Limitations on the Scope of Practice of Osteopathic Physicians

David G. Epstein
LIMITATIONS ON THE SCOPE OF PRACTICE
OF OSTEOPATHIC PHYSICIANS

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Last year, three hundred and sixty men and women graduated from the five osteopathic colleges in the United States. To receive the doctor of osteopathy degree, each completed at least three years of college work and four years of study at the osteopathic college, spent five thousand hours of classroom work in osteopathic college alone, finished a course of study virtually the same as offered at any allopathic medical school. And, each knows that he cannot professionally visit a patient at most hospitals; that medical doctors will not consult with him professionally; and that under the licensing laws of some states, he is no more than a glorified masseur. This article examines the limitations on the scope of practice of an osteopathic physician.

I. BRIEF HISTORY OF OSTEOPATHY

Disillusioned with recognized medical practice because of the loss of three of his children during an epidemic of spinal meningitis shortly after the Civil War, Dr. Andrew Taylor Still developed a new theory of structural therapeutics which he called osteopathy. His theory was that the human body was self-healing, containing within itself all of the elements necessary for its maintenance. He felt that all disease was due to abnormalities in or near joints and that any disease could be treated by correction of these abnormalities through manipulation. His ideas spread. In 1894, a college to teach osteopathy was started. In 1917, at Still's death, there were more than five thousand osteopathic physicians in the United States and abroad.

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2. Ibid.
3. His medical education was that of most doctors of his day, that is, he served an apprenticeship. For a history of the founder of osteopathy see G. Northup, OSTEOPATHIC MEDICINE: AN AMERICAN REFORMATION ch. 2 (1966); A. T. Still, Autobiography (1897); Young, Rising Fortunes of Bone Setters, Life, Sept. 26, 1960, at 108.
5. Id. at 26.
In the half century since Still's demise, osteopathy has undergone considerable change. The number of osteopaths in the United States is now over ten thousand.\(^6\) The quality of the education afforded by an osteopathic college has greatly improved. Osteopathic theory—while still stressing manipulation—now encompasses surgery and pharmacology.\(^7\) These changes\(^8\) have resulted in a measure of increased recognition for the osteopathic physician.\(^9\) However, numerous limitations on his scope of practice remain.

II. STATE LICENSING LAWS

The right to practice medicine is not an absolute right. A state\(^10\) in the exercise of its police power may impose whatever regulation necessary to protect the people from being mistreated or mislead by incompetent or unscrupulous practitioners. Accordingly, all fifty states have enacted legislation regulating the practice of medicine.\(^11\) Thirty years ago it was generally provided by statute and held that an osteopath could neither give or prescribe drugs nor perform surgical operations.\(^12\) However, as the field of osteopathy has developed to embrace drugs and surgery as well as manipulation, the state laws as to scope of practice by a doctor of osteopathy have changed.

Today in thirty-nine states and the District of Columbia it is possible for an individual osteopath to obtain a license which will permit him to use

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7. Ibid.
8. Osteopaths contend that the transformation in philosophy has not been great—that osteopathy has always been more than manipulation. See Mills, op. cit. supra, note 6, at page 3.
9. For example, by executive order on January 18, 1966, President Johnson called for doctors of osteopathy in the draft; osteopathic students are eligible for federal aid under the Health Professional Assistance Act of 1963; osteopathic colleges have been approved for federal construction funds under the Hill-Burton Hospital Survey and Construction Act.
10. Congress does not have the power to regulate the practice of medicine in the several states. See Du Vall v. Board of Medical Examiners of Arizona, 49 Ariz. 329, 66 P.2d 1026 (1937); 41 Am. Jur., Physicians and Surgeons § 7 (1942). It can, of course, regulate the practice of medicine and surgery within the District of Columbia. See, e.g., U.S. v. American Medical Ass'n, 110 F.2d 703 (D.C. Cir. 1940), cert. denied, 310 U.S. 644 (1940), 70 C.J.S., Physicians and Surgeons § 3 at 821 (1951).
medicine and surgery in his practice. In California, a recently enacted statute prevents the issuance of any kind of license to practice to osteopathic physicians. In Nebraska, almost all doctors of osteopathy now hold unlimited licenses, but, at present, no additional licenses are being issued. The law under which these osteopaths were licensed expired, and in 1963 the Nebraska legislature enacted a law providing that D.O.'s graduated from osteopathic schools approved by the Department of Health could qualify for unlimited licenses if they passed the examination of the Board of Examiners in Medicine and Surgery. The osteopathic colleges were inspected, and all were rejected. In the remaining nine states, osteopaths are still restricted completely, that is no doctor of osteopathy may obtain a license to prescribe drugs or perform surgery. In a majority of these states, the restrictions are imposed by the legislature, but in three of them courts have interpreted statutes, which seemingly extend equality to osteopaths, in a manner so as to severely limit their scope of practice.

