wrote one physician.⁶⁷ It was incumbent on the medical profession to secure legislation which had as its goal the protection of "the purity and welfare of the social fabric," among which were huge numbers of sanitary and health laws and, above all and most immediately, medical practice laws.⁶⁸ To those who raised their voices in opposition to the policies of organized medicine which sought the legal restriction of competition, it was replied:

That medical men, by virtue of their calling, are alone competent to measure the evils against which this legislation is aimed, should be its chief promoters, is but commendatory, rather than aspersive, as is alleged, of their championship. The conditions of modern life necessitate the expansion and broadening of the historic self-sacrificing exercise of charity by medicine toward the individual sufficient to include the public.⁶⁹

A selfless concern for the welfare of a befuddled and helpless public, preyed upon by incompetents and purveyors of poisons, easily became the rationale for medical practice laws and was gradually extended to laws regulating the conduct of individuals wherever such laws touched on questions of health and sanitation. So great is the capacity of individuals to identify their private interests with the public good, that physicians supported wholesale government intervention in the health field at least partially believing that their assessment was value-free and emerged solely out of a sense of public-spiritedness. If the interests of the community were consistent with the interests of the profession, so much the better! When Dr. Charles Winslow wrote that "to protect the state, the state must protect itself by making and enforcing such stringent laws that uneducated and unprincipled physicians will be unknown," his sentiments were heartily endorsed by other doctors. Indeed, his remarks on the physician and the state read before the AMA, reflected the general feelings of the profession. "The relation between the physician and the public," he observed,

cannot be too closely connected. The masses look to the physician as authority on medical knowledge. He who professes to try to prolong human life and ameliorate the sufferings of humanity, should be well qualified to advise in regard to all rules of health.

The public must be protected from medical imposters. Medicine must be elevated by the medical man alone.⁷⁰

Dr. Winslow is, of course, speaking of the need to strengthen legislation governing medical practice and other health-related matters, or, to use the phrase proposed by another physician, to enlarge the powers of the "State Sanitary Police."⁷¹

So extreme did the identification of organized medicine with governmental authority become that it was even suggested by the *JAMA* that the press be punished for daring to criticize the physicians working for the Public Health Service during the 1905 yellow fever epidemic in Louisiana. In one of its editorials appearing soon after the epidemic had abated, it called attention to charges leveled by a New Orleans daily that the public health authorities had been incompetent and dishonest during the outbreak and noted:

It is one thing to discuss debatable theories and to expose dishonesty wherever found, but the events of the epidemic can not by any artifice be twisted into any excuse for this offense of the New Orleans paper. . . . The time is close at hand for the creation by statute of a new variety of treason. If it is treason in time of war for a man to betray his country's military plans, it certainly should be made treason for a man or a publication in time of deadly peril from disease to foment by false allegations public lack of confidence in the government's plan of rescue, and in the integrity and ability of the men who risk their lives to save the community from unnecessary deaths. Than this no treachery can be more base. Physicians, citizens and the reputable press should join in asking stringent penalties for this crime against the nation, against humanity.⁷²

The hysterical tone exhibited by the *JAMA*'s editorial offended few physicians. The success of their campaigns in the state legislatures to stiffen requirements for medical practice encouraged them to view government as an ally who could potentially place vast powers in their hands. The increasing bureaucratization of American life at both the state and national levels—emphasizing substantial government involvement in the routine activities of the individual toward the end of furthering his health, welfare, and security—required the recruitment of large numbers of technicians and experts to act as planners and administrators. Naturally doctors stood at the head of the list of those needed to direct the new agencies concerned with health and they did much to promote the reforms which would enlarge their participation in government. Perhaps the most extensive treatment of these goals is that offered by Dr. Samuel Dixon, Commissioner of Health of Pennsylvania, in one of the major addresses before the American Medical Association at its annual meeting in Philadelphia in 1907. Starting with the premise that "on state medicine depends the happiness of our people and the success of our nation," Dr. Dixon proceeded to attack those who held that the myriad of new laws and regulations governing health and sanitation were invasive of personal liberty. "It is idle," he remarked,

to prate of the enforcement of sanitary laws as an infringement of personal liberty. Submission to reasonable personal restrictions intended for the welfare of all is the very foundation stone of civilized liberty. The individual who insists on what he is pleased to call his own rights in defiance of law and to the detriment of the common weal is "an undesirable citizen of the republic." If we are to aim . . . to render growth more perfect, decay less rapid, and life more vigorous, in civilized life we must give up many primitive or individual liberties to insure advanced civilized liberties and to permit a free social and commercial intercourse.⁷³

To the critics who held that persuasion is a superior tool in any society wishing to call itself free than is compulsion and who questioned the far-ranging extent of government intrusion, Dr. Dixon replied:

Let it be understood at the outset . . . that, no matter how great efforts we may make to educate the people, unless we have the *lex scripta*, the written law, to fall back on, state medicine, while it may be a beautiful science, can never be a practical art. . . . No, we must . . . fairly and squarely recognize the fact that, during conditions of ordinarily good public health, the great majority of mankind are neither wise enough voluntarily to submit themselves to the requirements of sanitary law for the sake of preserving their own health and those of their loved ones, or righteous enough to be willing to exercise self-denial and repress the cravings of avarice to save others from sickness, suffering and death. . . .

These laws must reach into all the relations of human life. As their basis they must start with the prompt and accurate registration of births, deaths and marriages, and of the presence of transmissible and communicable diseases, and they must embrace the control of epidemics by domiciliary quarantine; the employment of prophylactics and disinfectants; the supervision of the transportation both of the quick and the dead; the construction, heating and ventilation of our homes and public buildings; the protection of water supplies and the restoration to purity of our polluted streams and lakes; the manifold occupations and industries of the people; the protection of food stuffs, including milk and other beverages; and of drugs, from adulteration and impurity; the education of physicians, dentists and veterinarians, and the barring of our doors against the introduction of communicable diseases and pestilences from foreign countries.⁷⁴

There is a particular urgency to Dr. Dixon's proposed reforms. He, like so many educated Americans both in and outside the medical profession, was appalled by the masses of new immigrants entering the country, primarily from Eastern Europe, with their alien culture, religion, value-system, and personal habits. Only by weeding out the incorrigibles and forcibly imposing a more acceptable life-style on the rest, Dixon suggests, could the country survive the influx.

Only by the enactment of judicious legislation . . . , and its rigid enforcement when enacted, can we hope to perpetuate a vigorous race of American parentage on this North American continent, a race fired by

the lofty ideals of our ancestors and nurtured in their traditions. Consider for a moment what manner of men they were and their object in seeking these shores:

Of whatever faith—Pilgrim or Quaker, Huguenot or Catholic—they came here *for* their faith and with the highest standards of right and righteousness; they were, moreover, men of good social standing in their own lands. In the face of the direst ills, and with the highest courage, they conquered these inhospitable shores and made of this land the granary of the world and, delving into its bowels, unearthed its hidden mineral wealth.

Contrast this type of man with those who form the constantly swelling tide of immigration which, attracted by the success of our efforts, is now sweeping in, actuated by no higher motive than the accumulation of wealth, bearing on its bosom the ignorance, the vices, the follies and the pernicious political heresies of the lowest and the most dangerous stratum of European society.

In order to build up a race fitted to cope with these dangerous masses, we must combat the seeds which destroy the physiologic condition of the animal body in the same manner that mankind has always combatted the seeds that destroy vegetable life.⁷⁵

Dr. Dixon's argument casts light on one of the reasons why so many Americans were prepared to support the enormous enlargement of government's role in daily life which marked the Progressive era. He was, of course, not alone in holding such views. The medical journals echo with them, for they expressed the sentiments of a profession caught up in the almost evangelical euphoria of a crusade whose goal was nothing short of a sanitary utopia. "The scope of 'state medicine,'" Dr. W. H. Saunders, chief health officer of Alabama, announced before the AMA in 1906, "is practically boundless. With a complete and cooperative public health system—one extending in logical continuity from counties to nation—the principles of sanitary science could be enforced and taught in every educational institution of the land."⁷⁶

The Committee on Medical Legislation was created by the AMA in 1901 as part of its drive to increase the political effectiveness of the profession both at the national and state levels.⁷⁷ Its primary purposes were to bring about the reforms sought by the medical fraternity and to give direction to the widely disparate lobbying efforts of state societies. Additionally, in 1907, the AMA established its Bureau of Medical Legislation to act as a clearing house for information on the state of draft bills, laws, and court decisions relating to health matters, with particular concentration on the issue of medical practice.⁷⁸ The establishment of its political machinery after the turn of the century marks the point at which the AMA explicitly subordinated its other functions as a professional organization to that of being the most prominent and forceful spokesman of physicians in the state capitals and Congress. Beginning in 1900, when its major organizational drives began,⁷⁹

the AMA consolidated its role as the representative of the medical profession and cemented the alliance of orthodox practitioners with the law, an alliance which persists to the present day. When the profession, under the AMA's leadership, sought, in the first fifteen years of the new century, to establish a federal department of health, organized medicine was attacked by only a handful of dissidents in the country. Joined together in 1910 under an organization calling itself the National League for Medical Freedom, they warned of federal domination of medical care and the creation of a vast centralized bureaucracy if the advocates of a national health department were successful in their lobbying.⁸⁰ When the League's President, B. O. Flower, the editor of *Twentieth Century Magazine* and a long-time opponent of medical licensure laws,⁸¹ attacked the AMA for its encouragement of the increasing politicization of medicine in the United States, Dr. W. G. Moore of the St. Louis Medico-Chirurgical Society, in his address of welcome to the delegates attending the sixty-second annual convention of the AMA in 1910, replied:

Flower has caused to be printed in our daily papers the following question in "scare" headlines:

"Do you want government by political doctors?"

And I answer: "We do!"

"Do you want health and hygiene to be represented by an army of United States Inspectors under the direction of a Medical Bureau?"

And I answer, that this is a consummation devoutly to be wished.

He asks if we know that William H. Welch, president of the American Medical Association, told the Senate Committee on Public Health and National Quarantine, that physicians wanted such a National Department of Public Health for the purpose of influencing state and municipal boards of health and that he felt the Constitution could be so interpreted as to give the national board the power to regulate health affairs, nationally. We did not know this, but if it is true, it affords us another opportunity to hurrah for Welch and to applaud him.

