The History of the Federation of State Medical Boards:
Part One — 19th Century Origins of FSMB and Modern Medical Regulation

David Johnson, M.A., and Humayun J. Chaudhry, D.O.

ABSTRACT: The Federation of State Medical Boards celebrates its centennial anniversary in 2012. In honor of this milestone, the Journal of Medical Regulation offers the first in a series of articles presenting the history of the FSMB within the context of the growth of America’s medical regulatory system. These articles are adapted from Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards, set for release later this year by Lexington Books, a subsidiary of Rowman and Littlefield Publishing Group.

Keywords: Federation of State Medical Boards, centennial, state medical boards, medical regulation

The roots of the Federation of State Medical Boards (FSMB) stretch more than 20 years prior to its formal establishment in 1912. They extend into the last decades of the 19th century when America’s system for medical licensure developed into the broad framework characterizing it to this day. In constructing this state-based system, state legislatures reflected the growing importance of two critical forces: public expectations and professional interests. The laissez-faire milieu of late 19th century America did not prevent public sentiment from slowly coalescing around the need for modest measures of governmental protection against unqualified practitioners. Even stronger was the desire of a medical profession striving for greater autonomy and prestige — a desire that manifested itself directly in support of the creation of state medical boards.

Many individuals familiar with the work of state medical boards know of their origins in the last quarter of the 19th century. Less commonly known, however, is that the establishment of medical licensing boards throughout much of the United States beginning in the 1870’s constituted the rebirth of a system that had first taken hold in the late 18th and early 19th centuries. In order to fully appreciate the impetus for this rebirth — as well as the fundamental tensions inherent to the system and which galvanized the predecessor organizations from which the FSMB arose — it is necessary to first briefly review the collapse of this earlier licensing system.

Colonial and Early National Antecedents

After the Revolutionary War, individual states perpetuated the common practice of colonial authorities to invest their respective medical societies with the authority to regulate the practice of medicine. Such legislation was largely exclusionary as it used medical societies to control entry into the profession.¹ This regulatory model predicated upon localized control by non-governmental bodies comprised of a physician’s peers made sense for many reasons. The questionable diagnostic and therapeutic value of almost all medicine at the time meant the profession was truly more akin to an art than a science. As such, direct experiences with, and supervision by, an experienced physician represented a reasonable attempt to ensure a modicum of expertise. Furthermore, in the overwhelmingly rural America of that time, this decentralized approach represented the only practical model for oversight. At the dawn of the 19th century, the practice of medicine remained largely an empirical and experiential art, often passed on through an apprenticeship model of training. Increasingly, however, a burgeoning number of medical schools offered another means for presenting a credible alternative to this model.²

The emerging question this posed for individual states was, “Who would take the lead in regulating or
licensing physicians—the medical societies or medical schools?" The medical societies had already received the power to license physicians from many of the colonies prior to Independence, though some had also exempted medical school graduates from their licensing requirement. Yet, medical societies increasingly felt they should require all physicians, even those trained at the newest medical schools, to obtain licenses. The schools, in turn, asserted that their diplomas should be adequate for the lifelong practice of medicine. This underlying tension remained largely unresolved when the antebellum framework for medical licensing collapsed.  

In the first decades of the 19th century, inadequate knowledge of the science underpinning medicine helped promote a notion that popular knowledge was perhaps as accurate as that of experts. Such a proposal found a receptive climate during the Jacksonian Era (1828–1840) when the long political shadow of President Andrew Jackson inculcated a reverence for the wisdom of the common man and cast a skeptical eye on experts and authorities who they deemed more likely to protect their own interests than those of the average citizen. Concurrent to this anti-intellectual trend, others began to explore alternative methods for understanding the laws of nature, founding philosophies and professions that would ultimately find their place alongside mainstream medicine. These alternative approaches rejected the “heroic” philosophy of medicine often characterized by harsh treatments (e.g., bloodletting, purgatives) in favor of minimalist approaches based often upon herbal treatments, diet and fresh air. Such a philosophy struck many people as an appealing alternative to traditional treatments predicated upon “bleeding, blistering, purging, vomiting and sweating,” especially since the perceptive patient sensed the wisdom behind the adage of the doctor taking the fee while nature made the cure.  

