Chapter I

Early Nebraska Medicine

Health Conditions

When Nebraska became a territory in 1858, the American frontier was not a healthy place to live. Conditions, for the most part, were primitive. All but the most well-to-do lived in dugouts, in houses constructed of sod or logs, or in flimsy wooden shacks lacking even the simplest of amenities. Usually crowded, they were also cold, with the only heat from sooty stoves or dirty open fireplaces. Light was supplied by kerosene and candles, making them dark and shadowy. Because proper ventilation was often lacking, they most likely smelled from kerosene and greasy cooking odors.

The average frontier diet was heavy on greasy fried foods and short on fresh fruits and vegetables out of season since easy transportation was not available. Without refrigeration, milk quickly soured, meat spoiled. Water supplies were frequently contaminated.

Other problems existed. Clothing for most people was scanty, ill-fitting, worn or torn—not to mention dirty, stained and stinking. Sanitation methods were not practiced since their value was just beginning to be appreciated during the 1880's and '90s. Transportation was by horse or horse-drawn carriage, and because horses cannot be trained otherwise, they deposited their waste wherever they might be. With no indoor plumbing, people made do with unscreened outdoor privies. Clothes were washed, what little they were washed, either by hand in streams (the same streams people bathed in or drank from) or in primitive mechanical contraptions used as washing machines. Garbage was disposed of haphazardly, sometimes out the back door. As can be imagined, flies and other insect populations flourished.

Another health problem in towns of any size were the saloons and houses of ill-repute. Because communities had little to offer for entertainment, enterprising souls found a ready market for drinking, gambling and "consorting with ladies of the evening". Saloons and bawdy houses provided meeting places, at least for the male segment of the population, but also helped produce the town drunk, angry shoot outs and a reservoir of venereal disease.

Needless to say, these conditions greatly facilitated the spread of disease on the American frontier. There were outbreaks of everything from cholera to diphtheria to typhus, and much else great and small, for many of which the population couldn't supply the names. Some of these outbreaks turned into raging epidemics. For all but a few, the frontier was a health hazard.

The city of Omaha during this period remained relatively and surprisingly healthy. While certainly not immune to the natural consequences of its unsound health practices, it did escape the more dire outcomes. Historian Michael Harkins was quoted as saying:

Ox carts, northeast corner of 14th & Douglas in Omaha, 1860. Ready to move West. (Courtesy Union Pacific R. R. Museum Collection.)
Throughout the first 40 years of Omaha's checkered health history, it miraculously remained one of the healthiest cities in the United States. The impression first gained from reading local newspapers and periodicals of the late 19th century is that the community suffered massively from major health nuisances. However, in relation to other metropolitan areas...Omaha's annoyances were mild.1

Several mild epidemics did occur: cholera in 1868; measles and scarlet fever in 1872; in 1875 a diphtheria outbreak; an 1882 smallpox episode; other smallpox and typhoid outbreaks in the 1880's.2 But there were not the full-fledged epidemics of other unfortunate cities.

Omaha's incredible luck was certainly not due to any superior health practices on its part. Many sources of the period emphasize the extreme muddiness of its streets when it rained. Because of the thickness and pervasiveness of the mud most streets became impassable. This is not the picture of a clean, healthy city. John G. Saxe was quoted as saying of Omaha in bygone days,

'Has't ever been to Omaha
Where rolls the dark Missouri down,
Where six strong horses scarce can pull
An empty wagon through the town?'

Sanitation laws were few and late in coming. City garbage collection was not instituted until the 1890's, and it took about 50 city ordinances between 1881 and 1891 to outlaw indiscriminate garbage dumping in streets. It wasn't until September 1881 that Omaha obtained the beginnings of a water and sewer system, and not until the 1890's was there
widespread hookup to sewer connections. Many ordinances had been passed attempting to keep holes from being cut into the backs of privies to allow waste to run out into streets and alleys, but it wasn't until 1945 that privies were actually outlawed within the city limits. Many ordinances restricting houses of prostitution were also passed, but in 1880 there were about 17 such houses, and by 1900 the number had increased to at least 50. Although it may have had fewer than other communities, Omaha had a considerable share of health problems in the last half of the 19th century.

