The Thomsonian Movement and the Structures of American Health Law

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Abstract and Contextual Introduction

This work is a finite part of a larger project on the construction and evolution of American health law over the past 250 years. It is commonplace, during episodes of national health reform debate like the current one, to speak of the need to take account of entrenched legal structures, political interests, and normative values in framing reform efforts. Health law has developed incrementally and accidentally over time, but various attributes of the multimodal health law regime in the United States remain deeply entrenched against political change, such that reformers seeking success bear additional persuasive and political burdens in departing from such longstanding practices.

In other work I have attempted to assess in broad strokes the development and persistence of such structural features of the American health law system, such as the continuing placement of primary regulatory authority in the states well beyond any requirement of constitutional doctrine, and the longstanding devolution of authority to the medical profession, raising the question of whether, in their durability and foundational allocation of authority, such structures might be regarded as “constitutional” in an capacious sense of that term. However we label these entrenched structures, it is clear that to identify their development requires a longitudinal study of American legal and medical history. Unlike canonical constitutional law, health law possesses neither a set of framing moments, nor a small handful of landmark cases, nor a single predominant interpretive institution. If there is a health law constitution to be found, it is in the incremental and temporally disparate operation of various state legislatures, courts, and Congress.

As part of this longitudinal historical inquiry, this paper examines one historical period of great ferment and contestation over the shape of health law and regulation. In the early nineteenth century, established or “regular” medicine came under sustained assault from a number of alternative, or “irregular” medical movements. The most prominent of these was the one founded and propagated by Samuel Thomson, a “botanical” doctor whose treatment method relied on a small handful of compounded herbal remedies. More important than his medical theory, however, were Thomson’s organizational and promotional abilities, and his savvy strategic interactions with the legal infrastructure of the early
United States. Thomson well understood the fragmented nature, and inherent fragility, of the legal forms and institutions that sought to regulate medical practices in his day, and he leveraged disparate attributes of the health law regime to his advantage in clearing regulatory space to promote his medical system. The story of his movement’s struggles with early American health law regime, and of the movement’s role in dismantling and reshaping aspects of that legal regime, yields lessons about health law’s inherent fractures that remain relevant today.

I envision that this paper on Thomson’s movement and its interactions with the early American legal system will be a chapter in a longer work on the longitudinal development of health law in the United States. The workshop draft before you is the product of long research but relatively hasty drafting, and I appreciate your comments and suggestions for future drafts going forward. In particular I am aiming to strike a balance in tone between descriptive history and conceptual analysis, and have truncated some aspects of the Thomsonian movement history itself. I am interested in your thoughts on whether more (or less) detail would be worthwhile.

I. INTRODUCTION

“Murder! The crafty doctor cry’d,
Manslaughter cried the Priest;
The lawyer published wide the news;
To hide the truth at least.”

In the cold Massachusetts winter of 1809, Samuel Thomson lost a patient. He had treated a young Beverly man named Ezra Lovett, who died after a week of Thomson’s intensive therapy. This outcome in itself did nothing to distinguish Thomson – a “botanic” or “irregular” physician of rising regional acclaim – from the mass of more orthodox “regular” physicians in the Boston medical establishment. Medical treatment in the early decades of the nineteenth century was notoriously ineffective, in many cases doing more harm than good. Nor was the extreme purgative nature of Thomson’s herbal therapy meaningfully different from the orthodox methods of treating disease. Without question, his methods appear severe to the modern observer. According to the Massachusetts high court which heard his case the next year, Thomson “gave the patient a powder in water, which immediately puked him.” In the following week Thomson again and again “puked” the patient, who “lay in a profuse sweat all night” and eventually expired after more than a week of this severe

1 Samuel Thomson, Learned Quackery Exposed, or Theory According to Art 16 (1836).
therapy. But Thomson’s zeal in purging Lovett differed little from the prevailing methods of the “regular,” or allopathic, physicians, who resorted to even more “heroic” methods such as copious bloodletting and purging not with herbal remedies but with toxic mineral compounds like mercury and calomel.3

More notable than these medical details was the response of the Massachusetts legal and medical establishment to Thomson’s rising prominence and his role in Lovett’s death. In 1809 Thomson’s botanical mode of practice was rapidly gaining popularity across the Boston suburbs; within a few decades it would spread throughout the United States and into Canada, attracting as many as a million adherents.4 The regular physicians north of Boston regarded Thomson as a distinct commercial and conceptual threat to their manner of practice and traditional stature. And so, together with the state’s legal elite, they swore out an indictment for murder, and had him arrested and thrown in jail. As Thomson would later describe it, “I was bound with irons, and carried in [the sheriff’s] chaise, about 25 miles . . . the weather being so cold, and the irons so tight, that it caused my blood to settle under my nails.”5 The regional district court in Salem did not meet for almost a year, and bail was unavailable on a charge of murder, meaning that Thomson might well sit in jail for many months. At best Thomson faced incarceration for a year, with his burgeoning popularity stunted; at worst he would have died in jail, as Thomson thought his accusers intended.6

However, in a response that was to characterize his interactions with the law and legal institutions in the decades ahead, Thomson was anything but a passive subject in the face of this assault from the bastions of legal and medical orthodoxy. Instead of accepting his fate and awaiting the trial several months hence, he sought to actively shape and contest the legal framework that was asserted to prohibit or punish his alternative medical system. Thomson chose his attorneys shrewdly, hiring among them a former state legislator by the name of Joseph Story.7 The attorneys successfully transferred his case directly to a special session of the Massachusetts Supreme Judicial Court, which held a trial and

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5 Samuel Thomson, Narrative of the Life of the Author 124 (1836).
6 See id. at ___.
7 See John S. Haller, The People’s Doctors: Samuel Thomson and the American Botanical Movement 127-29 (2000) (describing that Story’s fee was paid in part by a Baptist congregation whose minister Thomson had cured). Story would become a justice on the U.S. Supreme Court and a major figure in nineteenth-century legal thought.
eventually made appellate rulings of law, both of which vindicated Thomson. The trial proceedings were portrayed in the press like a modern Hollywood thriller. At one point the state prosecutor produced a sample of Thomson’s favorite herbal remedy, *lobelia inflata* (or “Indian tobacco”), and pronounced that this was the “poison” that had killed Ezra Lovett. One of Thomson’s lawyers, Alexander Rice, then reportedly stunned the courtroom by getting hold of the state’s evidence and “immediately swallow[ing] it in presence of the court and spectators,” all while remaining in good health and offering to consume “thrice the amount.”

At the close of the prosecution’s case the court directed verdict in Thomson’s favor on legal grounds, holding that there was “no adequate remedy” under the common law forms of murder and manslaughter to criminalize even “ignorant” practice of medicine that caused harm.

This was among the first recorded instances of legal controversy provoked by Thomson and his followers, who would quickly grow in succeeding decades to number hundreds of thousands across the United States and Canada. Many of the themes raised by the 1810 trial and ruling were to recur in subsequent decades. The rise of Thomsonian medicine and other irregular schools posed a distinct challenge to the legal and medical institutions of the early nineteenth century, and existing legal forms proved incapable of resolving the questions of medical legitimacy and authority that the movement provoked. Just as common law forms were inadequate to police the boundaries of medical legitimacy, so too were efforts to strengthen state medical licensure laws ultimately incapable of stemming the populist movement aligned with Thomson and his adherents. Thomson’s long career, and the longer one of the movement he created, illuminate the disjointed, incomplete and inconsistent nature of the legal regime governing health law in nineteenth-century America.

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I will return to the nineteenth century shortly, after posing an explicitly presentist question for the purposes of this workshop draft: What, if anything, might the legal and regulatory battles of Thomson’s era have to do with contemporary health law and policy? To a certain extent the actual medicine that both he and the “regular” physicians of the time practiced was unrecognizable to the modern therapeutic eye. So too was the world of health finance – this was generally a world without third-party payors or other insurance forms, and so many structural elements currently on the table in the national health reform debate were absent from the legal and political struggles of Thomson’s day.

