

**A DYNAMIC EQUILIBRIUM:  
DOCTORS AND PATIENTS IN SEVENTEENTH-  
CENTURY ENGLAND**

by

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## Declaration

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I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Signed \_\_\_\_\_

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## Abstract

Throughout the social history of medicine, explorations of the doctor-patient relationship have often utilised the framework of power relations. Consequently, early modern patients tend to be depicted as more powerful than their modern counterparts. This was because early modern patients were seen to choose their doctors from a conceptual medical marketplace, subjugate them through an entrenched system of patronage, and argue over treatments within a medical culture that barely distinguished between lay and professional medicine. The language of power, however, has served to place early modern doctors and patients in an oppositional stance, thus portraying the relationship as competitive and adversarial. Rather than interpreting patient agency as a signifier of individual power, this thesis uses research in the field of power relations to develop a new conceptualisation of power, to better understand the behaviour of actors within the early modern medical setting. Doctors and patients were both subject to multiplex, multilayered and often hidden socio-relational forces that determined the processes of medical decision-making. Understanding how networks of power operated can reveal the existence of alliances, collaborations, friendships and mutual reciprocity between doctors and patients. The contribution the thesis makes to the scholarly field, therefore, is to offer the guiding principle of a *medical dynamic-equilibrium*. This terminology more aptly conveys the complexities of early modern medical relationships, in which socio-relational forces constantly influenced participants and shifted power in unexpected ways that delivered dynamic outcomes. The thesis explores early modern attitudes towards illness and cure, and considers the role of the doctor at the deathbed and the management of chronic disease.

## Abbreviations & Notes

BL	British Library, London
Bodl	Bodleian Library, Oxford
BSL	Barr Smith Library, Adelaide
EEBO	<i>Early English Books Online</i> Chadwyck-Healey. <a href="http://eebo.chadwyck.com/home">http://eebo.chadwyck.com/home</a>
CSPD	<i>Calendar of State Papers, Domestic</i>
LMA	London Metropolitan Archives
LRO	Lancashire Record Office, Preston
OBP	<i>Old Bailey Proceedings</i> Tim Hitchcock et al., <i>The Old Bailey Proceedings Online 1674-1913</i> <a href="http://www.oldbaileyonline.org">www.oldbaileyonline.org</a>
ODNB	<i>Oxford Dictionary of National Biography</i>
RCP	Royal College of Physicians, London
WL	Wellcome Library, London

The *Annals* of the Royal College of Physicians were mainly accessed via microfiche (Reading: Adam Matthew Publications, 1991) at the Barr-Smith Library, University of Adelaide. Accordingly, they are cited using microfiche card and image number, and original date of entry.

Contemporary spellings in quotations have been preserved.

For the sake of clarity, dates have been altered to begin the new year on 1 January.

## Table of Contents

<b>DECLARATION .....</b>	<b>I</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>II</b>
<b>ABSTRACT.....</b>	<b>III</b>
<b>ABBREVIATIONS &amp; NOTES .....</b>	<b>V</b>
<b>TABLE OF CONTENTS .....</b>	<b>VI</b>
<b>PART I.....</b>	<b>1</b>
<b>INTRODUCTION .....</b>	<b>1</b>
I.    CONCEPTUALISING POWER.....	6
II.   A MEDICAL DYNAMIC-EQUILIBRIUM.....	16
III.  BACKGROUND .....	19
IV.   SOURCES AND METHODOLOGY .....	30
V.   CHAPTERS .....	35
<b>CHAPTER 1. POWER RELATIONS AND PRACTITIONERS .....</b>	<b>40</b>
I.    PHYSICIANS .....	45
II.   THE PANOPLY OF MEDICAL PRACTITIONERS.....	60
<b>CHAPTER 2. SOCIO-RELATIONAL POWER AND ILLNESS.....</b>	<b>76</b>
I.    ILLNESS AND THE DOCTOR .....	77
II.   ILLNESS AND THE PATIENT .....	94
<b>PART II .....</b>	<b>112</b>

<b>CHAPTER 3. “CURE”: WHY DOCTOR’S CLAIMED CURE, HOW</b>	
<b>PATIENTS JUDGED CURE.....</b>	<b>113</b>
I.    THE DOCTORS’ CURES .....	114
II.   DOMESTIC CURES .....	136
<b>CHAPTER 4. “DEATH”: THE DOCTOR’S ROLE AT THE DEATHBED..</b>	<b>150</b>
I.   DYING IN EARLY MODERN ENGLAND .....	151
II.  INTERPRETING THE SIGNS OF DEATH .....	166
<b>CHAPTER 5. “OTHERWISE”: MANAGING CHRONIC ILLNESS .....</b>	<b>186</b>
I.   RICHARD BAXTER (1615-1691).....	187
II.  ANNE CONWAY (1631-1679).....	198
III.  SYMCOTTS AND POWERS.....	210
<b>CONCLUSION .....</b>	<b>219</b>
<b>BIBLIOGRAPHY .....</b>	<b>226</b>

## Part I

### INTRODUCTION

Late one evening in September 1630, above a shop in Eastcheap near London Bridge, Nehemiah Wallington (1598-1658) wood turner and shop owner, was sleepless and desperately worried about his three-year-old son. Samuel was ill and experiencing alarming convulsions. Wallington remembered that night in his diary:

It pleased the Lord my God to afflict my sweet sonne Samuel with sore fites of the convolution: the fites were so stronge that one would have thought that one feete would have broke the heartstring of him and he did start very much in his sleepe and groone very much: and I could geete no helpe for him: for I went unto Docktor Sanders...But he sayd he could not helpe him.<sup>1</sup>

Wallington's diary entry gave voice to the anxiety and desperation he felt at this time. He could only turn to God – he was at the mercy of illness and facing the possibility of Samuel's death, and he could not convince the doctor to help him. Nehemiah Wallington and his son were certainly not the only early modern patients to find themselves vulnerable and helpless in the face of illness. Less than a decade earlier John Donne had also lain sick and helpless in fear of death, trying to console himself by imagining “how many are sicker (perchance) than I, and laid in their

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<sup>1</sup> Nehemiah Wallington, *The Notebooks of Nehemiah Wallington, 1618-1654: A Selection*, ed. by David Boon (Aldershot: Ashgate, 2007), 68.



woful straw at home (if that corner be a home), and have no more hope of help, though they die.”<sup>1</sup> And in 1694, Will Atkins, who traversed the streets of London curing gout sufferers lamented, “what sad objects are daily seen, of persons afflicted with palsies and other diseases as we walk the streets...and great numbers do lie in beds, in chambers and garrets, hid from the world, and thus they lie till they die.”<sup>2</sup> Yet, despite an abundance of similar testimonies confirming the helplessness of the sick many scholars continue to make reference to “early modern patient power.”<sup>3</sup> At various stages throughout the social history of medicine patients have been considered to be powerful because they could pick and choose a doctor in the

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<sup>1</sup> John Donne, “VII. Meditation, The Physician Desires to Have Others Joined With Him” in *Devotions Upon Emergent Occasions On Severall Steps in My Sicknes*, (London, 1624), eBooks@adelaide (Adelaide: University of Adelaide, 2009) Accessed 15 June 2016. <https://ebooks.adelaide.edu.au/d/donne/john/devotions/index.html>.