If the American Medical Association be a trust, it furnishes a part of what our political brethren have sometimes said—that there is such a thing as a good trust—a statement which I never believed before.⁸²

Indeed, the establishment of a centralized system of public health administered by an army of bureaucrat-physicians was perfectly consistent with the wishes of the profession. In 1914, Dr. Frederick Green, secretary of the Bureau of Medical Legislation, published a lengthy article on state medicine and suggested a program of legislation on which practitioners should concentrate their efforts towards promoting:

It would seem to be self-evident that the most important subject in each state would be a law creating a state board, or a department of health, defining its power and duties in broad terms, so as to bring under this law many of the subjects now covered by special legislation. . . . After

this, and only secondary to it, on account of the necessity of having some machinery to operate it, is a model law for the registration of vital statistics. . . . A law authorizing county, township and city health organizations with definite provisions for jurisdiction and relation between those local health bodies and the state board of health should also be considered. A food and drugs act including the regulation and sale of habit-forming drugs; a law regulating sewage and waste disposal; water supply and the maintenance of the purity of water courses; a milk and dairy law; a law authorizing the health supervision of schools, and either a model housing law or a broad law on industrial diseases, covering factory inspection and regulation, prevention of occupational diseases, regulation of hours of women and girls, etc., might be included in this list.⁸³

Finally, and perhaps most importantly, Dr. Green stressed the singular necessity of a law

regulating not only the practice of medicine as it is popularly known, but also all those who desire to treat the sick for compensation as a profession. This should include the regulation of midwives and all sects desiring to treat the sick for compensation.⁸⁴

The medical profession never lost sight of the primary importance of extensive and strictly enforced medical practice laws. Indeed, the greater the number of quasi-official functions with which the physician was entrusted by health legislation, the more forcefully the profession agitated for restricting the practice of medicine. Addressing the Ohio State Medical Association, Dr. W. C. Woodward, the director of the AMA's Bureau of Medical Legislation, offered several reasons for yet stronger licensing laws even as late as 1923, when the number of new physicians turned out by the nation's medical schools had been reduced to sixty percent of those graduated in 1904. Besides reiterating the arguments based on the external costs of unhealthy citizens,⁸⁵ Dr. Woodward offered the following novel grounds for creating "upright and God-fearing boards" administering the strictest standards for medical practice:

A physician has a quasi-official status that makes it essential that the government know something of his moral and professional antecedents. The government accepts as the basis of its official records of births, certificates from physicians, which may blast the reputations of men and women and which contribute materially toward establishing record evidence of the course the property takes by inheritance or otherwise. Physicians certify to deaths, requiring the determination in every case whether crime has or has not been committed. A physician's report with respect to a communicable disease may at the very least result in quarantine, and in the cases of supposed venereal diseases may damn the reputation of the patient and even his offspring. Physicians' certificates may be a sufficient basis for commitments of the supposedly insane. It is to the physician that the prescribing of intoxicating liquors and narcotic

drugs is entrusted by the government. And in the event of war, it is upon the integrity, knowledge and skill of the medical profession that the nation must rely for the examination of volunteers and draftees, and for the care of the sick and injured in the military service. On the whole, then, the government has an overwhelming interest in the moral and professional fitness of the practitioners who treat its citizens in time of sickness and injury.⁸⁶

Dr. Woodward fails to point out that every law endowing physicians with official powers to which he refers was enacted in the first instance largely because of intense pressure from the medical profession, as, of course, were medical licensing laws themselves. Although it could be argued that the motive force behind some of these laws was—at least on the part of some physicians—a concern for the public welfare, no such argument could possibly be offered respecting a statute proposed by the New York medical fraternity in 1898 opposing free vaccination and the administration of free diphtheria antitoxin as “inimic to the best (financial) welfare of young medical men.”⁸⁷ Nor could such an argument be made concerning the profession’s intense and continued effort to extend the definition of medical practice to include, in the words of Dr. Frederick Green, “all those who desire to treat the sick for compensation.” Such a sweeping definition would, if strictly interpreted, bring within the purview of the law spiritual healers, particularly the growing number of Christian Scientists, and a large number of drugless practitioners—including osteopaths and chiropractors—whose only danger to the public was that they were a source of competition to the medical profession.

In most states physicians were successful in obtaining suitably broad definitions of medical practice in the licensing laws to exclude drugless and spiritual healers from their trade. Perhaps not surprisingly, the courts, once having sustained the legality of medical practice acts themselves, upheld these definitional provisions, thus holding that the attempt to cure or alleviate disease or suffering by faith and prayer or by purely mechanical means constituted the practice of medicine.

The attitude of the courts respecting the constitutionality of medical practice acts had been firmly established in 1889 in a case before the United States Supreme Court, *Dent v. West Virginia*.⁸⁸ In 1881, the West Virginia legislature enacted a statute requiring every medical practitioner either to have graduated from “a reputable medical college” or to pass an examination prepared by the State Board of Health. Exception was made for all those who had practiced medicine continuously in West Virginia for a period of ten years prior to the date of passage of the act.⁸⁹ Dr. Frank Dent had been in practice for five years only and, although he possessed a diploma in medicine from the American Medical Eclectic College of Cincinnati, it was not recognized, the college having been determined by the Board as not

reputable. Dent refused to sit the examination and was convicted of practicing medicine without a license. In 1889, a unanimous Supreme Court affirmed Dent's conviction, with Justice Stephen Field speaking for the bench. His introductory remarks are such that one might assume that the regulation of occupations and professions were to be regarded as a fundamental encroachment on the personal liberties protected by the Constitution:

It is undoubtedly the right of every citizen of the United States to follow any lawful calling, business or profession he may choose, subject only to such restrictions as are imposed upon all persons of like age, sex and condition. This right may in many respects be considered as the distinguishing feature of our republican institutions. Here all vocations are open to every one on like conditions. All may be pursued as sources of livelihood, some requiring years of study and great learning for their successful prosecution. The interest, or, as it is sometimes termed, the "estate" acquired in them—that is, the right to continue their prosecution—is often of great value to their possessors and can not be arbitrarily taken from them, any more than their real property can be thus taken.⁹⁰

However, one's property right in one's profession is to be regarded as neither unconditional nor above government regulation:

[T]here is no arbitrary deprivation of such right where its exercise is not permitted because of failure to comply with conditions imposed by the state for the protection of society. The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure, or tend to secure, them against the consequences of ignorance and incapacity, as well as of deception and fraud. As one means to this end, it has been the practice of different states, from time immemorial, to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely; their possession being generally ascertained upon an examination of the parties by competent persons, or inferred from a certificate to them in the form of a diploma or license from an institution established for instruction on the subjects, scientific or otherwise, with which such pursuits have to deal. The nature and extent of the qualification required must depend primarily upon the judgment of the state as to their necessity.⁹¹

The Court held that medicine, being a profession which necessitated careful preparation and extensive and complex knowledge, could properly be limited to those furnishing evidence of their fitness to practice. The West Virginia law was consequently upheld as a reasonable exercise of the state's police power.

Subsequent cases reaching the Supreme Court invariably upheld other medical licensing laws. In 1903, unanimously sustaining Michigan's medical practice act, the Court stated that "the power of a state to make reasonable

provisions for determining the qualifications of those engaging in the practice of medicine, and punishing those who attempt to engage therein in defiance of such statutory provisions, is not open to question."⁹² And, seven years later, Justice William Day, again speaking for a unanimous Court, held that "it is too well settled to require discussion at this day that the police power of the states extends to the regulation of certain trades and callings, particularly those which closely concern the public health."⁹³

The courts were equally pliant in upholding statutory provisions defining the scope of medical practice, even in such instances where medical practice laws encompassed spiritual healers. In 1894, the question reached the Nebraska Supreme Court, in *State v. Buswell*.⁹⁴ The defendant, a Christian Science practitioner, accepted compensation in return for treating those who called upon him solely by methods of prayer. He was charged with violating Nebraska's medical practice act, which defined a practitioner of medicine as "any person . . . who shall operate or profess to heal or prescribe for or otherwise treat any physical or mental ailment of another."⁹⁵ Buswell claimed that he was obligated by the tenets of his religion to minister to the sick when they were in mental distress. At the trial level, the jury was instructed to convict only if they were to find the defendant had practiced medicine "as the term is generally understood." The Nebraska Supreme Court held that this instruction was in error, that Buswell was indeed practicing medicine within the meaning of the statute and that "the exercise of the art of healing for compensation whether enacted as a fee or expected as a gratuity cannot be classed as an act of worship. Neither is it the performance of a religious duty."⁹⁶ A similar decision was reached by the Ohio Supreme Court in 1905, in *State v. Marble*,⁹⁷ where it was held that Christian Science treatment for a fee constituted the practice of medicine under the terms of the Ohio law, even though the cure was to come from God and not from the defendant.

The courts consistently ruled that the regulation of heterodox systems of treatment fell within the police powers of the state and that the broadly defined laws governing medical practice which most states had enacted encompassed spiritual and drugless healers of all types, among which were magnetic healers,⁹⁸ mental healers,⁹⁹ osteopaths,¹⁰⁰ chiropractors,¹⁰¹ vitapathic healers,¹⁰² practitioners of suggestive therapeutics,¹⁰³ neuropaths,¹⁰⁴ naturopaths,¹⁰⁵ and those employing the laying on of hands.¹⁰⁶ Additionally, the courts ruled that it is not a defense that patients treated by these methods knowingly accepted the mode of treatment offered,¹⁰⁷ nor that patients might have benefited by the treatment.¹⁰⁸ It was argued by the medical profession and by the courts that medical practice laws neither could nor should determine the mode of treatment of a physician; however, it could legitimately speak to the question of his training and competence and

demand of the prospective practitioner a thorough knowledge of regular medicine despite the method of treatment eventually employed.¹⁰⁹ The effect of these decisions was to require of religious and mechanical healers as thorough a course of training in medicine as that possessed by any physician, despite the fact that orthodox medicine might well be regarded by these practitioners as based on assumptions directly contrary to the tenets of their church or school of practice.