The significance of these medical philosophies, whose adherents were often characterized as sectarian or “irregular” practitioners in the 1800s, was their subsequent success in establishing strong challenges to traditional medicine. These challengers included the followers of Samuel Thomson’s populist herbal approach to medicine; Samuel Hahnemann’s homeopathic philosophy and various “eclectic” practitioners blending elements of all strands of medicine. The individualism and anti-regulatory climate of the Jacksonian Era, combined with the democratization of medicine as espoused by Thomsonians and others, contributed to the wholesale collapse of medical regulation in the first half of the 19th century. Nearly every state repealed its penalties for the unlicensed practice of medicine, with Illinois leading the way in 1826, followed over the next quarter century or so by Alabama, Ohio, Mississippi, Georgia, Massachusetts, Maine, South Carolina, the District of Columbia, Maryland, Vermont, Connecticut, New York, Texas, Michigan and, in 1852, Louisiana. As the governmental basis behind medical regulation disappeared in most states in the second quarter of the 19th century, many physicians simply pursued their vocation as best they could and were generally free to ply their trade in whatever fashion they chose. Others, however, sought to mobilize colleagues to action in fields where they believed progress could be made, particularly as a means for establishing medicine as a profession. One of the major examples of this was the establishment of the American Medical Association (AMA) in 1847. The organization’s early adoption of a consultative clause prohibiting its members from consulting with “sectarian” practitioners (i.e., Thomsonian, homeopathic, eclectic) created a schism within the medical profession. The growing lines of division separating regular from so-called irregular or sectarian practitioners later spawned a vigorous counterattack from adherents of alternative philosophies. When licensing laws returned in the 1870s, these practitioners waged successful legislative battles establishing separate licensing boards for homeopathic, eclectic (and later osteopathic) physicians.  

The Second Wave of Licensing Laws  
In post-Civil War America, the proliferation of medical schools having few requirements for admission contributed to an increasing number of physicians of varying philosophies possessing medical degrees.  

With the general collapse of the legislative structures that had supported medical regulation, the physician holding a medical degree or a license possessed a credential of limited utility. Where an earlier generation of the profession understandably viewed the medical degree as a path to socio-economic prestige and financial advantage, this was no longer a given. As for the public, they seemed uninterested in physicians’ intraprofessional debates. As one historian described it, the public “remained indifferent to progress in pathology, new germ theories of disease,
or...primitive ideas that ascribed ills to the influence of the stars, provided they were relieved of their pain and freed from the bonds of sickness.” Much of the public had come to view the credential of a physician (medical degree or medical license) as irrelevant; this disinterest continued as long as the diagnostics and therapeutics of medicine remained poorly understood and largely ineffective.10

The reinstitution of a medical licensing system in America can be traced to many factors, though perhaps the greatest of these was a general reassessment of what government regulation in the guise of licensing represented. Where once the licensing of physicians had been equated with “power and privilege,” the concept now became more closely linked to a genuine effort at protecting the public and the interests of independent educated professionals, both of which now seemed vulnerable in the emerging age of industrial titans like Rockefeller and Carnegie. The post-Civil War era witnessed the birth of large corporations that seemed to threaten the idealized vision of American as a nation driven by the economic engines of the yeoman farmer, artisan and small businessman. Recognizing the value of qualified physicians to help promote the public’s health, not to mention the value of qualified engineers and architects, occupational licensing developed anew. The basic idea was hardly new as colonial officials had licensed multiple trades from physicians to auctioneers to peddlers. The type of licensure familiar to us today for doctors, nurses, pharmacists and lawyers took root in the latter 19th century. While the justification was the same for almost all of the occupations (ostensibly to protect the public) this was perhaps the most obvious and persuasive argument in the case of doctors.11

North Carolina was one of the first states to emerge out of the professional and regulatory dark ages of the Jacksonian Era with the establishment of its medical board in 1859. Texas adopted its medical licensing authority in 1873 (its State Board of Medical Examiners was created in 1907), Nevada in 1875 (its State Board of Medical Examiners was created in 1899), Alabama and California in 1876, Illinois in 1877, Minnesota in 1883, Colorado and Washington in 1881, New Mexico in 1882, Virginia in 1884 and Oklahoma in 1890. Nearly all states had established licensing boards and independent examinations of their own by 1910.* And once states began insisting upon an examination as a prerequisite for medical licensure, proprietary schools—many of which were little more than diploma mills—could no longer blatantly exploit state law with abandon.12