Georgia is a good example. There the statute provides:

The license provided for in this Chapter shall authorize the holder to practice osteopathy as taught and practiced in the legally incorporated and reputable colleges of osteopathy, as provided for in this Chapter ... 22


18. At almost the same time, a distinguished team of M.D.'s and D.O.'s from Minnesota, acting pursuant to similar legislation, inspected and approved all of the osteopathic colleges. See Letter from Dr. George Taylor, member of the Nebraska Board of Examiners in Medicine and Surgery, to R. K. Kirkman, Director, Nebraska Bureau of Examining Boards, November 22, 1965.

19. Arkansas, Georgia, Idaho, Louisiana, Mississippi, Montana, North Carolina, North Dakota, and South Carolina. Some of the licensing laws make little sense. South Carolina's is an excellent example of this. There osteopaths have minor surgery and obstetrical rights but they cannot prescribe drugs. It would be difficult to imagine minor surgery or childbirth without drugs.


Every reputable college of osteopathy teaches surgery and pharmacology. Yet the Georgia Supreme Court in *Mabry v. State Board of Examiners in Optometry*, indicated that an osteopath in Georgia could neither prescribe drugs nor perform surgery.

Ten states or forty states are wrong. Either the former group is unduly limiting the scope of practice of an osteopathic physician or the latter has not imposed sufficient restrictions. John Doe, D.O., a graduate of Kirksville College of Osteopathy and living in Baton Rouge, Louisiana is as competent as John Doe, D.O., graduate of Kirksville College of Osteopathy and Surgery, living in St. Louis, Missouri.

As a practical matter, licensing laws are the most minor form of restriction on the osteopathic physician’s scope of practice. More than 95% of the osteopaths practicing in the United States today are located in states in which it is possible for them to obtain unlimited licenses. The following two sections of this article deal with restrictions which affect virtually all osteopaths.

III. County Medical Societies

Virtually every practicing M.D. belongs to the medical society of the county in which he practices. The advantages of such membership can most easily be understood by examining some of the disadvantages of non-membership. Non-members are ineligible for some specialty boards; members of medical societies are prohibited from having professional relations with doctors whose membership applications have been rejected; and, most important, the non-member will be denied the use of many hospitals. At present, very few osteopathic physicians belong to county medical associations. Until 1961, such membership was impossible. Section three of the Principles of Medical Ethics of the American Medical Asso-

24. 190 Ga. 751, 10 S.E.2d 740 (1940). The general counsel for the American Osteopathic Association is of the opinion that *Mabry* is read as deciding only the issue before the court: whether an osteopath can practice optometry without a license. See Letter from Langdon Ann Collins to David Epstein, May 1, 1967; *contra* Note, State Recognition of Doctors of Osteopathy Compared with State Recognition of Doctors of Medicine, 31 Notre Dame Law. 286, 293 (1956).
citation prohibits as unethical voluntary professional associations with cultists.\textsuperscript{30} Until 1961,\textsuperscript{31} osteopaths were regarded as cultists; in that year, the American Medical Association House of Delegates adopted a report to the effect that state medical societies could decide for themselves whether their members could voluntarily associate with osteopathic physicians.\textsuperscript{32} To date, seventeen states\textsuperscript{33} have determined that voluntary professional relations with doctors of osteopathy are ethical. In these states, however, at best, a handful of osteopaths have been admitted to full membership in county medical societies. Thus it is necessary to consider whether an osteopath has a legal right to be admitted to full membership in a county medical association.

It has long been settled that courts are loath to interfere in the internal affairs of private voluntary organizations.\textsuperscript{34} No early reported decision enunciates the reasons for such a rule; instead, the courts make statements such as “courts are indisposed to interfere”\textsuperscript{35} and “it is much wiser . . . that the court should hold aloof.”\textsuperscript{36} The underlying bases for the non-intervention policy were first set forth by Professor Chafee in a now classic law review article;\textsuperscript{37} he discussed at length three policies that underlie the judicial reluctance: (1) interpretation of ritual, obscure rules and doctrines might be too laborious; (2) judicial interference may be the cause of much resentment among members of the association involved; (3) growth of

\footnotesize{30. Cultists is defined as “one who in his practice follows a tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience.” Special Report of the Judicial Council, Osteopathy—JAMA, Sept. 16, 1961, at p. .........

31. In 1955, the American Medical Association’s Cline Committee composed of medical educators visited the osteopathic colleges and recommended that the cultist label be removed. See Report of the Committee for the Study of Relations Between Osteopathy and Medicine, 158 JAMA 736 (1955). The American Medical Association House of Delegates Reference Committee majority report approved removal of the label. One doctor who did not want the cultist designation removed filed a minority report. The minority report was approved by the House of Delegates.


34. See Annot., 137 A.L.R. 311 (1942). Rex v. Gray’s Inn, 1 Doug. 353, 99 Eng.Rep. 227 (K.B. 1780), is one of the earliest reported cases in point; there it was held that mandamus would not lie to compel the members of one of the Inns of Court to admit the movant because the Inn was a voluntary association.


37. See Chafee, The Internal Affairs of Associations Not for Profit, 43 HARV. L. REV. 993 (1930).}
free associations is beneficial to our society. Because of these policies, every court which considered the question prior to 1960 held that it could not compel membership in a county medical society.

