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MEDICAL LICENSURE IN RHODE ISLAND

A Review of the History and Current Status of the Regulation by Statute of the Practice of Medicine

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THE SUBJECT of medical licensure and the standards for certification are a vital concern to all members of the medical profession practicing within our state. This article has been prepared by the official licensing agency to acquaint our physicians with the history of the regulation of medical practice here and the requirements for certification together with the concomitant problems and responsibilities of the licensing officials. It might be noted here that from the time of the adoption of Rhode Island's medical practice law in 1895 to the close of 1961, a total of 3,531 licenses were issued to physicians. In 1961, 1196 of these applied for and were granted annual registration of their license; 107 of these were located outside of this state sufficiently distant from our borders to be excluded from consideration for availability for providing medical care to our residents. This indicates that in 1961 Rhode Island had one currently licensed physician for approximately every 790 residents.

A knowledge of the historical background of the social, economic, and political aspects is helpful in establishing a valid perspective of current accomplishments, needs, and objectives for medical licensure. Governmental regulation of any profession to some degree creates the paradox of promoting public health, welfare, and safety while at the same time laying the foundation for the potential creation of monopolistic conditions restricting free competition. This is an inevitable sequence. Thus the licensing agency must be ever conscious of its obligation in a democratic society to strike a fair balance between freedom and order.

In Europe, as a protective measure for both the community and the practitioner, the professional segments of medieval society organized into guilds or associations. In the early middle ages these were dominated by ecclesiastical influence. In colonial America the true guild idea never did take hold.

To a large degree, state-wide regulation of the medical profession covering license and competence to practice was delayed until the second half of the eighteenth century, when the earliest American medical societies were established. Unlike the lawyers, doctors were not necessarily considered public servants and did not practice before a body empowered to license. Thus it was not until local and state medical societies existed that rules governing the training and conduct of practitioners were held in common by an organized group. Once established, these societies had no system of legal control over the training and experience of practitioners. By the end of the century, with the rapidly increasing number of practitioners, these societies began to fear for the purity of the profession and the welfare of a society at the mercy of the unqualified. They appealed to the state for recognition.[1]

Early Legislative Efforts

In Rhode Island the first profession to be regulated by statute was pharmacy in the year 1871. The legislature made provision for the licensing and control of persons practicing dentistry in 1881. It was not until 1895 that the General Assembly passed a law regulating the practice of medicine. About eleven years prior to that time, plans and discussions were held by committees from the state medical society and various other medical associations throughout the state regarding the problem "How might the state be rid of the itinerant quack?" In 1885 a committee presented a bill to the

[1]Occupational Licensing Legislation In The States, p. 15. (Chicago: Council of State Governments, 1952)

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legislature that would control the practice of medicine but it was defeated in the Senate. The following year another bill was again defeated primarily because of objections from certain elements from the southern part of the state. It is reported by the Rhode Island State Board of Health that beginning in 1888 the Rhode Island Medical Society proposed legislation for the same purpose, and each year a bill was presented in the legislature but failed of enactment. Some of these bills provided for the strictest requirements while others proposed merely a simple registration law, but the legislature was persistent in its refusal to enact a bill that would control medical practice until 1895. The following excerpt from the Annual Report of the State Board of Health for that year is quoted because of its colorful portrayal of conditions prevailing at that time.

