

ENFORCING MEDICAL REGULATION IN THE UNITED STATES 1875 TO 1915

by

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## An Abstract of the Thesis of

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This thesis examines the enforcement of medical licensing laws in the United States between 1875 and 1915. Since all of these laws operated at the state level, I focus on the actions taken by various state medical boards around the country. These medical boards were typically composed of organized physicians, both regular and irregular, who worked together to purge the medical field of frauds, charlatans and unorganized sectarians through quasi-judicial self-regulation. I will argue that between 1875 and 1915 state medical boards effectively consolidated their control over medicine and unified the medical profession by relentlessly prosecuting various types of irregular medical practitioners including midwives, osteopaths, opticians, magnetic and electric healers and Christian Scientists. By eradicating unorganized irregulars, state medical boards not only eliminated their competitors, they laid the foundation for the reform of medical education.

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## CHAPTER I

### INTRODUCTION

Today, physicians are perhaps the most regulated professionals in the United States, but in 1870 almost every physician was unlicensed. In most jurisdictions, anyone could hang up a shingle and practice medicine. Before 1870, only the Dakota Territory and Ohio required physicians to register with local authorities. Quacks, charlatans and other assorted scoundrels swelled the nation's medical ranks in the nineteenth century, but between 1870 and 1900, the practice of medicine changed dramatically and by 1900, almost every state had passed some type of medical licensing.

Medical regulation forced fundamental changes in medical school curriculums, purged unlicensed quacks and charlatans, reduced the number of physicians who were not graduates of medical schools, marginalized midwives, revoked the licenses of abortionists and unified the best organized of both regular and irregular medical practitioners. When physicians lobbied state legislatures for these medical practice acts, organized physicians were the primary advocates for these laws. The allies of regular and irregular physicians battled each other and crafted compromises that were often objectionable to both of these groups. While both groups of physicians argued that licensing law would eliminate unqualified practitioners and prevent them from harming innocent patients; they clearly had ulterior motives. Not only did medical reformers seek to eliminate the dangers posed by scam artists and incompetent healers, they sought to enact laws which managed competition between organized physicians (both regular and irregular) and improve the general perception of physicians.

Despite the enormous impact of medical licensing in the past forty years only two scholars have focused on this legislative revolution, Richard Harrison Shryock and Ronald Hamowy. In 1967, Richard Harrison Shryock published *Medical Licensing in America, 1650-1965*. Shryock's book focused on the "dual themes of education and licensure – using each of those terms in a broad sense."<sup>1</sup> While Shryock's work was groundbreaking, it was not meant to be comprehensive. Shryock sought to explain the gradual professionalization of the medical profession, but his study did not adequately address the messy reality of medical licensing at the turn of the century. Harmowy's case differed from Shryock's because he argued that organized physicians (especially the American Medical Association) damaged health care in the United States by dramatically restricting the number of people who could become doctors or go to medical school. He rejected the idea that the adoption of medical licensing was an attempt by physicians to improve medical care. Unfortunately, Harmowy's article was undermined by his clear ideological position. This paper differs from these earlier approaches and will focus on the enforcement of medical licensing to understand how physicians consolidated their control over American medicine and unified their profession.

Aside from being a messy story, it is also a story of incremental change in over fifty separate states and territories. There was not one event or medical advance that convinced the general public or state legislatures that medical licensing was necessary. Open conflict between regular (medical science) physicians and the irregulars

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<sup>1</sup> Richard Harrison Shryock, *Medical Licensing in America, 1650-1965* (Baltimore, Johns Hopkins Press, 1967), viii.

(homeopaths, eclectics, osteopaths, and others) delayed the adoption of any medical licensing because legislatures were understandably concerned that the adherents of one medical system would use licensing to eliminate their sectarian foes.

While the previous literature focused on the battle between regular and irregular physicians, this dynamic need to be reevaluated. Organized regular and irregular physicians did not enforce these statutes to eliminate each other; they instead prosecuted their unorganized colleagues and marginal physicians. While William Rothstein's statement that "conflict between regular physicians and homeopaths and eclectics continued to be a dominant feature of the organized profession in the later years of the century" is certainly true, that conflict appears less important to the development of American medicine than the collaboration between the organized allopaths, eclectics and homeopaths to limit their unorganized competitors.<sup>2</sup> If anything, medical licensing allowed regulars and irregulars to discover their common interests. Medical laws were not enforced in ways to settle sectarian disputes so much as to drive the out unorganized sects and fraudulent practitioners.

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<sup>2</sup> William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science*, (Baltimore and London, The Johns Hopkins Press, 1972), 298.

## CHAPTER II

## THE EARLY HISTORY OF MEDICAL REGULATION

Before 1800, medical therapeutics had changed remarkably little over the previous two thousand years.<sup>3</sup> Traditional physicians or allopaths may have viewed themselves as learned professionals, but their therapeutic methods were informed by Galen's two-thousand-year-old "four humoral theory." "The body was seen, metaphorically, as a system of dynamic interactions with its environment" and physicians believed that specific diseases played an insignificant role in the system.<sup>4</sup> During the nineteenth century, this understanding of the human body came under assault because it was not effective in treating human illnesses.

Many formally educated physicians (regulars) were the inheritors of Galen's therapeutic legacy, but during the nineteenth century they became devoted to the principles of scientific medicine. They began to believe in the "long-term efficacy of such principles as rational research and cooperative intercommunication." The regulars created medical societies and journals and attempted to combat the abysmal standards of American medical schools.<sup>5</sup> Their approach to medicine was essentially scientific, but

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<sup>3</sup> Charles E. Rosenberg "The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth-Century America," in *The Therapeutic Revolution: Essays in the Social History of American Medicine*, ed. Moris J. Vogel and Charles E. Rosenberg, (University of Pennsylvania Press, 1979), 3.

<sup>4</sup> Rosenberg, *The Therapeutic Revolution*, 5, 6.

<sup>5</sup> James Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978), 33.

their alleged reliance on science produced few results until the late nineteenth century because they lacked the tools to truly understand viruses, bacteria and human physiology.<sup>6</sup> Partly for these reasons, the regulars' dominance of American medical practice eroded dramatically between 1820 and 1850 and competing medical sects and systems developed to fill the vacuum.

Although state legislatures began passing laws regulating the practice of medicine shortly after the American Revolution, the medical profession as a whole did not necessarily support licensure law in the early nineteenth century.<sup>7</sup> By 1830, 13 states had developed some type of licensing scheme, but these early statutes simply gave licensed physicians the right to sue for unpaid bills and were generally unenforceable.<sup>8</sup> Some historians have argued that the public's perception of the regulars declined after 1830 and this change in perception led to the elimination of these licensing statutes. By 1850, the number of states licensing physicians had fallen to two. According to Kenneth De Ville, physicians in the mid-1800s "saw an intimate connection between Jacksonian rhetoric, their decline in status, the abolition of licensure, and the increase in malpractice suits."<sup>9</sup> Not surprisingly, historians have not always agreed with physicians' overly optimistic

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<sup>6</sup> Joseph F. Kett, *The Formation of the American Medical Profession: The Role of Institutions, 1780-1860* (New Haven and London, Yale University Press, 1968), 162.

<sup>7</sup> William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science*, (Baltimore and London, The Johns Hopkins Press, 1972), 74-75.

<sup>8</sup> Ronald Numbers, "The Fall and Rise of the American Medical Profession," in *Sickness & Health in America*, ed. Judith Walzer Leavitt and Ronald L. Numbers, 3<sup>rd</sup> ed., (Madison, The University of Wisconsin Press, 1997), 225.

<sup>9</sup> Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (New York and London, New York University Press, 1990), 87.

view of their eighteenth-century colleagues. Richard Harrison Shryock argued that Americans had always distrusted their doctors and that perhaps they had only become more vocal in their opinions in 1840.<sup>10</sup>

While “the Jacksonian mentality was scornful of institutional restraints” such as medical licensing, a number of the medical profession’s problems were self-inflicted. The medical profession’s inability to maintain those laws was “hampered by disorganization and slackened requirements.”<sup>11</sup> A majority of regular physicians were seen as incompetent and ineffective. During the mid-nineteenth century, not only were regulars hampered by a fundamentally flawed understanding of medicine, but woefully inadequate medical schools sprouted like weeds throughout the country. These schools were staffed by poorly trained practitioners and driven by profit, not education goals. Admission standards for most American medical schools could be best described as non-existent. Ronald Numbers quoted a physician in “The Fall and Rise of the American Medical Profession” as saying, “[i]t is well understood among college boys that after a man has failed in scholarship, failed in writing, failed in speaking, failed in every purpose for which he entered college; after he has dropped down from class to class; after he has been kicked out of college, there is one unfailing city of refuge – the profession of medicine.”<sup>12</sup>

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<sup>10</sup> Shryock, *Medical Licensing in America*, 106.

<sup>11</sup> Kett, *American Medical Profession*, 31.

<sup>12</sup> Numbers, *Sickness*, 226.

Not only were many students unqualified to begin an education in medicine, many of them were woefully unprepared to practice as a physician after graduation. Answers on medical examinations by medical school graduates to some basic questions often displayed an appalling lack of education:

Q: What are your views as to the efficacy of vaccination?

A: I don't believe in it.

Q: How many bones are there in the human body?

A: Very many indeed, the principal ones however are the bones of the head and pelvis. The former are thin the latter are thick. All other bones are long.

Q: When is the use of an anesthetic contraindicated?

A: In case of a painful operation when the patient is capable of taking such.

Q: The head of the child in superior strait – forceps frequently applied but slip off on traction, pain lessening, mother growing weaker – what is your duty?

A: Send for the man who is to mark these answer papers if he will but reveal his identity.<sup>13</sup>

Regular physicians were well aware that American medical education was not adequately preparing most graduates for a career in medicine.

As the regulars' dominance of medicine waned during the nineteenth century, numerous medical sects quickly developed. Several unorthodox or irregular medical sects arose in opposition to the so-called heroic medical practice of the regulars, which relied on bleeding, purging and vomiting.<sup>14</sup> In time, these dissenters became known as irregulars. During the last half of the nineteenth century two of the most prominent

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<sup>13</sup> William Arthur Purrington, *A Review of Recent Legal Decisions Affecting Physicians, Dentists, Druggists, and the Public Health* (New York, E. B. Treat & Co., 1899), 18-20.

<sup>14</sup> Martin Kaufman, *Homeopathy in America: The Rise and Fall of a Medical Heresy* (Baltimore and London, The Johns Hopkins Press, 1971), 23.

competitors to the regulars were the homeopaths and the eclectics. Homeopathy replaced the earlier herbalist sect known as Thomsonianism to become the most prominent unorthodox medical practice in America. Homeopathy was developed from the medical theories of Samuel Christian Hahnemann (1755-1843), a German physician and theorist. Hahnemann's medical system was based on the in the principle of *similia* and the law of infinitesimals.<sup>15</sup> The principle of *similia* held that physicians should treat patients with drugs that created the same symptoms in a healthy person that were being exhibited by an illness. The law of infinitesimals was based on Hahnemann's belief that the smaller and more agitated or shaken the dose of medicine; the more potent it became. While Hahnemann's therapeutic theories were not particularly sound, homeopathic patients benefited from their doctor's willingness to allow the body to combat illness. Homeopathic physicians prescribed medicines that lacked active ingredients because they drugs were extremely diluted. Additionally, homeopaths were averse to utilizing heroic medicine.

Eclectic physicians differed from both homeopaths and regulars. They were the indirect descendants of the Thomasonians, but they had a more liberal approach to medical practice. Unlike traditional Thomasonians, the eclectics encouraged medical education and they took a far more pragmatic approach to medical treatment. They utilized both botanicals from the Thomasonian tradition and some orthodox or traditional treatments.<sup>16</sup> Eclectics saw themselves as reformers and dissidents from traditional

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<sup>15</sup> Kaufman, *Homeopathy in America*, 23, 24.

<sup>16</sup> Kaufman, *Homeopathy in America*, fn. 114.



European medical tradition. Eclectics rejected the four humoral theory and sought to end “the vast amount of human suffering, the anguish of soul, the premature decay, and death, resulting from this *Paganism* [Galenism] in medicine.”<sup>17</sup> A number of eclectic physicians were disenchanted with heroic medicine and they incorporated aspects of various sectarian practices into their medical practices.

Like regulars, homeopaths and eclectics were just as interested in organizing and formally educating their adherents. Homeopathic and eclectic physicians created medical societies and began publishing medical journals throughout the country. The homeopaths and eclectics created medical schools that taught their medical systems and these schools competed for students with regular schools. Eclectic physicians formed the National Eclectic Medical Association in 1848, around the same time as the American Medical Association. Homeopaths also formed local, statewide, and national medical societies. While eclectics and homeopaths may have rejected the regular medical therapeutics they were strong believers in the accouterments (societies, journals and schools) of organized medicine.

While Numbers argued that the development of the irregular sects undermined the status of the regulars, it is just as likely that the ineffectiveness of traditional regular medicine and the unclear benefits of early medical science spurred the expansion of these new sects.<sup>18</sup> Had the regulars demonstrated that their therapies were successful, patients would not have sought treatment from the irregulars. Instead, regular medicine was

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<sup>17</sup> *Transaction of the National Eclectic Medical Association for the Years 1870 and 1871* (Geo. R. Yeates & Co., New York, 1872): 142.

<sup>18</sup> Numbers, *Sickness*, 226.

ineffective and physicians who employed heroic medicine were often unintentionally harming their patients. John B. Beck wrote a series of articles in 1847 and 1848 in the *New York Journal of Medicine* that argued that heroic treatments such as blistering, mercury and bloodletting were dangerous and potentially lethal, especially when employed by reckless physicians.<sup>19</sup> Homeopathy, eclecticism, and later osteopathy gained adherents because of the growing public skepticism of the efficacy of regular medicine. Regulars were most threatened by the homeopaths, because homeopathic physicians persuasively argued that their therapeutic methods were potentially more scientific than the regulars.

Concerned physicians from the Medical Society of the State of New York sought to create a national movement to raise the standards in American medical schools. These regulars called for a national convention of medical societies and schools to be held in 1846. At the 1846 convention, the delegates decided to create a national medical society, the American Medical Association (AMA). The delegates hoped the AMA would enable the medical profession to regain some of its former luster.<sup>20</sup> The newly formed AMA immediately identified three aspects of American medical practice that needed to be reformed. First, the AMA believed that most students who attended medical schools were inadequately prepared for the rigors of a medical education. Medical schools needed to demonstrate the “firmness to reject all importunity not sustained by real and

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<sup>19</sup> Cited by Rothstein, *American Physicians*, 180.

