

Washington University Law Review

Volume 1967
Issue 3 *Symposium: Legal Regulation of Health Personnel*

January 1967

Licensure of Physicians

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Recommended Citation

Edward H. Forgotson, Ruth Roemer, and Roger W. Newman, *Licensure of Physicians*, 1967 WASH. U. L. Q. 249 (1967).

Available at: https://openscholarship.wustl.edu/law_lawreview/vol1967/iss3/3

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LICENSURE OF PHYSICIANS

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I. MEDICAL AND SURGICAL PHYSICIANS

Medical licensure laws were originally enacted in the United States during the late 19th and early 20th centuries as a matter of public necessity.¹ Protecting the public against quackery, commercial exploitation, deception, and professional incompetence required legally enforceable standards for entrance into and continuation in the medical profession. The states' medical practice acts therefore specified both ethical and educational requirements for physicians—requirements relating to personal character, scientific education, and practical training or experience.

The early licensure statutes reflected the recommendations of the Flexner Report on medical education published in 1910. This report initiated efforts to raise standards of medical school admission, instruction, and curriculum, to place these schools under the jurisdiction of universities, and to provide full-time faculty and adequate facilities for teaching and clinical experience.² The incorporation in medical licensure laws of requirements which proprietary schools could not meet resulted in the closing of "diploma mills," as the inadequate medical schools of the time were called. Standards of ethics and competency in the early licensure laws reflected the view of leaders of the medical profession that "medicine should be based on an educational system that was responsive to the needs and the social and scientific status of the country at that time."³

Although vast changes have taken place in the "social and scientific status of the country" since the original enactment of the medical practice acts, no fundamental changes have been made in the statutory standards of professional competence and ethical behavior. In investigating the ade-

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1. Sigerist, *The History of Medical Licensure*, in *ON THE SOCIOLOGY OF MEDICINE* 317 (M. Roemer ed. 1960); Shindell, *The Legal Status of the Physician*, 193 *J.A.M.A.* 601, 602 (1965).

2. A. FLEXNER, *MEDICAL EDUCATION IN THE UNITED STATES AND CANADA* (1910).

3. L. COGGESHALL, *PLANNING FOR MEDICAL PROGRESS THROUGH EDUCATION* 4 (1965).

quacy of current licensure laws to meet modern scientific and social conditions, this article examines the most significant features of state medical licensure laws: the scope of mandatory licensure, including the important question of authority for delegations of functions; the nature and role of state licensing agencies; qualifications for licensure candidates, including accreditation of medical schools; license registration and renewal, and reinstatement of lapsed licenses; recognition of licenses of other jurisdictions; and license suspension or revocation, and reinstatement of removed licenses.

A. *Mandatory Licensure*

1. *Definitions, Scope, and Effect*

In all states licensure of physicians is mandatory; therefore, it is necessary for the statutes to define the medical practice from which unlicensed persons are excluded. Although the language of statutory definitions varies considerably, the practice of medicine is universally defined in broad terms which encompass all health service functions.⁴ A person who in any way

4. Some representative statutory definitions of the practice of medicine include:

Any person shall be regarded as practicing medicine and surgery who shall advertise in any manner, or hold himself or herself out to the public, as a physician and surgeon, or either, or who shall investigate, diagnose or treat, or offer to investigate, diagnose or treat, a physical or mental ailment or disease, real or imagined, or any person with a view to relieving the same, as is commonly done by physicians and surgeons, or suggest, recommend, prescribe or direct for the use of any person, sick, injured or deformed, any drug, medicine, device or appliance for the intended relief, palliation or cure of the same, or who shall suggest, recommend, prescribe or direct an operation on any such sick, injured or deformed person or who shall perform, or offer to perform, any such operation whether or not such person receives therefor, either directly or indirectly, any fee, gift or compensation of any kind whatsoever or any manner whatsoever. IDAHO CODE ANN. § 54-1802 (1947).

No person shall, in connection with the practice of medicine, surgery, osteopathy, optometry, dentistry, chiropody, pharmacy, chiropractic, psychology or psychiatry, nursing, anesthesiology, physio or physical therapy, or any other profession or business having for its purpose the diagnosis, treatment, correction or cure of any human ailment, condition, disease, injury or infirmity, hold himself out as a doctor or employ or use in any manner the title "Doctor" or "Dr.," unless he actually has graduated and holds a doctor degree from a school, college, university or institution authorized by its governing body to confer such degree. KY. REV. STAT. ANN. § 311.375 (1963).

A person practices medicine within the meaning of this article, except as herein-after stated, who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity, or physical condition. N.Y. EDUC. LAW § 6501 (McKinney 1953).

The other statutory definitions of the practice of medicine are found in: ALA. CODE tit. 46, § 262 (1958); ALASKA STAT. § 08.64.380 (1962); ARIZ. REV. STAT. ANN. § 32-1402 (1956); ARK. STAT. ANN. § 72-604 (1957); CAL. BUS. & PROF. CODE § 2137 (1960); COLO. REV. STAT. ANN. § 91-1-6 (1963); CONN. GEN. STAT. REV. § 20-9 (1958); DEL. CODE ANN. tit. 24, § 1731 (1953); FLA. STAT. ANN. tit. 30, § 458.13 (1962); GA. CODE ANN. § 84-901 (1955); HAWAII REV. LAWS § 64-1 (1955); ILL. ANN. STAT. ch. 91, § 16i (Smith-Hurd 1966); IND. ANN. STAT. § 63-13 (1962);

performs, offers to perform, or holds himself out to the public as performing specific functions—*e.g.*, diagnosing, treating, operating, or prescribing for a disease, ailment, pain, or condition—must be licensed as a physician. In addition, almost half of the statutes specifically prohibit the unlicensed use of certain medical titles and degrees. A few definitions are qualified by a requirement that proscribed activities must be performed for compensation.

All medical practice acts provide certain exemptions from the requirement of state licensure.⁵ Exempt categories differ among the jurisdictions,

IOWA CODE ANN. § 148.1 (1949); KAN. GEN. STAT. ANN. § 65-2802 (1963); LA. REV. STAT. ANN. tit. 37, § 1261 (1950); ME. REV. STAT. ANN. tit. 32, § 3251 (1964); MD. ANN. CODE art. 43, § 139 (1957); MASS. GEN. LAWS ANN. ch. 112 (1965) (the Mass. Statutes contain no specific definition of the practice of medicine); MICH. STAT. ANN. § 14.537 (1956); MINN. STAT. ANN. § 147.10 (1945); MISS. CODE ANN. § 8888 (1956); MO. REV. STAT. § 334.010 (1959); MONT. REV. CODES ANN. § 66-1007 (1947); NEB. REV. STAT. § 71-1,102 (1966); NEV. REV. STAT. § 630.020 (1963); N.H. REV. STAT. ANN. § 329:1 (1966); N.J. STAT. ANN. § 45:9-5.1 (1963); N.M. STAT. ANN. § 67-5-10 (1961); N.C. GEN. STAT. § 90-18 (1965); N.D. CENT. CODE ANN. § 43-17-01 (1960); OHIO REV. CODE ANN. § 4731.34 (Page 1953); OKLA. STAT. ANN. tit. 59, § 492 (1963); ORE. REV. STAT. § 677.030 (1965); PA. STAT. ANN. tit. 63, §§ 401, 401A (1959); R.I. GEN. LAWS § 5-37-1 (1956); S.C. CODE ANN. § 56-1354 (1962); S.D. CODE § 27.0310 (1939); TENN. CODE ANN. § 63-608 (1955); TEX. REV. CIV. STAT. art. 4510 (1966); UTAH CODE ANN. § 58-12-17 (1963); VT. STAT. ANN. tit. 26, § 1311 (1967); VA. CODE ANN. §§ 54-273,-275 (1967); WASH. REV. CODE ANN. § 18.71.010 (1961); W. VA. CODE ANN. § 30-3-2 (1966); WIS. STAT. ANN. § 147.01 (1957); WYO. STAT. ANN. § 33-327 (1959).

5. ALA. CODE tit. 46, §§ 268, 269, 295 (1958); ALASKA STAT. §§ 08.64.365, 08.64.370 (1962); ARIZ. REV. STAT. ANN. § 332.1421 (1956); ARK. STAT. ANN. § 72-604(2) (1957); CALIF. BUS. & PROF. CODE §§ 2137.1-2147.6 (1960); COLO. REV. STAT. ANN. § 91-1-6(3) (1963); CONN. GEN. STAT. REV. § 20-9 (1958); DEL. CODE ANN. tit. 24, §§ 1731(c), 1742 (1953); D.C. CODE ANN. §§ 2-133,-134 (1966); FLA. STAT. ANN. § 458.13 (1962); GA. CODE ANN. § 84-906 (1955); HAWAII REV. LAWS ch. 64, § 2 (1955); IDAHO CODE ANN. §§ 54-1802,-1807,-1813,-1816 (1947); ILL. ANN. STAT. ch. 91, §§ 16f, 16v (Smith-Hurd 1966); IND. ANN. STAT. § 63-1310, 1311 (1962); IOWA CODE ANN. § 148.2 (1949); KAN. GEN. STAT. ANN. § 65-2872 (1963); KY. REV. STAT. ANN. §§ 311.550(8), 311.560 (1963); LA. REV. STAT. ANN. tit. 37, § 1290 (1950); ME. REV. STAT. ANN. tit. 32, §§ 3260, 3751 (1964); MD. ANN. CODE art. 43, §§ 139, 140 (1957); MASS. GEN. LAWS ANN. ch. 112, § 7 (1965); MICH. STAT. ANN. § 14.538 (1956); MINN. STAT. ANN. § 147.09 (1945); MISS. CODE ANN. §§ 8887, 8888 (1956); MO. REV. STAT. §§ 334.150, 334.155 (1959); MONT. REV. CODES ANN. §§ 66-1006,-1007 (1947); NEB. REV. STAT. § 71-1,103 (1966); NEV. REV. STAT. § 630.360 (1963); N.H. REV. STAT. ANN. § 329:21 (1966); N.J. STAT. ANN. § 45:9.21 (1963); N.M. STAT. ANN. § 67-5-10 (1961); N.Y. EDUC. LAW § 6512 (McKinney 1953); N.C. GEN. STAT. §§ 90-18,-19 (1965); N.D. CENT. CODE ANN. § 43-17-02 (1960); OHIO REV. CODE ANN. § 4731.36 (Page 1953); OKLA. STAT. ANN. tit. 59, § 492 (1963); ORE. REV. STAT. § 677.060 (1965); PA. STAT. ANN. tit. 63, § 409 (1959); R.I. GEN. LAWS §§ 5-37-14,-15 (1956); S.C. CODE ANN. §§ 56-1355,-1357 (1962); S.D. CODE § 27.0311 (1939); TENN. CODE ANN. § 63-608 (1955); TEX. REV. CIV. STAT. art. 4504 (1966);

but those provided by at least half of the states are as follows: (1) commissioned officers of the federal military services, the U.S. Public Health Service, and physicians employed by federal civilian agencies, while performing official medical duties;⁶ (2) religious practitioners, including those of Christian Science; (3) licensed practitioners of other health services; (4) practitioners licensed in other states when in consultation with a state licensed physician; (5) persons rendering emergency services, or dispensing domestic remedies; and (6) medical students, interns, and residents. The rationale of these and most other exceptions to mandatory licensure is that the exempt categories consist of practitioners whose qualifications are otherwise assured, and/or who are performing beneficial service under circumstances which do not involve undue danger to the public. Exemptions which meet the standard implicit in the rationale may be recommended for wider adoption by the state legislatures, and the standard itself may be a useful guide for state officials charged with enforcement of medical practice acts.

In the past, questions concerning unauthorized and illegal practice of medicine have arisen principally in connection with non-scientific healers.⁷ Since the main purpose of medical licensure laws is to protect the public against incompetence, quackery, and unscientific principles in the practice of medicine, these statutes have served to block fraudulent and deceptive activities of non-scientific healers. Today, well established policing methods, improved public education, the joint efforts of federal and state governments, and the medical profession have brought this problem under reasonable control.⁸ Future protection against non-scientific healers depends

UTAH CODE ANN. § 58-12-17 (1963); VT. STAT. ANN. tit. 26, §§ 1312, 1313 (1967); VA. CODE ANN. §§ 54-274, 276.7 (1967); WASH. REV. CODE ANN. §§ 18.71.030, 18.71.095 (1961); W. VA. CODE ANN. § 30-3-2 (1966); WIS. STAT. ANN. § 147.19 (1957); WYO. STAT. ANN. § 33-341 (1959).

6. The Attorney General of Wisconsin has recently ruled that a physician employed by a Veterans Administration hospital does not have to be licensed by Wisconsin for his service within the federal hospital, but he must be licensed by the state in order to participate in a rotating training program cooperatively conducted by the V.A. hospital and a non-federal hospital. However, requirements for appointment to the V.A. assured that the physician would qualify for a temporary educational certificate of licensure by reciprocity. WIS. OP. ATT'Y GEN. (Aug. 31, 1966).

7. Cases involving the illegal practice of medicine by non-scientific practitioners are legion; e.g., *Beck v. Cooper*, 147 Kan. 710, 78 P.2d 844 (1938); *People v. Hickey*, 157 Misc. 592, 283 N.Y.S. 968 (Ct. Spec. Sess. 1935), *aff'd*, 249 App. Div. 611, 292 N.Y.S. 968 (1936), *aff'd*, 280 N.Y. 559, 20 N.E.2d 14 (1939).

8. For reviews of these efforts, see reports of the A.M.A. Congresses on Quackery, the most recent of which was held in 1966.

upon continued vigilance in the enforcement of existing legal sanctions, and, in most states, upon re-examination of the legal status of chiropractors.⁹

2. *Delegation of Functions*

The most significant contemporary questions arising from mandatory licensure for the practice of medicine concern the delegation of functions by physicians to other health personnel. As previously noted,¹⁰ the statutory definitions of medical practice give physicians an unlimited license to perform all functions of health service, even those for which other health personnel may also be licensed.¹¹ However, the concomitant licensing of allied and ancillary personnel indicates that the statutes do not contemplate all health service to be conducted by physicians—a situation which would, of course, be impossible to realize with the present or even projected supply of physicians. Indeed, health authorities now generally agree that the serious shortage of physicians can be overcome only by allocating certain tasks not requiring the judgment and ability of a physician to specialized personnel with fewer skills and less education.¹² The need for such expansion of the professional productivity of physicians seems certain to continue, and even increase, over time. As medicine develops new methods of treatment requiring specialized skills, new functions must be authorized for existing health personnel, and new kinds of auxiliary personnel must be specifically created.

What is the legal basis for these innovations? For example, do the medical and nursing practice acts permit specifically trained nurses, under standing orders from a physician, to administer cardiopulmonary resuscitation by means of a Pacemaker machine to patients suffering heart stoppages?¹³ For most jurisdictions there can be no certain answers to such questions because legal authorities have not yet resolved the underlying issues. In a few states, however, the answers have begun to emerge from court decisions, attorney general opinions, or legislative enactments. These

9. For legal regulation of chiropractors and other non-scientific practitioners, see pt. III *infra*.

10. See note 4 *supra* and accompanying text.

11. Licensed physicians may even provide dental service, and several dental practice acts specifically exempt physicians from their application; e.g., GA. CODE ANN. § 84-723 (1955); TEX. REV. CIV. STAT. ANN. art. 4551b(4) (1960).

12. See NATIONAL COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR 77-100, 211-15 (1966).

13. For an account of the use and benefits of this practice in Standish, Michigan, see L.A. Times, Nov. 24, 1966, § V, at 3, col. 8.

initial efforts clearly indicate that the legality of delegations of medical functions involves not only mandatory licensure for the practice of medicine, as statutorily defined, but also the scope and effect to be given to (1) licenses of allied and auxiliary personnel, (2) prevailing customs of medical practitioners and institutions, and (3) physicians' supervision and control of assisting personnel.

In most states the only official guidelines for delegation are the functional definitions of allied and auxiliary personnel in statutes which provide for their licensure. But these definitions are often difficult to interpret and apply to new or unforeseen situations—hence the many advisory opinions of state attorneys general on the scope of these licenses. Faced with such uncertainties, the medical and nursing professions have recently adopted interprofessional agreements to clarify accepted customs and practices. As a practical matter, delegation of health service functions is predominantly governed by prevailing custom and practice. In the few relevant court decisions, however, it has been held that professional custom is no defense for a contravention of licensure statutes.¹⁴ Thus, in the majority of states, the authority of nurses, medical and surgical technicians, physicians' assistants, and other personnel to undertake new functions and to relieve physicians of certain tasks is limited by licensure statutes or is, at best, an open question. Also uncertain are the character and degree of medical supervision required to make such delegations of functions legitimate.

Two California cases illustrate the courts' handling of elements of licensure, custom, and supervision in deciding delegation questions. The more recent case, *People v. Whittaker*,¹⁵ involved the right of a neurosurgeon to use a trained surgical assistant to assist in brain surgery. The assistant was charged with practicing medicine without a license because he operated a cranial drill and Giegle saw, positioned by the surgeon, to bore holes and excise skull flaps during neurosurgical operations—even though he was always within sight and under direct supervision of the surgeon. The surgeon was charged with aiding and abetting an unlicensed person to practice medicine. The jury found both parties guilty of the charges. As a standard for judging the physician's use of an *unlicensed* trained assistant, working under *direct* supervision, the following instruction was given to the jury:¹⁶

14. *Barber v. Reinking*, 68 Wash. 2d 122, 411 P.2d 861 (1966).

15. No. 35307, Justice Court of Redding Judicial District (Shasta County, Cal., Dec. 1966).

16. Record at 861. *People v. Whittaker*, No. 35307, Justice Court of Redding Judicial District (Shasta County, Cal., Dec. 1966).

In determining whether acts in this case, if any, performed under the direct supervision and control of a duly licensed physician, were legal or illegal, you may consider evidence of custom and usage of the medical practice in California as shown by the evidence in this case.

The *Whittaker* judgment has been appealed because of its importance as a test of the right of a physician or surgeon to use an "extra pair of hands" under conditions not constituting a medical emergency. Regardless of the outcome of the appeal,¹⁷ the case is significant for its allowance of prevailing "custom and usage of the medical practice" in the state to determine the propriety of a physician's delegation and supervision of patently medical, but essentially mechanical, functions. Although this standard may seem both sensible and workable, it nevertheless illustrates the difficulties inherent in the court's attempt, on a case-by-case basis, to clarify policies and promulgate standards. Legal regulation developed through jury determinations of medical custom and usage may produce inconsistencies and uncertainties in the law, may impede innovations in health service, and finally, may not provide adequate assurance of patient safety.¹⁸ In addition, to rely upon medical custom and usage is to abdicate responsibility for the development of legal criteria governing the delegation of medical functions.

In an earlier California case, *Magit v. Board of Medical Examiners*,¹⁹ a physician's California license had been revoked for "unprofessional conduct" because he hired unlicensed, foreign-trained anesthesiologists for independent administration of anesthetics in a hospital. In affirming the Board's revocation, the California Supreme Court noted that professional nurses might administer general anesthetics under an exception to the medical practice act which regulates the customary functions of licensed health personnel. Similarly, the court indicated that if the foreign graduates had been registered as residents in an approved anesthesiology program, under another exception to the medical practice act for interns and residents, their administration of anesthetics under identical conditions of attenuated supervision would have been permissible. But the court could find no statutory authority for the performance of medical functions by unlicensed, non-resident anesthesiologists. The court did mitigate the penalty, how-

17. There would seem to be small probability of appellate reversal on the law in this case, since the instructions given the jury were essentially those requested by the defense. Telephone conversation with Robert W. Baker, Esq., District Att'y of Shasta County, Redding, Cal., January, 1966.

18. Compare the difficulties experienced with the so-called "community rule" in malpractice cases, discussed in Professor Leff's article pp. 339-44 *infra*.

19. 57 Cal. 2d 74, 366 P.2d 816, 17 Cal. Rptr. 488 (1961).

ever, stating that revocation of the physician's license was an abuse of the board's discretion in view of the facts that the anesthesiologists were foreign-trained specialists, that they had previously been similarly employed by a state hospital (under still another exception to the medical practice act regulating employees of state institutions), and that their authority was an unresolved legal question.

The *Magit* case demonstrates the strict construction given medical practice acts by the courts. Strict construction of these statutes is justified on the policy grounds that mandatory medical licensure is designed to protect the public against practitioners not meeting legally prescribed standards of ethics, education, and training. According to the *Magit* decision, the performance of medical functions by persons not licensed as physicians and only *minimally* supervised by licensed physicians is permitted only when expressly authorized by statutory exceptions. An example of such a case would be an *unlicensed* practitioner whose performance of tasks has been established by custom and prevailing conditions of practice.

Under this approach, primary responsibility for developing legal rules regarding delegation of tasks by physicians to non-physicians lies with the legislatures rather than the courts. If delegations are judged by strictly construed medical practice acts, they are permissible only to the extent that these medical licensure statutes, reflecting traditional policies of public protection, are expressly modified by exceptions accommodating new policies of increased physician productivity and manpower utilization. For example, the *Magit* case undoubtedly would have been decided differently (or, more probably, would never have arisen) if the California statute's exemption of hospital employees²⁰ were more broadly phrased to include non-licensed physicians working in either state or non-state institutions. Such an exemption, distinguishing between independently and institutionally rendered services, deserves further legislative consideration. The safety of patients may be adequately assured by the many institutional safeguards now required for hospital accreditation by the Joint Commission on Accreditation of Hospitals,²¹ and such accreditation could be statutorily required for exemption from mandatory licensure.