> The reason for the failure to pass a medical control act is readily explained when it is considered that the largest representation in this State comes from the rural portion of the State, where the population could not be expected to be familiar with the impositions and chicanery which was practiced in the larger cities. The main desire of the medical profession was to obtain a means of preventing the practice of medicine and surgery by persons who had not the slightest, or only a rudimentary, knowledge of the human system and the conditions going on within the body, and no knowledge of the structure of the same. Any one who saw fit and had sufficient boldness of address could establish himself in business, and placing a placard before the public eye, was privileged to juggle with the feelings, the health and the pocket book of anyone who was sufficiently gullible to employ him. And the laity, especially the poorer class of the public who do not have a family physician at their command and in whom they have confidence, are liable to call upon the first physician whose name is seen upon the side of a house. The case is usually an emergent one, and they have no means of making a distinction, for the signs all read alike. The physician is called, and by some action or advice it is seen by the patient that the person employed to assist him in his need is not what he represented himself to be. He can discharge him, to be sure, but it is too late, the mischief has been done, valuable time has been lost, and his money has been wasted. That the uninformed public might feel a safety in employing a reliable physician or surgeon to care for their welfare, and when called that the employed would at least have intelligence enough to refuse the case if his knowledge was not sufficient to cover the conditions found, it seemed desirable to have a law which should admit to practice only those whose education had been sufficiently complete, either by study or experience, and no others.
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> The itinerant doctor has been the bane of this State for years, and with the restrictions placed upon them in every State but three, we have had our share and more. Our population is a largely operative one, and one which is easily led to believe statements because they are placed in print. Every physician can testify to the harmfulness of this line of practice as a cause of the increase of his own practice. The wholesale advertiser induces those who have slight ailments to consider that there is little hope for them. They treat them for awhile for some imaginary ailment, and the patient having been thoroughly frightened or led to a state of despondency, and finding no relief, seeks another physician and who may be a physician having some knowledge of the practice of medicine and surgery, and who has cause to thank the liberal advertiser. The saddest form of this imposition is seen in the innumerable cases of consumption and other chronic or incurable disease which the charlatan positively guarantees (the guarantee being his own statement) that he will cure these patients for a given lump sum, if paid down at once. The treatment will be continued until the patient becomes discouraged or dies. The itinerant does not remain long enough to ascertain how much good he had done to the regular profession nor injury to the patient; nor does he care. He remains as long as he can stand the importunities of his patients, and then goes to reap another harvest in some state which opens its arms to him as this one has done for years past. To the regular physician who remains this is the oft repeated story. The patient comes with hopes and money gone, and the state is often asked to pay for the last expenses of the patient, who has often saved the little sum given to the charlatan, for the purpose of a decent burial.
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> From these statements it will be readily seen why the medical practitioner has no especial interest in the passage of such a law, except the loss of dignity which is involved by permitting an imposition and criminal procedure to continue under the guise of a profession which he had adopted. At the January session of the Legislature of this year a bill was presented which, with little or no opposition, passed and became a law on May 16 and took effect on July 16.

Initial State Control

Thus on July 16, 1895, we have the first governmental control of the practice of medicine in Rhode Island. At that time a person could become licensed as a physician by any of three methods; (1) the possession of a diploma from a reputable medical college endorsed by the State Board of Health and requiring a three year course, (2) by presenting to the Board satisfactory evidence that the applicant

was reputably engaged in the practice of medicine or surgery in this state prior to January 1, 1892, (3) the submission of the applicant to an examination by the Board to determine if the applicant possessed sufficient knowledge of medicine and surgery to qualify for licensure. The report calls attention to a sudden influx of "foreign and irresponsible" persons who suddenly appeared or professed to have arrived in this state a few months before the ascribed limit of time for the obtaining of a medical license by exemption from examination. These irresponsible persons, it is reported, used every manner of illegal procedure and misrepresentation to gain their ends and a livelihood. The report states, "It is astonishing to see the names of reputable physicians placed against the statement that they know these persons and state that they were reputably engaged in the practice of medicine before January 1, 1892. The names are obtained with the ease of a signature to a petition for a fourth of July celebration and are respected by the Board with this value." During the first year of operation of the Medical Practice Act the Board considered over four-hundred and fifty applications and conducted several examinations. Seventeen meetings were held for that express purpose.

In 1914 the Medical Practice Act was amended by the General Assembly to provide for the licensing of osteopaths. The licenses were issued by the State Board of Health upon recommendation of a Board of Examiners in Osteopathy that was appointed by the State Board of Health. Again in 1927 the so-called Medical Practice Act was further amended by the Legislature to provide for the licensing of chiropractors. That type of license was also issued by the State Board of Health on recommendation of a State Board of Chiropractic Examiners, the members of which were appointed by the governor with the advice and consent of the Senate.

