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SELF-REGULATION IN THE MEDICAL PROFESSION:

Some Uses of the Law in Early America

Steven A. Samson

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I

Delegation of the state's police power to private associations raises important constitutional and political issues. Starting from the premise that law is frequently regarded as a tool or instrument--a public means of attaining essentially private ends--it is possible to identify at least three motives for seeking such power: eliminating competition, expanding the association's control of its environment, and elevating its standards to the status of law.[1] This paper represents an attempt to clarify the constitutional and political issues raised by professional self-regulation. It will focus on a fairly narrow instance of the delegation of public power: the typical nineteenth century legislative practice of granting police power to medical societies, enabling them effectively to make public policy, determine practical and ethical standards within a recognized jurisdiction, and enforce these standards on medical practitioners. Any comparison of nineteenth century with current practice lies outside the scope of this essay, however, even though such an historical survey derives much of its value from the light it may shed on current circumstances. This last fact is worth further comment because of some peculiar connections between the study of history and the rise of the professions.

History, in many ways, serves as a scientific laboratory, despite the absence of experimental controls. Ample documentary evidence may be available for the detailed analysis of historical problems; hypotheses may be drawn from known facts even if not conclusively proven. The rules of evidence for

historical scholarship are not different in kind from those which characterize the so-called hard sciences. One reason for this methodological similarity is related to the late-ninteenth century academic revolution in this country. Many scholars and university administrators wished to put the academic disciplines on a scientific footing. This trend has continued since the period immediately following the Civil War when modern universities were organized or reorganized around an increasingly secularized scientific and professional curriculum. These changes are reflected in the organization of academic professional societies, the creation of separate social science disciplines, the incorporation of professional programs in the universities, the creation of land-grant colleges, and the founding of a multitude of new endowments to promote the arts and sciences. These changes also provide an historical context within which to examine the changing fortunes of medical societies and the use they made of the law in winning official status and public recognition.

A preliminary hypothesis characterizing the historical relationship between professional associations in general and the civil government may be proposed as follows: professional associations typically initiate the demand for regulatory legislation in order to consolidate their power within a market. A second hypothesis concerns the behavior of public officials: legislators and other public officials are most willing to concede police powers to those groups that successfully claim exclusive knowledge over certain matters that affect the general welfare. In other words, professional

associations must be able to assert authority within their respective fields, gain public recognition and approval for their activities, and define these activities in terms of the public interest. In many respects, the powers claimed by professional societies are equivalent to those of a parent or guardian. The boundaries between private and public affairs generally are ill-defined.[2] Under certain circumstances, as with citizen arrests, private parties may act in an official capacity, although they assume the hazards and the burden of justifying their actions. Professional societies, however, have not settled on such a legally risky venture as imposing and enforcing their rules on members and non-members alike. Instead, they have sought to combine the advantages of promoting their trade, like any private association, with those of regulating the terms of trade, like a public agency. It is this ability to define an area of exclusive domain, expertise, or special knowledge that distinguishes a profession from other vocations, giving it a practical monopoly within its self-determined competence, the prestige accorded to technical expertise in our "achieving society," and the status of a guardian of the public welfare. Let us turn to the medical profession now.

The above hypotheses would tend to be supported if any of the following circumstances could be shown: that such regulatory legislation was sponsored or actively promoted by physicians and by their medical societies, that physicians or their societies derived tangible benefits from such legislation, or that contemporary observers perceived such benefits and accordingly supported or opposed the legislation on this basis. These

hypotheses markedly contrast the received wisdom that regulatory legislation primarily was designed to assure consumers a high standard of medical treatment by qualified and professionally screened practitioners. If treated as an alternative hypothesis, this standard version would tend to be supported by evidence showing that such legislation resulted from an identifiable public demand, that it received general support from medical practitioners of various schools of practice, or, on the contrary, that it met considerable resistance from physicians of the various schools either before or after implementation (on the assumption that people tend to resist change unless they can perceive a tangible benefit). The emphasis in the last two cases is on the general agreement within the medical profession, whether favorable or unfavorable. If there were a general consensus, a revisionist viewpoint would be irrelevant and speculative. The onus would fall on the adherent of such a viewpoint to justify making an issue where none was perceived and where injured parties could not be identified. All knowledge, belief, value, and activity is based on unquestioned assumptions; selective scepticism for its own sake is without profit or purpose. It is necessary to set certain limits to inquiry.