However, even in early cases, courts overcame their “awe” of voluntary organizations when a member previously in good standing of a medical society was suspended or expelled. Traditionally three rationales have been used as bases for judicial intervention and relief: contract, property, and procedural standards. Under the contract theory, the constitution and by-laws of the voluntary association constitute a contract between the member and the organization. Discipline can be imposed only for offenses defined in the contract, and then only if the provisions are not contrary to law or public policy. This theory has been criticized on many grounds by numerous legal writers; its primary shortcoming is that it is simply inadequate. Most organizations word offenses in such vague terms that virtually any conduct can be punished. As its name implies, the property theory requires that plaintiff’s expulsion deprive him of a “property” interest; otherwise he does not have a justifiable

38. Professor Chafee assigned a colorful, descriptive name to each of the policies. He identified them, respectively, as the “Dismal Swamp,” the “Hot Potato,” and the “Living Tree.” Id. at 1021-23.

39. See Medical Society of Mobile County v. Walker, 245 Ala. 135, 16 So.2d 321 (1944); Harris v. Thomas, 217 S.W. 1068, 1077 (Tex. Civ. App. 1920, n.w.h.); State ex rel Hartigan v. Monogalia County Medical Society, 97 W.Va. 273, 124 S.E. 826 (1924). The language in Walker is especially strong: the court said:

The courts cannot compel the admission of an individual into such an association (county medical society) and if his application is refused, he is entirely without legal remedy, no matter how arbitrary, or unjust may be his exclusion. 16 So.2d at 324.

40. See, e.g., Annot., 20 A.L.R.2d 531 (1951); 70 C.J.S., Physicians and Surgeons § 80(h) (1951); Comment, Medical Societies and Medical Service Plans—from the Law of Associations to the Law of Antitrust, 22 U. Chi. L. Rev. 694, 697 et seq. (1955).

41. Legal writers have advocated additional theories. See, e.g., Chafee, The Internal Affairs of Associations Not for Profit, 43 Harv. L. Rev. 993, 1007 et seq. (1930) (tort); 41 Minn. L. Rev. 212, 213 (1957) (public policy). Only the three theories enumerated in the text have received judicial support.

42. See Medical Soc. of Mobile County v. Walker, 245 Ala. 135, 16 So.2d 321 (1944); Bernstein v. Alameda-Contra Costa Medical Ass'n, 139 Cal. App.2d 241, 293 P.2d 862 (Dist. Ct. App. 1956); Comment, Medical Societies and Medical Service Plans—from the Law of Associations to the Law of Antitrust 22 U. Chi. L. Rev. 694, 698 (1955).

43. See, e.g., Chafee, Internal Affairs of Associations Not for Profit, 43 Harv. L. Rev. 993 (1930); 5 Utah L. Rev. 270 (1956); Note, Exhaustion of Remedies in Private Voluntary Associations, 65 Yale L. J. 369 (1956). These same writers are equally critical of the property theory.

44. Cf. Summers, Legal Limitations on Union Discipline, 64 Harv. L. Rev. 1049, 1061 (1951).

45. The courts are at odds as to what constitutes a property interest. Some jurisdictions require a severable property right. See Gregg v. Massachusetts Medi-
interest. This explanation of the property theory exposes its primary defect—absent a property right, the court can do nothing; there may be serious injuries without loss of any property right. Under the third theory, a court balances the procedural requirements for expulsion against general notions of procedural due process. This theory has been used in a limited number of cases, and in each of them, the court has first found a property right.46

Finally, in *Falcone v. Middlesex County Medical Society*, a court did away with this expulsion/exclusion distinction. Recognizing that the loss is the same whether one is expelled or excluded,48 the New Jersey court ordered a county medical society to admit an applicant into membership. Because *Falcone* may one day become the osteopathic physician’s password into county medical societies, a detailed examination of the case is in order.

In 1946, Italo Falcone received the degree of Doctor of Osteopathy from an osteopathic college, not approved by the American Medical Association.49 After serving internship and residency in osteopathic hospitals, he passed the New Jersey State Board medical examination and received an unlimited license to practice medicine and surgery in the state. In 1951, Falcone attended the University of Milan, Italy—a medical school recognized by the American Medical Association—for seven months. The school gave him credit for his osteopathic studies and awarded him the degree of Doctor of Medicine. In the latter part of 1953, Falcone was admitted to the Middlesex County Medical Society as an associate mem-

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48. 162 A.2d at 330. The New Jersey Supreme Court decision simply ignored the traditional distinction between exclusion and expulsion.

49. It is perhaps redundant to say: “osteopathic college, not approved by the American Medical Association” since no osteopathic college has been approved by the American Medical Association.
ber for a two year probationary period.\textsuperscript{50} The society later learned of his osteopathic background and in 1956 refused to admit him into active membership and deleted his name from the associate member list. As a result of the society's action, two hospitals in the area terminated Falcone's staff membership and visit privileges. Falcone exhausted his internal remedies and brought an action in lieu of mandamus against the Middlesex County Medical Society requesting that the society be required to admit him into full membership. The Supreme Court of New Jersey upheld a decree ordering such action.