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8 *See* Raleigh Register, April 10, 1829 (quoting earlier story from *Albany Argus*).
However, given how much things have changed in the realms of treatment and health finance, is striking how similar many core features of the health law landscape of Thomson’s era are to our own. This was a regime thick with health law in all its dysfunctional fragmentation. The fragmented legal landscape, with multiple legal forms and multiple legal institutions in uneasy coexistence, looks quite a bit like the one that remains extant today.

Many of the nation’s leading health law scholars are in agreement about the eclecticism and fragmentation of the current health law system. Clark Havinghurst explains that health law rules “emanate from such diverse sources, and are so uncoordinated, inconsistent and incomplete that they fail to constitute a coherent legal regime that can be studied as an integrated whole.”10 Likewise, Gregg Bloche has described the field as “a jumble of statues and common-law doctrines” that in the main constitutes “a chaotic, dysfunctional patchwork.”11 According to Einer Elhauge, health law suffers from “an identifiable pathology” due to its haphazard borrowing from other fields, resulting in an “incoherent legal framework.”12 Carl Schneider and Mark Hall contend that health law has “no grand organizing principle” because it “borrow[s] from too many areas of law.”13

Thomson’s remarkable popularity in the several decades following 1820 placed stress on the existing legal institutions of his time, and exposed fault lines and dysfunction in the health law regime of that era that align with these modern critiques of health law. Every one of the forgoing scholarly statements about modern health law also aptly describes the legal world that confronted Samuel Thomson – a patchwork of incomplete common law rules and statutory forms, administered in uncoordinated and inconsistent fashion by multiple sovereignties and institutions at the federal and state level. Thomson and his advisors appear to have recognized this fragmentation, and leveraged it to good effect both to avoid the strictures of prosecution and licensure, and also to take affirmative advantage of other legal forms like patent law and contract law.

In a short concluding section, I return to some of these connections between Thomson’s era and the current health law regime. Beyond this general feature of fragmentation, several other conceptual features appear

in the early nineteenth-century and persist today. Thomson’s story reveals many of these fractures, which include, for instance:

- the inability, or unwillingness, of traditional legal institutions to meaningfully resolve debates over medical quality;
- the ambiguity in disparate regulatory frameworks between whether “medicine” is primarily a service or primarily a good or commodity; and
- the thick connections between debates over optimal health policy and deeper contemporaneous political structures and divisions.

I will briefly return to discussion of these structural features of the health law regime in the United States after describing and assessing the Thomsonian movement and its interactions with American law in the early nineteenth century, and hope to discuss these issues with you in next Monday’s workshop.

The remainder this essay is framed as follows. Part II below gives an overview history of Samuel Thomson’s career and the therapeutic movement he founded and largely controlled. Part III explores various ways in which Thomson and his allies challenged and exploited features of the early American health law landscape. Part IV takes up many of the above conceptual themes, to assess whether, and how, various structures in American health law from Thomson’s era persist in the modern regime of health law and regulation.

II. THE RISE AND FALL OF SAMUEL THOMSON’S MEDICAL MOVEMENT

In 1841, near the end of Thomson’s life, his son John would describe him as an “illiterate New Hampshire farmer” who “in less than fifty years” had devised a system of medical practice that “spread . . . from Mexico to Canada, and from the sea shore back to the Pacific, also in Europe and South America.”14 This claim exaggerates in two respects. Certainly the geographic coverage of Thomsonian practice by the 1830s

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14 Samuel Thompson, “General Introduction,” The Thomsonian Materia Medica or Botanic Family Physician (1841); see also Alex Berman, The Thomsonian Movement and its Relation to American Pharmacy and Medicine, 25 Bull. Hist. Med. 405, 406 (1951)
was impressive, but although nationwide and probably international,\textsuperscript{15} was not as vast as John Thomson claimed. More substantively, although he was unschooled in any formal sense, to label Thomson “illiterate” is profoundly misleading in the context of his overall movement, obscuring the crucial role that his and others’ writings played in promulgating and protecting the medical system that bore his name. As described below, this was a medical revolution spread in significant part by the written word.

Still, his son’s general description is otherwise accurate. Thomson’s upbringing on a backwoods New Hampshire farm was arduous even by late eighteenth century standards. Born in Alstead, New Hampshire, in 1769, Thomson worked full-time in the fields by age five, and recalled a stern and punitive father and a general dislike for farming. Despite this aversion to farm work, Thomson made use of his agrarian background both in the discovery and development of his particular herbal cures and methods, and also in the political and legal rhetoric he would later use to defend them against orthodox attack. His personal history as a self-made and self-taught practitioner fit the ethos of his era, and he rarely tired of reminding potential converts and customers of his story.\textsuperscript{16}

Thomson claims to have discovered the main elements of his botanical formulary through personal experience during his years as a young farmhand, a font of experiential knowledge that he would later in life strategically contrast with, and rhetorically deploy against, the formal training of the “regular” physicians. He wrote that while a boy in the fields, his “mind was bent on learning the medical properties of such vegetables I met with, and was constantly in the habit of tasting everything I saw.”\textsuperscript{17} In an autobiography he describes the first encounter with the herb that was to become his staple medicine, \textit{lobelia inflata}, or “Indian tobacco”:

“Sometime in the summer, after I was four years old, being out in the fields in search of the cows, I discovered a plant which had a singular branch and pods, that I had never before seen, and I had the curiosity to pick some of the pods and chew them; the taste and operation produced was so remarkable, that I never forgot it.”\textsuperscript{18}

The herb’s purgative properties that Thomson would later exploit for therapeutic purposes were a source of amusement to him as a child, when

\textsuperscript{15} See Connolly & Connolly, Thomsonian Medical Literature and Reformist Discourse in Upper Canada, \textit{supra} note __, at 140.

\textsuperscript{16} See Samuel Thomson, \textit{Narrative of the Life of Samuel Thomson} (1825) (pinpoint page number); see also Berman, Haller.

\textsuperscript{17} See Berman, “Thomsonian Movement,” \textit{supra} note __, at 412.

\textsuperscript{18} Samuel Thomson, \textit{Narrative of the Life of Samuel Thomson} (1825) (add page number).
he “used to induce other boys to chew it, merely by way of sport, to see them vomit.”\textsuperscript{19}

Thomson later claimed that as he grew to adulthood his existing affinity for herbal remedies was strengthened by episodes of family illness which involved unsatisfying interactions with “regular” physicians, and one memorable episode in which a severe gash in his own ankle was successfully treated by a New Hampshire herbalist named Dr. Kittredge. Thomson described his distinct preference for the latter’s medical philosophy, writing that Kittredge “was governed in his practice by that great plan which is dictated by nature; and the uncommon success he met with is evidence enough to satisfy any reasonable mind, of the superiority of it over what is the practice of those who became doctors by reading only, with their poisons and their instruments of torture.”\textsuperscript{20}

Important for Thomson’s later commercial success was the fact that he reduced the broad panoply of herbal remedies to a very small handful of universal cures. His wonder drug – and the one that produced the most accusatory backlash in manslaughter cases brought by regular physicians – was the herb \textit{lobelia inflata}, also known as Indian tobacco. Thomson later came up with various other herbal compounds – such as cayenne pepper and marsh rosemary—which for marketing and dissemination’s sake he grouped into six items. In addition to these herbal products themselves, the Thomsonian method entailed a regimen of vigorous purging and repeated hot steam baths, devised in order to return the body’s constitution to its proper state. This was hardly a gentle therapy. Letters from one patient treated by the method report alternating “powerful vomitives” with hot steam baths, followed by laying with hot bricks, and then another round of “extraordinary vomiting.” This patient ultimately recovered, though he wryly observed that he did “not believe the treatment [was] the cure.”\textsuperscript{21}

Despite such therapeutic severity, several attributes of Thomson’s medical theory and practice were crucial to its rapid rise to nationwide prominence after 1810. First was its universality – Thomson professed that his methods could treat virtually any disease with very little variation. This universality meant that Thomson’s method could be practiced by anyone with a rudimentary instruction in its method – advanced and nuanced training was not required. Thomson extolled the universality of his cures in two stanzas of a poem entitled “Seamen’s Directions” and designed for easy memorization by illiterate sailors:

\begin{quote}
\textit{Id.}
\end{quote}

\begin{quote}
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\begin{quote}
\textit{Frank G. Halstead, A First-Hand Account of a Treatment by Thomsonian Medicine in the 1830s, XX Bull Med. 680 (date)}
\end{quote}
“Th’ Emetic number one’s\textsuperscript{22} designed
A general medicine for mankind,
Of every country, clime and place,
Wide as the circle of our race.