Although these hypotheses cannot be tested through experimentation, useful evidence may be drawn from existing public and private records. A considerable secondary literature has accumulated on such topics as the history of medicine, the rise of medical societies and medical schools, and the

use of licensing powers to regulate medical practice. These sources will be cited where appropriate, especially where they offer insights into the immediate question of the purpose for granting police powers to medical societies. This discussion will be limited to the years prior to 1900.

I

The three most prominent professions in England and America during the nineteenth century were the law, medicine, and the clergy.[3] They held "estate-like positions" in society.[4] These professions were anchored firmly in an older, status-oriented social milieu that was already being replaced by an increasingly contract-based set of norms. Particularly during the Jackson era and immediately afterward, the remnants of the traditional order were battered and weakened by a new public philosophy which emphasized self-sufficiency, free enterprise, democratic decision-making, pluralism, and the end of special privileges. Although the United States did not have a native feudal tradition, its laws and practices were derived from an English and European environment which did. Feudalism, absolutism, and liberalism developed in succession, but each tradition left a permanent mark on English and later on American culture. Traditional statuses lost their rationale as the industrial and political revolutions gave power to an emerging middle class. This fact reflects a more general problem. The traditions and institutions of one era typically pose dilemmas for subsequent eras. We perceive the flow of historical change through these dilemmas. The task of ad-

justing these traditions, accommodating to them, or rooting them out is one of endless difficulty. Even revolutions have their reactionary propensities. Witness the paradox of an outwardly democratic, even populist, political culture under the guidance of a professional elite based on education, wealth, position, and the obligations these entail: in short, special privilege. The justice of this arrangement could be defended from the pages of Plato's Republic: "Medicine does not consider the interest of medicine, but the interest of the body."[5] But the paradox of it has not gone unnoticed. What Max Weber said about popular sentiments toward the merit system late in the nineteenth century could be said about attitudes toward the medical societies early in the century:

> Those American workers who were against the 'Civil Service Reform' knew what they were about. They wished to be governed by parvenus of doubtful morals rather than by a certified caste of mandarins. But their protest was in vain.[6]

The early medical societies, organized in the years immediately preceding and following the Declaration of Independence, lobbied for a role in the granting of medical licenses.[7] These societies were granted charters and certain regulatory powers almost from their beginning. The first comprehensive medical practice act in the colonies was passed by the New Jersey legislature in 1772, six years after the founding of the New Jersey Medical Society. By 1781, the newly incorporated Massachusetts Medical Society was empowered to examine the fitness of all candidates to medical practice. According to a later commentator, Louis Caldwell, "the mistake came in the attempt to forbid practice except under a license obtained from these societies, which,

after all, were organizations of private individuals."[8] Caldwell concluded that the "overzealousness" of these societies sparked a reaction that swept away virtually all state medical licensing laws in the 1820s and 1830s. Another commentator, Walter Hugins, noted that the Workingmen's movement in New York during this period challenged a "licensing provision... which created 'the medical monopoly,' attacked by the patient as well as the professional."[9] Considerable public controversy attended the overturning of such laws throughout the country, showing that an issue was perceived and brought to public attention.