<sup>2</sup> Will Atkins, *A Discourse on Gout* (London, 1694).

<sup>3</sup> References to patient power can be found in Robert Weston, “Knowledge, Status and Power: Negotiating Authority” in *Medical Consulting by Letter in France, 1665-1789* (Farnham: Ashgate, 2013), 93; Hannah Newton, *The Sick Child in Early Modern England, 1580-1720* (Oxford: Oxford University Press, 2012), 181-187; Keir Waddington, *An Introduction to the Social History of Medicine: Europe Since 1500* (Basingstoke: Palgrave Macmillan, 2011), 5-8; Michael Stolberg, *Experiencing Illness and the Sick Body in Early Modern Europe* (Basingstoke: Palgrave Macmillan, 2011), 74-75; Michael Stolberg, “The Decline of Uroscopy in Early Modern Learned Medicine (1500-1650),” *Early Science and Medicine* 12, 3 (2007): 313; Patrick Wallis, “Competition and Cooperation in the Early Modern Medical Economy” in *Medicine and the Market in England and Its Colonies, c.1450-c.1850* eds., Mark Jenner and Patrick Wallis (Basingstoke: Palgrave Macmillan, 2007), 61-62; Martin Dinges, “Social History of Medicine in Germany and France in the Late Twentieth Century,” in *Locating Medical History: The Stories and Their Meanings* eds., Frank Huisman & John Harley Warner (Baltimore: John Hopkins Press, 2004), 209-227; Margaret Pelling, *Medical Conflicts in Early Modern London: Patronage, Physicians, and Irregular Practitioners 1550-1640* (Oxford: Clarendon Press, 2003), 225; Andrew Wear, *Knowledge and Practice in English Medicine 1550-1680* (Cambridge: Cambridge University Press, 2000), 114-115, 252; Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 1999), 195; Gianna Pomata, *Contracting a Cure: Patients, Healers and the Law in Early Modern Bologna* (Baltimore: John Hopkins University Press, 1998), xiv; Andrew Wear, “Introduction,” in *History of the Doctor-Patient Relationship: Proceedings of the 14th International Symposium on the Comparative History of Medicine-East and West: September 3-9, 1989, Tokyo, Japan* eds., Kawakita, Yoshio, Shizu Sakai, and Yasuo Otsuka (Brentwood, Mo., U.S.A.: Ishiyaku EuroAmerica, 1995), x-xvii; Mary Fissell, *Patients, Power, and the Poor, in Eighteenth-Century Bristol* (Cambridge: Cambridge University Press, 1991), 1-15; Lucinda Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London: Routledge, 1987), 259; Roy Porter, ed. *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society* (Cambridge: Cambridge University Press, 1985), 13-14.

economic to and fro of medical supply and demand, and because the medical recipes they collected were considered little different from the medical knowledge displayed by doctors.<sup>4</sup> Some scholars argued that patients gained power from being able to narrate their own stories of illness, while others have shown how patients were able to treat and cure themselves.<sup>5</sup> In essence, power has periodically resided on the patients' side of the early modern doctor-patient relationship and the issue of power has been at the forefront of research, either stated or implicit.

In stark contrast to the power that is sometimes attributed to the patient, early modern doctors are generally considered to have lacked professional power in the early modern era.<sup>6</sup> Furthermore, a large and varied aggregate of publications from all eras have portrayed early modern doctors as much-maligned characters generally associated with quackery.<sup>7</sup> Some scholars have documented what they see as the

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<sup>4</sup> For shared medical knowledge see, Elaine Leong and Sara Pennell, "Recipe Collections and the Currency of Medical Knowledge in the Early Modern Medical Marketplace," in Jenner & Wallis, *Medicine and the Market*, 136; Doreen Nagy, *Popular Medicine in Seventeenth-Century England* (Ohio: Bowling Green State University Popular Press, 1988), 52.

<sup>5</sup> On patient narratives see, Fissell, *Patients, Power and the Poor*, 11. For self-treatment see, Olivia Weisser, "Boils, Pushes and Wheals: Reading Bumps on the Body in Early Modern England, Roy Porter Student Prize Essay," *Social History of Medicine* 22, 2 (2009): 321-339.

<sup>6</sup> Harold J. Cook, *The Decline of the old Medical Regime in Stuart London* (Ithaca: Cornell University Press, 1986); R. S. Roberts, "The Personnel and Practice of Medicine in Tudor and Stuart England," *Medical History* 6, 4 (1962): 368-382; Pelling, *Medical Conflicts*.

<sup>7</sup> Tobias B. Hug, *Impostures in Early Modern England: Representations and Perceptions of Fraudulent Identities* (Manchester: Manchester University Press, 2009), 48; David Gentilcore, *Medical Charlatanism in Early Modern Italy* (Oxford: Oxford University Press, 2006); Marianne Samayoa, "More Than Quacks: Seeking Medical Care in Late Colonial New Spain" *Social History of Medicine* 19, 1 (2006): 1-18; Hugh Ormsby-Lennon, *Hey Presto! – Swift and the Quacks* (Newark: University of Delaware Press, 2001); Jim Leavesley & George Biron, *Flies in the Ointment: Medical Quacks, Quirks and Oddities* (Pymble, N.S.W.: Harper Collins, 2001); A. W. Sloan, *English Medicine in the Seventeenth Century* (Durham: Durham Academic Press, 1996); S. Weir Mitchell, *The Autobiography of A Quack and the Case of George Dedlow* (Charlottesville: University of Virginia, 1996); Roy Porter, *Health For Sale: Quackery in England 1660-1850* (Manchester: Manchester University Press, 1989); Gordon W. Jones, "A Relic of the Golden Age of Quackery" *Bulletin of the History of Medicine* 37 (1963): 226-238; Eric Jameson, *The Natural History of Quackery* (London: M. Joseph, 1961); Stewart Hall Holbrook, *The Golden Age of Quackery* (New York: Macmillan, 1959); A. Dickson Wright, "Quacks Through the Ages," *Royal Society of Arts Journal* 105, 4995 (1957):

doctors' inability to cure.<sup>8</sup> Another major strand of scholarship explored conflict between doctors when the College of Physicians attempted to gain ascendancy over the multitudes of “irregular” medical practitioners.<sup>9</sup> Indeed, early modern medicine came to be described as a “medical marketplace” in which practitioners competed against each other in a frenzy of rivalry, with the aim of gaining money from the patient by dubious promises to cure.<sup>10</sup> In essence, medical practise and the doctor's authority often depended precariously on personal reputation, which might be won or lost with each new consultation.