One of the most comprehensive efforts to curb the blatant excesses ongoing in medical education took place in Illinois. That state’s 1877 legislation created a Board of Health under the leadership of John Rauch, who launched a vigorous campaign to verify physician credentials, assess their qualifications, identify bogus credentials and eliminate fraudulent practitioners. Additionally, the Illinois board introduced a classification system for medical schools that predated later national efforts. By 1883, Rauch and the board identified 24 schools whose graduates were not eligible for licensure. Illinois’ efforts soon constituted a de facto “authoritative” listing for all medical licensing boards.13 Additional pressure to standardize the quality of medical education occurred almost simultaneously with the creation in 1876 of a voluntary organization dedicated to improving medical education, the Association of American Medical Colleges (AAMC). Though the group’s aspirations proved untenable early on—the organization disappeared

STATE MEDICAL BOARDS FACED AN ARRAY OF ISSUES: MEDICAL EDUCATION STANDARDS, ASSESSING INDIVIDUALS’ QUALIFICATIONS FOR PRACTICE, THE MEDICAL PROFESSION’S SOCIO-ECONOMIC INTEREST IN FOSTERING A STRONG IDENTITY, ETC.

from 1882–1890 when its members fell out over a proposal concerning the duration of a medical education curriculum—the momentum toward a more meaningful medical education was clearly building. A good deal of impetus derived from progressive schools like Johns Hopkins, Harvard and the Universities of Pennsylvania and Michigan. State medical boards like those in Illinois provided a strong complementary force, especially in forcing proprietary schools to meet higher standards or shut down.14

Looking back, a narrative explaining the rebirth of medical licensing laws in the late 1800s in America might reasonably draw upon several factors: professional aspirations of physicians for greater prestige, competing schools of medicine striving for recognition, a growing number of medical schools, advances in medical science and growing public awareness of (and perhaps impatience with) the

* The following jurisdictions also set up separate licensing boards for homeopathic and eclectic medical practitioners: Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Louisiana, Maryland, New Hampshire, New York, South Carolina, Texas.
ramifications of a purely laissez-faire economic system upon individual consumers. Quality goods or services should, in theory, have driven out bad ones in the market, or forced lower prices. But many people, including the producers of quality goods and the providers of health care services (physicians), were not always willing to wait for the hidden hand of the marketplace. Indeed, the scientific and medical advancements characterizing the late 19th century created almost a moral imperative to some. According to at least one legal scholar, licensing laws and state medical boards reappeared beginning in the 1870s with the ostensible intent of correcting what the hidden hand of the marketplace had failed to resolve.15

The Federation’s Predecessor Organizations
The newly reconstituted state medical boards faced an array of challenging issues: medical education standards, assessing individuals’ qualifications for practice, the medical profession’s socio-economic interest in fostering a strong identity, etc. This soon prompted individual state medical boards and their leaders to seek opportunities for collective action among the licensing community. The deeper origins of the Federation rest with the regional and national licensing efforts that began in the 1890’s.

When addressing the Federation’s establishment in 1912, published histories of medical licensure and regulation in the United States have pointed correctly to the merger of two predecessor organizations as the genesis of the Federation: the National Confederation of State Medical Examining and Licensing Boards and the American Confederation of Reciprocating Examining and Licensing Boards.16 However, these accounts have not gone beyond referencing the merger to look more closely into the history of these organizations and the larger issues they confronted which prompted not only their creation, but that of the Federation itself. Their history, and particularly the key issues spurring their genesis (principally medical education and license reciprocity), reflected the multiple priorities and tensions at work within the medical profession and the emerging licensing community near the end of the 19th century.

