

THE JOURNAL OF CONTEMPORARY HEALTH LAW AND POLICY



ARTICLES

Bleedings, Purges, and Vomits: Dr. Benjamin Rush's
Republican Medicine, the Bilious Remitting Yellow Fever
Epidemic of 1793, and the Non Origin of the Law of
Informed Consent

Randall Baldwin Clark, Ph.D.

Deliberately Indifferent: Government Response to HIV
in U.S. Prisons

Kari Larsen

Duty to Third Parties in Employment References:
A Possible Poisonous Potion for the Health Care Industry?

Allan J. Jacobs, M.D.

COMMENTS

Pharmacogenomics: Tailoring the Drug Approval
Process for Designer Drugs

Margaret Crews

The Constitutionality of Opting Out of Adolescent Sex:
HPV Vaccine Mandate Legislation Raises Constitutional
Questions

Ariel Pizzitola

BLEEDINGS, PURGES, AND VOMITS:
DR. BENJAMIN RUSH'S REPUBLICAN MEDICINE,
THE BILIOUS REMITTING YELLOW-FEVER
EPIDEMIC OF 1793, AND THE NON-ORIGIN OF
THE LAW OF INFORMED CONSENT

*Randall Baldwin Clark, Ph.D.**

ABSTRACT

To the consternation of many physicians, the modern law of informed consent imposes certain constraints on their actions, not least that they respect patients' decisions to redefine at will the scope of care. The consequences of this transfer of power are often a nuisance and occasionally fatal, but always a reflection of democracy's leveling march: Physicians now take orders rather than give them. However frustrating the modern preference for process over result might be, we should ask ourselves—before condemning the law's evolution—about the consequences for patients' health of a more radically democratic practice of medicine. This paper proposes to examine this question as framed by the life of Dr. Benjamin Rush, who, in addition to signing the Declaration of Independence, crafted a medical practice uniquely suited to the young Republic's presumed moral character: Self-aware sufferers would promptly identify their own maladies and courageously treat themselves. In the end, his enterprise was flawed because his democratic instincts misled not only his scientific inquiries (disease is complex, not simple) but also his practice recommendations (patients are scared, not intrepid). Reflection on Rush's failed project should give pause to those who lament the passing of paternalistic medicine, for the law's requirements, however onerous they might be, tolerably accommodate both patients' need for physicians' expertise and our democratic belief that consent is the fundamental precondition of all rule.

* Visiting Assistant Professor, George Mason University School of Law. A.M., Ph.D., University of Chicago; B.A., J.D., University of Virginia. The author wishes to thank for their helpful comments John D. Arras, Peter Berkowitz, Allison D. Clark, Glenn W. Clark, Shawntel Fugate Clark, David Fontana, John Frazer, Stephen R. Galoob, D. Bruce Johnson, Harold Kildow, Stanton D. Krauss, Stephen R. Latham, Craig S. Lerner, Renée Lettow Lerner, Jeremy A. Rabkin, Andrew R. Varcoe, and participants in faculty workshops at George Mason, Ohio Northern, and Quinnipiac Universities, and at the Universities of Dallas and Virginia. I regret that I was only able to respond adequately to but a small number of their criticisms.

I. INTRODUCTION

Concluding an otherwise sympathetic account of the modern insistence that patients, not their physicians, be the arbiters of both the nature and scope of medical care, surgeon and author Atul Gawande provides his readers with a frightening illustration of the peril of this practice. His patient, Mr. Howe, an otherwise healthy husband and father, took a terrible turn for the worse while recovering from gallbladder surgery. A blood-borne bacterial infection had triggered a debilitating system-wide reaction, including, critically, imminent respiratory failure. Treatment (a course of antibiotics) was simple, but required time. To buy it, Gawande needed to hook Howe up to a mechanical ventilator by way of a tube down his throat. Gawande summoned a senior resident, who agreed; she then proceeded to explain the diagnosis and necessary treatment to the expiring man. But to their mutual surprise, Howe refused: “‘No,’ he gasped, and sat straight up. ‘Don’t . . . put me . . . on a . . . machine.’” The more experienced doctor did her best to convey the gravity of his situation. With some discomfort and a bit of high-tech support, Howe would likely recover in a couple of days; otherwise, he would surely die. Howe did not budge and shortly lost consciousness.

The moment that happened the senior resident rushed into action. Contrary to Howe’s clearly expressed desire, contrary to prevailing medical ethics, and contrary to controlling law, she tranquilized him, intubated him, and transported him to the intensive-care unit. As Gawande had predicted, their patient responded well. Within a day’s time the infection had receded and Howe was breathing on his own. Soon thereafter, once the patient had been weaned from the sedation, Gawande approached him, told him that he had made a fine recovery, and proceeded to remove the tracheal tube still protruding from his mouth. Howe coughed a few times and then, with a hoarse but steady voice, thanked Gawande for saving his life.¹

Dr. Gawande’s misgivings about the constraints under which he and his supervisor labored (and the personal risk she took to fulfill her more expansive conception of duty of care) have been articulated more broadly and pointedly by other doctors and observers of the medical profession, generally lamenting, not least, the negative medical outcomes that can result.² Even as doctors become more committed to the idea of patient involvement in medical decision-making, there remains great frustration that, at critical moments,

1. ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 224–27 (Picador 2003).

2. See, e.g., Thomas P. Duffy, *Agamemnon’s Fate and the Medical Profession*, 9 W. NEW ENG. L. REV. 21 (1987).

doctors are obliged *not* to do what they—and most other sane and sound observers—think best.

But physician deference to (and occasional frustration with) patient desire has not always been the norm, legally, ethically, or empirically. The phrase “informed consent” did not even enter into the case law until 1957³ and took much longer to find its way into the professional codes⁴ and daily practice.⁵ It is not absurd to suggest that, within the memory of some still practicing, the ruling phrase “doctor knows best,” could be uttered without eliciting ironic twitters.

The current state of affairs could not be more different. A doctor who now ignores the patient’s right to exercise detailed control over his own medical care exposes himself to liability for undertaking efforts to solve the very problem that brought the patient to his door. And not only for willful and deliberate actions, such as Mr. Howe’s intubation, but also for far slighter things such as failure to discuss the proposed course of treatment in the appropriate degree of detail.⁶ As even the most ardent advocates of patient-directed medical care concede, the doctor-patient relationship is now quite heavily papered.⁷

How did we arrive at such a state? How is it that the doctor-patient relationship, one historically endowed with (nay, dependent upon) great trust, is now treated as an arm’s-length consumer-goods transaction? How did it come to be that custom, medical ethics, and the law demand more forms for a routine tonsillectomy than for the purchase of a mortgaged time-share?

The proximate causes are not difficult to identify. The most obvious is the medical malpractice boom of the 1960s. Doctor and patient, historically accustomed to regard each other as profitable partners in the production of the patient’s health, came to learn that their interests (to the cost of the former and gain of the latter) could radically diverge. In the wake of this revolution, encounters paradigmatically characterized by deference (on the patient’s part)

3. *Salgo v. Leland Stanford Jr. Univ.*, 317 P.2d 170, 181 (Cal. 1st Dist. Ct. App. 1957).

4. *Culbertson v. Mernitz*, 602 N.E.2d 98, 103 (Ind. 1992).

5. CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* 4–5 (Oxford University Press 1998).

6. See FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* I-85 (Aspen Publishers 2000) (treatise presenting black-letter law).

7. Jay Katz, *Informed Consent: Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL’Y 69, 84 (1994).

and fiduciary care (on the physician's), are now, with frightening frequency, formed warily and opportunistically. Also prominent is the consumer movement of the 1970s. Under this new paradigm doctors were no longer to provide care, but, rather, sell services. What? How much? And with what guarantee? The rise of the HMO represents the movement's logical, if unintentional, culmination. Commodification conjoined with aggregated purchasing power transformed independent professionals into the wageling employees of publicly traded, limited-liability corporations. Even feminism can take some credit here, for highlighting in its medical manifesto, *Our Bodies, Ourselves*, that the medical guild was, after all, a fraternity. And the pressure remains today: With the explosion over the past decade of vast quantities of internet-accessible information, patients now frequently arrive at their doctor's door with WebMD print-outs in hand, demanding for their pre-diagnosed maladies the drugs they saw advertised on the sidebars, over the tube, and in *People* magazine.

While these events, and others from the past half-century, can properly claim credit for this new understanding of doctor-patient relations, this essay proposes to ask whether something larger might be at work here. Could it be that these and other events are but intermediary agents of a principal force, the uncaused cause of modern medical decorum? And if so, what might this be? This article suggests, and will soon explore, the hypothesis that it is the democratic spirit of our times that has driven this change.

I freely admit that this thesis is counterintuitive, at best. What bearing, one could reasonably ask, might the character of a political regime have on the practice of a scientific profession within its boundaries? Are not the trades of chemist, engineer, and exterminator independent of the government under which they are practiced? Is there not but one science of killing termites?

The answer, I submit, is that the practice of medicine has at its core a social element that necessarily brings it into conflict with our democratic instincts: the need, if the patient is to be healed, for him to obey his doctor's commands. Not as negotiated, compromised, or otherwise altered, but as prescribed.

Compare this with the situation of other practitioners of scientific professions, such as the economist or engineer. Along with these, the physician possesses an esoteric knowledge capable of granting a great human good. But technical expertise does not provide insuperable immunity from democratic leveling. Yes, the economist possesses a specialized skill beyond my ken, but I do not resent him for it. As Winston Churchill said of mathematicians and the subject of their study, "I am very glad there are quite a number of people born with a gift and a liking for all of this. . . . I promise never to blackleg their profession nor take the bread out of their mouths."⁸

8. WINSTON CHURCHILL, *MY EARLY LIFE: A ROVING COMMISSION* 27 (Thornton Butterworth 1930).

So why should good democrats begrudge the doctor his pretensions? Why do they insist that he take rather than give orders? The answer, I believe, is that, to produce the benefit the patient desires, the physician must do something that other professionals need not: get his patient to submit to an invasive, painful, nauseating, and potentially deadly course of treatment. To boot, he must do so while the sufferer is both physically and emotionally vulnerable. The doctor's calling is, therefore, to do for his patient that which the patient cannot do for himself: dispassionately consider the options, weigh their merits, and decide upon the treatment; seek to persuade the patient to cooperate in the administration of the prescribed course; and, if persuasion fails, to force compliance, all the while adhering to the most exacting fiduciary standard. Properly understood, the physician's task is, in short, to rule over his patient.

Before you dismiss this formulation as too tendentious, too extreme, too irrelevant, allow me to point out that this understanding of the doctor-patient relationship does, in fact, have deep philosophical, historical, and linguistic roots.

Most prominent, at least to me, is its appearance in the very first works of political philosophy: the writings of Plato and Aristotle. Unlike my present attempt—to understand medicine by reference to politics—both of these philosophical titans sought the reverse: to comprehend politics by reference to medicine. In the *Laws* and *Statesmen*, two late works, Plato exhaustively and favorably considered the possibility that the emergent art of Hippocratic medicine could help us understand the relationship between political rulers and their subjects. In particular, he considered the ruler's proper proportioning of persuasion with force to get his subjects to act in their own, and the city's, best interests.⁹ Aristotle takes up the thread, primarily in the *Politics* but also in the *Nicomachean Ethics*.¹⁰ Others in the Western tradition wove in other strands as they also considered the similarity of the physician's challenge, obtaining patient compliance to wise prescription, to the ruler's task.