In cases where the legislature did not see fit to include a comprehensive definition of medical practice, as was the case with New York's licensing law of 1893, the profession sought to obtain one through the courts. Dr. Floyd Crandall, chairman of the New York Board of Censors, recounts the efforts made to procure an extensive definition of the practice of medicine through a series of cases, each of which extended the compass of the term, until it had been interpreted as sufficiently comprehensive to meet the wishes of the profession. In this task, the Medical Society of the County of New York was the primary instigator and, in fact, prosecuted the cases itself, since it was felt that "many district attorneys can not be relied on, for in some localities neither the people nor the prosecuting officers or judges are educated to the belief that quackery is a very serious offense."¹¹⁰

Indeed, one of the primary functions of local medical societies, Dr. Crandall observed, was to bring before the courts possible violators of the licensing laws, even in instances where "inventive legal work" was required. "Enforcement of the medical practice laws," he noted,

and the protection of the public against illegal and criminal practitioners, are among the duties which the county society owes to the profession and the public. A never-ceasing warfare is waged by the charlatan and criminal practitioner, and they must be met on two battlefields, the legislature and the courts, and there the medical profession requires an alert and experienced champion who is ready not only to defend but also to attack.¹¹¹

The situation in New York is illustrative of what the profession accomplished through its diligence in harassing unlicensed practitioners. The New York legislature had refused to offer a definition of medical practice since 1881, when the New York courts had held that it could not be maintained that a person was engaged in medical practice unless drugs were administered.¹¹² As a result, in the words of Dr. Crandall, "the repudiation of drugs has been the most certain way to circumvent the medical laws and escape those annoying requirements of preliminary education, four expensive years in a medical college and a state examination." The requirements for practice in New York were, in fact, the strictest in the nation. Under the provisions of the 1896 act, applicants for a license were required to have completed a registered four-year high school course following a completed eight-year

elementary course of preliminary education. Additionally, candidates had to possess a medical degree after having studied medicine for "not less than four full school years of at least nine months each, including four satisfactory courses of at least six months each, in four different calendar years in a medical school registered as maintaining a satisfactory standard." Finally, the prospective practitioner had to pass a rigorous examination administered by the Board of Medical Examiners.¹¹³ In light of these requirements and the somewhat restricted definition of medical practice under which the courts of the state were operating, it is not surprising that large numbers of drugless practitioners established themselves in the state. Dr. Crandall continues:

Thus matters stood until 1901, when the counsel, with the full support of the censors, entered on a campaign to secure a definition. This campaign was undertaken in the belief that with well selected cases modern conditions of practice would be recognized by the courts, and the conviction of unlicensed practitioners could be obtained when no drugs were used. The first of these selected cases (*People v. Martin*, 1901) was brought against a man who used electricity in a case of fistula, and a conviction was obtained, the first in the state. The next case (*People v. Rohrer*, 1902) was brought against a man who styled himself "hydro-pathic physician" and employed steam baths and electricity. The third important case (*People v. Sadow*, 1904) was a prosecution for the employment of electricity and massage. The fourth case (*People v. Starcken*, 1904) was a prosecution for simply giving steam baths. Other convictions were secured, one for giving hypnotic treatment only. In all these cases the main question raised in the trial was as to whether the defendant undertook to diagnose and cure disease. The method of treatment, whether with or without drugs, was made incidental to the main question.¹¹⁴

Although these cases served the purpose of establishing precedents in the lower courts, none was apparently appealed and no definitive ruling from the high court defining medical practice could be secured until 1907. In that year, on appeal from the Appellate Division of the Supreme Court, the State Court of Appeals affirmed the conviction of a practitioner of "mechanico-neural therapy" and, in the process, sustained the broadest definition of medical practice yet established in any jurisdiction in the country. Speaking for the Appellate Division, Justice John Proctor Clark stated:

To confine the definition of the words "practice of medicine" to mere administration of drugs or the use of surgical instruments, would be to eliminate the very cornerstone of successful medical practice, namely, the diagnosis. . . . Diagnosis would seem to be an integral part of both the study and practice of medicine, so recognized by the law as well as common sense. The correct determination of what the trouble is, must be the first step for the cure thereof.¹¹⁵

Henceforth, *diagnosis* of illness alone, without the necessity of treatment, was sufficient to constitute the practice of medicine in New York. The decision of the Appellate Division was handed down in February and three months later a new medical practice law was enacted by the state legislature incorporating this broadened definition. Under it, the practice of medicine was defined as follows:

A person practices medicine within the meaning of this Act, . . . who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity, or physical condition.¹¹⁶

This unusually broad definition—the law exempted optometrists, chiropractors, and practitioners “of the religious tenets of any church” from its provisions—did much to reduce the number of drugless practitioners operating in the state. Perhaps just as important, the medical profession’s vigilance in initiating the prosecution of unlicensed practitioners discouraged all but the most foolhardy from practicing without a license.

The success of the New York society in establishing its own legal department to crack down on unlicensed practitioners encouraged the profession in other states to press for more vigorous enforcement of their own licensing laws. In 1901, the secretary of the Tennessee State Board of Medical Examiners declared that the medical laws “can not be enforced except through and by the medical profession, and it is a self-evident proposition that in such matters individual effort amounts to but little.”¹¹⁷ With refreshing candor, he remarked:

The enforcement of medical laws interest chiefly physicians, not the general public, and from a common business standpoint it becomes the duty of the profession to see that the laws do not become nonentities upon our statute books. It may be necessary in many cases to employ special attorneys to aid the prosecuting attorney. If this is done by the county medical societies, and the expense met out of the funds either of the state society, or the examining board, or out of the fines assessed against offenders, the laws can be easily enforced. Evildoers, unlicensed practitioners, would soon fold their tents and seek more profitable and congenial climes.¹¹⁸

The necessity of state and county societies employing their own legal counsel was underscored by a distrust of elected prosecuting attorneys, who often refused to prosecute in the absence of any complainant other than a competing physician. Indeed, so unpopular were medical practice acts among large segments of the population that it is unlikely that serious efforts at enforcement in many communities would have occurred at all had it not

been for the medical profession itself. This was especially true in smaller communities where the only effective price competition came from unlicensed practitioners and where the public were more inclined to base their selection of a physician on word-of-mouth advertising. Lack of public sympathy with the enforcement of licensure statutes led the secretary of the Michigan State Board of Registration in Medicine to complain: "We all know of the injury accruing to the medical man who swears out a formal complaint against an illegal and unqualified medical practitioner in his district."¹¹⁹ He felt compelled to observe that "it is the duty of the prosecuting or district attorney to use [the machinery of enforcement] irrespective of whether the law that is violated is popular or unpopular, important or unimportant," and to call for appointed district attorneys rather than elected ones. "In Ontario," he noted,

where the appointive method is in vogue, and where the prosecuting or district attorney holds office during good behavior only, all state laws, great or small, including the medical law, are enforced to the letter. Information to a crown attorney in a confidential way that a person is practicing medicine illegally is invariably followed immediately by investigation and arrest. A reputable physician in the same field is not made responsible for an unscrupulous and disreputable rival's downfall. The appointive prosecuting or district attorney does not attempt to evade responsibility in enforcing the law, but rather takes credit to himself for not only doing his duty but his whole duty.¹²⁰

Despite the situation which might have obtained in Ontario, even the most energetic attempts to enforce the states' medical practice acts would not have seriously curtailed the number of physicians practicing in the United States. This was true in spite of the fact that by 1901 all the states and territories excepting Alaska and Oklahoma had instituted examining boards. Of the fifty-one jurisdictions, thirty required graduates both to undergo an examination and to present a diploma in medicine. Of the twenty-one remaining, eleven made an examination mandatory, seven required either an examination or presentation of a diploma in medicine (of which five accepted diplomas only from colleges "in good standing" with the board), and two made as a prerequisite for practice the M.D. degree. Only Alaska, with hardly any population other than Eskimos and the prospectors who trekked there in search of gold, lacked a law regulating the practice of medicine. Notwithstanding these regulations, the number of physicians continued to increase, from 82,000 in 1880 to 120,000 in 1900. The rise in the number of graduates in medicine was even greater, growing from 3,250 in 1880 to 5,200, twenty years later. Despite the country's escalating population during the period, the ratio of physicians was almost able to keep pace, from 163 per 100,000 in 1880 to 157 per 100,000 at the turn of the century. In 1901, the *JAMA* could still complain that the profession was seriously overcrowded

and that the nation's medical schools were turning out far too many graduates. It observed:

In 1890 we were sixty-five millions, in 1900 we are seventy-five, an average net annual increase of 1,000,000, which at the ratio of one physician to 600 people (hardly a living ratio for the doctor) would make places for nearly 1700 additional physicians annually. This, therefore, with the 1600 or so vacancies by death would make room for nearly 3300 new doctors each year, provided the same annual increase in population continues, which is perhaps dubious. Our 160 medical colleges, however, turn out annually a crop of nearly 6000 graduates, or over 2000 more than can thus be provided for. These figures, it should be remembered, do not include a vast number of off-color practitioners, who nevertheless have their share of public patronage and thus serve to curtail the means of support of recognized physicians, nor the accessions from outside the country by immigration.¹²¹

This increase in the quantity of physicians was possible only because—despite constant and insistent statements to the contrary by established members of the profession—the 160 medical schools operating in 1901 were able to turn out graduates sufficiently qualified to pass the examinations made mandatory by forty-one state boards. The continuing contention of organized medicine that the “overcrowding” of the profession was the product of inept educational standards and a consequent proliferation of diploma mills¹²² must be called into question in light of the fact that over 5,000 graduates a year were able to be absorbed into the profession between 1900 and 1907 despite the existence of licensing laws which ostensibly acted as a control on the quality of new practitioners. Licensing laws mandating an examination were clearly not sufficiently restrictive to severely limit the numbers of new physicians entering the profession, even when these laws also required a diploma in medicine. The answer was to lie in statutes which both required a diploma and, in addition, empowered the state examining boards to exclude graduates of “sub-standard” colleges from consideration for licensure. By 1900, fifteen states had instituted such a requirement and in the following year, four more states had amended their medical practice laws to provide that all candidates possess diplomas issued solely by medical schools held “in good standing” by the state board before being considered for licensure.

During the period 1875 to 1900, the groundwork had been laid. The legislatures and the courts had accepted the principle that medical practice laws constituted a legitimate and salutary extension of the police powers of the states. Medical examining boards, in all instances composed of physicians who had taken active roles in securing their creation, existed in almost all the states and territories; and public health boards, also staffed by the more outspoken representatives of organized medicine, could be relied upon

to add pressure for stricter requirements for licensure.