Medicine on the Frontier
To quote one historian, "If the Old West offered a fertile field of endeavour for any profession, medicine was it." The need was great, yet medical knowledge was limited. Things taken for granted today were unthought of on the frontier. Many period pictures are available of surgeons hovering over operating tables, fully-bearded, street-clothed, with cigars hanging from the lips of some and surgical needles and sutures dangling from coat laps. This clearly demonstrates little or no knowledge (or certainly no acceptance) of antiseptic surgery. Discoveries in research were fewer then, and most medical advances took a long time to filter down to the frontier practitioner. The germ theory was not general medical knowledge before the 1880's. Indeed, hands and instruments were washed after an operation, not before. Understanding of bodily functions was rudimentary. There were few effective medications other than digitalis and purgatives. Knowledge of pathology was limited because of widespread superstition and religious prejudice against using cadavers for study purposes, forcing a truly dedicated frontier anatomist into the grave-reviving business.

The medical profession itself was in disarray. Various categories of "sects" practiced medicine. Among them were the regulars, also known as orthodox or allopaths, (the latter an ill-defined term encompassing those who had received a more traditional medical training and believed in the theory that specific diseases had specific causes and cures). These were the conventional doctors.
Competing in the medical arena were homeopaths, who believed that like cured like, in small doses; hydropaths, who believed in water therapy; Thompsonians, who built a theory around the use of natural herbs and botanical preparations; osteopaths, who rejected medicines and drug preparations, but rather emphasized joint massage and manipulations; and eclectics, who combined a little from this theory and a little from that. The regulars tended to label anyone other than themselves as quacks, although some of these sects were fairly legitimate, at least in intent, as were the regulars, having their own schools and eventually some regulatory societies.

Still other forms of medicine were practiced on the frontier. Granny medicine, a blend of folklore, superstition, Indian medicines and instinct, was quite common. This embodied self-diagnosis, or diagnosis by an older, respected member of the extended family or the community. It dealt with preventive medicine as well as specific cures. For example, it was thought that boiled pumpkin seed tea could cure stomach worms, or that drinking the hot blood of a chicken could cure shingles. Likewise, carrying onions in one's pocket could prevent smallpox and two tablespoons of India ink taken periodically could eliminate tapeworms.

Plants of all types were used as cures for one or another ailment. A source lists some:

A housewife’s kitchen was not complete without oak of jerusalem, hyssop, lavender, purple aster and blue, thyme, rue, and sweet bugle. The names of several others reveal their use—feverfew, fleabone, boneset. To spice up the brew, agents were added for their disgusting taste and sickening color: yellow poplar, sumac, tansy, pokeberry, jimson weed, red peppers, and dogwood. And, of course, no concoction was complete without at least one of the panaceas, sassafras oil or goose fat. If for no other purpose, these plants doubtless added vitamins to an otherwise deficient winter diet.

The same source notes, however, that despite the silly sounding nature of some of these “cures,” the pioneers did indeed stumble onto some bona fide drugs. Some 60 plant remedies used by early pioneers were listed in the U.S. Pharmacopoeia and included abortificients, soporifics, cathartics and emetics, which the frontiersmen colorfully called “pukes.”
Necessity, with trial and error, had actually led to some effective drugs. Also practicing on the frontier were many out and out fakes. Faith healers, medicine-show artists and purveyors of patent medicines proliferated on the frontier. Their claims, methods, and medications came in all shapes and varieties, from the fairly reasonable to the utterly fantastic. As one medical historian notes:

The third quarter of the nineteenth century saw virtual chaos in medical practice. New sects sprang up like weeds; the regulars continued undaunted and new medical schools to train them sprang up like weeds too. There were true quacks everywhere, within each discipline and outside them all; there were no quality controls even over the regulars. 6

Regular medicine, as practiced in the mid-19th century, would be almost unbelievable to the American 20th century mentality. When illness or mishap struck, most pioneers tried home remedies first, mostly of the granny medicine variety, even when a physician of some sort might be readily available. This happened for two reasons. First, the harsh economic conditions caused any kind of payment to a doctor to be a hardship. Secondly, quite often the patient did himself less harm than did the doctor.

This was the age of heroic medicine, so named not because of the heroism of the doctors involved, but because of the extreme measures often taken and the tremendous courage of the patients submitting to the medical treatments. Heroic medicine seemed to be based on the belief that sickness was caused by a buildup of poisons and other undesirable elements within the patient's system. The solution? Some very harsh remedies to rid the system of these infiltrators.