It is somewhat difficult to ascertain the basis of the New Jersey Supreme Court's holding.\textsuperscript{51} The major part of the opinion is rationalization for judicial intervention in the membership affairs of a private association.\textsuperscript{52} In this regard, the court relied heavily on labor cases ordering unions with closed shops to either admit all non-members or waive the compulsory unionism provisions as to them.\textsuperscript{53} The situations are analogous: exclusion from a closed shop costs a worker his job; exclusion from the Middlesex Medical Society had virtually the same effect on Falcone. It prevented him from privileges in the accredited hospitals in the area, virtually precluding his practice of medicine.\textsuperscript{54}

\textsuperscript{50} Associate membership in the Middlesex County Medical Society is a preliminary status and confers no right to election. See Brief for Appellee, pp. 5-6, Falcone v. Middlesex County Medical Society, 34 N.J. 581, 170 A.2d 791 (1962).

\textsuperscript{51} The opinion of the intermediate appellate court is much clearer. It set forth the following rule:

\begin{quote}
Where an organization is in fact involuntary and/or is of such a nature that the court should intervene to protect the public, and where an exclusion results in a substantial injury to a plaintiff, the court will grant relief providing that such exclusion was contrary to the organization's own laws, was without procedural safeguards, or the application of a particular law or laws of an organization was contrary to public policy. See 162 A.2d at 331.
\end{quote}

Under this rule there are three different situations in which a court will grant relief. In each of them, it is necessary to inquire into the nature of the organization and the injury to plaintiff resulting from the exclusion; in addition, the court must find either (1) violation of the organization's own rule; (2) absence of procedural safeguards; or (3) organization laws contrary to public policy.

\textsuperscript{52} See 170 A.2d 795-799.


\textsuperscript{54} The intermediate appellate court found that:

As a practical matter it (the Middlesex County Medical Society) is virtually an institution that controls the practice of medicine in the hospitals located within this county. Membership in defendant society is essential for any doctor wishing to freely and fully pursue his profession in Middlesex County. 162 A.2d at 332.

It mentioned the following facts to support this holding: (1) the joint commission on accreditation of hospitals was composed entirely of medical society members;

https://scholarship.law.missouri.edu/mlr/vol32/iss3/2
After deciding that intervention was warranted, the Falcone court promulgated the following rule:

When... [the society's] action has no relation to the advancement of medical science or the elevation of professional standards, but runs strongly counter to the public policy of our State and the true interests of justice it should be and will be stricken down.\(^5\)

Applying the rule, it concluded that the unwritten by-law requiring four years of study at an AMA approved school has no reasonable relationship to the purposes of the society in a case such as Dr. Falcone's.\(^6\)

Student writers have criticized the New Jersey court for making an unwarranted finding that an osteopathic education is equal to a medical one.\(^7\) They contend that a court is ill-equipped to make such a determination and great weight should be given to the society's own determination. While perhaps a court is not the proper tribunal to evaluate medical education, neither is a county medical society. It is well recognized that much of organized medicine's opposition to osteopathic practitioners is based on financial considerations.\(^8\) The proper body to evaluate the two schools of healing is the state legislature. In New Jersey, the legislature has made such a determination. It has determined that graduates of osteopathic col-

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\(^{(2)}\) by virtue of a rule of this commission, society membership is a requisite for hospital staff membership; \(^{(3)}\) deviation from the rule results in loss of accreditation for a hospital.


55. 170 A.2d at 800.

56. The New Jersey Supreme Court carefully limits its holding to the facts of Falcone. It gives no indication what the result will be when an osteopathic physician who practices osteopathy and who has never been inside a medical school applies for admission into a county medical society. The intermediate court's opinion goes beyond this; under it, the fact that an applicant is licensed to practice medicine and surgery is enough to require his admission to the county medical society. See 162 A.2d at 333.


leges should have an unlimited scope of practice. The *Falcone* decision merely augments this policy.

Since *Falcone*, three states have considered cases involving exclusion from voluntary medical associations. In *Blende v. Maricopa County Medical Society*, a licensed M.D. was denied membership in a county medical society. He brought a mandamus action against it alleging (1) the denial of membership was arbitrary and capricious; (2) such denial seriously limited his practice of medicine since society membership was a prerequisite to staff privileges in the hospitals in the county; (3) the society could deny him membership only on a showing of just cause. The trial court refused relief on the ground that a voluntary association may arbitrarily determine membership. The Arizona Supreme Court reversed and remanded setting out the following guideline: if there is even an informal relationship between membership in the society and maintenance of staff privileges in local hospitals then the society can deny a licensed physician’s application for membership only upon a showing of just cause. The court set forth a number of factors to be considered in determining whether just cause exists and indicated by way of dictum that failure to receive four years of training at a medical school approved by the American Medical Association was just cause.

In *Kronen v. Pacific Coast Soc. of Orthodontists*, a licensed dentist was denied membership in an orthodontic society. He sought injunctive relief, making much the same allegations as were made in the above two cases. The California District Court of Appeals held that it could and should inquire into whether the voluntary society in question was acting “arbitrarily and unlawfully in order to prevent plaintiff from practicing orthodontics,” but that in the case before it there was no arbitrary or unreasonable action.