The direction future legislation would have to take if the supply of new physicians were to be significantly diminished was, by the end of the period, apparent. If the state examining boards were to require for licensure graduation only from those schools whose requirements for the issuance of a degree were particularly rigorous, whose instructional staff and facilities were only of the highest calibre, and whose standards of admission were unusually high, than the other medical schools, whose diplomas would go unrecognized, would be forced to close their doors. This was to prove the weapon with which the medical profession eventually succeeded in drastically reducing the number of physicians entering practice.

During the first two decades of the twentieth century, organized medicine devoted a substantial portion of its resources and energy to the question of medical education in attempting to effect these changes. The ultimate outcome of its campaign is apparent to the 81,000 students who have unsuccessfully applied for admission to medical schools in the United States in the last three years.

NOTES

1. U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States* (Washington: U.S. Government Printing Office, 1960), p. 34 (Series B, 180-194). The proportion of physicians to the population in the United States as compared with other countries was a source of constant complaint in the medical journals. See, for example, Stanford E. Chaillé, "The Medical Colleges, the Medical Profession, and the Public," *New Orleans Medical and Surgical Reporter*, n.s. I (May, 1874): 819; and, Perry H. Millard, "The Necessity and Best Methods of Regulating the Practice of Medicine," *Journal of the American Medical Association* (hereafter cited as *JAMA*), XIX (July 30, 1892): 137. In 1887, Dr. Millard estimated that "the number of graduates in medicine in this country since 1880 closely approximates the combined output of the medical schools of the British Empire, France, Austria, and Germany." Millard offered the following figures on the ratio of physicians to the population as a whole: England: 1/1666; Hungary: 1/1666; Italy: 1/1639; Austria: 1/2932; Germany: 1/3225; France: 1/3780; Sweden: 1/7909; United States: 1/755. Perry H. Millard, "The Propriety and Necessity of State Regulation of Medical Practice," *JAMA*, IX (October 15, 1887): 492.
2. Although twenty states and the District of Columbia had some form of licensing prior to 1850, these laws were commonly short-lived and poorly enforced. Five states attached no penalty to practicing medicine without a license and six more provided that, at worst, unlicensed practitioners could not sue for the recovery of fees. A detailed analysis of these laws is contained in Joseph F. Kett, *The Formation of the American Medical Association: The Role of Institutions, 1780-1860* (New Haven: Yale University Press, 1968), pp. 181-84, and, William G. Rothstein, *American Physicians in the Nineteenth Century: From Sect to Science* (Baltimore: Johns Hopkins Press, 1972), pp. 332-39. Rothstein's data indicate that only in New York, South Carolina, Georgia, and Louisiana were penalties ever so severe as to include the possibility of imprisonment.
3. For a discussion of the therapeutic principles of regular medicine and those of homeopathy and eclecticism, see Rothstein, *op. cit.*, pp. 41-62 and 125-97, and, Harris Livermore Coulter, *Political and Social Aspects of Nineteenth-Century Medicine in the United States: The Formation of the American Medical Association and its Struggle with Homoeopathic and Eclectic Physicians* (unpublished Ph.D. dissertation, Columbia University, New York, 1969), pp. 23-33, 92-118, and 195-231.

4. Stanford E. Chaillé, "The Medical Colleges, the Medical Profession, and the Public," *op. cit.*, pp. 818-19.
5. "Medical Education in the United States," *JAMA*, LXXV (August 7, 1920): 382-83.
6. "The Late National Medical Convention," *The New York Journal of Medicine*, IX (September, 1847): 245.
7. "Proceedings of the National Medical Convention held in the City of Philadelphia, in May, 1847," *The New York Journal of Medicine*, IX (July, 1847): 112.
8. *Ibid.*, pp. 117, 121-22.
9. Victor Johnson, "The Council on Medical Education and Hospitals," in Morris Fishbein, ed., *A History of the American Medical Association, 1847 to 1947* (Philadelphia: W. B. Saunders Company, 1947), p. 887.
10. See Thomas W. Blatchford, "A Condensed Statement of What has been Attempted for the Advancement of Medical Education, by the Medical Conventions of 1846 and 1847, and by the American Medical Association since its Organization in 1847," *Transactions of the Medical Society of the State of New York, 1860* (Albany, 1860), pp. 120-31; Nathan S. Davis, *History of the American Medical Association* (Philadelphia: Lippincott, Grambo, 1855), *passim* [Dr. Davis' history originally appeared anonymously in various issues of *The New Jersey Reporter and Transactions of the New Jersey Medical Society*, viz.: Part 1: VII (January, 1854): 26-34; Part 2: VII (February, 1854): 41-49; Part 3: VII (April, 1854): 175-184; Part 4: VII (June, 1854): 245-52; Part 5: VII (August, 1854): 341-50; Part 6: VII (December, 1854): 501-509; Part 7: VIII (February, 1855): 51-62; Part 8: VIII (July, 1855): 333-43; Part 9: VIII (August, 1855): 387-99; and, Part 10: VIII (September, 1855): 435-441]; *idem*, *Contributions to the History of Medical Education and Medical Institutions in the United States of America, 1776-1876*, Special Report prepared for the United States Bureau of Education (Washington: U.S. Government Printing Office, 1877); and, Martin Kaufman, *American Medical Education: The Formative Years, 1765-1910* (Westport, Conn.: Greenwood Press, 1976), pp. 93-96, 100-117, and 159-67. See, also, American Medical Association, *Digest of Official Actions, 1846-1958* ([Chicago]: American Medical Association, 1959), pp. 215-22. The *Digest* contains a listing of all the resolutions and recommendations made by the Association up to 1958.
11. "Proceedings of the National Medical Convention," *op. cit.*, p. 115.
12. William Rothstein has made some attempt to interpret the effects of the AMA's recommendations with respect to medical education had its proposals regarding preliminary educational requirements actually been enforced. From an analysis of the data concerning high school and college attendance coupled with the availability of secondary school and academy places, Rothstein concludes that "rigid enforcement of the AMA's preliminary education standards would have closed down practically every medical school in the country, and would have depleted the ranks of formally educated physicians in a few years." *Op. cit.*, p. 120.
13. Stanford E. Chaillé, "The Medical Colleges, the Medical Profession, and the Public," *op. cit.*, p. 821.
14. *Ibid.*, pp. 825-27.
15. *Transactions of the American Medical Association*, XVIII (1867): 30.
16. Quoted in James Norment Baker, "Annual Message of the President," *Transactions of the Medical Association of the State of Alabama, 1916* (Montgomery, 1916), p. 160.
17. J. N. McCormack, "The Organization of the Medical Profession," *Northwest Medicine*, III (October, 1905): 296; W. H. Saunders, "The History, Philosophy, and Fruits of Medical Organization in Alabama," *Transactions of the Medical Association of the State of Alabama, 1914* (Montgomery, 1914), pp. 520-41.
18. James G. Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: Johns Hopkins Press, 1977), p. 18.
19. Physicians, naturally, opposed subjecting established members of the profession to the same requirements imposed on prospective practitioners. Indeed, when Minnesota enacted its medical practice act of 1887 [Minnesota Laws 1887, ch. 9, p. 46] requiring that "all persons hereafter commencing the practice of medicine and surgery" in Minnesota "present evidence of attendance on three courses of lectures of six months each" in a medical school, the *JAMA* complained bitterly that the phrasing of the statute might apply equally both to

- those just entering practice and to established practitioners coming from other states. "If the current methods and tendencies of medical legislation by the several States should continue," the *Journal* observed, "it will soon become as expensive and quite as vexatious for a practitioner to change his residence from one State to another and continue his practice in this country, as it is for the traveller to get himself and baggage through half of the custom-houses of Europe." "Medical Legislation," *JAMA*, X (January 28, 1888): 113-14. The medical profession therefore lobbied for reciprocity provisions in each of the state's medical practice acts. Needless to say, established practitioners *within* the state were *not* subject to the increasingly restrictive provisions of their state's licensure statutes. All such laws contained grand-father clauses exempting physicians already practicing from the requirements of the act. The courts consistently sustained the distinctions such statutes made between new and established members of the profession. See Kenneth C. Sears, "Legal Control of Medical Practice: Validity and Methods," *Michigan Law Review*, XLIV (1946): 693. The AMA, of course, approved such decisions and claimed that *not* to legally recognize the distinction between established and prospective practitioners would result in *ex post facto* legislation. For the AMA's reaction to the decision of the Oregon Supreme Court sustaining Oregon's medical practice act, see, "Rights of States to Regulate the Practice of Medicine and Surgery," *JAMA*, XIX (December 31, 1892): 778-79.
20. Texas Laws 1876, ch. 140, p. 231.
 21. California Statutes 1875-76, no. 518, p. 792.
 22. Stanford E. Chaille, "State Medicine and State Medical Societies," *Transactions of the American Medical Association*, XXX (1879): 352. Dr. Chaille notes that the Texas constitution provides that, while laws may be passed prescribing the qualifications of medical practitioners, "no preference shall be given by law to any school of medicine."
 23. The Code of Medical Ethics was unanimously adopted at the first meeting of the Association in 1847 and remained unrevised until 1903. Chapter II, article 4, section 1, of the Code provided that "no one can be considered as a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry." "Code of Medical Ethics," *The New York Journal of Medicine*, IX (September, 1847): 262. An analysis of this provision from the standpoint of someone writing some thirty-six years later is contained in Austin Flint, "Medical Ethics and Etiquette," *New York Medical Journal*, XXXVII (April 7, 1883): 371-73.
 24. "Domestic Correspondence: Legal Regulation of the Practice of Medicine," *JAMA*, II (April 5, 1884): 390.
 25. William Osler, "License to Practice," *JAMA*, XII (May 11, 1889): 650.
 26. "The License to Practice," *JAMA*, XII (May 25, 1889): 741.
 27. Twelve states and the District of Columbia, at one time or another, established boards of homeopathic examiners, and eight states in addition to D.C. created boards of eclectic examiners. By 1929, only five homeopathic boards and one eclectic board were still in existence, but these six boards were exceptionally durable. Arkansas' homeopathic and eclectic boards, Delaware's homeopathic board, and Maryland's homeopathic board all survived until the 1950's, and the homeopathic boards of Connecticut and Louisiana still exist.
 28. California Statutes 1877-78, no. 576, p. 918.
 29. Quoted in Richard J. Dungleison, "Report of Laws Regulating the Practice of Medicine in the United States and Canada," *JAMA*, IV (January 3, 1885): 24; referring to Ohio Laws 1868, p. 146.
 30. *Ibid.*, p. 22; referring to Nebraska Laws 1881, ch. 63, p. 282.
 31. "Registration Laws and Their Operation," *Philadelphia Medical Times*, XIII (July 14, 1883): 727; referring to New York Laws, ch. 513, p. 723, and Pennsylvania Laws 1881, no. 78, p. 72.
 32. By 1907, forty-two states and territories had provided for the refusal or revocation of a physician's license. The most common causes for such action, as stipulated in the statutes, were "dishonorable" or "unprofessional" conduct, which appeared in the language of two-

thirds of the states whose boards were so empowered. "Dishonorable" or "unprofessional" conduct was, in almost all instances, interpreted by the boards to mean violation of the AMA's code of medical ethics. In this connection, it is interesting to present several of the provisions of the code.