In recent years, scholars have clearly demonstrated that there was not a stark contrast between powerful patients and weak doctors. Rather, there was a much more nuanced picture to be had where agency and negotiation occurred between interested parties.<sup>11</sup> Several years ago Thomas Rütten pointed out how a new history of medicine had come into being, which was less about institutionally administered power and more about power that was “informally exercised and experienced

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161-178; Herbert Silvette, “On Quacks and Quackery in Seventeenth-Century England” in *Annals of Medical History* 1, 3 (1939): 239-251; C. J. S. Thompson, *Quacks of Old London* (New York & Paris: Brentano's Ltd, 1928); Anon, “Quackery in the Past,” *British Medical Journal* 1, 2630 (1911): 1250-63; Anon, “Some Notable Quacks,” *BMJ* 1, 2630 (1911): 1264-74; Robert Brundell Carter, *Doctors and their Work, Or, Medicine, Quackery and Disease* (London: Smith Elder, 1903); Arthur Joseph Cramp, “Nostrums and Quackery: Articles on the Nostrum Evil and Quackery Reprinted From the *Journal of the American Medical Society*” (Chicago: Chicago Medical Association Press, 1872).

<sup>8</sup> For inability to cure see, Roy Porter, *Bodies Politics: Disease, Death and Doctors in Britain, 1650-1900* (New York: Cornell University Press, 2001), 211; Lindemann, *Medicine and Society*, 229; Beier, *Sufferers and Healers*, 5.

<sup>9</sup> For a history of the College containing College disputes see, George Clark, *A History of the Royal College of Physicians of London* (Oxford: Clarendon Press, 1964-72); Frank H. Ellis, “The Background of the London Dispensary,” *Journal of the History of Medicine and Allied Sciences* 20, 3 (1965): 197-212; Pelling, *Medical Conflicts*.

<sup>10</sup> For a critique of the “medical marketplace” see Jenner and Wallis, *Medicine and the Market*, 1-23.

<sup>11</sup> See, Weston, *Medical Consulting By Letter*, 93; Wendy Churchill, *Female Patients in Early Modern Britain: Gender, Diagnosis and Treatment* (Farnham: Ashgate, 2012), 76; Stolberg, *Experiencing Illness*, 79; Pelling, *Medical Conflicts*, 225-228.

between individuals.”<sup>12</sup> Nevertheless, the phrase “early modern patient power” appears regularly and a detailed discussion of exactly what it means to leverage power would appear to be a useful contribution to current scholarship.<sup>13</sup> This thesis, therefore, takes a revisionist approach that explores notions of early modern patient power. In order to contribute to an increasing focus on the shifting power dynamics of early modern medicine, this thesis will examine the interactions and experiences of those who participated in the medical relationships of seventeenth-century England. Several new concepts of power have emerged in recent decades, which should prove helpful in establishing a conceptualisation of power that will suffice for exploration and interpretation of the early modern doctor-patient relationship. So far, the scholarship appears to define power as the patient’s ability-to-act, however, there were many more colliding, competing and harmonising components that coalesced at the site of medical interactions. In the introduction, I establish a conceptualisation of power and suggest the framework of a medical dynamic-equilibrium as a guiding principle for interpretation of the doctor-patient relationship. I trace how and why *patient power* emerged from the social history of medicine and I conclude with a description of sources and an outline of chapters.

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<sup>12</sup> Thomas Rütten, “Ch. 4: Early Modern Medicine” in Mark Jackson, ed., *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2013 edition), 66.

<sup>13</sup> See f/n 3, page 2.

## I. CONCEPTUALISING POWER

Taking stock of the power dynamics of early modern medicine is useful because the concept of power continues to be discussed, debated, and re-formulated.

Traditionally, power at its most simple understanding means that A dominates B, which is often referred to as “power-over” because A has *power over* B.<sup>14</sup> Another seemingly straightforward but altogether complicated type of power is a person’s agency or ability to act, often referred to as “power-to” because that person has the *power to* act.<sup>15</sup> Early modern patients potentially had power-over the doctor and also the power-to act. However, broader definitions of power now exist that further explain the political, economic, cultural and social forces that operate within social systems. These broader definitions show how power was conferred on agents, both structures and people, and how those agents construct possibilities for action.<sup>16</sup> For example, the early modern College of Physicians can be recognised as a structural agent that created the possibility for London medical practitioners to either join their ranks or be at risk of being hauled in front of a committee for practising without license, regardless of a practitioner’s individual agency. Another current view of power sees multiple forces of power contributing to a social web where individuals are constantly acting and reacting in relation to all sorts of power.<sup>17</sup> The development

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<sup>14</sup> Robert Dahl, “The Concept of Power,” *Behavioural Science* 2: 202-203.

<sup>15</sup> See Peter Morriss, *Power: A Philosophical Analysis* (Manchester: Manchester University Press, 2002); Steven Lukes, *Power: A Radical View* (London: Macmillan, 2005), 69.

<sup>16</sup> Mark Haugaard, “Power: A ‘Family Resemblance’ Concept” *European Journal of Cultural Studies* 13: 4 (2010): 425.

<sup>17</sup> Michael J. Braddick, John Walter, “Introduction. Grids of Power: Order, Hierarchy and Subordination in Early Modern Society” in *Negotiating Power in Early Modern Society: Order, Hierarchy and Subordination in Britain and Ireland*, eds. Michael J. Braddick and John Walter (Cambridge: Cambridge University Press, 2001), 4.

of this latter conception of power will be the most useful model towards an interpretation of the early modern doctor-patient relationship, because it suggests the greatest range of forces that can be seen to affect the medical encounter.

Definitions of power are further complicated because they sometimes appear to have emerged from agents that have their own power structures and from those who interpret power in ways that suit their own ends. An example of this can be seen in some early twentieth-century medical histories, which portray medicine as a triumphal march towards modern medicine by heroic doctors.<sup>18</sup> These histories can be interpreted as one of the many ways in which members of the modern medical community bolstered the importance of their profession. So, how we think about power may serve to reproduce current power structures or challenge existing ones. An example of a challenge to a dominant power structure was the feminist challenge to masculine views of power. Masculine views tended to adhere to the *power-over* view of dominance, while feminist views embraced the *power-to* view and championed the notion of empowerment.<sup>19</sup> These feminist interpretations of power increased the ways in which women could be seen to be powerful or empowered. All these explanations of power have raised contradictions and uncertainties, however, current research on power is integral to formulating a conceptualisation of power for use in conjunction with early modern medicine.

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<sup>18</sup> For a critique of this approach see David Wootton, *Bad Medicine: Doctors Doing Harm Since Hippocrates* (Oxford: Oxford University Press, 2007).