<sup>20</sup> Rothstein, *American Physicians*, 115.

appreciable qualification.”<sup>21</sup> At the time, medical schools rarely refused admission to any candidates regardless of their qualifications or abilities. Second, the AMA sought to ensure that each student received “competent and complete instruction.”<sup>22</sup> Finally, the AMA wanted to have a “severer test of qualification for admission into the profession.”<sup>23</sup>

While the efforts to reform medical education were largely ineffectual in the nineteenth century, the AMA successfully established itself as the national hub for local and state medical societies. In this role the AMA was a strong proponent of medical licensing and encouraged state and local societies to lobby their state legislatures as a way to limit their numerous competitors. The AMA believed that medical regulation would limit competition between the regulars and the irregulars, reduce the total number of practicing physicians, stop the growth of malpractice actions and improve the quality of medical care. Despite the efforts the AMA, the general public did not demand medical licensing. Public support for registration or licensing laws was tepid at best.

While the AMA was a strong advocate for licensing, its Code of Ethics and its general hostility towards irregular practitioners was generally counterproductive in its fight for medical licensing. In order for state societies to take part in these AMA conferences, the societies were required to adopt the AMA’s Code of Ethics. The Code barred regular physicians from consulting with any irregular practitioners and fostered an

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<sup>21</sup> *The Transactions of the American Medical Association, Vol. III* (Philadelphia, 1850): 147.

<sup>22</sup> *Transactions AMA* (1850): 146.

<sup>23</sup> *Transactions AMA* (1850): 146.

antagonistic environment between regular and irregular doctors. The Code further complicated efforts to pass medical licensing because regular physicians were often initially both unwilling to cooperate and openly hostile to the irregulars.

The AMA Code forced not only prevented regular physicians from consulting with irregulars, but encouraged local and state medical societies to purge regular physicians who utilized irregular treatments. If medical societies failed to purge their irregular colleagues they were not permitted to send delegates to the national AMA convention. In 1870, the Massachusetts was given an ultimatum by the AMA to expel questionable members or lose its privileges at the national convention. After a wrenching internal debate and the unpopular removal of several prominent physicians, the Massachusetts Medical Society ruined its reputation and created an enormous amount of public support for homeopathic physicians.<sup>24</sup> Instead of eliminating the influence of homeopaths in Massachusetts the “persecution [of the physicians] strengthened the will” of the martyred homeopaths and reinvigorated irregular practice.<sup>25</sup>

The willingness of regulars to battle irregulars during the mid-nineteenth century hampered the passage of any medical regulation. Legislators were often put off by the rancor between the parties and simply refused to license anyone. Some states, such as Texas, even banned laws which discriminated against different medical sects. The only states able to pass early medical registration or licensing statutes were those where physicians expressed a willingness to work across sectarian lines and compromise.

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<sup>24</sup> Kaufman, *Homeopathy in America*, 77-91.

<sup>25</sup> Kaufman, 91.

Consequently, medical licensing did not become widespread until the final two decades of the nineteenth century when state medical societies finally compromised with their irregular colleagues.

## CHAPTER III

### 1870 – 1890: THE REANIMATION OF MEDICAL LICENSING

During the 1870s, fifteen states passed either medical licensing or registration acts. Most medical registration acts simply required practicing physicians to be graduates of a medical school and to file a copy of their diploma with their county clerk.

Sometimes these registration statutes created medical boards to test non-graduates, but most of these laws had few enforcement powers. In contrast, medical licensing acts typically concentrated more power and authority with the state. These acts created state examining boards which not only licensed medical practitioners, but took responsibility for sanitary reforms and enforcing quarantines. In California and Illinois, the statutes created boards of health which maintained regulatory power over physicians and controlled sanitation laws. In other states, medical examining boards were created to govern the licensing and regulation of physicians. The latter would eventually bring about meaningful licensing standards.

These statutes typically divided doctors into two separate categories: new and old. Medical societies had advocated exempting older doctors from the rigorous licensing or registration standards in order to win their support in state legislatures. In Illinois, doctors who had practiced in the state for ten years were exempt under the statute and they had to neither be a graduate of medical school nor take an examination. These provisions often protected some of the worst physicians in the community, but were viewed by the laws proponents as a necessary compromise.

Though medical registration acts had been largely ineffective at either protecting the public or limiting the total number of practicing physicians, medical licensing acts proved to be far more successful. In Texas and Alabama, medical licensing acts required every new physician to pass a medical examination administered by the state boards. On the other hand, Illinois medical practice did not require each new applicant to pass an exam, but the Illinois State Board of Health made a concerted effort to evaluate both national and international schools of medicine to determine whether or not their applicants were qualified for automatic admission. During the 1870s, four other states (Kansas, Kentucky, Alabama, and California) created medical examinations. Over the next twenty years, most of the states would adopt one of these two models and a few even combined them.

Texas illustrates some the fits and starts typically involved in this nationwide process. Texas passed a medical registration act in 1873, but the provisions of that act were nullified after Article XVI, section 31 of the new Texas constitution mandated that “no preference shall ever be given by law to any school of medicine.”<sup>26</sup> This new constitutional provision forced the Texas State Medical Association (TSMA) to lobby for new legislation that steered “between [the] prohibitory provision...and the danger of too great laxity on the other.”<sup>27</sup> Despite a desire to limit the influence of irregulars, the TSMA realized the law would be enforceable only if it had “the unanimous and unbroken

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<sup>26</sup> *Texas Constitution 1873*, Article XVI, section 31.

<sup>27</sup> *Transactions of the Texas State Medical Association, Ninth Annual Session 1877*: 39.

support of the physicians themselves.”<sup>28</sup> In 1876, the Texas legislature passed a law which discarded the requirement that graduates have a medical degree and required each new applicant to pass a medical examination. While the TSMA argued before the legislature that the act would “establish a uniform, equable and unavoidable criterion by which to determine the qualifications” to practice medicine, the TSMA Chairman for the Committee on the State Board of Health argued that the new law would not break down the barrier between regular and irregulars. Instead, the TSMA hoped that the new law would create a stronger and more permanent “partition.”<sup>29</sup> The TSMA believed that only regular physicians would benefit from an act requiring a medical examination of all applicants.

Later attempts in Texas to draft new regulatory laws and create a state board of health faced common obstacles found in other states. Even after the TSMA assured legislators that they were not attempting to eliminate or marginalize other medical sects, the legislature balked. In 1885, the membership of the TSMA was clearly growing frustrated with their regulatory system, but even then, they were divided on how to convince the general public and the legislature of the necessity of passing new, more restrictive licensing laws.

While many physicians supported the goals of the TSMA and favored passing laws which excluded irregular practitioners, Joseph M. Toner, President of the AMA in

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<sup>28</sup> *Transactions of the Texas State Medical Association, Ninth Annual Session 1877*: 39-42.

<sup>29</sup> *Transactions of the Texas State Medical Association, Ninth Annual Session 1877*: 55.



1874, expressed skepticism that irregulars would be denied the right to practice medicine. He argued that regulars may have hoped to eliminate “irregular and incompetent practitioners from the profession by legislative enactment and penalties,” but “in our country” this result was unlikely.”<sup>30</sup> The AMA president knew that none of the medical systems had either sufficient support or influence to eliminate any of the other organized medical sects.

The Kansas legislature took a more conciliatory approach than the AMA. In 1879, the Kansas legislature and governor approved a medical licensing act (modeled after the California licensing act passed in 1876) which delegated state authority to license doctors to the Kansas Medical Society, the state eclectic medical society, and the homeopathic state medical society. Each society was entitled to appoint the members to each of their respective boards of examiners. The act permitted each sect to regulate its members, without intrusion by the Kansas state government. Additionally, any licensing fees would be paid directly to their respective societies. Some physicians were disappointed with the law because licensing applicants could petition all three of the examining boards. After one board declared an applicant incompetent, the applicant could simply reapply to another board.<sup>31</sup> The bill encouraged board shopping by potential applicants.

As soon as the board members attempted to exercise their authority, the attorney general challenged the constitutionality of the act and filed a suit in *quo warranto* against board members appointed by the Kansas Medical Society. The suit asked the court to

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<sup>30</sup> *Transactions AMA* (1874): 76.

<sup>31</sup> *Annual Report of Illinois State Board of Health* (1883): 71.

determine whether or not the board members had the authority to act under the 1879 statute. The attorney general believed that the licensing law violated the Kansas Constitution because it granted state powers to the Kansas Medical Society, a private corporate entity. The Court argued that Kansas was not entitled to delegate these powers to the Society and completely invalidated the law.<sup>32</sup> Kansas reverted back to its original registration law. It would take over twenty years for the medical community to pass a new licensing statute.

Like Kansas, the 1877 Illinois “act to regulate the practice of medicine” attempted to mend fences between regulars and irregulars. The President of the Illinois State Medical Society had argued for this approach at the society’s annual meeting shortly before the act was passed. While he demanded passage of a medical licensing law to protect the public from unqualified practitioners, he conceded that eclectic and homeopathic practitioners were, like regular physicians, “devoted to their patients and profession.”<sup>33</sup> He advocated détente between regulars and irregulars in Illinois and argued that the Medical Society should pass “wise and impartial legislation” which recognized only “well-educated men” but debarred incompetents, “whether regular or irregular.”<sup>34</sup> The Illinois statute, passed a year after the Texas law, reflected this more conciliatory approach. Instead of attempting to have state authorities weed out irregulars

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<sup>32</sup> *Kansas v. Stormont, et al.*, 24 Kan. 686, 695-699 (1885).

<sup>33</sup> *Transactions of the Twenty-Sixth Anniversary Meeting of the Illinois State Medical Society*, 1876 (Chicago, 1876): 196.

<sup>34</sup> *Transactions of the Twenty-Sixth Anniversary Meeting of the Illinois State Medical Society*, 1876 (Chicago, 1876): 196.

through a medical exam, the Illinois licensing act created the new Illinois Board of Health. The Illinois Board of Health was responsible for determining whether medical schools were in “good standing” and for testing applicants, who were not automatically admitted because their schools were found inadequate, and for creating and enforcing sanitary and quarantine policies. The Illinois Board also steered clear of any attempts to invalidate degrees only from irregular medical schools and instead tried to develop sectarian neutral criteria to evaluate the quality of medical schools. In addition to licensing irregulars, the Illinois law included a provision for licensing midwives. Midwives, like physicians, were licensed after presenting a diploma from a midwifery school in good standing, taking an examination in obstetrics, or demonstrating ten years of continuous practice in Illinois. The Illinois Board licensed large numbers of midwives.

The Illinois licensing law did not just create a system to regulate physicians; the law had much broader goals. The licensing law created the Illinois Board of Health which was charged with the responsibility of regulating physicians and midwives, creating and implementing sanitary regulations and enforcing public quarantines. By creating the Illinois State Board of Health, the legislature entrusted state medicine to a new governmental agency. A member of the Illinois Board of Health perhaps best described the necessity and dangers of implementing state medicine when he wrote that the Illinois Board was “charged with the protection of the health of the people from dangers which are beyond the control of public; its just functions are derived from necessity and the necessity constitutes their limit; in their exercise, every unnecessary

invasion of private right, every unnecessary interference with the perfect freedom of personal action, is a usurpation of power, an unjustifiable trespass upon the liberty of the citizen.”<sup>35</sup> The board member argued that state medicine had three separate, but equally important goals: creating well-educated medical corps by casting out “ignorance, pretension, incompetence, and all manner of quackery”, creating and enforcing sanitary regulations, and finally enforcing quarantines.<sup>36</sup> While the rationale for investing the state with sanitation and quarantine powers may have been “obvious and undisputed” to many people, regulating who could practice medicine was in many ways much more problematic.

Advocates for state medicine understood the public discomfort with overt governmental regulation of medicine. In this essay, the board member was clearly concerned by the potential for abuse and over-regulation by state medical agencies, but he argued that those problems were outweighed by the potential danger currently faced by patients. The regulatory systems designed by medical societies clearly demonstrated their discomfort with direct state action because they essentially lobbied state legislatures for self-regulation propped up by state powers. While the governor appointed board members, physicians controlled the medical boards and these boards lacked governmental oversight. The enforcement powers built into the medical licensing laws mimicked discipline systems employed by state medical societies. The state boards were essentially medical societies augmented by state police powers. If private medical

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<sup>35</sup> *Annual Report of the State Board Health of Illinois* (1881): 33-34.

<sup>36</sup> *Annual Report of the State Board Health of Illinois* (1881): 35.

societies could not effectively enforce discipline on their own, it was only natural that they would want to co-opt state police powers to reshape the medical landscape. Instead of relying on the vagaries of the free market to regulate medicine, quasi-public medical boards could reduce competition and protect patients.

New Jersey avoided the sectarian disputes entirely by passing a medical registration act. Unlike the Illinois medical licensing law, the New Jersey did not allow physicians to regulate themselves. Instead, county clerks registered anyone who presented a diploma from any medical college. Unfortunately, county clerks had little incentive or ability “to discriminate between fraudulent and legal diplomas, and cannot, or do not, take the trouble to tell a medical from a literary or a dental diploma...” A clerk even registered an individual who presented a document in Russian and claimed that it was medical school diploma. The clerk was not troubled that he could not read the diploma and simply registered the individual as a physician. If clerks would register diplomas in Russian, it is unlikely that they take the time to distinguish between eclectic, homeopathic or allopathic schools of medicine.<sup>37</sup> While several states passed medical registration acts similar to New Jersey, they were mostly ineffective. Ultimately, states that employed medical registration acts were virtually indistinguishable from completely unregulated states.

The ineffectiveness of medical registration acts pushed many states towards adopting one of the different medical licensing models. The Illinois practice act was the most influential licensing law of the 1870s and 1880s. It served as a model statute for

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<sup>37</sup> *Annual Report of the State Board of Medical Examiners of New Jersey*, (1891): 5-6.

numerous states because it created an acceptable compromise for both organized regulars and irregulars. Illinois also provided advocates of medical licensing a model for how to enforce medical licensing laws. The Illinois Board decision to revoke the licenses of doctors it believed behaved unprofessionally was appealing to organized physicians who were comfortable with medical societies that disciplined their members. The Illinois medical board adopted principles of professionalism from the organized regular and irregular medical societies. For years, state and local medical societies had expelled members who violated their code of ethics. The Illinois Board sought to enact a similar code and enforce the principles that had governed medical societies for years. A lot of the Illinois Board's enforcement actions focused on Chicago which was overrun by scam artists and unlicensable medical practitioners.

Instead of targeting any specific medical sect, the Illinois Board first focused on eliminating incompetents, regardless of their sectarian affiliation. Their efforts successfully reduced the total number physicians in the state and dramatically increased the percentage of physicians who had attended medical school. The Illinois law not only evaluated medical schools, but required an examination of both non-graduates and graduates of schools not in good standing. A large number of medical schools were encouraged to change their curriculum and adopt the minimum standards advocated by the Illinois Board. The medical practice act, the Illinois Board believed, allowed it to actively prosecute unlicensed physicians or licensed physicians who violated the Board's code of ethics.