The licensure statutes of four states, Arizona, Colorado, Kansas, and Oklahoma, provide more general exemptions for delegations of functions.²²

20. CAL. BUS. & PROF. CODE § 2137.1 (Deering Supp. 1966).

21. See generally AMERICAN HOSP. ASS'N, HOSP. ACCREDITATION REFERENCES (1964).

22. ARIZ. REV. STAT. ANN. § 32-1421 (Supp. 1966); COLO. REV. STAT. ANN. § 91-1-6(3) (1963); KAN. GEN. STAT. ANN. § 65-2872 (1964); OKLA. STAT. ANN. tit. 59, § 492 (Supp. 1966).

Although these four exemption clauses are similar in purpose, they have significantly different effects because of variations in their phraseology. The Arizona and Oklahoma exemptions apply only to delegations made by physicians, while the Colorado and Kansas provisions also cover other licensed practitioners of "the healing arts." Under the Oklahoma statute, exempt delegations must be made to "a physician's trained assistant, a registered nurse, or a licensed practical nurse." In the other three states delegations may presumably be made to any person, although in Arizona the delegatee must be "acting in his customary capacity, not in violation of any statute," and in Kansas he must be performing "professional services." Perhaps the most important differences among these statutes occur in their requirements of supervision. An exempt delegation may be performed in Kansas, "under the supervision or by order of or referral from" the delegator, and in Arizona, "at the direction of or under the supervision of" the delegator. The Oklahoma exemption specifies "direct supervision and control," and the Colorado statute requires "personal and responsible direction and supervision."

The latter criteria may well create as many problems as they solve. Without further statutory definitions, their terminology is subject to a variety of interpretations. Terms such as "supervision" and "direction" seem to be used with different meanings in the several statutes. Even within the individual states, considerable judicial decision or executive interpretation seems necessary to determine reasonably certain meanings for the criteria. On the other hand, semantic precision would only complicate problems caused by establishing a single statutory criterion of supervision to govern all delegations in a state—regardless of variations in the functions to be delegated, the conditions under which delegations are made, the qualifications of delegates, or under some statutes, the professional status of delegators. Furthermore, in light of the difficulties frequently encountered in amending medical practice acts, statutory criteria may not be sufficiently adaptable to future changes in the organization and requirements of health services and in the utilization and qualifications of auxiliary health manpower.

Because of the many variables, both medical and legal, involved in assessing the propriety of delegations, it is difficult to resolve this issue through either the enactment of a single statutory standard or the accumulation of case-law criteria. Ideally, the problem warrants a tripartite solution: first, broad statutory provisions in which the legislature strikes a balance between policies of public protection and manpower utilization; second, detailed regulations in which a specialized administrative agency applies

legislative policies to health service practices and needs; and third, an adjudicative process in which the administrative agency, the courts, or both, may construe and enforce the statutes and regulations. Early consideration of such a solution is necessitated by the real possibility that, until the issue of delegation is clarified, new and desirable utilizations of health manpower may be inhibited by uncertainties regarding physicians' liability to disciplinary actions,²³ civil judgments,²⁴ or criminal penalties.²⁵ Facilitating implementation of the suggested solution is the fact that every state already possesses a governmental agency charged with administration of its medical practice act.²⁶

B. *Licensing Agencies*

The licensure statutes of all states provide for the establishment and operation of official licensing agencies to regulate admission to and continuation in medical practice. The authority, composition, and procedures of these agencies determine to a considerable extent the manner in which licensure laws are administered, and thus have an important influence on the qualification and use of physicians.

Medical licensing boards, as primary creations of the medical practice acts, evolved historically to protect the public against incompetence, quackery, deception, and unethical practices. Their function is to assure compliance with minimum qualifications specified in the statutes by supervising the licensure process and policing the practice of medicine. They are empowered to determine the eligibility of candidates for licensure (including review of character and moral fitness, assessment of educational qualifications, administration of examinations, and approval of postgraduate internships); to accredit or approve medical schools; to issue, register, and renew medical licenses; to decide the recognition to be given to licenses of other jurisdictions; to make administrative rules and regulations concerning professional standards; and to suspend, revoke, and reinstate licenses in disciplinary proceedings.

23. *See* Magit v. Board of Med. Examiners, 57 Cal. 2d 74, 366 P.2d 816, 17 Cal. Rptr. 488 (1961), discussed in text accompanying note 19 *supra*.

24. *See* Barber v. Reinking, 68 Wash. 2d 122, 411 P.2d 861 (1966).

25. *See* People v. Whittaker, No. 35307, Justice Court of Redding Judicial District (Shasta County, Cal., Dec. 1966), discussed in text accompanying note 15 *supra*.

26. Medical licensing agencies are discussed at pp. 258-64 *infra*. Existing regulatory powers of many of these agencies seem sufficiently broad to authorize their promulgation of rules governing delegation of medical functions.

1. *Composition of Boards*

State Boards of Medical Examiners or equivalent agencies range in numbers of members from three to sixteen, with an average membership of about eight.²⁷ Physicians comprise the largest number of members, constituting the entire board in thirty-three states and a large majority in most others.²⁸ In sixteen jurisdictions the membership includes one or more members of other professions or occupations licensed by the same board—osteopaths, chiropractors, chiropodists, veterinarians, dentists, etc.²⁹ Thus, the vast majority of states require that all members of the board be practicing physicians or other professionals regulated by the board.

The statutes of seven states provide for one or two public members of the board, *i.e.*, persons other than practitioners licensed by the agency. In six of these states, the public members are state officials.³⁰ One state requires the appointment of a public member who is not a state official.³¹

2. *Selection of Board Members*

In the great majority of states, the governor appoints the Board of Medical Examiners or its equivalent from a list of licensed physicians recommended by the state medical society.³² In eight states appointments by the governor require the advice and consent of the senate. In eight jurisdictions, designated governmental agencies or officials make the appointments, although subject to the approval of the governor in some of these states.³³ In contrast, the state medical society has sole power to select mem-

27. Appendix 1, "Composition of Agency—Total Number" column.

28. Appendix 1, "Composition of Agency—M.D.'s" column.

29. Appendix 1, "Composition of Agency—Other Occupations" column.

30. IDAHO CODE ANN. § 54-1305 (1947) (Commissioner of Law Enforcement); KY. REV. STAT. ANN. § 211.040 (1963) (Commissioner of Health); MISS. CODE ANN. § 7024 (Supp. 1966) (Elected by State Board of Health); N.H. REV. STAT. ANN. § 329:4 (1966) (Director of Division of Public Health Services, *ex officio*); PA. STAT. ANN. tit. 71, § 122 (Supp. 1966) (Commissioner of Professional and Occupational Affairs, and Secretary of Health); W. VA. CODE ANN. § 30-2A-1 (Supp. 1967) (State Director of Health, *ex officio*). In five of the states the public officials must either be licensed or eligible to be licensed to practice.

31. CAL. BUS. & PROF. CODE §§ 2100, 2101 (Deering Supp. 1966) (one public member not licensed in medicine, osteopathy, or chiropractic).

32. Appendix 1, "Appointment by Governor" and "Recommendation by Medical Society" columns.

33. ILL. ANN. STAT. ch. 127, § 606 (Smith-Hurd 1966); KY. REV. STAT. ANN. § 211.040 (1963); MISS. CODE ANN. § 7024 (Supp. 1964); NEB. REV. STAT. § 71-117 (1966) (Dep't of Health); N.Y. EDUC. LAW § 6503 (McKinney 1953) (Board of Regents); R.I. GEN. LAWS § 5-26-2 (Supp. 1966) (Director of Health with approval of Governor); UTAH CODE ANN. § 58-1-6 (1953) (Director of Registration with approval of Governor); D.C. CODE § 2-109 (1967) (Commission on Healing Arts).

bers of the board in two states.³⁴ The most marked variations in methods of selection are represented by Alabama, where the Board of Censors of the state medical society constitutes the Board of Medical Examiners, and by Mississippi, where the State Board of Health performs the licensing function for physicians.

More important than who formally appoints members of the board is the source of recommendations for membership. In twenty-three states the state medical society recommends physicians for appointment, and in nine states other professional societies of personnel licensed by the same board may recommend one or more members.³⁵ One state provides for recommendations by the medical society after consultation with the deans of the medical schools of the state,³⁶ and another state provides for selection of the board by the "Medical and Chirurgical Faculty" of the state.³⁷ Thus, in the majority of states, selection of the members of the medical licensure board is determined largely by professional societies, and in only two states is the selection influenced by medical educators.

The Council of State Governments has listed the contention of those who support legal provisions permitting professional associations to nominate or select members of a licensing board:³⁸

(1) They [the legal provisions] are necessary safeguards to prevent the positions from being used for purposes of political patronage.

(2) They ensure the selection of competent, well-qualified individuals.

(3) They guarantee expert understanding of the problems faced by practitioners in the occupation.

(4) Above all, they give the practitioners being regulated a sense of participation in selecting their regulators and thus ensure their close cooperation in maintaining high standards of practice.

In the same report, the Council summarized opposing arguments:³⁹

Those who criticize the degree to which private associations play a role in selecting licensing board members emphasize the general principle that government officials should represent the public as a whole, not private groups. They assert that members of licensing boards, when selected by occupational associations, may find their loyalty to the public welfare in conflict with their allegiance to the association. Many such critics urge that chief executives of the states should have

34. ALA. CODE tit. 46, § 258 (Supp. 1965); N.C. GEN. STAT. § 90-3 (1965).

35. Appendix 1, "Recommendation by Other Professional Societies" column.

36. PA. STAT. ANN. tit. 71, § 122 (1962).

37. MD. CODE ANN. art. 43, § 120 (1965).

38. COUNCIL OF STATE GOV'TS, OCCUPATIONAL LICENSING LEGISLATION IN THE STATES 38 (1952).

39. *Id.*

wider latitude in selecting board members than now prevails. They point out that this accords with a general trend to increase the powers of Governors to appoint the members of their administrations. Applied to the occupational licensing boards, it is asserted, this principle would greatly increase their accountability to the public.

3. *Qualification of Board Members*

All states require physician members of the medical licensing board to be licensed practitioners. In more than half the jurisdictions, a physician member must have practiced in the state for a specified time, usually five years.⁴⁰

Thirteen states provide an absolute bar to board membership for faculty members or persons connected with educational institutions.⁴¹ These provisions were enacted with a double purpose: to exclude the possible bias of persons with commercial interest in proprietary schools training health personnel, and to prevent faculty members from exercising any predilection they might have in favor of their own graduates. The first reason is generally sound, since obvious conflict of interests should disqualify persons with a financial or managerial interest in profit-making schools engaged in preparing licensure candidates.⁴² This reason no longer applies to medical school faculties, however, and even the second reason is of questionable applicability. In view of the quality of modern American medical schools, their non-profit character, and their accreditation system, it may no longer be necessary for licensing boards to provide an independent check of licensure qualifications, separate from judgment of academic qualifications.⁴³ Furthermore, restricting medical school faculty members bars from the Board of Medical Examiners physicians who are eminently qualified to uphold standards of practice, and who can contribute to the licensing agency their knowledge of new directions in medical education and research. In recognition of these facts (and also, perhaps, because more states have developed their own medical schools), limitations on faculty members have been repealed in several states.⁴⁴ Indeed, one state

40. Appendix 1, "Requirement of Practice in State" column.

41. Appendix 1, "Limitation on Faculty" column.

42. Compare the unique Nebraska provision that no member of the board may be connected with a wholesale or jobbing house dealing in medical supplies. NEB. REV. STAT. § 71-115 (1966).

43. Of course, the statutes must distinguish between accredited medical schools and schools of chiropractic and other such educational institutions. The exclusion of faculty members of proprietary institutions and institutions offering degrees not recognized by the U.S. Office of Education is sound policy.

44. *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1402 (Supp. 1967) which replaced former § 32-1403(D) in 1964. But the repeal in Arizona is almost nullified by the concurrent

now has an affirmative provision requiring one member of the board to be a full-time member of the University of Illinois medical school faculty.⁴⁵

Nine states require that board members be selected on the basis of geographic distribution throughout the state.⁴⁶ As an administrative provision to facilitate the hearing and processing of disciplinary actions in various parts of the state, the geographic requirement may serve a valid purpose. Such a provision may also be intended to promote liaison between the board and the profession. If, however, the requirement is designed to assure representation of various sectional interests of the profession, then it is questionable. Good medical practice knows no geographic boundaries,⁴⁷ and licensing boards are established primarily to be protective of the public, not to be representative of the profession.

4. *Status of Boards*

In most states the agency licensing physicians is an autonomous agency of the state government. However, in seven states the medical licensing board is administratively attached to the state department of public health;⁴⁸ and in another ten states the licensing agencies for physicians are connected to various departments charged with regulation and licensure of other professions and occupations, which may or may not be limited to health fields.⁴⁹ Even in this minority of states in which the medical board is attached to a department of state government, the board generally operates independently of supervision or involvement by the department. Thus, the operation of medical licensure boards is usually separate from other health functions of state government. Board members are answerable only to the governor, who generally may remove them from office only for egregious conduct—incompetence, neglect of duty, or unprofessional or dishonorable conduct. In general, there is no supervision of the operations

requirement that board members must have engaged in the full-time practice of medicine in the state for five years preceding appointment.

45. ILL. ANN. STAT. ch. 127, § 60a (Supp. 1966).

46. ALASKA STAT. ANN. § 08.64.010 (1962); ARIZ. REV. STAT. ANN. § 32-1402(A) (Supp. 1967); ARK. STAT. ANN. § 72-602B(a) (1957); GA. CODE ANN. §§ 84-902, -903 (Supp. 1966); IDAHO CODE ANN. § 54-1805 (1947); MONT. REV. CODES ANN. § 66-1001 (1961); S.C. CODE ANN. § 56-1351 (1962); VA. CODE ANN. § 54-282 (1967); W. VA. CODE ANN. § 30-2A-1 (Supp. 1967).

47. Cf. *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), in which the Supreme Court of Illinois stated that a physician must exercise care and skill appropriate to the risk, and that the "community standard" can no longer justify less than adequate medical care.

48. See Appendix 1, "State Department" column.

49. *Id.*

of these boards except for the power of the courts to review some of their actions upon complaint of an aggrieved candidate or licensee.

The autonomy of medical licensing boards is reflected in the methods used to finance their operations. In thirty-nine states licensing fees support the boards' functions.⁵⁰ These fees are either deposited in a separate fund or are deposited in the state treasury but ear-marked for the boards' use. The other states and the District of Columbia finance the medical board from general revenues as an operational expense of state government.⁵¹

Despite the administrative independence of medical licensure agencies, only eighteen states limit their medical boards to the licensing of physicians, and establish other agencies to license other health practitioners. In the majority of states, the licensing agency for physicians also licenses members of other health occupations.⁵² These include both legitimate allied and auxiliary personnel (osteopaths, podiatrists, physical therapists, dispensing opticians, etc.) and, in some states, non-scientific practitioners (homeopaths, chiropractors, drugless healers, masseurs, etc.). Though the policy of licensing non-scientific practitioners is questionable,⁵³ it is significant that most states have elected to have a single agency license a variety of health personnel, thus to some extent administratively integrating the regulation of health manpower.

As currently constituted and operated, medical licensing agencies are generally adequate for the administration of medical practice acts. The competence and dedication of the boards' memberships usually offsets minor defects in the structure and procedure of their operation. As long as medical licensure is limited to its traditional function of prescribing minimal personnel standards necessary for the protection of the public, current legislative trends (such as the repeals of requirements of geographic representation and restrictions on medical school faculty members) should suffice to maintain the efficacy of the licensing agencies. If, on the other hand, it is ever proposed that the licensure mechanism be revised so that it no longer merely enforces minimum standards for public protection, but also promotes maximum standards for public service, then it would

50. Appendix 1, "Financing of Agency—Special Fund" column. Special financing of the board's operations may explain the statutory provisions for nominal compensation for board members. Compensation ranges to a high of \$30 per diem plus expenses in Texas, TEX. REV. CIV. STAT. art. 4502 (1966). Per diem rates of \$10, \$15, and \$25 are common for this highly skilled and exacting service.

51. Appendix 1, "Financing of Agency—General Fund" column.

52. Appendix 1, "Other Occupations Licensed by Same Agency" column.

53. See pp. 298-305 *infra*.

be necessary to re-examine the composition, selection, qualifications, and status of the medical boards. For example, if the governmental regulatory process were to assume a larger role in promulgating and administering criteria for the delegation of medical functions to allied and auxiliary personnel,⁵⁴ some of the present characteristics of the medical agencies would assume critical importance. Especially significant would be the domination of their memberships by physicians and, in some states, of their selection processes by medical societies. An additional problem would be their administrative detachment from state agencies regulating and planning comprehensive health services and, in some states, from licensing boards governing other health professionals.

C. *Licensure Qualifications*

All medical practice acts specify the personal and educational training and testing requirements which candidates for licensure must meet. These requirements are reviewed here for graduates of medical schools in the United States and for foreign medical graduates. The present review emphasizes issues in the licensure statutes which have implications for the development and use of high-quality medical manpower.

1. *Personal Qualifications*

a. age. Most state statutes require that licensure candidates be over twenty-one years of age, although some states have no age requirement.⁵⁵ In view of the length of medical training in the United States, existing minimum age requirements probably do not delay licensure of qualified physicians.

b. character. All states require "good moral character" for medical licensure. This requirement has generally been held by the courts to be negated by conviction of a felony or an offense involving "moral turpitude."⁵⁶ It is possible that standards specified in the statute for suspension or revocation of licenses may be deemed relevant in defining the "good moral character" requisite for admission to practice.⁵⁷ The paucity of

54. See text accompanying notes 23-25 *supra*.

55. States without age requirements are: Cal., Ga., Hawaii, Idaho, Ind., Iowa, Minn., Miss., Mo., Mont., Nev., N.M., Ore., Wash., and W. Va.

56. *E.g.*, *Hawker v. New York*, 170 U.S. 189 (1898); *State Bd. of Med. Educ. & Licensure v. Simon*, 62 Dauph. 215 (Pa. County Ct. 1951); *cf.* *Hirsh v. San Francisco*, 143 Cal. App. 2d 313, 325, 300 P.2d 177, 185 (1956).

57. *Cf.* *Hallinan v. Comm'n of Bar Examiners*, 65 Cal. 2d 447, 453, 421 P.2d 76, 81, 55 Cal. Rptr. 228, 233 (1966), in which California Supreme court stated:

Fundamentally, the question involved in both situations is the same—is the applicant for admission or the attorney sought to be disciplined a fit and proper

judicial interpretation of this vague requirement, except in cases of heinous offenses, indicates that licensing boards have wide discretion in defining "good moral character" as long as they do not act arbitrarily or capriciously.⁵⁸ Thus, procedures for contesting a board's interpretation of the criterion are important to protect both the rights of individual candidates and the interest of society in the admission to practice of all qualified candidates.⁵⁹ It would be an unsound limitation on medical manpower to bar qualified physicians for characteristics unrelated to professional responsibilities and duties.

c. citizenship. Full United States citizenship is required for medical licensure in twenty-three states.⁶⁰ Prior filing of a declaration of intention to become a citizen is required in another twenty-three states.⁶¹ Two states modify their full citizenship requirements to allow declarations of intent for Canadians.⁶² Six jurisdictions have no citizenship requirements for graduates of U.S. and Canadian medical schools.⁶³

Although the requirement of citizenship for licensure in a health occupation has been upheld as not palpably arbitrary,⁶⁴ some legal commentators

person to be permitted to practice law, and that usually turns upon whether he has committed or is likely to continue to commit acts of moral turpitude. At the time of oral argument the attorney for respondent frankly conceded that the test for admission and for discipline is and should be the same. We agree with this concession. Therefore, in considering the kinds of act which would justify excluding a candidate for admission we may look to acts which have been relied upon to sustain decisions to disbar or suspend individuals previously admitted to practice.

58. See Note, *Entrance and Disciplinary Requirements for Occupational Licenses in California*, 14 STAN. L. REV. 533, 538 (1962).

59. See note 153 *infra*.

60. Ala., Alaska, Ariz., Ark., Colo., Del., Fla., Ga., Kan., Ky., La., Mo., Mont., Neb., Nev., N.J., N.C., N.D., Ohio, Okla., S.C., Tenn., and W. Va.

For requirements for licensure by endorsement see ENDORSEMENT POLICIES OF MEDICAL LICENSING BOARDS FOR GRADUATES OF AMERICAN AND CANADIAN MEDICAL SCHOOLS, prepared by the Legal Department of the American Medical Association, [hereinafter cited as ENDORSEMENT POLICIES], dated June 6, 1966.

61. Conn., Hawaii, Idaho, Ind., Iowa, Md., Mass., Mich., Minn., Mont., N.H., N.J., N.M., N.Y., Ore., Pa., R.I., S.D., Tex., Vt., Va., Wis. and Wyo. (at discretion of board).