But this question is more than merely theoretical, more than just a tool for understanding the proper ordering of the city. Even before Plato started scribbling Socrates' ruminations, doctors have sought to understand how to apply their presumed scientific knowledge to the challenge of curing, not merely disease, but people too, a task which necessarily involves obtaining patient submission to terrifying commands. The earliest such debates are found

9. For an exhaustive consideration of Plato's analysis, see, for example, RANDALL BALDWIN CLARK, *THE LAW MOST BEAUTIFUL AND BEST: MEDICAL ARGUMENT AND MAGICAL RHETORIC IN PLATO'S LAWS* (Lexington Books 2003).

10. See, e.g., MARTHA C. NUSSBAUM, *THE THERAPY OF DESIRE: THEORY AND PRACTICE IN HELLENISTIC ETHICS* (Princeton Univ. Press 1994).

in the writings of the Hippocratic school, where the challenge is frankly acknowledged. They continue through antiquity, the middle ages, and the Enlightenment. Even today, well after the legal requirements for doctors' disclosure-making and patients' consent-giving have largely settled, doctors are still seeking to come to terms with the recent "shift of power from professional to patient."¹¹ A rich literature discussing this change is still in the making.¹²

Nor should we overlook the language long used to describe the relationship—and the current, politically correct changes therein. Traditionally, "doctors" gave "orders" to "patients." Their patience having run out, active "customers" now contract for treatment from "health-care providers." Even in less contentious modern formulations the political import of the linguistic shift is obvious: The "doctor-patient relationship," which bespoke paternalism, is now, with increasing frequency, the neutered "patient-doctor interaction."¹³

If my assessment of the politically problematic nature of this relationship—that the practice of medicine at its core requires the submission of one to the rule of another—is even slightly correct, an interesting historical puzzle emerges: How is it, over 500 years after the Protestant Reformation and 200 since the American Revolution, that physicians are still among us? How is it that doctors, whose core pretension is odious to the committed democrat, continue to ply their trade? This is especially curious when viewed from the perspective of Alexis de Tocqueville, who, in decades following the American and French Revolutions, both documented the leveling of those who presumed to rule—particularly monarchs and priests—and predicted the further flattening of other professional and social hierarchies.¹⁴ Adding to the complexity of the problem is the annoying fact that, if anything, the importance of the medical profession has vastly increased since de Tocqueville prophesied the unstoppable penetration of democratic principles into all precincts of social life. Two hundred years later medical spending amounts to approximately fifteen percent of our gross domestic product and is rising still.

11. Richard Horton, *What's Wrong with Doctors*, N.Y. REV. OF BOOKS, May 31, 2007 (vol. 54, no. 9), at 19 (reviewing JEROME GROOPMAN, *HOW DOCTORS THINK* (Houghton Mifflin Co. 2007)).

12. For a recent contribution to the corpus, see JEROME GROOPMAN, *HOW DOCTORS THINK* (Houghton Mifflin Co. 2007).

13. Horton, *supra* note 11, at 19.

14. ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* (Charles Gosselin 1835). See, in particular, his introduction to the first edition.

So how did doctors pull this off? How did physicians, in spite of their claim to rule over their patients, survive democracy's leveling scythe, even as the other governing professions have largely passed away? The answer, I think, is not that they dodged the path of the blade, but, rather, that they negotiated the terms of the physician's persisting presence. Learned doctors continue to prescribe; ignorant patients continue to comply. But the doctor must now explain and the patient must now assent. This compromise, this mediated settlement, is embodied in the modern law of informed consent, the presence of which vexes even young and sensitized practitioners like Dr. Gawande.

But there was nothing inevitable about this result. As de Tocqueville saw, other ruling professions were indeed destroyed by democracy's march. Any natural-born citizen—male or female, black or white, aged 35 or older—may become our President. American religion, in many respects and sects, embodies the Protestant ideal of a priesthood of all believers. Could not medicine have gone down the same path, replacing the work of physicians trained at elite and exclusive institutions with therapy by, of, and for the people? Why did it not? If it had, what would such a practice look like? Would it have been desirable? What, in sum, is democratic medicine—and do we democrats want it?

II. HISTORIOGRAPHY

To attempt a preliminary answer to this set of questions, I propose an examination of the life and thought of Dr. Benjamin Rush. Humbly born in 1745 on the outskirts of Philadelphia to a gunsmith father of Quaker stock and a shopkeeper mother of the Presbyterian persuasion, by the 1770s Rush had, by dint of his native intelligence and tireless diligence, risen into the ranks of America's political and medical elite. In 1776 he performed a great (and now unheralded) service to the nascent nation by engineering a remarkable electoral coup in Pennsylvania politics, thereby changing this holdout state's vote for independence from "nay" to "yea," for which he was rewarded with the opportunity to sign the Declaration. In the years that followed, he labored without office to effect many important republican reforms in his state, including, most prominently, changes to the penal code and creation of multiple educational institutions. In his work as a physician Rush was even more influential, moving over the course of his professional life from a merely successful Philadelphia practitioner to a towering totem of American medical science. In the 1780s it was to him that such men as George Washington turned for advice regarding the treatment of his dying mother; by the early nineteenth century his many books on diverse medical subjects had become the authoritative guides for the education of young doctors. If anybody could give us a sketch of the contours of democratic medicine, it would be Benjamin Rush. Doctor. Patriot.

There is, I regret to admit, another, less interesting reason for the selection of Rush for the honor of my affections: the attention paid him in the mid-1980s,

when the scholarly debate regarding the legal doctrine of informed consent was raging most intensely—coupled with his near-total omission from the continuing discussion.

As noted above, “informed consent” did not really enter the legal vocabulary until after World War II. But in the decades that followed its first introduction into the case law, furious debates ensued regarding the addition of this cause of action to the plaintiff’s arsenal. While most discussion had rightly centered over questions relating to the wisdom of the practice, a tangent spun off in the early 1980s, when Dr. Jay Katz, the legal professoriate’s most insistent advocate for patient involvement in medical decisions, asserted that “disclosure and consent . . . have no historical roots in medical practice.”¹⁵ Mark Siegler, an academic physician, countered in 1981 with evidence adduced from Plato’s *Laws* to show the existence of such a practice among free physicians in late-classical Greece¹⁶ and Martin Pernick, an American historian, attempted in 1982 to show the existence in America of “an indigenous medical tradition,” of which “truth-telling and consent-seeking have long been part” and for which Benjamin Rush was the principal advocate and example.¹⁷

Pernick’s assertion was appropriately qualified. Rush encouraged physicians to disclose and discuss, not out of respect for their patients’ autonomy, Pernick argued, but, rather, because a patient’s medical knowledge and exercise of will “had demonstrably beneficial effects on most patients’ health.”¹⁸ This was different, of course, from the informed-consent practices of the twentieth century, Pernick insisted, because the modern law of informed consent has as its goal respect for the patient’s autonomy, not the medical quality of the interaction’s outcome.¹⁹

15. Jay Katz, *Disclosure and Consent in Psychiatric Practice: Mission Impossible?*, in *LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY* 91, 98 (Charles K. Hofling, ed., Bruner-Mazel 1981).

16. Mark Siegler, *Searching for Moral Certainty in Medicine: A Proposal for a New Model of the Doctor-Patient Encounter*, 57 *BULL. N.Y. ACAD. MED.* 56, 65, 68–69 (1981). For a consideration of Plato’s treatment of physicians and patients in the *Laws*, please see CLARK, *supra* note 9.

17. Martin S. Pernick, *The Patient’s Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy*, in 3 *MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP* 1, 3 (U.S. Government Printing Office 1982).

18. *Id.* at 3.

19. *Id.*

Notwithstanding the modesty of Pernick's claims, they provoked a stern rejoinder from informed-consent advocates. Katz, in his now-monumental manifesto, *The Silent World of Doctor and Patient* (1984), insisted that, "despite some scholarly commentary to the contrary,"²⁰ Rush didn't go even so far as Pernick had suggested. In Katz's view, even before push came to shove, Rush (along with his European peer, Dr. John Gregory) was eager enough to engage in "deception" to "manag[e] the physician-patient relationship."²¹ Katz's verdict was sustained two years later by Ruth Faden and Tom Beauchamp, the authors of the other major informed-consent treatise from the decade, *A History and Theory of Informed Consent* (1986).²² In spite of Pernick's "attempts to enlist Gregory, Rush, and other Enlightenment figures in defense of his historical thesis about early consent practices,"²³ Faden and Beauchamp insisted that Rush "was not advocating informed consent."²⁴ His goal, rather, was merely to make patients "sufficiently educated so that they could understand physicians' recommendations and therefore be motivated to comply."²⁵

This verdict has thus been duly pronounced: Rush, having advocated merely instrumental dialogue with patients, made no contribution to the development of the modern practice of "disclosure and consent." Therewith consideration of Rush's life and work disappeared from scholarly treatment of the informed-consent doctrine. No further trace is found in the specialized informed-consent literature, where he, along with other possible historical anticipants, is now simply ignored.²⁶ Nor is Rush discussed at any length in the general law-review literature on the subject, in spite of the 300-plus references to him, his work, or his correspondence in other contexts. The most that he merits in the informed-

20. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 16 (Free Press 1984).

21. *Id.*

22. RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 67 (Oxford Univ. Press 1986) ("Katz sums it up well").

23. *Id.* at 66.

24. *Id.* at 65.

25. *Id.* (emphasis original).

26. See, e.g., JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND PRACTICE* (2d ed., Oxford Univ. Press 2001) (1987); SCHNEIDER, *supra* note 5.

consent articles is two brief statements, both citing Katz's conclusion with approval.²⁷

This neglect is unfortunate, I believe, not only because Katz, Faden, and Beauchamp, and even Pernick, err in their assessment of Rush (each in his or her own way), but also because the subject was dropped before the proper question was raised. The interesting inquiry is not how far short of our modern practice Rush fell, but, rather, what his life and work have to teach us about the proper role of medicine in a democracy. Or, rephrased more productively: How might Rush's flawed understanding of doctor-patient relations help us understand the strengths of our own conception? To this question this essay seeks to direct our attention.

III. BENJAMIN RUSH: PHYSICIAN

For a man who became a radical medical democrat, Benjamin Rush's career began quite conventionally. After preparation by the Reverend Samuel Finley at Nottingham Academy in southern Pennsylvania,²⁸ Rush studied at the College of New Jersey (now Princeton),²⁹ under the guidance of another prominent Presbyterian minister, the Reverend Samuel Davies.³⁰ Upon graduation in 1760,³¹ he returned to his hometown of Philadelphia and soon apprenticed himself to one of the city's most prominent physicians and fellow graduate of Finley's academy, Dr. John Redman.³² Under his tutelage, Rush did everything a dutiful apprentice should—and more. In addition to the drudgery of preparing pharmaceutical compounds in the apothecary and, later, making patient visits,³³ Rush eagerly sought to expand his medical knowledge. He

27. Emmanuel O. Iheukwumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373, 375 (2002); Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor Is Right" to "Patient Has Rights,"* 50 SYRACUSE L. REV. 1243, 1244 (2000).