Other states soon began cooperating and collaborating with the Illinois Board. In 1884, the Illinois Board helped Missouri organize its own medical board. Members of the two boards even attended each other's meetings. The similarities of the two states laws, allowed Missouri members to model the principles Illinois used to "establish precedents and formulat[e] principles upon which to base decisions in the many difficult and delicate questions which continually present themselves."<sup>38</sup>

The Illinois State Board of Health argued in its first annual report that the licensing law had already made the state safer for its citizens. The Board estimated that nearly 3,600 of the physicians practicing in the state were not graduates of a medical school before the law went into effect. The licensing act had forced almost 1,400 these physicians to either stop practicing or leave the state.<sup>39</sup> Additionally, it clearly sought to communicate to the state and its citizens that medical licensing was essential. In addition to driving out non-qualifying physicians, complaints about physicians began pouring into the Board's offices. Though the Illinois Board conceded that it did not have either the resources or the personnel to investigate each of grievances, the sheer volume of complaints indicated that the public was convinced the Board was the primary check on dangerous or unethical doctors. Physicians from around the state also filed numerous complaints against other physicians. The Board was deeply troubled, however, when it

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<sup>38</sup> *Annual Report of the State Board of Health of Illinois 1884* (1884): 70.

<sup>39</sup> *Annual Report of the State Board of Health of Illinois 1878* (1879): 5.

learned that physicians often took advantage of the new rules and discovered that many of these complaints against potential their competitors were “unreliable.”<sup>40</sup>

In an attempt to subvert the new licensing rules, bogus medical diplomas began to be sold soon after the licensing law went to effect. The Board reported that as many as “400 bogus diplomas” were submitted as evidence of a medical degree by applicants because “diploma – shops” hoped that the Board would recognize them because they were “issued by legally chartered institutions.”<sup>41</sup> These institutions were considered legally chartered because they were created under Illinois’s business law, but they did not possess any more gravitas than that. Unfortunately for the diploma mills, the Illinois licensing act gave the Board the power to accept only diplomas from medical schools which were in “good standing.” The legislature strengthened this power by allowing the Board to determine what “good standing” meant. During the first year of the act, the Board was not able to develop explicit criteria for what qualified as “good standing,” but it determined that institutions which “sold their diplomas” would not qualify.<sup>42</sup> The Board’s rejection of fraudulent diplomas was the first successful attempt to reform medical education by evaluating the merits of the medical education.

The Illinois Board did not stop at rejecting fraudulent diplomas. The Illinois board conducted quasi-judicial hearings. At times, it appears that prosecuting attorneys also prosecuted other illegal practitioners on their own volition. In 1879, the Illinois

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<sup>40</sup> *Annual Report State Board of Health of Illinois 1878* (1879): 16.

<sup>41</sup> *Annual Report State Board of Health of Illinois 1878* (1879): 16.

<sup>42</sup> *Annual Report State Board of Health of Illinois 1878* (1879): 16.



board resolved to investigate physicians who were accused of “practicing specialties under assumed names” and of “defrauding” their patients.<sup>43</sup> By 1880, the Illinois Board was conducting public investigations of unprofessional conduct by both licensed and unlicensed physicians. Despite its limited resources, the Illinois Board was committed to stamping out unprofessional conduct. In 1880, the Illinois Board reported that ninety-three suits had been filed under the 1877 medical practice act. While prosecutors dismissed most of the suits after the defendants promised to vacate the state, Illinois courts convicted nine individuals under the Illinois law.<sup>44</sup>

Glancing at these early proceedings reveals what type of conduct the Illinois Board sought to eliminate. In 1880, the Board conducted several hearings about the alleged misconduct of two licensed physicians, John Bate and Edward Osbourne. Bate and Osbourne were accused of practicing medicine under assumed names. Dr. Bate, a graduate of Chicago’s Bennett Medical College, had run a medical practice under the name “Dr. A. G. Olin” before he attended medical school. Dr. Olin’s medical practice was well known in the community because Bate had extensively advertised in the Chicago newspapers. Bate was admitted to Bennett Medical College (an eclectic medical school in good standing) only after he had agreed to relinquish his fictitious name and medical practice. After completing the program at Bennett and receiving his diploma, he immediately went back to work as Dr. Olin.<sup>45</sup> Edward Osbourne, Bate’s nephew and

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<sup>43</sup> *Annual Report State Board of Health of Illinois 1878* (1879): 53.

<sup>44</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 53.

<sup>45</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 4-5.

another graduate of Bennett College, was accused of being Bate's associate and Osbourne had also claimed to be "Dr. Olin." the Illinois board considered Dr. Bate's practice offensive and illegal because "Dr. Olin's Private Hospital" specialized in "chronic and sexual diseases of men and women," "sexual debility, impotency, nervousness, seminal emissions, loss of memory from self-abuse or other cause." Dr. Olin also provided marriage guides, "[r]eliable female pills[,] "rubber goods[,] and "special care...for ladies during confinement."<sup>46</sup> Bate's and Osbourne's ultimate sin was that they were accused by the Board of procuring abortions for their patients.

Bennett Medical College or a Dr. Henry Olin, a Bennett Medical College professor, initiated the actions against Bate and Osbourne by contacting the Illinois Board. Both Bennett College and Dr. Henry Olin believed that their good names were being tarnished by their association with the notorious "Dr. Olin." Dr. Henry Olin had offered \$500 to Dr. Bate and later \$250 to Dr. Osbourne to stop using the moniker "Dr. Olin." Both Drs. Bate and Osbourne had refused the offers and continued their practice.

Osbourne's and Bate's defense consisted of the contradictory claims that they had not practiced under assumed names, but they then argued that the marriage guides were not offensive, they had not sold rubber products for a year (their lawyer argued that the advertisements were erroneous), and that their alleged abortion or "female" pills were ineffective because they were actually made of "brown bread."<sup>47</sup> The Illinois Board was unimpressed by these claims and found that they were "guilty of gross professional

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<sup>46</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 5-7.

<sup>47</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 5-7.

misconduct” for practicing under assumed names and issuing grossly unprofessional circulars and advertisements.<sup>48</sup> The Board revoked their licenses and later denied the application for a license of the physician C. Pratt Sexton after learning that the notorious Dr. Olin employed him.<sup>49</sup> While C. Pratt Sexton did not appeal the Board’s decision, Illinois court’s would later question whether it had the authority to deny medical school graduates the ability to graduate if they attended a school in good standing.

Another physician, Generous L. Henderson, faced similar allegations. Henderson, like Bate and Osbourne, was a licensed physician, but he also practiced under the aliases “Dr. Stone” and “John Smith.” Dr. Henderson was accused of selling products “offered by the vilest class of specialists” and performing “an abortion for \$5.”<sup>50</sup> Dr. Henderson sought to insulate himself from his alleged abortion practice not only by performing the abortions under the name “Dr. Stone,” but also by adopting another moniker “John Smith.” As “Smith,” Dr. Henderson would solicit and then refer potential clients to the fictitious “Dr. Stone.” As “Dr. Stone,” Henderson would perform the abortion and collect the five dollar fee. The Illinois Board revoked and cancelled Henderson’s license for “dishonorable and unprofessional conduct.”<sup>51</sup>

In addition to licensed physicians practicing under assumed names, the Illinois Board was concerned about the potential damage caused untrained individuals who had

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<sup>48</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 7.

<sup>49</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 13.

<sup>50</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 7-8.

<sup>51</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 5-7.

stolen or bought valid medical school graduation certificates and practiced under those names. One of the more egregious stolen identity cases prosecuted by the Illinois Board involved a physician allegedly named Henry A. Luders. Luders was a graduate of the medical school at the University of Gottongen and he had submitted his certification of completion to the Board. Despite Luders' initial failure to submit any letters of recommendation from the faculty on his behalf, the Illinois Board issued him a license after some "reputable practitioners" finally vouched for him. After stories regarding the quality of his practice circulated throughout his town, concerned physicians contacted the University of Gottongen. The university informed the physician that Dr. Luders had practiced in the Duchy of Braunschweig until his death a few years earlier.<sup>52</sup> Luders' was not Luders, a man allegedly named Lambrecht had assumed his identity. Lambrecht, a barber, had fabricated the letters of recommendation and somehow come into possession of Luders' diploma. The Illinois Board revoked Luders' license, but not before Lambrecht accidentally had butchered and killed a woman and her child during a botched birth. After the local physicians learned of his deception, Lambrecht fled to Cincinnati before he could be prosecuted for violating the medical practice act.<sup>53</sup> In Cincinnati, Lambrecht enrolled in the Cincinnati College of Medicine and Surgery, but suddenly left after the Illinois Board published its initial report describing his practice. He then moved to Cleveland and enrolled in the Keokuk College of Physicians and Surgeons and received a diploma in 1884. After graduating from Keokuk College he moved to

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<sup>52</sup> *Annual Report State Board of Health of Illinois 1883* (1883): xli.

<sup>53</sup> *Annual Report State Board of Health of Illinois 1884* (1884): 11.

Bismarck, Dakota Territory where he was using the alias William Lambert. The Board cited Luders as the perfect illustration for “the necessity of the strict enforcement of matriculation requirements and of proof of previous study and college attendance.”<sup>54</sup>

The Board also sought to eliminate the influence of the itinerant or traveling doctors. Before the Illinois legislature passed the medical practice act, the Board stated that 78 itinerant doctors practiced throughout the state and fleeced its “sick, afflicted, and credulous” citizens of no less than \$225,000 a year.<sup>55</sup> Of these 78 practitioners, only 5 were eligible for a license ten years later. The remaining itinerants had successfully received licenses under the exemption for physicians who had practiced for at least ten years.<sup>56</sup> These itinerants made a living by combining show business and drug sales. They would hock nostrums and cure-alls as “Indian Remedies” often during performances. These doctors would often accompany or organize “Wild West” concert troupes in order to facilitate sales. Some of these companies employed as many 100 different people. These medical practitioners had more in common with a traveling church revival than a medical practice.

Still, the licensing act failed, however, to eliminate itinerants and their shows altogether. An alleged “Indian medicine man” named James I. Lighthall accompanied a travelling show comprised of “40 to 100 persons.” Lighthall used a number of colorful aliases to establish his *bone fides* including “Kansas Jim,” “Rastic Jack,” and “The Indian

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<sup>54</sup> *Annual Report State Board of Health of Illinois 1885* (1885): xlviiii-xlix.

<sup>55</sup> *Annual Report State Board of Health of Illinois 1887* (1890): xix.

<sup>56</sup> *Annual Report State Board of Health of Illinois 1887* (1890): xix-xx.

Medicine Men.”<sup>57</sup> Lighthall and his concert troupe appear several times in the Board’s annual reports. As an itinerant medical man he would return to the state and sell his wares and services. His wares and services included secret Indian “cure-all” remedies and teeth pulling. Instead of applying for a medical license, Lighthall circumvented the medical practice act in a number of ingenious ways. In 1883 and 1886, he hired licensed doctors “to shield himself from the law.”<sup>58</sup> In 1886, he even procured “an itinerant vendor” license from the county clerk in Peoria. A prominent local attorney convinced the clerk to give Lighthall a license even though the clerk lacked the statutory authority to do so. The Illinois Board quickly revoked the licenses of the two physicians who worked for Lighthall on the grounds of “unprofessional and dishonorable conduct.”<sup>59</sup> In 1883, local physicians complained to the Board about Lighthall, and he was arrested for violating the practice act. In 1883, Lighthall left Illinois to avoid prosecution, but the Illinois Board could not prevent his return in 1886. The Illinois Board simply did not have the capital or manpower to successfully prevent itinerants like Lighthall from conduct quick strikes into the state.

The Illinois Board also actively investigated a number of physicians who sent allegedly false and potentially obscene materials through the United States mail. The Illinois Board issued a resolution which classified advertising or circulating “marriage guides” which described or illustrated pictures of venereal disease or offered to prescribe

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<sup>57</sup> *Sixth Annual Report State Board of Health of Illinois 1883* (1883): 62-63.

<sup>58</sup> *Sixth Annual Report State Board of Health of Illinois 1883* (1883): 62-63.

<sup>59</sup> *Eight Annual Report State Board of Health of Illinois 1885* (1885): lix.

drugs designed to prevent conception or procure an abortion as “grossly unprofessional.”<sup>60</sup> At the same time, the Illinois Board settled on a fairly broad definition of “unprofessional misconduct”: taking part in fraudulent or deceptive transactions, practicing under false aliases, or distributing circulars or handbills which were false or deceptive to attract patients.<sup>61</sup> In one case, the *James Medical Institute* was accused sending circulars by mail to public school girls. These circulars advertised nervine pills (pills of roots and herbs designed to cure “leucorrhoea or whites, nervous headaches, nervous debility, night sweats, melancholy feelings and general weakness” caused by “latent sexual feeling”), marriage guides, gentlemen’s and ladies’ rubber goods, and female pills.<sup>62</sup> Smith Whittier, operating under the alias of Dr. James and the *James Medical Institute*, had successfully gotten the addresses of several public school girls and their female instructors.<sup>63</sup> Whittier was arrested for his actions because his circulars violated decency laws maintained by the United States Postal service. The Board was able to track down Whittier because he had legally chartered the *James Medical Institute* under Illinois corporate law. In an attempt to subvert the medical practice act, he and others had been legally chartering dispensaries which could be accomplished for under five dollars under the state’s corporation act in order to give their enterprises the sheen of credibility.

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<sup>60</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 10.

<sup>61</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 11.

<sup>62</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 21.

<sup>63</sup> *Annual Report State Board of Health of Illinois 1880* (1881): 21-23.

In 1880, Dr. Lucas R. Williams, like Whittier, formed the corporation “Dr. Lucas’ Private Dispensary” to treat “private, nervous and chronic diseases.”<sup>64</sup> He formed the dispensary with two other individuals, Axel W. Boye and Dr. George J. Williams.<sup>65</sup> Unlike Whittier, Dr. Williams formed this corporation after he had lost his license to practice medicine. Dr. Williams’ blatant attempts to practice medicine without a license would become a thorn in the side of the Board for the next six years. While the Board was clearly empowered by its initial success in investigating unprofessional practices, its dispute with Dr. Lucas would demonstrate some of the limits of the 1877 law. While the medical practice act had been found constitutional by various Illinois courts, Dr. Lucas would demonstrate the difficulty of enforcing its criminal provisions.

Dr. Lucas R. Williams received his certificate to practice medicine after he presented the Illinois Board with his diploma and letters of reference. Soon after receiving his certificate, the Illinois Board learned that Williams was practicing under an assumed name, Dr. Lucas. In addition to practicing under an assumed name, Dr. Lucas published a circular which the Illinois Board found to be evidence of unprofessional and dishonorable conduct. In the circular, Williams made a number of implausible claims. He stated that he had been in practice for over twenty years (despite being only 24 years old), had founded “the mammoth Bellevue Medical Institute in San Francisco,” and

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<sup>64</sup> *Annual Report State Board of Health of Illinois 1880* (1880): 26.