Chapter II, article 5, section 9 reads: "A wealthy physician should not give advice *gratis* to the affluent; because it is an injury to his professional brethren. The office of a physician can never be supported as an exclusively beneficent one; and it is defrauding, in some degree, the common funds for its support, when fees are dispensed with, which might justly be claimed."

Chapter II, article 7, section 1, effectively suggests a fee schedule: "Some general rules should be adopted by the faculty, in every town or district, relative to the *pecuniary acknowledgments* from their patients; and it should be deemed a point of honor to adhere to this rule with as much steadiness as varying circumstances will admit."

Thus, an injunction against ministering to "the affluent" without compensation and the establishment of a local fee schedule were part of the code of ethics the violation of which could, theoretically, result in revocation of one's certificate of practice! The code of ethics is contained, in full, in "Code of Medical Ethics," *op. cit.*, pp. 258-65. A lengthy apologia of its provisions, almost humorous in its attempt to contort the language of the code into a declaration of high and selfless principle, is contained in Austin Flint, "Medical Ethics and Etiquette," *New York Medical Journal*: Part 1: XXXVII (March 17, 1883): 285-90; Part 2: XXXVII (March 24, 1883): 312-15; Part 3: XXXVII (March 31, 1883): 340-47; Part 4: XXXVII (April 7, 1883): 369-376; Part 5: XXXVII (April 14, 1883): 395-400; Part 6: XXXVII (April 21, 1883): 429-432; Concluding Remarks: XXXVII (April 28, 1883): 453-56.

Of the other causes for which licenses could be either refused or revoked, the most common were habitual use of liquor or narcotic drugs, found in the statutes of twenty-one states; the performing of an abortion, eighteen states; immoral conduct, fifteen states; and, conviction of a crime involving moral turpitude, thirteen states. In only two states, Iowa and South Dakota, was incompetence a ground for revocation of a certificate to practice! For a synopsis of revocation provisions in the various medical practice acts as of 1907, see "Medical Practice Laws," *American Medical Association Bulletin*, III (November 15, 1907): 80-87.

33. In 1909, the Committee on National Legislation of the AMA reported that at least 217 laws relating to the practice of medicine had been in force at one time or another in the various states and territories, but even their figures underestimate the total number as of that date. "Report of the Secretary of the Committee on Medical Legislation," *American Medical Association Bulletin*, IV (March 15, 1909): 162-63.
34. Illinois Laws 1877, p. 154.
35. John H. Rauch, "Address in State Medicine," *JAMA*, VI (June 12, 1886): 647.
36. Richard J. Dunglison, "Report on Laws Regulating Medical Practice," *JAMA*, XVI (January 24, 1891): 110.
37. C. J. Lundy, "State Regulation of Medical Practice," *JAMA*, VIII (January 15, 1887): 59.
38. Florida Laws, no. 35, p. 113.
39. Florida Laws, no. 37, p. 72.
40. The *JAMA* found this provision of the Florida statute "singular." It commented that the AMA "has nothing to do with medical colleges, recognizing in its organization and membership medical societies only." "The Present Status of Medical Legislation in the United States," *JAMA*, XIV (February 1, 1890): 168.
41. "Medical Education in the United States," *JAMA*, LXXV (August 7, 1920): 383.
42. John B. Roberts, "The Legal Control of Medical Practice by a State Examination," *JAMA*, IV (March 7, 1885): 258.
43. Perry H. Millard, "The Propriety and Necessity of State Regulation of Medical Practice," *op. cit.*, pp. 491, 493.
44. Minnesota Laws 1887, ch. 9, p. 46. Minnesota was the first state to enact a medical practice law calling for a minimum of time to be spent in the study of medicine before the commencement of practice.

45. Perry H. Millard, "The Legal Restriction of Medical Practice in the United States," [Address before the Section on State Medicine at the 40th annual meeting of the AMA, June, 1889], *JAMA*, XIII (October 5, 1889): 472.

The *JAMA* was immensely pleased with the Minnesota law, noting, in 1893, that St. Paul "has the lowest proportion of physicians to the population of any of the larger cities of this country." With reference to the requirement that all prospective practitioners present evidence of having attended a medical school for three years, the effect was felt to be most salutary. "Commencing with this year's session," the *JAMA* observed, "every college in the United States will require three full courses of lectures before graduation." "Medical Legislation," *JAMA*, XX (January 28, 1893): 105.

46. Perry H. Millard, "The Legal Restriction of Medical Practice in the United States," *op. cit.*, p. 472.
47. "Medical Legislation," *JAMA*, IX (December 17, 1887): 785. It is instructive to offer some indication of what organized medicine regarded as "sound principles of political economy." The *JAMA* offered the following lesson in the economics of the profession in 1888: "Wholesome competition is the life of trade; unrestricted competition may be the death of it. . . . Wholesome competition is the life of *trade*; but competition does not make or increase the business of the physician." And, in response to those who claimed that the forces of supply and demand determined both the level of training and the number of physicians practicing in the country, the *Journal* replied: "The law of supply and demand has nothing to do with the matter, either of the number of colleges or of the output of graduates, nor can it have, for the reason that the public does not purchase its supply of physicians from the manufacturers (the colleges). . . . When supply and demand regulate the schools and the graduates, we shall confidently expect the free-agency of shoes to regulate their size and price." "Competition, Supply and Demand, and Medical Education," *JAMA*, XI (September 15, 1888): 382-83.

Despite the confusions in economic analysis suggested by the *JAMA*'s editorial, it is beyond dispute that the medical profession was as fully aware as was the trained economist that, in the words of one economist, "licensing raises the cost of entry, which, in turn, benefits practitioners already in the occupation at the time of licensing." An economic analysis of licensing laws is offered by Thomas G. Moore, "The Purpose of Licensing," *Journal of Law and Economics*, IV (1961): 93-117.

48. "How to Limit the Number of Medical Colleges, and Lessen the Crowded Condition of the Medical Profession," *JAMA*, X (June 9, 1888): 722.
49. "Medical Legislation and the Standard of General Education," *JAMA*, IX (December 24, 1887): 815.
50. "Proposed Medical Legislation: 'An Act Entitled, An Act to Regulate Medical Education and the Practice of Medicine and Surgery; and to Punish Persons Violating the Provisions Thereof,'" *JAMA*, XII (March 9, 1889): 355.
51. "The first important function of the board," wrote Osler, "would be the regulation of the minimum standard of education required in entering the profession. It is perfectly legitimate that the profession should say, through its representatives, what should be the qualifications of a candidate who desires to enter upon the study of medicine. In law this holds good; why should it not be so with us. A guarantee of uniformity would thus be given which cannot be expected in the schools. The examiners at the preliminary test should be independent teachers, not professional men, and the examination could be arranged in different parts of the State. The period of study would date from the passing of this preliminary examination. Such a measure would effectually prevent the entrance of men whose education was such that they could not subsequently grapple with the subjects of professional study." William Osler, "License to Practice," *op. cit.*, p. 652.
52. Perry H. Millard, "The Legal Restriction of Medical Practice in the United States," *op. cit.*, pp. 472-73.
53. Charles A. Todd, "Medical Legislation in the State of Missouri," *JAMA*, XIV (April 11, 1891): 532-33.
54. New Jersey Laws 1890, ch. 190, p. 300; New York Laws 1890, ch. 507, p. 908.
55. New Jersey Laws 1894, ch. 306, p. 454.

56. E. L. B. Godfrey, "The Medical Law of New Jersey," *JAMA*, XXXI (July 16, 1898): 119.
57. "Methods of Medical Instruction," *JAMA*, XVIII (January 16, 1892): 83.
58. Code of Iowa, 1897, ch. 17, p. 893.
59. Montana was the first state to require a diploma granted after four years of study for admission to the state licensing examination, in its medical practice act of 1895 [Codes and Statutes of Montana, 1895, Part III, ch. 3, art. 16, § 602, p. 44]. In the same year, Delaware enacted a licensing statute providing a similar requirement [Delaware Laws 1895, ch. 40, p. 45] and, in the following year New York followed suit [New York Laws 1896, ch. 111, p. 42]. Iowa thus became the fourth state to institute a four-year requirement. Additionally, the Minnesota State Board of Medical Examiners stipulated in 1896 that, as of January 1, 1899, it would require four years of study but not a diploma as a prerequisite for admission to the examination.
60. John B. Hamilton, "'Medical' Legislation and How to Obtain It," *JAMA*, XXVIII (May 29, 1897): 1005.
61. Quoted in "Iowa Medical and Legislative Comments," *JAMA*, XXXIV (March 31, 1900): 831.
62. *Ibid.*
63. John B. Hamilton, "'Medical' Legislation and How to Obtain It," *op. cit.*, pp. 1006-1007.
64. Ephraim Cutter, "More Physicians and Less Lawyers in Congress and Legislature," *JAMA*, XXIX (October 23, 1897): 838. The author deplored the small proportion of doctors sitting in the national legislature compared to their numbers as a percentage of the population as a whole. Inasmuch as the population of the country was approximately 72,000,000 in that year and the number of doctors about 120,000, physicians would have been entitled, on strictly numerical grounds, to half a seat in the House and none in the Senate. In fact, one Senator and nine Representatives were physicians in the 55th Congress, thus over-representing doctors by a factor of 20!
65. *Ibid.*, pp. 838-39.
66. The definition given the term "state medicine" adopted in 1872 by the AMA. Morris Fishbein, ed., *A History of the American Medical Association*, *op. cit.*, p. 84.
67. H. C. Markham, "State Regulation of the Practice of Medicine—Its Value and Importance," *JAMA*, X (January 7, 1888): 5.
68. The secretary of the Bureau of Medical Legislation reported in 1914 that "during the legislative session last year there were in the forty-eight legislatures then in session over 1,000 bills on public-health topics alone." Frederick R. Green, "Sixty-six Years of Medical Legislation," *American Medical Association Bulletin*, IX (March 15, 1914): 223.
69. H. C. Markham, "State Regulation of the Practice of Medicine—Its Value and Importance," *op. cit.*, p. 5.
70. Charles E. Winslow, "The Physician and the State," *JAMA*, XXIII (August 25, 1894): 296.
71. Perry H. Millard, "The Necessity and Best Methods of Regulating the Practice of Medicine," *op. cit.*, p. 137.
72. "Treason Against the Government," *JAMA*, XLV (October 28, 1905): 1331.
73. Samuel G. Dixon, "Law, the Foundation of State Medicine," *JAMA*, XLVIII (June 8, 1907): 1926-27.
74. *Ibid.*, pp. 1927-28.
75. *Ibid.*, p. 1928.
76. W. H. Saunders, "State Medicine: Its Foundation, Superstructure and Scope," *JAMA*, XLIX (July 6, 1907): 6.
77. James G. Burrow, *AMA: Voice of American Medicine* (Baltimore: Johns Hopkins Press, 1963), p. 56.
78. Morris Fishbein, ed., *A History of the American Medical Association*, *op. cit.*, pp. 1020-21.
79. For a discussion of the growth of the American Medical Association, both in representational and political importance, see James G. Burrow, *AMA: Voice of American Medicine*, *op. cit.*, pp. 27-66, and, *idem*, *Organized Medicine in the Progressive Era*, *op. cit.*, pp. 16-28.
80. James G. Burrow, *AMA: Voice of American Medicine*, *op. cit.*, pp. 100-101.