28. DAVID FREEMAN HAWKE, *BENJAMIN RUSH: REVOLUTIONARY GADFLY* 12 (The Bobbs-Merrill Co., Inc. 1971).

29. *Id.* at 17.

30. *Id.* at 19.

31. *Id.* at 21.

32. *Id.* at 26.

33. *Id.* at 27–28.

spent the “late and early hours” of his day reading his master’s favorite authors, Drs. Thomas Sydenham and Hermann Boerhaave, the respective English and Dutch medical authorities,³⁴ and otherwise snatched time to attend Dr. William Shippen’s lectures on anatomy, organized by Dr. John Morgan, both Finley’s students,³⁵ as well as other medical offerings at the College of Philadelphia.³⁶ Following his five-year apprenticeship, he spent two years at the University of Edinburgh,³⁷ where he studied under the leading medical figures of the Scottish Enlightenment, Drs. John Gregory and William Cullen.³⁸ Rush duly earned his medical degree from Edinburgh³⁹ and then undertook a few months of clinical training with Dr. Richard Huck in London.⁴⁰ By 1769, upon his return to Philadelphia,⁴¹ Rush had received the very best medical education available to his generation.

Rush plied his trade well, resulting very quickly in great prosperity. He began, as most young physicians did, by working social contacts and providing cut-rate services to the poor: Rush expanded his social circle by attending “Old Side” Presbyterian congregations (he, his family, and his teachers were of the “New Light” persuasion)⁴² and gained great practical knowledge of the city’s diseases from those whom,⁴³ he later frequently noted, he was obliged to treat

34. HAWKE, *supra* note 28, at 30.

35. *Id.* at 32.

36. CLAIRE G. FOX ET AL., BENJAMIN RUSH, M.D.: A BIBLIOGRAPHIC GUIDE xxi (Greenwood Press 1996).

37. HAWKE, *supra* note 28, at 43.

38. *Id.* at 48.

39. *Id.* at 60.

40. *Id.* at 65–66.

41. *Id.* at 82.

42. *See* HAWKE, *supra* note 28, at 85.

43. *Id.* at 85.

generously, “for God is their paymaster.”⁴⁴ But Rush also strode beyond this conventional cursus. He arranged, as soon as he began his practice, to teach classes in chemistry at the College of Philadelphia,⁴⁵ and wrote a multitude of articles on a variety of medical subjects for publication in the city’s newspapers.⁴⁶ Early on he bought a slave⁴⁷ and soon had the business to support several apprentices.⁴⁸ His success was crowned in 1776 with his marriage to Julia Stockton, daughter of Richard Stockton, a Presbyterian patrician from Princeton and signer of the Declaration of Independence,⁴⁹ a union memorialized with portraits by the young Charles Willson Peale.⁵⁰ Benjamin Rush, the son of a widowed shopkeeper,⁵¹ had arrived.

Rush’s early financial success also bought him the freedom to work for the benefit of his city and the rebelling colonies. In 1775 Pennsylvania’s Safety Committee named him Physician-Surgeon of Philadelphia’s newly constituted gunboat fleet.⁵² Then, in 1776, while serving in the Continental Congress, Rush chaired the committee responsible for provisioning the northern army with food and medical supplies.⁵³ This position enabled him, among other things, to require a close-cropped coif eventually called the “G.I. haircut.”⁵⁴ (“It saves time and trouble and prevents lice,” Rush noted.) Even after leaving Congress

44. Benjamin Rush, *On the Vices and Virtues of Physicians*, in SIXTEEN INTRODUCTORY LECTURES TO COURSES OF LECTURES UPON THE INSTITUTES AND PRACTICE OF MEDICINE 120, 132 (2d ed., Bradford & Innskeep 1811).

45. See HAWKE, *supra* note 28, at 86.

46. *Id.* at 92–95.

47. *Id.* at 84.

48. *Id.*

49. *Id.* at 84, 140.

50. See HAWKE, *supra* note 28, at 140.

51. *Id.* at 11.

52. *Id.* at 136.

53. *Id.* at 169.

54. *Id.* at 174.

in 1777,⁵⁵ Rush continued his army work, serving as Physician-General of the Middle Department of the Continental Army,⁵⁶ during which time he drafted a manual, “To the Officers in the Army of the United American States: Directions for Preserving the Health of Soldiers,”⁵⁷ whose sensible hygienic advice has survived the test of time.⁵⁸

But these were times that tried men’s souls, Benjamin Rush’s not excepted. The Continental Army was undersupplied and undisciplined, leading, in Rush’s opinion, to innumerable and unnecessary soldier deaths.⁵⁹ He argued for changes in camp hygiene, to no effect other than to bring him into conflict with his superiors, Dr. Shippen, now the army’s Director-General, and Gen. George Washington.⁶⁰ His dispute with Shippen was particularly contentious,⁶¹ leading, in the short run, to Rush’s forced resignation⁶² and, several years later, to Shippen’s.⁶³ Dispirited, he retired to his father-in-law’s estate in Princeton, resolving to read and practice law in New Jersey, but was driven back to Philadelphia by a retreating British army.⁶⁴

For this, Rush had good cause to be thankful, as his return to his home and to medical practice occasioned great prosperity. His medical practice flourished, as the City of Brotherly Love was, still, a swampy, sickly place.⁶⁵ He resumed his teaching duties at the College of Philadelphia⁶⁶ and in 1783 received a

55. See HAWKE, *supra* note 28, at 187.

56. *Id.* at 192.

57. *Id.*

58. *Id.*

59. *Id.* at 203–10.

60. See HAWKE, *supra* note 28, at 214.

61. *Id.* at 217.

62. *Id.* at 220.

63. *Id.* at 246.

64. *Id.* at 223.

65. See HAWKE, *supra* note 28, at 249.

66. *Id.* at 236.

prestigious appointment to the staff of the Pennsylvania Hospital.⁶⁷ Rush was also somewhat vindicated in his simmering dispute with Shippen when a court found that Rush's charge—that Shippen had engaged in “reprehensible” wartime profiteering—was true.⁶⁸ By the late 1780s Rush's fame was such that he was receiving many requests for mail-order consultations.⁶⁹ By the age of 41, Rush had become America's most prominent medical authority.⁷⁰

IV. BENJAMIN RUSH: REPUBLICAN

His professional pedigree notwithstanding, Rush became an early and ardent advocate, both for political independence and of republican politics broadly understood. While others, including such prominent and vocal separationists as Benjamin Franklin and John Adams, agonized over both the wisdom of rebellion and the character of the polity to succeed the Crown, Rush supported the revolutionary enterprise, perhaps rashly, without any of his less sanguine colleagues' reservations.⁷¹

The historical record first notes Rush's political stirrings as early as the Stamp Act of 1764, when he, in private correspondence with Ebenezer Hazard, excoriated Franklin, then Pennsylvania's agent in England, for his supine acquiescence to Parliament.⁷² Rush's sentiments soon intensified during his sojourn in Edinburgh and London, where Franklin, appreciative of Rush's republican inclinations but ignorant of his personal criticisms, provided him with introductions to various supporters of the colonies' cause.⁷³ By the time of his return home, Rush was a confirmed rebel.⁷⁴

67. *Id.* at 267.

68. *Id.* at 244.

69. *Id.* at 373.

70. *See* HAWKE, *supra* note 28, at 372.

71. *Id.* at 134.

72. *Id.* at 39–40.

73. *Id.*

74. *Id.* at 76.

His first public efforts to provoke separation came in response to the Tea Act (1773), which he opposed in a series of essays.⁷⁵ His advocacy of a substitute beverage made of white-oak twigs and myrtle leaves,⁷⁶ though published pseudonymously, put him in touch with other pamphleteers.⁷⁷ Over the next two years, as delegates for both the First and Second Continental Congresses, along with other agitators for independence, convened in Philadelphia, Rush freely circulated among them, sharing gossip and encouraging their efforts.⁷⁸ In the process Rush formed two notable alliances: The first was with John Adams, whom he met while attempting to warn the Massachusetts delegation of the royalist inclinations of its Pennsylvania counterpart;⁷⁹ the other was with Thomas Paine, whose great work, *Common Sense*, was conceived in conversation with Rush.⁸⁰

But Rush's great contribution at this time was his coup of the Pennsylvania delegation. Of the colonies represented in the Second Congress, most delegations favored independence, but Pennsylvania's definitely did not.⁸¹ In concert with a band of other political outsiders, radical democrats all, Rush obtained an electoral victory that resulted in an exceedingly democratic constitution for Pennsylvania and, more immediately, a pro-independence congressional delegation.⁸² On July 20 Rush was elected to Congress, on July 22 he took his seat, and in August he signed the Declaration of Independence.⁸³

Rush's political career was furious but brief, ending with a characteristic indiscretion. In late 1776, Adams persuaded Rush of defects in Pennsylvania's

75. See HAWKE, *supra* note 28, at 109–11.

76. *Id.* at 110–11.

77. *Id.* at 111.

78. *Id.* at 118, 130.

79. *Id.* at 131.

80. *Id.* at 137–39.

81. Lyman H. Butterfield, *Benjamin Rush, the American Revolution and the American Millennium*, in *PHYSICIAN SIGNERS OF THE DECLARATION OF INDEPENDENCE* 26–29 (Science History Publications 1976).

82. HAWKE, *supra* note 28, at 142–43; see also Butterfield, *supra* note 81, at 33–37.

83. HAWKE, *supra* note 28, at 163–64; see also Butterfield, *supra* note 81, at 37.

new constitution.⁸⁴ Rush lost no time in criticizing the document and, when his term expired in February 1777, his erstwhile allies saw no need to send him back.⁸⁵ Rush never again held elective office.

Rush's abandonment of, or eviction from, electoral politics did not, however, dampen his enthusiasm for the republican project, broadly conceived. If anything, his political fall led him to redouble his efforts to inculcate republican virtue in the nascent nation.

Rush, as with his friend and fellow republican, Thomas Jefferson, was in awe of the importance and uniqueness of the American experiment and strove mightily to effect its success. As Rush declared in a letter to Richard Price, independence was but the "first act of the great drama."⁸⁶ The second should, he hoped, present "a revolution in our principles, opinions, and manners so as to accommodate them to the forms of government we adopted."⁸⁷ With the political project thus conceived, Rush's absence from the legislative fray presented no detriment whatsoever to him or his ambitions. From the early 1770s until his death in 1813, the vigor of Rush's deeds matched the earnestness of these words.

Many of his activities were typical of the stereotypical republican busybody. His earliest writings (initially pseudonymous,⁸⁸ later signed⁸⁹) inveighed against the slave trade, but he soon directed his wrath at the evils of alcohol⁹⁰

84. HAWKE, *supra* note 28, at 163–64 (Rush recorded Adams' reaction: "Good God! [T]he people of Pennsylvania in two years will be glad to petition the crown of Britain for reconciliation in order to be delivered from the tyranny of their constitution.").

85. *Id.* at 187.

86. Letter from Benjamin Rush to Richard Price (May 25, 1786), in 1 LETTERS OF BENJAMIN RUSH 388 (Lyman H. Butterfield ed., Princeton Univ. Press, 1951).