New Hampshire, New Jersey and Wyoming provide for temporary licenses to those who have filed declarations. N.H. REV. STAT. § 329-15 (1966); N.J. REV. STAT. § 45:9-14 (1963); WYO. STAT. ANN. § 33-333(a)(iii) (Supp. 1965). In Rhode Island and Wyoming full citizenship must be acquired in the minimum allowable time to obtain permanent licensure. R.I. GEN. LAWS ANN. § 5-37-2 (Supp. 1966); WYO. STAT. ANN. § 33-333(a)(iii) (Supp. 1965).

62. MONT. REV. CODES ANN. § 66-1003(b)(2) (1962); NEV. REV. STAT. § 630.160 (1963).

63. Cal., D.C., Ill., Me., Utah, and Wash.

64. *Sashihara v. Board of Pharmacy*, 7 Cal. App. 2d 563, 46 P.2d 804 (1935).

have contended that citizenship requirements in professional and occupational licensing are of doubtful constitutionality and basically inconsistent with the national policy of welcoming aliens and encouraging them to make their maximum contribution.⁶⁵ Licensure laws are constitutional only if they are proper regulations of qualifications to assure competence to practice,⁶⁶ and "it is difficult to see any rational connection between citizenship and the appropriate qualifications of the various professions and occupations."⁶⁷ Whether or not the requirement is constitutional, citizenship seems an irrelevant and unnecessary restriction upon available medical manpower as a matter of public policy.

d. residence. Only one state requires residence in the state as a qualification for initial licensure.⁶⁸ In all other jurisdictions, no period of residence in the state is required for United States medical graduates.⁶⁹ States faced with a considerable influx of physicians, such as California and Florida, rely on stringent reciprocity-endorsement policies rather than residence requirements to restrict licensure of physicians from other states.⁷⁰ With respect to residence requirements, the medical practice acts erect no barriers to the location and mobility of physicians.

e. health. Unlike licensure requirements for other health professions and occupations, the qualifications for physicians do not generally specify health requirements. Only one state requires affirmatively that the candidate be ". . . physically and mentally able safely to engage in the practice of medicine. . . ."⁷¹ Another specifies that the candidate must be free of active tuberculosis and venereal disease.⁷² Although almost all states provide that a license may be revoked because of physical or mental illness under certain circumstances,⁷³ only a few states provide that a license may be initially denied for these reasons.⁷⁴ Health requirements, unlike citizenship requirements, are relevant to a candidate's qualifications as a physician, and to the statutory objective of assuring the safe and effective practice of medicine.

65. Fisher & Nathanson, *Citizenship Requirements in Professional and Occupational Licensing in Illinois*, 45 CHI. BAR REC. 391, 397 (1964).

66. *Dent v. West Virginia*, 129 U.S. 114 (1889).

67. Fisher & Nathanson, *supra* note 65, at 397.

68. HAWAII REV. LAWS § 64-3(b) (Supp. 1963) (one year).

69. Jurisdiction of the medical licensing agency is not acquired because of the residence or citizenship of licensure applicants, but because of its duty to protect the health and welfare of the people of the state.

70. *See* pp. 277-80 *infra*.

71. ARIZ. REV. STAT. ANN. § 32-1423(7) (Supp. 1967).

72. OKLA. STAT. ANN. tit. 59, § 493 (Supp. 1967).

73. *See* p. 281 *infra*.

74. *E.g.*, MO. REV. STAT. § 334.100 (1)(11) (Supp. 1965).

2. *Educational Qualifications*

The medical practice acts of all the states specify numerous and varied educational, training, and testing requirements for medical licensure candidates. These statutory provisions relate to (1) specific course requirements in college and medical school, (2) basic science examinations, (3) graduation from approved medical schools, (4) postgraduate medical education, and (5) licensure examinations.

a. specific course requirements. Requirements in the medical licensure statutes of high school graduation or its equivalent, and of at least two or three years of collegiate premedical education,⁷⁵ are merely repetitions of admission requirements of all accredited medical schools in the United States and Canada. Requirements in the statutes of some states for completion of specific college courses, generally in chemistry, biology, and physics,⁷⁶ may unnecessarily inhibit innovations in the educational preparation of physicians. In light of changing trends in American medical education and the control of the quality of medical schools through the present system of accreditation, premedical requirements should be left to admission policies of the medical schools rather than be dictated by statutes.⁷⁷

With respect to medical education, statutes of only two states specify the content of the medical curriculum in any detail,⁷⁸ but twenty-five states set forth, with varying specificity, the amount of instruction which must be completed.⁷⁹ These detailed requirements, holdovers from the 1910 Flexner Report, should be re-examined in light of more recent developments in medical education and its accreditation. If requirements concerning content or length of the medical curriculum are still deemed necessary, such criteria should be promulgated by regulations of an agency with sufficient expertise and flexibility to keep pace with essential curricular revisions. For the modern temper in medical education requires that

medical-school curricula must remain under ruthless and unceasing scrutiny; they cannot be permitted to grow by sheer accretion. They must be reviewed at regular intervals by imaginative men who have talent for abstraction and generalization and who are attuned to the great syntheses which occur in both the physical and biological sciences.⁸⁰

75. Appendix 2, "High School" and "College" columns.

76. *E.g.*, CAL. BUS. & PROF. CODE § 2192 and Appendix 2.

77. *See generally* CITIZENS' COMM'N ON GRADUATE MEDICAL EDUC., THE GRADUATE EDUCATION OF PHYSICIANS (1966); L. COGGESHALL, PLANNING FOR MEDICAL PROGRESS THROUGH EDUCATION (1965); Address by Ruhe, Federation of State Medical Boards of the United States, in Chicago, Feb. 11, 1967.

78. CAL. BUS. & PROF. CODE § 2192; WASH. REV. CODE ANN. § 18.71.055 (1961).

79. Appendix 3, "Medical School Curricula" column; Ruhe, *supra* note 77.

80. Gengerelli, *Education in the Sciences*, 193 J.A.M.A. 583, 584 (1965).

b. basic science examinations. In twenty-one states and the District of Columbia, a candidate for medical licensure must pass a basic science examination given by a basic science board, separate from the licensing examination and the licensing board.⁸¹ This is an omnibus requirement for a number of health professions and occupations which is designed to assure a minimum of scientific knowledge on the part of practitioners of the healing arts. A corollary purpose of the basic science examination is to exclude from practice cultists and healers without grounding in science; however, these examinations have not proved an insurmountable barrier to non-scientific practitioners.⁸²

Non-statutory prerequisites for admission to all accredited United States and Canadian medical schools include at least one course in each of the following sciences: basic biology, inorganic chemistry, organic chemistry, and physics. Medical school instruction in the pre-clinical sciences has advanced far beyond levels tested by the basic science examinations. In criticizing the requirement of the basic science examination for physicians, the Secretary of the New York State Board of Medical Examiners stated:⁸³

. . . [W]e have come to the period in which the curricula of the basic science courses probe so deeply into underlying fundamental scientific knowledge, actually at the molecular level in many instances, that the separation between the various specific subjects becomes artificial.

For modern physicians, the basic science examination is thus an anachronism. It does not demonstrate knowledge of science as well as graduation from an approved medical school, and it does not test such knowledge as appropriately as the medical licensure examination. For in fact, all states, whether or not they have basic science requirements, test knowledge of basic sciences in their medical licensure examinations.⁸⁴ The basic science examination should be eliminated as a requirement for medical licensure.

c. approval of medical schools. Forty-seven states require graduation from an approved medical school as a prerequisite for licensure.⁸⁵ Power

81. Appendix 2, "Basic Science Certificate" column. For basic science requirements for licensure by endorsement, see ENDORSEMENT POLICIES, *supra* note 60.

82. See WRIGHT, *The Point of View of Medical Examining Boards*, in BASIC SCIENCE IN MEDICAL EDUCATION AND IN QUALIFICATION FOR THE PRACTICE OF MEDICINE 51, 52 (1966).

83. *Id.* at 53.

84. In fifteen jurisdictions the statute which establishes the basic science board is sufficiently broad to permit the board to accept examinations of the National Board of Medical Examiners or state medical boards in lieu of its own: Ala., Alaska, Ariz., Ark., Conn., D.C., Iowa, Kan., Minn., Neb., Okla., R.I., Tenn., Wash., and Wis.

85. Appendix 2. Iowa, South Carolina, and Texas do not require that the medical school be approved. *Id.* In Hawaii an acceptable alternative to graduation

to approve medical schools is given to the Board of Medical Examiners or its equivalent in each state, but the statutes of several states specifically require graduation from a medical school approved by the American Medical Association or the Association of American Medical Colleges. Some statutes provide other standards for approval, such as a medical curriculum equivalent to that of the state medical school of the licensing state.⁸⁶ In practice, all state licensing agencies accept the accreditations of schools by the Joint Liaison Committee on Medical Education of the Association of Medical Colleges and the Council on Medical Education of the American Medical Association, whether or not required to do so by statute. With the elimination of proprietary and "diploma-mill" medical schools, and the development of a national accrediting body for existing schools, it now seems possible for statutory educational requirements to avoid dealing with premedical or medical curricula, and to base their regulation upon graduation from an accredited school.⁸⁷

d. postgraduate medical education. The internship was established as part of medical education to provide one year of supervised clinical experience in a hospital following graduation from medical school. Twenty-five years ago only a few states required an internship,⁸⁸ but today all but seventeen states require some form of internship.⁸⁹ Where required, the internship must be an approved program, sanctioned either by the state board or by the Council on Medical Education of the American Medical Association. In three states the internship requirement is discretionary with the board.⁹⁰ In two states a rotating internship is required,⁹¹ and two

from an approved medical school is active practice in another state, or medical service with the United States Army, Navy, or Public Health Service for seven of the eleven years preceding licensure application. HAWAII REV. LAWS § 64-3(d)(2) (Supp. 1963).

Approved Canadian medical schools are also accepted in all United States jurisdictions because they are accredited and approved by the same accrediting body as are American medical schools.

86. *E.g.*, TENN. CODE ANN. § 63-611 (1956).

87. One problem which the state boards or the national accrediting body may face in the future results from the policy in some states of favoring their own residents for admission to state supported medical schools. This policy, although understandable, can have a detrimental effect on the quality of medical students in some cases and could potentially affect the quality of the school as well as the number of graduates. *See* Johnson & Hutchins, *A Study of Medical Student Attrition*, 41 J. MED. EDUC. 1097, 1121-38 (1966); ASS'N OF AM. MED. COLLEGES, 2 DATAGRAMS no. 3 (1965), for correlations indicating that students in medical schools with low expenditures and geographic restrictions have lower median scores on the Medical College Admission Test.

88. *See* Sigerist, *The History of Medical Licensure*, in *ON THE SOCIOLOGY OF MEDICINE* (M. Roemer ed. 1960).

89. Appendix 2, "Internship" column. For internship requirements for licensure by endorsement see ENDORSEMENT POLICIES, *supra* note 60.

90. ARK. STAT. ANN. § 72-605(f) (1957); OKLA. STAT. ANN. tit. 59, § 493 (Supp.

states have other statutory provisions relating to the specific content of educational experience beyond medical school.⁹² In two additional states a specified number of years of practice is acceptable in lieu of an internship.⁹³

As experience with patient care has been incorporated in medical school curricula through clinical clerkships, and as increasing numbers of physicians continue from internships to specialty training in residencies, the nature and purpose of the internship have come under new scrutiny.⁹⁴ The recent growth of medical and scientific knowledge renders impossible the teaching of "everything" in four years of medical school, or even medical school plus internship, so that internship, like medical school graduation, can no longer be relied upon for adequate preparation of physicians. Furthermore, required internships delay effective graduate education by repeating clinical experience that is now obtained in the third and fourth years of medical school. Accordingly, the recent *Report of the Citizens Committee on Graduate Medical Education* (the "Millis Report") recommends "that the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole."⁹⁵

Implementation of this recommendation would require modification of many licensure laws to permit the first year of such a graduate program to be accepted in lieu of internship. Only two state statutes currently specify that one year of postgraduate training may be substituted for an internship.⁹⁶ In some other states, it is possible that existing statutory provisions regarding the internship requirement may be interpreted to allow new forms of graduate medical education in place of an actual internship. Ironically, however, the greatest opportunities to improve postgraduate medical education would seem to exist in the states with only a discretionary requirement of internship or no internship requirement at all. Where necessary, state licensure laws should be amended to permit, if not to re-

1967); VT. STAT. ANN. tit. 26, § 1392 (1967).

91. *Medical Licensure Statistics for 1966*, 200 J.A.M.A. 1055, table 10 at 1067 (1967).

92. HAWAII REV. LAWS § 64-3(f) (Supp. 1963) (certificate of familiarity with Hansen's disease from state institution treating this disease); WASH. REV. CODE ANN. §§ 18.71.050 (2), (3) (1961) (experience in obstetrics and pathology).

93. ALASKA STAT. § 08.64.200 (1962) (four years); NEV. REV. STAT. tit. 54, § 630.160(2) (1963) (seven years).

94. See generally authorities cited *supra* note 77.

95. CITIZENS' COMM'N ON GRADUATE MEDICAL EDUC., *supra* note 77, at 62.

96. ARIZ. REV. STAT. ANN. § 32-1423(4) (Supp. 1967); N.J. REV. STAT. § 45:9-8(3) (1963).

quire,⁹⁷ the substitution of postgraduate educational programs for the internship.

At the same time, consideration should be given to appropriate methods of regulating and accrediting these programs. Existing residency programs are generally designed by teaching hospitals in accordance with requirements prescribed by various non-governmental specialty certification boards.⁹⁸ The adequacy of this procedure for licensure purposes should now be assessed, and the proper roles of governmental agencies, specialty boards, organized medicine, and medical schools and institutions should be determined. Although no United States jurisdiction currently requires graduate training beyond the internship as a requisite for licensure, once an appropriate system of accreditation is devised, the licensure statutes could require completion of an approved residency just as thirty-five jurisdictions now require completion of an approved internship. If medical licensure is to signify the end of supervised preparation and the beginning of independent practice, this amendment of the statutes would most realistically approximate the transformation.

e. licensure examinations. The purpose of examinations for licensure, required in all states, is to test the candidates' medical knowledge, judgment, and skills. Requirements of examination by a state agency originated in the United States when proprietary medical schools of dubious quality were still in existence.⁹⁹ Since all the present medical schools are of high quality and fully accredited, and since all states now require graduation from such schools, it is questionable whether separate licensure examinations are still necessary. It may well be that greater public protection can now be afforded through an approach analogous to that of the United Kingdom, whereby fitness to practice is assured only through careful accreditation of medical educational programs, including postgraduate training. For it is also doubtful that any real test of competence to practice medicine can be obtained from an examination given at the completion of an educational process which no longer produces physicians sufficiently prepared to engage in unsupervised, independent practice of medicine.¹⁰⁰ Examinations can only test the candidates' recall of what they learned in medical school, not the complex attributes of fitness and competence to

97. Cf. CITIZENS' COMM'N ON GRADUATE MEDICAL EDUC., *supra* note 77, at 63: "We recommend that state licensure acts . . . be amended to eliminate the requirement of a separate internship and to substitute therefor an appropriately described period of graduate medical education."

98. The requirements are described in A.M.A., ANNUAL DIRECTORY OF APPROVED INTERNSHIPS AND RESIDENCIES.

99. See Sigerist, *supra* note 88.

100. See generally authorities cited *supra* note 77.

practice medicine. Thus, the examination device should be retained only if it is considered desirable as a check upon medical education or useful as an index of future competence. If, for these reasons, licensure examinations are continued, every effort must be made to assure that the testing instruments are the best that can be devised, and that the examinations demand a uniformly high level of performance by candidates.

Preparation and administration of licensure examinations are the responsibility of the Boards of Medical Examiners or equivalent agencies in all states. Clearly, this is a function peculiarly within the province of physicians, and it is primarily for this reason that the membership of licensure agencies is dominated by physicians.¹⁰¹ Depending upon the rationale chosen to justify licensure examinations, the occasional exclusions of medical faculty members from the boards¹⁰² are either consistent (if the examination is an independent assessment of past medical education) or inconsistent (if it is a reasonable prediction of probable future competence).

Written examinations for initial licensure are given in all states, and in sixteen states provision is also made for an oral or practical examination,¹⁰³ although the latter requirements are discretionary with the board in some states. A candidate's performance on an oral examination is not subject to the same objective review as his performance on a written examination, and the statutes of two states deal with the possibility of prejudicial judgment of oral examinations by either requiring written transcripts¹⁰⁴ or by authorizing recording of oral examinations.¹⁰⁵

In forty-one states and the District of Columbia, certification by the non-governmental National Board of Medical Examiners¹⁰⁶ is acceptable for initial licensure in lieu of the state examination,¹⁰⁷ and many state

101. See note 28 *supra* and accompanying text.

102. See notes 41-45 *supra* and accompanying text. It should be noted that college and university faculty members are generally assigned responsibility for administering statutory basic science examinations, and medical school faculty members participate in development of the examinations given by the National Board of Medical Examiners.

103. Ariz., Cal., Iowa, Minn., Mont., Neb., Nev., N.D., Ore., Pa., R.I., S.C., Tenn., W. Va., Wis., and Wyo.

104. ARIZ. REV. STAT. ANN. § 32-1428(e) (Supp. 1967).

105. WYO. STAT. ANN. § 33-333(b) (Supp. 1965).

106. The membership of the National Board includes representatives from the Federation of State Medical Boards of the U.S., the Council on Medical Education of the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the U.S. Armed Services, and the Veterans Administration. In addition, members at large are elected from among leading physicians throughout the nation. See generally Womack, *The Evolution of the National Board of Medical Examiners*, 192 J.A.M.A. 817 (1965).

107. The nine states which do not recognize National Board certification for initial licensure are: Ark., Del., Fla., Ga., Ind., La., Mich., N.C., and Tex. However, Delaware,

boards purchase questions prepared by the National Board for use in their own examinations.¹⁰⁸ Two states require an oral examination if the application for licensure is made five or more years after National Board certification.¹⁰⁹ No state requires passage of the entire three-part examination of the National Board of Medical Examiners as a condition of licensure, although many medical educators, practitioners, and state-board members agree that Parts I and II of the National Board examination are the best available tests of medical school education, and that Part III approaches more closely than anything yet devised a reasonably valid test of competence to practice medicine. In view of these achievements of the National Board, all states should at least recognize its certification for initial licensure.

The number of physicians certified by the National Board could perhaps be increased if more medical schools required students to take the examinations. Present use of the National Board examinations varies among medical schools, but in some schools students may be required to pass Part I before being promoted to the junior class, and/or to pass Part II before being awarded the M.D. degree.¹¹⁰ In 1966, seventy-five per cent of the sophomore or senior classes in sixty-six of the nation's eighty-five medical schools took National Board examinations.¹¹¹

3. *Foreign Medical Graduates*

All but three states have specific statutory authority for licensure of graduates of foreign medical schools.¹¹² Several states issue to foreign medical graduates a special certificate for limited institutional training or prac-

Indiana, North Carolina, and Texas accept National Board certification if the diplomate has been licensed by another state, and Georgia accepts certificates of the National Board issued prior to October, 1953.

108. See Fordham, *Medical Licensure; A Comparative View*, 192 J.A.M.A. 832 (1965).

109. CAL. BUS. & PROF. CODE § 2321 (Deering 1960); ORE. REV. STAT. § 677.120(5) (1965).

110. Letter from the National Board of Medical Examiners to the authors, Feb. 16, 1967.

111. 14 NAT'L BD. EXAMINER 3 (Nov. 1966).

112. Arkansas, Louisiana, and Nevada have no provisions for the licensure of foreign medical graduates. See Appendix 2, "Foreign Medical Graduates" column. In Delaware the licensure statute requires graduation from an approved medical school in the United States or Canada, but exceptions may be made on the unanimous recommendation of the licensing agency. DEL. CODE ANN. tit. 24, § 1733(b) (Supp. 1966).

This discussion of licensure of foreign medical graduates is not applicable to graduates of approved Canadian medical schools, who are generally treated the same as United States graduates because their schools are accredited by the same accrediting body as are American medical schools.

tice.¹¹³ One state sets a maximum limit of fifty licenses a year which may be issued to foreign graduates.¹¹⁴

In general, the age, character, and citizenship requirements applicable to graduates of United States medical schools¹¹⁵ also apply to foreign medical graduates. Several states also require a period of residence in the state for foreign graduates,¹¹⁶ although this is almost never a requirement for United States graduates.¹¹⁷ One state requires that a foreign graduate be recommended by the medical society in the county of the applicant's residence.¹¹⁸

Licensure is a process for determining professional competency and should not be used as a substitute for sound immigration policies.¹¹⁹ The only valid special provisions for foreign medical graduates are those related to education, training, and language ability. The object of statutes regulating licensure of foreign graduates is therefore limited to assuring that candidates are adequately educated, with sufficient proficiency in the English language and familiarity with the practice of modern American medicine.