Still a favorite medical procedure of the time, inherited from centuries of medical opinion and practice, was bleeding. Citing Dr. Anthony A. Benezet, a well-respected medical author of the mid-1800's, one source says that "Bleeding, according to Benezet, was considered proper at the beginning of all inflammatory fevers, inflammation of the lungs, intestines, bladder, stomach, kidneys, throat and eyes, and good for coughs, headaches, rheumatism, apoplexy, and epilepsy." Bleeding was considered the best way to rid the body of "bad humors" or "bad blood" so it was used extensively for almost everything. When in doubt, bleed the patient.

Some variation existed in amounts and frequencies of bleeding. Ten to fifty or more ounces at a time seemed right. Frequency varied from patient to patient, depending on how long and how many bleedings it took for the patient to achieve the proper state of debilitation and near collapse. One Indianapolis doctor reportedly had to have a trough built from the window of his office to relay his patient's blood to the street. 7
Specialized instruments were used to administer the bleeding procedure. One was the lancet, a long, tapering pocket-knife type of instrument, which came in varying sizes and grades. Nature's old standby, the leech, was still employed, although less as time went on. The skin at the desired spot would be covered with something sticky or sweet to attract the parasite, then it would set about its task. "Cups" were also used, wherein air was first expelled by sucking or by burning hot wax, then the cup applied over the incision, and blood thereby sucked out of the wound. A truly state-of-the-art instrument was the combination lancet cup, a device consisting of a box with concealed, spring action knives to make the incision, and an attached glass cup to proceed with the withdrawal of blood.

Another favored release for "peccant humors" was "blistering", encompassing various methods of skin irritations designed to cause blistering and then release of fluid. Along with the fluid, so the theory went, would flow the offending poisons as well. Ingenious and torturous irritants were conceived. Ground mustard, ground Spanish flies, vinegar or the like would be rubbed into the skin until raw, the skin peeled off and thensome drug guaranteed to burn would be poured on, literally rubbing salt in the wound. Thin threads of horsetail were sometimes sewn through a shallow layer of skin at the wound and periodically shifted, or a small lump of cloth would be introduced into the wound, or specially treated cords of thread would be burned slowly on or in the wound. All of these were designed to "maintain an issue" at the wound, to keep it open and draining, thus purifying the body.

An even more popular treatment was the purge, another way to rid the body of unwanted impurities. These included emetics to induce vomiting, diaphoretics to induce perspiration, cathartics to purge the bowels and diuretics to induce urination. Most of the time, all or most of these were used as part of a single treatment, one after the other. In fact, most often a doctor would first bleed the patient, then blister, if necessary, then purge and finally "lock the bowels" with opium.

If all of these treatments seem barbaric, it should be mentioned that they were practiced by the legitimate regulars of the period, for the most part also highly respected civic leaders and men of intelligence and education. It is also true that given the medical conditions of the day, doctors worked "against odds which no reasonably sober faro dealer would accept." They used all the ammunition available in the medical arsenals of the time; unfortunately, the arsenals were not stocked with powerful weapons. The character of the frontier physician is exemplified in this understatement: "Timidity and irresolution were not outstanding weaknesses of the pioneer doctor." The fact that many frontiersmen survived medical treatment and actually recovered is a true testimonial both to the resilience of the human body and the tenacity of the pioneer spirit.

If doctors were limited in medical knowledge, the public was even more so, many of them willing to embrace cure-alls and gadgetry. "Medical hankies," restorative amulets, and cancer pastes were eagerly snapped up by consumers. A small sampling of patent medicine names is descriptive:
Quacks were especially successful when combining their sales pitches with religion, as in the case of faith healers, or with entertainment, as in the traveling medicine shows. They were then able to tap two sources of pioneer dissatisfaction, medicine and boredom, with one fraud. No doubt contributing to the success of patent medicines also was the fact that they contained up to 44% alcohol. Even teetotalers could take the cure without the least bit of guilt.

Despite the quacks, the granny medications and the heroic measures, the quality of medical care did improve as the frontier moved westward. Better diagnosis, better surgical procedures with good use of anesthesia and better medications were being introduced. The Civil War introduced the importance of trained nursing care to the United States and by the 1880's, Pasteur's germ theory was being accepted. Lister's antisepctic surgical techniques were bringing about important changes.

