No. 24-539

IN THE

Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF REGULATORY AGENCIES, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF OF ANTHONY M. JOSEPH AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*[1]

Amicus Anthony M. Joseph is a professor of history at the University of St. Thomas, Houston. He has nearly thirty years' experience in teaching, research, and public engagement on the history of the United States. He has a special interest in the history of American law, legal institutions, and medicine. He has published articles and reviews on taxation and abortion law in the early American republic. He is the author of *From Liberty To Liberality: The Transformation of the Pennsylvania Legislature, 1776-1820* (Lexington Books, 2012), an institutional study of an American state legislature at the dawn of American republican governance. He is an associate editor of two volumes of *The Documentary History of the Supreme Court of the United States, 1789-1800*,[2] a scholarly edition of primary materials relating to the first decade of the Court's history. His interest is to bring to the Court's attention the long and deep American tradition of therapeutic freedom, according to which legislative licensing laws have not been used to prohibit particular therapies but rather to ensure the foundational training and competence of licensed professionals in ever-developing and changing fields of practice.

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1. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. The University of St. Thomas, Houston provided funding for printing costs. The views expressed are those of the author alone. The University of St. Thomas, Houston did not review or approve the brief.

2. Maeva Marcus et al., eds., *The Documentary History of the Supreme Court of the United States, 1789–1800*, vols. 1–8 (Columbia Univ. Press 1985–2007).

SUMMARY OF THE ARGUMENT

The authority of American states to regulate the practice of medicine, and particularly to enact medical licensing laws, is firmly embedded in our legal tradition. But the use of a licensing law to prohibit a particular therapy, as the Colorado counseling restriction at issue in this case does, is a substantial departure from that tradition. Our medical licensing laws historically have protected and accommodated the therapeutic freedom of physicians, a freedom expressed in both conduct and speech. The chief purpose of the laws has been to credential practitioners, not to arbitrate and decide contested questions of practice, much less revoke licenses for practitioners' choice of therapies. This is not to say that there have been no proper *loci*—legal, medical, and cultural—for the resolution of disputed issues of treatment, but only that, historically, medical licensing laws have not been one of those *loci*.

ARGUMENT

I. Oaths and codes of ethics in eighteenth- and early nineteenth-century America articulated the duties of medical practitioners without prejudice to particular therapies, and the subsequent closedness of the American Medical Association to alternative therapies was a departure from the tradition the oaths and codes represented.

Before Independence, the American colonies were part of a British world in which medical practice was defined primarily by norms of care developed among the practitioners themselves rather than through licensing laws enacted by governments.

A vivid illustration of this reality were midwives' oaths, which reflected a relatively intrusive state presence in midwifery practice, and yet left the question of particular treatments or therapies largely untouched. In England, midwives were required to take an oath for licensure by ecclesiastical authorities.[3] Versions of English midwives' oaths are extent from as early as 1555 and they contain many elements in common.[4] The oaths reflected to some degree the particular concerns of the Church, including prohibitions on witchcraft and requirements for baptism; more generally, they reflected the authority the Church of England exercised over marriage and family.[5]

In the American setting, a midwives' oath is extant in a 1716 version in use in New York City. This oath required that the midwife affirm true paternity of a child; that she not allow the death or injury of the child; that she seek the counsel of other midwives in difficult deliveries; that she not induce miscarriage; that she not charge excessive fees; that she not keep secret the birth of a child; and that she not conceal the birth of a bastard child. The oath also contained general injunctions that the midwife come to the aid of "any woman in labor, whether she be poor or rich" and that the midwife be "of good behavior."[6] The oath thus did contain requirements and prohibitions, keyed to important public health and family goals, with special

3. Robert Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* 23 (Oxford Univ. Press 2013).

4. Id., at 21.

5. Id., at 21-23.

6. Id. at 19.

attention to criminal actions that midwives were presumed to be tempted to commit (e.g., inducing miscarriage, concealment of the birth of a bastard). But the midwives' oaths gave no direction on midwifery techniques and certainly did not prohibit or require any particular form of medical care.