The outstanding fact about the history of state medical licensing legislation is that it falls into two distinct phases. The first phase began in New Jersey in 1772 when Supreme Court judges were empowered to grant licenses. A fine of five pounds was levied for unlicensed practice. While this law may not have been enforced, it served as a model for future legislation in New Jersey. In 1816, district chapters of the state medical society were granted the licensing power and only licensed physicians were allowed to sue for fees. By the 1830s, however, this law was no longer enforced. It finally was repealed in 1864. Other states followed a similar pattern. In some states, like New Hampshire, Maine, Rhode Island, Tennessee, and Vermont, unlicensed physicians were not penalized. Incorporated state medical societies, however, were granting the power to license, thus legitimizing their authority. In other states, like Alabama, Connecticut, Illinois, Indiana, North Carolina, and Vermont, unlicensed physicians were not allowed to sue for

fees, but otherwise were not penalized. Yet all of this served to question their competence. Some states mandated stiffer penalties at times. Georgia, Louisiana, New York, and South Carolina laws subjected unlicensed physicians to fines and imprisonment. Other states simply levied fines. By the end of the first phase of legislation, around 1840, the only states that had not enacted licensing laws were Virginia, Pennsylvania, Kentucky, and Missouri.[10]

From the late 1830s until the second phase of legislation began after the Civil War, most state medical licensing laws fell into disuse. Penalties for practicing medicine without a license were repealed in all but a handful of states. New medical sects were born amid an upsurge of anti-institutional, populist sentiment. Many of the old traditions and authorities lost their acceptance. Vested interests were held in suspicion. Old orthodoxies and idols were destroyed. What legislation there was after 1840 brought about some innovations in medical licensing and inklings of a new rationale. Delaware and Georgia extended formal recognition to the botanic, eclectic, and homoeopathic schools of medicine by creating separate licensing boards for them. By 1900, twenty states had established licensing boards on which more than one medical sect was represented. Only three states retained the older practice of extending recognition only to regular physicians and their medical societies.[11] But populism and free enterprise values were not the only forces at work. Following the Civil War, the greatest impetus to the new phase of medical licensing appears to have come from a new orthodoxy of scientific medicine,

which could count among its strongholds the new secular universities, various endowments, and the middle-class reform movement. The characteristic professionalization of various disciplines brought about what Corinne Lathrop Gilb called a return "to status as the basis of many private rights."[12]

This new phase appears to have incorporated elements of the old orthodoxy and its challengers. The early nineteenth century medical societies sought the same prerogatives that had been granted to medieval English medical guilds: the power to define ethical and practical standards, restrict the admission of newcomers, fix prices, and assure "fair competition." Their opponents generally sought either official recognition of competing sects or the repeal of restrictions on their practice. Toward the end of the century medicine was redefined. In the words of William Rothstein, medicine was "transformed...from sect to science."[13]

Medical schools, which were rare early in the century, gradually took a commanding position within the profession. The diploma put an official seal of approval on physicians and rivalled the license in prestige. Medical education became more prolonged and arduous. The early medical societies represented two English medical callings, physicians and surgeons, which had virtually merged under the frontier conditions of colonial America. Few physicians were educated in the British Isles or on the Continent. Most had served as apprentices. Only two medical schools were founded during the

colonial period, but their numbers began to increase dramatically from six in 1810 to 22 in 1830 to 42 in 1850. Before 1810, only 564 medical students had graduated. During the following ten years, 1375 more were added. In the decade preceding the Civil War, graduates of medical schools numbered 17213.[14] Allowing a margin for error, these figures depict the rise of a major industry. Formal education gradually displaced the traditional apprenticeship system, and with this change, a new medical profession led by national associations emerged. But commercial medical schools began to wane by the turn of the century or were absorbed into universities. Adoption of a three-year graded curriculum by Harvard Medical School in 1871 led the way toward escalating costs and declining enrollments which taxed the ability of the commercial schools to remain competitive.[15] The result coincided with the guild technique of curbing admissions in order to assure higher fees and greater cohesion among members by eliminating competition. Many other practices had their parallels in medieval guild techniques.

This broad overview invites the reader to conclude that each phase of legislation responded to different political conditions and was dominated by different interest groups. It is important to examine the evidence next to determine its strength and consistency.