The National Confederation of State Medical Examining and Licensing Boards
The National Confederation of State Medical Examining and Licensing Boards represented the elder of the Federation’s two predecessor organizations. The National Confederation was established in 1890 and held its first annual conference the following year in conjunction with the annual gathering of the American Medical Association (AMA). John Rauch provided the initial impetus for the National Confederation and served as its president until his death in 1894.17 The selection of Rauch signaled the unwavering emphasis of the organization “to establish a uniform standard of requirements” for both medical schools and the state medical licensing boards who would subsequently be evaluating their graduates. Previously, Rauch served as a catalyst in the early efforts of state medical boards to raise the educational standards of medical schools, starting with Illinois’ 1878 legislation restricting the issuance of a medical license to graduates of approved schools with clear standards for pre-medical and medical education.18 Throughout its 22 year history, the National Confederation devoted the bulk of its attention and resources to issues related to medical education and the minimum standards that should be required of physicians for medical licensure. This emphasis—specifically the insistence upon raising educational standards as the best long-term means for achieving uniformity of the standards for licensure—ultimately created a fundamental disagreement within the physician and licensing communities among those pressing for more immediate progress on practical issues such as license reciprocity, i.e., the prerogative of one state board to recognize and authorize for their jurisdiction the licensure decisions made by another state.

Upon Rauch’s death, leadership of the organization passed to William Warren Potter, a New York physician and former Civil War surgeon.** Potter continued the National Confederation’s focus on educational reform. That Potter and other early leaders of state-based medical licensure placed so much emphasis upon common standards for medical education is not surprising as influential

** Potter’s reminiscences of his Civil War experience were reprinted in 1996 as One Surgeon’s Private War: Doctor William W. Potter of the 57th New York (John Michael Priest, Editor). A shorter reminiscence by Potter appeared as “Three Years with the Army of the Potomac — A Personal Military History,” Buffalo Medical Journal LXVII (July 1912): 678-683.
medical educators shared their concerns. It seems telling that the National Confederation arose in the same year (1890) as the reorganized AAMC. That organization had essentially disappeared for several years when its earliest members withdrew their membership in protest over the “too rapid” application of higher standards for medical entrance requirements and curricula. The problems inherent to the largely unregulated practice of medicine in mid-19th century America provided a natural intersection of interests later between state medical boards and medical educators on the issue of educational standards. These complementary efforts can be seen in the curriculum standards adopted by the National Confederation which mirrored those set by the AAMC. The written summaries of National Confederation meetings reflect its growing alignment with the AAMC and later the AMA Council of Medical Education.19

In retrospect, the efforts of the National Confederation to facilitate “uniform standards” in the requirements set forth by both state medical boards and medical schools appear to reflect a strategic approach to resolving a seemingly intractable issue.20 The period of the mid-to-late-19th century witnessed a proliferation of medical schools, many of which were dedicated to specific philosophies of medicine. Because medicine was only just acquiring valid scientific underpinnings for its study and practice, the field was rife with practitioners with minimal or no qualifications for practice and a dubious knowledge base. Consequently, the medical profession struggled to acquire the gravitas necessary to set even minimum standards without accusations of “protectionism” — an updated version of the Jacksonian Era anti-privilege accusations that destroyed earlier legislative attempts at medical regulation.21 Voluntary associations such as the AMA and the AAMC, while potentially influential, lacked the authority to drive needed change. The only recourse was legislative. As the duly constituted legal authority regulating the practice of medicine within each state or territory, the state medical boards were poised to accomplish what others could not: establish or strengthen standards that protected the public from incompetent and unsafe practitioners and create a foundation for medicine as a legitimate profession. This fact was not lost upon advocates for medical education reform such as Abraham Flexner who in his 1910 report on the state of medical education in America dedicated an entire chapter to the critical role of state boards in fostering reform. By the mid-1890’s, 27 states had established (or re-established) state oversight of the practice of medicine through the creation of a medical licensing and examining board. According to one source, in 16 of these 27 states the requirement for a diploma from a “recognized medical college” was mandated for the issuance of a license.22 The National Confederation’s twin priorities of uniform standards for both medical education and licensure reflected not merely the vision of its early leaders but the reality of state medical boards actively weighing in on the educational standards of the day.

Potter and the leadership of the National Confederation applied a long-term strategy to achieve higher uniform licensure standards by raising medical education standards nationally, a laudable commitment serving the best interests of the public and patient care. But in playing such a long endgame dependent upon statutory changes among the various states, the organization risked sacrificing short-term victories that might address the more immediate concerns of all licensees. The key issue for many was license reciprocity and the failure to address this more vigorously fractured the organization in 1902.