<sup>19</sup> Amy Allen, "Feminist Perspectives On Power" *Stanford Encyclopaedia of Philosophy* (Stanford: Stanford University, 2015) Accessed 23/09/2016. <http://plato.stanford.edu/entries/feminist-power>

Although the primary definition of power is now understood as “the ability to act” the *Oxford English Dictionary* provides well over three thousand further definitions.<sup>20</sup> In order to narrow down these definitions and understand the shifting dynamics of power more fully the work of sociologist John Scott, and other scholars of power, is indispensable.<sup>21</sup> Also vital, of course, is the work of Michel Foucault whose influential ideas contributed to creating the discussion in the first place.<sup>22</sup> As a result of some of the overly theoretical approaches to defining power, the theory has sometimes failed to match the lived experience. Any conceptualisation of power in regard to early modern medicine would need to accentuate the lived experience of the medical relationship so as to demonstrate its susceptibilities to the vagaries of power.

One of the most influential ideas that Foucault put forward was that of centralised and decentralised power, whereby power either emanated from the state or became individualised and resided in every social relationship.<sup>23</sup> Foucault’s ideas of power were refined by John Scott, who defined three major aspects of power, which now inform current approaches to research. The first of those was the

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<sup>20</sup> *Oxford English Dictionary Online*, s.v. “power,” accessed August 12, 2015, [http://www.oed.com.proxy.library.adelaide.edu.au/search?searchType=dictionary&q=power&\\_searchBtn=Search](http://www.oed.com.proxy.library.adelaide.edu.au/search?searchType=dictionary&q=power&_searchBtn=Search)

<sup>21</sup> John Scott, *Power* (Cambridge: Polity, 2001); John Scott, “Ch. 7: Studying Power” in *The Wiley-Blackwell Companion to Political Sociology* eds., Edwin Amenta, Kate Nash and Alan Scott, (Oxford: Blackwell Publishing, 2012); Lukes, *Power: A Radical View*; Clarissa Rile Hayward, *De-Facing Power* (Cambridge: Cambridge University Press, 2000); Stephen R. Bates, “Re-structuring Power” *Polity* 42: 3 (2010): 352-376; Braddick and Walter, *Negotiating Power* (see chap. 1, n. 17); W. F. Bynum and Roy Porter, eds., *Companion Encyclopaedia of the History of Medicine* (London: Routledge, 1993).

<sup>22</sup> On power in the doctor-patient relationship see, Colin Jones and Roy Porter, eds., *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1998), 18.

<sup>23</sup> Michel Foucault, *Power*, ed. James D. Faubion, trans. Robert Hurley (New York: The New Press, 2000), 328, 332.

“reputational approach”, which seeks to identify people who appear to hold power, that is, agents who are reputed to be powerful or who project an image of being powerful.<sup>24</sup> The second area of research was that of “structural power”, which investigates positions of power within society in the form of groups or associations (such as the early modern College of Physicians), and explores how positions within these groups are occupied.<sup>25</sup> The third area of study was observing the occurrence of personal agency, which was now expressed as the “decision-making approach”, which explores how decision-making occurs “directly at its point of exercise.”<sup>26</sup> The point of exercise is why, how and where decisions are made. The problem in attempting to recognise agency is that all aspects of power are so closely interwoven that they cannot be disentangled with any measure of exactitude.

Recognition of agency can only ever be a guide that indicates change has occurred and power has been transacted. Any candid observation of a person’s agency, or decision-making, fails to reveal the complex story of what actually influenced that transaction of power. In other words, the end point of observable agency can be a measure of the effect of power, however, it may or may not correlate with how that effect was actually produced. Wallington’s medical experience can be used to demonstrate how the idea of agency as power can be misleading. For instance, the doctor refused to attend Wallington’s son and so displayed agency, but suppose the doctor had been in trouble with the College of Physicians and was prohibited from practising medicine at that time. If so, although he appeared to

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<sup>24</sup> Scott, *Companion to Political Sociology*, 71.

<sup>25</sup> Scott, *Companion to Political Sociology*, 71.

<sup>26</sup> Scott, *Companion to Political Sociology*, 71.



demonstrate agency/power, his decision-making came about as a direct consequence of conflict with the structural power of the College of Physicians, which exerted a force that directed his response to Wallington. These convoluted social relations elaborate the difficulties in interpreting agency as power and show that agency cannot be taken at face value.

Paradoxically, the key to understanding power is to separate its strands while at the same time observing how they work together. Again, Wallington's experience demonstrates how the reputational, structural and decision-making categories of power are fused. When his son was sick with disturbing convulsions Wallington sent for medical help. Initially, Wallington appears to be exercising agency, yet his son's illness was fused with other strands of *power* that drove Wallington to seek medical help. The fact that Wallington loved his son contributed to his behaviour, while the expectation that a good parent would seek help for a sick child was a type of moralistic structural power that existed within society that also exerted some sway. His first port of call was to Doctor Sanders, which suggests the force of social convention and tradition in turning to a particular group in society that held a certain amount of structural power. At the same time, the doctor may have had reputational power due to his individual medical expertise, rather than his being credited with the structural power of the group to which he belonged. The way in which these strands of power are fused together demonstrates the complexities of social relations and as Scott argues they "must be seen as complimentary perspectives rather than as all-or-

nothing rivals.”<sup>27</sup> Once it is accepted that there were many aspects of power acting and reacting within social relationships it raises the possibility of including additional aspects of power that might have previously gone unrecognised in regard to the doctor-patient relationship, such as religion, gender, patriarchal structures, and the force of emotions.

Individualised power or agency can be a creative force or it can cause limitations for individuals, or both can occur simultaneously. For example, Wallington’s love for his son was a creative and beneficial emotion, yet that love also brought responsibilities that affected his ability-to-act, such as searching for a doctor in the early hours of the morning while experiencing agitation and anxiety. Anna Jónasdóttir adopted a Marxist perspective to argue that love is “a creative/productive - and exploitable - human capacity, comparable in significance to labour or labour power.”<sup>28</sup> Although Jónasdóttir described love as power for a feminist exploration of gender and patriarchy in Western societies, its meaning can be expanded further to include parental and other human relationships, and it can encompass the full emotional range that includes fear, sympathy and compassion. Thus, although power denotes an ability-to-act, any action that occurs is innately manifest with both positive and negative stimuli and effects, which are often driven by emotions.

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<sup>27</sup> Scott, *Companion to Political Sociology*, 69.

<sup>28</sup> Anna Jónasdóttir, “Ch. 3, What Kind of Power is ‘Love Power?’” in *Sexuality, Gender and Power: Intersectional and Transactional Perspectives* eds., Anna G. Jónasdóttir, Valerie Bryson and Kathleen Jones (Abingdon: Routledge, 2011), 45.