87. *Id.*

88. *See, e.g.*, BENJAMIN RUSH, AN ADDRESS TO THE INHABITANTS OF THE BRITISH SETTLEMENTS IN AMERICA, UPON SLAVE-KEEPING (1773), *reprinted in* THE SELECTED WRITINGS OF BENJAMIN RUSH, 3–18 (Dagobert D. Runes ed., Philosophical Library 1947); HAWKE, *supra* note 28, at 103.

89. HAWKE, *supra* note 28, at 260.

90. RUSH, AGAINST SPIRITUOUS LIQUORS (1782), *supra* note 86, 270–73; HAWKE, *supra* note 28, at 260; BENJAMIN RUSH, THE DRUNKARDS EMBLEM, OR AN ENQUIRY INTO THE EFFECTS OF SPIRITUOUS LIQUORS UPON THE HUMAN BODY, AND THEIR INFLUENCE UPON THE HAPPINESS OF SOCIETY (1784); HAWKE, *supra* note 28, at 303.

and tobacco.⁹¹ He also worked, largely successfully, to create social institutions. Some were charitable in nature, like the Philadelphia Dispensary, a day clinic for the city's poor,⁹² but others were more programmatically didactic, seeking to form young people into "republican machines."⁹³ The most successful of such ventures was the founding in the mid 1780s of Dickinson College for Pennsylvania's Anglophones and Franklin College for the German-speaking.⁹⁴ But he also canvassed for broad and early education throughout the Commonwealth⁹⁵ (women not excepted),⁹⁶ as well as for the creation of a federal university.⁹⁷ Rush even lobbied those who did hold elective office for a reform of Pennsylvania's penal code, notably resulting in a reduction of the number of capital crimes and the elimination of public punishment.⁹⁸ He also tried his hand at industrial chemistry during the war itself, developing a method of producing saltpeter from tobacco stalks.⁹⁹ Suffice it to say that over the course of Rush's relatively long life there was no project for nurturing republican souls for the democratic state that did not at some point engage this preternaturally political man.

91. BENJAMIN RUSH, *Observations on the Influence of the Habitual Use of Tobacco upon Health, Morals, and Property* 155 (1798), in BENJAMIN RUSH, *ESSAYS: LITERARY, MORAL, AND PHILOSOPHICAL* (Michael Meranze ed., Union College Press 1988); HAWKE, *supra* note 28, at 369.

92. HAWKE, *supra* note 28, at 320–22.

93. RUSH, *Of the Mode of Education Proper in a Republic*, *supra* note 91, at 9 ("I consider it . . . possible to convert men into republican machines.").

94. HAWKE, *supra* note 28, at 283–319.

95. RUSH, *A Plan for Establishing Public Schools in Pennsylvania, and for Conducting Education Agreeably to a Republican Form of Government*, *supra* note 91, at 1; HAWKE, *supra* note 28, at 331–33.

96. RUSH, *Thoughts upon Female Education, Accommodated to the Present State of Society, Manners, and Government, in the United States of America*, *supra* note 91, at 44; HAWKE *supra* note 28, at 333–34.

97. HAWKE, *supra* note 28, at 342.

98. *Id.* at 362–66.

99. Benjamin Rush, *An Account of the Manufactory of Salt-Petre*, in *SEVERAL METHODS OF MAKING SALT-PETRE* (Benjamin Edes, ed., 1775); HAWKE, *supra* note 28, at 127.

V. BENJAMIN RUSH: REPUBLICAN PHYSICIAN

<p>There was a London doctor Who searched the starry skies And gathered from the planet That poplar helped the eyes, That clary took out splinters And borage cleansed the skin; And borage grew at Deptford And clary by Gray's Inn.</p>	<p>For plague he gave star-thistle, For gout the garden bean (Star-thistle, and in plenty, Spring up on Mile End Green); And lilies-of-the-valley Were comforting and mild And helped the vital spirits And grew at Hampstead wild.</p>
<p>The victim of the vapours He dosed with hellebore; He made up buck's-horn plantain The agued to restore; In Tothill Fields he found it (Or "Tuttle," as he spells), And juniper at "Dulledge" Beside "the New-found Wells."</p>	<p>He served his generation Till 1654, Culling his easy simples Where we shall see no more; But many a London doctor Would find life pretty thin If borage grew at Deptford And clary by Gray's Inn.¹⁰⁰</p>

Rush was energetic and effective in the promotion of republican politics, morals, and science, but his most distinctive contribution to the republican project was his attempt to recast the nature and practice of medicine in the new nation. Here Rush joined his political and moral anxieties for democratic rule with his scientific pretensions to craft a genuinely American understanding of the nature of his fellow citizens' diseases and the proper social relations necessary for their cure.

100. Annon., PUNCH, OR THE LONDON CHIAVARI, Aug. 7, 1929, at 159, *reprinted in* W. Buchanan, Nicholas Culpeper, *Physick for Rheumatics*, 14 *CLINICAL RHEUMATOLOGY* 81, 85 (1995). Culpeper, an English apothecary and radical republican, thrived during the Cromwellian Interregnum by providing low-cost herbal pharmaceuticals and medical information directly to the common people. One of his most audacious acts was the translation from Latin into English of the PHARMACOPOEIA LONDONESIS, the London College of Physician's medicinal guidebook. Not merely a translation, Culpeper's work added commentary on the various drugs' inefficacies and the superiority of his herbal treatments. He followed this with, among other things, a book on midwifery and his great work, THE ENGLISH PHYSITIAN. Not surprisingly, he was hated by the physicians' guild but, with the abolition of the star chamber, his competition was unable to prosecute him. *See generally* BENJAMIN WOOLLEY, *HEAL THYSELF: NICHOLAS CULPEPER AND THE SEVENTEENTH-CENTURY STRUGGLE TO BRING MEDICINE TO THE PEOPLE* (HarperCollins 2004).

The first thing to recognize about Rush's medical theories is his belief that a man's health is dependent on the quality of his nation's social order. The citizens of simple, orderly, and pious democracies had few diseases; the subjects of complex, disorderly, and impious monarchies had many. There is, Rush asserted, "an indissoluble union between moral, political and physical happiness," all of which are fostered by "elective and representative governments."¹⁰¹ For proof, one need only observe that the world's healthiest people are the citizens of "the enlightened and happy state of Connecticut," where "republican liberty has existed above one hundred and fifty years."¹⁰²

Rush's understanding of this dynamic is nicely presented in an early (1774) essay, *An Inquiry into the Natural History of Medicine among the Indians of North America and a Comparative View of their Diseases and Remedies with those of Civilized Nations*.¹⁰³ Indians, on account of their social simplicity, suffered from few disorders, mostly fevers,¹⁰⁴ which were easy both to identify and to treat with strong and effective remedies,¹⁰⁵ principally sweating, purging, emetics (described by Rush as "vomits"), bleeding, and topical caustics.¹⁰⁶ In contrast to the Indians were modern Europeans, whose dissolute and ever-changing ways had multiplied their diseases.¹⁰⁷ Dr. Cullen, Rush's Scottish teacher, had identified 1387 illnesses, a number that would surely grow as each generation devised its own perversions.¹⁰⁸ But the choice between civilization and salubrity need not be so stark. The simple, republican mores of

101. RUSH, LECTURES ON ANIMAL LIFE, *supra* note 88, at 133, 168.

102. *Id.*

103. BENJAMIN RUSH, *An Inquiry into the Natural History of Medicine among the Indians of North America and a Comparative View of Their Diseases and Remedies with Those of Civilized Nations*, in 1 MEDICAL INQUIRIES AND OBSERVATIONS 55 (4th ed., Griggs and Dickinson Printers 1815).

104. *Id.* at 64.

105. *Id.* at 68.

106. *Id.* at 67–68.

107. *Id.* at 72.

108. *Id.* at 74.

the Pennsylvanians of old, Rush concluded, provided evidence that men could enjoy the fruits of civilization in good health.¹⁰⁹

But this blessed state of political affairs and corporeal health was not, alas, enjoyed by Americans in the Revolutionary era. As we might say: That was then; this is now. Admittedly, the war itself brought numerous benefits to advocates of freedom, including marital fecundity, cheerfulness, and general health,¹¹⁰ as well as detriments to royalists, notably a fever known as “revolutiana”¹¹¹ and a derangement called “tory rot.”¹¹² But freedom also brought a destabilizing increase in the number and objects of ambition,¹¹³ resulting in “anarchia,” a mental illness afflicting those whose imaginations were inflamed by post-war liberty.¹¹⁴

Of even greater concern to Rush was the political revolution’s failure to reverse America’s acquisition of British mores and, therewith, British diseases. Rush pointed out as early as 1774 that the bills of mortality from American hospitals had come to resemble their English counterparts: “All these diseases have been produced by our having deserted the simple diet and manners of our

109. RUSH, *An Inquiry into the Natural History of Medicine among the Indians of North America and a Comparative View of Their Diseases and Remedies with Those of Civilized Nations*, *supra* note 103, at 55, 85–86 (“The food of the inhabitants was then simple; their only drink was water; their appetites were restrained by labour; religion excluded the influence of sickening passions; private hospitality supplied the want of a public hospital; nature was their only nurse, and temperance their principal physician.”).

110. RUSH, *An Account of the Influence of the Military and Political Events of the American Revolution upon the Human Body*, *supra* note 103, at 125, 131–32; *see also* RUSH, *On the Influence of Physical Causes in Promoting an Increase of the Strength and Activity of the Intellectual Faculties of Man*, *supra* note 44, at 110 (describing salutary effects of Revolution).

111. RUSH, *An Account of the Influence of the Military and Political Events of the American Revolution upon the Human Body*, *supra* note 103, at 133–34.

112. BENJAMIN RUSH, *MEDICAL INQUIRIES AND OBSERVATIONS UPON DISEASES OF THE MIND* 114 (Hafner Publishing Company 1962) (1812).

113. *Id.* at 66.

114. RUSH, *An Account of the Influence of the Military and Political Events of the American Revolution upon the Human Body*, *supra* note 103, at 134; *see also* RUSH, *Lectures on Animal Life*, *supra* note 88, at 169 (speculating over the issuance of scrip by the bank of the United States caused madness and death).

ancestors.”¹¹⁵ The consequent task for America, as Rush conceived it, was to recapture its lost moderation: “America has advanced but a few paces in luxury and effeminacy. There is yet strength enough in her vitals to give life to those parts which are decayed. She may tread back her steps.”¹¹⁶ The post-war challenge for Rush and his fellow republicans was, therefore, to walk America home and, thereby, restore her people’s health.

In the years that followed the war, Rush strove vigorously to accomplish that great task in a multitude of ways. Many were programmatically republican: Working at the level of high politics, he advocated constitutional revisions to perfect both state and national polities and, laboring in the vineyard of social reform, he sought to reestablish the social sway of pre-Georgian manners through his pro-education and anti-slavery activities. He also engaged in a number of enterprises more cognizable to modern public-health censors, namely, his attacks on alcohol, tobacco, and urban sweatshops, as well as his efforts to improve city sanitation¹¹⁷ and warn citizens of water-borne dangers.¹¹⁸ There is no task here that one cannot easily imagine Thomas Jefferson, Benjamin Franklin, David Rittenhouse, or anyone else from their circle undertaking with alacrity.