For all that, the medical regulation embedded in midwifery oaths was actually more articulate and developed than in physicians' oaths.[7] Indeed, European medical oaths were centered on loyalty to a particular Church and monarch rather than compliance with state-imposed standards of medical practice.[8] In this context, the Edinburgh medical oath, first introduced for medical students at the University of Edinburgh in the 1730s, became a watershed in the history of medical ethics.[9] The oath omitted pledges of loyalty to church and state, effectively opening up Edinburgh's medical school to students of every religious belief.[10] The medical student instead pledged loyalty to the university and committed himself to practice medicine "cautiously, purely and honorably, and, as far as I can, to take care faithfully that all [my actions] are conducive to [effecting] health in sick bodies."[11] The Edinburgh oath shifted the focus from fidelity to church and state to fidelity to patients. Like the midwives' oaths, however, the Edinburgh oath did not require or prohibit a particular school of

7. Id. at 35.

8. Id. at 40.

9. Id. at 45.

10. Id. at 44.

11. Id.

medicine or set of therapeutic treatments. The one specific commitment the oath-taker made as to medical practice was patient confidentiality.[12] The focus of the oath was on the "motivation and character"[13] of the physician: his honorable attempt "*as far as I can*" (*emphasis added*) to bring healing to the patient, rather than his use of particular treatments in doing so.

The Edinburgh oath and all that it represented were particularly important to the growth of American medicine. The University of Edinburgh became one of the central inspirations for early American practitioners who became known as "regular" physicians on account of their association with standard, formal medical education. America's first medical school, at the College of Philadelphia (now the University of Pennsylvania), was founded in 1765 on the Edinburgh model.[14] At that time, there were as many Americans as Scots enrolled as medical students at Edinburgh.[15] Between 1747 and 1800, more than 100 Americans received medical degrees from Edinburgh.[16] In Philadelphia, America's medical capital, nearly every regular physician had either attended Edinburgh or trained under a physician who had.[17]

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12. Id.

13. Id. at 50.

14. Id. at 39.

15. Simon Finger, *An Indissoluble Union: How the American War for Independence Transformed Philadelphia's Medical Community and Created a Public Health Establishment*, 77 Pa. Hist. 37, 39 (2010).

16. Id.

17. Baker, *supra* note 3, at 39.

Edinburgh was also influential in the development of American medical ethics. Until the 1820s, the Edinburgh approach to medical ethics dominated discussion in the English-speaking world, including in the United States.[18] Thomas Percival, who studied at Edinburgh's medical school, published in 1803 a code of medical ethics that shaped early American articulations of medical ethics.[19] Percival's code heavily influenced the code of medical ethics approved by the Association of Boston Physicians in 1808.[20] The Connecticut Medical Society followed in 1817 with a concise version of the Boston Code that soon spread to medical societies across the nation.[21]

These codes addressed the importance issue of medical consultations, which underpinned both collegiality among physicians and their dissemination of effective treatments.[22] Percival himself had encouraged physicians to consult with practitioners who lacked a regular medical education but who nonetheless had acquired competency in the profession. These "irregulars" were not to be excluded from consultations, according to Percival, since the wellbeing of the patient, in Percival's words, was "the sole object in view."[23]

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18. Id. at 63.

19. Thomas Percival, *Medical Ethics: Or A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (Manchester 1803).

20. Baker, *supra* note 3, at 102.

21. Id. at 104.

22. Id. at 104-106.

23. Percival, *supra* note 19, at 37.

In the United States, Percival's rule on consultations was at first faithfully recapitulated. In the early 1820s, The Kappa Lambda Society of Hippocrates, a short-lived precursor to the American Medical Association (AMA), published for its members *Extracts* of Percival's work. The *Extracts* included Percival's acceptance of consultation with irregulars.[24] America's regular physicians, however, soon abandoned Percival's openness. When regular physicians founded the AMA in 1847, more than half of the code they adopted was drawn verbatim from the Percival *Extracts*.[25] But the AMA code excluded irregular physicians from both consultation and membership, on the ground that their practice was "based on an exclusive dogma" and contrary to medical tradition and science.[26] The AMA's rule remained in place for the rest of the nineteenth century.[27] It provoked immense controversy and that controversy fundamentally shaped American medical practice and the American medical regulatory environment. As will be discussed below, the AMA's delegitimization of irregular medicine was never effectively enshrined in America's medical licensing tradition.

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24. *Extracts from the Medical Ethics of Dr. Percival* 9–10 (Phila. 1823) (art. XI); Baker, *supra* note 3, at 138.

25. Baker, *supra* note 3, at 138.

26. Id. at 153.

27. Id. at 214.

II. American medical licensing laws in the colonial period and in the fifty years after Independence were tentative and not effectively enforced, amounting to certification laws rather than true licensing laws.