State of Medical Education

With the expansion of the country westward, the need for doctors was increasing. Railroad construction crews, Army posts on the farthest boundaries of civilization, Indian missionaries, boom towns created by the Railroad or the discovery of gold—all of these desperately needed trained doctors. Just how were doctors trained during this period? What system of education served as preparation for the monumental task of fighting disease on the frontier?

Before the Civil War, one popular route that many an individual took to being a doctor was simply to decide he wanted to be one. The only thing needed was the inclination. A shingle was hung, advertising was done and a doctor was born. It really was that simple. For the most part, in the wilderness that was the majority of western America, there were few licensing laws (and those few unenforced), background investigations were nonexistent, and no questions were asked. A man was a doctor if he said he was. In a majority of cases this was not true, but in more instances than one would like to believe, totally untrained or self-trained do-it-yourself doctors practiced medicine (the operative word here being "practiced") on an unsuspecting public.
Two other avenues of medical preparation were available to aspiring physicians, one more informal than the other, but neither one assuring quality medical education. The informal route to becoming a doctor was the apprentice system. A young medical aspirant would be apprenticed to an established physician, called his preceptor. For a period of generally two to three years, the student, usually living in the doctor’s home, would assist the doctor in every aspect of his practice. He would “read medicine” with the doctor go on all sick calls (“ride with the doctor”) and perform all tasks assigned to him in connection with the case at hand. The apprentice “ground powders, mixed pills and rode with the doctor on his rounds. He held the basin for his preceptor when he bled a patient; he adjusted plasters and learned to sew up wounds by watching the doctor at work.”15 This was learning by observing and then, quickly, by doing.

Between rounds of medical observation, the apprentice took care of the preceptor’s horse, cleaned the office and instruments, replenished supplies, washed clothes, swept the stable, repaired the buggy, cooked meals and ran errands. In short, the apprentice served as a sort of indentured servant, all for the sake of being able to emerge from his apprenticeship a full fledged physician.

At the completion of his apprenticeship period, the student would be issued a certificate proclaiming him to be a physician. His career would thus be launched. The apprentice/preceptor relationship was mutually beneficial. The student gained access to a respected and sometimes lucrative profession that carried with it social prestige. The preceptor, for his part, encouraged the apprenticeship. For one thing, a yearly fee of $100, paid to the preceptor, was not uncommon, and was a welcome addition to annual income.16 Also, the apprentice provided free labor, and served as a signal to the community that the physician was a source of knowledge and skill, capable of transmitting both to his students. Thus, the apprentice was a source of prestige to the preceptor.

The drawbacks to such a training are obvious. All depended on the knowledge, skill and professionalism of the preceptor and the aptness and motivation of the student. There were no regulatory controls, no check lists, no standardization in what was taught or learned. Even given optimum conditions—a thoroughly qualified teacher and willing, eager and capable student—there still was the problem of keeping abreast of medical advances. It was simply not an effective system of transmitting medical knowledge, yet it was the system most commonly practiced during the latter part of the 19th century, especially on the frontier.

The formal alternative to the apprentice system of medical education was the medical school. Although “most frontier doctors never saw the inside of a medical school,”17 they did certainly exist, and in greater and greater numbers as the 19th century progressed. However, when we speak of a medical school of the mid 19th century, we are talking, for the most part, about a totally different institution than the medical schools of today.

It was a sad fact that “the majority of medical schools from the 1820’s through the 1890’s were proprietary (profit making) establishments, which were owned by physicians who often were more concerned with account ledgers than with education.”18 There were notable exceptions, but not many. The professors who staffed the medical colleges were the owners, and for them teaching was a part-time business, incidental to their private practices, and almost totally motivated by the profit motive. The entire college staff usually numbered less than ten. Any profits left after expenses were split among the owners. Because few additional expenses
were incurred with increasing the number of students, competition was intense to attract as many students as possible. The more students, the higher the profit margin.

This competition for higher enrollments led to increasingly short and inadequate curricula, and to students of inferior capability. The curriculum usually consisted of two terms of about sixteen to twenty weeks each, the second term many times simply a repeat of the first. Many schools did not comprise even the whole of one building, but only one or two floors of buildings whose main occupants were offices or other businesses. Few labs existed and research was almost unheard of. Six to eight hours of daily instruction was almost totally didactic, with no patient experience and often no access to a hospital or clinic setting to gain this experience.