Emotional driven actions must be included in any discussion of power and agency. Power and emotion have been described by Jonathan Heaney as “conceptual twins.”<sup>29</sup> He argued that if social relations are seen to imply relations of power, “they should also be seen to imply relations of emotion: relations of power are emotionally valanced.”<sup>30</sup> The role of emotion has often been underplayed in claims of patient agency in early modern medicine, when such claims rely on the observation of agency itself and not the story that lies behind the action. Fear, satisfaction, happiness, confidence, trust, anger and shame are some of the drivers of decision-making in the sphere of medicine and further exploration is needed of how they were enmeshed in the lives of early modern doctors and patients. In Healey’s words, “emotions and power are the fundamental and constitutive features of the lived lives of individuals and the social context in which they are embedded.”<sup>31</sup> Therefore, any conceptualisation of power must include the emotions as a compelling and indispensable form of power.

The complexities of power deepen even further when it becomes apparent that some aspects of power are present in unfathomable ways that are not overt and observable. When non-decision-making and non-events occur it raises the prospect that a reluctance to act is a form of agency in itself and a non-action can easily be mistaken as not occurring at all.<sup>32</sup> Some surreptitious markers of power can be the transaction of social myths, the use of gossip, language and symbols, as well as the

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<sup>29</sup> Jonathan G. Heaney, “Emotions and Power: Reconciling Conceptual Twins” *Journal of Political Power* 4: 2 (2011): 259.

<sup>30</sup> Heaney, “Emotions and Power”, 259.

<sup>31</sup> Heaney, “Emotions and Power”, 272.

<sup>32</sup> Elisheva Sadan, *Empowerment and Community Planning*, 43.

processes of communication and “how social legitimations develop around the dominant groups.”<sup>33</sup> These social legitimations could be restrictions in what might be said to various people, for example, a patient might not feel comfortable criticising a doctor face to face, yet it is legitimate for the patient to complain to other lay people and influence their medical choices. The use of frankness, rudeness and humour all play a role in social legitimations. An exploration of the societal structures and conventions within which medical decisions are made, and an awareness and recognition of where and how power was precisely exercised, can contribute to a greater understanding of the early modern doctor-patient relationship.<sup>34</sup>

Designating patients as a cohesive category within society leads to what is known as “the third face of power” articulated by sociologist John Gaventa.<sup>35</sup> Gaventa wondered why groups of people who were powerless remained quiescent without fighting back in some way. He argued that their quiescence was produced by power relations that over time led to a sense of powerlessness in a formerly resistant group, regardless of whether the original power was still present or not. Such behaviour was an adaptive response to withdrawing from the subjective sense of powerlessness.<sup>36</sup> Arguably, this stance can be found in the early modern patient’s acceptance of painful and harmful treatments. Even though patients might not have always believed in the efficacy of treatments, nevertheless, they chose to endure them, perhaps to counteract their own sense of powerlessness when facing disease

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<sup>33</sup> Elisheva Sadan, *Empowerment and Community Planning*, 44.

<sup>34</sup> Scott, *Companion to Political Sociology*, 70.

<sup>35</sup> John Gaventa, *Power and Powerlessness: Quiescence and Rebellion in An Appalachian Valley* (Chicago: University of Illinois Press, 1982).

<sup>36</sup> Gaventa, *Power and Powerlessness*, 16-17.

and death. In addition, the belief of some that suffering was a spiritual gift was both a counteraction to the fear of imagined disease and to the actual physical presence of illness.<sup>37</sup>

According to Michael Karlberg, discourses of power within Western societies continue to be “almost exclusively conflictual and adversarial.”<sup>38</sup> This can be seen in current interpretations of power relations in the field of early modern medicine, which occasionally explain that power resided in the strongest individual, narrative or entity. For example, Robert Weston stated that the person who dominated in the doctor-patient relationship “was dependent on the circumstances and the moment at which one or other sought to exert their power.”<sup>39</sup> Although power is now seen as nuanced, multifaceted and sophisticated, the emphasis on *domination* and the *exertion* of power shows how difficult it is to escape the notion of power as old-fashioned brute force, or *power-over*. Hannah Newton related how sick and dying children exerted power when “they demanded things from their carers”, when they were rude to their parents and when they refused to take medicines or “prepare spiritually for death”, - all forms of a child’s power over the parents.<sup>40</sup> Any observation of the agency of the child has to take into account how parents used agency to deliberately relinquish their “ability to act” when confronted with their sick child’s behaviour. Rather than seeing this behaviour as power over the parent,

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<sup>37</sup> Jan Frans van Dijkhuizen and Karl A. E. Enenkel, *The Sense of Suffering: Constructions of Physical Pain in Early Modern Culture* (Leiden: Brill, 2009).

<sup>38</sup> Michael Karlberg, “The Power of Discourse and the Discourse of Power: Pursuing Peace Through Discourse Intervention,” *International Journal of Peace Studies* 10, 1 (2005): 1.

<sup>39</sup> Weston, *Medical Consulting by Letter*, 94.

<sup>40</sup> Newton, *The Sick Child*, 181, 183.

the parent's passivity can also be recognised as a form of power. So, as Karlberg stated, "Given that the ways we think and talk about a subject influence the ways we act in relation to that subject, these adversarial discourses of power can be problematic because they obscure the mutualistic dimensions of power that have played a significant role in human history."<sup>41</sup> If power is only understood as *power-over*, then the relationship between early modern patients and doctors frequently appears antagonistic rather than co-operational. The concept of power as domination over another engenders a tendency to seek out confrontation, antagonism, accusation and argument in social relations, while establishing a holistic view of the range of forces at play can help to discover the mutualistic dimensions of the relationship.

Regarding early modern medicine, issues of power have sometimes ignored common ground and joint effort between doctors and patients. The lens of power has, from time to time, rested on a patient's agency without considering the overwhelming vulnerability that illness brought. When the type and severity of illness is taken into account it can be observed that a patient's agency necessarily underwent rapid and changing actions and responses. While this might seem obvious, it has not always been articulated. By conceptualising power as a complex labyrinthine network of social relations, which include reputational, structural, decision-making, and other elements and emotional forces, the occasions when doctor and patient were aligned in agreement can more easily be recognised. Such an approach can highlight the cases where there were joint efforts to combat illness,

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<sup>41</sup> Karlberg, *The Power of Discourse*, 1.

reciprocal friendship, and shared emotional support. As Chapter 3 will demonstrate, this approach might even prove complimentary to the early modern doctor's ability to cure.