The State Board of Health was replaced by the Public Health Commission in 1929 by a reorganization act passed by the Legislature. The functions of the new commission included the licensing and regulation of medical practitioners and the supervision of the examining boards for the other disciplines of the healing art. In 1935 the General Assembly completely reorganized the structure of the executive branch of the state government. All independent boards and commissions were abolished and administrative functions were assigned to state departments each headed by a director who was responsible to the governor. All examining boards with a health orientation or interest were placed within the jurisdiction of the Division of Examiners in the state Department of Public Health. Also created by the reorganization act in this Division was a Board of Examiners in Medicine which took the medical licensing and regulation that was formerly administered by the Public Health Commission. A later modification of the organization of state government in 1939 resulted in a change in the name of the department to State Department of Health, and shortly thereafter the Division of Examiners was given the more descriptive name Division of Professional Regulation. By statute the administrator of this division was made the administrative officer of all of the boards coming within the division's purview including the Board of Examiners in Medicine.

Basic Science Law

The year 1940 saw the passage of the state's basic sciences law the adoption of which had been urged for several years by both the Health Department and the State Medical Society. The need for such a law was indicated by the appearance of increasing numbers of medical cultists throughout the country, especially the so-called natureopaths who with little or no training in the premedical sciences were setting up offices for the treatment of the sick. In several states these cultists succeeded in winning statutory recognition. The stated purpose of our basic sciences law was to require certification of the education and knowledge in the basic sciences underlying the practice of the healing art of all applicants for a license to practice.

It is interesting to note that since shortly after its formation in 1915 the National Board of Medical Examiners was recognized by the Rhode Island licensing agency and diplomates of that board were licensed by endorsement after an oral examination or interview, provided they possessed the qualifications required for licensure in the state. However, Rhode Island did not issue any licenses by reciprocity or endorsement to licentiates of other states until 1947, when we entered into endorsement agreements with Connecticut, Massachusetts, New Hampshire and Vermont. In 1950 a communication was sent to the licensing agency of all other states in the country to explore the possibility of establishing endorsement agreements with them. As a result of this by the end of 1950 Rhode Island completed such agreements with thirty-three other states. Within the next few years similar agreements were in effect between Rhode Island and all of the other fifty states with the exception of New York and Florida. Under these endorsement agreements the applicant must have passed a licensing examination in another state and must present evidence of meeting our requirements as an individual. He must also appear for an oral interview before the members of the Rhode Island Medical Board. The endorsement agreements stipulated that the other state would accord similar recognition on the same basis to Rhode Island licensees. This widespread recognition and acceptance of our licensees is tangible evidence of the high regard and good repute that the nation accords to Rhode Island's medical standards.

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It is interesting to note that on several occasions during recent years applicants for licensure in Rhode Island who were diplomates of the National Board and therefore eligible for certification by endorsement elected to waive this privilege and to submit instead to our two-day written examination. Their explanation of this seemingly odd choice of the more difficult method of licensure was that in their opinion a Rhode Island medical license based on regular state board examination was more readily accepted by some other jurisdictions than the National Board. This was especially true in some instances because of the fact that we are a basic sciences state. An even more remarkable incident attesting to this occurred a few years ago when a physician, who had been practicing in this state for several years on a license obtained by endorsement of his National Board examination, asked that he be allowed to submit to our regular written test. He was advised that this could be done only if he would surrender the license he already held and waive all rights to it and then take and pass the regular state board battery of tests. This he did.

Board Responsibilities

The members of the Medical Board devote a considerable amount of time to their official duties and accept the public responsibilities that go with such service with serious consciousness of the need to strike a fair balance between individual rights with their attendant problems and the need for public order through strict enforcement of the requirements for certification. These board officials are vested with wide discretionary powers and must exercise them with mature judgment and complete objectivity. It is regrettable that at times the decisions of the board are made more difficult by the intervention of established practitioners in the community that are made on behalf of an applicant who has either failed to pass the examinations or who has been refused admission to the examination because of some lack of necessary qualification. It is realized that in most instances these petitioners who are seeking some special consideration or waiver are acting in good faith, and the board appreciates receiving all available professional opinions and evaluations of an applicant's fitness and ability. It should be known, however, that it is the board's standing policy to review with great care all borderline questions concerning qualifications or examination grades before final disposition of the matter. Whenever it can in good conscience, the board tries to resolve borderline questions in favor of the candidate. If it is necessary in order to reach a fair and valid evaluation of an inconclusive written examination, the board allows the applicant the opportunity to appear for a supplemental oral examination. This privilege is reserved for only those few real borderline situations that occur only infrequently. Obviously the board cannot grant special reviews of examinations or arrange special oral examinations for every applicant who is rejected as some members of the profession appear to feel should be done if a candidate appeals to them for intervention.