As for the students, most were not of exceptional ability. Entrance requirements were usually no better than those for a good high school. In some cases students were not required to be literate. The ability to pay seems to have been a prime consideration for entrance. Given these conditions, it is understandable that discipline was sometimes a problem. Drunken students in class created many a disturbance. One instance is cited in which firm measures needed to be taken against a medical student in an anatomy lab found merrily flinging cadaver parts out a window at passers-by.19

The physicians turned out under such a system lacked social graces. D. W. Cathell, a popular physician author of the 1880's and 1890's, wrote many books of etiquette style advice to physicians, beginning with his 1882 edition, The Physician Himself and What He Should Add to his Scientific Acquirements. The matters about which he finds it necessary to advise the physician tell us a great deal about the physicians of that day. He advises doctors to have clean shirts and clean collars, along with polished boots and clean hands. The doctor should not be seen in billiard parlors, or cigar stores, or in his shirt sleeves, nor should he be squirting tobacco juice around. He should acquaint himself with literature, but is advised against "frittering away precious time on educational frivolities after practice is begun."20 The physician should use new instruments and methods not only because they may aid diagnosis, but also because they will make him look good and inspire confidence. He is further advised to have displayed prominently in his office a fee table stating "Office Consultations from $1 to $10":

Having you charge from $1 to $10 will enable you to get an extra fee for cases of an extraordinary character, and still allow you to charge minimum fees for ordinary cases. Such a schedule will make those who get off by paying the lowest fees, feel gratified; it will also show everybody that you are skillful enough to attend ten dollar cases. 21

U.S. medical colleges proliferated in the 19th century as the need for new physicians increased. The need was quite legitimate; most of the new medical schools were not. They were opportunistic attempts to earn money quickly. In 1800 the United States had 3 medical schools, between 1810 and 1840, 26 new schools opened and between 1840 and 1876, 47 new medical schools were established. 22 From 1875 to 1890 it is estimated that there were 100 new medical schools opened in the United States.23

As inadequate and inappropriate as many proprietary schools were, even worse frauds were being perpetrated. The so-called diploma mills were schools that existed usually only on paper, and literally sold M.D. degrees to students sight-
unseen. These schools had agents who worked on commission, and were quite adept at seeking out prospective students. Once issued an M.D. degree, given the lack of licensing laws, the doctor by mail would travel west, hang out his shingle and generally be accepted by an unsuspecting frontier public.

Conditions in medical colleges were almost criminally lax. The situation was so dire that in 1869 the President of the American Medical Association requested federal intervention in the form of legislation to raise the standards of medical education. In 1876 the American Medical College Association (forerunner of the Association of American Medical Colleges), was established, whose goal also was to raise the educational standards of member medical colleges. By 1898 all states had licensing laws for physicians, with about one half requiring an examination to fulfill the requirement. Still other attempts were made to police the profession and impose at least minimal standards by the formation of local medical societies. The efforts were made. Progress toward achieving at least competence in medical education were slow, but steady. The 1890's were the years in which reform of medical education became a national movement. And it is within this decade of change that the John A. Creighton Medical College was founded.

Early Nebraska Medicine — Medical Societies

Like the rest of the nation’s physicians, Nebraska doctors were also concerned with the chaotic state of medicine and medical education in the mid-to-late 19th century. Following national trends, they too attempted to organize in order to effectively “police” their profession. As early as March 2, 1855, the first Nebraska Medical Society was formed “with a view to the elevation and maintenance of the requirements for the practice of medicine in Nebraska.” It was authorized to establish branches at local levels and to maintain surveillance over drug preparations sold throughout the Nebraska Territory. One of the incorporators is listed as Dr. George Miller, who was the first physician in Omaha. No person could practice medicine in Nebraska without being a member of this society.

Apparently this organization ceased or failed to function, for the records show that again in February 1857 the Territorial Legislature approved articles of incorporation for a second Nebraska Medical Society, listing five Omahans physicians as being incorporators, among them again Dr. George Miller of Omaha. This society had similar goals as the first, and also had the specific right to grant licenses to practice in Nebraska, and to revoke or refuse said licenses.

Another medical society, apparently only local in nature, was established in Omaha, also in 1857, for the establishment of professional fees and their collection. Having no name, its other main purpose was to “draw a line between regular practitioners and the irregulars or quacks, and only the regulars could become members.”

