Dynamic Chiropractic

PHILOSOPHY

The Birth of the AMA, 1845-47

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It has been said by someone, that associated action constitutes the mainspring -- the controlling motive power -- of modern society ... Of all the voluntary social organizations in our country, none are at this time in a position to exert a wider, or more permanent influence over the temporal interests of our country, than the American Medical Association. -- N.S. Davis, MD, 1855

In the United States during the second quarter of the 19th century, the first medical practice acts were repealed by request of the voters, who had grown weary of the horrors of "heroic medicine." As late as the dawn of the 20th century, strong cathartics, emetics and mercurial preparations vied with the lancet and bloodletting as prominent tools in the physician's black bag (Joachims, 1982). George Washington, it may be recalled, died from the ministrations of his doctors, who drained pints of his blood to purge him of suspected toxins. Patients viewed hospitals as last resorts, a mere step away from the grave.

Populist movements, such as that of the Thompsonians (Armstrong & Armstrong, 1991; Starr, 1982, pp. 51-4), encouraged the belief that the typical family was as well or better equipped than any doctor to meet its own health care needs. Similar trends were also seen in other professions, such as in the law, where requirements for professional study were repealed in a majority of states by 1860 (Starr, 1982, p. 57). Many forms of alternative or "irregular" healing, already widespread among the rural populace, now grew in popularity even in the cities and towns. Among these practices were botanical medicine, faith healing, homeopathy, and magnetism.

During 1830-1845, the number of medical schools in the nation "more than doubled, leading to a most active rivalry" (Davis, 1855, p. 19). The first historian of the American Medical Association (AMA) noted that the schools vied for students in a fierce competition that could not be restrained by members of the wider profession. And with the loss of the authority inherent in the granting of medical licenses (see Table 1), the prestige of a medical school diploma (what little there was) carried as much weight in the public's mind as had a license from the state. Medical education was as likely to take place in the private offices of a practitioner as in any formal institution. Indeed, those who wished the maximum training usually trained under a practicing physician before enrolling in a medical school. And there was little to prevent the completely untrained individual from setting up shop and hanging a shingle as a doctor.

Table 1: Repeal of medical statutes in several American states, 1826-1852 (Starr, 1982, p. 58).

1826 Illinois
1832 Alabama
1833 Ohio
1836 Mississippi
1838 Maryland, South Carolina, Vermont
1839 Georgia

1844 New York
1852 Louisiana

Medical school offerings in the mid-19th century certainly did not merit much respect. Curricular lengths varied from 13-16 weeks in to earn the doctorate. The educational poverty of these short courses was recognized, but it seemed little could be done to upgrade. The overwhelming majority of medical schools were proprietary affairs, for which profit, rather than quality of education, was the bottom line. But even those few nonprofit institutions attached to universities relied upon tuition revenues to sustain themselves.

Any school that attempted to upgrade its curriculum could expect to lose its financial viability. When several state societies, encouraged by the Medical College of Georgia, called for a national medical convention in 1835, their intentions were seen as a threat to the schools, and no meeting was convened at that time. A second initiative to organize a "National Medical Convention" was led by the Medical Society of the State of New York in 1839, but the invited state societies and medical schools did not respond to the invitation to meet in Philadelphia (Davis, 1855, pp. 20-1).

Continuing concerns over the brevity of medical education and minimal standards for admission persisted among the members of the New York society, perhaps prompted by the loss of medical licensure in New York State in 1844 (Starr, 1982, p. 91). Younger physicians, whose status and upward mobility was more threatened by this loss of legal authority, felt compelled to have organized medicine itself fill the role that the state had previously played.

Medical education was a major discussion topic at the New York group's February, 1845 conference, and physicians in the Empire State passed resolutions calling for increased training. It was recognized that each school had a tendency to claim that its standards were as high as any other school's, but this truism side-stepped the pressing issue: the low standards of all the schools. Yet no state society could hope to enforce a higher standard within its borders without loss of medical students to other states. Once again a national policy seemed the only means of raising the quality of instruction. The secretary of the New York State organization began a letter writing campaign directed to the leaders of other societies.

At the New York group's February, 1846 convention N.S. Davis, MD reported a favorable response to his correspondence from colleges and associations in Connecticut; Delaware; the District of Columbia; Georgia; Indiana; Kentucky; Louisiana; Mississippi; New Hampshire; New Jersey; New York; North Carolina; Ohio; Pennsylvania; South Carolina and Tennessee. Mention favorable to convening a national medical convention was also published in a majority of the nation's medical journals. Accordingly, the New York group nominated 16 delegates for a meeting to be held at New York University (NYU) in May, 1846. Davis spelled out his concerns in the New York Journal of Medicine:

"First. The standard of preliminary or preparatory education should be greatly elevated, or, rather, a standard should be fixed, for there is none now, either in theory of in practice.