Since no procedures exist for evaluating and accrediting foreign medical schools (except for Canadian schools, the American University of Beirut, and the University of the Philippines), most foreign medical graduates must be evaluated individually and thoroughly in terms of their individual competence to practice medicine. The task of evaluating and verifying individual qualifications and credentials cannot be based upon the quality of a candidate's medical school. The task is eased, however, by the services of the Educational Council for Foreign Medical Graduates (the "ECFMG"—sponsored by the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Federation of State Medical Boards) in establishing standards and ad-

113. *E.g.*, MO. REV. STAT. § 334.045 (Supp. 1965); OKLA. STAT. ANN. tit. 59, § 498(d) (Supp. 1967); S.D. CODE § 27.0308 (1960). *Medical Licensure Statistics for 1966*, *supra* note 91, table 10 at 1104.

114. WIS. STAT. ANN. § 147.15 (1m) (Supp. 1967).

115. *See* pp. 264-66 *supra*.

116. DEL. CODE ANN. tit. 24, § 1733(a)(4) (Supp. 1966); HAWAII REV. LAWS § 64-3(b) (1963); W. VA. CODE ANN. § 30-3-4 (1966). *See also* CAL. BUS. & PROF. CODE § 2193(d) (Deering 1960) (requiring one year of internship in the state).

117. *See* notes 68-70 *supra* and accompanying text.

118. W. VA. CODE ANN. § 30-3-4 (1961).

119. *See* 2 THE PRESIDENT'S COMM'N ON HEART DISEASE, CANCER AND STROKE: A NATIONAL PROGRAM TO CONQUER HEART DISEASE, CANCER AND STROKE 281 (1964) for discussion of the propriety of importing physicians from other countries to the United States.

ministering examinations to determine whether foreign medical graduates are qualified to serve as interns and residents in graduate training programs.

In forty states and the District of Columbia, the licensure law requires an ECFMG certificate as a requisite for licensure, either as the exclusive educational requirement or as one of several requirements for a foreign graduate.¹²⁰ Graduate medical education, consisting of either an internship or residency or both, is generally required.¹²¹ In at least six states more than one year of graduate medical education in an approved internship or residency is required for foreign medical graduates.¹²² Another state statute provides that if an applicant's medical school is not approved, the dean of the medical school of the state university may examine the qualifications of the applicant and advise the board as to whether the applicant has had training equivalent to that required.¹²³ At least six states also require an existing license to practice from either the country of the applicant's medical school or elsewhere.¹²⁴

The statutes of only two states specifically require proficiency in the English language for licensure.¹²⁵ Although language proficiency is tested by the ECFMG examination and may be evaluated by the licensure boards in oral examinations or interviews (frequently required of foreign graduates), nevertheless the statutes do not reflect the importance of this qualification.

Since foreign graduates cannot be judged by their completion of an accredited educational process, and since the ECFMG examinations test only competency to perform as hospital interns or residents, an exacting licensure examination is necessary to determine the fitness of foreign graduates to practice medicine. The statutes or regulations of all states except three subject foreign graduates to the same examination requirements as United States graduates,¹²⁶ although the special need for uniformly rigorous and comprehensive testing in these cases could best be met by requiring, instead of sometimes permitting, substitution of the National Board examinations.¹²⁷

120. Appendix 2, "ECFMG Certification" column.

121. Appendix 2, "Internship or Residency" column.

122. ARIZ. REV. STAT. ANN. § 32-1424(4) (Supp. 1967) (two years); CAL. BUS. & PROF. CODE § 2193 (Deering 1960) (two years); HAWAII REV. LAWS § 64-3(d)(3) (Supp. 1963) (three years); IOWA CODE ANN. § 148.3(1)(b) (Supp. 1966) (three years); KY. REV. STAT. ANN. § 311.570(1) (1963) (five years); VA. CODE ANN. § 54.306.3 (1950) (two years).

123. WIS. REV. STAT. § 147.15(lm) (Supp. 1965).

124. Appendix 2, "Existing License" column.

125. *E.g.*, ARIZ. REV. STAT. ANN. § 32-1424(5) (Supp. 1967)

126. Appendix 2.

127. *Cf.* pp. 271-73 *supra*.

D. *Registration, Renewal, and Reinstatement of Licenses*

Nearly all states require that medical licenses be registered or recorded with a public agency and thus be open to public inspection.¹²⁸ Some require registration of the license with the clerk of the county in which the licensee intends to practice, or with some other local official.¹²⁹ Other states have statutory provisions that require an official state agency to publish an annual directory of licensees.¹³⁰ All registration provisions are designed to provide a public record of physicians licensed to practice medicine in the state. A list of active licenses cannot be maintained, of course, without a system of periodic license renewal.

Forty-six jurisdictions, require renewal of medical licenses either each year (thirty-five) or every two years (eleven).¹³¹ The significant feature of license renewal is not what it entails but what it does not entail. A routine and clerical measure, renewal requires only the signature of the physician and the payment of a nominal fee. No other information is required—no showing of continuing education undertaken or its effect on the physician's skills, and no evidence of the physician's having updated his knowledge and credentials to keep pace with medical progress. Not a single state attempts to prevent educational obsolescence by requiring evidence of further education or professional growth as a condition for maintaining licenses in good standing.

Continuing ability to practice medicine is also potentially involved in the reinstatement of lapsed licenses.¹³² In most states, however, the statute requires only an application for reinstatement and the payment of a required fee, which may include a delinquency charge.¹³³ In one state, if a license has lapsed for five years, the physician may be required to repeat the entire licensure procedure, including examination.¹³⁴ Another unusual provision requires a retired physician who wishes to return to active practice to demonstrate that he is "physically and mentally able safely to en-

128. *See, e.g.*, MO. REV. STAT. § 334.060 (1959); TEX. REV. CIV. STAT. art. 4499 (1966).

129. *See, e.g.*, MO. REV. STAT. § 334.060 (1959); TEX. REV. CIV. STAT. art. 4498(a) (1966).

130. *See, e.g.*, CAL. BUS. & PROF. CODE § 2111 (Deering 1960); N.Y. EDUC. LAW § 6510 (McKinney Supp. 1966).

131. The five states without renewal requirements are Ky., Mass., Miss., N.J., and Ohio.

132. For discussion of reinstatement of licenses after disciplinary suspension or revocation, see P. 290 *infra*.

133. *E.g.*, COLO. REV. STAT. ANN. § 91-1-23 (1963); NEB. REV. STAT. § 71-110(3) (1943).

134. CAL. BUS. & PROF. CODE § 2376.5 (Deering Supp. 1966).

gage in the practice and still possesses the medical knowledge required therefor."¹³⁵ This is the only statute which requires evidence of continuing qualifications for reinstatement.

Thus, educational obsolescence is generally involved in the licensure process only when it becomes sufficiently grievous to provide grounds for disciplinary action,¹³⁶ and may be recognized by the judicial process only when it satisfies the negligence standard in malpractice cases.¹³⁷ Since both protection of the public welfare and preservation of manpower resources require the prevention of educational obsolescence among practicing physicians, the question arises whether the legal process should somehow establish higher standards than those enforced in disciplinary and malpractice proceedings. For the present, non-governmental agencies, such as medical institutions and professional associations, are acting to prevent educational obsolescence by assessing physician performance in hospitals and by establishing and requiring programs of continuing education and re-evaluation.¹³⁸ Statutory requirements for license renewal and reinstatement are the logical means of reinforcing these non-governmental efforts. Despite admitted problems of accreditation, specialty differentiation, and individual evaluation, requirements of formal continuing education as a condition of license renewal are deserving of further consideration by the profession.

E. *Recognition of Other States' Licenses*

All states except Florida and Hawaii provide some means of recognizing licenses of other states. Physicians licensed in other states and seeking licensure in these two states must take the state board examinations¹³⁹ and fulfill all other requirements for initial licensure.

Recognition of other states' licenses in the remaining forty-eight states and the District of Columbia may be accomplished through endorsement of the existing license or through reciprocity with the licensing state.¹⁴⁰ Theoretically, endorsement requires only that either the qualifications of of the licensee or the standards required for licensure in the original licensing state be equivalent to the licensure requirements of the state in which

135. ARIZ. REV. STAT. ANN. § 32-1429(F) (Supp. 1967).

136. Cf. pp. 280-87 *infra*.

137. See W. PROSSER, THE LAW OF TORTS § 40 (2d ed. 1955); Professor Leff's article *infra*.

138. See *The Quality of Medicine is Strained*, 200 J.A.M.A. 1122 (1967).

139. However, Hawaii will accept certification by the National Board of Medical Examiners. HAWAII REV. LAWS § 64-3 (Supp. 1963).

140. See generally ENDORSEMENT POLICIES, *supra* note 60.

licensure is being sought. Reciprocity has two components—equivalence of licensure requirements in the two states, and recognition by the original licensing state of the licenses of the state in which licensure is sought.¹⁴¹ As a practical matter, endorsement and reciprocity are often used interchangeably.

In addition to the basic factors of equivalence and reciprocity, the statutes may provide other requirements for recognition—such as a basic science certificate, internship, prior professional practice for a specified number of years, citizenship, state residence, or an oral or practical examination.¹⁴² Although forty-nine jurisdictions reciprocate with or endorse licenses issued by other states, in sixteen of these all endorsements of licenses are at the discretion of the licensing board,¹⁴³ and only eight states reciprocate with or endorse the licenses of all other jurisdictions.¹⁴⁴

Restrictions upon recognition of other states' licenses, like all provisions of medical licensure laws, are constitutionally justifiable exercises of state police power only insofar as they regulate the competence of physicians for the protection of the public.¹⁴⁵ In an era of medical manpower shortages it is especially important that this be the sole criterion for restrictions upon the interstate mobility of physicians. The constitutional test must be applied to existing restrictions which, as noted above, are primarily based upon either a lack of equivalence in licensure requirements or a lack of reciprocity in recognition policies of the states involved.

Equivalence of individual qualifications and licensure standards is clearly related to professional competence and public protection. The most fundamental licensure standards, required by all states, are graduation from an approved medical school and passage of a licensure examination. For the former, equivalence of medical education is assured by national accredi-

141. Although some licensure statutes refer to reciprocity agreements between states, no formal agreements exist. Reciprocity is determined by regulations of the licensing boards or by informal arrangements between jurisdictions.

142. *See* ENDORSEMENT POLICIES, *supra* note 60. A few states also require that the existing license for which endorsement is sought must have been procured without fraud, or within a specified number of years preceding the current application, and/or that it must never have been suspended or revoked. In some states an applicant who has failed the state licensing examination cannot thereafter be granted a license on the basis of credentials from another state.

143. Ala., Ariz., Cal., Del., D.C., Idaho, Ill., Iowa, Kan., Ky., Md., N.H., N.Y., Okla., Pa., and Wyo.

144. Conn., Ind., Mass., Mont., Neb., Ohio, S.C., and Va. *See* ENDORSEMENT POLICIES, *supra* note 60.

145. *Dent v. West Virginia*, 129 U.S. 114 (1888). For a more comprehensive statement of the constitutional scope of the states' police power, see *Nebbia v. New York*, 291 U.S. 502 (1934).

tation, which has eliminated sub-standard medical schools and provided certifications used by all state licensing agencies.¹⁴⁶ For the latter, equivalence of examination performance may eventually be assured by universal requirement and recognition of the examinations given by the National Board of Medical Examiners.¹⁴⁷ In the meantime, states should be free to discriminate against licenses issued by other states on the basis of examination standards inferior to their own.

Even if licensure standards are equivalent, the states should also be able to refuse recognition to physicians originally licensed elsewhere whose ability to practice has been impaired by educational obsolescence or physical or mental infirmities. Similarly, in determining conditions for practice within their boundaries, states may prohibit the entrance of physicians for part-time, semi-retired, or semi-vacation practice, where this regulation is designed to protect the public. There is a real question, however, as to whether states should be free to impose such limitations upon the immigration of physicians licensed by other states, and not require similar standards for continued practice by physicians already licensed in the jurisdiction. Another kind of "equivalence" is involved here, and its disregard can produce doubts as to whether regulations are protections of patients against incompetent practice or protections of physicians against economic competition. Regulations which establish different, discriminatory requirements for out-of-state licensed physicians may thus lose their constitutionally required "reasonable relationship" to public health, safety, and welfare, and may violate the spirit, if not the letter, of the full faith and credit clause¹⁴⁸ or the commerce clause¹⁴⁹ of the Federal Constitution.

Reciprocity restrictions upon license recognition may also exceed state police power, since the existence or non-existence of interstate mutuality

146. See pp. 268-69 *supra*.

147. See notes 106-07 *supra* and accompanying text. As there indicated, 42 jurisdictions currently accept National Board certification in lieu of state examination for initial licensure, and 46 accept such certificates for endorsement of other states' licenses.

148. U.S. CONST. art. IV, § 1. In no instances have medical licenses, or any other state licenses limiting certain activities to qualified individuals, been construed as "public acts" entitled to full faith and credit by sister states. See Jackson, *The Full Faith and Credit Clause; The Lawyer's Clause of the Constitution*, 45 COLUM. L. REV. 1 (1945).

149. U.S. CONST. art. I, § 8. Whether a state's restrictions upon the entrance of physicians could be held to violate the commerce clause would depend on whether the applicable regulation of the practice of medicine was construed to affect interstate commerce, and whether the regulation was considered to impose an undue burden on such commerce. In the absence of precisely relevant precedent, these questions cannot be definitively answered since they involve some of the most complex issues in constitutional law. See, e.g., *A Symposium on State Taxation of Interstate Commerce*, 46 VA. L. REV. 1051 (1960).

is entirely irrelevant to a physician's professional competence and licensure qualifications. Although pressures created by the shortage of physicians have seldom effected liberalization of license recognition policies,¹⁵⁰ there are some indications that at least the force of reciprocity requirements is currently yielding to such pressures. Of the forty-nine jurisdictions which have some provision for recognizing other states' licenses, the licensing agencies of all but six currently have discretionary authority to endorse licenses issued by non-reciprocating states.¹⁵¹ Two states have recently amended their statutes to specify that their reciprocity requirements are discretionary rather than mandatory.¹⁵² If this discretion is exercised clearly and consistently—as, for example, the basis for regulations establishing conditions under which non-reciprocating states' licenses will be recognized—the effect of reciprocity may not be so objectionable.

F. *Suspension, Revocation, and Reinstatement of Licenses*

Legal provisions for disciplinary actions against licensed physicians involve balancing the interest of the public in ethical and competent medical practice, with the interest of physicians in continuing their practice without unjust interference. Accordingly, state medical practice acts specify the grounds which must be satisfied for the removal of medical licenses, and the procedures which must be followed in the enforcement of licensure criteria.¹⁵³

1. *Grounds for License Removal*

Statutory grounds for suspension and revocation of medical licenses can be summarized within three general and somewhat overlapping categories:¹⁵⁴

150. F. MOTT & M. ROEMER, *RURAL HEALTH AND MEDICAL CARE* 377 (1948).

151. See *ENDORSEMENT POLICIES*, *supra* note 60. The six states without discretionary qualifications of their reciprocity requirements are Alaska, Ark., Ga., La., Nev., and Vt.

152. IOWA CODE ANN. § 148.5 (1962); MINN. STAT. § 147.04 (Supp. 1966).

153. It is possible that statutory grounds for suspension or revocation of an existing license may influence the interpretation of statutory requirements for the issuance of a new license, especially criteria such as "good moral character." See notes 57-59 *supra* and accompanying text. And, in general, the same statutory procedures may be used by an aggrieved physician to test a licensing agency's initial refusal to license him or subsequent decision to discipline him. The present section, however, considers both grounds and procedures only in disciplinary contexts.

154. ALA. CODE tit. 46, § 270 (Supp. 1965); ARIZ. REV. STAT. ANN. § 32-1401 (Supp. 1967); ARK. STAT. ANN. § 72-613 (Supp. 1967); CAL. BUS. & PROF. CODE §§ 2416-17 (Deering Supp. 1966); COLO. REV. STAT. ANN. § 3-16-3 (1964); DEL. CODE ANN. tit. 24, §§ 1741(a)(7)-(8) (Supp. 1966); FLA. STAT. ANN. § 458.12(1)

1. personal disqualifications—physical or mental illness or disability; drug addiction, alcoholism, gross immorality, etc.;

2. illegal acts—conviction of a felony or a misdemeanor involving moral turpitude, violation of narcotics laws, performing or procuring or aiding the performance of an abortion, aiding or abetting an unlicensed person to practice medicine, fraud in obtaining a license, violations of the licensure law or of state public health laws and regulations, etc.; and

3. unprofessional conduct—improper advertising, fee-splitting, representing an incurable condition as curable, conduct likely to deceive or defraud or injure the public, betrayal of a professional secret, habitually negligent conduct, wilful neglect of a patient, gross malpractice, etc.

Despite some general similarity among disciplinary grounds, there is no uniformity among the states in either their incidence or their statement. A 1961 survey, which is still remarkably accurate, found the following statutory configuration:¹⁵⁵

Among the states there are more than 90 reasons for the revocation or suspension of a medical license. No one ground, stated in the same words, is to be found in all medical practice acts. Nine grounds are found repeated in thirty or more state laws. These are: drug addiction in forty-seven states; unprofessional conduct (whether defined or not) in forty-five states; fraud in connection with examination or obtaining a license in forty-four states; alcoholism in forty-two states; advertising in forty states; abortions in thirty-nine states; conviction of an offense involving moral turpitude in thirty-six states; and mental incompetence in thirty-two states.

a. general grounds. Complicating this variety are problems of statutory terminology, and the greatest semantic difficulties arise in connection with broad, undefined terms such as “unprofessional conduct,” “conduct un-

(1) (1965); GA. CODE ANN. § 84-916 (Supp. 1966); ME. REV. STAT. ANN. tit. 32, § 3152 (1965); MD. ANN. CODE art. 43, § 145 (Supp. 1967); MINN. STAT. ANN. § 147.19 (Supp. 1966); MISS. CODE ANN. § 8892.1(5) (Supp. 1966); NEB. REV. STAT. §§ 71-1,104.01, -1,104.04 (1966); N.J. STAT. ANN. § 45:9-16 (1963); N.M. STAT. ANN. § 67-5-24 (1953); N.Y. EDUC. LAW § 6514(2)(d)-(f) (McKinney Supp. 1966); N.D. CENT. CODE ANN. § 43-17-31 (1960); ORE. REV. STAT. §§ 667.190(10), 677.225 (1965); PA. STAT. ANN. tit. 63, § 410 (Supp. 1966); R.I. GEN. LAWS § 5-37-4 (Supp. 1966); VA. CODE ANN. §§ 54-317, -317.1, -317.2 (1967); WIS. STAT. ANN. §§ 147.20(1)(g) (1957), 147.225 (Supp. 1967); WYO. STAT. ANN. § 33-340(1) (1957). See generally MEDICAL DISCIPLINARY PROCEEDINGS, A Study prepared by the Legal Department of the American Medical Association, undated but distributed as current, November 1, 1966.

155. A.M.A. MEDICAL DISCIPLINARY COMMITTEE, REPORT TO THE BOARD OF TRUSTEES 41 (1961). This report was based upon the same statutory survey as MEDICAL DISCIPLINARY PROCEEDINGS, *supra* note 154. For subsequent amendments of the statutes, see note 154 *supra*.

becoming a physician," or "conduct harmful to the public." These terms, especially "unprofessional conduct," are used in most jurisdictions in either of two ways: as a generic category under which specific proscribed acts are listed, with a notation that the category "includes but is not limited to" the listed acts; or as a final miscellaneous ground following a list of more specific disciplinary grounds. In either case, the terms constitute vague catch-alls which significantly affect the enforcement of the statutes.

First of all, because of the quasi-criminal nature of disciplinary actions, some courts may invalidate such statutory terms as unconstitutionally vague, even in cases of obvious violations:

"Unprofessional or dishonorable conduct," for which the statute authorizes the revocation of a license that has been regularly obtained, is not defined by the common law, and the words have no common or generally accepted signification. What conduct may be of either kind remains, as before, a mere matter of opinion. In the absence of some specification of acts by the law-making power, which is alone authorized to establish the standard of honor to be observed by persons who are permitted to practise the profession of medicine, it must, in respect of some acts at least, remain a varying one, shifting with the opinions that may prevail from time to time in the several tribunals that may be called upon to interpret and enforce the law.¹⁵⁶

. . . . Doubtless all intelligent and fair-minded persons would agree in the opinion of the board of medical supervisors that the act charged against the appellant in the case at bar amounted to conduct both unprofessional and dishonorable. But this is not the test of the validity of the particular clause of the statute. The underlying question involved in all cases that may arise is whether the courts can uphold and enforce a statute whose broad and indefinite language may apply not only to a particular act about which there would be little or no difference of opinion, but equally to others about which there might be radical differences, thereby devolving upon the tribunals charged with the enforcement of the law the exercise of an arbitrary power of discriminating between the several classes of acts.¹⁵⁷

On the other hand, most courts have upheld disciplinary actions based upon these vague grounds, at least in cases of clear and convincing evidence, by applying principles of strict and "saving" statutory construction:¹⁵⁸

In the sections of the statutes dealing with the grounds upon which a license may be revoked, the Legislature has used language specifically

156. *Czarra v. Board of Med. Supervisors*, 25 App. D.C. 443, 451 (D.C. Cir. 1905).
157. *Id.* at 453.