<sup>65</sup> George J. Williams unsuccessfully challenged a jury verdict convicting him practicing medicine without a license in *Williams v. People*, 20 Ill. App. 92 (1886).



guaranteed that he had permanently cured all of his patients during his lengthy career.<sup>66</sup> During his February 1880 hearing in front of the Illinois Board, Williams stated that he was only practicing under the name Dr. Lucas because it was cheaper to advertise under the shorter alias. Even though he had been asked to stop the advertisements before by the Board, he had not done so because he had an “unexpired contract with the newspapers.” Needless to say, the Illinois Board dismissed these excuses and quickly revoked his license.<sup>67</sup>

Approximately one month later, Dr. Williams reorganized his medical practice as “Dr. Lucas’s Private Dispensary” under Illinois corporation law, not the medical practice act. The Board was powerless to revoke the charter of the “Private Dispensary.” Williams began to practice medicine under the banner of his “Private Dispensary” and was arrested for violating the medical practice act. Williams was prosecuted under section 13 of the medical practice act which stated that “any person practicing medicine or surgery in this State without complying with the provisions of the act shall be punished...”<sup>68</sup> After his conviction, Williams appealed the verdict of the criminal trial.

In 1885, Justice McCalister of the Illinois Court of Appeals rendered a decision that construed the authority of the Board narrowly and eliminated its ability to revoke licenses and conduct investigations. The court found that the medical practice act gave the Board the authority to conduct two only types of activities: first, the Board could

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<sup>66</sup> *Annual Report State Board of Health of Illinois 1886* (1886): lxxv-lxxviii.

<sup>67</sup> *Annual Report State Board of Health of Illinois 1880* (1880): 7.

<sup>68</sup> *Annual Report State Board of Health of Illinois 1886* (1886): lxxxix.

conduct a simple verification of medical diplomas and the applicant's identity. Once the Board verified the diploma and the identity of the applicant, it had absolutely no discretion to take any other action, ever. After the Illinois Board issued a certificate "its power [was] exhausted and forever gone."<sup>69</sup> Second, the Illinois Board could administer medical examinations to applicants who lacked a medical diploma. According to the court, the Illinois Board was not authorized to conduct investigations, hold hearings or revoke certificates from graduates of medical schools. Additionally, the court found that the Board was authorized only to consider the character only of the applicants who took an examination, not those who were automatically approved after graduating from a medical school in good standing.<sup>70</sup> The court rejected the principle that the Board had any power to regulate graduates of medical schools after they received their certificates.

The court was particularly angered by the Illinois Board's actions against Williams. Under the 1877 law, people like Williams could not appeal any revocation of their certificate, but they would instead be required to resubmit their application to the same board that revoked it. Justice McCalister stated it was "highly improbable that the Legislature" ever intended to give the Illinois Board such "absolute power over the reputation and fortunes of ...graduates of medicine." If the legislature had invested such powers in the Illinois Board, they would have been "flatly against the teaching of the sages of the law and the best traditions of our revolutionary history; for it naturally leads

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<sup>69</sup> *Annual Report State Board of Health of Illinois 1886* (1886): lxxxix.

<sup>70</sup> *Annual Report State Board of Health of Illinois 1886* (1886): lxxxviii.

to and terminates in favoritism, abuse and oppression...<sup>71</sup>” The principle that the medical school graduate’s hard work and money could be invalidated was particularly offensive to the court. The court did not believe that it would ever be wise to give the Illinois Board quasi-judicial enforcement powers.

While the Board believed that the Court’s decision completely misconstrued the legislative intent of the statute, the legislature had to pass a new act because the Board lacked most of the authority originally granted to it by the 1877 statute. The court’s decision forced the Illinois legislature to pass a new medical licensing bill. Despite the court’s strenuous objections to the Board’s quasi-judicial authority, the new bill attempted to eliminate any potential technical objections that could be made regarding the Board’s authority. Additionally, the 1887 bill clearly enumerated the powers possessed by the Board and the basis of its authority. Second, the bill sought to eliminate any ambiguous language contained in the first medical practice act. Otherwise the only major difference between the two bills was that physicians could file an appeal with the governor if the Illinois Board revoked their license.

While the concerns expressed by the Illinois court in the *Williams* case appeared to be widespread, courts in other states seldom successfully challenged the quasi-judicial authority of medical boards to discipline physicians. For example, in Minnesota Dr. E. C. Feller had his license revoked by the Minnesota State Board of Medical Examiners. He had purchased advertisements in local newspapers claiming that he had the “ability to speedily cure all chronic, nervous, blood and diseases of both sexes, also all diseases of

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<sup>71</sup> *Annual Report State Board of Health of Illinois 1886* (1886): lxxxviii.

the eye and ear, without injurious drugs or hindrance from business, etc.”<sup>72</sup> Since Feller knew that these advertisements were false and misleadingly, the Minnesota board revoked his license. The Supreme Court of Minnesota did not question the Minnesota board’s authority and approved its decision in a fairly perfunctory manner.<sup>73</sup> The Court agreed that unknowingly advertising false cures to desperate patients was clearly despicable conduct and qualified as unprofessional and dishonorable conduct for a physician.

The Illinois Board achieved some of the goals sought by regular and irregular doctors after enforcing the medical practice act for ten. When the law went into effect, Illinois had approximately 7,400 physicians. These physicians were almost evenly split between graduates of medical schools (48.6%) and non-graduates (51.4%). By 1887, graduates comprised 89.2% of the 6,135 practicing physicians. Most of the physicians who were not medical school graduates were physicians originally exempted. Within three years of the law going into effect 1,923 unqualified physicians left the state. Additionally, diploma mills ceased to be a major problem. The Illinois Board identified thirty-one diploma mills and widely published their names throughout the country. Surprisingly, only 41 licenses were revoked by the Board for unprofessional or dishonorable conduct, despite receiving over 2,000 complaints. By 1887, the Illinois Board had restored six of these diplomas after the physicians met conditions imposed on them.

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<sup>72</sup> *Feller v. State Board of Medical Examiners* 26 N.W. 125 (1885).

<sup>73</sup> *Feller* at 125.

By 1887, a large majority of states (thirty-nine states and territories) had followed Illinois's lead and passed either medical registration or licensing. Seven states created statutes similar to Illinois's and allowed the state boards to determine whether or not medical schools were in "good standing." While only seven states evaluated medical schools that was enough to force most of the nation's medical colleges to comply with Illinois's minimum standards. Another five states at this time went beyond the Illinois requirements and forced all physicians, regardless of education, to pass their medical examination. The remaining twenty-five of states and territories had instituted only a medical registration law.<sup>74</sup>

During the last twelve years of the nineteenth century, the pace of medical licensing dramatically quickened. Other states passed or began strengthening their medical licensing acts. Attempts to enforce these more stringent standards created substantially more litigation. In almost every state, physicians who failed examinations or were refused medical licenses for some other basis sued their state medical boards. Newly formed boards faced questions regarding the constitutionality of the statutes and what tools boards could use to enforce these laws. Even Illinois continued to struggle with cases which potentially undermined the Illinois Board's authority regulate its members.

In 1888, in the case *People v. John C. McCoy*, the Illinois Board was faced with another potential challenge their authority. McCoy had been a licensed physician in

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<sup>74</sup> Hamowy, Ronald, "The Early Development of Medical Licensing Laws in the United States, 1875-1900," *The Journal of Libertarian Studies*, 1979: 113-114.

Illinois, but the Board revoked his certificate for unprofessional conduct after reading several advertisements he had purchased in St. Louis and Belleville Illinois newspapers. In these ads, he emphasized his extraordinary healing prowess. The Illinois Supreme Court did not believe that advertisements could be used as proof to convict an individual for practicing illegally and ruled that the “contents of these ‘advertisements’” were essentially “harmless.”<sup>75</sup> While the Court decided *McCoy* under the 1877 law, its decision made it more difficult for the Illinois Board to prosecute individuals for buying fraudulent advertisements. The *McCoy* decision threatened the newly minted 1887 medical practice act because the 1887 law explicitly stated that purchasing false or misleading advertisements was unprofessional and could be grounds for revocation. The decision *McCoy* required the Board to provide stronger evidence in order to support revocations.

While Illinois Board was attempting to expand and consolidate its authority, other states were taking their first steps towards enforcing their medical regulations. Oftentimes, even the barest medical regulations faced stiff challenges. In 1888 Michigan was operating under a medical registration law passed in 1883. Michigan would grant licenses to any practitioner who was a graduate of any “legally authorized medical college.” Therefore, only graduates of diploma mills could be excluded from the practice of medicine. William W. Phippin was not a graduate of a legally authorized medical school and not qualified to practice medicine in Michigan. Despite this minor hindrance, Phippin began advertising in the Grand Rapids that he was physician. While Phippin was

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<sup>75</sup> *People v. McCoy*, 125 Ill. 289, 296 (1888).

not a medical school graduate, he claimed that he had practiced medicine in Canada for over nine years and one year in Michigan. His experience in Canada did not protect him from being prosecuted in Michigan for violating its medical practice act. The Michigan Court convicted him for “unlawfully advertising and holding himself out to practice medicine.”<sup>76</sup>

Phippin could not successfully challenge the facts in the case so instead choose to test the constitutionality of Michigan’s law. Like most attempts to challenge the constitutionality of the statutes, it was rejected. Most courts, even the most skeptical, held that states had a right to regulate medicine under a state’s police power. What makes the Phippin case intriguing is not the holding or facts of the case, but the dissent by Justices Campbell and Morse. Despite the growing numbers of cases supporting the constitutionality of these statutes, two justices still questioned the underlying wisdom of state medicine. Courts still viewed medical regulation as unnecessary and unconstitutional restrictions of individual freedom because they prevented patients from consulting with the physician of their choice and barred some individuals from practicing medicine.

The dissenting justices argued that this was the first instance where “citizens ...have been prevented from employing such medical aids and advisors as they have seen fit.” They were concerned that licensing would eliminate dissenting views in medicine. Instead of an active dialogue, those with “new or peculiar views” would be completely shut out. Apprenticeship should not have been rejected in favor of formal collegiate

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<sup>76</sup> *People v. Phippin*, 37 N.W. 888, 889 (1888).

medical education because there was only one medical school in the state and medical education was uneven throughout the country. The justices described the quality of medical schools outside of Michigan as “notoriously imperfect, and some [were] fraudulent. There can be no possible equality under such a system.” The justices were also concerned that potential physicians who did not agree with the two medical systems taught at the Michigan medical school would be prevented from receiving a medical education. Licensing would create an “aristocracy in a free government.” People with talent and experience would be prevented from practicing medicine, while “a mere quack or ignoramus, without learning or experience, with a bogus certificate, or a *bona fide* graduate” could become a physician. Examinations, they argued, would have been a much fairer method to evaluate applicants for licenses and would not exclude physicians who did not attend medical school. By 1888, most states had provisions which still permitted non-graduates to take the medical examination and practice medicine.<sup>77</sup>

In other states medical boards were beginning to institute programs to eliminate diploma mills which Illinois had successfully eliminated. These diploma mills often formed as states adopted medical registration act similar to Michigan. The case of Alfred Booth provide an excellent of how these schools operated and explain why state boards were hard pressed to prevent their formation. While state boards could not prevent these organizations, newly formed medical boards proved to be effective at prosecuting these organizations. In 1893, Alfred Booth created a diploma mill in New York in his hotel room. After moving to the city, he began selling M.D.s for \$50 and Ph.D.s for an

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<sup>77</sup> *Phippin* at 898-904.



additional \$25 from the Excelsior Medical College of Massachusetts. Unlike before, Booth and other con artists risked prosecution by the increasingly vigilant medical boards and societies. Booth was ultimately convicted of selling fraudulent diplomas and he was sentenced to six months in jail.<sup>78</sup>

The Illinois Board attempted to vigorously enforce the state's medical practice. The Illinois Board clashed with the courts, but it retained most of its enforcement powers. Additionally, the Illinois Board attacked physicians which were objectionable to organized physicians, regardless of their medical system. The Illinois Board's enforcement actions laid an effective groundwork to expand its assault on different types of physicians in the 1890s. Instead, of focusing the most objectionable physicians, the Illinois Board and others would began to focus their enforcement efforts on unorganized or less organized medical sects.

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<sup>78</sup> Purrington, 23-24.

## CHAPTER IV

## 1890-1897: EXPANSION OF MEDICAL LICENSING LAWS

In 1889, Oregon physicians finally ended a twenty-five year battle to pass a medical licensing statute. In 1887, dentists had convinced the legislature they should be licensed while the OSMA's proposed medical practice act was again voted down by the Legislature. After repeated failures to pass an act, the OSMA bribed state legislators from their "corruption fund." The OSMA essentially hired a legislator and paid him \$200 to introduce and promote a medical practice bill in Salem. The OSMA's bribery paid off and a medical practice act was overwhelming passed by the legislature. The Oregon Medical Practice Act may have been an imperfect reproduction of the Illinois statute, but it was a vast improvement over the previous situation. Critics complained that one of the chief failings of the Oregon licensing act was that the Oregon Board lacked the power to revoke certificates for dishonorable conduct and lacked a code of ethics. This omission was a result of the compromise that the OSMA was forced to accept to satisfy legislators who were generally critical of medical licensing. Additionally, the OSMA hoped to convince older Oregon physicians that they were hoping only to reduce the number of incoming physicians and not to attack older, less-qualified practitioners. The OSMA preferred a bill similar to Illinois' because it would be amendable to all sectarian constituencies and permit rigorous regulation.

After the new medical licensing laws went into effect, the Oregon Board of Medical Examiners was faced with the daunting task of enforcing these statutes in a state that had become a magnet for medical castoffs. Elements within the OSMA had

questioned for years whether any type of medical regulation could be effective in preventing unlicensed practitioners from preying on the public. Despite these misgivings, the medical community was united behind enforcing these laws because after the influx of new physicians over the previous decade.

A drafting mistake in the 1889 law prevented the Oregon Board from developing any criteria for determining whether a medical school was in good standing. The Board felt compelled to accept diplomas from medical schools it believed were completely unacceptable. In 1891, the drafting error in the first statute was corrected and the Oregon Board developed standards for medical schools and began purging its ranks of individuals who had presented fraudulent diplomas. By 1891, the State Board reported that several physicians had presented either bogus or suspect degrees when attempting to become licensed.<sup>79</sup> Presenting false credentials was a crime under the medical regulatory scheme and the Board pursued several violators including a prominent member of the OSMA.<sup>80</sup>

While Oregon was one of the last states to enact a law, it signaled the death knell of simple registration statutes and demonstrated the appeal of more muscular licensing statutes. Only one state passed a medical registration law after Oregon's law was passed. Additionally, during the 1890s, states rewrote their medical licensing by passing new licensing acts which significantly strengthened and augmented the power of state medical

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<sup>79</sup> Dickson, James, M. D., "Report of the State Medical Board," *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society*, (1891): 181-182.