During World War II and the period immediately following those war years it was the policy of the board in its discretion to give a liberal interpretation of its rule requiring applicants for licensure to serve at least one year of rotating internship in an accredited hospital. In many instances the board accepted what it considered to be clinical training that was comparable to the experience a candidate would normally acquire during his internship. The current regulation of the board of examiners in medicine concerning internship and hospital training reads as follows: "Candidates must . . . file . . . proof of at least one year's rotating internship in a hospital approved for internship by the Council on Medical Education and Hospitals of the American Medical Association and then only if such hospitals are approved by this division at the time the internship was served. No candidate will be admitted to the examination pending the completion of his internship year. The Rhode Island Board of Examiners in Medicine in its discretion may accept as a substitute for the year of rotating internship the satisfactory completion by an applicant of the two-year program for General Practice approved by the Council on Medical Education and Hospitals of the American Medical Association. Candidates who submit satisfactory evidence to the division that they have completed at least three years of either intern or resident training or a combination of both in a specialty in a hospital accredited for training in that specialty by this division will not be required to present evidence of having completed one year of rotating internship. This exemption applies only to graduates of approved medical schools located in the United States or Canada and does not modify the rotating internship requirement for foreign graduates."

Since the World War II period there has been a great influx of foreign-trained physicians, and it has been necessary to screen their credentials and evaluate their education and fitness with the greatest of care. The board is proud of its record in the treatment and handling of the foreign diplomate. It has considered each of these applications on an individual basis, cognizant of the often tragic conditions which necessitated the physician's removal to this country and the corollary problems of readjustment and reorientation to a different set of professional standards and ethics. The success of the board in this area is demonstrated by the number of foreign-trained physicians who have successfully established practice in Rhode Island. Many of these contributed greatly to the health of our citizens by

completing several years of hospital training and practice prior to establishing their own offices. With the advent of the Educational Council for Foreign Medical Graduates in 1958 the problem of evaluation of the foreign medical graduate was greatly simplified. It is now required that all applicants who are graduates of foreign medical schools must possess a full qualifying certificate from that national screening agency before they can be considered by our board (Table 1).

The Rhode Island Board of Examiners in Medicine is truly appreciative of the co-operation that has been accorded to it by the Rhode Island Medical Society and its several component associations. It is also thankful for the understanding and confidence in it that has been manifested by the individual practitioners throughout the state and by the public.

Because we who minister to the human body and mind hold a sacred trust in our hands, we are solemnly obligated to keep medicine free from impurities and defects. Nothing but the best should be tolerated by medicine.[2]

[2]Excerpt from address by Leonard W. Larson, M.D., President of the American Medical Association. *Medicine Role in Self-discipline and Continuing Education*

TABLE 1

Portrays the comparative results achieved on medical licensing examinations by graduates of domestic medical schools and candidates who received their training at foreign medical schools. Also included for each year is the number of foreign and domestic applicants who were licensed by endorsement either on the basis of having passed the examination of the National Board of Medical Examiners or prior licensing examination in another state.

Year	Foreign Graduates *Passed*	Foreign Graduates *Failed*	Domestic Graduates *Passed*	Domestic Graduates *Failed*	Licensed by Endorsement *Foreign*	Licensed by Endorsement *Domestic*
*1962	20	6	2	1	2	28
1961	18	9	3	0	7	22
1960	22	7	5	0	1	23
1959	25	9	5	0	0	32
1958	42	1	3	0	11	17
1957	36	1	8	0	4	29
1956	39	8	5	0	2	25
1955	35	16	8	0	3	29
1954	34	8	7	0	1	21
1953	25	4	5	0	0	31
1952	24	1	12	0	0	26
1951	7	0	5	0	0	30
1950	2	1	10	2	0	17

*First eight months.

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