III

So far, this paper has been limited to a consideration of secondary sources and a discussion of various factors from which two hypotheses and several corollaries have been drawn. Much of the evidence is scanty, especially where it relates to

the role of the universities and endowments. More attention should be given to the silent revolution fostered by the latter in the professional career market.[16] The myth that professional groups are guided by a politically neutral set of standards should not be taken at face value. "Neutral competence" is a value which turns on questions of fact that are open to public scrutiny.

Much of the best evidence concerning the motivation of medical interest groups--such as transcripts of legislative testimony, speeches, and private correspondence--is not readily accessible. Court records, however, provide some insights into the terms of debate. An adversary proceeding is designed to ferret out evidence relating to motives. It is to this evidence that we now turn.

The common law doctrine with reference to who may practice medicine is simple:

> In the absence of a statute upon the subject, any person is at liberty to practice medicine or surgery or both. This is the common law. And yet in the absence of a statute the physician necessarily assumes certain responsibilities that grow out of his relation to those whom he treats. He is bound to bring to the discharge of his duties the learning, skill and diligence usually possessed and exercised by physicians similarly situated.[17]

A presumption or test of skill appears to have operated in some courts. These courts held that as long as a physician followed a professed or recognized school, system, or treatment, he or she would not liable for damages, assuming that he or she had the requisite "learning, skill and diligence."[18] The question of who may practice medicine was decided in most cases, however, by statute. The courts largely dealt with challenges to these statutes or to the agencies empowered to enforce them.

The Massachusetts case of Hewitt v. Charier dealt with several of the issues and parties that ordinarily were involved in the public debate concerning the propriety of delegating police powers to private medical associations. The Court upheld an 1818 statute which vested the licensing power in two agencies. A key passage in the decision states that

> If the power of licensing were given to the Medical Society, exclusively, there would be much more plausible ground, at least, to maintain, that the power was conferred on a body who would have a temptation to abuse it, so as to promote their private interests; but where the power is conferred equally on the University charged with the great interests both of general and of professional education, and which cannot be perceived to have any such interest, that ground of argument seems to be wholly removed; and it seems difficult to perceive how a power which it is important to the community should be placed somewhere, could be placed more safely.[19]

This decision was handed down during the period that medical licensing laws throughout the country were coming under attack and falling into disuse. While the strength of the opposition might have been drawn in part from recently enfranchised small property owners, who suspected political privileges in general, the intent of many of the laws was conceded even by proponents. An amendment to a New Jersey statute from 1816 states that

> This act shall be so construed as to prevent all irregular bred pretenders to the healing art, under the names or titles of practical botanists, root or Indian doctors, or any other name or title involving quackery of any species, from practicing their deceptions, and imposing on the ignorance and credulity of their fellow citizens.[20]

Licensing laws generally were upheld by the courts, although they were often narrowly construed. Hewitt v. Charier indirectly testifies to an earlier controversy between the medical societies and the medical schools. Established medical schools eventually gained recognition for their diplomas. Cases

involving medical schools with poor reputations or which had not gained official recognition generally were decided against the schools.[21]

Monopolistic practices, such as the use of "fee scales," were choice targets. The New York Court in People v. Medical Society of Erie County held that medical societies may make reasonable by-laws and regulations relative to the admission and expulsion of members. Violation of fee scale rules, the court held, did not constitute grounds for expulsion.[22]

Codes of ethics also were challenged. The New York Court in Fawcett v. Charles held that the county medical society could not expel a member for "immoral conduct or habits" unless he were convicted in a court of law.[23] In this instance, the plaintiff had been expelled after it was learned he had been admitted under false pretenses. Two years earlier, however, the same court had ruled the trial and acquittal of a physician in a criminal court did not prevent an inquiry under the licensing statute "for the purpose of depriving him of his right to practice physic and surgery."[24] The California Court in Ex parte McNulty held that rules against advertising by physicians were not enforceable by the state.[25]