158. *E.g.*, *In re Mintz*, 233 Ore. 441, 378 P.2d 945 (1963). *See also* "Cases on Revocation of Physicians' Licenses" (Am. Med. Ass'n, mimeograph, undated); 41 AM. JUR. *Physicians & Surgeons* § 46 (1938); 70 C.J.S. *Physicians & Surgeons* § 31 (1951); *Annots.*, 5 A.L.R. 94 (1920), 79 A.L.R. 323 (1932), 163 A.L.R. 909 (1946).

defining certain of them, or has used words having a reasonably certain meaning in the law, but it has then added certain general words such as 'immoral,' 'dishonorable,' or 'unprofessional,' as indicating the character of conduct which is a ground for revoking a license. These words in themselves have no significance in law even to a reasonable certainty and might seem to authorize the revocation of a license for acts having no reasonable relation to the underlying purpose of the statute, the protection of the public. Giving these words a broad meaning, it would be difficult to justify the grant to the board of power to revoke a license for any conduct which it might deem to be immoral, dishonorable, or unprofessional. . . . But if we did give to these words so broad a meaning, we would be attributing to the Legislature an intent to vest the board with power going beyond the scope of its purposes and to enact a law of at least doubtful constitutionality. We cannot assume that the Legislature intended to give expression to such an intent and must, if it is reasonably possible to do so, so construe the words it has used as to make the provision a valid and reasonable one. . . . The words must have been used in the light of the fundamental purpose of the statutes to regulate the profession in the public interest and they can only be construed as intending to include conduct within their fair purport which either shows that the person guilty of it is intellectually or morally incompetent to practice the profession or has committed an act or acts of a nature likely to jeopardize the interest of the public.¹⁵⁹

It might be expected that this judicial uneasiness and reluctance to enforce nebulous terminology would lead the legislatures or the licensing agencies to promulgate more precise definitions. Instead, however, the result has been found to be "a fear of litigation" which generally discourages disciplinary actions, except possibly "when a statute is clear or where the evidence is clear cut."¹⁶⁰ In other words, judicial principles of strict construction are adopted by the licensing agencies, which generally enforce only obvious disciplinary grounds defined in the statutes, or particularly egregious or even heinous instances of undefined "unprofessional conduct."¹⁶¹ The result is that the disciplinary process of the licensure statutes protects the public only against relatively infrequent and extreme offenses.¹⁶²

159. *Sage-Allen Co., Inc. v. Wheeler*, 119 Conn. 667, 678-79, 179 A. 195, 199-200 (1935).

160. A.M.A. MEDICAL DISCIPLINARY COMMITTEE, *supra* note 155, at 45, 46.

161. In most states the statutes give the licensing board discretionary authority to suspend or revoke licenses on the grounds listed. In only a few states does the board have a statutory "duty" to suspend or revoke licenses; *e.g.*, GA. CODE ANN. § 84-916 (Supp. 1966).

162. Compare the reported incidence of various complaints against physicians by the A.M.A. MEDICAL DISCIPLINARY COMMITTEE, *supra* note 155, at 18, with the grounds most frequently involved in disciplinary actions, *id.* at 25.

This result may well be consistent with policies of limiting licensure laws to the enforcement of minimal standards, and relying upon the self-discipline of medical associations and institutions for further maintenance of professional competence. Regardless of questions concerning the feasibility of these policies,¹⁶³ however, their implementation through administrative conservatism based upon predicted judicial restriction of vague legislative phrases seems a curious subversion of the legal process. For the statutes' general grounds, even those recently enacted, do purport to provide comprehensive discipline through the licensure mechanism, with suspension or revocation justified by:

Any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health, welfare or safety of the patient or the public, or any conduct, practice or condition which does or might impair the ability safely and skillfully to practice medicine.¹⁶⁴

b. specific grounds. The statutory definitions of some specific disciplinary grounds indicate an intent that licensure criteria be less stringent than other legal standards to which physicians may be accountable. For example, while a physician may be civilly liable for malpractice based upon "ordinary" negligence (failure to exercise the care and skill ordinarily exercised by other physicians),¹⁶⁵ in the fifteen states which list malpractice among grounds for licensure discipline, the standard is usually phrased as "gross malpractice [or] repeated malpractice or any malpractice"¹⁶⁶ "gross malpractice or gross neglect,"¹⁶⁷ "gross carelessness or manifest incapacity,"¹⁶⁸ or "gross incompetence."¹⁶⁹ The disciplinary criteria are thus analogous to less stringent criminal standards of gross malpractice, which are usually included in state penal statutes.

Another aspect of this point is illustrated by some recent developments regarding license revocation for performing an abortion.¹⁷⁰ These disci-

163. See generally A.M.A. MEDICAL DISCIPLINARY COMMITTEE, *supra* note 155.

164. ARIZ. REV. STAT. ANN. § 32-1401(8)(t) (Supp. 1966).

165. For more complete statement and discussion of the standard applicable to civil malpractice cases, see Leff, *Medical Devices and Paramedical Personnel: A Preliminary Context for Emerging Problems*, 1967 WASH. U.L.Q. 332.

166. ARIZ. REV. STAT. ANN. § 32-1401(8)(h) (Supp. 1966).

167. N.J. STAT. ANN. § 45:9-16(h) (1963).

168. ORE. REV. STAT. § 677.190(19) (1961).

169. R.I. GEN. LAWS § 5-37-4(j) (Supp. 1966).

170. For discussion of abortion laws, see Leavy & Kummer, *Abortion and the Population Crisis; Therapeutic Abortion and the Law; Some New Approaches*, 27 OHIO ST. L.J. 647, 654 (1966); Roemer, *Due Process and Organized Health Services*, 79 PUB. HEALTH REP. 664, 666 (1964).

plinary grounds generally incorporate a state's penal provisions governing abortions. Thus, in most states, where it is a crime to perform an abortion except to save a woman's life, the licensure statute provides for revocation for performance of an "unlawful," "illegal," or "criminal" abortion, or for performance of an abortion except to save a woman's life. In those states in which the criminal law permits an abortion to preserve either the life or health of the woman,¹⁷¹ the licensure statute is also interpreted less restrictively. In Oregon, although the criminal statute allows an abortion only to save a woman's life, the licensure statute provides that an abortion for a woman whose health is imperiled by the pregnancy, after consultation with and concurrence of another licensed physician, is not a ground for suspension or revocation of a medical license.¹⁷² The Oregon Supreme Court has held that a physician who undertakes such an abortion, with proper consultation, is not subject to criminal prosecution.¹⁷³ And in Mississippi, even before the 1967 amendment of the abortion law to permit abortions in cases of rape, the licensure statute had been amended to exempt a medically indicated abortion from the sanction of revocation.¹⁷⁴ Thus, where criminal standards are more stringent than criteria approved by the medical profession, there is some tendency for licensure discipline to follow the latter, which may in turn lead to liberalization of the former.

For many specific disciplinary grounds, however, it is difficult to determine the precise standards, if any, contemplated by the licensure statutes. The grounds are often inadequately defined, and, although the differences may not be reflected in administrative practices, statutory phraseology varies from state to state—for example: "habitual intemperance," or addiction to alcohol to such a degree as to render the physician unfit to practice; "conviction" of a felony or a misdemeanor involving moral turpitude, or "knowing and wilful commission" of such a criminal act; "wilful betrayal of a professional secret," or simply "betrayal" of such a confidence. These interstate differences may be of minor importance in

171. In 1967 Colorado (which previously allowed abortion to preserve health) and North Carolina amended their abortion laws along the lines of the MODEL PENAL CODE § 207.11, (Tent. Draft No. 9, 1959). COLO. REV. STAT. § 40-2-50 (1967); N.C. GEN. STAT. §§ 14-44, -45.1 (1967). California adopted a statute permitting abortions to preserve a woman's health and in cases of rape and incest. Therapeutic Abortion Act; CALIF. SESS. LAWS 1967, ch. 327. In all these states, license revocation will now be authorized only for abortions outside the exceptions set forth in the criminal law.

172. ORE. REV. STAT. § 677.190(2) (1961).

173. *State v. Buck*, 200 Ore. 87, 262 P.2d 495 (1953). For discussion of this case, see Leavy & Kummer, *supra* note 170, at 654.

174. MISS. CODE ANN. § 8893.1(5) (Supp. 1964).

the discipline of obvious disqualifications and patently unethical practices, but for some grounds, such as mental incompetency, the differences have more serious implications.

Some statutory provisions, particularly those recently enacted,¹⁷⁵ provide for license suspension or revocation only when a physician evidences mental illness or mental incompetence "to a degree and of a character which renders such person unsafe or unreliable as a practitioner,"¹⁷⁶ or when any physical or mental disability makes further practice dangerous.¹⁷⁷ Other statutes, however, make admission to a mental hospital a ground for suspension or revocation without specifying inability to practice. The latter provisions, by delaying hospitalization, may endanger the physician and even the public. It seems unreasonable to permit a mentally ill physician to continue to practice while being treated with medication, but to revoke his license if he enters a hospital. While he is hospitalized, the physician is unable to practice medicine in any event. One state provides for automatic suspension of a license in case of voluntary hospitalization exceeding twenty-five days,¹⁷⁸ but this exception which permits initial diagnosis or treatment without suspension still does not relate the suspension to ability to practice. Another state has a particularly inequitable provision whereby voluntary admission or commitment to a state hospital creates a license suspension, while admission to a private mental facility presumably does not so operate.¹⁷⁹ While these statutes may be prejudicial to physicians, other statutes which authorize suspension or revocation only after a court's adjudication of "insanity" or "incompetency"¹⁸⁰ may not provide sufficient protection for the public. Revocation on grounds of mental disability should be related to the physician's capacity to practice and the safety

175. ARIZ. REV. STAT. ANN. § 32-1452D.3 (1956); ARK. STAT. ANN. § 72-613(11) (Supp. 1967); FLA. STAT. ANN. § 458.12(1) (1965); GA. CODE ANN. § 84-916 (Supp. 1966); IDAHO CODE ANN. § 54-1810(k) (1957); ILL. ANN. STAT. ch. 91, § 16a (1966); KY. REV. STAT. ANN. § 311.595(1)(g) (1963); MASS. GEN. LAWS ANN. ch. 112, § 61 (1965); NEV. REV. STAT. §§ 630.300, 630.030(15) (1963); N.H. REV. STAT. ANN. § 329:17 (1966); N.Y. EDUC. LAW § 6514.2(c) (1953); N.C. GEN. STAT. § 90-14 (1965); OKLA. STAT. ANN. tit. 59, § 516 (1963); ORE. REV. STAT. § 677.225(1)(a) (1965); PA. STAT. ANN. tit. 63, § 410 (Supp. 1966); VA. CODE ANN. § 54-317.1(2) (1967); WASH. REV. CODE ANN. § 18.72.030(14) (Supp. 1966).

Mental disability grounds are indicated in MEDICAL DISCIPLINARY PROCEEDINGS, *supra* note 154. Recent amendments are specially compiled at note 154 *supra*.

176. ALA. CODE tit. 46, § 270 (Supp. 1965).

177. WYO. STAT. ANN. § 33-340(1)(e) (1959).

178. ORE. REV. STAT. § 677.225(a) (1961); *cf.* ORE. REV. STAT. § 677.190(18) (1961).

179. CAL. GEN. LAWS ANN. act 13, § 13.5 (Deering 1965).

180. *E.g.*, VA. CODE ANN. § 54-317.1(2) (1966).

of the public. These provisions also must not inhibit proper medical care for physicians.

Some potential grounds for licensure discipline are conspicuously absent from the statutes. For example, in no jurisdiction is educational obsolescence a ground for suspension or revocation, unless or until manifested as "unprofessional conduct," "gross malpractice," or, in a few states, "gross incompetence."¹⁸¹ Also, few states have adjusted their disciplinary grounds to changes in the organization of medical practice. Only one statute provides that publication, distribution, and circulation of information concerning physicians by any group organized and existing as a non-profit insurance plan do not constitute advertising forbidden by the licensure law.¹⁸² The latter provision is significant for the development of consumer-sponsored prepaid health care plans.

2. *Procedures for License Removal*

a. disciplinary agencies. A few states separately administer the issuance and suspension or revocation of medical licenses, and delegate disciplinary authority to agencies other than the licensing board. In five jurisdictions the courts are given exclusive or concurrent power to suspend or revoke medical licenses.¹⁸³ The state board or department to which the licensing agency is attached has sole primary jurisdiction for disciplinary actions.¹⁸⁴ In some states where the examining board does not issue licenses, but advises another agency on qualifications for licensure, it, nevertheless, has the authority to revoke licenses.¹⁸⁵ In Delaware, disciplinary matters are delegated to the Medical Council which consists of a judge and two physicians.¹⁸⁶ An independent Medical Disciplinary Board is elected by physicians licensed in Washington.¹⁸⁷ With these exceptions, disciplinary authority resides in the same agencies responsible for licensing.¹⁸⁸

181. Compare the proposal that periodic re-examination and/or regular participation in continuing education programs be made "requirements for continuing membership in organized medicine and other medical associations." Gunderson, *Medical Responsibilities in a Changing World*, 170 J.A.M.A. 280, 282 (1959).

182. N.Y. EDUC. LAW § 6514-2(d) (McKinney 1961).

183. CONN. GEN. STAT. REV. § 20-5 (1958); D.C. CODE ANN. §§ 2-123, -131 (1966); IOWA CODE § 147.58 (1962); LA. REV. STAT. tit. 37, § 1285 (1950); WIS. STAT. ANN. § 147.20(2) (1957).

184. ILL. ANN. STAT. ch. 91, § 16a (Smith-Hurd 1966); NEB. REV. STAT. § 71-149 (1966); R.I. GEN. LAWS ANN. § 5-37-4 (Supp. 1966).

185. ALA. CODE tit. 46, §§ 259, 270 (Supp. 1966); TENN. CODE ANN. §§ 63-605, -618 (1956).

186. DEL. CODE ANN. tit. 24, §§ 1701, 1741 (1953 and Supp. 1966).

187. WASH. REV. CODE ANN. §§ 18.72.010, .050 (1961).

188. For the designation and composition of medical licensing agencies, see p. 259 *supra*; Appendix 1.

Most arguments for separate disciplinary administration proceed from the comprehensive role that the medical licensing boards play in disciplinary actions. The boards may act as promulgators of regulations, investigators of complaints, prosecutors of offenses, triers of fact questions, and judges of final decisions. This composite role, however, characterizes many regulatory agencies, and the virtues of such agencies—expertise, experience, flexibility, perspective—seem especially appropriate for licensing boards. Even the domination of the boards' memberships by physicians and their selection by medical societies¹⁸⁹ enhance rather than handicap their disciplinary role; for licensure discipline must, after all, reflect and reinforce the goals of traditional medical self-discipline:

. . . (1) to impose a penalty which is just and proper; (2) to develop measures which will exert a deterrent effect upon others who might become involved as well as the offender; and (3) to ensure that the potentialities for rehabilitation are present.¹⁹⁰

Indeed, the Medical Disciplinary Committee of the American Medical Association has recommended that the medical boards consider discipline their primary function:¹⁹¹

The committee would suggest that greater emphasis be given to ensuring competence and observance of law and ethics *after* licensure. Agencies already exist which can prepare and correct written examinations to be given applicants for medical licensure. Additionally, much more reliance can be placed on our medical schools of today. . . . Thus it may be an appropriate time to re-appraise the primary function of state medical boards.

. . . . It is the recommendation of the committee, therefore, that State boards of medical examiners seriously consider the advisability and necessity of making discipline their primary responsibility. . . .

b. disciplinary procedures. Especially in light of the extensive powers of disciplinary agencies, procedural safeguards are important to assure full protection of individual licensed physicians. Depending upon whether a license is regarded as a property right or a revocable privilege,¹⁹² all the elements of due process may or may not be constitutionally required in disciplinary proceedings. In most states, however, the licensure statutes provide a licensee with basic rights to receive a copy of the charges against

189. See pp. 259-61 *supra*.

190. A.M.A. MEDICAL DISCIPLINARY COMMITTEE, *supra* note 155, at 60.

191. *Id.* at 55, 68.

192. See F. GRAD, PUBLIC HEALTH LAW MANUAL 62-74 (1965); Reich, *The New Property*, 73 YALE L.J. 733 (1964).

him and prior notice of any hearing thereon, and to have such a hearing at which he may be represented by counsel.¹⁹³ In addition, the omission of any of these rights from the licensure statutes may be remedied by state administrative practice acts, where they exist. If these or other rights of due process are not available for initial administrative proceedings, the statutes generally provide for appeal and judicial review.¹⁹⁴

Under former statutes without guarantees of procedural safeguards, the courts frequently implied them. It has been held that a licensee is entitled to judicial review even without statutory authorization,¹⁹⁵ that the requirement of a hearing implies a requirement of notice,¹⁹⁶ and that a statute is unconstitutional absent a provision for notice and hearing.¹⁹⁷ That the courts still strive to protect licensed physicians' rights is demonstrated by a recent decision of the California Supreme Court granting the right of discovery of evidence to physicians charged with "unprofessional conduct" for having performed hospital-approved therapeutic abortions in cases of maternal rubella. The court extended the right of discovery to the administrative hearing before the Board of Medical Examiners, which it analogized to a criminal proceeding, in order to afford the physicians full opportunity to prepare their defense.¹⁹⁸

Alert to protect the rights of individual physicians, the courts have also been aware of the impact of procedural requirements on protection of the public. It has been held that a board's decision was not invalid where all the board members were not physically present to hear the evidence but instead read the record,¹⁹⁹ that a jury trial is not constitutionally required for revocation of a license,²⁰⁰ and that a trial court was justified in refusing

193. Authorities cited note 154 *supra*.

194. Authorities cited note 154 *supra*.

195. *Horton v. Clark*, 316 Mo. 770, 293 S.W. 362 (1927).

196. *Ramsay v. Shelton*, 329 Ill. 432, 160 N.E. 769 (1928).

197. *Board of Med. Examiners v. Lewis*, 149 Ga. 716, 102 S.E. 24 (1920).

198. *Shively v. Stewart*, 65 Cal. 2d 475, 481-82, 421 P.2d 65, 68, 55 Cal. Rptr. 217, 220 (1966):

The criminal law analogy is appropriate here. The medical board has the resources of the state at its command to enable it to secure complete information and to prepare its case before filing an accusation. Since the agency is the accuser, a party to the proceeding, and ultimately makes a decision on the record, its concentration of functions calls for procedural safeguards. Petitioners have been charged with crimes and should have the same opportunity as in criminal prosecutions to prepare their defense. Moreover, when, as in this case, a busy professional board must be assembled to hear the charges, it is of the utmost importance that full preparation be promoted so that needless continuances can be avoided.

199. *Cooper v. Board of Med. Examiners*, 35 Cal. 2d 242, 217 P.2d 630 (1950).

200. *State v. Hanson*, 201 Iowa 579, 207 N.W. 769 (1926).

to admit new or additional evidence in mitigation where the evidence could have been offered at the original hearing.²⁰¹

3. *Reinstatement of Removed Licenses*

Licensure statutes generally provide for reinstatement of suspended or revoked licenses upon evidence that the reason for removal of the license no longer obtains, and that the former practitioner's privilege to practice may safely be restored.²⁰² Additional evidence may be required, for example, that the physician is of "good moral character" and has not engaged in practice during the period of suspension or revocation. In some states, in cases of suspension for a definite period of time, reinstatement is automatic at the expiration of the period. But for indefinite suspension or revocation, written application for reinstatement is necessary,²⁰³ and the statutes authorize or require a hearing, an oral or written examination, or an interview to determine fitness to resume practice. The statute may allow the board to set terms and conditions for restoration of a license, but, even without such a provision, all boards have wide discretion in determining reinstatements.²⁰⁴

Separate provisions in many states govern reinstatement of licenses removed because of mental disability.²⁰⁵ Generally, two requirements must be satisfied: (1) removal of any adjudication of mental illness or incompetency, and discharge from hospital; and (2) independent judgment by the board of recovery and ability to practice safely.²⁰⁶ The latter requirement, related to professional competence and public safety, is in accord with the criteria recommended above for determining removal of licenses on grounds of mental disability.²⁰⁷

II. OSTEOPATHIC PHYSICIANS

Osteopathy began in 1894 as a drugless, non-surgical system of healing based on a theory that physical ailments result from misalignment of the

201. *Schoenen v. Board of Med. Examiners*, 245 A.C.A. 972, 54 Cal. Rptr. 364 (1966).

202. *E.g.*, ARIZ. REV. STAT. ANN. § 32-1452(A)(1) (Supp. 1967); N.M. STAT. ANN. § 67-5-26(B) (1961); WIS. REV. STAT. ANN. § 147.26(2) (1957).

203. *E.g.*, ARIZ. REV. STAT. ANN. § 32-1452(A)(1) (Supp. 1967); CAL. BUS. & PROF. CODE § 2376.5 (Deering Supp. 1966).

204. *E.g.*, CAL. BUS. & PROF. CODE § 2376.5 (Deering Supp. 1966); N.M. STAT. ANN. § 67-5-26(C) (1961); WIS. REV. STAT. ANN. § 147.26(2) (1957).

205. Separate reinstatement criteria and procedures especially characterize recently enacted mental disability provisions. See statutes compiled, note 154 *supra*.