In August 1866 the Omaha Medical Society was officially established, with thirteen original members. In November of the same year, Dr. James P. Peck was elected the first President. On December 17, 1866, a comprehensive fee bill was adopted for all
members' professional services, and was a detailed basis for standardization city-
wide by all members. As updated and revised in 1871, a sampling of some of the
charges include:

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<thead>
<tr>
<th>Service Description</th>
<th>Charge</th>
</tr>
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<tbody>
<tr>
<td>Office prescription and advice (ordinary)</td>
<td>$1.00-3.00</td>
</tr>
<tr>
<td>Ordinary visit within city limits</td>
<td>3.00</td>
</tr>
<tr>
<td>Visit to country, per mile, additional</td>
<td>1.00</td>
</tr>
<tr>
<td>Visit to steamboat</td>
<td>5.00</td>
</tr>
<tr>
<td>Night visit to steamboat</td>
<td>7.00</td>
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<tr>
<td>Cupping or leeching, each application</td>
<td>3.00</td>
</tr>
<tr>
<td>Cases of sudden poisoning</td>
<td>10.00-100.00</td>
</tr>
<tr>
<td>For removing stone from bladder</td>
<td>100.00-500.00</td>
</tr>
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It also provided that extra charges could be incurred if there was a risk to the
physician, such as infection, or if it involved night travel over bad roads or if the
weather was bad. A physician could also charge extra to examine "putrid subjects,"
or could black-list (refuse to treat) persons who saw physician after physician,
refusing to pay medical bills as they went from one doctor to another. Apparently
this organization continued to be viable until the mid-1870's. Because of internal
dissension, membership dwindled and it ceased to exist about 1881.

In May 1868 the Omaha Medical Society aided in the formation of the Nebraska State
Medical Society, the forerunner of the present state medical society. The first convention
in June of that year elected Omaha Dr. Gilbert C. Monell as President. A highlight of the
convention was Case #5, in which Dr. R. C. Moore of Omaha reported his treatment of
William Thompson, a Union Pacific employee, who was scalped by Cheyenne Indians near
Plum Creek, Nebraska: "The scalp was en-
tirely removed from a space measuring 9
inches antero posteriorly and seven in-
ches laterally." After describing in some
detail the wound and his treatment of it, Dr. Moore
notes: 'The only inconvenience . . . was a
severe neuralgic pain, extending down the
right side of the head and face." This serves to remind us that times were, indeed,
rugged for the pioneers and their doctors.

There were other Omaha medical organizations that formed and declined
during this early period. Two rival groups formed: the Omaha Pathological and
Sanitary Society in 1876, and the Academy of Medicine and Surgery in 1881. Both
were disbanded and merged into the newly-formed Douglas County Medical
Society formed in 1883, which itself died out in 1887. Again two rival groups
established themselves: The Omaha Medical Club and the Omaha Academy of
Medicine, both founded in early 1888. The latter organization was said to have
Early Nebraska Medicine

included most of the "later Creighton College group,"68 those men influential in the founding and early administration of the Creighton College of Medicine. Among these were: D. C. Bryant, J. P. Lord, Charles Rosewater, B. F. Crummer, William H. Galbraith and P. S. Keogh, later the first Creighton dean.

Dissension and competition for members continued and a feeling developed that one organization was needed to unite all Omaha physicians. In 1890 a new Omaha Medical Society was formed, incorporating both rival groups of physicians. This was the direct forerunner of the Omaha-Douglas County Medical Society.

While medical societies were clearly coming into their own on the professional as well as social scene, other medical landmarks were being laid in Nebraska. The year 1881 saw the first law regulating medical practice in Nebraska. It provided three ways to obtain legal certification in Nebraska: A person holding a diploma from a legally chartered medical school could be certified upon registration of his diploma; anyone attending one course of lectures in a recognized medical school and having already practiced 3 years could get a certificate; and anyone practicing ten continuous years, the last two in Nebraska, could be certified. This was still relatively weak, but it was a start, and as amended in 1891 and again in 1897 gave at least some semblance of regulation of entrants into the medical profession in Nebraska.

Several other important medical milestones also occurred in Nebraska during this period of time. In 1881 the Omaha Clinic, the first medical periodical in Nebraska, began publication. In 1891 a State Board of Health was finally created in the state. Nebraska certainly had a long way to go, but these early steps provided a foundation for what was to come later.