State legislatures had already begun to develop that tradition, in ineffective and contested fits and starts, by the time the AMA was formed in 1847. Indeed, the licensing of physicians had never been entirely out of view in America. During the colonial period, licensure was most often an honorific that legislatures bestowed on individual physicians of particular distinction.[28] The first American licensing law of broader scope was enacted by the New York legislature for New York City and county in 1760. The law gave licensing authority to local officials. The New Jersey legislature followed in 1772 with a statute empowering the colony's Supreme Court judges to issue medical licenses. Both colonies imposed a £5 fine for practicing medicine without a license. But neither law appears to have been effectively enforced against the unlicensed.[29] Physicians in Pennsylvania and Connecticut both requested the grant of licensing authority to their own medical societies in the 1760s but were rejected in both cases.[30]

The colonial licensing precedents were much supplemented but ultimately not much improved upon in

28. William G. Rothstein, *American Physicians In the Nineteenth Century: From Sects to Science* 72 (Johns Hopkins Univ. Press 1972).

29. Id. at 337, 338 (App. II).

30. Paul Starr, *The Social Transformation of American Medicine* 44 (Basic Books 1982).

the half century after American Independence. Around 1776, the United States had some 3,500 to 4,000 physicians. Most had neither formal training nor a medical diploma.[31] Medical societies of regular physicians encouraged state legislatures to enact licensing laws. Before 1840, at least 20 state legislatures created some sort of mechanism for licensing physicians, most commonly by empowering the medical societies themselves to issue licenses.[32]

The intention of the laws was exclusionary, but given that purpose their reticence is remarkable. In their provisions:

> no standard was set for education or achievement, no power was given to rescind a license once awarded, no provision was made for enforcement against unlicensed practitioners, and no serious penalties were imposed for violating the law. The only restriction usually placed on the unlicensed was that they were blocked from using the courts to recover debts…If the law included a fine for unlicensed practice, its imposition required a jury trial, and juries would not convict. The laws usually exempted apothecaries, midwives, and botanics; unlicensed practitioners who identified themselves as one of these avoided legal sanctions.[33]

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31. Id. at 40.

32. Rothstein, *supra* note 28, at 332-339 (App. II).

33. Starr, *supra* note 30, at 44.

Taken as a whole, these laws are best viewed as, in effect, certification laws rather than licensing laws. Certification "'does not bar someone from practicing the certified trade; it only prohibits him from presenting himself to the public as a "certified" practitioner.'"[34] The laws accorded licensed physicians a higher status in relation to unlicensed ones but in effect did not actually bar the latter from practicing medicine.

III. With popular support, states repealed or greatly weakened their exclusive medical licensing laws after 1830, but states had other means of supporting public health that did not preempt the therapeutic freedom at the heart of the American medical tradition.

The limitations of the licensing laws, in content and enforcement, reflected the social realities of medical practice at the time. American medicine in the early republic was a patchwork of varied forms of therapeutic care. Homeopathy was among the best established of irregular methods of treatment. Homeopaths practiced alongside botanical physicians, Thomsonians, eclectics, and hydropaths.[35] Even among regular physicians "a wide range of theory and therapy" existed. Whatever may have been the true merits of all of these therapies, regular physicians at the time did not prove the superiority

34. Robert Kry, *The "Watchman for Truth": Professional Licensing and the First Amendment* 23 Seattle U. L. Rev. 885, 887 (2000).

35. James C. Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* 87 (Johns Hopkins Univ. Press 1993).

of theirs. "[I]n actual practice the regulars could not demonstrate more effective results than the irregulars."[36] Not surprisingly, popular support for irregular medicine was substantial and politically impactful.

Some states simply did not enact statutes for medical licensing. Pennsylvania was one of these.[37] Thus the illustrious nineteenth-century history of the medical profession in Philadelphia unfolded in the absence of a state licensing regime. But it would be a mistake to say that Philadelphia's medical community was entirely self-regulating. Rather, America's most robust medical community relied on the combined forces of medical societies, competition, public hygiene laws, criminal statutes, and the freedoms of speech, press, and association to guard and advance the practice of medicine.

These forces shaped such medical advances as the gradual abandonment of therapeutic bleeding despite the absence of effective licensing laws in important medical states like Pennsylvania. Indeed, had early republican Pennsylvania crafted a licensing regime, and taken the additional step of favoring some treatments over others, regular physicians would have been poised to enshrine therapeutic bleeding into law, and the treatment would have endured longer than it did. That such a counterfactual scenario strikes us as brazenly unrealistic only highlights how alien therapeutic requirements have been to the American medical licensing tradition—and how central therapeutic freedom has been to that tradition instead.