The American Confederation of Reciprocating Examining and Licensing Boards

The genesis of the Federation’s other predecessor organization — the American Confederation of Reciprocating Examining and Licensing Boards — can be found in countless stories like that of Edwin Klebs. This German physician had achieved a considerable measure of professional success and in 1895 relocated to North Carolina. State law required every physician entering the state to sit for the medical board’s examination and provided the board with no discretion for exceptions. Similarly, no allowances were provided to the board for establishing reciprocal relations with other states that might have precluded the need for an examination. This minor contretemps involving a prominent physician exposed the board to criticism despite Klebs’ willingness, and subsequent
success, in passing the board’s examination. Licensed physicians less sanguine than Klebs often balked at mandated examinations and pressed state medical boards and legislatures for license reciprocity.\textsuperscript{23}

The immediate impetus for the American Confederation arose from a meeting of the Wayne County (Michigan) Medical Society whose members voiced frustration with real and perceived barriers for interstate physician licensure. Their conversations led directly to efforts by the state medical boards in Michigan, Wisconsin, Illinois and Indiana to address license reciprocity on a regional basis for their respective boards.\textsuperscript{24} In June 1900, Emil Amberg of Michigan and William Spurgeon of Indiana made a forceful push on the issue of license reciprocity at the National Confederation’s annual meeting. They argued that such an initiative could move forward in parallel with the organization’s ongoing efforts to support higher standards in medical education. Amberg also called for an aggressive media campaign to mobilize the profession and draw in the “lay press” as an ally in the “improvement of medical laws.”\textsuperscript{25} Written accounts of the meeting reflect that many National Confederation leaders were less than enthusiastic on the subject but grudgingly agreed to establish a committee to investigate the topic.\textsuperscript{26}

The committee reported back at its June 1901 meeting. The published transactions of the organization for that year appeared in the \textit{Bulletin of the American Academy of Medicine}, the National Confederation’s official publication, and appear to show a seemingly terse treatment of license reciprocity as an issue for consideration by the organization’s membership. The report was “received and filed,” the committee thanked for its work and then formally “discharged.” While the transactions did not convey any of the prior year’s contentious tone, the treatment of the committee and its report clearly ranked. Representatives from the same four boards that brought the issue forward originally gathered seven months later in January 1902 at a meeting that culminated in the formation of the American Confederation. Looking back at this development, the National Confederation’s Secretary (A. Walter Suiter) admitted the causal chain of events leading to the American Confederation’s genesis. He acknowledged that the National Confederation “summarily disposed” of the reciprocity topic in a manner leading directly to the formation of the American Confederation. He further regretted the creation of a second “association” drawn from the state medical board community; and particularly one whose name was sure to create confusion as it mirrored the elder organization so closely. Suiter’s overall assessment proved telling when he asserted the issue (license reciprocity) had received more “attention…than its importance really deserves” and that interstate legislation was premature. Such sentiments reflected a fundamental disagreement over the utility of a national organization attempting to resolve an issue arising from state-specific circumstances.\textsuperscript{27}

The American Confederation may have received an additional boost from an abortive contemporary effort to establish a national examining board whose credential might bridge varying state standards and thus foster license portability. Proponents of such a body argued that this represented the best means for resolving the difficult practical issues stemming from the varying standards for licensure among the states and territories. They chafed at the “inelastic” nature of the U.S. Constitution, which seemed more reflective of 18th century socio-political values and mores that feared placing trust in the people, as opposed to the progressive American spirit at the dawn of the 20th century.\textsuperscript{28} Inevitably, opponents of such a national licensing board forestalled these proposals by playing their Constitutional trump card (i.e., the 10th Amendment reserving rights not otherwise elucidated from state-specific circumstances).\textsuperscript{27}

The American Confederation’s leadership — J.R. Currens, James Dinnen, Beverly Drake Harrison — moved quickly to formulate a series of “qualifications”
that might serve as the basis for license reciprocity. These qualifications centered upon a medical diploma and either examination or recommendation by a state board.