In what cases is it to be used?

In ev’ry case, and state, and stage,
Whatever malady may rage;
For male or female, young, or old,
Nor can its value half be told.”\textsuperscript{23}

Coupled with his patented medicine and his copyrighted medical
texts, this theory of illness made Thomson’s products and methods ideal
for mass distribution. The Thomsonian refrain of “every man his own
doctor” was made possible in large part by his repudiation of therapeutic
variation, which would have called for greater nuance and training in
diagnosis and treatment and which, unsurprisingly, was central to the
treatment philosophy of the regular physicians of the era.

The spread of Thomsonian medicine after 1810 was also fueled by
public dissatisfaction with traditional “regular” physicians. As severe as
his treatment protocol was, it was consciously framed as a kindler, gentler
version of the “heroic” purgative techniques employed by many regulars.
One standard therapy for multiple maladies was copious bloodletting by
opening a vein with a lancet or suctioning blood from scarified skin.\textsuperscript{24} This
had been popular in England in a prior century,\textsuperscript{25} and prominent
American physicians like Benjamin Rush continued to defend the benefits
of this practice well into the nineteenth century. Orthodox physicians also
employed violent purgative remedies as often as Thomson, but used

\textsuperscript{22} “Number One” was the lobelia powder.
\textsuperscript{23} Samuel Thomson, Seamen’s Directions, reprinted in Learned Quackery Exposed
(1836).
\textsuperscript{24} John Harley Warner, “Power, Conflict, and Identity in Mid-Nineteenth Century
Medicine: Therapeutic Change at the Commercial Hospital in Cincinnati,” 73 J. Amer.
\textsuperscript{25} An English medical record reprinted by historian Joseph Kett illustrates in stark
terms the dangers, and therapeutic simplicity, of treatment by bleeding:

“April 1, 1729: Order’d William Allen of Brigend blooded for the Pleurisie.
April 2: Ordered him blooded again.
April 3: He was blooded again, 10 ounces being taken away as before.
April 4: He dyed.”

See Diary of Benjamin Rogers, Rector of Carlton, England (reprinted in Joseph F. Kett,
The Formation of the American Medical Profession: The Role of Institutions 97(1968)).
potentially toxic mineral compounds containing mercury (calomel) and antimony (tartar emetic).

The poor outcomes from, and rampant public dissatisfaction with, such therapies made them attractive targets for Thomson’s promotional literature. In a representative pamphlet periodical he decried the regulars’ practices of “tak[ing] man’s blood” and argued that orthodox physicians knew nothing about healing except “how much poison [could] be given without causing death.” Mineral drugs like calomel received particular scorn in the Thomsonian publicity materials, and Thomson repeatedly extolled the relative virtues of his herbal therapies. In a didactic poem called “Calomel,” he mocked the orthodox physicians’ drug of choice:

“The learned quacks of highest rank,
(To pay their fees we need a bank)
Combine all wisdom, art and skill,
Science and sense, in Calomel.”

In contrast to these learned “mineral doctors,” Thomson touted his own naturalistic medicine as fitting better with public attitudes and providential design, claiming that “[t]he God of nature has our wants supplied,” This added a nativist component to his medicine’s growing popular appeal, particularly given the era’s concerns about dangerous patent medicines from abroad; these were American herbs he was selling. Efficacy issues aside, it is clear that Thomson’s depiction of his botanical therapies was well received by the public, particularly when set against the severity of the regulars’ regime. As one historian has noted, “[t]his was medicine’s ‘heroic age’. Not every sick man felt like being a hero, and irregular practitioners appealed to the cowards with promises of mild medication.”

By the time he was acquitted in the 1810 Massachusetts murder trial, Thomson had these basic elements of his medical treatment regime in place. What made him a national figure thereafter were his diligence and innovation in patenting, marketing, and commercially distributing his methods throughout the states. Thomson was exceptionally energetic and generally successful in all of these efforts – his skills as a businessman and legal entrepreneur exceeded his medical innovations, and bear greater connection to his success relative to the mass of other irregular and

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26 Thomson, “Modern Practice,” in Learned Quackery Exposed (1836).
27 Young, “Medical Quackery,” supra note ___ at 581 (citing Thomson).
28 Samuel Thomson, “Calomel,” in Learned Quackery Exposed (1836).
29 Thomson, Learned Quackery Exposed, supra note __, at 28.
eclectic physicians who populated early American life. A later section will assess Thomson’s skillful use of early American patent law and related legal forms in service of his product promotion efforts; here I will summarize his successful business model that spread his treatment widely through the United States.

Thomson’s great success was not in the practice of medicine but in his innovative and structured dissemination of medical products and methods. His first move after the trial was to patent his medicines (lobelia and a few other herbal remedies). Thomson maintained that “every man can be his own doctor” with the use of his medicines and some rudimentary course of training from Thomson or an agent. In the early decades in Massachusetts Thomson traveled to the towns around Boston himself, selling “family rights” to use the system for twenty dollars each, and setting up a distribution network for the medicines which compounded and later would patent.

Thomson’s organizational decision to distribute his medicines, and his medical techniques, by the sale of “family rights” was instrumental in his rapid rise to prominence. By 1839 Thomson claimed to have sold about 100,000 such family rights nationwide, typically for a fixed fee of twenty dollars. Upon payment in full, the typical rights holder received, in writing, “the right of preparing and using, for himself and his family, the medicine and System of Practice secured to Samuel Thomson by Letters Patent from the President of the United States.” As his acclaim grew beyond Massachusetts and the areas he could visit personally, he retained and organized a large network of agents to sell the family rights, medicines, and associated guidance literature. In 1833 he had over 160 authorized agents working in twenty-two states.

The prepayment structure of the family rights model was attractive in multiple ways to Thomson. Most importantly, it consummated the transaction, and provided payment, on an *ex ante* basis, thus enabling Thomson to avoid the barriers to fee collection that plagued treating physicians – both regular and irregular – in that era. In states that had not yet repealed licensure laws in the 1820s and 1830s, Thomsonians would have faced additional barriers to *ex post* fee collection – they were specifically estopped in some states from resorting to the courts to collect debts.

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31 See Berman, Thomsonian Movement, *supra* note __, at 416.
32 Family Right of Joseph Chapman of Alton, Illinois, April 19, 1839 (reprinted in Lucius Zeuch, *1 History of Medical Practice in Illinois* 326 (1927)).
33 2 Thomsonian Recorder no. 6 (1833) (cited in Berman, “Thomsonian Movement”, *supra* note __, at 417).
Ironically, it was the printed word that converted this “illiterate New Hampshire farmer” from a regional curiosity in the Boston area into a major national figure. Thomson realized that he could expand his reach if he sold his medicines and family rights alongside a primer on methods for use by lay purchasers. Accordingly, in 1822 he published two lengthy works, the *New Guide to Health* and the *Narrative of the Life of the Author*. These works were distributed widely for many years – records show fourteen different publishers produced at least twenty-one different editions in the three decades following their inception.34 In addition to these durable works, Thomson and his supporters produced and circulated huge numbers of journals. Historian Joseph Haller has located eighty-six Thomsonian journals published between the years 1822 and 1860, most circulated monthly or semimonthly.35 The most important of these was the *Thomsonian Recorder*, a weekly which gained a circulation in 1832 of at least 2,000 copies sent to “the disciples of Dr. Samuel Thomson scattered throughout every State and almost every Territory of this Republic.”36

A final component of this structure served both commercial and political ends, particularly in the licensure battles described in the following section. Thomson required purchasers of family rights to join a local “Friendly Botanic Society” or similarly designated organization. These groups had their own constitutions, received a share of the profits from the regional sale of family rights, and held meetings and published local journals. More importantly for the shape of law and politics in the states where Thomsonian practice was most popular, the societies formed a preexisting network of political and legal activists already committed to Thomson’s cause, and ready and willing to challenge licensure laws and other burdens imposed by established medicine and law. They formed a key part of the mobilization that occurring in response to the regular physicians’ efforts to implement more stringent licensure laws.