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36. Id. at 88.

37. Rothstein, *supra* note 28, at 339.

Whether states in the early republic had weak licensing laws or none at all, they had other means for protecting public health. Public hygiene regulations had a long and robust history, and that history was built upon in the early American republic.[38] Civil litigation was also possible. Medical malpractice suits were not as common in the early republic as they would become later. Only two percent of all such suits reaching state appellate courts from 1790 to 1900 arose in the years between 1790 and 1835.[39] Yet clearly malpractice litigation was not entirely unheard of before 1835. In 1824, the father of a child who had died after receiving a smallpox vaccination sued the administering physician. The physician escaped liability when his fellow physicians testified that the child probably had already contracted smallpox at the time of the inoculation.[40]

The three decades that followed, when states retreated from their licensing laws (discussed below), became a period of rising medical malpractice suits. From 1830 to 1860, malpractice suits reaching state appellate courts grew 950 percent, far outstripping the growth in national population.[41] We might be tempted to ascribe this growth to the removal of licensing laws and increased public exposure to medical misconduct. But many of these lawsuits were filed not against irregular

38. William J. Novak, *The People's Welfare: Law & Regulation in Nineteenth-Century America* 191-233 (Univ. of N.C. Press 1996).

39. Mohr, *supra* note 35, at 111.

40. Id. at 110.

41. Id. at 113.

unlicensed physicians now allowed to run wild, but against well-established and reputable regular physicians. Not surprisingly, the growth in medical malpractice suits did not abate when licensing laws returned in the later nineteenth century (discussed below).[42]

Criminal prosecutions, finally, were a mechanism of medical regulation, whatever a state's licensing regime. In 1839, Philadelphia botanical physician Charles Chauncey was convicted of second-degree murder in the death of Eliza Sowers, on whom he had performed a botched abortion. Chauncey was sentenced to five years' imprisonment in the Eastern State Penitentiary.[43] Criminal prosecutions like Chauncey's deterred medical misconduct with more severe penalties than the revocation of license.

The various forms of medical regulation noted above survived the demise of the licensing laws themselves in the Jacksonian era. State legislatures enacted licensing laws through the 1820s but after that the trend moved decisively in the other direction. Licensing laws or penalties for unlicensed practice were repealed in southern states such as Alabama, Mississippi, South Carolina, Maryland, and Louisiana, and in northern states such as Illinois, Ohio, New York, Massachusetts, and Vermont.[44] By 1860, most states had repealed their licensing regimes entirely, and in

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42. Id. at 121.

43. Anthony M. Joseph, *The "Pennsylvania Model": The Judicial Criminalization of Abortion in Pennsylvania, 1838–1850*, 49 Am. J. Legal Hist. 284, 295 (2007).

44. Starr, *supra* note 30, at 58.

no state did a practically effective licensing regime exist. The main impact of the surviving licensing laws seemed to be to increased hostility toward the regular physicians the laws were meant to prefer.[45]

In dismantling their licensing regimes, legislatures followed and articulated the views of practitioners and patients who in large numbers opposed therapeutically restrictive medical licensing laws. In New York, the state's mounting effort to enforce medical licensing crashed into a wall of popular resistance after three decades. In 1806, the state had empowered medical societies to license physicians and prohibited unlicensed practitioners from suing for debts in the state's courts. A year later, the legislature introduced a fine of $5 per month of unlicensed practice; in 1812, that fine was raised to $25 per offense. In 1827, a new statute made unlicensed practice of medicine a misdemeanor punishable with fine and imprisonment. By the early 1840s, however, at least 30,000 New Yorkers had signed petitions in opposition to the exclusive licensure of regular practitioners. In 1844 the New York legislature repealed all penalties for the unlicensed.[46] The people are "accustomed to govern themselves," a New York legislator explained, and "want no protection but freedom of inquiry and freedom of action."[47]

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45. Lewis A. Grossman, *Choose Your Medicine: Freedom of Therapeutic Choice in America* 25, 26 (Oxford Univ. Press 2021).