<sup>80</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society*: 182.

boards. By 1903, all but one state required that every applicant take a licensing exam. Fifteen states still allowed non-medical graduates to practice without a medical degree, but all of these states required them to pass a medical examination. During the 1890s, vigorous medical licensing came to be seen as essential to eliminate the dangers presented by quacks and charlatans. Strong licensing statutes in places like Illinois had pushed large numbers of non-licensable practitioners into states such as Oregon. The primary reason Oregon adopted the Illinois model was to drive out recent physician refugees from other states.

In 1891, the Oregon Medical Board asked the OSMA to create a committee consisting of OSMA members from each county in Oregon to investigate claims of illegal medical practice. The State Board wanted any accusations regarding physicians practicing without a license to be reported to the OSMA's committee. The Board hoped that the committee would investigate each of these claims. Only after the committee's investigation would the Oregon Board began its involvement,<sup>81</sup> thus eliminating the Oregon Board's fears about serving as both judge and juror in cases where illegal practice had been alleged.<sup>82</sup> After the 1891 law took effect, the Oregon Medical Board, like the Board in Illinois, decided to force graduates from medical schools not in good standing to take an examination if they did not believe that the medical schools' curriculum was sufficiently rigorous. The first individual to challenge the Oregon medical board's

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<sup>81</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society:* 181-182.

<sup>82</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society:* 181.

authority was William Barmore, a graduate of the University of Cincinnati Medical School.

The Oregon Board required medical schools require students to attend three six-month lecture terms over three a three year period to remain a medical school in good standing.<sup>83</sup> The Medical Board determined that even though Barmore had a diploma from a nationally respected medical school, it found at the time of his graduation, the University of Cincinnati's curriculum was inadequate because it only required a two term course of less than six months each.<sup>84</sup> In lieu of devising new criteria, the Oregon Medical Board simply adopted the standards developed by Illinois and required medical schools to teach graduates for at least three six-month terms over a three year period. After the Medical Board refused to accept him based on his diploma, Barmore offered to take the examination "under protest."<sup>85</sup> The Medical Board refused his request to take the examination under protest and asked him to waive any objections. Barmore agreed and took the exam.<sup>86</sup> Barmore performed dismally on the exam and failed after answering only fifteen percent of the questions correctly.<sup>87</sup> At the time, the Oregon

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<sup>83</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society*: 179.

<sup>84</sup> *Barmore v. State Board Medical Examiners*, 21 Ore. 301, 301-04 (1891).

<sup>85</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society*: 179.

<sup>86</sup> *Proceedings of the Eighteenth Annual Meeting of the Oregon State Medical Society*: 179.

<sup>87</sup> *Barmore*, 301-304.

Medical Board required that applicants successfully answer seventy-five percent of the questions correctly.

Before the Oregon Supreme Court, Barmore's lawyers argued the 1891 law was never intended to restrict regular physicians, such as William Barmore, from receiving a license. Instead, the aim of the 1889 and 1891 laws was "to prevent a class of charlatans from practicing upon the credulity of people to the profit or the former and the serious detriment of the latter."<sup>88</sup> Barmore found it highly irregular that the Oregon Board of Medical Examiners could transform Barmore's alma mater from a school in good standing to an unacceptable one almost overnight.<sup>89</sup> Barmore questioned whether "this Board of wiseacres" had the authority by "simple fiat" to change "the standing of the leading medical institutions of the country."<sup>90</sup> The board's decision that Barmore lacked the necessary qualifications and learning to become a physician was upheld by the Oregon Supreme Court.<sup>91</sup> The Court found that the act was designed to "protect the inhabitants of the state from imposition by presumptuous pretenders."<sup>92</sup>

In 1892, R. H. Randolph, an unlicensed Oregon physician, challenged the constitutionality of the licensure act. Randolph claimed that the act violated the Oregon

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<sup>88</sup> *Barmore v. Dickson*, Brief of the Plaintiff in the Circuit Court of the State of Oregon for Multnomah County, 4.

<sup>89</sup> *Barmore*, Brief of the Plaintiff, 8-9.

<sup>90</sup> *Barmore v. Dickson, et al.*, Brief of Plaintiff and Respondent, In the Supreme Court of the State of Oregon, (1891), 8.

<sup>91</sup> *Barmore*, 301-04.

<sup>92</sup> *Barmore*, 308.

State Constitution because it had grandfathered in physicians and surgeons who practiced in Oregon before the act was passed.<sup>93</sup> Randolph argued that the act discriminated against out of state physicians who had moved their practice to Oregon. The Supreme Court again upheld the licensing act because the state had the power to enact laws to protect the general public from “ignorant pretenders and charlatans.”<sup>94</sup> Nearly every state’s special provisions for physicians who had practiced in a state for a certain length of time were upheld because those physicians were seen as having experience which offset the degree requirement.<sup>95</sup>

By the early 1890s, state courts repeatedly found state medical licensing statutes to be constitutional. Specific provisions were still questioned by the courts, but generally they had accepted that state’s right to regulate medicine. Still, these issues were heavily litigated throughout the country because these laws differed state to state. Oftentimes, rejected applicant attacked the constitutionality because they believed that the laws were an invasion of natural rights, interfered with vested rights, and discriminated against persons engaged in the same business or professions.<sup>96</sup> While these regulatory schemes were universally upheld, they occasionally “contained some specifically objectionable

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<sup>93</sup> *State of Oregon v. Randolph*, 23 Ore. 74-79 (1892).

<sup>94</sup> *Randolph*. at 84.

<sup>95</sup> Taylor, Arthur N., *The Law in its Relations to Physicians* (New York, D. Appleton and Co., 1900), 19.

<sup>96</sup> Taylor, 18.

feature.”<sup>97</sup> These objectionable features included carving out specific privileges for a select group of physicians, such as graduates of a particular school or limiting fees for certain physicians.<sup>98</sup> On the whole, Courts found that licensing statutes were simply part of the state’s police power, which extended to the protection of “the lives, limbs, health, comfort, and convenience as the property of all persons within the state.”<sup>99</sup>

While state courts generally upheld the constitutionality of these statutes, rejected applicants repeatedly attacked other provisions of the licensing statutes. In *Craig v. Board of Medical Examiners of the State of Montana*, a physician who had practiced for fourteen years in Maine moved to Montana. In 1891, the doctor, a medical graduate from a school in good standing, applied for a medical license in Montana and was granted a temporary license. The Montana board determined that his diploma was genuine and verified his identity. In order for his license to become permanent he was required to present himself to the medical board within three months and pass an examination. Montana required all applicants, graduates and non-graduates, to pass medical licensing exam. Craig “refused to submit to such examination, or to any examination whatsoever.” The Montana Supreme Court ruled against Craig and stated that state had the power to regulate physicians to protect its citizens “against the consequences of ignorance and incapacity as well as of deception and fraud.” The state had an absolute

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<sup>97</sup> Taylor, 18.

<sup>98</sup> Taylor, 21.

<sup>99</sup> Taylor, 18.



right to require an examination and determine what qualifications were necessary to practice medicine.<sup>100</sup>

In 1895, Oregon changed its medical licensing law by requiring all applicants to pass a licensing exam and empowered the Oregon Medical Board to revoke the license of a physician for unprofessional or dishonorable conduct.<sup>101</sup> Dr. Fred D. Miller, a graduate of the Hahnemann Medical College, of Chicago, moved to Portland, Oregon in 1883 to practice medicine. After the passage of the 1889 law, Miller claimed that he had “presented to the Board of Medical Examiners, a certificate of registration from the County Clerk of Multnomah County.” He claimed that the Board of Medical Examiners had retained the certificate and failed to return it to him. In 1891, when Miller was required to present proof of his certificate he failed to provide it because he claimed that the Board was still in possession of it.<sup>102</sup>

In 1895, the Board of Medical Examiners required him to present his certificate again. Miller was not able to present a certificate and he was required to submit to an examination in front of the Board. Miller refused to comply and challenged the Board’s authority to require him to take an examination. Had Miller provided proof that he had been issued a license in 1889, the case would have been moot because Miller would have

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<sup>100</sup> *Craig v. Board of Medical Examiners of the State of Montana*, 29 P. 532, 533-534 (1892).

<sup>101</sup> *Oregon Laws*, 1895, p.61 65, sec. 6.

<sup>102</sup> *Miller v. Board of Medical Examiners for the State of Oregon*, Appellant’s Abstract of Record, 6-7.

been granted a license. The Supreme Court of Oregon refused to interfere with the authority of the legislature to require physicians to take medical examinations.

The 1895 statute specified the grounds for unprofessional or dishonorable conduct: taking part in a criminal abortion, employing “cappers” and “steerers,” obtaining a fee and claiming the ability to cure an incurable disease or condition, betraying a professional secret, using untruthful or improbable statements in advertisements, conviction of any offense involving moral turpitude and habitual intemperance, and advertising medicines claiming to regulate the monthly periods of women. These or similar criteria were being increasingly adopted by state medical boards throughout the country. Before 1890, only nine states had adopted codes of ethics, but during the 1890s, twenty-four more states developed codes to regulate the conduct of physicians.

These codes governed what grounds could be used by the board to either deny a license or revoke one after issuance. Typically, “the exercise of the same wide discretion cannot be extended to a case where, when one has been regularly admitted, the revocation of his license is sought under another independent provision of the statute.”<sup>103</sup> Similarly to Oregon’s, these codes typically barred unprofessional or dishonorable conduct, procuring abortions, gross immorality, false statements and promises, false advertising,

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<sup>103</sup> Hugh Emmett Culbertson, *Medical Men and the Law: A Modern Treatise on the Legal Rights, Duties and Liabilities of Physicians and Surgeons*, (Philadelphia and New York, 1913), p. 47. Culbertson was citing *Czarra v. Board of Medical Supervisors of District of Columbia*, 25 App. D.C. 443.

distributing indecent and obscene material, and the fraudulent use of a diploma.<sup>104</sup>

Several of these criteria were similar to those adopted by the Illinois Board in the 1880s.

In 1893, Dr. Edwin Kellogg of Helena, Montana ran afoul of the state's ethics code when he had his license revoked for unprofessional and dishonorable conduct. Dr. Kellogg was summoned to a woman who he claimed had suffered a miscarriage. Dr. Kellogg attempted to deliver the child, but during the procedure he was only able to deliver the headless body. The mother asked him to dispose of the body. In an attempt to conceal the birth, Dr. Kellogg went to the Masonic Temple and placed the child in its furnace. Dr. Kellogg indicated that he had used the furnace in the past to dispose of body parts removed during amputations.<sup>105</sup>

It is not clear from the case, but at some point the baby's body was discovered and a coroner's inquest was initiated. Clearly the inquest was started to determine if Dr. Kellogg had provided a late term abortion to his patient. During the inquest, Dr. Kellogg initially claimed that he believed that the baby was three months and one week old. During the inquest it became clear that the baby was closer to seven months old. Dr. Kellogg refused to disclose the name of his patient without her approval. After learning that his patient had left Montana, he decided to remain silent and he informed the coroner that he did not want to incriminate himself. The coroner, the court and the Montana Board of Medical Examiners agreed that Dr. Kellogg did not provide an abortion. Therefore, the court had two questions to consider: First, was concealing the miscarriage

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<sup>104</sup> Culbertson, p. 47 – 51.

<sup>105</sup> *State v. Kellogg* 14 Mont. 426, 426-433 (1894).

of a seven month old fetus unprofessional or dishonorable? Second, was Dr. Kellogg's failure to disclose the mother's name unprofessional or dishonorable?

The Court did not believe that it was either immoral or dishonorable to quietly dispose of the fetus after the miscarriage. The Court also agreed with Dr. Kellogg and stated that publicity of the miscarriage "might bring needless suffering, mortification and distress..."<sup>106</sup> In regards to the second question, despite Dr. Kellogg's statement that he did not want to incriminate himself, the Court argued that "a wholly innocent man could have acted just as Kellogg did."<sup>107</sup> Had the Montana board alleged that Dr. Kellogg had attempted to conceal evidence of a criminal abortion his actions would have been unprofessional and dishonorable. But the Montana board failed to allege any criminal conduct by Dr. Kellogg and his own assessment of his situation could have been a reference to any concerns he may have had regarding the miscarriage.

While the Montana board failed to allege that Kellogg had committed an abortion, Kellogg's fear that he could incriminate himself and lose his license for providing an abortion was well-founded. The Oregon Medical Board attempted to enforce its ethics code and revoke the license of an Astoria physician, Otis Burnett Estes, for providing an abortion. Estes was a regular physician and a graduate of College of Physicians and Surgeons at St. Joseph, Missouri. Estes had been described in the community as "Daddy" Estes because he had delivered over 2,500 babies around Astoria, Oregon.<sup>108</sup>

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<sup>106</sup> *State v. Kellogg* 14 Mont. 426, 434-435 (1894).

<sup>107</sup> *Kellogg*, 440.

<sup>108</sup> Larsell, *The Doctor in Oregon*, 285.

Estes's medical license was revoked by the Medical Board after being convicted in the Oregon criminal court of performing an illegal abortion. After his conviction, three members of his own community commenced a revocation proceeding before the Board.<sup>109</sup> Estes challenged the Board's decision to revoke his license and the trial court reversed the revocation.<sup>110</sup> While Estes had been convicted of performing an illegal abortion, his patient recanted her testimony during the license revocation hearing and claimed that she was confused and sick with a fever during the criminal trial.<sup>111</sup> His patient's inability to speak English also hampered the efforts of the prosecutor to cross-examine her. The prosecution failed to provide any other admissible evidence to support the charges and the Board failed to file an appeal of the circuit court's decision in a timely fashion.<sup>112</sup> The Board was forced to reinstate Estes as practicing physician and surgeon.

The Oregon Medical Board's ability to enforce its regulations was imperfect and medical boards throughout the country faced similar problems. Many medical boards were often hampered by a lack of funds because they were often self-supporting. Additionally, like Illinois, the penalties against physicians who engaged in illegal practice were fairly minimal. Convicted physicians were often only fined and did not have to

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<sup>109</sup> *State v. Estes*, 1897 Ore. LEXIS1. Citing LEXIS because it is not clear if this portion of the decision is cited in the other reproductions of this decision.

<sup>110</sup> *Estes*, 14-15.

<sup>111</sup> *Estes*, 20-21.

<sup>112</sup> *Estes*, 24.

serve jail sentences. The Oregon State Medical Board reported to the President of the Washington State Medical Association that while Oregon had a good law by 1895, juries were unwilling to convict illegal practitioners.<sup>113</sup> Both juries and judges were clearly skeptical of the broad powers granted to medical boards. The *Medical Sentinel* of Oregon reported that a Chinese doctor was tried three times before he was convicted. Ultimately, the Chinese physician reportedly paid the \$50 fine because it was cheaper than challenging the conviction.<sup>114</sup> In another instance, an allegedly illegal Salem physician was acquitted after a trial.