All of this reflects a shrewd organizational vision that, to the modern eye, far surpasses the actual therapeutic merit of Thomson’s medicine itself. Such institutional savvy also sharply differentiated Thomson from the mass of itinerant medicine sellers who worked in the early nineteenth century. If Thomson was a “quack”, as his allopathic opponents repeatedly charged, he was an extraordinarily well-organized one, and one backed by a loyal and structured network of agents and rights holders. This network spread Thomsonian medicine broadly and rapidly. By 1835 the Governor of Mississippi estimated that half of the state’s citizens employed Thomsonian medical practices; the regular

36 Flannery, The Early Botanical Medical Movement, *supra*, at __.
physicians of Ohio estimated that one-third of that state’s residents followed Thomson’s methods.\textsuperscript{37} Thomson himself claimed three million adherents in 1839, and although that figure is probably overstated, one historian places the figure at close to one million (this in a nation of approximately 15 million).\textsuperscript{38}

Whatever the precise zenith in popularity for Thomson’s medicine, it did not last long after his death in 1843. This was due in large part to the disintegration and decentralization of his administrative and marketing apparatus – his network of agents and rights-holders was essentially a grand sole proprietorship, with no clear single successor. Instead a number of would-be disciples achieved regional prominence but never unified the movement nationally. A major source of discord were debates about whether Thomsonians ought to appropriate the trappings of more established regulars, and found Thomsonian medical schools, hospitals, and medical societies (Thomson himself vigorously opposed such suggestions in the last years of his life).

More fundamentally, Thomsonian practice was undone by new developments in both regular and irregular medical practice. On the one hand, regular physicians made dramatic improvements both in their treatment efficacy and their professional and political organization after midcentury. The American Medical Association was founded in 1847, in no small part in response to the challenges posed by Thomson and other irregulars. Thereafter allopathic physicians became more organized and assertive in political contests.\textsuperscript{39} They also became dramatically more sophisticated medically – the era of bleeding and purging was over. And for those patients who still balked at the surgical and pharmaceutical rigor (or high cost) of regular medicine and sought a cheaper, gentler alternative, the second half of the nineteenth century saw the rise of homeopathy, a school which outpaced Thomsonianism in both therapeutic nuance and superficial scientific and intellectual rigor. If the Thomsonians achieved fleeting prominence by dismantling the fragile medical-legal structures of the early nineteenth century, the homeopaths secured a longer span of influence by gaining a limited place within the reconstructed medical establishment of the late 1880s and beyond.

As the twentieth century began, a fit epitaph for Thomson’s movement appeared in the \textit{New York Times}:

\textit{Does anybody ever hear nowadays of the Thomsonian doctor and his patented practice? He was to be found in the rural towns of }

\textsuperscript{37} See Berman, The Thomsonian Movement, supra note __, at 407.
\textsuperscript{38} See Haller, The People’s Doctor, supra note __, at .
New England and the Middle States half a century ago and had many enthusiastic disciples and adherents . . . I wonder if there are any of the Thomsonian kind now left, or if, in a rural community, such a system still survives. So far as I can find out, it would seem as if the system has faded away with only a shadow of its history left.  

III. THE THOMSONIAN CHALLENGE TO EARLY AMERICAN HEALTH LAW

The rise and fall of Thomsonian practice took place in a world of medicine that is hardly recognizable today, with regular physicians profligately bleeding and purging patients with predictably poor outcomes. Samuel Thomson’s challenge to such orthodoxy, however, was often contested within a legal framework that looks much more similar to the modern eye. If the medical world of 1820 is one we have lost, the legal structures of that time remain substantially in place, and the characteristic features of health law then and now bear more than a superficial resemblance.

This section assesses several points of intersection or collision between the Thomsonian movement and the legal institutions of the early nineteenth century United States. It is divided into three sections. The first one, “Law’s Limitation” describes the efforts of the medical and legal establishment to restrain the Thomsonian challenge through existing doctrines of criminal law and tort. This was ultimately a failed effort – judges repeatedly declined to modify baseline common law doctrines to proscribe or regulate the conduct of Thomson and other irregular physicians, sometimes with explicit disclaimers of institutional power or responsibility.

A second section, entitled “Law’s Contestation,” explores another, more democratic, venue where the legitimacy of the Thomsonian and other irregular practitioners was debated in the early nineteenth century. As Thomsonian practice spread widely in the 1820s, established physicians in many states sought to enact new licensure laws or strengthen existing ones in order to prohibit irregular practice. Although enacted temporarily in some states, these new laws generated deep popular debate and ultimately popular rejection, often spurred by political

40 Joel Benton, “A Dead Medical System,” New York Times, Sep. 22, 1901. Though Thomson’s movement is no more, one “shadow of its history” that remains is the ready availability of his standard herbal medicines – lobelia, marsh rosemary, and cayenne – on various supplement and herbal websites. See, e.g., http://www.getnutri.com/product6832/lobelia-herb.html (offering lobelia tablets for sale as a “mild expectorant” with the warning (ironic, given Thomson’s methods) that the pills “may cause nausea or vomiting.”) (visited September 26, 2009).
rhetoric generated by the Thomsonians and their allies. By 1845 the licensure laws had been routed – in almost every state such laws were repealed or rendered unenforceable. Accompanying such repeal efforts was a rich public rhetoric grounded in Jacksonian antimonopoly political theory and various claims of constitutional right to use, and to practice, the medicine of one’s choosing.

Finally, in a section called “Law’s Allure,” the paper explores Thomson’s active embrace of various legal forms and institutions, such as federal patent law, to promote his methods and products. Thomson differs from other irregulars of his era in his strategic interest in using law to achieve his marketplace ends. He recognized and capitalized on the divided sovereignty of health law in his era, pursuing federal patent rights which he hoped would “put [him] above the laws of any state” at the same time his practice was besieged by state criminal law and licensure efforts engineered by the regulars.

A. Law’s Limitation

“It is to be exceedingly lamented, that people are so easily persuaded to put confidence in these itinerant quacks, and to trust their lives to strangers without knowledge or experience. If this astonishing infatuation should continue, and men are found to yield to the impudent pretensions of ignorant empiricism, there seems no adequate remedy by a criminal prosecution.”

The rise of the Thomsonians and other irregulars provoked a medical quality crisis in early America. Established physicians sought to prohibit, punish, or make less lucrative the practices of Thomson and similar botanical doctors. Though clearly motivated in part by competitive pressures and professional self-interest, medical writings of the day do evince a genuine concern among the “regulars” about patient safety in light of the unorthodox treatment methods of the Thomsonians, whom they called “steamers” or “pukers” or “sweating doctors.” One prong of established medicine’s response was the enactment and enforcement of more stringent licensure laws; this is discussed in the subsection below. The first response, though, reflects the scavenging, or borrowing, dynamic that persists in health law’s more recent development. Faced with a new challenge to medical orthodoxy, the regulars sought to adapt existing common law forms to criminalize, or make civilly liable, the practice of irregular healing.

The 1809 murder case again Thomson himself provides the earliest example of this effort directed at practitioners of alternative medicine. The complaint against Thomson was sworn out by a Dr. French, a prominent regular physician in the north Boston suburbs (Thomson’s prime territory in those years) and a vocal critic of Thomson’s methods. The effort to criminalize Thomson’s practice was supported by the Boston legal establishment as well; the state’s solicitor general brought the case forward in the Supreme Judicial Court. The solicitor general argued that the death of Ezra Lovett was only the latest in a line of Thomson patient deaths, claiming that he “had administered like medicines with those given to the deceased, to several of his patients, who had died under his hands.”

Thomson’s attorneys Joseph Story and Alexander Rice appear to have defended the murder charge on both factual and legal grounds. They retained one of the nation’s leading botanists, Dr. Manasseh Cutler, who testified that Thomson’s primary herbal drug, lobelia inflata, was one that he himself had ingested in the course of experimentation. Cutler also listed some potential medical uses for the herbal compound. Thomson also testified in his own defense about various successful treatments, and claimed this was the first of his patients to die. If the justices, however, were persuaded by this defense testimony on the causal issues of death, their opinion didn’t show it. The court said that it “did not seem to admit of any reasonable doubt” that “the deceased had lost his life by the unskillful treatment of the prisoner.” Later the court stated its view that Thomson’s “ignorance” in medical matters was “very apparent.”