46. Rothstein, *supra* note 28, at 338 (New York statutes); Mohr, *supra* note 35, at 88 (petitions).

47. Starr, *supra* note 30, at 58.

IV. States reintroduced medical licensing in the late nineteenth century, but on terms that respected therapeutic freedom.

In the late nineteenth century, states enacted a new generation of medical licensing laws that differed greatly from their defunct predecessors of the early nineteenth century. The new laws accorded legitimacy to alternative or "irregular" schools of medicine. This was an understandable outcome of the previous century of medical practice and legislation. In the era of the early republic, the closed posture of regular medical societies stimulated the proliferation of alternative medicine. Irregular practitioners, excluded from regular societies and kept at arms-length for consultation, formed their own medical societies and medical schools, elaborating their own lines of therapy.

Eclectics and homeopaths were the main alternative "sects" (professional, not religious) of medicine after 1850. Eclectics claimed to draw from all the other schools. They embraced most of regular medicine but opposed the regulars' heavy drugging and bleeding.[48] Homeopaths diverged further from regular medicine, in part by embracing the "law of similars," which held that "drugs which produced the same symptoms when given to a healthy person" were a key to the cure of disease.[49] In truth, however, the three schools were mostly the same. All believed in scientific training and "most of their curriculum was indistinguishable."[50] Even so, regulars had long sought to marginalize the irregulars. Yet by the

48. Id. at 96.

49. Id.

50. Id. at 97.

late nineteenth century, irregulars constituted perhaps twenty percent of all American physicians. And wherever irregulars practiced, regular physicians failed to revive the exclusive licensing laws they had secured in the early nineteenth century.[51]

At the same time, however, interaction among the three sets of practitioners, and dissatisfaction with their separation, grew. The Michigan legislature's decision to require the inclusion of homeopathy at the University of Michigan Medical School resulted in regulars and homeopaths teaching there side-by-side for the first time. The science courses for each program were the same but therapeutics classes were distinct.[52] In addition, the growing body of regular medical specialists chafed at the AMA prohibition on consultation with irregulars, which deprived them of valuable patient referrals from irregular practitioners. New York's medical society in 1882 went so far as to repeal the consultation clause in the AMA's code of ethics, a move that resulted in the society's expulsion from the AMA.[53] After the AMA in 1903 abandoned its prohibition on consultation with irregulars, however, regular medical societies began admitting them as members.[54]

By then, regulars and the main alternative practitioners had also united in support of the new generation of

51. Id. at 99, 100-101.

52. Id. at 100.

53. Id. at 101.

54. Grossman, *supra* note 45, at 52 (AMA abandonment of prohibition); Starr, *supra* note 30, at 107 (admission of irregulars to regular medical societies).

licensing laws.[55] According to an 1895 study, licensing laws still remained "loose or nonexistent" in ten states, effectively allowing anyone in those jurisdictions to practice medicine. But in the remaining thirty-six states, the requirements of the new licensing regime had taken hold: satisfactory completion of a state medical board examination or a diploma from an approved medical college.[56]

A. States respected therapeutic freedom through the creation of therapeutically representative medical boards.

Cooperation and acceptance of the new licensing regime was only made possible by the inclusion of irregulars on a proportionate footing with regulars. Gone from these laws was the exclusive preference given to regular physicians in the short-lived licensing laws of the early nineteenth century. Most of the new statutes gave homeopaths and eclectics representation alongside regulars on state medical boards established to conduct exams and issue licenses. Nearly one-fourth of states created separate boards for the main schools of medicine. Pennsylvania's 1881 medical licensing law created one board each for regular, homeopathic, and eclectic physicians.[57] Most of the remaining states created

55. Starr, *supra* note 30, at 102.

56. David A. Johnson & Humayun J. Chaudry, *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards* tbl. 2.1, Survey on Medical Regulation in U.S. States and Territories, 1895 (Lexington Books 2012) (Kindle ed.).

57. Starr, *supra* note 30, at 58.

a single board composed of representatives of the same three groups.[58] California's licensing law created a board of medical examiners to be composed of five physicians appointed by the state's regular medical society, two by its homeopathic society, and two by its eclectic society—an arrangement upheld by the Supreme Court of California in 1904.[59]

B. States respected therapeutic freedom by accommodating the therapeutic affiliations of medical students and license applicants.