81. In 1898, Mr. Flower published a sober and well-reasoned attack on medical licensure statutes where he held, in part, that "any laws or conditions which remove the wholesome free competition and rivalry which exist where men of diverse views are striving for success tend to make a large percentage of the profession enjoying a monopoly careless and less alert than they are when others are sharply competing with them. One of the most impressive lessons taught by history and confirmed by general observation is that a large proportion of the members of any class or profession become careless when they feel secure; and this is very noticeable in the medical profession.

"As long as there are strong rivals and a perfectly free field, and people have the right and power to choose whomsoever they desire, the most successful practitioners will win the best patronage; hence all who would live must do their best. Moreover, so long as a physician has strong competitors, who represent rival methods, watching him, he will be careful not to make mistakes, for there is too much danger that he will be held responsible for his blunders. But when the law steps in and removes the security which such conditions afford, a large proportion of physicians become careless. They have little to fear, for all or most of their competitors of other schools and methods are outlawed, and the people are compelled to employ them, while the argus eyes of those who do not believe as they do are no longer upon them. They have also the comfortable assurance that behind them stands a powerful body, bound to them by a common cause and interest. When this is the case the people are in real danger, especially if the physicians are those who employ powerful and deadly remedies." B. O. Flower, "Restrictive Medical Legislation and the Public Weal," *The Arena*, XIX (June, 1898): 798-99.

Flower's remarks were borne out by the increasing difficulties encountered in successfully prosecuting malpractice suits after the introduction of strict licensing laws. In light of this, it is a salutary development that awards have been steadily escalating over the past ten years. Certainly a profession so protected from competition as has the medical profession been, should be held to the strictest accountability for its mistakes.

82. "Address of Welcome on Behalf of the Medical Profession of St. Louis," *JAMA*, LIV (June 11, 1910): 1989.
83. Frederick R. Green, "Sixty-six Years of Medical Legislation," *op. cit.*, pp. 226-27.
84. *Ibid.*
85. "If ignorance and quackery on the part of those who undertake to treat my sick fellow-citizen endanger his health, and thus make him less capable, or incapable, of bearing those economic and military burdens that actually or potentially are his, then I as a member of the body politic, in order that his burdens may not be thrust on me, have the right to see that he is not exposed to ignorance or quackery. For I must pay taxes to support and care for my fellow-citizen, when he is disabled by disease, and I, therefore, am entitled to see that he does not recklessly or ignorantly endanger his health." William C. Woodward, "Regulation of the Healing Arts, in Principle and Practice," *Federation Bulletin*, IX (September, 1923): 209.
- Essentially the same sentiment was expressed almost three decades earlier by the then-President of the National Confederation of State Medical Examining and Licensing Boards, Dr. William Potter, when he declared: "The State is ever jealous of her rights and of the welfare of her citizens. She is particularly so of their health, which means economy. She has assumed to decide who shall and who shall not minister to the sick and injured and she especially has determined to administer the laws of prevention with a constantly increasing rigidity." William Warren Potter, "The Relations of Medical Examining Boards to the Schools and to Each Other," *JAMA*, XXVI (May 16, 1896): 951.
86. William C. Woodward, "Regulation of the Healing Arts, in Principle and Practice," *op. cit.*, pp. 209-10.
87. "Proposed 'Practical' Medical Legislation for New York State," *JAMA*, XXX (March 12, 1898): 625.
88. 129 U.S. 114, 9 S.Ct. 231 (1889).
89. West Virginia Acts 1881, ch. 60, p. 325.
90. 129 U.S. at 121.
91. 129 U.S. at 121-22.

92. *Reetz v. Michigan*, 188 U.S. 505, 23 S. Ct. 390 (1903).
93. *Watson v. Maryland*, 218 U.S. 173, 30 S. Ct. 644 (1910).
94. 40 Neb. 158, 58 N.W. 728 (1894).
95. Nebraska Laws 1891, ch. 35, p. 280, § 17.
96. 40 Neb. at 169, 58 N.W. at 732.
97. 72 Ohio St. 21, 73 N.E. 1063 (1905). Similarly, the New York courts held that a member of the Spiritualist Church engaged in the treatment of the ailing by prayer supplemented by patent medicines of his own compounding was engaged in the practice of medicine. *People v. Vogelgesang*, 221 N.Y. 290, 116 N.E. 977 (1917).
98. *People v. Gordon*, 194 Ill. 560, 62 N.E. 858 (1902); *State v. Hughey*, 208 Iowa 842, 226 N.W. 371 (1929).
99. Ex parte *Smith*, 183 Ala. 116, 63 So. 70 (1913).
100. *Eastman v. People*, 71 Ill. App. 236 (1896); *Little v. State*, 60 Neb. 749, 84 N.W. 248 (1900); *Bragg v. State*, 134 Ala. 165, 32 So. 767 (1901); *State v. Gravett*, 65 Ohio St. 289, 62 N.E. 325 (1901).
101. *State v. Smith*, 233 Mo. 242, 135 S.W. 465 (1910); *State v. Greiner*, 63 Wash. 46, 114 Pac. 897 (1911); *People v. Ellis*, 162 App. Div. 288, 147 N.Y. Supp. 681 (2d Dept. 1914); *State v. Frutiger*, 167 Iowa 550, 149 N.W. 634 (1914); *Harvey v. State*, 96 Neb. 786, 148 N.W. 924 (1914); *State v. Rolph*, 140 Minn. 190, 167 N.W. 533 (1918); *People v. Walker*, 290 Ill. 535, 126 N.E. 120 (1920); *Cummings v. State*, 214 Ala. 209, 106 So. 852 (1926).
102. *Smith v. State*, 8 Ala. App. 352, 63 So. 28 (1913), *aff'd* 183 Ala. 116, 63 So. 70 (1913).
103. *Witty v. State*, 173 Ind. 404, 90 N.E. 627 (1910); *People v. Mulford*, 140 App. Div. 716, 125 N.Y. Supp. 680 (4th Dept. 1910), *aff'd* 202 N.Y. 624, 96 N.E. 1125 (1911); *State v. Peters*, 87 Kan. 265, 123 Pac. 751 (1912); *State v. Pratt*, 80 Wash. 96, 141 Pac. 318 (1914).
104. *Commonwealth v. Seibert*, 262 Pa. 345, 105 Atl. 507 (1918).
105. *State v. Smith*, 127 Ore. 680, 273 Pac. 343 (1929); *State v. Miller*, 59 N.D. 286, 229 N.W. 569, (1930).
106. *Singh v. State*, 66 Tex. Crim. Rep. 156, 146 S.W. 891 (1912); *People v. Moser*, 176 Ill. App. 625 (1913). See also, *Territory v. Newman*, 13 N.M. 98, 79 Pac. 706 (1905); and, *Newman v. State*, 58 Tex. Crim. Rep. 223, 124 S.W. 956 (1910), on massage for the treatment of ailments, ruled as practicing medicine.
107. *State v. Fenter*, 204 S.W. 733 (Mo. App. 1918).
108. *Germany v. State*, 62 Tex. Crim. Rep. 276, 137 S.W. 130 (1911); *State v. Miller*, 146 Iowa 521, 124 N.W. 167 (1910); *Swerts v. Siveny*, 35 R.I. 1, 85 Atl. 33 (1912); *People v. Saunders*, 61 Cal. App. 341, 215 Pac. 120 (1923); *People v. Eiferssen*, 136 Misc. 32, 239 N.Y. Supp. 111 (Sup. Ct. 1930); *State v. Miller*, 59 N.D. 286, 229 N.W. 569 (1930).
109. "There was nothing, so the courts said, to prevent a candidate, once he had met the requirements and obtained his license, from practicing according to any system of therapeutics he was pleased to select," notes one commentator on the laws of medical practice. In support of this, he cites the following cases: *Carpenter v. State*, 106 Neb. 742 at 749, 184 N.W. 941 at 944 (1921); *Germany v. State*, 62 Tex. Crim. Rep. 276 at 279, 137 S.W. 130 at 132 (1911); and, *Johnson v. State*, 267 S.W. 1057 (Tex. Civ. App. 1925). Harold Wright Holt, "The Need for Administrative Discretion in the Regulation of the Practice of Medicine," *Cornell Law Quarterly*, XVI (June, 1931): 508.

The profession, of course, supported a similar policy. "If the State undertakes to secure for the people an educated medical profession, its laws should define clearly the standard of education required for all, and provide an efficient and impartial Board of Examiners to enforce it alike on all applicants. Then every person having passed the ordeal satisfactorily must be allowed to exercise the most perfect right of private or individual judgment in the application of his knowledge in the practice of any or all departments of his profession." Editorial, "The License to Practice," *JAMA*, *op. cit.*, p. 741.