In another respect, however, Rush’s exertions were idiosyncratic in the extreme: To restore America’s health he undertook a project no less ambitious than the reinvention of medicine itself. Its science, presently characterized by great complexity, could and should be simplified. This leaner, more capacious art would be taught to the American people, who could, with greater success than the learned physician, self-administer proper remedies. No longer would expert doctors be needed to persuade recalcitrant patients to take unpalatable medicines. Instead, strong and self-aware sufferers would promptly identify their own maladies and eagerly heal themselves. Physicians, practically speaking, would disappear and the people would not suffer from their absence.

To appreciate the radical character of Rush’s programme, it is important to understand, as a preliminary matter, what Rush saw as the two fundamental defects of American medicine. The first was medical science’s unnecessary complexity; the second was the patient’s frequent failure to comply with even

115. RUSH, *An Inquiry into the Natural History of Medicine Among the Indians of North America and a Comparative View of Their Diseases and Remedies with Those of Civilized Nations*, *supra* note 103, at 84–85.

116. *Id.* at 88.

117. HAWKE, *supra* note 28, at 322.

118. *Id.* at 241.

the wisest order. In combination, these features rendered medicine ineffective at best and dangerous at worst.

The basic problem with the science of medicine, as propounded by Benjamin Rush's contemporaries, was that it was just too difficult. Part of this complexity was a function of physicians' social conventions and could easily be altered. Examples are the profession's use of Latin for the publication of its discoveries¹¹⁹ and the connection of medicine with such useful but otherwise medically irrelevant disciplines as mathematics.¹²⁰

But another medical complexity, the multiplicity of diseases afflicting the American people, presented a more serious challenge, if only because it took on an undeniably physical manifestation. As with their British cousins, late-eighteenth-century Americans suffered from a large number of diseases. Although the count was not yet 1387, the number was climbing because of America's mimicry of England's bad manners. In response to this multiplication, physicians (both here and in Europe) engaged in the exercise of "nosology," the classification, with Linnæan specificity, of all extant diseases.

However rational this practice might seem (at least from our present perspective), nosology for Rush was a positive nuisance, as it impaired both the theoretical advance and the daily practice of medicine. On a conceptual level, it was wrong because diseases both defy categorization (they mutate over time) and manifest themselves differently in different bodies.¹²¹ On a practical level, it impeded proper treatment because it diverted the physician's attention away from the patient himself. Instead of treating his condition promptly (more about this later), the nosologically minded physician focused his attention on the correct identification of the precise disease. Thus dithering, the doctor could inadvertently miss the opportunity, provided early in the course of illness, to cure the patient with ease. Nosology also encouraged the proliferation of drugs in the doctor's bag, to the confusion of apothecary, physician, and patient alike.¹²²

Compounding this complexity, in Rush's view, is another fundamental obstacle to effective medical practice: the patient's unwillingness to seek a physician's care or—in the event a doctor is called—to comply with the unpleasant prescription eventually ordered. From Rush's experience treating

119. RUSH, *Upon the Causes Which Have Retarded the Progress of Medicine, and the Means of Promoting its Certainty and Greater Usefulness*, *supra* note 44, at 141, 142.

120. *Id.* at 141.

121. *Id.* at 151.

122. *Id.*

patients, he learned the lesson common people acquire without extensive and expensive medical training: Going to the doc ain't no fun. A physician's visit requires, at the very least, that the patient disrobe before him, a necessity which, for many prospective patients, serves as an insuperable bar to seeking treatment. This apprehension, Rush frequently notes, particularly afflicts women, whose "excess of delicacy" disposes them to "conceal the nature and seats of their diseases."¹²³ But the physician's company can also and, in fact, usually does lead to far greater invasions. Some are merely uncomfortable, like the blistering induced by the topical application of caustic substances.¹²⁴ Others are degrading, like the clyster, an enema discharged into the colon by means of a large metal syringe.¹²⁵ Yet others are nauseating, like jalap, a strong purgative prepared from the roots of *Ipomæa purga*, a plant whose common name is derived from the Mexican city of Xalapa (think jalapeño).¹²⁶ And the most effective remedy, blood-letting, Dr. Rush's favorite, is downright terrifying.¹²⁷

The immediate consequences are not hard to predict. For starters, Rush noted, patients are slow to summon the doctor, waiting, instead, until the symptoms become severe. This is pernicious rather than prudent, as most illnesses, Rush believed, could be cured if treated "in the *forming* state of the disease."¹²⁸ But, even if patients have the foresight to call the doctor early on, they nonetheless lack the fortitude to comply with his orders. In many cases, where the treatment is generally administered by the doctor or his apprentice, like bleeding or the clyster, patients simply refuse.¹²⁹ And in many others,

123. RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 65, 79.

124. See HAWKE, *supra* note 11, at 242.

125. See RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 75. Rush found objection to the clyster particularly mischievous, "from its disguising itself under the apparent dictates of judgment." *Id.* One of the most common substances discharged via the clyster was tobacco smoke, designed to revive fainting women, giving rise to a vulgar phrase involving the stimulating upward blowing of smoke.

126. See HAWKE, *supra* note 11, at 374.

127. See RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44 at 75.

128. *Id.* at 73–74; see also RUSH, *On the Duties of Patients to Their Physicians*, *supra* note 44, at 318, 320, 327 (1811).

129. See RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 74.

where medication is left with the patient for later consumption, it is often found untouched, near the deceased, “upon a mantle-piece, or in the drawers of a dressing table.”¹³⁰ Rush recounts with scorn the behavior of one patient, who, when asked whether the prescribed medicine had been taken, told his doctor: ““If I had, I should certainly have broken my neck, for I threw it out of my window.””¹³¹

This sort of behavior, Rush lamented, had often provoked him to wish that tombstone epitaphs would record, in addition to the deceased’s virtues, the cause of their deaths, if arising from their “refusal or neglect . . . to comply with the prescriptions of their physicians.”¹³² “Here lies the body of A. B.,” one such plinth would read, “who died because he refused to be bled.”¹³³ Another would declare: “Here lies the body of C. D. who died because he refused to submit to a gentle course of mercury.”¹³⁴

But Rush identified yet another, more subtle, consequence of this fear: physician pandering to patient prejudice. The proper remedy in most circumstances, Rush firmly believed, is uncomfortable at best. His favorites were blood-letting, purgatives, and emetics, but he also liked sweating and blistering.¹³⁵ Many of his colleagues agreed with him, Rush supposed, but declined to prescribe these treatments for fear of patient refusal. This phenomenon, Rush insisted, was illustrated by the practice of Dr. Thomas Sydenham, a towering medical authority from the seventeenth century.¹³⁶ Like Rush, Sydenham’s prescriptions sought to restore vigor by evacuations, his favorite compound being made of “bark [a quinine preparation whose active ingredient was extracted from the bark of the Peruvian cinchona tree], opium, and mercury.”¹³⁷ But Sydenham, to Rush’s disapproval, “frequently prescribed

130. *Id.*

131. *Id.* at 75.

132. *See* RUSH, *On the Duties of Patients to Their Physicians*, *supra* note 44, at 324.

133. *Id.* at 325.

134. *Id.*

135. RUSH, *On the Character of Dr. Sydenham*, *supra* note 44, at 50.

136. *Id.* at 51.

137. *Id.* at 42, 50–51.

medicines of less efficacy” as “peace offerings to the prejudices of his patients.”¹³⁸

Rush’s contemporaries also pulled their punches. Responding to patient demand, physicians easily become, Rush charged, “apothecaries of their patients,”¹³⁹ “study[ing] more to please than to cure.”¹⁴⁰ “Downy doctors,” they should be called, “who prescribe for the whims of their patients, instead of their disease.”¹⁴¹ Even when the gentle treatment is the more effective one, Rush still found cause to complain. He condemns, for instance, the Philadelphia physician who first deviated from the traditional Suttonian method of smallpox inoculation, which involved anticipatory mercury purges followed by infection through a “deep incision in the arm.”¹⁴² The novel method (developed by Edward Jenner) prepared the patient only with “purges and low diet” and a “small puncture.”¹⁴³ Though admittedly an “improvement,” Rush assailed the introduction for having been “happily calculated to seize upon the feelings of the female sex, who govern much more than men in the choice of a physician.”¹⁴⁴

Rush, too, proved himself susceptible to this temptation in certain circumstances. In one of his late works, *Medical Inquiries and Observations on the Diseases of the Mind*, he describes the difficulty of administering mercury to patients “in the state of madness.”¹⁴⁵ Because they cannot be “compell[ed] . . . to take mercury in any of the ways in which it is usually administered,” Rush obtained compliance by “sprinkling a few grains of

138. *Id.* at 51.

139. See RUSH, *Causes Which Have Retarded the Progress of Medicine*, *supra* note 44, at 149.

140. RUSH, *On the Vices and Virtues of Physicians*, *supra* note 44, at 120, 127 (1811).

141. *Id.* at 127.

142. RUSH, *On the Means of Acquiring Business and the Causes Which Prevent the Acquisition, and Occasion the Loss of It, in the Profession of Medicine*, *supra* note 44, at 222, 244.

143. *Id.*

144. *Id.*

145. RUSH, *supra* note 112, at 199.

calomel [mercury chloride] daily upon a piece of bread, and afterwards spreading over it a thin covering of butter.”¹⁴⁶

The combined effect of these two problems, theoretical complexity and patient fecklessness, was, in Rush’s view, dangerous to patient health: Doctors were slow to treat and patients were loath to comply. As Rush noted, “[t]he neglect in patients to make use of the remedies of their physicians, at the *time*, and in the *manner*, in which they were prescribed, is a frequent cause of death in curable diseases.”¹⁴⁷ One might correctly observe that this situation might not be so bad for the patient. After all, if the prescription is wrong, or simply untimely, the patient might be better off for his failure to follow orders. (The author is reminded here of the illogic of Hobbes’ culinary complaint: If the pub’s food is rodent-gnawed, burnt, salty, and rancid, why be upset, too, that the portions are small?) But Rush was, if anything, an optimist, and expended much of his professional energy toward the creation of a better medical art for the American people, one in which the sick would be healed by the faithful administration of treatments prescribed pursuant to timely and correct diagnoses. To achieve this effect, Rush proposed, not surprisingly, to reconstruct those two features that vexed late-eighteenth-century medicine (as he contemporaneously viewed its condition): diagnostic complexity at the core of medicine’s science and social resistance to effective treatment.

Rush’s first and predicate task was the simplification of medical science itself. As noted above, Rush decried the practice of nosology, not least because the doctor’s search for a precise diagnosis of the patient’s disease delayed prompt and effective treatment. On its face, this critique of nosology seems absurd. How can any reasonable doctor proceed to treat if he does not know what he is treating? Is not this basic information absolutely necessary? Ready, fire, aim. Strangely enough, Rush did not think precise diagnoses particularly useful. For him there was, practically speaking, only one diagnostic variable, the irritation of the nerves and blood vessels, and only two treatments, stimulation and evacuation. How could this be?