"Secondly. We should elevate the business of private teaching to that position which its intrinsic importance demands.

"Thirdly. A more uniform standard of qualifications should be required of the candidates for medical honors.

"Fourthly. We should devise some mode to stimulate the ambition, and arouse the energies of the profession to a higher state of intellectual activity and scientific inquiry." (Davis, 1855, p. 27)

The same issue of the NYJM also heard preliminary calls for more than a national meeting, but for the establishment of a "permanent National Society," to be patterned after the "British Association." Soon, however, objections were raised to the whole proposition, including the convening of national delegates as well as the formation of a permanent organization. Ironically, the loudest objections came from faculty members (particularly Professor Martyn Paine, MD) of NYU, the institution scheduled to host the national meeting. Objections were raised that Dr. Davis, who had been so explicit in delineating the improvements needed in medical training, "had been slandering and defaming the profession" (Paine, quoted in Davis, 1855, p. 29). Others expressed concern that national standards would create an elitism in medicine, and discourage enrollments.

Despite this brouhaha, the various delegates met on May 5, 1846 at NYU, with John Bell, MD, of Philadelphia chairing the proceedings. The meeting included 119 delegates "representing societies and colleges in sixteen different states" (Davis, 1855, p. 32). The assembled body elected Jonathan Knight of New Haven, Connecticut as its president, and complimented itself on the harmony that prevailed. This sentiment was quickly challenged, however, when Gunning S. Bedford, MD, a faculty member of NYU, observed that less than half of the American states were represented at the meeting, and called for the conference to adjourn, a motion quickly seconded by G.S. Pattison, MD, also of NYU. The motion was defeated by an overwhelming majority of those voting. The assembly briefly considered moving the meeting from the NYU campus, but this was resisted.

A major order of business was consideration of medical education, and the first committee appointed to review this matter offered the following resolutions, essentially in support of Dr. Davis' recommendations:

"First. That it is expedient for the medical profession of the United States to institute a National Medical Association.

"Secondly. That it is desirable that a uniform and elevated standard of requirements for the degree of MD should be adopted by all the medical schools in the United States.

"Thirdly. That it is desirable that young men, before being received as students of medicine, should have acquired a suitable preliminary education.

"Fourthly. That it is expedient that the medical profession in the United Sates should be governed by the same code of medical ethics."

This seminal national convention of the AMA adopted these resolutions in principle, and called for an organizational meeting of the "National Medical Association" to be held in Philadelphia at the Academy of Natural Sciences the following May. One year later, on May 5, 1847, nearly "two hundred and fifty delegates, representing more than forty medical societies and twenty-eight colleges" convened as planned in the city of brotherly love. Once again, Jonathan Knight, MD, was elected to preside over the meeting. Among the major policies adopted by the AMA at this time were several that bore on the issues of educational qualification and alternative healing. The curriculum of medical schools would have to be increased from four months to a minimum of six months, and should include the following subjects:

Theory and practice of medicine
Principles and practice of surgery
General and special anatomy
Physiology and pathology
Materia medica
Therapeutics
Pharmacy
Midwifery
Diseases of women and children
Chemistry
Medical jurisprudence

The association endorsed the proposal that any applicant to medical school be required to present a letter of recommendation from a "regular" medical practitioner with whom that would-be student had preceptored; that "the certificate of no preceptor shall be received, who is avowedly and notoriously an irregular practitioner, whether he shall possess the degree of MD or not" (Davis, 1855, p. 44). The AMA was also adamant about the need to separate the conferral of degrees from the issuance of medical licenses (in those few states which still licensed physicians); they felt strongly that abuse was the inevitable consequence of granting licensing authority to the medical schools. The national society called for one medical board of examiners in each state; it would be many years before this objective was achieved in even a few of the American jurisdictions (see Table 2).

Table 2: Enactments of medical statutes in the United States, 1873-1886.

1873 Arizona Territorial Act
1874 Missouri
1875 Nevada
1876 California
1878 Cherokee and Choctow Nations in Indian Territory
1879 Kansas, Texas
1881 Colorado
1886 Iowa

Nathaniel Chapman, MD, of Pennsylvania was elected the AMA's first president. Among the permanent committees that were formed at this time were those concerned with: Medical Sciences; Practical Medicine; Surgery; Obstetrics; Medical Education; Medical Literature; Indigenous Medical Botany; and Publication. This seminal meeting of the AMA also established the national society as a federation of state and county medical societies.

The meeting adjourned after three days, having selected Baltimore for its 1848 convention. A spirit of cordiality and accomplishment was reported to prevail among the majority of those who attended this first conference. No one could predict the future, but a sense of optimism marked the formation of the AMA. In unity, they believed, they would find strength. This was ultimately true, but the founders of the nation's preeminent medical society would not live long enough to see its goals realized.

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NOVEMBER 1997