What saved Thomson from the law here was the law itself – namely the stringent intent requirement in the common law of crimes that prevailed in the early nineteenth century. For him to be convicted of murder, the state would have had to prove that he acted with “malice, either express or implied.” There was no express malice in this case, and the judges rejected the state’s claim that Thomson treated Lovett with implied malice, finding instead that he had a good faith intention to cure the patient. For similar reasons the court declined the government’s argument that “rash” and “grossly ignorant” behavior by Thomson was enough to support a charge of manslaughter. The Massachusetts court concluded with an express disclaimer of institutional competency, stating

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44 Id. at 138.
45 Id. at 138.
46 See id.
that criminal law offered “no adequate remedy” to the problem of irregular medical practice, and suggesting that legislation might be the answer.47

This dynamic of doctrinal mismatch arose in other jurisdictions, where Thomsonians were criminally prosecuted for murder or manslaughter based on failed treatments, but acquitted due to substantial intent requirement which were often supported in part by the Thomson court’s reasoning in the 1810 opinion. That case became an important precedent in Massachusetts and other jurisdictions through the late nineteenth century, probably eclipsing in longevity Thomson’s medical legacy by a few decades. In various cases that received significant media coverage, Thomsonian defendants were acquitted by juries.48 In other rare instances where convictions resulted and were appealed, state appellate courts through the end of the nineteenth century generally followed the rule of Commonwealth v. Thomson and vacated the convictions.49 Finally, in one highly publicized and hotly contested New York trial, the jury did convict but only for fourth-degree manslaughter with a recommendation for mercy in sentencing; the Thomsonian physician-defendant received only a trivial fine.50

These cases illustrate the manner in which nineteenth century criminal law forms were incapable of addressing the medical quality questions raised by the diversity of irregular practice flourished in Thomson’s day. The stringent intent requirements of criminal doctrine combined with the institutional reluctance of judges to modify the law to imprison Thomsonian healers, produced an unsatisfying result for regular physicians. One response was to seek legislative change, another was to attempt to hold Thomsonians civilly liable in malpractice for poor results.51 In another failed criminal case against an irregular practitioner later in the century, the Iowa Supreme Court made just such a suggestion, maintaining that “[t]he interests of society will be subserved by holding a physician civilly liable in damages for the consequences of his ignorance, without imposing upon him criminal liabilities when he acts with good motives and honest intentions.”52

47 See id.
49 See, e.g., Rice v. State, 8 Mo. 561 (1844) (adopting rule of Commonwealth v. Thomson to overturn jury’s manslaughter verdict against Thomsonian practitioner whose patient had died in childbirth).
50 See Haller, The People’s Doctors, supra note __, at 129-31.
51 As historian Kenneth DeVille reports, malpractice had become a viable and more frequent cause of action by the middle decades of the nineteenth century. See generally DeVille, Medical Malpractice in Nineteenth Century America, supra note __, at 25-64 (describing a “deluge” of malpractice suits in the decades following 1835).
52 State v. Schulz, 55 Ia. 628 (1881).
However, due to doctrinal structures that still persist today, nineteenth-century malpractice law was no better equipped to deal with the medical quality concerns raised by irregular practice than was the criminal law. Then, as now, malpractice cases turned on proof of an applicable customary standard of care. And courts were unwilling or unable to resolve medical quality disputes by ruling that some schools of thought were beyond the bounds of that doctrinal safe harbor for customary treatment.\footnote{See DeVille, supra note __, at 51.} Allegations of poor care by Thomsonian practitioners were to be assessed according to the testimony of Thomsonian expert witnesses and Thomsonian standards of practice. An 1862 Maine supreme court case made this doctrinal point starkly.\footnote{Patten v Wiggin, 51 Me. 594 (1862). See also Spead v. Tomlinson (N.H. 1878).} After outlining the basic point that malpractice liability resulted from failure to use “ordinary knowledge, skill, and care” the court explained that:

“If there are distinct and differing schools of practice, such as Allopathic or Old School, Homœopathic, Thompsonian, Hydropathic, or Water Cure, and a physician of one of those schools is called in, his treatment is to be tested by the general doctrines of his school, and not by those of other schools.”

Moreover, said the court,

“in cases where authorities differ, or ‘doctors disagree,’ the competent physician is only bound to exercise his best judgment in determining which course is, on the whole, best.”\footnote{Patten, 51 Me. at __.}

The Maine supreme court’s doctrine of ardent judicial neutrality between competing medical schools of thought was typical in the nineteenth century cases.\footnote{See Bowman; see also Stephens v. Bowe, 34 S.C.L. 80 (SC App. 1848) (neutrally describing medical disagreement between Thomsonian witnesses and regular physicians as “a diversity of opinion among the learned doctors who were examined at trial,” and refusing to give greater weight to either school).} Malpractice doctrine might offer a remedy against particularly incompetent Thomsonian doctors, but was as framed by the Patten court this civil form of action was useless in policing the overall boundaries of legitimacy and quality in medicine. In sum, neither criminal law nor civil law forms administered by state courts provided any meaningful mechanism for resolving questions of medical quality and medical legitimacy in nineteenth century America. These legal doctrines failed the regular physicians who sought to employ them against the Thomsonian threat.
The limits of nineteenth-century health law in these areas can be attributed to the shape of formal doctrine—for instance the stringent intent requirements in criminal law, and the broad neutrality that courts applied in defining medical practice and taking expert testimony in civil liability cases. More importantly in a causal sense, though, is the institutional story that underlies this failure of doctrine. Courts and judges in Jacksonian America were almost as fragile as the medical establishment in the face of antiprofessional assault. In many states in this era appointed state courts were replaced with elected judiciaries, to better comport with majoritarian preferences.\textsuperscript{57} In this populist atmosphere, to expect doctrinal innovation from a judicial elite that was as besieged as their medical brethren would be expecting too much.

B. Law’s Contestation

“For more than twenty years the Faculty tried to destroy the Thomsonian System by holding it up as quackery. In Massachusetts, they began in 1808 to get the Legislature to help them put me down, and in that state and many others, laws have been passed since that time to prevent my collecting my debts, and to make medical practice, without a college diploma, a crime. But in nearly every state where these unjust laws were passed, the people have caused them to be repealed.”\textsuperscript{58}

The previous section illustrates the inability, or unwillingness, of nineteenth-century courts to use existing doctrinal tools to resolve medical legitimacy disputes. In this institutional context, if the Thomsonians and other eclectics were to be delegitimated, it would require new legal forms enacted by legislatures and enforced by new medical/legal institutions. Many courts of this era acknowledged this fact and made explicit appeals to the legislatures to take action. The Iowa Supreme Court was typical, in a malpractice case involving a Thomsonian doctor. The court “lamented” that:

so many of our citizens are disposed to trust, health and life to novices and empirics, to new nostrums and methods of treatment. But these are evils which courts of justice have no power to remedy. Enlightened public opinion, and judicious legislation, may do much to discountenance quackery, and advance medical science.”\textsuperscript{59}

\textsuperscript{57} Add citation and background from Jed Shugerman, Kermit Hall, Ruger Kentucky article.

\textsuperscript{58} Samuel Thomson, Report of a Trial 50 (1830).

\textsuperscript{59} Bowman v Woods, 1 Greene 441, (Ia. 1848):
Likewise, the Massachusetts S.J.C. in Thomson’s original 1810 murder case made a similar appeal for legislative action, suggesting the “interference of the legislature” put a stop to the public’s “astonishing infatuation” with irregular practitioners. Against an early nineteenth century backdrop nonexistent or toothless medical licensure laws, the medical establishment in many states regarded new, more stringent legislation as the most promising solution to the Thomsonian dilemma.