Several states even approved nondiscrimination clauses that prohibited the rejection of medical license applicants on account of their adherence to alternative medicine. Virginia's 1884 licensing law explicitly prohibited the rejection of any applicant for his association with "any particular school of medicine or system of practice" or for "his views as to the method of treatment and cure of diseases." Rhode Island included a similar provision in its 1895 licensing law. The Texas state constitution of 1876 permitted the state legislature to enact medical licensing laws but stipulated that "no preference shall ever be given by law to any schools of medicine."[60]

The ensure the quality of medical education, the new licensing laws empowered state boards to reject applicants with diplomas from medical schools the boards considered

58. Grossman, *supra* note 45, at 52.

59. Lawrence M. Friedman, *Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study,* 53 Calif. L. Rev. 487, 496 n. 41 (1965); *Ex parte Gerino*, 143 Cal. 412 (1904).

60. Tex. Const. of 1876 art. XVI, § 31.

unacceptable. West Virginia's law empowering its state board of health to determine reputability of medical colleges was upheld by this Court in *Dent v. West Virginia* (1889).[61] Frank Dent, a regular physician, had sought a West Virginia license on the basis of his diploma from an eclectic medical college in Cincinnati.[62] The West Virginia medical board rejected Dent's application on the ground that his diploma was not issued by a "reputable" school as required by the state's law. A unanimous Court upheld the denial of the license. Speaking for the Court, Justice Field affirmed a person's right to pursue an occupation, but also placed a state's right to license medical practitioners squarely within the state's police powers.[63]

By 1900, then, the states' general medical licensing authority had been established by both statutory and judicial precedent. That this authority included the power to prohibit particular therapies, however, was not established. On the contrary, the structure of the new licensing regimes made it clear that states were most concerned about the basic soundness of medical education rather than picking winners and losers in controversies over treatments. Indeed, had Dent earned a diploma from a school the board accepted as reputable, he would have been free with respect to West Virginia's licensing law to practice any form of therapeutics he chose.

The authority of state medical boards over the actual curricula of medical schools was more difficult

61. *Dent v. West Virginia,* 129 U.S. 114 (1889).

62. Grossman, *supra* note 45, at 57 (Dent as a regular physician).

63. Friedman, *supra* note 59, at 493.

to establish than their power simply to accept or reject diplomas. In his influential 1910 report on American medical schools, Abraham Flexner envisioned a medical education grounded in rigorous study of the basic sciences rather than the varied therapeutic traditions.[64] That might suggest a separation of the basic sciences from therapeutics, the former being more subject to government standardization than the latter. Without tracking that distinction, the Supreme Court of California in 1904 determined that California's licensing law was not to be construed to require the same curriculum at all medical colleges. The colleges need not follow "the same course of study, nor the study of the same text-books… but it must be such as requires of the student a degree of proficiency in the studies necessary to prepare him for practice." That standard, the Court went on, "must change as the discoveries in natural science open new fields of investigation and suggest or reveal new curative agencies. *The legislature cannot successfully prescribe in advance a standard to meet these new and changing conditions*" (*emphasis added*).[65]

State legislatures did take clear steps to preserve applicants' therapeutic freedom in state board licensing examinations. Some state boards excluded questions on the controverted field of therapeutics. In 1876, the Texas legislature stipulated that its state board examination

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64. Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* 61, 156 (Carnegie Found. 1910; reprint ed., Cosimo Reports 2022).

65. *Ex parte Gerino*, *supra* note 59, at 418 ("the same course of study"), 419 ("must change") (1904).

cover anatomy, physiology, pathological anatomy and pathology, surgery, obstetrics, and chemistry. The omission of therapeutics helped keep the law in compliance with the state constitutional provision of the same year prohibiting legislative preference of any school of medicine.[66] On the other hand, Missouri was a single-board state that insisted on a single test in therapeutics.[67] However, "[t]he Texas approach—omitting contentious fields from the explicitly identified content of the medical licensing exam—more reflected the norm in those states where a single board had been established."[68]

States with multiple boards allowed candidates to be tested according to their own respective therapeutic affiliations. In New York, regulars pushed for a single board, represented mostly by regulars and empowered to include therapeutics in its examinations. Homeopaths and eclectics vigorously opposed those efforts. Ultimately the legislature created in 1890 three separate boards. A common examination would be administered but questions on therapeutics would address only the applicant's preferred practice. As the AMA noted in 1907, the general belief was that licensing exams should test knowledge of the human body and leave choices of treatment to the "perfect freedom" of the applicant.[69]

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66. Act of Aug. 21, 1876, ch. 140, 1876 Tex. Gen. Laws 231; Tex. Const. of 1876 art. XVI, § 31.