Early Nebraska Medicine — Medical Education

While established physicians were busy organizing themselves and the medical profession in Nebraska was gaining regulation and some sense of conformity, what was the state of medical education itself within the state? It can be assumed that the apprentice system was alive and flourishing in Nebraska, as was the case elsewhere in the middle and far West. Unfortunately, we do not have sources giving us exact names, dates or numbers as to the preceptor/apprentice relationships.

We do, however, have historical information concerning attempts to establish medical schools in the state. The first such attempt in Nebraska came in May 1869 when the Omaha Medical College was incorporated. By all accounts, things appeared hopeful for the enterprise. Among the organizers were some of the city's leading physicians. Most of the prerequisites for a medical college were attended to: a Board of Trustees was formed, a faculty chosen, by-laws adopted, a course and length of study agreed upon, and, very important for a proprietary institution, each organizer pledged $500 of his own money to the venture.69

![Ware's Block, Omaha, 1869 (Courtesy Union Pacific R. R. Museum Collection.)](image-url)
There were, however, several very real problems for the proposed school. One was difficulty in locating a site for the college. Another problem was in-fighting and dissension among the faculty. The medical community of Omaha, as evidenced by its professional organizations and affiliations, was a somewhat contentious lot. The pairs of rival (and very competitive) medical associations that formed and reformed in Omaha have already been noted. Now we see Omaha's first attempt at the establishment of a medical school, foiled by further disagreement and animosity. Later still it will be seen that the establishment of the Creighton College of Medicine was also based in part on rivalries and factionalization within the medical community of Omaha.

One source speculates that a major drawback to this early plan was the lack of clinical facilities in Omaha, namely a hospital. As will be seen, no hospital really worthy of the name existed in Omaha prior to the founding of St. Joseph Mercy Hospital in 1870 and "in a city without hospitals, a medical college would probably be doomed to failure." Not formally dissolved until 1881, the first Omaha Medical College never got farther than the planning-on-paper stages. Medical education in Omaha was stillborn.

In 1880 came the second attempt at Nebraska medical education, with the opening in Omaha of the Nebraska School of Medicine, Preparatory. It opened its doors to medical students on October 18 of that year. Unlike its predecessor, it did actually have doors to open, in rented rooms on the third floor of the Hellman block on 13th & Farnam Streets. The facilities were meager, consisting of two rooms and a closet that contained dissection materials in a box. One room, presumably the lecture room, was 20 by 20 feet. The other, the dissection room, was about 10 by 12 feet, and had a 6 by 8 foot closet for storage. Not much of a start, but it did attract a faculty of at least nine, and a class of 14 students to its 20 week curriculum. This first class included 2 women and the first black Omaha physician, W. H. C. Stephenson. Students paid $30 tuition each for the privilege of being taught by a faculty including Dr. Samuel Mercer, Lecturer on Surgical Anatomy and Clinical Surgery; Dr. J. C. Denise, a Physiology instructor and clinical Lecturer on diseases of eye and ear; Dr. Robert R. Livingston, Lecturer on Principles and Practices of Surgery; Dr. W. S. Gibbs, Demonstrator of Anatomy; Dr. James Carter, Chemist Chairperson; Dr. Alexander S. von Mansfeld, Lecturer on Pathology and Practice of Medicine; and Dr. Richard Moore, Lecturer on Materia Medica and Therapeutics.

After a successful first year of operation, the leaders of the Nebraska School of Medicine, Preparatory, sought two things: to enlarge their scope of operations, building upon the foundation of the present school, and to change their name. The latter was accomplished easily. On June 14, 1881, a new Omaha Medical College was incorporated after the original 1869 version was finally officially disbanded.
The expansion efforts were longer in coming, but were likewise successful. New faculty members were added, and a more roomy location was sought. Two lots at the Southwest corner of 11th & Mason were purchased for $3,100 and a new building was erected costing $4,266. The new location was ready for use by September 1881. The choice of location was significant, and couldn’t have been by accident. It was adjacent to St. Joseph’s Hospital, 12th & Mason, which agreed to allow use of its facilities for clinical teaching purposes.

The fall of 1881 saw 35 people registered for classes, taught by a faculty of 13. The new college building seemed truly luxurious by comparison with the old cramped rooms in the Hellman block. It even included a museum, a library, and a laboratory.

Things continued to go well for the medical college. In 1886 the building of the school was moved to 12th & Pacific streets, and enlarged. In the 1890s new faculty, including specialists, were added to the college roster. Also in 1890 the curriculum became three years in length, following a national trend toward longer courses of study.