This then, was to become the next ground of legal and political contestation over medical legitimacy in the first half of the nineteenth century. In these debates regulation of medical practice was assessed against an explicitly political battleground, belying the notion of an objective standard for medical legitimacy. This was not an isolated issue area debated with any measure of reserve; rather it was bound up in broader debates about authority, wealth and privilege in Jacksonian America, and explicitly linked to such broader themes by opponents of the licensure laws. Relatedly, critics of the licensure laws employed a broader range of constitutional arguments than generally surrounds health law and policy debates today. Both sides made direct popular appeal, and here Samuel Thomson’s abilities in marketing and information dissemination were on full display.

Ultimately these battles produced a resounding (if temporary, on the longer view of American health law) victory for the Thomsonians and others who challenged the validity of the licensure laws. Although organized medicine had collectively made gains in the states between 1815 and 1830 in generating new, stricter, licensure laws, this legislative success was ephemeral, and ultimately counterproductive given the massive public backlash they created. Spurred by a populist backlash encouraged by Thomsonian journals and other Jacksonian press outlets, the public in all but a few states forced legislative repeal or significant amendment of the nascent licensure regimes. By 1850 only New Jersey had an act in place that meaningfully prohibited Thomsonian practice. These battles illustrate the ongoing contingency and fragility of medical regulation in the face of organized political opposition.

New York’s experience is instructive of this larger trend, all the more so because existing legal and medical structures in the early nineteenth century made it plausible that the state would retain its licensure regime against Thomsonian opposition. The state began the century with a licensure statute, which was rare for that time, and after strengthening the law held out many decades before the legislature ultimately acquiesced to the repeal movement. Reflecting the influence of an organized urban cohort of elite physicians, New York’s first colonial

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60 Commonwealth v. Thomson, supra, at 142.
61 Haller, The People’s Doctors, supra note __, at 131.
regulatory law applied only to the city of New York. Styled “An Act to Regulate the Practice of Physic and Surgery in the City of New York,” the legislature in 1760 empowered a group of public officials with the right to grant licenses to practice medicine in the city, which were made mandatory on penalty of a civil fine. After minor reenactments once New York became a state, the law was reshaped dramatically in 1807 when, under pressure from “regular” physicians, the legislature reshaped the licensure bodies to be physician-run entities. Notably, the 1807 law contained a proviso expressly exempting from prohibition “any person from using or applying for the benefit of any sick person any roots, bark or herbs, the growth or produce of the United States.” Although this was likely too early to reflect Samuel Thomson’s political influence (his popularity was at that time limited to Massachusetts), the botanical exception cleared the way for Thomsonian practice in New York once it did spread widely after 1815.

Regulars viewed this exemption as a “dangerous clause” under whose “broad license, great and irreparable mischief [was] constantly perpetrating,” and thus repeal of this perceived loophole became a crucial goal for the regulars in the 1820s. Referring to Thomsonians and other irregular physicians, the regulars disclaimed any desire to “urge a crusade against these pretenders,” but were adamant that “the law should not . . . throw around them the broad shield of its protection.” In 1827, after years of committee wrangling in Albany, the regulars scored a major victory over Thomsonian practice when the legislature repealed the botanical exemption, thus making Thomsonian practice unlawful, and more importantly perhaps, disabling irregular physicians from using state courts to due for unpaid medical fees.

Unsurprisingly, this ouster of the Thomsonians from the bounds of medical legitimacy provoked an immediate and sustained backlash. A contemporaneous editorial in the New York Telescope proved prophetic. The paper’s editors said that:

“We are really astonished that a law of this kind should pass, under a free government. Surely the legislature was completely duped by these doctors, and acted as mere tools in their hands, to pass one of

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62 See Charles B. Coventry, “History of Medical Legislation in the State of New York,” N.Y. J. of Med. & Coll. Sci. 4, 11 (March 1845). The fine was five pounds. This colonial act differed from the nineteenth century enactments – and those of today – by vesting the assessment of physician qualifications in a body comprised of legal, not medical, officials: the Attorney General, the Judges of the Supreme Court, the Mayor, and “his Majesty’s council.” Id.
64 See id.
65 Rothstein?
the most absurd, unreasonable, oppressive, and unconstitutional laws on record.

But it will no doubt in the end have a good effect, as it will produce a reaction on the part of the people, and in all probability overthrow the whole law regulating the practice of Physic and Surgery, by which medicine like religion will stand or fall on its own intrinsic worth.”66

The Telescope’s remark about “a reaction on the part of the people” to the new licensure requirement for botanical practitioners proved to be an understatement, and its prediction of ultimate overthrow was likewise correct. The new law created an immediate and sustained public outcry, fueled both by Thomsonian rhetoric and backed by the well-organized network of Thomsonian societies in the state. These groups formed a preexisting political action network which was available for political protest, and immediately set about mobilizing to deconstruct the licensure laws. In a notable stunt attesting to both the broad public support for repeal and the Thomsonian gift for political publicity, Thomson’s son John brought a petition to the legislature containing 40,000 signatures – the document was “thirty-one yards long and closely signed,” and Thomson marched it to the capitol building with great fanfare.67 Ultimately the legislature completely repealed the state’s medical licensure law in 1844. In a wry epitaph to the New York licensure battles, one state judge opined that the 1844 repeal meant that “quackery” could “boast its triumphant and complete establishment by law.”68

The conclusion to New York’s licensure battles mirrored that of other states in every region of the country. The state is distinguished only by the fact that the relatively well-organized regular physicians held off the Thomsonian political pressure for so long, and secured various incremental statutory victories along the way. In other states the populist rout was swifter and more absolute. Pennsylvania never succeeded in placing a medical licensure law in force; one the passed the legislature in 1824 was vetoed by the governor John Andrew Shulze, who cited both constitutional concerns and general policy objections.69 In South Carolina in 1835, a medical society of established physicians brought a suit for illegal practice against four Thomsonians. The grand jury refused to issue an indictment. Three years later the state legislature repealed all penalties for illegal practice.70 Connecticut’s response was more

67 Berman, supra note __, at 23.
68 Bailey v Mogg, 4 Den. 60 (add full cite).
69 See John Andrew Shulze, Veto Message, Dec. 8, 1824.Papers of the Governors 543.
specifically accommodating to the Thomsonians; rather than repeal the licensure laws altogether, the legislature in 1848 folded them into the existing licensure scheme, chartering a “Botano-Medical Society” with power to grant licenses similar to that of a regular medical board.71

The general result is clear, however: by 1850 virtually no medical licensure legislation existed in the states; and where a few statutes did exist – New Jersey was one state that resisted complete repeal – they were underenforced. It would be several decades before the medical profession retrenched and reorganized and succeeded in persuading legislatures to enact licensure schemes again, and even then these late nineteenth-century statutes reflected a greater eclectic impulse, reserving some permission in most states for non-allopathic physicians to continue practice.

Before leaving this discussion of the licensure battles in this era, a few conceptual points merit further examination. Although the debates over such laws provoked strong rhetorical disagreement about legitimacy in medical practice, they were fueled in significant part by broader political and ideological disputes in the early nineteenth century United States. The licensure laws became one of several focal points where disagreements over authority and prestige, and the law’s role in structuring such institutions, exposed deep difference in political philosophy. In typical rhetoric, a new Ohio statute in 1824 that restricted the practice of medicine by forming medical socities was decried as an attempt to eviscerate the “high and pure character . . . of republican institutions.”72

In particular, proposals to strengthen licensure laws provoked sustained ideological opposition grounded in more general antimonopoly sentiment commonplace in Jacksonian America. Samuel Thomson repeatedly wrote that “every man is his own physician,” and argued that laws restricting such rights were unjust and oppressive.73 The New York Thomsonians achieved repeal of that state’s licensure regime in part by arguing generally that “every profession, business, or trade not hurtful to the community, shall be equally open to the community.” Invoking deep constitutional structures, they claimed that “[e]very act which gives support to any particular class of practitioner is a violation of the sacred compact, and at war with the rights and liberties of the people.”74

72 See Haller, supra note ___ at 131.
73 See Kett, supra note ___, at 107.
74 See Berman, supra note ___, at 412.
By aligning their movement with broader anti-professional and anti-monopoly sentiment of this era, the Thomsonians sought to capture elements of the populist energy that had dismantled other institutions of professional privilege in this time period. Samuel Thomson was explicit in invoking these connections between the professions in much of his writing, as this short doggerel poem illustrates:

“The nests of college birds are three,
Law. Physic and Divinity;
And while these three remain combined;
They keep the world oppressed and blind.”75

Beyond these general anti-professional arguments, opponents of licensure laws also made explicit constitutional arguments against such measures. In making such claims in the arena of legislative debate – petitions to legislators, committee and floor debate statements, gubernatorial veto messages – participants in debate were aware that the locus of constitutional interpretation in this era lay primarily outside the courts. In comparison with current notions of judicial supremacy over constitutional construction at the state and federal level, courts in the early nineteenth century were strategically modest and constrained in their explication of constitutional meaning, particularly where to do otherwise would entail invalidation of popular statutes. So the claims that the licensure laws were unconstitutional were directed not to judges but to elected officials like legislators and state governors.