Physicians also subverted medical practice acts by refusing payment from patients for medical services. These physicians would then accept payment from patients for drugs or other supplies. In Oregon, an unlicensed physician in Baker City would not charge for services or drugs, but he would simply solicit his patients for a gratuity.<sup>115</sup> Such strategies were often successful in states where physicians could be prosecuted only if they had accepted money for their services. These statutes failed to punish physicians who were paid for selling goods or drugs to patients.

The failure to adequately define the practice of medicine would lead to problems in several states. New medical sects continued to develop during the last half of the nineteenth century and a number of these sects' treatment methods were unorthodox. Ultimately, the courts, not the medical community, were required to determine what

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<sup>113</sup> Thomson, R. L., *Medical Sentinel*, (Vol. 5, No. 7, July 1897), p. 318.

<sup>114</sup> "The Medical Law," *Medical Sentinel*, (Vol. 3, No. 11, Nov. 1897): 456.

<sup>115</sup> "The Medical Law," *Medical Sentinel*, (Vol. 3, No. 3, March): 112.

constituted “the practice of medicine.” Clairvoyants, electric physicians, Christian Scientist physicians and osteopaths challenged traditional notions of medical practice and complicated efforts to regulate physicians.

A Wisconsin clairvoyant physician or spiritualist was sued for malpractice after he had unsuccessfully treated the hip injury of a fifteen-year-old patient. The clairvoyant was an unlicensed physician but he held himself out as “competent to treat diseases of the human system” and he had treated patients in the past. In this specific case, the clairvoyant failed to conduct an examination of his patient and misdiagnosed his hip pain as rheumatism. Walking was prescribed by the clairvoyant as treatment for his patient. Instead of getting better, the hip condition deteriorated. Despite the noticeable worsening of the patient’s hip, the physician continued to prescribe walking as treatment and informed the patient that he was not in fact getting worse, but better. The patient finally was not able to walk and lost the use of his leg. Over time the patient regained some movement, but he “will be a cripple for life.”<sup>116</sup>

The clairvoyant physician countered that he should not be sued for malpractice as a physician, because he was not one. Therefore, any potential damages against him should have been limited to an action for breach of contract. The clairvoyant claimed that he had not violated any of the principles of clairvoyant medicine during his treatment of his patient, because they did not practice in accordance within any existing rules for treating or diagnosing disease. Instead “his mode of diagnosis and treatment consisted of

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<sup>116</sup> *Nelson v. Harrington* 72 Wis. 591, 592-593 (1888).

voluntarily going into a sort of trance condition..”<sup>117</sup> Needless to say, the clairvoyant’s legal position was designed to limit his monetary liability because the patient would have been entitled to far less money for a breach of contract than in tort.

The court disagreed with the clairvoyant and determined that simply because a person resorted “to a peculiar nature of determining the nature of the disease and the remedy” it did not exonerate any unskillfulness on his part. The court held that clairvoyant physicians were still physicians and their actions would be evaluated against a more rigorous standard of care. Instead of being compared only to physicians within their own medical sect, clairvoyants would be evaluated against “the ordinary skill and knowledge of physicians in good standing, practicing in that vicinity.” The verdict against the clairvoyant physician did not disturb the original verdict and the damages were upheld.<sup>118</sup> Even though the clairvoyant case was a malpractice action and not a criminal prosecution, its definition would have been applicable to any licensing case.

In Missouri, an unregistered electric physician, attempted “to recover upon an account for services for electric treatments.”<sup>119</sup> Under the Missouri medical registration and revised licensing act, physicians who failed to become licensed under the act could not collect any fees for services rendered. In order to collect his fees, the electric physician argued that the services rendered “were not necessarily those of a physician or

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<sup>117</sup> *Nelson*, 598.

<sup>118</sup> *Nelson*, 603-606.

<sup>119</sup> *Davidson v. Bohlman*, 37 Mo. App. 576, 577 (1889).



surgeon.”<sup>120</sup> The Missouri Court of Appeals stated that this was a fairly easy case. Before becoming an electric physician, he had originally been allopath or regular doctor and currently possessed a diploma from an electric medical school. He had also testified that he had practiced as a physician for over thirty years. Additionally, the bill he gave to his patients stated that the fee was for an “electric treatment.” The court did not bother inquiring as to the nature or type of treatment rendered. The only relevant fact to the court was that he held “himself out as a professor of the art of healing diseases.”<sup>121</sup> Therefore, he was an illegally practicing physician under the statute and ineligible to collect any fees for his practice.

While in the *Nelson* and *Bohlman* cases the physicians appeared, at least superficially, to practice medicine, Christian Scientists were not doctors in the traditional sense. Christian Scientists believed “that the work of healing through Christian Science is accompanied by religious instruction or spiritual teaching which is calculated to destroy the foundation of disease.”<sup>122</sup> Following Mary Baker Eddy’s teaching in *Science and Health with Key to the Scriptures*, they argued that Jesus “demonstrated the power of Christian Science to heal mortal minds and bodies.”<sup>123</sup> Eddy believed that she had rediscovered Christ’s healing powers after carefully analyzing the Bible. Essentially, she

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<sup>120</sup> *Bohlman*, 578.

<sup>121</sup> *Bohlman*, 579.

<sup>122</sup> Smith, Clifford Peabody, *Christian Science, Its Legal Status: A Defense of Human Rights* (Boston, 1914), 8.

<sup>123</sup> Eddy, Mary Baker, *Science and Health: With Key to the Scriptures* (Boston, 1916), 110.

believed that the “mind governs the body, not partially but wholly.”<sup>124</sup> Christian Scientists believed it was a sin to take drugs to alleviate suffering or cure a disease.<sup>125</sup> Because the mind governs the body, medicines were not seen as necessary to heal the sick.

Unsurprisingly, physicians who were Christian Scientists and lay Christian Science practitioners quickly ran afoul of the medical licensing laws. Christian Scientists argued that their system of healing was as valid as any other, and any attempts to limit its practice was a violation of the First Amendment right to freedom of religion. Clifford Smith, a judge and Christian Science advocate, argued that medical regulations discriminated against other healing practices “create[d] a monopoly, and in effect establish[ed] a state system of healing”<sup>126</sup> which unfairly discriminated against Christian Scientists.

In Nebraska, a Christian Scientist, Ezra M. Buswell was charged with the violating the Nebraska medical practice act. Buswell had been acquitted by the district court after it ruled that he was not engaged in the practice of medicine. The Court of Appeals came to the opposite conclusion and found that Buswell was a physician. Buswell had studied with Mary Baker Eddy at the Metaphysical College in Boston. Buswell was convinced that Christian Science was valid system because he had been

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<sup>124</sup> Eddy, 110.

<sup>125</sup> *Nebraska v. Ezra M. Buswell* 58 N.W. 728, 730 (1894).

<sup>126</sup> Smith, Clifford Peabody, *Christian Science, Its Legal Status: A Defense of Human Rights* (Boston, 1914), p. 12.

cured of his ailments after his conversion. Buswell stated that he had never administered any medicine to his patients. Instead, his treatment was centered on reading the scriptures and prayer. “When persons request aid and come to us for and assistance we treat them as a mother treats her child that is frightened of objects it fears...we seek to dispel the fear by showing them the presence of love...Perfect love casts out fear.” Buswell admitted to treating as many as a hundred patients in the previous eighteen months in this way.

One of the key questions for the court was whether Buswell was paid for his treatments. Buswell stated that he did not demand payment. Instead, when he finished treating a patient he would “leave the question to them and God.”<sup>127</sup> Still, Buswell expected to be remunerated for his services. He informed his patients that, “[i]f they are not willing to part with the sacrifice themselves, it is not expected that those should reap the benefit.”<sup>128</sup> The expectation of a fee or a gratuity prevented Buswell’s actions from being classed as either “an act of worship” or “the performance of a religious duty.”<sup>129</sup> The Court found that Buswell believed that he was a physician. The Court was convinced that Buswell “was engaged in treating physical ailments of others for compensation.”<sup>130</sup> The *Buswell* case was subsequently cited in over twenty different cases in eleven separate states even though the holding was fairly narrow.

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<sup>127</sup> *Buswell*, 731.

<sup>128</sup> *Buswell*, 731.

<sup>129</sup> *Buswell*, 732.

<sup>130</sup> *Buswell*, 732.

In Rhode Island, a Christian Scientist was indicted for practicing medicine after he received money “to cure malaria, grippe and whatever other diseases persons who came to him ‘imagined they had.’” Unlike the court in *Buswell*, the court in Rhode Island determined that engaging in silent prayer did not constitute the practice of medicine. He had not used any instruments, conducted an examination or diagnosed any illness. Unlike *Buswell*, the Christian Scientist in this case did not see himself as a physician. The court also held that if Christian Science was a medical sect then it would be entitled to the recognition by the State Board of medicine.<sup>131</sup>

In addition to Christian Scientists, medical boards were faced with the development of a new sect of physicians, osteopaths. Starting in the 1890s, medical boards prosecuted osteopaths for violating medical practice acts. Courts, medical boards and legislatures did not agree on how to regulate osteopaths. Courts could not even consistently agree on whether or not osteopaths were physicians. Eugene Holt Eastman was a practicing osteopath in Illinois. He was a graduate of the newly formed American School of Osteopathy in Kirksville, Missouri.<sup>132</sup> As a practicing osteopath, Eastman’s treatment “consisted wholly of rubbing and manipulating the affected parts with his hands and fingers, and flexing and moving the limbs of the patient in various ways.”<sup>133</sup> Eastman argued to the Illinois Board that he was not a practicing physician because he

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<sup>131</sup> *State v. Mylod*, 40 Atl. 753.

<sup>132</sup> *Eastman v. Ohio* 6 Ohio Dec. 296, 297 (1897).

<sup>133</sup> *Eastman v. People* 71 Ill. App. 236, 238 (1896).

did not prescribe medicine or use any instruments to treat his patients.<sup>134</sup> The Illinois Board ignored his arguments and determined that his was a physician because Eastman believed that his treatments could cure a “long list of diseases” relying only on the “manipulation, flexing, rubbing, extension” of his client’s limbs. Both the Illinois Board and the Court of Appeal simply defined medicine as “the art of understanding diseases and curing or relieving them when possible.”<sup>135</sup> Under this definition Eastman was believed to practicing medicine and his conviction was upheld.

Eastman left Illinois and moved to Akron, Ohio late in 1896. In Akron, he continued his practice, but within one month he was charged with practicing medicine without a license. The Court of Common Pleas in Ohio did not believe that Eastman was a physician. The court refused to find that osteopaths, clairvoyants, mind healers, faith curers, massage therapists and Christian Scientists were physicians under the Ohio statute. If the legislature sought to ban or regulate these practices, it would need to explicitly state, as Iowa had done, that these individuals were physicians.<sup>136</sup>

While most of the early cases prosecuted by state medical board were primarily focused on purging and prosecuting the most marginal members of the medical community, medical boards by the 1890s now had the tools to expand their list of targets. Medical boards and the courts no longer had to attack only quacks, charlatans and abortionists. Stronger laws and positive judicial precedents permitted medical boards to

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<sup>134</sup> *Eastman*, 238.

<sup>135</sup> *Eastman*, 239.

<sup>136</sup> *Eastman v. Ohio*, 299-301.

prosecute physicians or individuals who would have been viewed far more sympathetically by the general public.

The Illinois State Board of Health had licensed midwives since 1877 alongside physicians. By 1895, the Illinois Board had licensed over one thousand midwives in the state. Like physicians, midwives were able to become licensed in three ways: by examination, by graduating from a school of midwifery in good standing, or by demonstrating that they had practiced for ten years in the state when the law was enacted. Between 1877 and 1895, there were very few instances where the Board actively investigated midwives for illegally practicing medicine. Most of the Board's investigations during this period focused on illegal or dishonorable conduct by licensed or unlicensed physician. By the 1890s, however, the Illinois Board had the time, money and inclination to turn their attention to midwives.

The *People v. Fredericka Arendt* was the earliest appellate decision in the state rendered against midwife. Arendt and a relative were prosecuted for illegally practicing medicine and midwifery. Her relative had been convicted and fined a \$100, but Fredericka Arendt was found not to have violated the statute. Arendt ran into trouble when she attempted to collect money for her services. Neither the Board nor the court provided much information regarding her case and it is not clear why the trial court found in her favor. Either the jury or the judge must simply have ignored the law because it was unquestioned that she was a practicing unlicensed midwife. Arendt's attorney's only argument was that midwifery was not the practice of medicine. The Board appealed the

decision and the Appellate Court reversed and remanded the case back to the trial court.<sup>137</sup>

States did not take a unified approach to the licensing or registration of midwives. Some states, such as Alabama exempted midwives from licensing laws, while others required midwives to acquire a license under the state's medical practice act, such Illinois. Whether intentionally or not, (in some cases it was clearly intentional), midwives were gradually marginalized by the medical licensing laws. Midwives were not represented on the medical boards and had little influence over their decisions. When medical boards were organized, midwives were not included in any leadership positions, because they had failed to effectively lobby legislatures on behalf of their profession. The medical boards were typically comprised solely of regular and irregular physicians and there would have been very little incentive for physicians to strengthen the position of one of their low cost competitors.

Medical licensing created a split in the midwifery community. While traditional midwives were been apprentice trained, most of the new midwives were graduates of midwifery schools. Medical boards were biased in favor of midwife graduates and often did not require them to submit to an obstetrics examination. Schooled midwives began to replace traditional midwives, but unlike physicians and nurses became "increasingly subservient to physicians, their autonomy decreased, and, ultimately, they ceased

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<sup>137</sup> *State v. Fredericka Arendt*, 60 Ill. App. 89, 89-91 (1894).

functioning in the United States.”<sup>138</sup> The erosion of the influence and use of midwives accelerated in the 1890s. By 1900 only half of all births were delivered by midwives.<sup>139</sup>

The Illinois Board also received a complaint from the Commissioner of Health of the city of Chicago regarding “the abuses of the powers and privileges granted midwives by the State certificate.” Midwives were accused of “prescribe[ing] for the serious illness of the lying-in, to apply instruments, to perform grave operations and to assume the conduct of other than cases of natural labor.” The alleged abuses by midwives led the Board to issue new rules governing the scope of midwives’ responsibilities. A midwife’s practice was to be limited to “cases of natural labor only, and no other” and that any act of prescribing drugs or medicine or using a medical instrument would constitute a violation of the medical practice act.<sup>140</sup> The city of Chicago developed rules governing the conduct of midwives and even specified when midwives were required to consult with a physician. The Chicago rules regarding midwife conduct were extremely specific and detailed and they were introduced to reduce the independence of midwives.