Finally, in *Kurk v. Medical Society of County of Queens, Inc.*, a county medical society, acting pursuant to its by-laws, denied a licensed

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60. 393 P.2d at 930.
61. Ibid.
62. Ibid.
64. 46Cal.Rptr. at 819.
65. The court gives no indications as to what does constitute arbitrary or unreasonable action.
osteopathic physician membership on the ground that he did not complete a four year course in a college of medicine. The Supreme Court, Queens County, wholeheartedly endorsing Falcone, directed that the society admit him on the grounds that the by-laws in question were unreasonable and contrary to public policy. The Supreme Court, Appellate Division, reversed, holding that absent allegations of a monopoly and proof of economic necessity, the medical society could exclude him from membership. As the holding indicates, Kurk is factually distinguishable from Falcone: in Kurk the movant merely alleged that he could not obtain hospital privileges where he desired unless admitted to membership in the county medical society; there were other hospitals in the county which did not require membership as a prerequisite to qualification for hospital privileges. The holding also indicates that if an osteopathic physician could show either economic necessity or a monopoly then he could compel admission into a county medical society.

Thus New Jersey is the only state whose highest court has affirmed a decree ordering a county medical society to admit an osteopathic physician to membership—only in New Jersey do osteopaths have any sort of legal right to belong to a county medical association.

IV. STAFF PRIVILEGES

Twenty-three states have no osteopathic hospitals; in most of the other twenty-seven, there are just a few such hospitals. For example, Indiana has one osteopathic hospital; New York has four. Thus if osteopathic physicians are to have an unlimited scope of practice it is essential that they be permitted to use the facilities of allopathic hospitals.

As with regard to exclusion from county medical societies, the courts

67. Kurk was awarded the Doctor of Osteopathy degree in 1960. That same year he passed the New York examination and received an unlimited license to practice medicine and surgery in that state. In 1962, without attending any additional classes, he was awarded the Doctor of Medicine degree by the California College of Medicine. For an explanation of how this was accomplished, see Crothers, Those §65 M.D. Degrees: How Good Are They?, MEDICAL ECONOMICS, May 18, 1964 at 250.
68. 260 N.Y.S.2d at 529.
69. 264 N.Y.S.2d at 859.
70. There is, however, language in Kurk that tends to indicate that the court will be extremely reluctant to order a county medical society to admit an osteopath under any circumstances. See 264 N.Y.S.2d at 860-61.
72. Id. at 555.
73. Id. at 557. Missouri has seventeen. Ibid.
have been hesitant to intervene in the exclusion from staff membership or privileges in hospitals.\footnote{74} In deciding whether to review a hospital's admission policies, the court's first concern has been the nature of the hospital—public or private.\footnote{75} A public hospital is one owned, maintained, and operated by a governmental unit and supported by governmental funds; a private hospital on the other hand is one owned, maintained, and operated by private persons or a corporation, the government having no voice in its management or control.\footnote{76}

An osteopathic physician although duly licensed to engage in the unlimited practice of medicine or surgery in a state has no constitutional right,\footnote{77} statutory right,\footnote{78} or right per se\footnote{79} to use the facilities of any public hospital in that state. Admission to these facilities is a privilege, subject to the rules and regulations of the hospital administration. However, these rules must be reasonable.\footnote{80} One cannot be excluded from practice in a public hospital by rules, regulations or acts of government officials which are arbitrary, capricious or discriminatory.\footnote{81}

In Hayman v. Galveston,\footnote{82} the United States Supreme Court considered whether a regulation adopted by the governing board of a municipal hospital which excluded all osteopaths from practicing in the hospital was reasonable; it held that it was.\footnote{83} Eight of the ten other courts which

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75. For a detailed study of the administrative organization of the two types of hospitals see J. A. Hamilton, \textit{Patterns of Hospital Ownership and Control} (1961).


80. See, \textit{e.g.}, Annot., 24 A.L.R.2d 850, 852 (1942); 26 Am.Jur., \textit{Hospitals and Asylums}, § 9 (1940).


82. 273 U.S. 414 (1927).

83. The hospital involved in \textit{Hayman} was a municipal hospital in Texas. It should be noted that under Texas law at that time anyone who offered to treat
have considered this question have reached a similar conclusion.\textsuperscript{84} Most of them assign no reason for so holding;\textsuperscript{85} others say that the state licensing laws do not extend the right to use the facilities of public hospitals to osteopaths.\textsuperscript{86} The reasoning of the two courts in the minority can best be illustrated by the following excerpt from Morgan v. State.\textsuperscript{87}

To grant appellant the authority to practice osteopathy and then deny him the right to have the use of a recognized and useful facility for the care of his patients . . . is to take away much of the value and importance of the grant made.\textsuperscript{88}

Three courts have considered whether a public hospital’s requirement of membership in a county medical association is a reasonable one. In Alpert v. Board of Governors of City Hospital,\textsuperscript{89} the court said by way of dictum that the hospital regulations were reasonable; membership in the county medical society was one of the regulations. In both Hamilton County Hospital v. Andrews,\textsuperscript{90} and Ware v. Benedikt,\textsuperscript{91} the question of the reasonableness of a public hospital’s requiring membership in a medical association was squarely before the court. In both cases, the plaintiff was a licensed medical doctor who was denied admission to the county medical society and then denied admission to a public hospital because of a by-law of the hospital requiring medical society membership. In both cases, the court held the rule unreasonable and discriminatory, reasoning that it was an invalid delegation to the medical society of the power to determine who might use the hospital.