For instance, participants in the New York legislative debate, like those of other states, explicitly linked opposition to the licensure laws to deeper constitutional rights. An 1828 petition to the New York legislature is exemplary of this style of argument:

“We . . . respectfully represent to your Honorable Body that we feel ourselves aggrieved and injured by the provisions of [the law, which] deprives us of those means, which we believe to be the most safe and certain, as well as the least expensive, for relieving the diseases to which we are liable. . . . This statute we deem arbitrary, oppressive, and unconstitutional, and unprecedented in this country. . . . [We pray for repeal] so that we may have liberty to employ any physician in whom we have confidence.”76

A Boston journal echoed these themes, declaring that “any man in the United States has not only a natural right, but a constitutional right to employ at pleasure, any person to administer medicine to himself of family; and any man has a natural and constitutional right to administer,

75 Thomson, Learned Quackery Exposed, at ___.
when requested, such medicine as he judges best to cure the sick.” Note that constitutional arguments were framed both in terms of the right to receive care (the modern analog is the D.C. Circuit’s Abigail Alliance holding of a right to access unapproved drugs, later overturned en banc), as well the right to practice medicine (more evocative of the Lochner-era precedents a century later). My sense from reading primary sources from the era is that the former right – of the citizen to access the healing arts – was prioritized in the public rhetoric even as alternative grounds were advanced.

This was not merely fringe group rhetoric swirling outside of the political centers of power. It is clear that many incumbent constitutional actors, with power to retain or repeal the licensure laws, were sensitive to, and in several cases amplified, these constitutional concerns about such restrictions on the practice of medicine. A New York state senate committee in 1828 recommended repeal of the just enacted licensure restrictions on irregular practice because the new law “work serious evils, and is an abridgement of the rights of individuals.” Pennsylvania never enacted regular licensure legislation because the governor in 1824 vetoed a bill that had passed the legislature, citing constitutional concerns. He wrote in his veto message that:

“provisions of this bill seem to interfere with the undoubted right of our citizens, secured by the constitution and laws, to exercise their talents in the manner best calculated to advance their individual interests, nor the right which every man claims of employing the person, who, in his opinion, may be best qualified to afford relief to his suffering.”

Likewise, the Arkansas governor vetoed the territorial legislature’s bill because “it’s operation on those now engaged in the profession in this Territory, is retrospective, tyrannical and oppressive.” Further, he was of the view that “[t]he bill violates that part of the Bill of Rights, contained in the [Arkansas’s territorial constitution], which declares that . . . no man shall be deprived of life, liberty, or property, but by the judgment of his peers and the law of the land.”

The conclusion of all of this political ferment was an utter rout of the regular physicians and their regulatory goals at midcentury. Orthodox physicians were for a time resigned to this state of affairs. One wrote that

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77 Anon., Medical Newspaper; or The Doctor and the Physician, Feb. 15, 1824.
“[t]he people regard it among their vested rights to buy and swallow such physick, as they in their sovereign will and pleasure shall determine.”81 Another was more fatalistic: “The degradation of the doctors is deplorable, but utterly hopeless.”82 This would change a few decades later, with a greater organizational structure, scientific method, and a changed America the regulars were able to successfully achieve the legal structures they sought: between 1875 and 1891, 40 states enacted medical laws.83 Even here, however, the influence of the Thomsonians and the early irregulars was felt, as these late century laws typically recognized and made legitimate institutional space for multiple schools of medicine, including osteopathy and homeopathy, alongside established allopathy.

C. Law’s Allure

“In obtaining a patent . . . [I wanted to] put myself and my medicine under the protection of the laws of my country which would not only secure to me the exclusive right to my system and medicine, but would put me above the reach of the laws of any state.”84

Samuel Thomson’s doctoring was vigorous, and his promotional and marketing activity no less so. He applied equal zeal to his interaction with the legal system of early nineteenth century America. As the previous section two sections indicate, where state laws threatened to prohibit or curtail Thomsonian practice, Thomson and his allies were nimble in pointing out deficiencies in the common law system or leveraging political opposition to dismantle the state licensure regimes. But Thomson’s relationship with law was more complex than a single-minded deregulatory impulse. He differed from many of the prototypical irregular practitioners of his era in that he did not merely seek to avoid the imposition of law, but rather he was quick to seize on legal forms that he thought offered advantage in the competitive medical marketplace. In this sense Thomson was a legal entrepreneur who sought other ways to protect his gains and secure further competitive advantages. His efforts to do so cast light on the fragmented and multimodal health law regime of his day, and perhaps illuminate some features of our current system as well.

One of Thomson’s first strategic acts after being acquitted in the Lovett murder trial was to begin preparing and then advancing an application for a patent on his medicines and method with the United States government. In February 1813 he went to Washington and met with various advisors in advance of filing. Historian Joseph Haller

81 Young, “Medical Quackery,” supra note __, at 582.
82 Quoted in Warner, “Power, Conflict and Identity,” supra note __, at 948.
83 See “Closing Door of Quackery,” add full cite.
describes initial resistance by the patent office head, William Thornton, who demanded that Thomson more specifically designate his medicines and methods. Thomson worked to revise the patent language but met with continuing resistance from Thornton. Never one to yield to initial legal obstacles, Thomson with the aid of advisors threatened to directly petition Thomson’s superior, Secretary of State James Monroe. Ultimately Thornton relented and Thomson had his patent, signed by Monroe and dated March 3, 1813. The patent language, designated for a “Fever Medicine,” specifies both the content of Thomson’s preparation (directions for compounding lobelia and other herbs) and also a method of administration. He would update the product and method descriptions and obtain additional patents in 1823 and 1836.

Thomson’s patents were rare in his day. Even in an epoch where the term “patent medicine” became commonplace, the number of actual valid patents granted by the federal government for medicines was fairly limited. One historian of early patent law had found that from 1790 to 1836 about seventy-five patents were granted for medicines – an average of fewer than two per year. Thomson obtained three of these. Thomson’s initial patent was the twenty-sixth granted for medical purposes in the United States. Moreover, it was unusual in that it covered his method of administration as well as the specific herbal compounds.

In seeking and then publicizing (and litigating on) his patent, Thomson understood that he was arbitraging the multiple jurisdictions with authority over aspects of health law. Thomson reasoned that he wanted to “put [himself] and [his] medicine under the protection of the laws of [his] country which would not only secure to [him] the exclusive right to my system and medicine, but would put [him] above the reach of the laws of any state.” If he meant that having a patent would immunize him from state criminal and malpractice charges, he is over-reading the preemptive effect of the federal patent right, but his statement perhaps be taken as a more general endorsement of national legitimacy in the licensure battles that were ongoing. Thomson regarded his patents as public relations banners as well as legal devices, and his journals frequently reprinted them in full, often with inaccurate claims that the Patent Office approval connoted a full endorsement of the product’s quality.