**Qualification 1:** Possession (for at least one year) of a “satisfactory” medical diploma and an examination by a state medical board; or

**Qualification 2:** Possession (for at least one year) of a medical license presented by virtue of a “satisfactory” medical diploma and upon the “recommendation” of that state medical board in lieu of an examination.\(^3^0\)

Some critics pointed to Qualification 2 as a pathway for graduates of substandard schools and/or sectarian schools to gain further recognition. The concern that this allegation might gain traction led the American Confederation to ultimately adopt a Qualification 3, requiring evidence of “moral and professional character” through an attestation by a medical society. While not a panacea, it represented a good faith effort to flag “charlatans” and practitioners of questionable ethics.\(^3^1\)

The American Confederation’s efforts appear to have come at a propitious time. Between 1905 and 1908, more than 2,500 “reciprocal registrations” were issued by 21 reporting state boards. The detailed statistics for 1905–1906 reveal that the vast majority of physicians (938 out of 1,187) were issued reciprocal licenses under Qualification 1.\(^3^2\) Thus, it appears that younger physicians who had been licensed in part based upon an examination were finding fewer barriers than their older colleagues.

As the parallel work of the American and National Confederations unfolded, distinct perceptions developed regarding the nature of both organizations. Because several leaders of the National Confederation

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**Original Charter Member Boards of the Federation of State Medical Boards of the United States**

<table>
<thead>
<tr>
<th>Board</th>
<th>Date Enrolled</th>
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</thead>
<tbody>
<tr>
<td>Arkansas Eclectic Medical Board</td>
<td>January 23, 1913</td>
</tr>
<tr>
<td>Arkansas Regular Medical Board</td>
<td>February 13, 1913</td>
</tr>
<tr>
<td>Illinois State Board of Health</td>
<td>July 10, 1913</td>
</tr>
<tr>
<td>Iowa State Board of Health</td>
<td>March 5, 1913</td>
</tr>
<tr>
<td>Louisiana Board of Medical Examiners</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Maryland Regular Board of Medical Examiners</td>
<td>January 29, 1913</td>
</tr>
<tr>
<td>Massachusetts Board of Registration in Medicine</td>
<td>February 20, 1913</td>
</tr>
<tr>
<td>Michigan State Board of Registration in Medicine</td>
<td>July 24, 1913</td>
</tr>
<tr>
<td>Minnesota State Board of Medical Examiners</td>
<td>July 17, 1913</td>
</tr>
<tr>
<td>Montana State Board of Medical Examiners</td>
<td>July 30, 1913</td>
</tr>
<tr>
<td>New Jersey State Board of Medical Examiners</td>
<td>May 1, 1913</td>
</tr>
<tr>
<td>New York State Board of Medical Examiners</td>
<td>February 17, 1913</td>
</tr>
<tr>
<td>North Dakota State Board of Medical Examiners</td>
<td>February 19, 1913</td>
</tr>
<tr>
<td>Ohio State Board of Medical Examiners</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Oregon State Board of Medical Examiners</td>
<td>March 13, 1913</td>
</tr>
<tr>
<td>Pennsylvania Bureau of Medical Education and Licensure</td>
<td>March 25, 1913</td>
</tr>
<tr>
<td>Rhode Island State Board of Health</td>
<td>February 17, 1913</td>
</tr>
<tr>
<td>South Carolina State Board of Medical Examiners</td>
<td>July 30, 1913</td>
</tr>
<tr>
<td>Utah State Board of Medical Examiners</td>
<td>February 5, 1913</td>
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<tr>
<td>Vermont State Board of Medical Registration</td>
<td>February 7, 1913</td>
</tr>
<tr>
<td>Virginia State Board of Medical Examiners</td>
<td>July 30, 1913</td>
</tr>
<tr>
<td>Wisconsin State Board of Medical Examiners</td>
<td>July 26, 1913</td>
</tr>
</tbody>
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Source: Quarterly of the Federation of State Medical Boards of the United States, October 1913
(T. J. Happel, J. N. McCormack, George Webster) held leadership positions with the AMA, the perception took hold of a pro-AMA bias on the part of the National Confederation. This view deepened after 1904 when the AMA established its Council on Medical Education, which moved quickly to adopt minimum standards for medical education (i.e., four years of high school; four years of medical school) consistent with those advocated by the National Confederation and the AAMC. Not surprisingly, the harshest criticism of the National Confederation arose within the medical profession along sectarian lines, especially among physicians graduated from homeopathic and eclectic medical schools who had long been wary of the AMA and took umbrage at the organization’s consultative clause.33