The American Medical Association was reacting atypically when, in reply to an address delivered by the Counsel of the Medical Society of the County of New York declaring that the law "cannot prohibit the practice of sectarian medicine and such delusions as the mind-cure and Christian science" if the statutory requirements for practicing medicine had been met, its *Journal* responded: "True, the law cannot prohibit theories and opinions of mind-

curers and Christian scientists; it cannot prohibit thought; but to say that it cannot prohibit certain practices is a very different matter." In this instance, the *JAMA* felt that "there is too much of the *laissez faire* policy exhibited" by these sentiments. Editorial, "How Far Can Legislation Aid in Maintaining a Proper Standard of Medical Education?", *JAMA*, XI (November 3, 1888): 631-32. On the whole, however, the Association, together with the state societies, supported the notion that the law should have no power over the methods of treatment given by licensed members of the profession.

For extensive discussions of the treatment of medical practice by the courts, see, in addition to Harold Wright Holt, "The Need for Administrative Discretion in the Regulation of the Practice of Medicine," already cited, Frances R. Schoenbach and Anne Snider, "Physicians and Surgeons—What Constitutes the Practice of Medicine within the Statutes Regulating the Same," *Boston University Law Review*, XVI (April, 1936): 488-506; Note, "The Practice of the Healing Arts: Some Regulatory Problems," *Fordham Law Review*, VI (November, 1937): 438-47; and, Kenneth C. Sears, "Legal Control of Medical Practice: Validity and Methods," *Michigan Law Review*, XLIV (April, 1946): 690-714. Perhaps the single most important analysis of the rise of licensing laws in the United States in terms of their reception by the courts is, Lawrence M. Friedman, "Freedom of Contract and Occupational Licensing, 1890-1910: A Legal and Social Study," *California Law Review*, LIII (1965): 487-534.

110. Floyd M. Crandall, "Enforcement of Medical Practice Laws by County Societies," *JAMA*, L (February 8, 1908): 413.
111. *Ibid.*
112. *Smith v. Lane*, 24. Hun. 632 (1881). As a result, the New York statute of 1893 defined the practice of medicine as "the practice of medicine and surgery." New York Laws 1893, ch. 661, p. 1495, art. 8 (p. 1540).
113. New York Laws 1896, ch. 111, p. 42. A thorough discussion of this law is contained in James Russell Parsons, Jr., "Preliminary Education, Professional Training and Practice in New York," *JAMA*, XXVI (June 13, 1896): 1149-52.
114. Floyd M. Crandall, "Enforcement of Medical Practice Laws by County Societies," *op. cit.*, p. 414.
115. *People v. Allcutt*, 117 App. Div. 546, 102 N.Y. Supp. 678 (1st Dept. 1907).
116. New York Laws 1907, ch. 344, p. 636.
117. T. J. Happel, "Enforcement of Medical Laws Dependent on an Organized Profession," *JAMA*, XXXVII (November 16, 1901): 1302.
118. *Ibid.*
119. Beverly D. Harison, "Difficulties Met With in Enforcing State Medical Laws," *JAMA*, XXXVII (November 16, 1901): 1303.
120. *Ibid.*
121. "Oversupply of Medical Graduates," *JAMA*, XXXVII (July 27, 1901): 270.
122. For an account of the profession's contentions respecting the quality of medical education from the viewpoint of an historian whose sympathies lie squarely with organized medicine, see Martin Kaufman, *American Medical Education*, *op. cit.*, *passim*. See also Kaufman's "American Medical Diploma Mills," *Bulletin of the Tulane Medical Faculty*, XXVI (February, 1967): 53-57.

APPENDIX I
DATES OF ENACTMENT OF FIRST MEDICAL LICENSING LAW,
BY STATE AND TYPE OF LAW

	Registration Law ¹	Examining Board Created ²	Examination Mandatory ³	Diploma Mandatory ⁴	Sub-standard Colleges Excluded ⁵	Preliminary Education Requirements ⁶	Code of Ethics ⁷
Alabama		1877	1877	1923	1923	1923	1907
Alaska		1913	1913	1913	1917	1917*	1913
Arizona	1873 ⁺	1881	1897	1897	1913	1913*	1903
Arkansas		1881 ^a	1903 ^b	1909	1909	1909*	1903
California		1876 ^c	1901	1901	1901	1901*	1876
Colorado		1881	1927	1927	1881	1905	1905
Connecticut	1881	1893 ^d	1897	1901	1893	1907	1893
Delaware	1883 ⁺	1895 ^e	1895	1895	1907	1895	1899
Dist. of Columbia	1874 ⁺	1896 ^f	1896	1896	1929	1929	1896
Florida		1881 ^g	1889	1889	1921	1921*	1921
Georgia	1881 ⁺	1894 ^h	1894	1894	1913	1913	1913
Hawaii #	1864 ⁺	1896	1896 ⁱ	1896 ⁱ	1939	1939*	1896
Idaho	1887 ⁺	1899 ^j	1899	1899	1899	1899*	1899
Illinois		1877	1899	1899	1877	1907	1877
Indiana	1885 ⁺	1897	1897	1897	1897	1897*	1897
Iowa		1886	1897	1897	1886	1897*	1886
Kansas	1870 ⁺	1901 ^k	1901 ^m	1901 ⁿ	1901	1901*	1901
Kentucky		1874 ^o	1904 ^p	1904	1904	1904*	1893
Louisiana	1882 ⁺	1894 ^q	1894	1894	1894	1894*	1894
Maine		1895	1895	1901	1901	1901	1895
Maryland		1888 ^r	1892	1892	1888	1892*	1888
Massachusetts		1894	1894	1915	1936	1933	1894
Michigan	1883 ⁺	1899	1903	1903	1899	1903	1905
Minnesota		1883	1887	1895 ^s	1883	1895*	1883

	Registration Law ¹	Examining Board Created ²	Examination Mandatory ³	Diploma Mandatory ⁴	Sub-standard Colleges Excluded ⁵	Preliminary Education Requirements ⁶	Code of Ethics ⁷
Mississippi		1882	1882	1912	1912	1912*	1922
Missouri	1874 [*]	1883	1901	1907	1883	1907	1901
Montana	1876 [*]	1889	1895	1895	1889	1895*	1895
Nebraska	1881 [†]	1891 [†]	1903	1891	1891	1891	1891
Nevada	1875 [*]	1899	1905	1905	1899	1905*	1899
New Hampshire	1875 st	1897	1897	1897	1897	1897	1915
New Jersey	1880 [*]	1890	1890	1890	1890	1894	1890
New Mexico		1882	1923	1903	1882	1903	1882
New York	1874 ^v	1890 st	1890	1890	1893	1890	1893
North Carolina		1885 ^x	1885 ^x	1899	1899	1913	1885 [*]
North Dakota [†]	1869 st	1890	1890	1905	1905	1911	1890
Ohio	1868 [†]	1896	1900	1900	1896	1900	1896
Oklahoma [§]	1890 st	1903	1903	1903	1903	1908	1908
Oregon		1889	1895	1915	1889	1920	1889
Pennsylvania	1875 [*]	1893 ^{aa}	1893	1893	1911	1893	1911
Rhode Island	1882	1895	1901	1908	1895	1908	1895
South Carolina	1881 [†]	1887 ^{bb}	1894	1894	1904	1904	1908
South Dakota [†]	1869 st	1893	1903	1903	1903	1903*	1893
Tennessee		1889	1897	1915	1889	1915	1889
Texas	1873 [*]	1876 ^{cc}	1876	1907	1907	1907	1907
Utah		1892	1892	1892	1892	1911	1892
Vermont	1876 ^{dd}	1898	1898	1898	1904	1904*	1898
Virginia		1884	1884	1900	1912	1912	1912
Washington	1881 [*]	1890	1890	1901	1909	1909*	1890
West Virginia		1881	1895	1907	1881	1917	1895
Wisconsin	1881 [†]	1897	1897	1897	1903	1903	1903
Wyoming	1875 [*]	1899	1905	1905	1899	1899*	1899

Source: The laws and statutes of the various states and territories.

Kingdom of Hawaii until 1894; Republic of Hawaii from 1894 to 1898; Territory of the

Hawaiian Islands from 1898 to 1959.

† Dakota Territory until 1889.

§ Oklahoma Territory until 1907. Statutes enacted between 1890 and 1907 were not applicable to the Indian Territory, joined to Oklahoma in 1907.

1. Registration laws provided that practitioners were to register with either the county medical society or some county official in order to practice in the state. When marked (*), the statute additionally provided that practitioners possess either a license or diploma in medicine issued by some legally chartered medical school or medical society.
2. Earliest law creating a medical examining board or several boards representing homopathy and eclecticism in addition to regular medicine. Such laws generally required examination for all those not holding a diploma from some legally chartered medical school; where dates differ from those in column 3, statutes provided that holders of M.D. degrees were automatically issued licenses to practice upon visiting of their diploma for the period between the two dates. [Exceptions are Arkansas, Kentucky, and Nebraska; see notes (b), (p), and (1).]
3. First law mandating examination of all candidates seeking to practice in the state, whether medical graduates or not.
4. Earliest law making a diploma in medicine a prerequisite for certification.
5. First law empowering the medical examining boards to exclude graduates of "inferior" medical colleges from certification.
6. Earliest law empowering the medical examining boards to set pre-professional educational requirements. When marked (*), authority, though not explicit, is implied in the statute. In the case of some state boards, authority was assumed and made use of before the date shown through their refusal to recognize medical colleges which did not set certain admissions requirements.
7. First law empowering the medical examining boards to refuse or revoke certification for "dishonorable" or "unprofessional" conduct, thus effectively legislating the code of ethics of the American Medical Association.