The theoretical landscape of power has absorbed multiple meanings over the last half century, which are not always explicit in the phrase "patient power." Moreover, besides the patient and the doctor, medical interactions intermittently included families and friends, and they all operated under the sway of diverse cultural values and changing beliefs. By conceptualising power to include the range of emotional, moral and ethical considerations, and factors such as resilience and adaptability, it is possible to expand on and explore an increasing number of factors that acted upon the site of medical decision-making. To explore the myriad factors that affected early modern medical relationships, and to account for the multiple contextual layers that can arise from such an exploration, I suggest moving beyond the ambiguous terminology of *power*, to define the early modern medical relationship as one of "dynamic-equilibrium."

## II. A MEDICAL DYNAMIC-EQUILIBRIUM

When power is conceptualised as a social relational network of multiple dimensions, the word "power" becomes amorphous and fails to indicate any specific meaning. In the words of Andrew Sayer, power becomes "an overburdened term."<sup>42</sup> The terminology of dynamic-equilibrium can provide an alternative term that signifies the

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<sup>42</sup> Andrew Sayer, "Power, Causality and Normativity: A Critical Realist Critique of Foucault" *Journal of Political Power* 5: 2 (2012): 179.

full range of social relations that were inherent in the early modern medical relationship. In an interdisciplinary approach, the phrase “Dynamic Equilibrium” is borrowed from the code of chemistry. It denotes a closed and continual reaction that responds to the energy produced by its reactants, yet it maintains an overall consistency, longevity and balance.<sup>43</sup> Similarly, the doctor-patient relationship has maintained longevity even though it experiences changes through time. I have added a hyphen between dynamic and equilibrium to emphasise the dynamic nature of the doctor-patient relationship, which never realises equilibrium but always exists in a state of constant change. Equilibrium simply refers to the constancy with which protean positive and negative power mechanisms besieged medical relationships and created unceasing dynamism. The exchanges amongst reactants, or agents, are the various types of power that include reputational, structural, decision-making and emotional forces, as well as other relevant factors that exist within social relations. In chemistry, there is also a constituent called *Le Chatelier's Principle*, which states that any change in conditions will cause a shift in the dynamic equilibrium.<sup>44</sup> In medicine, changes in illness, its type, its severity and its treatments, and the social and cultural attitudes it delivers and attracts, change the nature of medical relationships across the synchronic-diachronic spectrum. The full range of social forces combined with the effects of illness, all vary considerably in each medical encounter and create continual dynamism. Indeed, “dynamism” is an expression that

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<sup>43</sup> Jim Clark, “An Introduction to Chemical Equilibria” (2013), accessed July 27, 2015, <http://www.chemguide.co.uk/physical/equilibria/introduction.html>; P. W. Atkins and J. de Paula, *Physical Chemistry* 8<sup>th</sup> edition (Oxford: Oxford University Press, 2006), 198-240.

<sup>44</sup> *Le Châtelier's Principle* states that if changing conditions disturb a dynamic equilibrium, the position of equilibrium shifts to counteract the change, to re-establish equilibrium.



has previously cropped up in discussions of the interactions between doctors and patients.<sup>45</sup>

In seventeenth-century England, a range of factors affected the doctor-patient relationship and altered the behaviour of participants. For example, doctors were unable to prevent deaths during plague epidemics and so the patients' own responsibility for their health increased, as they tried their own medical and magical recipes and wore amulets to ward off the plague. So far, the occurrence of these phenomena has been described in terms of *power-over*; of the doctor's power over the patient or *vice versa*. A medical dynamic-equilibrium implies the existence of specific factors in each individual doctor-patient encounter, such as the age and gender of the patient, the medical experiences and skills of the doctor, the societal status of the doctor or the patient, the triviality or seriousness of the illness, and even the personality and the emotional state of each participant. Again, there are infinite factors at play and power in the form of dominance is only one shifting variant.

The doctor-patient relationship has gone through many changes, some of which can easily be recognised. Besides the development of medical education, changes can be observed in the management of disease epidemics such as plague or small pox, in increased anatomical knowledge and breakthroughs in medical science, and in the incremental introduction of new standards of medical professionalism

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<sup>45</sup> Roy Porter wrote of "the dynamic interplay between sufferers and practitioners" in Porter, "The Patient's View," 185; Sawyer, "Patients, Healers and Disease," 12, wrote, "The exchange between healer and client was a dynamic one filled with drama." More recently, Robert Weston described "an authority matrix involving patients, *ordinaires* and consultants" as *dynamic* in, Weston, *Medical Consulting by Letter*, 93; Michael Stolberg wrote "the development of medicine always has its own dynamic" in Stolberg, *Experiencing Illness*, 216; Patrick Wallis wrote of "the dynamic of ongoing patient-practitioner relationships" in Jenner and Wallis, *Medicine and the Market*, 62.

since the 1518 inception of the College of Physicians. In addition, the advent of anesthesia, analgesia and antibiotic therapy have all brought about significant changes for both doctors and patients, and the society in which they exist. The adaptations that occurred in response to these changes created a medical dynamic-equilibrium by their ceaseless fluctuations. This thesis begins the process of exploration by recognising some of the many factors that contributed to making the early modern medical relationship into a medical dynamic-equilibrium. It examines the effects of these various factors and seeks to highlight the occurrence of epiphenomena. The model of a dynamic-equilibrium also has the potential to be extended to current medical encounters, as changes develop rapidly and patients consult the internet before the doctor. Before outlining the chapter structure of the thesis, the following section will trace how the social history of medicine has dealt with the concept of power.

### III. BACKGROUND

Exploring past scholarship highlights how evolving notions of power have been used to interpret the early modern doctor-patient relationship so far. In the early twentieth-century, some medical writers portrayed patients as gullible and stupid, fooled by medical tricksters who sold them useless nostrums; a situation which can now be recognised as the practitioners *power-over* patients.<sup>46</sup> For many early modern patients, particularly the poor, the options available to them were either “self-

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<sup>46</sup> For example, Jameson, *The Natural History of Quackery*, 77, 134. See p.3, n 7.

medication, cunning men or unlicensed physicians” and magical cures.<sup>47</sup> Although these patients were seeking out local healers and not necessarily consulting qualified physicians, nevertheless, they constitute a significant body of patients who were dependent on the opinions of their practitioners. As late as 1971 Keith Thomas documented the decline of magical healing and stated that patients seeking magical cures sought guidance from local authorities as to which cures were acceptable or not.<sup>48</sup> Thomas suggested that these patients displayed unquestioning trust in their practitioners and were often kept in ignorance of the medical formulas they took.<sup>49</sup> Clearly these patients were generally thought to be powerless in their medical relationships.

The view that many early modern patients were powerless changed with the publication of an article written in 1976 by Nicholas Jewson, which proved to be a pivotal juncture in the historiography of the doctor-patient relationship and its affiliation with power.<sup>50</sup> In a critique of modern medical relationships, Jewson argued that medical knowledge had steadily moved into the hands of the increasingly professionalized and powerful doctors of the modern era.<sup>51</sup> Modern patients seemed to have disappeared under the weight of the doctors’ power and the impact of Foucault’s “medical gaze,” which served to bolster that power.<sup>52</sup> Edward Shorter

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<sup>47</sup> Hug, *Impostures in Early Modern England*, 53.