\textsuperscript{85} See, e.g., Hayman v. City of Galveston, 273 U.S. 414 (1927); Newton v. Board of Commissioners, supra.

\textsuperscript{86} See, e.g., Richardson v. City of Miami, 144 Fla. 294, 198 So. 51 (1940); Monroe v. Wall, 66 N.M. 15, 340 P.2d 1069 (1959).

\textsuperscript{87} 155 Neb. 247, 51 N.W.2d 382 (1952).

\textsuperscript{88} Id. at 386. For a discussion of how much of the "value and importance" would be taken away, see R. P. Sloan, TODAY'S HOSPITAL ch 5 (1966).


\textsuperscript{90} 227 Ind. 217, 84 N.E.2d 469 (1940), cert. denied, 338 U.S. 831 (1949).

\textsuperscript{91} 255 Ark. 185, 280 S.W.2d 234 (1955).
In contrast to the requirement of reasonableness with regard to exclusionary rules of public hospitals has been the judicial rule of no review of private hospital staff decisions. The actions of private hospitals are said to be within the discretion of the managing authorities, and the courts have consistently refused to review the actions of private hospitals. Thus, private hospitals have excluded a licensed physician from practicing because he did not receive his training in an American Medical Association approved medical school; a private hospital may exclude a practitioner on the ground that he is not a member of the county medical society; and a private hospital is under no obligation to give a reason for excluding a physician. The justification for this severe rule was set forth in Shulman v. Washington Hosp. Center:

Judicial tribunals are not equipped to review the action of hospital authorities in selecting or refusing to appoint members of medical staffs . . . . In matters such as these the courts are not in a position to substitute their judgment for that of professional groups . . . . The Court is not unmindful of the fact that due to the shortcomings of human nature an occasional injustice may result . . . . The Courts, however, do not sit to remedy every ill caused by the frailties of mankind. Their function is but to vindicate and redress legal wrongs.

In numerous cases, this public-private dichotomy has been attacked. Doctors have argued that privately owned hospitals which receive public funds should be considered public for purposes of judicial review and should be subjected to the same reasonableness requirement applied to hospitals owned by the government. Until recently, this argument was

93. See Osteopathy in Hospitals, 8 P.A. D. & C. 273 (1926).
94. See Note, Expulsion and Exclusion From Hospital Practice and Organized Medical Societies, 15 Rutgers L. Rev. 327, 345 (1961); cf. Harris v. Thomas, 217 S.W. 1068 (Tex. Civ. App. 1920, n.w.h.).
97. Id. at 64. According to one student writer, such reasoning "has no place in modern jurisprudence . . . . Courts in this era should not be unmindful of their duty to protect not only rights which other courts have protected in the past, but also those rights which necessarily emerge out of the trend toward overlapping private and public responsibilities." See 18 Rutgers L. Rev. 704, 712 (1964).
98. See, e.g., West Coast Hosp. Ass'n v. Hoare, 64 So.2d 293 (Fla. 1953); Hughes v. Good Samaritan Hosp., 289 Ky. 123, 158 S.W.2d 159 (1942); cf. Mack, Physician's Use of Hospital Facilities: Right or Privilege, 8 Cleve-Mar. L. Rev. 437 (1959).
uniformly rejected. In the last four years, however, three courts have examined the exclusionary rules of private hospitals.

In Simkins v. Moses H. Cone Memorial Hospital, a class action was brought by a group of negro doctors and dentists to restrain two North Carolina hospitals from refusing them hospital privileges. Both hospitals met the above definition of private hospitals—they were owned, maintained and operated by a non-profit corporation; both participated in the Hill-Burton program; and both had previously excluded all negroes from staff membership. The Fourth Circuit held that participation in the Hill-Burton program was sufficient involvement with government action to bring the hospitals’ conduct within the fifth and fourteenth amendments prohibition against racial discrimination. It logically follows that the constitutional prohibitions against unreasonable classification would also apply, and so, at least so far as the Fourth Circuit is concerned, exclusionary rules of private hospitals must be reasonable.

In Greisman v. Newcomb Hospital, the New Jersey Supreme Court accepted the public-private distinction but held that a combination of factors may exist which imbue a private hospital with public aspects. The court said:

[W]hile the managing officials may have discretionary powers in the selection of the medical staff, those powers are strongly imbedded in public aspects, and are rightly viewed . . . as fiduciary powers to be exercised reasonably and for the public good. . . .