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85 Haller, supra note __, at 37-38.
86 See 1813 Patent, reprinted in Haller, Appendix A.
88 Id., at 487.
More so than in the twentieth century, Thomson's obtaining and leveraging his patent rights was itself resented and opposed by the medical establishment, and became another point of legal contestation. For the regular physicians, medicine was entirely a service and in no way a good, and any effort to commodify medicines through the patent system was vigorously opposed. At the same time that they sought government protection for their exclusive practice rights from new licensure laws, regular doctors decried the patenting of medical products as monopolistic and overly commercial. At midcentury, the young A.M.A., in one of its first code of ethics, held that it was “derogatory to professional character . . . for a physician to hold a patent for any surgical instrument or medicine.” Contemporaneously the regulars mounted a pressure campaign directed at Congress to amend the patent laws to specifically exclude medicines from their ambit. In an 1849 special report to the U.S. House of Representatives, physicians warned that patents gave protection to “the unprincipled and mercenary, [who] with fertile ingenuity, have been daily prostituting a noble science at the shrine of public interest.”

Although Congress declined to follow the physicians’ recommendation, Thomson’s characterization of his patent strategy reflects his unease about the monopolistic connotations of being a patent holder, particularly given the tone of his populist rhetoric in opposing the licensure laws. He explained to his adherents that:

“In obtaining a patent it was my principal object to get protections of the government against the machinations of my enemies more than to take advantage of a monopoly; for in selling family rights, I convey to the purchaser the information gained by thirty years practice; and for which I am paid a sum of money as an equivalent.”

This was at least a little disingenuous, unless one construes Thomson’s “enemies” here to include the large numbers of individual botanical healers against whom he would litigate his patent rights later in life. Thomson was an energetic litigant in striving to protect his patents, and met with mixed success. He sought other legal mechanisms for protecting his market position, gaining copyrights on his widely distributed books, and entering contracts with his thousands of family rights holders that included them swearing an oath of confidentiality to a justice of the peace before consummating the sale.

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91 Id. at 124.
92 Id. (add citation to full report)
94 James Young, Medical Quackery in the Age of the Common Man, at 583.
An incomplete review of the extant case literature suggests that Thomson did not fare as well in the role of prosecuting litigant as he did when defending himself from the regulars. He appears to have lost many of the patent, copyright infringement, and libel suits he pursued in the last decades of his life, and wrote of being ultimately frustrated by the law’s failure to protect what he viewed as his entitlements. In this litigation he was hindered by the same judicial timidity and legal ambiguity that worked to his advantage when thwarting more frontal challenges from the regular physicians. Just as courts were reluctant to mediate in medical quality disputes and declare Thomsonian practice unlawful or illegitimate, they were disinclined to enforce a strong-form version of his intellectual property rights against other alternative practitioners.

Ironically, given Thomson’s lifelong claims of persecution by the legal and medical establishments, the remarkable success of his system operated against his legal rights in at least one line of cases. Less than three decades after being jailed as a rogue practitioner for murder in the Lovett case, Thomson was back in the Massachusetts Supreme Judicial Court in a case decided in 1837. Here Thomson assumed the legal posture of the establishment, bringing a claim for trade name infringement against a sole practitioner apothecary named Hosea Winchester who had compounded and sold “Thomsonian” medicines.95 The court, in a ruling drafted by Lemuel Shaw, rejected Thomson’s claim, in part because the court considered that “Thomsonian” medicines “had acquired a generic meaning, descriptive of a general kind, quality and class of medicines.”96 In this respect at least, the law failed Thomson just as it had the regulars.

IV. “A SHADOW OF ITS HISTORY”97: CONNECTIONS BETWEEN THE THOMSONIAN MOVEMENT AND CONTEMPORARY HEALTH LAW

Much has changed, in medicine and law, since the early nineteenth century. But Thomson’s struggles with the legal system of his era illuminate some features of that system that persist today, and highlight various unresolved tensions that remain embedded in modern health law structures. Several thematic features of the health law structures that existed in Thomson’s day remain entrenched and unresolved in current law. This workshop draft will briefly identify a few of these elements for purposes of discussion in next Monday’s seminar; future work will explore these themes in the context of health law developments in other historical eras up to the present.

95 Thomson v. Winchester, 36 Mass. 214 (1837).
96 Id. at 216.
First, and most broadly, the legal structures touching on health law topics in Thomson’s day exhibit the same dysfunctional fragmentation and multiplicity that scholars decry today. Thomson’s interactions with the legal system in the early nineteenth century highlight the borrowing, or scavenging, dynamic that characterized health law today, as “off the rack” legal forms from civil or criminal law are applied to new health law problems, and often don’t fit well. The frustration that nineteenth century courts expressed at the “inadequacy” of traditional legal forms directed at new modes of practice reflects this tension. Moreover, health law then as now was institutional eclectic, constructed of multiple sovereignties often operating inconsistently. Thomson well understood this dynamic, and sought to capitalize by seeking federal patent protection to put him “above the laws of any state.” Modern debates over preemption and colliding federal and state authority clearly implicate these issues.

Beyond such general features, it is possible to be more specific on a few conceptual features of the health law of Thomson’s day that persist today. One of these is the inability, or unwillingness, of legal institutions to meaningfully resolve medical quality disputes. Malpractice law proved a poor vehicle for dealing with the Thomsonians because of its embrace of the customary standard and the multiple schools of thought doctrines; both doctrines remain in malpractice law today, albeit in more muted or contingent form in some jurisdictions. Licensure law as well polices quality only at the outer bounds – most modern licensure regimes do not resolve tensions between various schools of practice (allopathic vs. osteopathic, for instance) nor do they administratively monitor individual physician quality.

Another conceptual tension that Thomson’s career implicated and that remains entrenched in our health law regime is the ambiguity about whether medicine is best regarded as a good or a service. Of course it includes both functional components, but which one is emphasized leads to different regulatory implications. This fracture is most evident today in pharmaceutical regulation, and in the curious gaps in FDA’s regulatory jurisdiction. FDA acts as a safety gatekeeper for new drug products, regarding medicine as a good whose safety and efficacy can be measured objectively. But it has historically disclaimed authority over actual use, such that it does not regulate physician use of pharmaceuticals, even for other conditions and in contradistinction to the approved labeling. This is an unstable equilibrium, however, particularly as new pharmaco-epidemoeological techniques permit data-driven assessment of optimal drug therapies for various conditions, and developments in the near future will likely force an overt contestation over the locus of authority in this area. In an incremental move that likely portends greater future change, Congress in 2007 gave the FDA jurisdiction to devise and implement usage protocols and restrictions for certain classes of drug products.
A related disagreement that was overt in Thomson’s day and which resonates more faintly now is the debate between universality and specificity in medical treatment. Recall that Thomson purported that his medicine and method was a virtually universal cure, capable of treating any malady. The regulars of his era reflected the opposite extreme, claiming that every person’s constitution was different, and might require different therapeutic intervention. Here too FDA policy is beginning to strain under this tension; historically most drugs have been approved for general use (including off-label use), but spurred by more sophisticated data with population-group analysis, the FDA has begun to consider approving drugs for specific subpopulations of patients. This fits uneasily with its traditional generalized approval regime, and will continue to force controversial agency choices. The opposite dynamic may be occurring, or will soon, in terms of physician authority. Historically physicians have had substantial bedside authority to make individualized treatment decisions and resisted centralized imposition of standard treatment protocols. New quality control literature on the benefits of guidelines and protocols backed by outcomes research may unsettle this traditional freedom, as will payors and other institutional players who will aim to force doctors to give up some of their license to individually tailor treatments to specific patients.

Also still present in modern health law’s structure is the idea that naturalistic or botanical therapies ought to be placed outside, and remain unburdened by, the strictures of the medical regulatory framework. Durable examples which persist today include the exclusion of homeopathic remedies from FDA’s normal safety and efficacy requirements, and the separate and significantly less rigorous regulatory regime for dietary supplements embodied in the Dietary Supplement and Education Act of 1994. As periodic public health tragedies underscore, however (see, e.g., ephedra), botanical substances can carry significant health risks, and their categorical exclusion from more searching safety assessment regimes threatens to undermine optimal health policy.

A final commonality that is obvious in both the Thomsonian debates and the current political discourse over health policy, goes to the fundamentally political construction of medical legitimacy. Conceptions of good medicine, and the manner in which to organize a medical system, are embedded in the political structures of the era in which they arise. It is impossible to understand the public debate over Thomsonian practice and other forms of irregular medicine without understanding the broader currents of Jacksonian political thought. And, as many have noted, the present health reform debate is deeply constrained, and defined, by the broader political context in which it takes place.