<sup>48</sup> Keith Thomas, *Religion and the Decline of Magic: Studies in Popular Beliefs in Sixteenth and Seventeenth Century England* (Harmondsworth: Penguin, 1978), 227.

<sup>49</sup> Thomas, *Religion and the Decline of Magic*, 214.

<sup>50</sup> N.D. Jewson, “The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870” *Sociology* 10, 2 (1976): 225-244.

<sup>51</sup> Jewson, “Disappearance of the Sick-Man,” 225, 234-235.

<sup>52</sup> For a discussion on the “medical gaze” see, Flurin Condrau, “The Patient’s View Meets the Clinical Gaze,” *Social History of Medicine* 20, 3 (2007): 525-540; Foucault, *Power*, 334-335; Jones and Porter, *Reassessing Foucault*; Waddington, *An Introduction to The Social History of Medicine*, 5-8

later supported this viewpoint by arguing that modern patients had lost their humanity and had become just another number in the medical clinic.<sup>53</sup> He described a “massive break-down in doctor-patient relations.”<sup>54</sup> Both Jewson and Shorter saw the bedside of the early modern patient to be a site where patients had the power to choose their own doctor and dictate their own medical treatment.<sup>55</sup> Jewson suggested that the early modern layperson had exerted much greater control in past medical encounters than “we are familiar with nowadays.”<sup>56</sup> And Shorter looked back to an age when pre-modern patients were treated holistically.<sup>57</sup> A growing awareness of the power of early modern patients thus emerged because of critical attitudes towards modern hospital medicine and the growing professionalisation of doctors. At this stage, it was a generalised awareness that still required further refinement of the notion of power and an appreciation of the many other social forces at play.

Jewson demonstrated how early modern patients held some degree of power from the system of early modern patronage, however, this type of power was limited to a minority, which “consisted of a small coterie of patients drawn from the ruling class” and “centered around the collection of fees.”<sup>58</sup> He argued that doctors had “formulated their definitions and explications of illness to accord with the expectations of the client.”<sup>59</sup> Although patronage explained one aspect of early modern patient power, more importantly, this was only the beginning of discovering

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<sup>53</sup> Edward Shorter, *Bedside Manners: The Troubled History of Doctors and Patients* (Harmondsworth: Viking, 1986).

<sup>54</sup> Shorter, *Bedside Manners*, 21.

<sup>55</sup> Jewson, “Disappearance of the Sick-Man,” 232; Shorter, *Bedside Manners*, 21.

<sup>56</sup> Shorter, *Bedside Manners*, 211.

<sup>57</sup> Shorter, *Bedside Manners*, 21.

<sup>58</sup> Jewson, “Disappearance of the Sick-man,” 232.

<sup>59</sup> Jewson, “Disappearance of the Sick-Man,” 232.

how patients experienced the medical interaction. When Jewson suggested that patient voices lacked power and were missing from modern medical cosmology, Roy Porter asked historians to try and identify early modern patients to discover how they viewed their medical world.<sup>60</sup> Porter thought that scholars had ignored the sufferers role in the healing process, instead favouring the doctors medical achievements.<sup>61</sup> He flagged a growing revolution against “physician-focused history” and turned towards the newly-articulated social history of medicine.<sup>62</sup> Porter’s rallying cry for the patient’s point of view came a decade after Jewson’s article and this renewed interest in the patient’s experience can still be seen partly as a reaction to modern medicine, which was thought to be missing holistic values. Rediscovering early modern patient viewpoints seemed to be connected in some way to counteracting the power of the modern doctor. Finding the voices of these early modern patients subsequently served to imbue them with a degree of power, as their agency or ability to act could now be observed. However, in exactly what way they were powerful was yet to be fully articulated.

The historical trope of patient power was increasingly utilised in the scholarship yet the meaning of power remained ambiguous. In 1987, Lucinda Beier concluded her book had “returned repeatedly to the joint issues of responsibility and

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<sup>60</sup> Porter, “The Patient’s View,” 175-198.

<sup>61</sup> For example: Dorothy A. Stansfield, *Thomas Beddoes M.D. 1760-1808: Chemist, Physician, Democrat* (Dordrecht: D. Reidel Publishing Company, 1984); Derrick Baxby, *Jenner’s Smallpox Vaccine: The Riddle of Vaccinia Virus and its Origin* (London: Heinemann, 1981); George Whitfield, *The First Thirty-Seven Registrars of the College* (Birmingham: University of Birmingham Press, 1981); Alexander Peddie, *Recollections of Doctor John Brown: With A Selection From His Correspondence* (London: Percival, 1893); John Watson, *A Doctor of the Old School*/by Ian McLaren (London: Hodder & Stoughton, 1895); Mrs Alec Tweedy, *George Harley F.R.S. The Life of a London Physician/ Edited by his Daughter Mrs. Alec Tweedy* (London: Scientific Press, 1899).

<sup>62</sup> Porter, “The Patient’s View,” 176.

power” and that ultimately, “power rested in the hands of the sufferers.”<sup>63</sup> By 2007, Michael Stolberg detailed certain factors that were apparent in the early modern decline of uroscopy as a diagnostic tool. He ascribed the continuation of the practise of uroscopy to “early modern medical market patient power.”<sup>64</sup> In what way, however, did this form of power work? It is not clear whether patients had power as a group, or that patient agency in the form of personal demands for uroscopy might be the reason. There is also the structural power of the medical marketplace and issues of supply and demand. Stolberg pointed out the physicians’ fear of making fools of themselves if they resorted to uroscopy; fears which can be interpreted as an expression of social-relational power. It appears that a more explicit conceptualisation of power could prove helpful in exploring these processes and explaining both the doctor’s and the patient’s experiences in greater detail.

Recent historiography has dealt with a range of factors that were not specifically articulated as relating to power, yet, they implied issues of power. Jennifer Evans demonstrated how fathering children was “important to male social standing”, thereby indicating that men as well as women could be prey to the structural power of patriarchal society.<sup>65</sup> The role of women in early modern medicine has been at the forefront of research and scholars have looked at the “female matrix of knowledge” and the medical care performed by and on women.<sup>66</sup>

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<sup>63</sup> Beier, *Sufferers and Healers*, 259.

<sup>64</sup> Stolberg, “The Decline of Uroscopy”, 313.

<sup>65</sup> Jennifer Evans, “‘They Are Called Imperfect Men’: Male Infertility and Sexual Health in Early Modern England” *Social History of Medicine* 29: 2 (2014): 311.