Still, Omaha Medical College was a proprietary school. The money to finance the new building had come from the faculty. Besides the obvious problem of lack of funding that comes from lack of affiliation with a university, there was a severe PR problem for proprietary schools. The public looked somewhat askance at them and many times with good reason. So many were guilty of outrageously fraudulent behavior that even those sincerely attempting quality education were viewed with skepticism.

Therefore, to legitimize itself in the public eye, several apparently unsatisfactory attempts were made to affiliate the Omaha Medical College with a university. "The Omaha Medical College attempted to rid itself of the stigma of being a proprietary school by affiliating first with the Methodist Episcopal College of York in 1885, and later with Bellevue College in 1891." The former lasted only two years.

The 1891 affiliation with Bellevue College, which changed its name to the University of Nebraska (no relation to the present University of Nebraska at Omaha), lasted until 1902. At that time the Omaha Medical College became united in a loose fashion to the University of Nebraska, becoming The College of Medicine of the University of Nebraska. Despite the duration of the tie, apparently the University of Omaha did not contribute much to the Omaha Medical College except its name.

There was a brief four year fling at medical education in Lincoln, beginning in 1883. The Legislature appropriated a small amount of money toward the establishment of a college of medicine within the University system, on condition that a faculty serve without pay. This medical school was located in the basement of old University Hall in Lincoln. It had serious problems from the very start. Besides having virtually no teaching equipment or really suitable classrooms, it had access to no clinical facilities, as Lincoln had no hospital. Even more serious, however, was the factionalization of the faculty, which consisted of regulars, homeopaths and eclectics. So serious was the rift that separate graduations were held for the various sects. Because of an offer of free tuition, the school at times had enrollments as high as 55 students. Yet all of the other problems proved too much for the Legislature.
to further tolerate. In 1885 it refused to give continued funding to the school. Despite a brave two year attempt on the part of some doctors to persevere without legislative support, the Regents officially closed the school in May 1887.43

Sources mention one other serious attempt at medical education in the state prior to the founding of the Creighton College of Medicine. The Cotner University Medical College was established by the eclectic medical sect in 1890 as a medical department of Cotner University, located in a suburb of Lincoln. Little is known of this school, save that it graduated more than 275 persons before ceasing to exist in 1918.44

These were the general conditions and the local conditions of medicine circa 1892. When John Creighton decided to fund the establishment of a medical college bearing his name, medicine and medical education were in a state of flux. As we have already seen, a great deal of chaos, disorganization, indecision and in-fighting existed, but the times were ripe for change.

Dr. Kenneth Ludmerer, a historian of medical education, points out that licensing laws were beginning to be reenacted in the U. S. on a widespread basis by the 1890's, and the "educational ladder" of the U. S. public school system was in place. That is, there was a logical educational sequence—the grade school leading to the high school, leading to college and then on to medical school, with courses now building on one another, and one level of education sequentially preparing the student for the next. Thus the caliber of medical aspirants was reaching a level far higher than in previous years.

Ludmerer further points out that although the Flexner Report of 1910 is usually given credit for causing massive reform efforts within medical education, in reality these reform efforts reached a high level on their own by the 1890's. By then, it was recognized that to be a viable component in the medical education field, a medical college must have laboratory instruction and facilities as well as strictly didactic methods, and hospital facilities must be available for use as a hands on teaching tool. Moreover, affiliation with a university was becoming more than merely desirable, but rather a near economic necessity, guaranteeing continued financial existence, prestige and legitimization. Furthermore, the late 1800's were a time when extending medical education to a length of 3 years was a hot issue, with the better schools opting for the longer course.

Founded within this social, professional and educational milieu, the Creighton College of Medicine was able to incorporate the new reform ideals into its early structure and gain a head start at quality medical education. As will be seen, at its inception John Creighton's medical college had labs and laboratory courses. It had a guaranteed teaching hospital affiliation—St. Joseph's, and a natural affiliation with a major university, Creighton. It began operation as a medical school with a 3 year curriculum at the very onset. Thus, although problems remained, the Creighton College of Medicine from the very start exhibited an impetus toward top quality medical education, incorporating a desire to succeed with a willingness to accept fresh new thought.
References

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12. Pickard and Buley, p. 73.
14. Pickard and Buley, p. 112.
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