206. *E.g.*, CAL. BUS. & PROF. CODE § 2416 (Deering Supp. 1966); N.M. STAT. ANN. § 67-5-26(A) (1961).

207. See text accompanying notes 177-181 *supra*.

musculo-skeletal system. All the original tenets of osteopathy have since been scientifically disproved, and most have even been rejected by the osteopathic profession.²⁰⁸ The five accredited osteopathic colleges—located at Chicago, Des Moines, Kansas City, Kirksville, and Philadelphia—have revised their curricula to virtually eliminate mechanotherapy and manipulation as subjects of study, and to include scientific medicine, surgery, pharmacology, and other clinical and pre-clinical subjects.²⁰⁹ In 1955 a study committee of the American Medical Association surveyed the osteopathic colleges and found no evidence that osteopathic courses interfere with the achievement of a sound medical education. This survey concluded that “teaching in present-day colleges of osteopathy does not constitute the teaching of ‘cultist’ healing.”²¹⁰

The transformation of osteopathy from cultist healing to scientific medicine is significant because osteopaths comprise more than four per cent of American medical manpower.²¹¹ The contribution that osteopathic physicians can make to American medical care depends upon standards enacted for their licensure, facilities utilized for their training and practice, and perhaps, eventually, agreements reached for their integration into the medical profession.

A. *Licensure Provisions*

Although osteopathy has made great progress in the direction of scientific medical practice, state licensure statutes for osteopaths retain some vestiges of its origins as a healing cult. These vestiges may characterize the scope of functions authorized for licensees, the organization and operation of licensing agencies, and/or the qualifications required for licensure.²¹²

All states and the District of Columbia license osteopathic physicians. Ten states issue licenses for osteopaths to practice only what is taught in schools of osteopathy, but three of these states permit performance of major surgery if the osteopath has taken the same qualifying examination as all-

208. 2 W. McNERNY, *HOSPITAL AND MEDICAL ECONOMICS* 1274 (1962); Northrup, *Perspectives from the Past: Sixty-five Years of Progress*, 60 J. AM. OSTEOPATHIC ASS'N 81 (1960).

209. 2 W. McNERNY, *supra* note 208, at 1275.

210. A.M.A. COMM. ON OSTEOPATHY & MEDICINE, REPORT (1955), reprinted in *Appointment of Doctors of Osteopathy as Medical Officers, Hearings on H.R. 483 Before a Subcomm. of the Senate Comm. on Award Services*, 84th Cong., 2d Sess. 79, 87 (1956).

211. Of the 305,115 physicians in the United States as of December 31, 1965, the degree of Doctor of Osteopathy was held by 13,027. 1965 U.S. DEPT. OF HEALTH, EDUCATION & WELFARE, HEALTH RESOURCES STATISTICS 98.

212. See generally Holman, *Osteopathy and the Law*, 195 J.A.M.A. 283 (1966).

opathic physicians.²¹³ In twenty-one states osteopaths are specifically prohibited from performing major surgery or using drugs, but in five of these states the use of drugs or performance of major surgery is allowed if the osteopath has completed certain graduate requirements and in three of these states if he has taken the same qualifying examination as allopathic physicians.²¹⁴

In the other twenty-nine states and the District of Columbia, an osteopath may obtain an "unlimited" license to practice medicine and surgery and in nineteen of these states osteopaths take the same qualifying examinations as allopathic physicians.²¹⁵ Twenty-four states which permit osteopaths to use drugs and perform major surgery require completion of a satisfactory internship.²¹⁶ In three states osteopaths are examined by boards containing no osteopathic members.²¹⁷ In thirty-two states boards containing only osteopaths examine the qualifications of candidates for licensure.²¹⁸ Since the merger of osteopathy and medicine²¹⁹ in California, the osteopathic board gives no new licenses.²²⁰ The Board of Medical Examiners now is the exclusive licensing agency and licenses only M.D.'s.²²¹ In the remaining states the boards can contain M.D.'s and D.O.'s.²²²

All states require graduation from an acceptable or approved osteopathic college.²²³ In general the states rely on the American Osteopathic Association for accreditation of osteopathic schools, but as a matter of practice some state boards inspect osteopathic schools independently.²²⁴ All the osteopathic colleges in the United States are approved by the American Osteopathic Association, and all require high school diplomas and collegiate education for admission.²²⁵

213. Appendix 3.

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.*

219. CAL. BUS. & PROF. CODE § 3600 (Deering 1960).

220. *Id.*

221. *Id.* §§ 2100-2101 (Deering Supp. 1966).

222. Appendix 3.

223. *Id.*

224. Interview with the Louisiana Board of Osteopathic Examiners.

225. Kisch & Viseltear, *Doctors of Medicine and Doctors of Osteopathy in California: Two Separately Legitimized Medical Professions Face the Problem of Providing Medical Care*, a case study prepared by the U.C.L.A. School of Public Health, and soon to be published by the Division of Medical Care Administration, U.S. Public Health Service. In general interstate recognition of osteopathic licenses is based on equivalence of education. See, e.g., ORE. REV. STAT. § 681.090 (1961); WASH. REV. CODE ANN. § 18.57.130 (1961).

Federal funding is now available to facilitate the improvement of osteopathic colleges, but there is no requirement that these schools must meet the accreditation standards of the AMA-AAMC Joint Liaison Committee in order to qualify for federal financial assistance.²²⁶

Twelve states require osteopaths, as a condition of renewal of their licenses, to furnish evidence of completion of a one- or two-day "refresher" course.²²⁷ These provisions, unique among licensure laws for health personnel, were enacted at the insistence of state osteopathic associations, which sponsor refresher programs for practicing osteopaths. Although the specific requirements are inadequate to keep practitioners abreast of expansions in medical knowledge, the provisions are sound in principle.²²⁸ They should be made at least as strong as any new continuing education requirements for medical and surgical physicians,²²⁹ and perhaps even stronger, in view of the limitations of osteopathic education and training.²³⁰

B. *Relationship of Osteopaths to Hospitals*

Full understanding of the status of osteopaths in the United States requires not only review of the licensure laws but also analysis of the relationship of osteopaths to hospitals. The latter involves clinical training of osteopathic students, accreditation of osteopathic hospitals, and osteopaths' staff privileges in non-osteopathic hospitals.

1. *Facilities for Education and Training*

Although the licensure statutes for osteopaths ostensibly require educational qualifications equivalent to those for M.D.'s,²³¹ the weaknesses of osteopathic colleges produce significant differences in actual preparation. Educational limitations of the osteopathic physician may result from (1) the lack of clinical facilities large enough to provide adequate training and

226. Health Professions Educational Assistance Act of 1963, 42 U.S.C. §§ 292-292b, 292d-292j, 293-293h, 294-294e (1964).

227. ARIZ. REV. STAT. ANN. § 32-1825(B) (1956); FLA. STAT. ANN. § 459.19 (1965); ME. REV. STAT. ANN., tit. 32, § 2703 (1965); MICH. STAT. ANN. § 14.573 (1956); NEV. REV. STAT. § 633.110(3) (1963); N. MEX. STAT. ANN. § 67-8-17 (1961); N.D. CENT. CODE ANN. § 43-14-17(2) (1960); OHIO REV. CODE ANN. § 4731.37 (Page 1964); OKLA. STAT. ANN. tit. 59, § 641 (1963); TENN. CODE ANN. 63-908 (Supp. 1966); VT. STAT. ANN. tit. 26, § 1836 (1967); W. VA. CODE ANN. § 30-14-10 (1966).

228. In nearly all the 12 states cited in note 227 *supra*, attendance at the annual educational program conducted by the state osteopathic association, or its equivalent, satisfies the requirement of refresher education.

229. *See* pp. 276-77 *supra*.

230. *See* Section B. *infra*.

231. *See* pp. 291-93 *supra*.

close enough to osteopathic colleges to permit integrated didactic and clinical education; (2) the shortage of qualified teachers in osteopathic colleges; or (3) the inadequacy of postgraduate education for osteopathic physicians.²³² The first factor is primarily a product of the quality and location of osteopathic hospitals:

Most of the osteopathic hospitals are too small to provide adequate clinical material and broad undergraduate teaching programs, and the colleges have been forced to send their students to hospitals that are widely separated from them geographically: e.g., Chicago College of Osteopathy makes extensive use of the 400-bed Detroit Osteopathic Hospital in its undergraduate program. This obviously weakens the school's contact with its students and could be quite disruptive of the continuity of the educational program.²³³

The other two factors are closely related to the first. Since osteopathic colleges are not affiliated with universities or university medical centers, they offer neither the same resources for clinical training nor the same attractions for faculty as medical schools. The limited number and size of osteopathic hospitals results in utilizing fewer and smaller hospitals for internship and residency training than is the case for postgraduate training of M.D.'s.²³⁴ Moreover, in non-osteopathic hospitals, internships and residencies are awarded first to M.D.'s and then, if places are available, to D.O's.²³⁵

2. *Hospital Accreditation and Privileges*

Once an osteopath is licensed, the most important determinant of his status is his ability to admit patients to an accredited hospital. Although osteopathic hospitals may be approved by state licensing agencies and by the American Osteopathic Association and are eligible for federal construction grants under the Hill-Burton and Hill-Harris Acts,²³⁶ nevertheless, only hospitals with combined medical and osteopathic staffs may be accredited by the Joint Commission on Hospital Accreditation.²³⁷ For accredited, non-osteopathic hospitals, staff privileges are commonly made contingent upon graduation from an approved medical school, or upon membership in the county medical society. These rules have frequently been contested in the courts by osteopathic physicians.

232. 2 W. McNERNY, *supra* note 208, at 1281-82.

233. *Id.* at 1275-76.

234. *Id.* at 1278.

235. *Id.* at 1275-78, 1281-83, 1442.

236. 42 U.S.C. §§ 291 et seq. (1964).

237. *See* AMERICAN HOSP. ASS'N, HOSP. ACCREDITATION REFERENCES (1964).

In a recent New York case,²³⁸ the right of admission to a county medical society was denied to an osteopath who was licensed in New York and had subsequently received an M.D. degree in California after the merger of medicine and osteopathy there. The court held that the medical society, in exercising its right to make membership rules not inconsistent with law, could restrict admission to graduates of medical schools provided there was no showing of either economic necessity for society membership or monopolistic practices by the society. This holding is in accordance with the decisions of most appellate courts which have considered the question. These courts have generally held that public hospitals may adopt reasonable rules regarding admission to their staffs, and that exclusion of osteopaths does not constitute arbitrary or discriminatory action.²³⁹

On the other hand, attorneys general in two states have expressed the opinion that osteopaths are entitled to staff privileges in county hospitals,²⁴⁰ and a similar result has been reached by the courts of at least three other states.²⁴¹ This position is illustrated by two decisions of the New Jersey State Supreme Court. The first, *Falcone v. Middlesex County Medical Society*,²⁴² involved an osteopath who had been licensed to practice medicine and surgery by the New Jersey Board of Medical Examiners and subsequently was awarded an M.D. degree in Milan, Italy, after seven months' study. Thereafter he served a 16-month, A.M.A.-sponsored internship in a medical hospital in the United States. As a probationary member of the county medical society, he had staff privileges at two medical hospitals; but when his probationary membership was revoked, his staff privileges were automatically terminated because both hospitals required membership in the county medical society for staff physicians. In

238. *Kurk v. Medical Soc'y*, 18 N.Y.2d 928, 223 N.E.2d 499, 276 N.Y.S.2d 1007 (1966), *aff'g* 24 App. Div. 2d 897, 264 N.Y.S.2d 859, *rev'g* 46 Misc. 2d 790, 260 N.Y.S.2d 520 (1965).

239. *Newton v. Board of Comm'rs*, 86 Colo. 446, 282 P. 1068 (1929); *Richardson v. City of Miami*, 144 Fla. 294, 198 So. 51 (1940); *Lambing v. Board of Comm'rs*, 45 Idaho 468, 263 P. 992 (1928); *Munroe v. Wall*, 66 N.M. 15, 340 P.2d 1069 (1959); *Wallington v. Zinn*, 146 W.Va. 147, 118 S.E.2d 526 (1961); *Duson v. Poage*, 318 S.W.2d 89 (Tex. Civ. App. 1958); *Harris v. Thomas*, 217 S.W. 1068 (Tex. Civ. App. 1920).

240. Iowa and Michigan, cited by Holman, *supra* note 212, at 284.

241. *Stribling v. Jolley*, 362 Mo. 995, 245 S.W.2d 885, *modified*, 241 Mo. App. 1123, 253 S.W.2d 519 (1952); *Morgan v. State*, 155 Neb. 247, 51 N.W.2d 382 (1952); *Greisman v. Newcomb Hosp.*, 76 N.J. Super. 149, 183 A.2d 878 (1962), *aff'd*, 40 N.J. 389, 192 A.2d 817 (1963); *Falcone v. Middlesex County Medical Soc'y*, 62 N.J. Super. 184, 162 A.2d 324 (1960), *aff'd*, 34 N.J. 582, 170 A.2d 791 (1961).

242. 62 N.J. Super. 184, 162 A.2d 324 (1960), *aff'd*, 34 N.J. 582, 170 A.2d 791 (1961).

his suit to gain admission to the county medical society, the court held that a medical society cannot refuse membership to an osteopath when the effect of this refusal is to exclude him from hospital privileges and thus from the practice for which he was licensed:

The State of New Jersey has determined that it is in the public interest that graduates of the Philadelphia College of Osteopathy who successfully pass the State Board examination be admitted to the practice of medicine and surgery in this State. The State of New Jersey is the appropriate authority for the declaration of public policy in relation to this field and the same may not lawfully be exercised by any independent agency.²⁴³

The second New Jersey case, *Greisman v. Newcomb Hospital*,²⁴⁴ involved an osteopath's application for staff privileges in a private non-profit hospital. A by-law of the hospital requiring staff members to be graduates of A.M.A.-approved medical schools was held to be unreasonable as applied to a licensed osteopath.

C. *Merger of Osteopathy and Medicine*

In California, medicine and osteopathy have been merged.²⁴⁵ This accomplishment is the culmination of many years of effort on the part of the California Osteopathic Association and the California Medical Association to effect a single system of medical practice.²⁴⁶ It suffices here to note the effects of this merger upon the status of osteopathic physicians and osteopathic colleges.

Under the California legislation, osteopathic licenses are no longer issued.²⁴⁷ Since 1962 all graduates of the California College of Medicine, the former osteopathic college, have been awarded M.D. degrees.²⁴⁸ All living licensed graduates of this and other osteopathic schools have also

243. *Id.* at 207, 162 A.2d at 336-37. *Cf.* *Group Health Ins. v. Howell*, 40 N.J. 436, 193 A.2d 103 (1963), discussed in the article by Forgotson, Roemer, and Newman p. 400 *infra*, in which a restrictive enabling act for medical care plans was held to be an unconstitutional delegation of the legislature's licensing power to the state medical society.

244. 76 N.J. Super. 149, 183 A.2d 878 (1962), *aff'd*, 40 N.J. 389, 192 A.2d 817 (1963).

245. CAL. BUS. & PROF. CODE § 3600 (Deering 1960).

246. For an historical account of the forces and interests involved in this unique accomplishment, see Kisch & Visel tear, *supra* note 225.

247. CAL. BUS. & PROF. CODE § 3600 (Deering 1960). This section of the Osteopathic Practice Act no longer provides for licensing osteopaths, but states that the law governing licenses of the Board of Osteopathic Examiners is to be found in the division of the code relating to the practice of medicine.

248. Kisch & Visel tear, *supra* note 225.

been given an M.D. degree, if they would accept it, under a "grandfather" clause whereby they agreed to cease identifying themselves as osteopaths.²⁴⁹ This procedure merged into the regular medical profession all but 400 of the 2250 doctors of osteopathy practicing in California.²⁵⁰ The Board of Medical Examiners is now the licensing agency for all physicians. The Board of Osteopathic Examiners exists only to monitor the remaining licensed osteopaths in the state.²⁵¹

An integral and essential term of the merger was an agreement to transform the California College of Osteopaths into the California College of Medicine, a regular medical school accredited by the Joint Liaison Committee on Medical Education.²⁵² For a time after the merger, by agreement between the osteopathic and medical associations, the California College of Medicine operated as an independent institution with financial support from the two professional associations. In 1962 the college became a medical school of the University of California, and it is now the fully accredited medical school of the University of California at Irvine.

Another term of the merger agreement related to membership of former osteopaths in the California Medical Association. It was agreed that the state medical association would direct its efforts toward admitting former osteopaths into existing county medical societies. Until such admission could be accomplished, a special medical society was created as a professional base for these physicians.²⁵³

Problems of specialty status and interstate recognition are more difficult to resolve. Former osteopathic physicians certified as specialists by osteopathic specialty boards are not eligible for certification by medical specialty boards, since they have not graduated from approved medical schools or completed approved internships and residencies. The same requirement of graduation from an approved medical school blocks the recognition by other states of California medical licenses issued to former osteopaths.²⁵⁴ Thus, full medical licensure of these osteopathic physicians is operative only in California.

In the state of Washington, negotiations are under way to effect a merger of osteopathy and medicine similar to that in California. The Washington State Board of Medical Examiners has approved an M.D. degree awarded by an osteopathic college; the Washington State Medical Association voted

249. CAL. BUS. & PROF. CODE § 2396 (Deering Supp. 1966).

250. Kisch & Viseltar, *supra* note 225.

251. *Id.*

252. *Id.*

253. *Id.*

254. *See* pp. 277-80 *supra*; note 238 *supra* and accompanying text.

in 1967 to merge with those osteopaths who wish to give up sectarian practice and become part of the medical community devoted to scientific medical care.²⁵⁵ In other states the Committee on Osteopathy and Medicine of the American Medical Association is exploring the possibility of integrating the two professions, but the trend toward merger has not entirely eliminated interprofessional rivalry and resentment.²⁵⁶

III. CHIROPRACTORS AND OTHER CULTISTS

Medical cultism involves the practice of purported "healing" according to theories or methods which do not have a scientifically accepted foundation.²⁵⁷ Although chiropractic is not the only existing cult, it is the only one which still constitutes a significant hazard to the public. Osteopathy, which in its origins was similar to chiropractic, has progressively incorporated the rigors of medical science and is currently being integrated with scientific medicine.²⁵⁸ Homeopathy has also been transformed and merged into legitimate allopathic medicine. Naturopathy and naprapathy are rapidly disappearing by attrition. On the other hand, recent estimates place the number of chiropractors practicing in the United States between 14,360 and 35,000, and the number of patients treated by chiropractors as high as three million a year.²⁵⁹

A. *The Cult of Chiropractic*

Chiropractic had its origin in an alleged cure of deafness by a back-cracking performed in 1895 by D. D. Palmer, an Iowa grocer and "magnetic healer."²⁶⁰ Subsequent growth of the cult's dogma and practice has been narrated so often²⁶¹ that it need only be summarized here.

255. A.M.A. News, Jan. 9, 1967, at 9, col. 2.

256. AMERICAN OSTEOPATHIC ASSOCIATION, A.O.A.-A.M.A. RELATIONSHIPS (undated White Paper).

257. Cultists should be distinguished from religious healers, such as Christian Science practitioners, who are excepted from the operation of medical licensure laws. See pp. 251-53 *supra*. This exemption is based upon constitutional freedom of religion and the legal right of competent adults to refuse medical treatment.

258. See *supra* p.

259. STANFORD RESEARCH INSTITUTE, CHIROPRACTIC IN CALIFORNIA 3 (1960) (estimated 25,000 chiropractors in U.S. in 1957); Smith, *Chiropractic: Science or Swindle?* 43 TODAY'S HEALTH 56 (1965): "Today chiropractors may be treating as many as three million people a year for ailments ranging from headaches to cancer. . . . The 1960 census listed 14,360 chiropractors in the United States but the American Chiropractic Association claims there are 25,000 and a public relations firm for the chiropractors says there are 35,000."

260. A.M.A., CHIROPRACTIC: THE UNSCIENTIFIC CULT 5 (1966).

261. E.g., A.M.A., *supra* note 260; BOYD, THE CULT OF CHIROPRACTIC (2d ed. un-

Chiropractic is represented by its adherents as a complete and independent healing art which can prevent and cure all human disease.²⁶² The basic tenet of chiropractic is that diseases are caused by a dislocation or "subluxation" of the vertebrae in the spine.²⁶³ This "subluxation," it is alleged, is accompanied by a narrowing of the apertures between the vertebrae, which exerts pressure upon the nerve branches issuing from the spinal cord, and supposedly results in disease in parts of the body activated by the pinched nerves. Chiropractic treatment is to reduce the "subluxation," thereby relieving pressure on the nerves, aiding the return of "nerve force," and purportedly curing the patient's illness.

Medical authorities unanimously agree that chiropractic has no validity.²⁶⁴ The cult's theories have never been supported by objective evidence, and they have been thoroughly refuted by medical science.²⁶⁵ Besides considerable economic consequences, the dangers inherent in this "healing" cult are twofold. First, chiropractic treatment frequently delays proper and effective medical care until it is too late.²⁶⁶ Second, chiropractic treatment often produces actual physical damage to patients.²⁶⁷ Ideally, statutes licensing chiropractors should be repealed to remove the cult's shield of legitimacy. Realistically, however, since repeal is unlikely in light

dated); DOYLE, *SCIENCE VS. CHIROPRACTIC* (1953); Smith, *supra* note 259; Stalvey, *What's New in Chiropractic?* 57 N.Y. STATE J. MED. 49 (1959).