The strongest support for the American Confederation arose from the ranks of these irregular practitioners.34 This support is not surprising given the ‘Qualification’ model set forth by the American Confederation as the basis for reciprocal licensing. In essence, the examination and recommendation components removed all issues of the relative merits of a given school of medicine from the equation. Practitioners educated in homeopathic or eclectic medical schools had already experienced considerable success legislatively in either gaining representation on state medical boards or having a separate board constituted for their practitioners.11 Consequently, they looked favorably upon the American Confederation’s efforts at reciprocal licensing agreements among state boards as this would only serve to further legitimize these practitioners and offer additional practice opportunities. In addition, the American Confederation’s vigorous program for having state licensing boards inspect the medical schools within their state seemed less threatening than a process under the control of the AAMC and the AMA Council on Medical Education.35

The Merger Creating the Federation
Despite outward appearances of viability for both organizations continuing as separate entities, forces were at work moving them toward what many perceived as an inevitable and desirable merger. First, neither organization possessed significant financial resources or the infrastructure for a truly sustainable national organization. Second, there was a clear understanding that the interests of the public and medical regulation were not well-served by two national organizations operating within this realm and sometimes directly at cross purposes. Third, by 1911, half of the National Confederation’s officers and executive committee were drawn from the Arkansas, Illinois and Ohio state boards—all of which were members of the American Confederation.36 One might reasonably speculate that these individuals’ exposure to the American Confederation through their respective boards’ participation created a familiarity that may have transcended philosophical differences between the two organizations. Finally, there seems to have been a clear push from the AAMC and AMA acting as mediators to bring about a union of the American and National Confederations. Indeed, as early as 1908 one hears a gentle, but direct, chiding of both organizations from speakers at the AMA Council on Medical Education. “You gentlemen...ought to organize a body that will bring together all states....”37

Exploratory discussions between the two organizations took place starting in 1910 though the critical meetings did not occur until February-March 1911 at the Congress Hotel in Chicago. Representatives from the American Confederation (William Spurgeon, Beverly Drake Harrison), the National Confederation (Charles Tuttle, George Matson); the AAMC (William Harlow, Fred Zapffe); the AMA Council on Medical Education (Nathan P. Colwell, Arthur Dean Bevan); and the Carnegie Foundation for the Advancement of Teaching (Abraham Flexner) met and concluded that a merger of the two organizations was “desirable” and in the best interests of the nation’s state medical boards. A session on March 2 identified a proposed name for the new organization as put forth by George Matson of the Ohio medical board—the National Federation of State Medical Boards. (The word “national” was soon dropped without explanation though one might speculate this represented an attempt to avoid overt reference...
to either predecessor’s name.) The following day the American Confederation met for apparently the last time.38

A draft Constitution and Bylaws for the Federation were adopted on February 28, 1912. Within the first year, there were 22 original charter member boards to the Federation (see table on page 26). Looking back, one senses that the National Confederation held considerable sway in the nascent Federation. Most of the Federation’s early leadership had prior links to the National Confederation and, with the exception of Beverly Drake Harrison, few of the American Confederation’s leaders assumed comparable roles with the Federation. However, the American Confederation seemed to have achieved its primary purpose as the Federation’s bylaws contained a section on “minimum standards” that its member boards were required to uphold specific to educational standards for licensing physicians. More importantly, the subsequent description of “qualifications for indorsement (sic) of state licenses” drew almost verbatim from the qualifications criteria set forth previously by the American Confederation.39

Despite the apparent success of the merger, some within the licensing community could not help but wonder what the future held for the Federation. With the notable presence of representatives from the AMA Council on Medical Education and AAMC in establishing the Federation, and the dearth of medical education issues on the program of the Federation Bulletin and, with the exception of Beverly Drake Harrison, few of the American Confederation’s leaders assumed comparable roles with the Federation. However, the American Confederation seemed to have achieved its primary purpose as the Federation’s bylaws contained a section on “minimum standards” that its member boards were required to uphold specific to educational standards for licensing physicians. More importantly, the subsequent description of “qualifications for indorsement (sic) of state licenses” drew almost verbatim from the qualifications criteria set forth previously by the American Confederation.39

Endnotes

7. Duffy, Humors to Medical Science, 85; Haller, American Medicine, 237.
9. Haller, American Medicine, 192.

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20. 18th Annual Report of the State Board of Health of the State of Illinois, xli.


34. “A Medical Comedy,” 122.