- a. Arkansas' statute of 1881 called for the creation of county boards of medical examiners to license practitioners. In 1903, a new law was enacted creating three boards, regular, homopathic, and eclectic, to examine all candidates wishing to practice in the State. These three separate boards continued in existence until 1955, when new legislation abolished the homopathic and eclectic boards.
- b. By act of 1895, Arkansas replaced its 1881 law with a new statute authorizing the State Board of Medical Examiners "to examine all persons who may desire to practice medicine" in the State. However, unlike the 1881 law, this mandate was interpreted by the board to apply only to non-graduates, registration of a diploma with the county clerk being sufficient for holders of an M.D.
- c. In 1878, the California law of 1876 was amended to provide for homopathic and eclectic boards of examiners. In 1901, a new law created a single board in place of three separate boards.
- d. Connecticut's original medical practice act of 1893 called for the creation of three boards of examiners, representing regular, homopathic, and eclectic medicine. In 1935, the eclectic board was abolished. There is still a homopathic medical examining board. In 1976, the membership of this board was reduced to one!
- e. Delaware's 1895 law provided for two medical boards, representing regular and homopathic medicine. In 1955, the homopathic board was abolished.
- f. The District of Columbia originally provided for three boards, regular, homopathic, and eclectic, by its act of 1896. In 1929, a single board was created.
- g. Florida passed its first medical practice act in 1881, providing for six local boards of examiners throughout the State to examine all persons wishing to practice who were not

Notes to Appendix I

graduates of medical schools. By amendment in 1889, a statewide homeopathic board was created and by a further statute of 1899, a board of eclectic medicine was added. In 1921, a new medical practice act created a single board.

- h. By law of 1913, a single board was created in Georgia to replace the three medical boards, regular, homeopathic, and eclectic, set up by the 1894 statute.
- i. The Hawaiian Republic's statute of 1896 empowered the Board of Medical Examiners to "duly examine" all candidates to determine whether they were "possessed of the necessary qualifications" for practice, and the same act was re-enacted by the Territory's first legislature two years later. This statute effectively empowered the Board to determine what constituted the qualifications necessary for practice in the Islands and was, in fact, interpreted by the Board to include a diploma from a medical college.
- j. Idaho's medical practice act of 1899 was preceded by a law enacted in 1897, very similar in nature to the 1899 law excepting its provisions defining the practice of medicine. The 1897 law was held unconstitutional by the state Supreme Court in 1898 and was, accordingly, replaced by the 1899 law.
- k. Kansas' medical practice act of 1901 was preceded by a law enacted in 1879, which created three boards of medical examiners, regular, homeopathic, and eclectic. These boards were empowered to examine all candidates other than graduates of reputable medical colleges and to issue licenses. In 1881, the 1879 law was held unconstitutional by the state Supreme Court and was not replaced by another medical practice act until 1901.
- m. The Kansas Board was empowered, "at its discretion," to exempt from examination "graduates of legally chartered medical institutions in good standing, as determined by the board." In effect, almost all candidates were required to sit the examination.
- n. Strictly speaking, the Kansas statute did not require a diploma; the law stipulated that "not less than three periods of six months each, no two within the same twelve months, or if after April 1, 1902, four periods of not less than six months each, no two within the same twelve months" must have been devoted to the study of medicine.
- o. Kentucky's 1874 law, entitled "an act to protect citizens of this Commonwealth from Empiricism," provided for the appointment of medical examining boards for each judicial district in the State to examine all candidates wishing to begin practice in Kentucky. This law gradually fell into disuse and was replaced, in 1893, by a new law empowering the State Board of Health to issue certificates to practice to anyone either (1) possessing a diploma from a reputable medical college in the State; (2) possessing a diploma from a reputable medical college legally chartered under the laws of another State or country, endorsed as such as the Board; or (3) having ten years' practice as a physician. The 1893 law did not provide for examination of any candidate and was, effectively, a strictly enforced registration law.
- p. Kentucky's 1874 statute also called for mandatory examination of all candidates. The 1893 law which replaced it contained no provision for examinations of any sort, and it was not until 1904 that a new act was passed once again requiring examination of all prospective practitioners.
- q. Louisiana's law of 1894 created both a regular board of examiners and a homeopathic board. By act of 1942, a Department of Occupational Standards was established by merger of the Homeopathic State Board of Medical Examiners with the Board of Architectural Examiners, the Real Estate Board, the State Board of Osteopaths, and the State Board of Library Examiners.
- r. In 1892, Maryland enacted a new medical practice act providing for two boards of examiners, regular and homeopathic. In 1957, the homeopathic board was abolished.
- s. Minnesota's law of 1895 does not explicitly stipulate possession of a diploma as a prerequisite. The statute required the completion of three full courses of lectures of at least twenty-six weeks each, no two courses being within the same year, "at a medical school recognized by the board." In 1905, the period of study was lengthened to "four entire sessions of twenty-six weeks each."
- t. Nebraska's 1891 law did not provide for examination of any candidates; rather it empowered the State Board of Health to certify physicians on the basis of presentation of a diploma from a medical school or college in good standing, i.e., "requiring a preliminary examination for admission to its courses of study, and which requires as requisite for the

granting of the degree of M.D. attendance on at least three courses of lectures of six months each, no two to be held within one year, and having a full faculty of professors in all the different branches of medical education."

- u. New Hampshire's law of 1875 provided that each local medical society select a board of censors to issue certificates to all practitioners. Certification required either presentation of a diploma from some medical college or examination by the board. Uncertified practitioners could not sue for recovery of fees. The law was never effectively enforced and was eventually dropped from the codification of New Hampshire statutes in 1891. In 1897, a new statute was enacted creating three boards of examiners, regular, homeopathic, and eclectic, with both a diploma and examination mandatory. In 1915, the three boards were abolished and one board substituted for them.
- v. New York's 1874 statute required that "every practitioner of medicine and surgery . . . , excepting licentiates or graduates of some medical society or chartered school, shall be required . . . to obtain a certificate from the censors of some one of the several medical societies of this State," certificates to be recorded with the county register. The law was, thus, an early attempt to institute licensing boards and was somewhat stronger than contemporaneous registration laws. The statute was feebly enforced and was replaced in 1880 with a registration law requiring practitioners to register with the county register either their diploma or some license, indicating by whom the diploma or license was issued.
- w. New York's 1890 statute provided for three boards, regular, homeopathic, and eclectic. By act of 1907, the homeopathic and eclectic boards were abolished and a single board created.
- x. North Carolina's law of 1885 was in actuality an amendment to a statute respecting medical practice originally enacted in 1859, which provided for the creation of a board of medical examiners comprised of members of the State Medical Society. The board was empowered to examine all candidates wishing to practice. Failure to procure a license disallowed a practitioner to sue for recovery of medical fees. However, the 1859 law explicitly provided that violation of its provisions did not constitute a criminal offense. In 1885, the North Carolina legislature amended the provisions of this law to make noncompliance a misdemeanor.
- y. The Dakota Territory enacted a statute in 1869 which required all practitioners in the Territory to have attended "two full courses of instruction and graduated at some school of medicine, either in the United States or some foreign country," or to have been issued a certificate of qualification by some state or county medical society. In 1885, the Territorial legislature passed a more restrictive law, making it a misdemeanor for anyone to practice medicine "unless he be a graduate of a medical college, or unless upon examination before a board composed of the superintendent of public health and two other physicians to be selected by the territorial board of health, such person shall be found to be proficient in the practice of medicine and surgery and shall also be found upon proof to have been actually engaged in the practice of medicine for a term of not less than ten years." The 1885 act was, therefore, a registration law requiring examination only of physicians without a medical degree, provided they had been practicing for ten years.
- z. Oklahoma's law of 1890 was modeled on the statute enacted by the Dakota Territory in 1885 [see (y) above], the major difference being that physicians without degrees were required both to undergo an examination and prove that they had been in practice for five years.
- aa. Pennsylvania's 1875 statute, although essentially a registration law, provided that physicians without degrees could apply to the prothonotary of the court of common pleas for the court to strike a committee of three physicians to examine the candidate. The law was disregarded and, in 1877, was replaced by a pure registration law. The 1875 law can be regarded as an early attempt to set up examining boards.
- bb. South Carolina's 1887 law was created by amending the 1881 law to create a State Board of Medical Examiners with power to examine applicants who did not possess medical degrees. In 1890, the legislature repealed the provisions of the 1887 amendment and the situation reverted to that which prevailed under the 1881 registration law.

South Carolina's law of 1904 called for two examining boards, one representing regular medicine, the other, homeopathic medicine. In 1908, a new law abolished the two boards and created a single board in their place.

- cc. By act of 1901, the Texas legislature created three boards of examiners, regular, homeopathic, and eclectic. In 1907, a new medical practice act established a single board.
- dd. Vermont's 1876 law empowered every medical society chartered in the State to elect a board of censors to examine and license practitioners. The law was ineffective even when treated solely as a registration law and fell into disuse.

APPENDIX II

PHYSICIANS, AND RATIO OF POPULATION
TO EACH PHYSICIAN, 1850 TO 1929

	Number of Physicians	Population per Physician
1850	40,755	568
1860	55,055	571
1870	60,000	667
1880	82,000	614
1886	87,521	662
1890	100,180	629
1893	103,090	649
1896	104,554	680
1898	115,524	637
1900	119,749	637
1902	123,196	641
1904	128,950	637
1906	134,688	633
1909	134,402	671
1910	135,000	685
1912	137,199	694
1914	142,332	694
1916	145,241	704
1918	147,812	709
1920	144,977	730
1921	145,404	746
1923	145,966	769
1925	147,010	787
1927	149,521	794
1929	152,503	800

Source: U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States* (Washington: U.S. Government Printing Office, 1960), p. 34 (Series B. 180-194).

APPENDIX III

STATES ESTABLISHING BOARDS OF HOMEOPATHIC AND
ECLECTIC MEDICAL EXAMINERS, WITH DATES OF OPERATION

HOMEOPATHIC BOARDS

Arkansas:	1903	-----	1955	
California:	1878	-----	1901	
Connecticut:	1893	-----		present
Delaware:	1895	-----	1955	
Dist. of Columbia:	1896	-----	1929	
Florida:	1889	-----	1921	
Georgia:	1894	-----	1913	
Louisiana:	1894	-----		present
Maryland:	1892	-----	1957	
New Hampshire:	1897	-----	1915	
New York:	1890	-----	1907	
South Carolina:	1904	--	1908	
Texas:	1901	--	1907	

ECLECTIC BOARDS

Arkansas:	1903	-----	1955	
California:	1878	-----	1901	
Connecticut:	1893	-----	1935	
Dist. of Columbia:	1896	-----	1929	
Florida:	1899	-----	1921	
Georgia:	1894	-----	1913	
New Hampshire:	1897	-----	1915	
New York:	1890	-----	1907	
Texas:	1901	--	1907	

---- = ten years