99. Ibid.
100. It must be noted that during this same period of time, several courts have expressly endorsed the public-private distinction. See, e.g., Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.D.C. 1963); Cowan v. Gibson, 392 S.W.2d 307 (Mo. 1965); State v. Ohio Gen. Hosp. Ass'n, 149 W. Va. 229, 140 S.E.2d 457 (1965).
103. In addition to the federal funds, the court stressed the following aspect of the Hill-Burton program as constituting government action: (1) right of the government to recover part of the funds if the hospital is conveyed to persons not qualified under the Act to receive aid directly; (2) minimum standards and licensing procedures; (3) federal participation in the actual planning of the proposed facilities; (4) and General's approval of the state program of hospital construction.
105. 192 A.2d at 820.
106. The factors deemed important to this finding were government support, general voluntary support, public dedication in the hospital's charter, and public function as the only hospital available within the area of the doctor's practice.
[T]hey must never lose sight of the fact that the hospitals are not operated for private ends but for the benefit of the public...\(^\text{107}\)

In *Woodward v. Porter Hospital, Inc.*,\(^\text{108}\) the Vermont court adopted the holding and the reasoning of *Greisman*.

Although *Simkins* and *Greisman* overlap in the sense that both may be applicable in a single situation, they are separate and distinct. Under the former, the test for judicial intervention is sufficient governmental involvement; under the latter it is the public aspect of the hospital. Also, under *Simkins*, the standard to be applied is that of the fifth and fourteenth amendment; under *Greisman*, the standard is that of a fiduciary.\(^\text{109}\)

*Greisman* is significant also because of the by-laws there involved: an applicant for membership on the courtesy staff must be a graduate of a medical school approved by the American Medical Association and must be a member of the County Medical Society. Greisman was neither; he had graduated from the Philadelphia College of Osteopathy, and, because of his schooling, his application to the County Medical Society was never acted upon. In holding the by-laws unreasonable, the court simply extended *Falcone* to private hospitals.\(^\text{110}\)

*Greisman* represents an extension of *Falcone* in still a second respect. In *Falcone*, the court conditioned its judicial intervention on the existence of a monopoly power in the county medical association. In *Greisman*, there was a hospital which allowed osteopathic physicians to use its facilities that was only seven and a half miles from one of Greisman’s offices and fourteen miles from the other yet the court said:

[N]or does it suffice to say that there are other hospitals outside the metropolitan Vineland area, for they may be too distant or unsuitable to his needs and desires.\(^\text{111}\)

Thus, in New Jersey, an osteopathic physician must be given full consideration when he applies for staff privileges in a private hospital regardless of other available hospital facilities.\(^\text{112}\) It is only logical that the same would be true as to public hospitals.

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107. 192 A.2d at 824, 825.
110. 192 A.2d at 824.
111. *Ibid*.
It seems that the state of the law as to hospital privileges is much the same as it is with regard to staff membership. In New Jersey, an osteopath is judicially protected; a hospital can exclude him, but not because he is an osteopath. In Missouri and Nebraska the same is true when the hospital involved is a public one. This is not to say that these three states are the only ones in which osteopaths have hospital privileges in hospitals other than osteopathic hospitals. There are hospitals in the other states that extend their facilities to osteopathic physicians. They are, however, relatively few and far between.

V. MERGER DEVELOPMENTS

Although the osteopathic counterpart of the American Medical Association, the American Osteopathic Association, strongly advocates that doctors of osteopathy have the same scope of practice as allopathic physicians, it has consistently opposed any form of merger between the two schools of healing. Undoubtedly, this stand is in part motivated by a selfish desire to preserve the organization. The seemingly dominant reason, however, for the anti-merger view is a genuine desire to perpetuate osteopathic theories and methods. Osteopaths feel that osteopathic medicine is distinctive and distinguishable from allopathic medicine, and that merger would result in destruction through absorption. Despite this opposition, medical societies in three states, California, Washington, and Michigan, have with varying degrees of success recently attempted to bring about a merger of allopathic and osteopathic physicians.

Prior to 1961, California was no different from the majority of the states with regard to the scope of practice of an osteopathic physician: he had the right to use drugs or surgery in his practice but no judicially enforceable right to either county medical society membership or hospital staff privileges. In 1961, the California Medical Society and the California Osteopathic Society effected a merger. There were many facets to the

113. See note 8 supra.
merger contract,\textsuperscript{119} but the principal factors were (1) that the California College of Osteopathic Physicians and Surgeons must be converted to a medical school; (2) osteopaths holding an unlimited license to practice medicine in California were awarded M.D. degrees;\textsuperscript{120} (3) that doctors of osteopathy having these M.D. degrees be required to elect under which degree—D.O. or M.D.—they wished to practice; (4) that legislation to deny reciprocity licensure to future D.O. applicants become effective;\textsuperscript{121} (5) that Board of Osteopathic Examiners continue only as an agency to relicense those D.O.'s who chose not to practice as M.D.'s.\textsuperscript{122}