As medical boards were empowered by their expanding powers, they continued to try to reform American medical education. In its early years, the Illinois Board focused simply on the number of terms of lectures taught at medical schools. It had not

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<sup>138</sup> Charlotte G. Borst, “The Training and Practice of Midwives: A Wisconsin Study” in *Sickness & Health in America*, ed. Judith Walzer Leavitt and Ronald L. Numbers, 3<sup>rd</sup> ed., (Madison, The University of Wisconsin Press, 1997), 237.

<sup>139</sup> Judith Walzer Leavitt, *Brought to Bed: Child-Rearing in America, 1750-1950*, (1986), 12.

<sup>140</sup> *Nineteenth Annual Report of the Illinois State Board of Health* (1896): xxxv.



developed any additional methods to police medical schools. In 1882, the Illinois Board requested that medical colleges require a minimum of three or more courses of lectures over a three-year period. In 1882, twenty-two medical schools had complied with the Illinois Board's request, but by 1890, sixty-four schools required the three courses. Over the same eight-year period, the average duration of the terms went from approximately twenty-three weeks to twenty-five weeks. The Illinois Board had also required medical schools to create admission standards. In 1882, only forty-five schools had any meaningful admission standards, but eight years later 124 schools had admissions standards.<sup>141</sup>

As approval by the Illinois Board became more important for medical schools, the schools began to submit voluntarily substantial amounts of information to the Board. Schools began to send more and more detailed descriptions of their faculty, courses, admissions policies, laboratories, and clinical facilities. The Illinois Board's publications on medical education became increasingly important and "attracted attention in newspapers as well as in medical journals."<sup>142</sup> This allowed the Illinois board to require to schools lengthen students' studies and teach specific subjects.

During the 1890s, the Illinois Board of Health continued to pressure medical schools to comply with their more stringent demands. In 1896, the Iowa, Missouri and Illinois medical boards held a meeting in Des Moines, Iowa to discuss which standards

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<sup>141</sup> *Report of Medical Education, Medical Colleges, and the Regulation of the Practice of Medicine in the United States and Canada 1765-1890, Illinois State Board of Health (1890): iv.*

<sup>142</sup> Shryock at 54.

the three boards should approve. Collective action by the boards would put more pressure on schools to comply. At the summit the boards addressed admissions requirements for medical students. These boards wanted medical schools to require a certificate of “good moral standing,” “diplomas from literary or college or high school” and test students on these subjects: English, grammar, arithmetic, elementary physics, United States history, geography, and Latin.” While the boards struggled with developing criteria for medical school applicants, there was a general agreement that medical school admissions needed to be more rigorous.<sup>143</sup>

By 1896, the Illinois Medical Board began requiring increasingly specific information from medical schools to determine their standing. The Illinois board had representatives conducting site inspection of schools like the Dunham Medical College in Chicago. The inspector described the building, its lease, and facilities. The inspector noted the condition and number of laboratories. The Board refused to find that it was a school in good standing because it lacked sufficient clinical facilities.<sup>144</sup> The Illinois Boards’ efforts to regulate medical education were no longer limited to requiring certain number of terms, but ensuring that students would receive a comprehensive medical education during those terms. Illinois’ board appears to have had sufficient resources to both manage medical licensing and enforce sanitary regulations. The efforts and reports

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<sup>143</sup> *Nineteenth Annual Report of the Illinois State Board of Health* (1896): xxviii-xxx.

<sup>144</sup> *Nineteenth Annual Report of the Illinois State Board of Health* (1896): xxxiii.

of the Illinois Board “may have exerted more influence” than the reform efforts of any one college.<sup>145</sup>

While the efforts of the Illinois Board were significant, they did not fundamentally improve medical education. The worst medical schools were still awful, but the Illinois Board created a mechanism and system that could change medical schools. A number of the schools were still more concerned with making money than developing well-prepared students. Even in Illinois predominately commercial schools, like Harvey Medical College thrived. William Rothstein argued that Harvey Medical College was perhaps “the most extraordinary example” of unrestrained commercialism because it ran “a day college, an evening college, a hospital, a free dispensary, a training school for nurses, a dime drug store, and an ‘out practice’.”<sup>146</sup>

During the 1890s, medical boards across the country confidentially began to attack illegal practitioners, frauds and unorganized medical sects. This trend would continue during the early twentieth century. While medical boards did not have the power to eliminate fraudulent physicians completely, they began to prosecute them frequently. Even though they could not guarantee convictions, marginal practitioners could no longer practice freely. If a physician provided abortions to their patients, they could lose their medical licenses. Additionally, as more states created medical boards, medical boards became empowered to make increasingly specific demands of medical schools and they pushed schools to meet their demands. Medical schools were going to

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<sup>145</sup> Shryock, 54.

<sup>146</sup> Rothstein, 291-292.

have to cater to the demands of these boards to ensure the future employment of their graduates.

## CHAPTER V

## 1897 – 1915: CONSOLIDATION

After twelve years of laboring under a medical registration law, Indiana passed a medical licensing act in 1897. Before 1897, county clerks issued to certificates to practice medical to applicants. Applicants went to their county clerk, presented them a copy of their medical diploma, and submitted the required affidavits. Dr. William P. Whery, of the Indiana State Medical Society, argued that county clerks did not try “to prevent fraudulent claims.”<sup>147</sup> Not only did the state not make an effort to restrict the practice of medicine to qualified practitioners, it did not have any way to supervise medical study or practice in the state. While Illinois, Indiana’s next-door neighbor, had mandated changes in the medical education and prosecuted illegal practitioners, Indiana registered anyone who presented a diploma and affidavit.

All of this changed when the Indiana legislature created a licensing statute very similar to the 1887 Illinois medical practice act. Indiana was one of the last states to adopt a vigorous medical licensing statute. Applicants could receive a certificate if they had a diploma from medical school in good standing or they could submit to a medical examination. Like previous licensing laws, practitioners who served in the state for more than ten years would be waived in after they presented their original registration license and two affidavits attesting to that fact. Midwives had exactly the same privileges as physicians and they too could apply for a license. They were required to pass the

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<sup>147</sup> *Transactions of the Indiana State Medical Society 1896, Forty-Seventh Annual Session* (1896): 111.

obstetrics portion of the medical examination administered by the Indiana Board. Again, midwives lacked representation on the Indiana Board.

Just as in Illinois twenty years earlier, passage of Indiana medical licensing act caused a panic among the state's marginal medical practitioners. Physicians who possessed questionable legal credentials attempted to comply with the new requirements by obtaining new medical diplomas. Some physicians obtained diplomas "from alleged schools of medicine so utterly disreputable as to require but little if anything more than a commercial consideration for graduation."<sup>148</sup> Due to the large volume of applicants and the dubious nature of numerous diplomas, the newly formed State Board of Medical Registration and Examination lacked sufficient funds and time to meet all of its responsibilities and fell behind processing the applicants.<sup>149</sup> Like other state medical boards, the Indiana Board did receive any money from the state. It was supported financially solely from applicant fees. The Indiana Board did not have a sufficient amount when it was required to start processing applications for licenses.

The Indiana Board sped up its verification process of early applications and approved for physicians whose qualifications were later questioned. Dr. John A. Burroughs initially slipped through the approval process, but the Indiana Board later reevaluated his eligibility. Burroughs began practicing medicine in Indiana in 1896. Burroughs claimed that he was a graduate of both the American Eclectic Medical College of Cincinnati and the American Medical College of Indianapolis. Burroughs had received a license under

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<sup>148</sup> *Sixteenth Annual Report of the State Board of Health of Indiana* (1897): 409.

<sup>149</sup> *Sixteenth Annual Report of the State Board of Health of Indiana* (1897): 410.

the previous law in 1896 and he applied under the new licensing act in 1897. The Indiana Board issued Burroughs a new license March 1897 based on provision in the 1897 medical practice act which permitted current license holders the right to new licenses. This issuance appears to have been perfunctory, because by October 1897, the Indiana Board sought to revoke his license. The Indiana Board alleged that he had misrepresented “the character of the colleges” which the original license was based, circulated false and obscene literature, and provided false guarantees of cures.<sup>150</sup>

Burroughs took the Indiana Board to court, but he was unable to successfully challenge the validity of the Indiana Board’s power or the constitutionality of the statute. While the court was concerned that the licensing law was perhaps unwise, because “such laws repress independent investigation, and so retard the progress of medical knowledge,” it found that was a question better left to the purview of the legislature.<sup>151</sup> Additionally, the Indiana legislature had clearly learned from previous licensing laws’ mistakes because the new act gave physicians had a right to appeal any revocation to the Indiana courts. Courts had previously struck down medical boards’ enforcement abilities because they failed to provide for an appropriate appellate process. While courts were still skeptical of the utility of licensing laws, acts that had an appellate procedure withstood court scrutiny.

Like Burroughs, Eliza Coffin also challenged a decision by the Indiana Board for refusing to grant her a license to practice medicine. Coffin practiced in Indiana before

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<sup>150</sup> *State, ex. Rel. Burroughs v. Webster, et al.*, 150 Ind. 607, 609-610 (1898).

<sup>151</sup> *Burroughs*, 614-615.

the 1897 law took effect and she was not a graduate of a medical school. The Indiana Board denied her a license because she was “guilty of gross immorality.” After the Indiana Board denied Coffin a license, a proxy of the prosecuting attorney for Starke County came to an agreement with Coffin and decided to terminate the prosecution the Indiana Board’s appeal. Under the agreement, Coffin was awarded a license and the board’s objections to her licensing were ignored. The new prosecuting attorney for Starke County challenged the agreement made by his proxy and argued that the prosecuting attorney could not simply dismiss the Indiana Board’s complaint and license Coffin. The Indiana Supreme Court agreed and contended that prosecuting attorneys in Indiana had the duty to the advocate the position of the board until the appeal’s conclusion. In the *Coffin* case, the medical board’s case was being handled by an attorney who was filling in for the prosecuting attorney. This case highlighted a problem faced by medical boards throughout the country. They typically only had direct control over the administrative hearings that they held. Once the physician appealed the Indiana Board’s decision to the local trial court, medical boards relied on either prosecuting or contract attorney to advocate for their positions. Medical boards were essentially required to outsource their prosecution efforts. In the *Coffin* case, the failure of their attorney to prosecute Coffin undermined the ability of the Indiana Board to enforce medical licensing. If the next prosecuting attorney had not reexamined this case, the Indiana Board would have licensed Coffin.<sup>152</sup>

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<sup>152</sup> *In Re Application Eliza E. Coffin*, 152 Ind. 439, 439-442 (19).



By 1901, the Indiana Board contracted a private legal firm, Gavin & Davis (Gavin), to represent the Indiana Board and to prosecute individuals under the medical practice act. Gavin appears to have been working in concert with prosecuting attorneys around the state. In some cases Gavin served as the prosecuting attorney, but in others the county prosecuting attorney was in charge. Regardless of who handled the prosecution, Gavin began to issue yearly reports to the Indiana Board in 1901. While Gavin identified the defendants, it often failed to provide details of its cases. In its first report to the Indiana Board, Gavin stated it had prosecuted twenty-seven separate physicians. Gavin's report showed that eleven of the cases prosecuted by it were ultimately successful; it had either secured a conviction or affirmed the decision of a trial to revoke a medical license. Each of the convictions resulted only in twenty-five dollar fines. Five of the cases were concluded when the defendants either fled or left the state. On four occasions, juries acquitted defendant physicians. The Indiana Board or circuit courts dismissed another three cases and five cases were still pending.<sup>153</sup>

In 1902, Gavin failed to provide a complete breakdown of all of the cases prosecuted, but discussed a number of key cases decided during the year. In *State v. Parks*, George Parks, a magnetic healer, was convicted of practicing without a license. Parks appealed his conviction, but the Court sided with the Indiana Board. It upheld the medical practice act and found that magnetic healing was not a separate school of medicine. Parks argued that the provision of the 1901 law granting osteopaths a limited

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<sup>153</sup> *The Fourth Annual Report of the Indiana State Board of Medical Registration and Examination 1901* (1902): 99-101.

right to practice medicine was discriminatory, because it did not provided for other sects, such magnetic healers. The court disagreed and determined the legislature was well within its authority to provide limited practice right to osteopaths. Therefore, it was unnecessary for the Indiana Board to license specifically magnetic practitioners. If magnetic healers wanted to practice medicine they would need to be a graduate of a medical school in good standing and pass the examination administered to physicians.<sup>154</sup>

The *Parks* decision had an immediate impact in Indiana because another magnetic healer in Montgomery County left the state two days after the decision was rendered. This magnetic healer had been indicted for numerous violations of the medical practice act and tried once for violating the act. In his first trial, the jury became deadlocked and failed to decide the case. Under the *Parks* case, any ambiguity regarding the status of magnetic healing would have disappeared. Therefore, a conviction, while not assured, became much more likely. Instead of fighting the case, the healer fled for greener pastures.<sup>155</sup>

Fairly quickly the Indiana Board was able to define the practice of medicine in the Indiana courts on its own terms and determine what constituted unprofessional conduct. In 1904, Gavin reported that they had successfully convicted a Christian Scientist and traveling specialist. Additionally, the Indiana courts held that the Indiana

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<sup>154</sup> *The Fifth Annual Report of the Indiana State Board of Medical Registration and Examination 1902* (1903): 89-90.

<sup>155</sup> *The Fifth Annual Report of the Indiana State Board of Medical Registration and Examination 1902* (1903): 91.

Board “had the right to investigate the character of the diplomas held by osteopath.”<sup>156</sup> The Indiana Board did not face any early setbacks and as did the medical boards in the 1880s and 1890s.

In 1904, Gavin reported that it had initiated approximately 20 prosecutions. Of those prosecutions, a third resulted in convictions, a third in acquittals or dismissals and the other third were still pending.<sup>157</sup> While Gavin was prosecuting 20 cases a year, the Indiana Board did not have the resources to investigate questionable practitioners throughout the state of Indiana. Therefore, the Seventh Annual Report of the Indiana Board asked people to conduct investigations on their own and report any evidence of a criminal practice to the Board. In order to facilitate this, the Annual Report included a checklist and affidavits for potential informants to use to substantiate their claims. The checklist included the following suggestions:

- “1. Ascertain from County Clerk or Secretary of the Medical Board whether accused has license to practice medicine.
  2. Get statements, signed and in writing if possible showing-
    - a. Who made first arrangement with the accused.
    - b. The name of the patient and the character of the disease treated.
    - c. What examination and diagnosis was made.
    - d. What treatment was prescribed or given.
    - e. How long the treatment continued.
    - f. What was the result.
    - g. What was the compensation paid and by whom paid.
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<sup>156</sup> *The Sixth Annual Report of the Indiana State Board of Medical Registration and Examination 1903 (1904): 54.*

<sup>157</sup> *The Sixth Annual Report of the Indiana State Board of Medical Registration and Examination 1903 (1904): 54.*

- j. A copy of any advertisement.
- ...
- m. Examine records for birth or death returns.”<sup>158</sup>

Whether or not this checklist was distributed only through the Indiana Board’s annual reports is unknown, but it clearly was encouraging physicians to investigate and report any suspicious activities by other physicians.