67. Johnson & Chaudry, *supra* note 56, at ch. 3, Beginnings, Growth and Challenges: Examinations for Medical Licensure.

68. Ibid.

69. Grossman, *supra* note 45, at 52 ("perfect freedom"), 53 (New York legislation).

Thus the story of the late-nineteenth century laws was very much a story of accommodation and of reluctance to require or prohibit particular therapies in medical college curricula and board examinations. Heading into the twentieth century, a clear pattern of assimilation of the medical sects became apparent even as licensing regimes had accommodated them. As these declined, new medical therapies arose, including osteopathy, Christian Science, and chiropractic, each with its own subsequent historical trajectory.[70] But the assimilation of the three main nineteenth-century schools of medicine was sufficient to encourage the development by state boards of medical school curriculum requirements and common therapeutic questions on board exams.

Even so, two points must be kept in mind. First, the standardization of curricula and board exams followed rather than preceded medical consensus. Second, such common standards fell far short of prohibiting the use of particular therapies in medical practice. Whatever a physician may have been taught in medical school, and whatever he or she may have been tested on in a state board examination, the freedom to choose one's own treatments and to develop them in light of one's own clinical experience and the growth of medical knowledge remained intact.

70. Starr, *supra* note 30, at 107, 108.

C. States respected therapeutic freedom through the exclusion of therapeutic choice as a cause of action in state medical board disciplinary proceedings against physicians.

This therapeutic freedom was further expressed in the contours and limits of medical licensing discipline. By the early twentieth century, states had reached "considerable uniformity" regarding grounds for the revocation of a medical license.[71] A 1926 study of state licensing laws found that in most states such grounds included "habitual intemperance, conviction for crimes involving 'moral turpitude,' criminal abortion, false or deceptive advertising, aiding and abetting an unlicensed practitioner, fraud and unprofessional conduct." Among these grounds, only unprofessional conduct potentially could have had any direct connection to therapeutic choice. And yet, unprofessional conduct "appears to have seldom, if ever, been used [in state board disciplinary proceedings] in a manner that addressed questions about the physician's technical competence."[72]

Similarly, a study of 938 state board disciplinary proceedings conducted in the mid-1960s found causes of action to include narcotics violations, mental incompetence, fraud and deceit in practice, felony conviction, abortion, unprofessional conduct, alcoholism, moral turpitude, and a miscellaneous category of other causes. Narcotics violations was the most common cause of action, comprising 47% of the total. Unprofessional conduct was

71. Johnson & Chaudry, *supra* note 56, at ch. 3, "Beginnings, Growth, and Challenges: Discipline."

72. Id.

low on the list at only 7% of the total. As in the 1920s, there is little likelihood that this category in the 1960s included any significant number of cases involving choices of treatment.[73] We can say confidently that state licensing regimes at least through the first half of the twentieth century rarely if ever included disciplinary actions against physicians merely for their choice of therapeutics, whether that choice was expressed in conduct or speech. A host of behaviors could bring physicians legal troubles, but their therapeutic decisions, unless they indirectly involved some other violation, remained untouched by licensing laws.

CONCLUSION

State medical regulation is firmly established in our legal tradition, and it has not been the purpose of this brief to deny or disparage that fact. Rather, this brief has highlighted the therapeutic freedom of medical practitioners in the history of medical licensing. American medical licensing laws were first introduced to honor the most outstanding practitioners and then to elevate the profession by what amounted to a form of certification. After popular opposition brought about the repeal of those laws, state legislatures in the late nineteenth century enacted a new generation of licensing laws that more clearly and more fully respected therapeutic freedom. The essentials of those new licensing laws, particularly the role of medical schools, licensing examinations, and disciplinary proceedings, are with us still, and form the

73. Id. at ch. 6, The Push for Public Accountability, 1961–1979: Changing Expectations for State Medical Boards and Their Disciplinary Role, tbl. 6.3 *Causes for Disciplinary Actions Taken by State Medical Boards, 1963–1967.*

legal context of the counselor licensing laws that are of much more recent vintage.

The Colorado counseling restriction at issue in the present case departs widely from tradition by converting licensing from a mechanism for credentialing practitioners to an instrument of state-imposed coercion against free speech.

For the foregoing reasons, amicus supports petitioner's right to relief and asks that the judgment of the Court of Appeals be reversed.

Respectfully submitted,

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