Surprisingly, the merger was not welcomed by all osteopathic physicians practicing in California.\textsuperscript{123} Approximately twenty-five per cent of the osteopathic physicians in the state for one reason or another\textsuperscript{124} elected to continue practice as D.O.'s. They united to form the Osteopathic Physicians and Surgeons of California and brought an action attacking the validity of the merger. It was charged that the agreement was an intentional interference with the right of osteopaths to pursue lawful business, a violation of the anti-trust laws, a violation of state statues prohibiting the sale of medical degrees, and an ultra vires act of the corporate California Osteopathic Associations. All contentions were rejected.\textsuperscript{125}

It is extremely difficult to make any sort of accurate statement as to what, if any, effect the merger has had on the scope of practice of the D.O.'s turned M.D.'s. Only with regard to membership in county medical societies is change discernable. After the merger agreement, the doctors of osteopathy who obtained their M.D. degrees and elected to practice as such did not automatically become members of the medical society in the county in which they resided or practiced. Instead, they were assigned

\textsuperscript{119} The terms of the merger agreement are set out at 36 Cal. Rptr. 647 et seq.
\textsuperscript{120} In New York State Osteopathic Society, Inc. v. Allen, 51 Misc.2d 849, 273 N.Y.S.2d 968 (1966), the New York court refused to recognize this M.D. degree. No other court has considered this question. See generally Crothers, Those §65 M.D. Degrees: How Good Are They?, MEDICAL ECONOMICS, May 18, 1964, at 250.
\textsuperscript{121} Cal. Bus. & Prof. Code § 2396.
\textsuperscript{122} Ibid.
\textsuperscript{123} The Executive Secretary of the Osteopathic Physicians & Surgeons of California speaks of the merger as “prostituting a degree long honored.” See Letter from David J. Rodgers to David G. Epstein, March 13, 1967.
\textsuperscript{124} These four hundred and fifty three persons consist of four groups: (1) osteopaths holding an unlimited license to practice in California who practice in other states; (2) osteopaths in California who do not hold an unlimited license to practice; (3) osteopaths practicing in California under an unlimited license who for one reason or another were denied an M.D. degree; (4) osteopaths practicing in California under an unlimited license who chose not to obtain an M.D. degree.
to a separate state-wide society composed of only former osteopathic physicians.128 Today, most of these ex-D.O.'s are now members of the regular county medical societies.127

The Washington merger is much more informal. There the medical society established a medical college, set up a ten day course, and awarded an M.D. degree to the osteopaths who completed the course.128 Several of these new M.D.'s then applied to the Washington Division of Professional Licensing for an M.D. license. At present none have been issued pursuant to the merger; the Division of Professional Licensing refuses to take such action until the courts approve the merger.129

Finally, in Michigan, merger has been delayed, if not permanently defeated. In 1966, the House Affairs Committee of the Michigan state legislature sent each osteopath a questionnaire inquiring whether "amalgamation of allopathy and osteopathy would be in the best interest of the people of the state."130 Almost ninety percent131 of the osteopaths replied to the questionnaire: 1,338 answered "no"; 195 replied "yes."132

CONCLUSION

A determination of whether a doctor of osteopathy is as competent as a medical doctor is beyond the scope of this paper.133 The question is complex and controversial and involves primarily non-legal considerations. Regardless of whether John Doe, D.O., is now the professional equal of

126. See Aspinwall, This M. D. Works in a D. O. Hospital, MEDICAL ECONOMICS, Feb. 24, 1964, 111, 126.
128. Once again the state osteopathic association is opposed to any form of merger with M.D.'s. See Letter from Dr. Leo A. Hoover, Secretary, Washington Osteopathic Medical Association, to David Epstein, April 24, 1967.
131. Ibid.
132. Ibid. The same questionnaire was mailed to every M.D. in the state. Only two thirds responded: 5,520 voted for the merger; 1,234 voted against it.
133. In some states M.D.'s and D.O.'s take the same licensure examinations. There is no clear difference in their scores. See Medical Licensure Statistics, 196 JAMA 857, 858 (1966). Chicago College of Osteopathy requires that all applicants take the Medical College Admission Test, as do all medical schools. The scores of the successful applicants to the Chicago school are quite similar to the scores of successful applicants to the medical schools. See Sedlacek, The Study of Applicants 1965-66, J. MED. ED., January, 1967, p. 28. The above supports the statement by the Secretary to the Texas State Board of Medical Examiners that "[T]here is no difference in the two (osteopaths and medical doctors) as far as their medical and surgery ability is concerned." Letter from M. H. Crabb, M.D., to David Epstein, December 30, 1966.
LIMITATIONS ON PRACTICE

John Doe, M.D., he should be. This nation is now experiencing a severe shortage of trained physicians; it is senseless to waste any healing talent or training. Accordingly, an osteopathic physician's background and professional education should be such that the standard of the treatment that he gives equals that of an allopathic physician, and the law should be such that the scope of practice that he has is also equal.\textsuperscript{134}

\textsuperscript{134} See Silver, \textit{Physician Shortage, Health Manpower and National Policy}, Hospital Tribune, p. 6, July 3, 1967. This has prompted the AMA to adopt a resolution, to, "begin negotiations directed toward the beginning official change of schools of osteopathy to schools of medicine." See, Report of Board of Trustees, \textit{Report E}, adopted by the House of Delegates, June, 1967.