The Indiana Board’s efforts to enlist informants bore fruit in 1905 when it revoked Dr. John Milton Rhodes’ license for offering to perform an abortion. Rhodes had graduated from the Marion-Sims College of Medicine of St. Louis in 1899. He received his license from the Indiana Board that year and began practicing medicine in Indianapolis. Rhodes claimed that the witness against him, Eva Boykin, was hired by the Indiana Board to entrap him. Rhodes believed that Boykin was going to falsely testify that she had approached him for an abortion and he had offered to abort her pregnancy for “\$10, \$15, or \$25 according to the character of the operation.” Rhodes alleged that the Indiana Board had hired Boykin to solicit abortions from various physicians. He also alleged that the Indiana Board had used Boykin and an unnamed man because it “desired to make some examples in order to stop abortions.”<sup>159</sup> Rhodes was concerned that the Indiana Board would not make Boykin or her statement available to him at the revocation hearing. When Rhodes learned that he had been summoned to appear before the Indiana Board, he short-circuited the process by filing a permanent injunction and temporary

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<sup>158</sup> *The Seventh Annual Report of the Indiana State Board of Medical Registration and Examination 1904* (1905): 21-22.

<sup>159</sup> *Spurgeon, et al. v. Rhodes*, 167 Ind. 1, 2-7 (1906).

restraining order against the Indiana Board in order to prevent it from revoking his license. A circuit court judge granted Rhodes's injunction and temporary restraining order and the Indiana Board appealed his decision.<sup>160</sup>

The five members of the Indiana Board stated on appeal that it had not hired Boykin and did not plan to make an example of him. Instead, the Indiana Board stated that not only would Rhodes be permitted to question Boykin, but he could also produce his own witnesses to refute her testimony. The Indiana Board claimed that it would evaluate the evidence fairly and impartially determine whether the preponderance of the evidence supported revocation.<sup>161</sup> The only fact that the Indiana Board and Rhodes agreed on was that Boykin was no longer in Indiana and she could not be compelled to testify at his hearing.

The Supreme Court of Indiana found that Rhodes could not prevent the Indiana Board's hearing from going forward. If Rhodes wanted to challenge the allegations, he could do so at their hearing. Additionally, the medical practice act permitted Rhodes to appeal any decision made by the Indiana Board to the court system. It reversed the decision of the trial court and annulled the temporary injunction. Despite the Supreme Court decision, the Indiana Board did not revoke Rhodes' medical license. As late as 1911, Rhodes was still a legally practicing physician in Indianapolis.

Indiana essentially went through the same process as other states that adopted the medical licensing statutes. This process was much smoother than the transitions in earlier

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<sup>160</sup> *Spurgeon*, 5-7.

<sup>161</sup> *Spurgeon*, 5-8.

states. The Indiana courts did not challenge the authority of the Indiana Board to regulate physicians and midwives because they were persuaded by earlier decisions in other states supporting licensing. The Indiana Board was able to quickly move from simply eliminating incompetent physicians and expand enforcement efforts to unorganized medical practitioners.

Like Indiana, the State Board of Medical Registration and Examination of Ohio also reported its prosecutions in its annual report. Unlike Indiana, the Ohio Board had intensified its assault on the illegal practice of midwifery. In 1904, the Indiana Board did not prosecute any midwives under the medical practice act. In Ohio, four of the twenty prosecutions in the state were for the illegal practice of midwifery. The remaining sixteen actions were for either the illegal practice of medicine or were revocation hearings for illegally selling narcotics. Still, the number of prosecutions of midwives in Ohio appears fairly high. By 1904, there were 11,499 licensed physicians and only 342 licensed midwives. The small number of licensed midwives suggests that there may have been a large number of unlicensed midwives illegally practicing, but Ohio appeared to take a special interest in midwifery. By 1914, the percentage of prosecutions of midwives increased dramatically. In 1914, thirty of the fifty-six prosecutions by the Ohio Board were for the illegal practice of midwifery.

Ohio was not the only state beginning to focus on the illegal practice of midwifery. The Massachusetts medical board was considered to exceptionally hostile to

midwives.<sup>162</sup> In 1905, the Massachusetts Board prosecuted Hanna Porn, a Massachusetts midwife, with illegally practicing midwifery. Porn did not deny the charge and was convicted. The Massachusetts practice act, unlike numerous other states, failed to license midwives separately. The Massachusetts Board successfully convinced the Supreme Judicial Court of Massachusetts that midwifery was essentially obstetrics. Porn attempted to convince the Court that the Legislature could not discriminate against midwives while preserving the rights of “clairvoyants or persons practicing hypnotism, magnetic healing, mind cure, massage, Christian Science cosmopathic healing.”<sup>163</sup> Unsurprisingly, the Court determined, as had other courts in numerous states, that legislatures had the right to discriminate between different medical sects. After this conviction, the Massachusetts Board and local prosecutors tried Porn an additional nine times for the illegal practice of medicine before she died in 1913. Despite the repeated prosecutions by the Massachusetts Board, Porn refused to stop delivering babies.<sup>164</sup>

While efforts to marginalize midwives were gaining strength, osteopaths continued to carve out niches in medical licensing laws throughout the country. Just as Indiana created a special and limited medical license for osteopaths, other states incorporated them into medical licensing boards. Minnesota established a separate osteopathic board and Illinois began licensing osteopaths. The New York examining

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<sup>162</sup> Stacey Tovino, American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth, 11 *Cardozo Women's L. J.* 61 2004-2005: 82-83.

<sup>163</sup> Tovino: 84.

<sup>164</sup> Tovino: 85.

board also included a number of osteopaths. Instead of claiming that they were not practicing medicine, osteopaths decided to seek recognition. By organizing themselves and lobbying state legislatures, osteopaths received recognition for their sect and avoided elimination.

While osteopaths lobbied separate licensing laws, opticians were accused of practicing medicine by various state medical boards. The Illinois board sought to regulate any health care practitioners who were connected to medicine. The Illinois Board did not care if these connections were weak. In *Smith v. People*, the Illinois Board sought to classify opticians as physicians. The Illinois Board prosecuted an optician who advertised that he could help reduce headaches and dizziness by properly fitting individuals for glasses. In the advertisement, the optician explicitly stated that he did not provide medical treatment and he did not make any false pronouncements. Despite the evidence, the Illinois Board believed that he needed a physician's license and was testing the limits of its authority. The court refused to expand the definition of the "practice of medicine" to include opticians and dismissed the action.<sup>165</sup>

Only six states and territories (Michigan, Idaho, Oklahoma, Vermont, Kansas and Alaska) created examining boards after Indiana. By 1903, Alaska (1913) was the only state or territory that had not created a state medical examining board. Additionally, by 1901, a large majority of the states required new applicants to be graduates of approved medical schools. Fourteen states did not require applicants to be graduates of medical school and another seventeen states did not exclude graduates from underperforming

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<sup>165</sup> *Smith v. People*, 92 Ill. App. 22 (19).



medical schools.<sup>166</sup> Medical licensing laws were even becoming standardized enough that several states began developing reciprocity agreements with each other. As standards became more consistent across state lines, physicians again were given the opportunity to move freely from state to state without having to take an examination for each move.

As medical boards successfully consolidated the medical profession, they strengthened the requirements for medical schools. As state medical boards increasingly emphasized clinical and laboratory education, commercial medical schools became less able to pay for these educational necessities. By 1906, there were 160 medical schools in the United States and a study by the AMA concluded that many of those schools were worthless. The worst schools lacked laboratory equipment that was essential for teaching medical science. Not only did the study demonstrate that many of the schools were woefully underperforming, but it highlighted that medical students could no longer afford to pay what it cost to teach them. Medical schools had to “secure state aid and private endowment” to ensure a quality education.<sup>167</sup>

While the state medical boards were not able to fundamentally improve the quality of medical education on their own, Abraham Flexner in his 1910 study recognized that they were “the instruments through which the reconstruction of medical education

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<sup>166</sup> Hamowy: 113.

<sup>167</sup> *Transactions of the Indiana State Medical Association Fifty-Eighth Annual Session* (1907): 452-453.

will be largely effected.”<sup>168</sup> The state medical boards had both direct and indirect power over medical education. They could both require higher standards from medical schools and make their medical examinations much more rigorous.<sup>169</sup> The Flexner report effectively identified the primary concerns with medical education in the United States. His report served as a catalyst to reform medical education in the twentieth century. While his conclusions were not revolutionary, his report was widely reported by the news media because he clearly explained why medical education desperately needed reform.

The examinations given by medical boards from 1880 through 1910 were not difficult. The passage rates for most state examination were often fairly high. For whatever reason, medical boards did not want to make the tests harder. Medical boards could have easily reduced the number of incoming physicians if they had instituted more rigorous standards. Passage rates of eighty to ninety percent were not uncommon. Flexner pointed out that the graduates of the worst medical school in Chicago, a school recently labeled by the Illinois Board as not in good standing, achieved the best results on the Illinois medical examination.<sup>170</sup>

Flexner argued that the medical boards created in the nineteenth century were too political, weak, poorly financed, insufficiently staffed, and cozy with local medical schools to enforce the rigorous standards necessary to improve medical education. These

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<sup>168</sup> Abraham Flexner, *Medical Education in the United States and Canada* (New York, 1910), 167.

<sup>169</sup> Flexner, 167-168.

<sup>170</sup> Flexner, 170.

problems are unsurprisingly, because these medical boards were never intended to reform medical education. They were designed to consolidate the medical profession and purge frauds and unorganized sectarians from the medical ranks. In this regard, medical licensing was an unqualified success. Medical education reform developed in Illinois simply as an effort to eliminate the diploma mills which sold medical degrees to fraudulent practitioners.

The publication of *Medical Education* in 1910 symbolically concluded of the first phase of medical licensing in the United States. While frauds and charlatans continued to practice medicine, medical licensing made their lives increasingly difficult and precarious by ruthlessly prosecuting them. Instead of practicing medicine, these individuals increasingly gravitated away from the practice of medicine and more towards selling medical devices or medicines directly to consumers.

## CHAPTER VI

### CONCLUSION

Regulars originally sought to procure medical licensing to drive irregulars out of the medical profession. Instead, medical licensing became part of a broad and aggressive agenda promoted by organized physicians during the last half of the nineteenth century to purify their profession. During this time, physicians became increasingly organized and institutionalized. Medical societies and journals (both regular and irregular) proliferated throughout country. Doctors not only organized, but they kept in close contact with their colleagues throughout the country. Regular physicians organized the American Medical Association and state medical societies to encourage open communication. The rationale for their interconnectedness was born out of a belief that physicians could learn from each other and treat new and different medical problems, but these networks also became critical to advancing their efforts to create state medicine. Without these organizations it is inconceivable that physicians could have passed any medical regulation in the nineteenth century.

By comparison, unorganized irregular sects, such as midwives, suffered because they failed to organize and effectively defend their interests. Midwives, who initially received comparatively favored treatment by licensing schemes, were ultimately marginalized because they never effectively lobbied to control their own profession. Midwives were placed under the control of licensing boards managed by regulars, eclectics and homeopaths. The medical boards mandated changes in the training of

midwives, regulated their medical practice and placed them under the control of physicians. Licensed physicians had little incentive to protect the rights of midwives and it is unsurprising that midwives vanished. Other sects, such as electric, magnetic, and Christian Scientists, were absolutely routed by medical boards. Osteopaths and opticians effectively withstood the onslaught of state medical boards and carved out niches for themselves.

In many ways, the creation of these state medical boards was remarkable. Medical boards were permitted to not only violate traditional notions of freedom by determining who had the right to be a physician, but by preventing patients from consulting with whomever they choose regarding their health and welfare. While courts expressed concerns regarding the medical boards far reaching powers, they only occasionally sought to curb the medical boards' powers. In many ways, the creation of these medical boards violated some of the sacred principles of the United States, but the dogged determination of organized physicians wore down the objections and allowed these laws to thrive.

By examining the enforcement of medical registration and licensing acts, several patterns begin to develop. Medical registration laws proved to be ineffective and almost unenforceable. County clerks were given the responsibility to determine who could or could not become a physician. These laws did not achieve any of the goals they set out to accomplish. While some of these medical registration laws lasted for decades, most states quickly adopted medical licensing statutes. After 1885, only two states passed

medical registration laws. Most states realized that they were useless, but their passage often permitted physicians to get their feet in the legislature's door.

The next wave of states passed medical licensing statutes which gave quasi-judicial powers to essentially self-regulated medical boards comprised solely of physicians from the organized sects of medicine. While all of these early laws faced numerous constitutional challenges, courts uniformly upheld them. The state medical board quickly assumed broad powers to investigate and discipline their members for the misdeeds and criminally prosecute unlicensed practitioners. The early prosecutions targeted abortionists, physicians who advertised falsely and itinerant doctors.

After courts upheld these boards' powers to prosecute obvious frauds and quacks, the boards shifted their focus to unorganized irregulars and attempted to broaden the definition of the practice of medicine. In numerous states, osteopaths, midwives, opticians, Christian Scientists, and electric and magnetic healers were prosecuted for illegally engaging in the practice of medicine. Only opticians and osteopaths were able to withstand these direct challenges. Opticians, for the most part, clearly did not practice medicine. Osteopaths were sometimes successfully prosecuted for practicing medicine, but quickly organized themselves and successfully lobbied legislatures for practice privileges. The other sectarians failed to organize and were crushed.

Due to the success of the medical boards in uniting regulars, homeopaths, and eclectic, earlier differences were ignored to achieve common goals. The distinctions between the physicians became less meaningful over time and the organized irregular

sects gradually disappeared. Medical licensing played a meaningful role in breaking down these distinctions and blurring the lines between organized practitioners.

In addition to prosecuting physicians, medical boards became increasingly involved in reforming medical education. Initially, medical boards sought to eliminate diploma mills, but their requirements for medical schools soon expanded. Medical boards became increasingly interested in dictating the length and type of education medical schools taught. These efforts were only marginally successful. Medical boards lacked the resources to carefully investigate the existing 160 medical schools in the United States. Additionally, the medical boards were not designed to reform medical education. Medical boards were modeled after state and local medical societies. These medical societies never effectively reformed medical education on their own. While many physicians railed against woeful medical schools, organized physicians were more interested in eliminating their more unorganized colleagues. Still, medical boards would play integral roles in the medical education reform movement in the early twentieth century. By 1910, all but twelve states would exclude physicians from practicing in their state if their schools were not found to be in good standing. State after state would adopt the methods and criteria used by the Illinois medical board to evaluate medical school education.

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