262. See *England v. State Bd. of Med. Examiners*, 246 F. Supp. 993 (E.D. La. 1965), *aff'd mem.*, 384 U.S. 885 (1966).

263. *Id.* at 995: "There seem to be two schools of chiropractic. The members of the International Chiropractic Association apparently believe that there is one cause of disease—subluxation of the vertebrae—and one cure—manipulation of the spine to relieve the subluxation. The American Chiropractic Association, while not as absolute in its approach to the problem of disease, nevertheless feels that chiropractic is a complete and independent healing art which not only can prevent disease, but can cure disease if the manipulation of the spine begins in time."

264. See, e.g., BAYER, *MEDICINE MEN AND MEN OF MEDICINE* (1940); REED, *THE HEALING CULTS* (1932); Statement of Deans of Univ. of Rochester School of Medicine & Dentistry, Cornell Univ. School of Medicine, Albert Einstein College of Medicine, and New York Medical College, presented to the Rules Committee of the New York State Assembly, Mar. 25, 1963; authorities cited note 261 *supra*.

265. MEDICAL SOC'Y OF THE STATE OF N.Y., *MYTH AND MENACE: THE TRUTH ABOUT CHIROPRACTIC* (1948); authorities cited notes 261, 264 *supra*.

266. See, e.g., Smith, *supra* note 259, at 59; Statement of Chief Medical Examiner, City of New York; President, Medical Soc'y of the County of N.Y.; and Chairman, Joint Comm. of the N.Y. State Bar Ass'n and the Medical Soc'y of the State of N.Y., presented to the Rules Committee of the New York State Assembly, Mar. 25, 1963.

267. See, e.g., A.M.A. DEPT. OF INVESTIGATION, *DATA SHEET ON CHIROPRACTIC 3* (1966); BOYD, *supra* note 261, at 56-57; Marsel, *Can Chiropractic Cure?* 1946 *HYGIENE* 6.

of the power of the chiropractic lobby,²⁶⁸ suggestions are made here for improvements in statutory formulation and enforcement. It should be recognized that no matter how high they are set, no matter how strictly they are enforced, licensure standards cannot redeem the scientific invalidity of chiropractic. Increased official attention to licensure provisions can only lend credence to public misconception regarding chiropractors.

B. *The Legal Status of Chiropractic*

In light of these facts, the only legal issue regarding chiropractic is how best to protect the public from its dangers. The goal of licensure laws for health professions and occupations, as previously noted,²⁶⁹ is to permit only those who are properly qualified by their education, training, and ethics to provide particular kinds of health care. Mandatory medical licensure laws have significantly contributed to the elimination of cultism, quackery, and inferior medical education.²⁷⁰ However, there is one paradoxical exception to this accomplishment—the licensing of chiropractors.

1. *Licensure*

Among the many triumphs of chiropractic, none is more remarkable than its achievement of licensure status in all but three states The first licensing act was passed by Kansas in 1913. By 1915, five states had such laws; by 1925, 32 Legislators in most of the remaining states, caught between the clear fact of the falsity of chiropractic practice and belief and the equally clear fact that chiropractors enjoyed licensure in more than half of the states, threw up their hands in embarrassed confusion. Most decided that the lesser evil was to license the cult and thus at least bring it under regulation.²⁷¹

The rationale for mandatory licensure of chiropractors, in all states except Louisiana and Mississippi, is to limit chiropractors' functions to a sphere in which they are supposedly qualified, to assure that they meet specified educational requirements, and otherwise to control their activities. The following review of selected features of licensure statutes demonstrates that these goals have not been realized.

268. Illustrative is the most recent enactment of chiropractic licensure in 1963 by the New York legislature, despite the adamant and unanimous opposition of the educational, medical, and scientific communities. N.Y. EDUC. LAW §§ 6550-65 (McKinney Supp. 1966).

269. See notes 7-8 *supra* and accompanying text.

270. *Id.*

271. Smith, *supra* note 259, at 59.

a. definitions, scope, and effect. Mandatory licensure statutes provide varying definitions of the practice of chiropractic.²⁷² Several statutes describe the peculiar theories of chiropractic, but most define its practice in terms of the particular methods used by chiropractors. Although these definitions differ considerably in specific details, all are generally designed to confine chiropractors to manual manipulation or mechanical adjustment of the spinal column and to exclude them from the prescription of drugs, the performance of surgery, or the administration of other medical therapy. Some statutes, however, either define or allow chiropractors to practice chiropractic "as taught in chiropractic schools or colleges"²⁷³ or "in accordance with the method, thought and practice of chiropractors."²⁷⁴ The latter phrases, unless restrictively interpreted by licensing boards or by the courts,²⁷⁵ may "open the door to the full practice of medicine except for major surgery."²⁷⁶ Chiropractors have proclaimed their opposition to definitional constraints upon their practice:²⁷⁷

There is no special merit in having any single definition of chiropractic, for any such would tend to straightjacket [*sic*] the educational process I would urge avoiding any narrow limiting of the scope and definition of practice which can only tend to prevent growth and understanding. At work is the pragmatic factor . . . where the scope of practice is determined by practitioners in their offices.

Because of this tendency of practicing chiropractors to expand the actual scope of their functions, a special burden is placed upon state legislatures to specify prohibited activities,²⁷⁸ and upon state licensing agencies to enforce such proscriptions.²⁷⁹

272. See BOYD, *supra* note 261, at Table 1; A.M.A. DEP'T OF INVESTIGATION, SCOPE OF CHIROPRACTIC PRACTICE IN THE UNITED STATES (1966).

273. CAL. GEN. LAWS ANN., act 4811, § 6 (Deering 1954); FLA. STAT. § 460.11 (1965); PA. STAT. ANN. tit. 63, § 602(b) (Supp. 1966).

274. *E.g.*, MONT. REV. CODES ANN. § 66-509 (1947); N.C. GEN. STAT. § 90-151 (1965).

275. The California courts have held that the scope of chiropractic is not enlarged by such statutory language. *Crees v. Medical Examiners*, 213 Cal. App. 2d 195, 28 Cal. Rptr. 621 (1963); *People v. Mangiagli*, 97 Cal. App. 2d 935, 218 P.2d 1025 (1950); *People v. Fowler*, 32 Cal. App. 2d 737, 84 P.2d 326 (1938). *Cf. Ellestad v. Swayze*, 15 Wash. 2d 281, 130 P.2d 349 (1942), holding that licensure standards may be more demanding than training given in chiropractic schools, as long as they have "real and substantial relation" to the protection of public health and welfare.

276. BOYD, *supra* note 261, at 27.

277. ANDERSON REPORT, ISSUES CONFRONTING THE DELEGATES AND MEMBERS OF THE AMERICAN CHIROPRACTIC ASSOCIATION AS THEY SEEK TO SOLVE THE PROBLEMS OF CHIROPRACTIC EDUCATION 8, 9-10 (1964).

278. In addition to basic prohibitions of drugs and surgery, one or more licensure statutes also proscribe the practice of obstetrics, osteopathy, physiotherapy, dentistry,

In most jurisdictions where they are licensed, chiropractors are permitted to use the titles of "doctor"²⁸⁰ or "physician."²⁸¹ Some statutes, however, limit licensees to the title "doctor" or the prefix "Dr.," which must be accompanied by the words "chiropractor" or "chiropractic" or by the letters "D.C."²⁸² These titles only increase the possibilities of public confusion created by chiropractic licensure.²⁸³ More particularly, designations of chiropractors as having achieved doctorate degrees seem to misrepresent the nature of chiropractic education.

b. educational qualifications. Chiropractic education and training are appallingly inadequate, as documented by both independent²⁸⁴ and chiropractic²⁸⁵ studies. There are currently twelve schools of chiropractic recognized by the two chiropractic associations, but none is accredited by any agency recognized by the National Commission on Accreditation or the U.S. Office of Education, and no school has full "accreditation" even by the American Chiropractic Association or the International Chiropractic Association. The faculties of these schools are poorly qualified, and the ratio of faculty to students is extremely low.²⁸⁶ Admission require-

optometry, or chiropody; the use of X-rays for therapeutic purposes; or the piercing of tissue for any purposes. See authorities cited note 272 *supra*. The New York statute contains a rather comprehensive list, and this statute is also one of the few which designate certain types of diseases which may not be treated by chiropractic. N.Y. EDUC. LAW § 6558(3) (McKinney Supp. 1966).

279. Since statutory enforcement is notoriously lax in those states in which the licensing agency is a board of chiropractors, consideration should be given to enforcement by non-chiropractic agencies as a prerequisite for any improvement.

280. MONT. REV. CODES ANN. § 66-509 (1947), specifying that licensed chiropractors "shall be permitted to use the prefix Dr. or Doctor as a title."

281. FLA. STAT. § 460.11(3) (1965); IDAHO CODE ANN. § 54-714 (1957); NEV. REV. STAT. § 634.120(3) (1963). *But see* N.D. CENT. CODE § 43-06-11 (Supp. 1967): "A licensed chiropractor may not use the title physician, or surgeon, but may use the title doctor of chiropractic, or D.C."

282. *See, e.g.*, COLO. REV. STAT. ANN. § 23-1-18 (1963); CONN. GEN. STAT. REV. § 20-33 (1958); HAWAII REV. LAWS § 60-14 (Supp. 1963); KAN. GEN. STAT. ANN. § 65-2885 (1964); ME. REV. STAT. ANN. tit. 32, § 454 (1964); N.J. STAT. ANN. § 45:9-14.5 (1963); N.D. CENT. CODE § 43-06-11 (Supp. 1967); VA. CODE ANN. § 54-279 (1950); W. VA. CODE ANN. § 30-16-9 (1966); WYO. STAT. ANN. § 33-142 (1957). *Cf.* IOWA CODE ANN. § 151.6 (1947); N.M. STAT. ANN. § 67-1-22 (1953); TENN. CODE ANN. § 63-117 (1955), which require chiropractors to identify themselves in other ways.

283. *See* BOYD, *supra* note 261, at 46-47.

284. *Id.* at 19-23; Smith, *supra* note 259, at 59-61; authorities cited *infra* notes 295, 296.

285. *See* ANDERSON REPORT, *supra* note 277, at 32.

286. STANFORD RESEARCH INSTITUTE, *supra* note 259; A.M.A. Dep't of Investigation, *Educational Background of Chiropractic School Faculties*, 197 J.A.M.A. 999 (1966).

ments, although also low, are dubiously enforced. A study of actual admission applications showed that chiropractic schools do not observe their own admission rules, and admit students with less than high school educations and questionable credentials.²⁸⁷

Licensure statutes which specify educational attainments prior to admission to chiropractic schools are about evenly divided between requirements of high school graduation or its equivalent and requirements of two years of college.²⁸⁸ For chiropractors, however, perhaps the most significant licensure requirement is passage of basic science examinations in jurisdictions where they are required.²⁸⁹ In those states in which the same examinations are given to medical and chiropractic students, and the examinations are uniformly graded by the same board, an average of 81.4 per cent of all physicians pass their first examination, whereas an average of 84.5 per cent of chiropractors fail.²⁹⁰ Chiropractic students show improved performance on examinations separately administered and graded by boards of chiropractors,²⁹¹ so that, nationally, about a third of them pass this test of non-clinical scientific knowledge.²⁹² However, basic science requirements, like other licensure standards, may be subverted through licensure by interstate reciprocity between "tough" and "easy" jurisdictions.²⁹³ Similarly, since chiropractic licensure is entirely a 20th century creation, a substantial number of chiropractors are insulated from such standards by "grandfather" clauses which exempt chiropractors already (and usually illegally) in practice when licensure statutes were passed.²⁹⁴

287. A.M.A. Dep't of Investigation, *Special Report: Requirements for Admission to Schools of Chiropractic*, 190 J.A.M.A. 763 (1964).

288. A high school diploma or its equivalent is required by the statutes of Alabama, Arizona, Arkansas, California, Colorado, Iowa, Kentucky, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York (until 1968), Rhode Island, South Dakota, Tennessee, Texas, and Vermont. Two years of approved college is the statutory requirement in Alaska, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Maine, Montana, New Jersey, New York (after 1968), North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Virginia, West Virginia, Wisconsin, and Wyoming. The statutes of Georgia, Maryland, Pennsylvania, and Utah require either one year of college or college credits in specified courses. See A.M.A. DEP'T OF INVESTIGATION, *SCOPE OF CHIROPRACTIC PRACTICE IN THE UNITED STATES* (1966).

289. Cf. p. 268 *supra*.

290. Such comparative data may no longer be available if the American Chiropractic Association succeeds in its efforts to prevent identification of the schools from which examination applicants come. Smith, *supra* note 259, at 59.

291. Accordingly, the International Chiropractic Association is attempting to prevent the same boards from grading the examinations of medical and chiropractic students. *Id.*

292. DOYLE, *supra* note 261, at 10.

293. See Smith, *supra* note 259, at 59-60.

294. *Id.* at 59.

c. alternate licensure. The experience of the last half-century with attempts to control chiropractic through licensure laws leads to the conclusion that more effective safeguards are needed.²⁹⁵ The Louisiana Medical Practice Act may well serve as a model. Basically, the Louisiana licensure statute prohibits the practice of chiropractic unless the practitioner is also a medical doctor.²⁹⁶ This requirement provides a more effective safeguard than licensure of chiropractors because it assures that the practitioner will possess the education and training necessary to understand his diagnosis and prescribed therapy in terms of medical principles as well as those of chiropractic. Medical education and training should be required of adherents to chiropractic because:

There should be no such thing as limited education and training when one is dealing with human illness. You cannot limit the extent to which a disease process or an ailment will affect the human body. The person who assumes the responsibility for treating human beings must be prepared to treat the whole person. He must be qualified to provide the care of the whole person. He cannot restrict himself to just one system of treatment; he must employ all techniques that will be of benefit to the patient.²⁹⁷

2. *Other Regulation and Recognition*

A few courts have held that chiropractors must satisfy medical standards of performance:

If a person undertakes to cure those who search for health and who are, because of their plight, more or less susceptible of following the advice of any one who claims the knowledge and means to heal, he cannot escape the consequence of his gross ignorance of accepted and established remedies and methods for the treatment of diseases. . . .²⁹⁸

Chiropractors may also be subject to the same state and municipal public health regulations which apply to physicians. Most chiropractic licensure statutes so provide, and require or permit licensed chiropractors to execute

295. For example, although chiropractors were not licensed by New York until 1963, over 3,000 were illegally practicing in the state as of 1957. Stalvey, *supra* note 261, at 56. See also MEDICAL SOC'Y OF THE STATE OF N.Y., *supra* note 265.

296. "There is no special statute covering chiropractic [in Louisiana] . . . [P]ersons desiring to practice chiropractic in the State of Louisiana must qualify under the provisions of the Medical Practice Act." *England v. State Bd. of Med. Examiners*, 246 F. Supp. 993, 995 (E.D. La. 1965), *aff'd mem.*, 384 U.S. 885 (1966). The refusal of the Louisiana legislature to provide special licensure for chiropractors has been sustained against constitutional objections. *Id.* at 997.

297. Stalvey, *supra* note 261, at 58.

298. *Gian-Curiso v. State*, 180 So. 2d 396, 398 (Fla. Dist. Ct. App. 1965), quoting *State v. Heins*, 144 Fla. 272, 275, 197 So. 787, 788 (1940).

various health reports and certificates.²⁹⁹ These provisions usually include death certificates, and four states specifically include birth certificates.³⁰⁰ On the other hand, chiropractors are prohibited by statute from signing birth certificates in Tennessee,³⁰¹ birth or death certificates in Maryland,³⁰² and any reports or certificates in New Jersey.³⁰³ Although most statutes do not deal with hospital privileges, the North Carolina statute gives licensed chiropractors access to public hospitals,³⁰⁴ and in North Dakota these licensees "may practice in any public or private hospital or other institution . . . when requested so to do by any patient or the guardian of any patient."³⁰⁵

Chiropractic has achieved an impressive array of other legal and official recognitions. For example, federal funds are available to chiropractic students and practitioners under programs established by the Social Security Act (but not "Medicare" or "Medicaid"), the U.S. Employee's Compensation Act, and the G.I. Bills of Rights.³⁰⁶ In addition, the United States Bureau of the Budget classifies chiropractic as one of the four major healing professions; the United States Immigration Service admits foreign chiropractic students outside of quotas; the Selective Service Act has permitted the deferment of chiropractic students;³⁰⁷ and the Internal Revenue Service permits income tax deductions for chiropractic fees.³⁰⁸ Chiropractic services qualify for indemnification under most state workmen's compensation acts and under a great many insurance policies.³⁰⁹ These official recognitions of chiropractic tend to promote chiropractic rather than limit its scope and effect, which is the premise of licensure. The basic assumption of licensure of chiropractors—that licensure facilitates regulation—should be re-examined.

299. See generally A.M.A. DEP'T OF INVESTIGATION, SCOPE OF CHIROPRACTIC PRACTICE IN THE UNITED STATES (1966).

300. MONT. REV. CODES ANN. § 66-508 (1947); N.D. CENT. CODE § 43-06-16(2) (1960); ORE. REV. STAT. § 684.030 (1965); S.D. CODE § 27.0508 (Supp. 1960).

301. TENN. CODE ANN. § 63-415 (1955).

302. MD. ANN. CODE art. 43, § 510 (1957).

303. N.J. STAT. ANN. § 45:9-14.5 (1963).

304. N.C. GEN. STAT. § 90-153 (1965). The same right of access to public supported institutions is granted by the South Carolina State Board of Chiropractic Examiners, *Rules and Regulations* § 17.

305. N.D. CENT. CODE § 43-06-17 (1960).

306. Stalvey, *supra* note 261, at 57.

307. *Id.*

308. Rev. Rul. 55-261, 1955-1 CUM. BULL. 307; I.T. 3598, 1943 CUM. BULL. 157.

309. Stalvey, *supra* note 261, at 57.

CONCLUSIONS

Licensure laws clearly affect the quality of medical care by physicians. By setting minimum qualifications for entrance into the medical profession, these laws affect educational curricula, approval of educational institutions and programs of graduate education, delegation of responsibilities to allied and auxiliary personnel, geographic mobility, and substantive and procedural rules governing actions for violation of these minimum standards.

This study of licensure laws affecting physicians, osteopaths, and chiropractors indicates, among other things, that:

1. Current statutory provisions impose constraints on medical school curricular innovations;
2. Specific statutory requirements restrain needed developments in graduate medical education, such as elimination of the internship as a separate entity and substitution therefor of appropriate programs of graduate medical education integrated with undergraduate medical education;
3. Initial licensure examination requirements of the states do not measure many of the qualities relevant to fitness to practice and are not necessarily relevant to current goals of undergraduate medical education;
4. Legal requirements for programs in continuing medical education to prevent educational obsolescence are absent;
5. Incomplete interstate recognition of medical licenses results in barriers to geographic mobility of physicians;
6. Licensure requirements for foreign medical graduates are not generally geared specifically to fitness to practice high quality American medicine;
7. Delegation of tasks to allied and auxiliary personnel is governed by statutes which may be restrictive, ambiguous, or unrelated to accepted custom and usage;
8. Statutory interpretations relevant to delegations of tasks by physicians to allied and auxiliary personnel are not always based on the realities of modern medical care;
9. Osteopaths cannot, under present laws, be integrated fully into the practice of medicine so as to permit their addition to the pool of physician manpower; and
10. Attempts to control unscientific schools of practice or cultism by licensure can endanger the public by giving unscientific schools, such as chiropractic, protection through the sanction of law.

Resolution of these problems will require legislative, rather than judicial, action. Judicial action permits resolution of problems only on a case by case basis, with decisions limited to the facts and circumstances of each case. Since licensure laws are quasi-criminal in nature, judicial decisions in these cases are unlikely to result in the establishment of broad principles which would transcend the immediate facts before the courts.

The legislative process, however, can establish broad principles. It can consider facts, evidence, and social policy without the procedural limitations of the judicial process. Moreover, it can delegate many interpretative functions to the administrative process in which the tribunals have both expertise and flexibility.

Among the many problems presented by the medical licensure laws, without question, the issue of delegation of tasks is a highly significant, if not the most significant, problem requiring resolution. It involves not only the medical profession, but also nursing and other allied and auxiliary professions and occupations. Solution of the problem of delegation will require consideration of the legal regulation and scope of functions of all the professions and occupations comprising the manpower matrix rendering personal health care. If the legal authority affecting the functions of physicians and other health professions and occupations is amended, the composition of the official licensing agency and its relation to other agencies of government must be reconsidered. Careful study, analysis, and consultation among the health professions will be necessary to develop guidelines for legislative resolution of the issue of delegation and other problems in licensure.