State medical licensing laws did not get attention from the United States Supreme Court until 1888 with Dent v. West Virginia. Justice Field, in a decision upholding the state law, wrote that

> The same reasons which control in imposing conditions, upon compliance with which the physician is allowed to practice in the first instance, may call for further conditions as new modes of treating diseases are discovered....[26]

Two new elements distinguished the decision in _Dent v. West Viginia_. First, state licensing laws came under the scrutiny of the federal judiciary. Moreover, at a time when many regulatory laws were struck down in the name of free enterprise, the Supreme Court upheld medical laws which had been opposed on the same ground. This seeming paradox may be attributed to the fact that, second, medical licensing laws were now being justified in the name of science. A subtle change was taking place. Although _Dent v. West Virginia_ did not directly broach the issue of whether failure to keep abreast of the latest medical techniques could justify revoking a physician's license, the implication is clear. By contrast, _Ex parte McNulty_ from the same year was decided in favor of a physician who continued his medical practice after having his licensed revoked, although not for the same reason. The difference turns on the question of professional status. Medicine increasingly was being regarded as a science with attendant professional obligations, not as a craft which merely required an initial certificate of competence. The terms of the debate changed. The free enterprise arguments that stressed freedom of contract began to lose their power in the face of reforms that were wrapped in the banner of science. As a result, the American public was presented with "a certified caste of mandarins."

IV

Two hypotheses were presented near the beginning of this essay. The paper itself represents a case study in professionalism. The first hypothesis--that professional associations

typically initiate the demand for regulation in order to consolidate their power within a market--is suggested by the tangible benefits the early medical societies derived from the licensing laws, namely their ability to control admissions, issue licenses which testified to competence, and formulate standards of professional etiquette. In many states, the medical societies were the exclusive licensing authority. Eventually this authority was expanded to include medical schools and fragmented to include competing sects. Although this evidence has been only briefly considered, it suggests that the medical societies had the motive and ability to assert limited control over their market through the use of regulatory legislation. Whether they acted alone in initiating the demand for such legislation has not been considered. This requires further attention before the first hypothesis can be fully sustained.[27]

The second hypothesis--that legislators and other public officials are most willing to concede police powers to those groups that successfully claim exclusive knowledge over certain matters that affect the general welfare--must stand or fail on different grounds than the first. The variables offered for the first hypothesis are inapplicable here. A new variable might be the degree to which public officials justified regulation by appealing to arguments made by the professional societies. Several court cases suggest the rationale and even the terminology of the professional societies greatly influenced the decisions. A comparison of the success of the medical profession with that of other professions is required before the second hypothesis can be fully sustained.[28]

NOTES

[1] J. A. C. Grant, "The Gild Returns to America, I," The Journal of Politics, vol. 4, no. 2 (August, 1942), pp. 316-17.

[2] See, for example, Lane W. Lancaster, "Private Associations and Public Administration," Social Forces, vol. 13, no. 2 (December, 1934), pp. 283-91. Several law reviews have included occasional notes on the delegation of public authority to private groups: for example, 8 Va. Law Rev. 450, 32 Colum. Law Rev. 80, 37 Colum. Law Rev. 447, 51 Harv. Law Rev. 201, 67 Harv. Law Rev. 1398.

[3] See Daniel H. Calhoun, Professional Lives in America: Structure and Aspiration, 1750-1850. Cambridge, Harvard University Press, 1965; and W. J. Reader, Professional Men: The Rise of the Professional Classes in Nineteenth-Century England. New York, Basic Books, 1966.

[4] See the Introduction to Professions for the People: The Politics of Skill, edited by Joel Gerstl and Glenn Jacobs. New York, John Wiley and Sons, 1976, p. 3. Another Marxist analysis may be found in Magali Sarfatti Larson, The Rise of Professionalism: A Sociological Analysis. Berkeley, University of California Press, 1977.

[5] Plato, The Republic, translated by B. Jowett. New York, The Modern Library, n. d., p. 25.