To understand, one must briefly step back to the world of Hippocrates and his mediæval descendants. For most of Western history, all disease had been viewed as a manifestation of an imbalance of the body’s four “humors”: blood, phlegm, black bile, and yellow bile. The goal of treatment was, therefore, to restore this balance, usually by introducing a lacking element or expelling an

146. Rush writes that, in treating “deranged patients a physician’s directions for discontinuing painful or disagreeable remedies, and all his pleasant prescriptions, should be delivered in the presence of his patients; while all such as are of an unpleasant nature, should be delivered only to their keepers.” *Id.* at 180.

147. See BENJAMIN RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 75.

overwhelming one. Thus conceived, a physician's treatment options were relatively limited. A doctor could, without extensive tests and consultations, effect a diagnosis and prescribe a treatment.

Viewed from this perspective, one can appreciate the therapeutically incapacitating consequence of a nosological view of disease. True, it presents to practitioners the promise of greater precision, in both diagnosis and treatment, but it simultaneously increases their options. While some doctors might be sufficiently capacious to master the complexities of the new system, Rush feared that many could not. Nor was such an attainment actually necessary, since attention to, and treatment of, the symptoms of humoral imbalance was all that a conscientious doctor need do. And the sooner the better, as it was an action impeded by diagnostic dithering.

But Rush was not arguing for a return to a conventional humoral understanding of the body and its ills. His proposal was more radical yet. Drawing upon the work of his Scottish teachers,¹⁴⁸ Rush postulated that illness was a function of but one variable, the irritation of the body's nerves and blood vessels, which he compared to the unity of God ("the multiplication of disease . . . is as repugnant to truth in medicine . . . as polytheism is to truth in religion") and the elemental unity of "water, dew, ice, frost, and snow."¹⁴⁹

And with this one variable there were but two therapeutic options, stimulation or agitation, to achieve the goal of moderate tone. When the vessels were overly agitated, they needed to be calmed and when overly calm, they needed to be agitated. With illness thus conceived, treatment was significantly simplified. All that a doctor really needed to do was ascertain the state of irritation (by taking the patient's pulse), select the appropriate stimulant or depressant, and determine the dosage and timing of its administration.¹⁵⁰

The remaining questions focus, then, around medication: Which agent, how much, and when? Unsurprisingly, here, as before, Rush radically simplifies: strong, large, and soon. The best agent should be powerful, so that its effects might be readily observed and replaced, if need be, with an even stronger medication.¹⁵¹ So-called "lenient and safe medicines" should be abjured in

148. J. WORTH ESTES, A MELANCHOLY SCENE OF DEVASTATION: THE PUBLIC RESPONSE TO THE 1793 PHILADELPHIA YELLOW FEVER EPIDEMIC 1, 9 (J. Worth Estes & Billy G. Smith, eds., Science History Publications 1997).

149. BENJAMIN RUSH, *An Account of the Bilious Remitting Yellow Fever, as It Appeared in Philadelphia in 1793*, in 3 MEDICAL INQUIRIES AND OBSERVATIONS 37, 49 (1815).

150. RUSH, LECTURES ON ANIMAL LIFE, *supra* note 88, at 177.

151. RUSH, *Observations on the Duties of a Physician, and the Methods of Improving Medicine*, *supra* note 103, at 262–63 (Feb. 1789).

favor of “efficient remedies.”¹⁵² His own personal favorites were jalap and calomel, both powerful purgatives, accompanied by the letting of blood. Nor should the dosing be gentle. The “means” of cure, he noted, must accommodate the “ends.”¹⁵³ In treating yellow fever (more below), Rush increased the typical one-time dosage of ten grains each of calomel and jalap to ten and fifteen respectively, administered thrice at six-hour intervals.¹⁵⁴ Further, Rush believed that only rarely should medication be sweetened, for the “Author of Nature” made medicines unpalatable to prevent them from “becoming articles of diet” and thus “los[ing] their efficacy.”¹⁵⁵ Finally, all of this should occur as soon as possible so as to arrest the disease’s development in its formative stage.¹⁵⁶

Having thus simplified and fortified medicine, Rush moved to the logical conclusion of his premises: He took the daily practice of medicine from the physicians and handed it to the patients themselves. Medicine, having been “strip[ped]” of “mystery and imposture” and “clothe[d]” in “simple and intelligible” garments, would be added to the curriculum of “all” the new republic’s “seminaries of learning.”¹⁵⁷ There the “few” and “plain” principles of medicine would be easily taught and quickly learned.¹⁵⁸ The tools for the preservation of health (clothing, nutrition, and exercise) would be apprehended “with as much ease as the multiplication table.”¹⁵⁹ The knowledge necessary to read the pulse would be “acquired at a less expense of time and labour” than is

152. RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 69.

153. *Id.* at 71.

154. RUSH, *supra* note 149, at 128–30.

155. RUSH, *Observations on the Duties of a Physician, and the Methods of Improving Medicine*, *supra* note 103, at 263.

156. RUSH, *On the Causes of Death, in Diseases That Are Not Incurable*, *supra* note 44, at 73.

157. RUSH, *Causes Which Have Retarded the Progress of Medicine*, *supra* note 44, at 154.

158. *Id.* at 155.

159. *Id.*

wasted on “committing the contents of the Latin grammar to memory.”¹⁶⁰ The practice of bleeding “might be taught with less trouble” than “teach[ing] boys to draw, upon paper or slate, the figures in Euclid.”¹⁶¹ And the properties of medicines would be acquired with greater facility “and much more pleasure than the rules for composing logical syllogisms.”¹⁶² “Millions of lives would be saved” by educating the people themselves to maintain their own health.¹⁶³

Rush acknowledged, of course, certain limits to this delegation. Specially trained physicians would always be necessary to treat victims of “[c]asualties which render operations in surgery necessary” and to diagnose “such diseases as occur rarely.”¹⁶⁴ But even then, the training would be simple, as “the knowledge that is necessary for these purposes may be soon acquired.”¹⁶⁵ Nor would the public’s need for such specialists be terribly great, as “two or three persons, separated from other pursuits, would be sufficient to apply it to a city consisting of forty thousand people.”¹⁶⁶

For all intents and purposes physicians would cease to exist in the new republic. Virtuous citizens, understanding their needs and their tools, would apply the latter to the former, expeditiously and bravely, and live.

VI. THE BILIOUS REMITTING YELLOW-FEVER EPIDEMIC OF 1793

At no time in the late eighteenth century was Philadelphia a model of public health. In spite of Dr. Rush’s best efforts to cover polluted streams, guard the water supply, and clean the streets, the young nation’s capital remained a marshy, dirty, smelly, and, most important, sickly city. So unhealthy was it, in fact, that its residents and physicians bore a perennial expectation that the hot, humid, but rain-free month of August would bring with it a bout of epidemic

160. *Id.*

161. *Id.*

162. *Id.* at 155–56.

163. RUSH, *Causes Which Have Retarded the Progress of Medicine*, *supra* note 44, at 156.

164. *Id.*

165. *Id.*

166. *Id.*

disease, generally known as “autumnal fever.”¹⁶⁷ (Not excepted was Rush, who sent his wife and their many children to summer, every summer, at her parents’ estate in bucolic Princeton.) But not all “autumnal fevers” were equal, in the experience of the city’s inhabitants. As predictable as was their occurrence, their ferocity could not be anticipated. In some years the fever’s effects were slight, in others harsh, but come they did. The resultant annual challenge for the city’s physicians was to identify that year’s disease so that they might properly treat it and, it was hoped, successfully cure its victims.

But the fever that struck in 1793 overwhelmed the city’s physicians, both diagnostically and therapeutically. As with all epidemics, recognition of this plague’s uniqueness came slowly, with individual doctors treating their respective patients for the first few weeks, unaware of the emerging larger problem. The dots were connected, however, on the evening of August 19, when Rush was summoned to a residence on Water Street, near the docks, to consult with two of his colleagues regarding the treatment of a prosperous merchant’s wife. Rush observed her extraordinarily high fever, accelerated pulse, frequent vomiting, and yellow eyes and skin; he further noted its likeness to cases he had recently treated in the same part of the city. The other two doctors recounted other similar cases in recent weeks, also near the docks. They also told him of the dumping, at the end of July, of a load of spoiled coffee on a wharf not far from the merchant’s house. This final revelation led Rush to his conclusion: The rotting coffee had brought the “bilious remitting yellow fever” to Philadelphia, its first appearance since 1762. Never reluctant to speak his mind, Rush shared his conclusion as to both the identity and origin of the illness with his colleagues that evening, to many others in the following days, and to the public in a newspaper article printed August 29.

Attaching a name to a disease is one thing, curing it is another, and even Rush, a man abounding with answers, did not know how to treat this one. With his first few patients, Rush administered gentle purges, the same treatment he had applied when apprenticed to Dr. Redman in 1762, but now found them ineffectual and gave them up after a few tries. In his next attempt he used a gentle emetic, syrup of ipecac (made from the root of the Brazilian *Psychotria ipecacuanha*), on the first day of the fever, followed by “the usual remedies for exciting the action of the sanguiferous system,” bark, wine, brandy, and “aromatics,” along with blistering of the “limbs, neck, and head.” When these did not work, he “attempted to rouse the system by wrapping the whole body . . . in blankets dipped in warm vinegar.” Finally, he tried rubbing the right side with mercurial ointment, hoping thereby to “excit[e] the action of the vessels in the whole system through the medium of the liver.”¹⁶⁸ Frustrated that his

167. Martin S. Pernick, *Politics, Parties, and Pestilence: Epidemic Yellow Fever in Philadelphia and the Rise of the First Party System*, 29 WM. & MARY Q. 559 (1972).

168. RUSH, *supra* note 149, at 125.

patients were still dying, Rush consulted with Dr. Edward Stevens, a physician from St. Croix, who recommended a somewhat different set of stimulating, or “tonic,” treatments: bark, wine, and cold baths.¹⁶⁹

Rush shortly concluded, however, that these treatments were no better than his own.¹⁷⁰ Frustrated by his failures and alarmed by the furious spread of the disease, Rush “ransacked” his library in search of any information that might help.¹⁷¹ What he discovered, after much searching, was Dr. John Mitchell’s account of the 1741 yellow-fever epidemic in Virginia. Mitchell’s recommendation of early evacuations, principally purges, to relieve the “irritation of [the digestive tract’s] stimulus,” in spite of the weak pulse, comported well with Rush’s observations and frustrations.¹⁷² Rush had seen the low pulse as an indicator of a depressed state and had, accordingly, attempted to stimulate the patient’s system, to no avail. Mitchell’s account suggested, rather, that the low pulse, in the case of this fever, obscured the body’s otherwise agitated state. Rush thereupon “adopted [Mitchell’s] theory and practice,” needing only the appropriate evacuant.¹⁷³

The necessary treatment, Rush decided, was a strong one. Out of hand he dismissed the gentle laxatives used on his first few patients, owing to the drugs’ “feebleness.” Rush initially tried a stronger preparation, a combination of ten grains of calomel and another ten of jalap, a dosage he had as a young man regarded as disproportionately “violen[t] and danger[ous],”¹⁷⁴ but he soon increased the jalap to fifteen grains.¹⁷⁵ The entire compound was administered thrice at six-hour intervals, until it “procured four or five large evacuations.”¹⁷⁶

169. *Id.*

170. *Id.* at 126.