APPENDIX I
LICENSING AGENCIES FOR PHYSICIANS*

STATE and STATUTE	LICENSING AGENCY	STATE DEPT.	Total No.	COMPOSITION OF AGENCY						METHOD OF SELECTION					FINANCING OF AGENCY			
				MD's	Other Occupations	Publ. Members	Limitation on Faculty	Rept. of Practice in State		Appointment by		Recommendation by			Spec. Fund	Gen. Fund		
								Gov.	Other	Med. Soc.	Other Prof. Soc.	Ed. It. Self	Other					
OTHER OCCUPATIONS LIC. BY SAME AGENCY																		
Alabama tit. 46, §§258, 292	State Bd. of Med. Exam'rs		10	10				x		x							x	
Alaska §08.64.010, §08.64.110	State Med. Bd.		5	5				x	x								x	
Arizona §32-1402, §32-1406	Bd. of Med.		5	5				x	x								x	
Arkansas §72-602, §72-618	State Med. Bd.		9	9			x		x								x	
California Bus. & Prof. §§2100-2122	Bd. of Med. Exam'rs		12	11	1	2 may be full time			x								x	
Colorado §91-1-3, §91-1-30	State Bd. of Med. Exam'rs	Sec. State of	9	9			x										x	

Connecticut §20-8	Med. Exam'g Bd.	State Dept. of Health	5	5	1	1	x	x	x	x	x	None		x
Delaware tit. 24, §1706, §1721	State Bd. of Med. Exam'rs		10	10			x	x	x	x				x
D. C. §2-135, §2-209	Bd. of Exam'rs in Med. and Osteo- pathy		5	4	1		x	x	x			Osteopaths	x	
Florida §458.01, §458.02	State Bd. of Med. Exam'rs		10	10			x	x	x			Physical Therapists	x	
Georgia §84-902 to 84-905	State Bd. of Med. Exam'rs	Sec. of State	10	10			x	x	x			None	x	
Hawaii §64-4, §64-5	Bd. of Med. Exam'rs	Dept. of Reg. Agencies	7	7					x			None	x	
Idaho §54-1805 to 54-1809	State Bd. of Med.	Dept. of Law Enf.	7	6		1		x	x			Physical Therapists	x	
Illinois ch. 91, §16b-1; ch. 127, §60a	Dept. of Reg. & Educ.	Dept. of Reg. & Educ.	7	5	2	1	x		x	1 must be full time		Gen'l lic. agency — not limited to health prof. Midwives	x	

APPENDIX 1 (continued)

STATE and STATUTE	LICENSING AGENCY	STATE DEPT.	Total No.	COMPOSITION OF AGENCY						METHOD OF SELECTION					FINANCING OF AGENCY		
				MD's	Other Occupations	Publ. Members	Limitation on Faculty	Regt. of Practice in State	Appointment by		Recommendation by			Spec. Fund	Gen. Fund		
									Gov.	Other	Med. Soc.	Other Prof. Soc.	Bd. of Self			Other	
Indiana §§63-1304 to 63-1306	Bd. of Med. Reg. & Exam.		7	5	2						X						X
Iowa §§147.12 to 147.25	State Bd. of Med. Exam'rs		8	6	2	X		X			X						X
Kansas §§65-2812 to 65-2823	State Bd. of Healing Arts		11	5	6			X			X						X
Kentucky §§211.040, 211.070; §311.610	State Bd. of Health	State Dept. of Health	10	7	3	1		X			X						X
Louisiana §§1262-1269	State Bd. of Med. Exam'rs		5	5							X						X
Maine tit. 32, §3201	Bd. of Reg. in Med.		6	6			X				X						X

APPENDIX 1 (continued)

STATE and STATUTE	LICENSING AGENCY	STATE DEPT.	Total No.	COMPOSITION OF AGENCY					METHOD OF SELECTION					FINANCING OF AGENCY		
				MD's	Other Occupations	Publ. Members	Limitation on Faculty	Rqmt. of Practice in State	Appointment by		Recommendation by			Spec. Fund	Gen. Fund	
									Gov.	Other	Med. Soc.	Other Prof. Soc.	Bd. of Self			Other
OTHER OCCUPATIONS I.A.C. BY SAME AGENCY													Spec. Fund	Gen. Fund		
Nevada §§630.050 to 630.110	State Bd. of Med. Exam'rs		5	5				X	X						X	
New Hampshire §§329.2 to 329.5	State Bd. of Reg. in Medicine		6	6	1			X	X							X
New Jersey §45:9-1	State Bd. of Med. Exam'rs		13	9	2			X	X		X				X	
New Mexico §§67-5-1 to 67-5-3	Bd. of Med. Exam'rs		5	5				X	X				X		X	
New York Educ. §§508, §5516	State Educ. Dept.	State Educ. Dept.	9	9				X	X							X
N. Carolina §§90-2, §90-3, §90-15	Bd. of Med. Exam'rs		7	7											X	

N. Dakota §43-17-03	State Bd. of Med. Exam'rs		9	9										None			x
Ohio §§4731.01 to 4731.03	State Med. Bd.		8	7	1			x						Chiropractors, Physical Therapists			x
Oklahoma tit. 59, §§481, 482	State Bd. of Med. Exam'rs		7	7				x						None			x
Oregon §667.230, §677.290	Bd. of Med. Exam'rs		6	6				x						Osteopaths			x
Pennsylvania tit. 71, §122	State Bd. of Med. Educ. & Licensure	Dept. of State	7	6		2		x					x	None			x
Rhode Island §5-28-1 to -4, §5-28-6	Div. of Prof. Reg- ulation	Dept. of Health	3	3										Gen'l lic. agency not limited to health prof.			x
S. Carolina §56-1351, §56-1358	State Bd. of Med. Exam'rs		8	8					x					Naturopaths, Homeopaths, Magnetic Healers			x
S. Dakota §27.0301, §27.0313	State Bd. of Med. & Osteopathic Exam'rs		5	4	1				x					Osteopaths, Physical Therapists			x
Tennessee §§63-601 to 63-604	State Bd. of Med. Exam'rs		5	5										None		x	x

APPENDIX 1 (continued)

STATE and STATUTE	LICENSING AGENCY	STATE DEPT.	Total No.	COMPOSITION OF AGENCY						METHOD OF SELECTION				FINANCING OF AGENCY	
				MD's	Other Occupations	Publ. Members	Limitation on Faculty	Regt. of Practice in State	Appointment by		Recommendation by			Spec. Fund	Gen. Fund
									Gov.	Other	Med. Soc.	Other Prof. Soc.	Bd. or Self		
Texas arts. 4495 to 4502	State Bd. of Med. Exam'rs		12	12			X			X				X	
Utah §58-1-5, §58-1-6, §58-1-22	Dept. of Reg.	Dept. of Reg.	5	5			X			X	X				X
Vermont tit. 26, §1351, §1352, §1355	Bd. of Med. Reg.		7	7			X	X		X					X
Virginia §§54-282 to 54-284, §54-294	Bd. of Med. Exam'rs		16	10	6				X	X	X				X
Washington §43.24.060; §§18.71.040 to 18.71.060	Bd. of Med. Exam'rs, Div. of Prof. Lic.	Dept. of Licenses	5	5					X					X	

W. Virginia §30-2A-1, §30-2A-5	Med. Lic. Bd.	11	9	2	1 ex- off- icio	x	x				Podiatrists	x
Wisconsin §147.12, §147.13	State Bd. of Med. Exam'rs	8	7	1	x	x	x		x		Physical Therapists, Osteopaths, Podiatrists	x
Wyoming §33-328 to 33-332	State Bd. of Med. Exam'rs	5	5			x	x				Osteopaths	x

*The lack of a notation indicates the absence of a statutory provision.

APPENDIX 2
EDUCATIONAL AND PROFESSIONAL QUALIFICATIONS FOR LICENSURE (M.D.'s)

State and Statutory Citation	U.S. MEDICAL GRADUATES										FOREIGN MEDICAL GRADUATES					
	High Schl.	College	Basic Sci. Cert.	Med. Schl.	Sub-jects	Med. School Curricula Mos, Wks, or Hrs.	Intern-ship	Grad. Med. Educ.	English Profi-iciency	Basic Sci. Cert.	Med. Schl.	Grad. Med. Educ. Recd.	ECEMG Cert.	St. Bd. Exam	Exist- ing License	
Alabama tit. 46, §259	X	2 yr	X	X			X			X	X	1 ⁷	7	X		
Alaska §35.3.85			X	X			X ¹			X		1 ¹		X		
Arizona §§32-1423 to 32-1424			X	X			X ²	X ²	X	X	X	2	X	7		
Arkansas §72-605			X	X			X ³			---	NOT	ACCE	PTED	---	---	
California Bus. & Prof. §§2168.5 to 2173, 2191, 2192, 2193, 2198.5	X	3 yr		X	X	X	X				X	2		X	X	
Colorado §§91-1-7 to -10			X	X			X			X	X	1; 2 ⁷	X	X		
Connecticut §20-10		2 yr	X	X	X	X	7			X		3 ⁷		X		
Delaware tit. 24, §§1732, 1733	X	2 yr		X			X				X	1	X	7		

APPENDIX 2 (continued)

State and Statutory Citation	U.S. MEDICAL GRADUATES							FOREIGN MEDICAL GRADUATES							
	High Sch.	Col-lege	Basic Sci. Cert.	Med. Sch.	Med. School Curricula		Intern-ship	Grad. Med. Educ.	English Proficiency	Basic Sci. Cert.	Med. Sch.	Grad. Med. Educ. Req.	ECFMG Cert.	St. Bd. Exam	Exist-ing License
					Sub-jects	Mcs, Wks, or Hrs.									
Maryland art. 43, §124				X	X						X	3 7	X	X	X
Massachusetts ch. 112, §2		2 yr		X		X							X	7	
Michigan §14.533	X	X	X	X	X		X			X	1		X	X	X
Minnesota §147.02				X		X				X	2 7		X	7	
Mississippi §8879				X	X		X						X	7	
Missouri §834.031	X	2 yr		X		X					1 7		X	7	
Montana §66-1003	X	X		X				X			1 7		X	X	
Nebraska §§71-1, -104, §71-128	X	2 yr	X	X	X					X			X	7	
Nevada §§630.160, 630.170				X					X ¹		NOT ACCE	PTED		---	---
New Hampshire § 329:12		2 yr		X		X			X		1		X	7	

APPENDIX 2 (continued)

State and Statutory Citation	U.S. MEDICAL GRADUATES							FOREIGN MEDICAL GRADUATES							
	High Schl.	College	Basic Sci. Cert.	Med. Schl.	Med. School Curriculum Sub-Subjects	Mos, Wks, or Hrs.	Internship	Grad. Med. Educ.	English Proficiency	Basic Sci. Cert.	Med. Schl.	Grad. Med. Educ. Req.	ECFMG Cert.	St. Bd. Exam	Existing License
Tennessee §63-611			X	X	X					X			X	7	
Texas arts. 4501, 4503		2 yr	X	X ⁶	X	X				X			X	7	
Utah §§58-12-2, -5, -9; §58-27-8		1 yr	X	X	X	X	X			X		37	X	X	
Vermont tit. 26, §§1391, 1392, 1396	X	2 yr		X	X	X	X ³					1 ³	X	X	
Virginia §§54-305, -306, -306.3		2 yr		X		X						2	X	7	
Washington §§18.71.050, -18.71.055	X	2 yr	X	X	X		X	X ⁸	X	X		1	X	X	
West Virginia §30-3-4		2 yr		X			X				X	17	X	X	
Wisconsin §147.15	X	3 yr	X	X	X	X	X			X		X	X	X	

Wyoming
§33-333

x

x

17

x

x

FOOTNOTES TO APPENDIX 2

1. In lieu of internship, a specified number of years of practice is acceptable.
2. In lieu of internship, graduate medical education acceptable to the board or at the discretion of the board.
3. Internship voluntary or discretionary with board.
4. In lieu of graduation from approved medical school, practice in another state or medical service with armed forces or Public Health Service for seven of eleven years preceding application.
5. Certificate of familiarity with Hansen's Disease required.
6. Approval of medical school not required.
7. Required according to statistics based upon actual practices as opposed to the statutes alone compiled by the Council on Medical Education, *Medical Licensure Statistics for 1966*, 200 J.A.M.A. 1055, 1106 (1967).
8. Supplementary requirement of experience in obstetrics and pathology.
9. Length of internship not specified by statute.

APPENDIX 3
OSTEOPATHIC LICENSURE

STATE	COMPOSITION OF LICENSING AGENCY AND EXAMINING BOARD WHERE NO SEPARATE EXAMINING BOARD EXISTS				COMPOSITION OF SEPARATE EXAMINING BOARD			TYPE OF LICENSE GRANTED**	TYPE OF EXAMS GIVEN***	LENGTH OF INTERNSHIP REQUIRED (YEARS)	EDUCATION: GRADUATION FROM SCHOOL
	M.D. Only	Compo-site*	D.O. Only	Non-Prof.	M.D. Only	Compo-site*	D.O. Only				
Alabama tit. 46, §257(1) §258 §259 §260				X	X			1	SAME X		X
Alaska §08.64.200	X ⁹							3,4 ⁰	SPEC'L ⁰	1	X
Arizona §32-1801 §32-1822 §32-1823 §32-1852		X ¹⁰						3 ¹ 3 ¹	SPECIAL SPECIAL		X X
Arkansas §72-901 §72-903 §72-906			X					3,4 ²	SPECIAL		X
California Bus. & Prof. §2004 §2192 §3600	X ⁷							1	SAME	1	X

APPENDIX 3 (continued)

STATE	COMPOSITION OF LICENSING AGENCY AND EXAMINING BOARD WHERE NO SEPARATE EXAMINING BOARD EXISTS				COMPOSITION OF SEPARATE EXAMINING BOARD			TYPE OF LICENSE GRANTED**	TYPE OF EXAMS. GIVEN***	LENGTH OF INTERNSHIP REQUIRED (YEARS)	EDUCATION GRADUATION FROM SCHOOL	
	M.D. Only		D.O. Only		Non-Prof.	M.D. Only	Comp-sites*					D.O. Only
	Comp-sites*	D.O. Only	Comp-sites*	D.O. Only								
Hawaii §46-1 §70-1 §70-4 §70-6 §70-7 §70-8			X X					X			X	
Idaho §54-1601 §67-2901 §67-2902 §67-2903 §67-2906					X X X						X	
Illinois ch. 91, §5 ch. 91, §8 ch. 91, §16b-1											X	
Indiana §63-1302 §63-1305 §63-1316			X								X	
Iowa §147.2 §147.12-.15 §150.8, .11 §150A.3											X	

Kansas §65-2813 §65-2830 §65-2873		x				1	SAME	5	x
Kentucky §211.040 §311.550 §311.570		x				1	BOTH	1	x
Louisiana §37:3 §37:6 §37:1111 §37:1112 §37:1116 §37:1117		x	x			3,4	SPECIAL		x
Maine tit. 32, §2651 §2701 §2702 §2704				x		2,3 ²	SPECIAL	6	x
Maryland art. 43, § 467 § 474 § 477				x		3,4	SPECIAL		x
Massachusetts ch. 112, §2		x				1	SAME		x
Michigan §14.571 §14.572 §14.574				x		2 ²	SPECIAL		x

APPENDIX 3 (continued)

STATE	COMPOSITION OF LICENSING AGENCY AND EXAMINING BOARD WHERE NO SEPARATE EXAMINING BOARD EXISTS				COMPOSITION OF SEPARATE EXAMINING BOARD			TYPE OF LICENSE GRANTED**	TYPE OF EXAMS. GIVEN***	LENGTH OF INTERNSHIP REQUIRED (YEARS)	EDUCATION: GRADUATION FROM SCHOOL		
	M.D. Only		D.O. Only		Non-Prof.		M.D. Only					Compo-site*	D.O. Only
	Compo-site*	D.O. Only	Non-Prof.	M.D. Only	D.O. Only								
Minnesota \$147.01 \$147.02 \$147.031											x		
											x		
											x		
											x		
Mississippi \$7024 \$8880 \$8891											x		
											x		
											x		
											x		
Missouri \$334.021 \$334.031 \$334.040 \$334.120											x		
											x		
											x		
											x		
Montana \$66-1401 \$66-1403 \$66-1405 \$66-1406											x		
											x		
											x		
											x		
Nebraska \$71-102 \$71-111-114 \$71-1,139 \$71-1,141											x		
											x		
											x		
											x		

APPENDIX 3 (continued)

STATE	COMPOSITION OF LICENSING AGENCY AND EXAMINING BOARD WHERE NO SEPARATE EXAMINING BOARD EXISTS				COMPOSITION OF SEPARATE EXAMINING BOARD			TYPE OF LICENSE GRANTED**	TYPE OF EXAMS GIVEN***	LENGTH OF INTERNSHIP REQUIRED (YEARS)	EDUCATION: GRADUATION FROM SCHOOL
	M.D. Only	Compo-site*	D.O. Only	Non-Prof.	M.D. Only	Compo-site*	D.O. Only				
Ohio §4731.01 §4731.09 §4731.13 §4731.14		x					x	1	BOTH		x
Oklahoma tit. 59, §625 §629 §630 §632 §633			x					1, 3	SPECIAL	x ⁶	x x
Oregon §681.020 §681.040 §681.060 §681.160								1 x x	SAME ⁹	1	x
Pennsylvania tit. 63, §261 §262 §266							x	1	SPECIAL	1	x
Rhode Island 5-26-2-3 5-36-1											x

5-36-2									1				
5-36-3										BOTH			
5-36-4									1,1,3				
South Carolina													
\$56-1101									3,4				x
\$56-1103	x									SPECIAL x			
\$56-1109													
\$56-1110													
\$56-1112													
South Dakota													
\$27.0401													
\$27.0403	x								2,3	SPECIAL			x
\$27.0405													
Tennessee													
\$63-901													
\$63-904													x
\$63-907									1	SPECIAL			
Texas													
art. 4495													
art. 4501													x
Utah													
\$58-1-1													
\$58-1-5													
\$58-1-7													
\$58-12-6-8													
\$58-12-7													x
Vermont													
tit. 26,													
\$1791													
\$1831													x
\$1835									1	SPECIAL			

APPENDIX 3 (continued)

STATE	COMPOSITION OF LICENSING AGENCY AND EXAMINING BOARD WHERE NO SEPARATE EXAMINING BOARD EXISTS				COMPOSITION OF SEPARATE EXAMINING BOARD			TYPE OF LICENSE GRANTED**	TYPE OF EXAMS GIVEN***	LENGTH OF INTERNSHIP REQUIRED (YEARS)	EDUCATION: GRADUATION FROM SCHOOL
	M.D. Only	Compo-sitio*	D.O. Only	Non-Prof.	M.D. Only	Compo-sitio*	D.O. Only				
Virginia \$54-273 \$54-282 \$54-298 \$54-299 \$54-306		X						1, 3, 4	BOTH X	5	X
Washington \$18.57.020 \$18.57.080 \$43.24.020 \$43.24.060				X			X	1	SPECIAL	1	X
West Virginia \$30-14-1 \$30-14-2 \$30-14-3 \$30-14-4 \$30-14-5 \$30-14-9										5	X X
Wisconsin \$147.13 \$147.15 \$147.16 \$147.17		X						1	SPECIAL		X
Wyoming \$33-328 \$33-333		X						1	SAME	1	X

FOOTNOTES TO APPENDIX 3

*The states listed under this heading either permit or require osteopaths to be on the board.

**The entries in this column indicate the scope of permissible practice of osteopathy in the United States. Numeral "1" indicates that licensed osteopaths have an unlimited license. The numeral "2" indicates osteopathic practice is limited to that which is taught in osteopathic schools. The numeral "3" indicates licensed osteopaths may not perform major surgery and the numeral "4" indicates osteopaths may not administer or prescribe drugs.

***The entries in this column indicate whether osteopathic candidates for licensure must take the same examination given to graduates of medical schools or whether osteopathic candidates are given a special examination.

1. License to perform major surgery will be granted only upon completion of postgraduate education: Arizona, two years in hospital training; Hawaii, one year in hospital training and one year as an assistant to a licensed surgeon; Rhode Island, one year of internship; Utah, one year as surgical intern.
2. License to perform major surgery may be granted to an osteopath by the medical examining board.
3. Only certain narcotic drugs may be used for alleviation of pain in Georgia.
4. State v. Sawyer, 36 Idaho 814, 214 Pac. 222 (1923).
5. Length of internship not specified by statute.
6. License to perform major surgery requires two years practice and two years of graduate education or one year graduate education and one year as a surgical assistant.
7. Osteopaths electing to use the suffix "M.D." are governed by the Board of Medical Examiners while those retaining the use of the suffix "D.O." are governed by the Board of Osteopathic Examiners. Cal. Bus. & Prof. Code §2004. Osteopaths are no longer licensed in California. Cal. Bus. & Prof. Code §3600.
8. One member is a dentist.
9. Holman, *Osteopathy and the Law*, 195 no. 10, J.A.M.A. 283 (March 7, 1966).
10. The Arizona board consists of four osteopaths and one public member.
11. No osteopaths are on the New Hampshire board, Holman *supra* note 9, although the statutory wording permits an osteopath to serve on the board.
12. Although the statutory language is ambiguous the courts have decided osteopaths may obtain an unlimited license. Chicago College of Osteopathy v. Puffer, 3 Ill. App. 2d 69, 120 N.E.2d 672 (1954).
13. Osteopaths have not been separately licensed in New Jersey since 1941.
14. State v. Baker, 229 N.C. 78, 48 S.E.2d 61 (1948).