[6] From Max Weber, edited by H. H. Gerth and C. Wright Mills. New York, 1958, p. 71.

[7] See Joseph F. Kett, The Formation of the American Medical Profession: The Role of Institutions, 1780-1860. New York, Yale University Press, 1968, pp. 1-31; Francis R. Packard, History of Medicine in the United States, vol. 1. New York, Hafner Publishing Company, 1963 (originally 1931), pp. 163-77.

[8] Louis G. Caldwell, "Early Legislation Regulating the Practice of Medicine," 18 Ill. Law Rev. 237.

[9] Walter Hugins, Jacksonian Democracy and the Working Class: A Study of the New York Workingmen's Movement, 1829-1837. Stanford, Stanford University Press, 1960, p. 166.

[10] These data are drawn from Appendix II of William G. Rothstein, American Physicians in the Nineteenth Century: From Sects to Science. Baltimore, The Johns Hopkins Press, 1972, pp. 332-39.

[11] See Table XVI.1 from Rothstein, ibid., p. 308.

[12] Corinne Lathrop Gilb, Hidden Hierarchies: The Professions and Government. New York, Harper and Row, 1966, p. 5. See also Jethro K. Lieberman, The Tyranny of the Experts: How Professionals Are Closing the Open Society. New York, Walker and Company, 1970.

[13] Rothstein, op. cit., p.326.

[14] See Table V.2 from Rothstein, op. cit., p. 98.

[15] See Rothstein, op. cit., pp. 285, 292-94. For comparison with the development of legal science, see G. Edward White, "The Impact of Legal Science on Tort Law, 1880-1910," 78 Colum. Law Rev. 213 (March 1978), esp. part 1.

[16] The Flexner Report on medical education (1910) was sponsored by the Carnegie Foundation with the cooperation of the American Medical Association. It marked the beginning of a concerted and successful campaign to upgrade standards in the medical schools. See Elton Rayack, Professional Power and American Medicine: The Economics of the American Medical Association. Cleveland, The World Publishing Company, 1967, pp. 66-89. Other studies on the A. M. A., which was founded in 1847, include Oliver Garceau, The Political Life of the American Medical Association. Hamden, Archon Books, 1961 (originally 1941); and "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," 63 Yale Law Journal 938 (May, 1954).

[17] H. B. Hutchins, "Characteristics and Constitutionality of Medical Legislation," 7 Mich. Law Rev. 295 (February, 1909).

[18] For example: Burnham v. Jackson, 1 Colo. App. 237, 28 Pac. 250; Patten v. Wiggin, 51 Me. 594, 81 Am. Dec. 593; Nelson v. Harrington, 72 Wis. 591, 40 N.W. 228, 7 Am. St. Rep. 900, 1 L.R.A. 719.

[19] Hewitt v. Charier, 33 Mass. (16 Pick.) 356.

[20] Quoted in Caldwell, op. cit., p. 239.

[21] For example: Iowa Eclectic Medical College Ass'n v. Schrader, 87 Iowa 659, 55 N. W. 24. See Rothstein, op. cit., pp. 104-08, 224, 294-96.

[22] People v. Medical Soc. of Erie County, 24 Barb. 570 (1857).

[23] Fawcett v. Charles, 13 Wend. 473 (1835).

[24] Ex parte Smith, 10 Wend. 449 (1833).

[25] Ex parte McNulty, 77 Cal. 164 (1888).

[26] Dent v. West Virginia, 129 U. S. 114 (1888).

[27] Other studies of occupational licensing include: Lawrence M. Friedman, "Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study," 53 Calif. Law Rev. 487 (1965); Council of State Governments, Occupational Licensing Legislation in the States. Chicago, 1952; Thomas G. Moore,

"The Purpose of Licensing," 4 Jour. of Law and Econ. 93

[28] Magali Sarfatti Larson provides a sociological framework for an overall stidy of professionalism. She does not, however, examine the political changes which affected the professions at different periods. See Larson, op. cit.