171. *Id.*

172. *Id.* at 127–28.

173. RUSH, *supra* note 149, at 128.

174. *Id.* at 128–29.

175. *Id.* at 129.

176. *Id.*

Its results “not only answered, but far exceeded [Rush’s] expectations,” curing “four out of the first five patients” to whom he gave it.¹⁷⁷

Rush was not content, however, with his initial success and soon added other remedies “to abstract excess of stimulus” from his patients’ systems.¹⁷⁸ These treatments—“blood-letting, cool air, cold drinks, low diet, and applications of cold water to the body”—were those suggested also by Dr. Mitchell’s depletitive theory.¹⁷⁹ Particularly useful was bleeding, which Rush effected at regular intervals.¹⁸⁰ Overjoyed, Rush publicized his treatment, first in a letter on September 3 to the College of Physicians,¹⁸¹ but also in printed directions to the city’s apothecaries when requests for his services overwhelmed his apprentices¹⁸² and in the newspapers, for all to read and follow.¹⁸³

All things considered, Rush’s accomplishments were remarkable. In several weeks’ time he had figured out that a terrible plague had come upon the city, that the disease was yellow fever, that it had been caused by rotting coffee beans, and that it could be cured by means of an aggressive purgative regimen. This was, all in all, too good to be true.

Indeed it was. Yes, effects of the disease became disastrous and, yes, it was yellow fever, but, from what we now know about the disease, Rush misunderstood both the origin and proper treatment. Since 1901, on the basis of Walter Reed’s experiments in Cuba during the Spanish-American war, we have known that the virus is transmitted from infected to non-infected humans via the *Aedes aegypti* mosquito. (In fairness to Rush, he frequently complained of the “miasmata” rising from the city’s swamps and fetid pools, which he implicated as contributing to the epidemic.)¹⁸⁴ To this day, there is no known

177. *Id.* at 129.

178. RUSH, *supra* note 149, at 130.

179. *Id.* (original emphasis omitted).

180. *Id.* at 130–31.

181. *Id.* at 130.

182. *Id.* at 131.

183. RUSH, *supra* note 149, at 173.

184. *Id.* at 198.

treatment for the fever, other than bed rest and supportive treatment of the symptoms.¹⁸⁵ Rush was dead wrong in thinking otherwise.

For better or worse, many of Rush's fellow citizens, doctors included, did not accept any of Rush's assertions, especially regarding its origin and treatment. Rush came to his conclusion regarding the identity and cause of the disease on the evening of August 19 and proceeded to share his thoughts with anyone who would listen, first orally, then ten days later in print. His medical colleagues were not as quick to judgment, at least as a body. On August 26, the College of Physicians published its own findings in a document that failed either to name the disease or to suggest its cause.¹⁸⁶

In the meantime, an alternative explanation for the illness had emerged and was quickly gaining currency. This theory postulated that the disease had been transported to Philadelphia by the recent (mid-July) influx of Francophone refugees escaping a slave revolt in St. Domingo (now Haiti).¹⁸⁷ The proposed public-health response was to quarantine the immigrants and cease commerce with the island; the favored individual therapy was the stimulant course that Dr. Stevens, a Caribbean, had recommended to Rush: bark, wine, and cold baths.¹⁸⁸ As the plague progressed and the death toll mounted, doctors favoring this view became increasingly voluble, if only to match Rush's intensity.¹⁸⁹ In an early-September publication Dr. Adam Kuhn, for example, recommended the tropical bark-wine-bath treatment as appropriate for a tropical disease.¹⁹⁰ Dr. Stevens also weighed in, making the same positive prescription, but, in a pointed rebuttal to Rush, with a warning to avoid evacuations of all kinds.¹⁹¹

This criticism of Rush was, all things considered, relatively innocent. These doctors, with different training and experience, were doing their best to make sense of this terrifying phenomenon. To that end they offered their patients and their city their best advice. But some of Dr. Rush's critics were not so naïve. They fully recognized the political roots and ramifications of Rush's theory and

185. Estes, *supra* note 148, at 7.

186. RUSH, *supra* note 149, at 46–47.

187. *Id.* at 47.

188. *Id.* at 125.

189. *Id.* at 131.

190. *Id.*

191. RUSH, *supra* note 149, at 131

therapy and eagerly exploited the division among the city's medical fraternity to advance their own politics.¹⁹² The principal offender here was Alexander Hamilton, then Secretary of the Treasury, who in early September sent a letter to the College of Physicians ascribing his own recovery to Dr. Stevens' personally administered remedies.¹⁹³ Hamilton's letter had its anticipated effect. Rush's ideas regarding the fever's origin and cure became "Republican;" those of Drs. Kuhn, Stevens, et al. became "Federalist." From that point on, the city—patients and practitioners alike—therapeutically divided itself along party lines.

The reason for this division is readily apparent. Rush's understanding of the disease mapped nicely onto the ideology of the nascent Democratic-Republican party, if only because they shared a common source: a belief in the native origin of evil and the importance (and efficacy) of strenuous exertions to exorcize it. Politically speaking, America's ills—its lack of education, religion, sobriety, equality, etc.—were indigenous; their cure lay in the citizens' extirpation of undemocratic mores. Medically speaking, the fever's source was also native, in the city's filth, notably its rotting coffee and (later added) its fetid pools and marshes; its cure also lay in purification, both cleaning the city and purging the body. As Pogo famously noted: "We have met the enemy and he is us."

Hamilton's advocacy of the Caribbean stimulus treatment also, for its part, fit into Federalist political dogma. Crudely speaking, the Federalists saw America's debility in the weakness of the federal government relative to the states; of decidedly lesser concern was the quality of the citizens' souls. So when this terrible plague struck the nation's capital, Hamilton and his fellow Federalists saw no reason to blame Philadelphia first. The disease, they reasoned, had been brought to America's shores by foreigners (creole relations of blood-letting Frenchmen, even). And the foreign disease could be treated by the appropriately gentle foreign treatment. There was certainly no need to strike so hard, so viciously, at Americans themselves when the fault was in the stars.

Hamilton's shot was but the first. Other Federalists followed soon thereafter. Henry Knox, then Secretary of War, took aim at Rush a few days later.¹⁹⁴ Local hacks joined the fray and pursued Rush for the next half decade, led by their most persistent and effective expositor, William Cobbett.¹⁹⁵ This prickly

192. Pernick, *supra* note 167, at 568.

193. *Id.*

194. *Id.* at 574.

195. *Id.*

pamphleteer, a recent English immigrant who wrote under the name Peter Porcupine, had begun political life in America as a Jeffersonian sycophant, so initially followed Rush in ascribing to the city's unsanitary state the source of the fever, but by 1794, once the epidemic had ended, he converted to Federalism and pursued Rush with vigor.¹⁹⁶ (Some pursuers did so quite adroitly. On September 2 a certain "Medicus" complained that the rotting coffee had "made as much noise, and with equal cause, as the scratchings of the Cock Lane Ghost," noting further that the poor from Passyunk Road taken some of the coffee and brewed it up, but remained in perfect health.)¹⁹⁷

Rush was not one to shun a fight. He responded, most immediately, to Kuhn, Stevens, and Hamilton, both in correspondence to the College of Physicians and in newspaper articles, defending both his aetiological theories and therapeutic practices.¹⁹⁸ To the Federalist press he offered not only innumerable defenses of the same, but also a libel suit against Cobbett, whom he ruined in 1799 with a successful and sizable judgment.¹⁹⁹ To partisan Federalist attacks Rush responded with partisan Republican ones, with predictable results: Loyal Republicans sought out Rush's depleting therapy, even into the nineteenth century, well after its danger had been proved.²⁰⁰ Indeed, Rush famously declared, "[t]he people rule here in medicine as well as government."²⁰¹ What had begun as a serious medical inquiry quickly degenerated into a genuinely fatal Tom-and-Jerry show.

Though the plague's politicization was lamentable, at least for those Philadelphians who expired under Rush's care, it did provide him with the occasion to clarify and articulate the more subtle—and for our purposes crucial—political implications of his medical theories.

Soon after Rush announced his new therapy, he found himself overwhelmed by the public's demands on his time and resources. To avoid leaving his

196. *Id.* at 566.

197. J.H. POWELL, BRING OUT YOUR DEAD: THE GREAT PLAGUE AND YELLOW FEVER IN PHILADELPHIA IN 1793 72 (Time Inc. 1949).

198. RUSH, *supra* note 149, at 132.

199. Pernick, *supra* note 167, at 574.

200. *Id.* at 586.

201. Letter from Benjamin Rush to Julia Rush (Sept. 29, 1793), in 2 LETTERS OF BENJAMIN RUSH 687 (Lyman H. Butterfield, ed., Princeton Univ. Press 1951).

desperate would-be-patients without recourse, Rush sought to give their potential caregivers the information necessary to replicate his treatment. He initially provided it, generally via the newspapers, to other professionals—doctors and apothecaries—but soon started writing instructions directed at patients themselves.

What he witnessed was something both heartwarming and deeply confirmatory of his republican biases: The common people of Philadelphia had succeeded in saving themselves by following these minimal instructions. A Catholic priest, the “Rev. Mr. Fleming,” “carried the purging powders in his pocket, and gave them to his poor parishioners with great success.”²⁰² John Keihmle, a “German apothecary,” cured all but 47 of his 314 patients.²⁰³ Two ordinary women, “Mrs. Paxton” and “Mrs. Evans,” were “indefatigable[,] the one in distributing mercurial purges composed by herself, and the other in urging the necessity of *copious* bleeding and purging among her friends and neighbors.”²⁰⁴ The Reverends Absalom Jones and Richard Allen—two free blacks and founders of what is now the African Methodist Episcopal Church, who courageously organized the city’s nursing care and burials after many whites had fled—bled and purged their charges, “agreeably to the directions which had been printed in all the newspapers.”²⁰⁵ Rush found particularly gratifying the account of Widow Long, who, “after having been twice unsuccessful in her attempts to procure a physician, undertook at last to cure herself,” taking “several of the mercurial purges, agreeably to the printed directions, and had herself bled *seven* times in the course of five or six days.”²⁰⁶ Even without formal education in the rudiments of medical science, good republican citizens were capable of self-diagnosis and, more critically, self-treatment with the most powerful weapons in the medical profession’s armamentarium.

Rush’s conclusion should not surprise: “[I]t is time to take the cure of pestilential epidemics out of the hands of physicians, and to place it in the hands of the people.”²⁰⁷ The reasons for such were apparent from the recent

202. RUSH, *supra* note 149, at 172.

203. *Id.* at 172.

204. *Id.* at 173 (emphasis in original).

205. *Id.*

206. *Id.* at 174 (emphasis in original).

207. RUSH, *supra* note 149, at 174.

epidemic. Not only are medical personnel in short supply (due, not least, to their “desertion, sickness, and death”),²⁰⁸ they are superfluous at best. The people are certainly capable of discerning the presence of an epidemic fever and treating it themselves.²⁰⁹ (After all, in almost all cases the proper treatment is the “abstraction of stimulus in a greater or less degree.”²¹⁰) In fact, if history be any guide, physicians themselves complicate matters, as the patient must delay treatment until the doctor’s arrival and deal with the confusion occasioned by intra-physician consultations.²¹¹ The most, really, that physicians in such circumstances need do is identify the disease’s early symptoms,²¹² answer the basic purgative questions—(What sort of evacuations? In what order? When?)²¹³— and publish their findings.²¹⁴ The people can take it from there.

Rush was not content, however, to limit his conclusions to those suggested by the evidence at hand. As he read the data, the sick were fully capable of treating themselves in epidemics once the disease was identified and the treatment protocol publicized. But this success intimated the future. In many other (indeed, almost all) diseases the people could be trusted to take full, not just executory, responsibility for their own medical care.

For many years the medical profession had, according to Rush, not only withheld from patients knowledge of those cures freely available to the sick, namely “air, water, and even the light of the sun,” but also maintained “the same monopoly of many artificial remedies.” But the modern era had given rise to “a new order of things . . . in medicine.” (Glance, now, at the hindside of a dollar bill.) Not only had patients learned to take healthful advantage of nature’s beneficence “without the advice of a physician,” “nurses and mistresses of families” had taken the initiative in prescribing “bark and laudanum [tincture of opium] . . . with safety and advantage.”²¹⁵ So far, in fact,

208. *Id.*

209. *Id.* at 174–75.

210. *Id.* at 175.

211. *Id.*

212. RUSH, *supra* note 149, at 178.

213. *Id.*

214. *Id.*

215. *Id.* at 176.

had the people's knowledge progressed that "[t]here are many things which are now familiar to women and children, which were known a century ago only to a few men who lived in closets, and were distinguished by the name of philosophers."²¹⁶

But the world was changing quickly, too fast for even physicians to control. "The time must and will come," Rush declared, when, in addition to these modestly powerful artificial remedies, more powerful ones, such as "calomel, jalap, and the lancet," would find "general use," not just at the public-health authorities' direction, but as "the most essential articles of the knowledge and rights of man."²¹⁷ For, Rush concluded, it was "no more necessary that a patient should be ignorant of the medicine he takes, to be cured by it, than that the business of government should be conducted with secrecy, in order to insure obedience to just laws."²¹⁸

Patient, heal thyself.

VII. BENJAMIN RUSH: MILLENARIAN

We have it in our power to begin the world over again.

—Thomas Paine, *Common Sense*

John Adams, shortly after meeting Benjamin Rush, recorded in his diary a damning indictment of the man who soon became his political ally and eventually his good friend: "Rush, I think, is too much of a Talker to be a deep Thinker."²¹⁹ It is easy to see how Adams (then), Rush's contemporaries (later), and scholarly detractors (now), came to this assessment: In Rush's adult lifetime there were few matters of public or scientific import that did not prompt this voluble man to publish his opinion, multiple times, in multiple places. He could not have known half of what he wrote. Expressed medically, Rush was afflicted with a severe case of logorrhea.

As correct as this criticism might be, it fails to perceive, in my estimation, his chief intellectual disability: Rush never learned the great lesson of the twentieth century, viz., that the source of man's woes is his irremediable evil. Or,

216. *Id.* at 177.

217. RUSH, *supra* note 149, at 176.

218. *Id.* at 177.

219. John Adams, Sept. 24, 1775, Sunday, in 2 DIARY AND AUTOBIOGRAPHY OF JOHN ADAMS 182 (Lyman H. Butterfield et al., eds. Belknap Press of Harvard Univ. Press 1961).

expressed less tendentiously, that conflict is an ever-present feature of social life. Invaders cannot be dissuaded; criminals cannot be rehabilitated; apprehended school-yard bullies cannot express genuine remorse. Those who threaten a community's peace must be destroyed or, at the very least, checked. Rush's studied ignorance of this, the most enduring attribute of politics, runs like a vein through his life's works.

This is most evident from some of his practical projects. To eliminate crime, Rush proposed broad-based education, private punishment in "penitentiaries," and abolition of capital punishment. (Credit—or blame—for the statutory division of common-law murder into two degrees belongs to Rush.) Combined with the influence of "humanity, philosophy and christianity," these things would "teach men . . . that they are brethren," thereby "prevent[ing] their preying any longer upon each other."²²⁰ And to stave off war, Rush rested his hopes (in addition, once again, to education) on "negociation, or mediation," as these had successfully terminated "many national disputes" in Europe.²²¹ To that end, he also recommended the establishment of a "Peace-Office" for the United States.²²² Witnessing already "an improving state of affairs," Rush was eagerly "look[ing] forward with expectation to the time . . . when the weapons of war shall be changed into implements of husbandry, and when rapine and violence shall be no more."²²³

But Rush's moral bantam weight is also seen in the choice of the men he praises. His most admired fellow, Anthony Benezet, possessed, according to Rush, many virtues, not least of them being his eagerness to seek to persuade the world's evil-doers to cease their wicked ways. "To the queen of Great Britain, and the queen of Portugal," he wrote letters urging them "to use their influence in their respective courts to abolish" the slave trade.²²⁴ Rush notes with satisfaction that the English queen received the letter and tracts "with great politeness" and declared that "the author appeared to be a very good

220. RUSH, *supra* note 91, at 79, 90.

221. *Id.* at 95, 104.

222. *Id.* at 106.

223. *Id.* at 95, 104.

224. RUSH, *supra* note 103, at 93, 122.

man.”²²⁵ Benezet “also wrote an affectionate letter to the king of Prussia,” Rush tells us, “to dissuade him from making war.”²²⁶

Indeed, it might be said that at the core of Rush’s thought is the earnest aspiration that men might soon cease to be men. As science—that which has “produced the[] triumphs of medicine over diseases and death”—is “applied to the moral science,” Rush expected the “banish[ment] from the world” of “most of those baneful vices” that “convulse the nations of the earth.”²²⁷ Benefits of this application are not limited, however, to political peace—no crime, no war—but also to a moral transformation of men themselves. Rush modestly recognizes that physical immortality is out of the reach of man. (“I am not so sanguine as to suppose that it is possible for man . . . to cease to be mortal).²²⁸ But he is “fully persuaded” that with science “it is possible to produce” a mighty change in his moral character, raising him not only “to a resemblance of angels,” but also “to the likeness of God himself.”²²⁹

This is nonsense, of course. But it does expose the sandy intellectual foundation of Rush’s thought: All conflicts—physical, moral, not least political—are soluble. Once men are properly educated, their strife will come to an end. Pickpockets will steal no more, even as the state abjures punishment. Kings will invade no more, even as their neighbors invite aggression by waging peace. And doctors will command no more, even as sickness persists. Sooner rather than later, all conflict, all opposition, all rule, must cease.

VIII. MADISONIAN MEDICINE

If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary.

— James Madison, *Federalist Papers*, No. 51

If Dr. Gawande’s harrowing account of Mr. Howe’s near-death is anything close to a reliable indicator of the attitudes of today’s young doctors toward the

225. RUSH, *supra* note 91, at 185.

226. RUSH, *supra* note 103, at 93, 122.

227. *Id.* at 120.

228. *Id.*

229. *Id.* at 121.

doctrine of informed consent, we can only conclude that the medical community remains deeply ambivalent, at best, about this legally imposed constraint on its craft. One half century into the revolution, doctors still chafe at the command—from courts, legislatures, and the culture itself—to stand by with folded arms as their patients, from transitory fright, make fatally foolish decisions. As late as 1994, Jay Katz was lamenting (in his swan song on the subject, aptly titled *Informed Consent: Must it Remain a Fairy Tale?*) the profession's failure to fulfill his dreams.²³⁰ Many physicians, no doubt, have followed Dr. Katz and internalized the new ethic, if only because the past fifty years have witnessed the replacement of at least one generation of doctors. But, as Dr. Gawande's story suggests, there appears to be a stubborn, perhaps even congenital, insistence that the practice of medicine necessarily entails the benevolent rule of the knowledgeable and foresightful physician over the weak, frightened, and ignorant patient.

However legitimate, however worthy, however correct this persistent insistence might be, the work of Benjamin Rush should give pause to those who harbor it (myself included) as they reflect on the disastrous form that radically democratic medicine might have taken. Had Benjamin Rush's republican medicine—self-diagnosis and self-treatment—carried the day, the conflict that so vexes informed-consent detractors, between wise physician prescription and transitory patient preference, would have disappeared, if only because doctor-patient interactions, too, would have passed. Had Rush prevailed, strong, virtuous, and medically educated patients (nay, citizens), upon recognizing their illness and the necessity of treatment, would quickly self-administer painful treatments and live. The only interaction between doctors and patients would be in the case of surgery for cancer or wounds, or the diagnosis of rare and subtle diseases. (Think Dr. Gregory House.) As doctors, for practical purposes, disappeared, so would the possibility of physician-patient disagreement. And along with it our health.

For if we have learned anything in the past two centuries about the nature of disease it is that illness is infinitely more complex and, therefore, difficult to diagnose than even the notorious nosological medical scientists had supposed. Dr. Cullen, with his 1387 diseases, was far closer to the truth than Rush with his two. And internet-based medical information, the latter-day instantiation of Rush's programme, misleads at least as often as it heals. The problem of compliance, too, remains a live one: Patients avoid treatment still, whether administered by their own hand or others. (Query: Did you floss your teeth last night?) Contrary to Rush's hopes and predictions, people still need doctors both to diagnose their illnesses and to coax them, in their moments of doubt, to undergo the necessary treatment. We should all be grateful that Benjamin Rush's medicine is not our own.

230. Katz, *supra* note 7, at 69.

But what sort of medicine, then, should we desire? Certainly not Rush's republican medicine, because it—predicated as it is upon the universal educability of man—can never deliver on its promise of self-generated health. Nor paternalistic medicine, even if capable of averting the self-destructive consequences of patients' short-sighted "decisions," for its requisite servility offends our liberal sensibilities. (It is not without reason that doctors have traditionally called the sick "patients," not "consumers," "clients," or "stakeholders.") Better than either republican or paternalistic medicine, I suggest, would be a practice of medicine that conforms both to our democratic conventions and our fallible human nature, a practice that would acknowledge both the citizen's aversion to the pride and pretensions of would-be rulers (even if the healer's hand were to be governed by a knowledgeable head and magnanimous heart) and the sufferer's undeniable ignorance, vulnerability, and fear. What is needed is a practice of medicine that would both respect us and heal us.

Though running the risk of sounding too complacent, I would suggest that the modern law of informed consent does a tolerable job of accommodating, even reconciling, these antipodal needs, and is, therefore, worthy of our begrudging respect. The law acknowledges, on the one hand, the patient's genuine need for the technical expertise and practical wisdom that only physicians can provide. But, on the other, it also respects our deepest democratic belief that consent is the fundamental precondition of all rule. As a result of this compromise, a great good was wrought: Medicine's priests were permitted to live among us, to perform their labors, and, most importantly, grant us our secular salvation. All they had to concede was a nominal check on their propensity to assume absolute rule in matters touching on the healing art. And we, the nominally non-governed, are probably all the better for it. The science of medicine has progressed. Our diseases are being cured. And we, all the while, have doctors in our midst still, serving as a standing reminder that nature itself has set an insuperable obstacle—de Tocqueville's prediction notwithstanding—in the path of democracy's ruthlessly leveling scythe.