<sup>66</sup> Jennifer Wynne Hellwarth, “‘Be Unto Me as a Precious Ointment’: Lady Grace Mildmay, Sixteenth-Century Female Practitioner” *Dynamis* 19 (1999): 116; Daphna Oren-Magidor, “Literate Laywomen, Male Medical Practitioners and the Treatment of Fertility Problems in Early Modern England” *Social History of Medicine* 29: 2 (2016): 290-310; Lyn Bennett “Women, Writing, and

Several scholars have looked at the structural power of religion in regard to medicine.<sup>67</sup> David Harley discussed the efficacy of the rhetoric used in constructing disciplines of knowledge, particularly medical and scientific knowledge, thereby analysing the communicational processes of power. Harley also highlighted how the history of medicine “has yet to develop its own distinctive methods and approaches.”<sup>68</sup> And, while Mary Fissell suggested historians might rethink “some of the categories of analysis we have been using for the past few decades of the social history of medicine”, Hal Cook pointed out that because medicine is “intimately connected to other aspects of life” we should “seek fresh means to address histories of body and mind united rather than divided.”<sup>69</sup> Conceptualising a specific understanding of power and describing the processes of power as a medical dynamic-equilibrium, is an attempt to meet these calls for a more distinct methodology for understanding the history of early modern medicine.

Inherent methodological difficulties have contributed to controversy in the realm of patient power. Ronald Sawyer’s 1986 thesis determined that a distinguishing characteristic of clergyman-doctor Richard Napier’s (1559-1634) practice was “the power of the patient” in being able to choose Napier and accept his

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Healing: Rhetoric, Religion, and Illness in An Collins, “Eliza”, and Anna Trapnel” *Journal of Medical Humanities* 36 (2015): 157-170.

<sup>67</sup> Anne Lear, “Thank God for Haemorrhoids! Illness and Identity in a Seventeenth-Century Woman’s Autobiography” *Women’s Writing* 12: 3 (2005):337-345; John R. Yamamoto-Wilson, *Pain, Pleasure and Perversity: Discourses of Suffering in Seventeenth-Century England* (Farnham: Ashgate, 2013); Michael Stolberg, “Metaphors and Images of Cancer in Early Modern Europe” *Bulletin For the History of Medicine* 88 (2014): 48-74.

<sup>68</sup> David Harley, “Rhetoric and the Social Construction of Sickness and Healing” *Social History of Medicine* 12” 3 (1999): 407.

<sup>69</sup> Mary E. Fissell, “Introduction: Women, Health and Healing in Early Modern Europe” *Bulletin For the History of Medicine* 82: 1 (2008): 1; Harold J. Cook, “The History of Medicine and the Scientific Revolution” *Isis* 102: 1 (2011): 1.

treatment.<sup>70</sup> Patients, therefore, displayed power/agency through their choice of doctor. Since the meaning of power has expanded to include structural power and socio-relational forms of power, this apparent and observable choice becomes more complicated and it is possible to conclude there were other reasons behind patient choices, which have yet to be recognised or explored. By applying a new conceptualisation of power it becomes clear that various other forces besides agency were at play in Napier's interactions with his patients. Indeed, Sawyer depicted Napier's status as clergyman as a form of leverage in his medical practice and demonstrated how Napier frightened his patients with the threat of excommunication if they did not comply with his recommendations.<sup>71</sup> As Napier was a clergyman-doctor he was likely to get more deference from patients, and "it was a price the patient had to pay to take advantage of this Godly healing."<sup>72</sup> Furthermore, "some topics were completely taboo" and Napier had few patients with venereal disease because it elicited "condemnation and embarrassment."<sup>73</sup> These observations demonstrated that consulting Napier was not simply a matter of patient agency, because once this particular doctor was chosen patients were required to submit and comply. Napier's expectations influenced the patient's choice of doctor. It can be seen that many individual circumstances, of both the doctor and the patient, influenced patient choice. For example, if a doctor had a good reputation, lived nearby, offered a particular treatment, or followed a specific religion, then patient

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<sup>70</sup> Sawyer, "Patients, Healers and Disease," 35.

<sup>71</sup> Sawyer, "Patients, Healers and Disease," 35.

<sup>72</sup> Sawyer, "Patients, Healers and Disease," 34.

<sup>73</sup> Sawyer, "Patients, Healers and Disease," 35.



choice was conditioned by these limitations or conveniences. Patient agency was necessarily mediated by prevailing social and cultural influences, and decision-making combined these influences with a range of personal and pragmatic reasons.

The issue of power in the form of patient choice inevitably raised questions about which doctors that patients were choosing. Discourse on patronage supposed that rich patients wielded power over lower status doctors, however, historical debate produced contradictory findings.<sup>74</sup> On the one hand, doctors were thought to be compelled to be obsequious in the employ of powerful patrons, yet on the other hand, powerful physicians were thought to condescend to treat elite patients, and they were often disrespectful towards them.<sup>75</sup> When Mary Lindeman wrote of medical status, she argued “It is simply not true that the well-to-do patronized ‘legitimate’ practitioners while the less well-off...visited ‘quacks’.”<sup>76</sup> Robert Weston found “little evidence of social position interposing in the decision-making in the letters from patients.”<sup>77</sup> Overall, there was a great deal of intermingling between all layers of society when it came to medical care, which indicates a medical dynamic-equilibrium that was influenced by all kinds of power relationships.

Social historian Hal Cook documented a loss of professional power for doctors in the late seventeenth century and finished his study with an account of the

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<sup>74</sup> See, Jewson, “Disappearance of the Sick-Man,” 232; William Birken, “The Social Problem of the English Physician in the Early Seventeenth Century,” *Medical History* 31, 2 (1987): 201-216; F. Dawbarn, “Patronage and Power: The College of Physicians and the Jacobean Court,” *British Journal of History and Science* 31, 1 (1998): 1-19; Cook, *Decline of the Old Medical Regime*, 53.

<sup>75</sup> For John Radcliffe’s disrespect towards King William III, see *Munk’s Roll*, 455. “In 1699 king William, after his return from Holland, sent for Radcliffe, and, showing him his swollen ankles, while the rest of his body was emaciated, said - “What think you of these?”...“I would not have your Majesty's two legs for your three kingdoms” - which freedom lost the king's favour.”

<sup>76</sup> Lindemann, *Medicine and Society*, 199.

<sup>77</sup> Weston, *Medical Consulting by Letter*, 97.

Rose Case, which awarded apothecaries the right to prescribe and greatly upset the medical fraternity, who saw it as a loss of power.<sup>78</sup> Cook's study demonstrated the power of occupational structures clashing within early modern society. Cook, credited with introducing the terminology of the "medical marketplace", recognised that doctors were engaged in an economic struggle to maintain their businesses, which was yet another network of structural and socio-relational power.<sup>79</sup> As Andrew Wear noted in 2000, however, the implication of the "medical marketplace" was that there were "no ethical constraints or charitable impulses", simply a striving for profit.<sup>80</sup> In a substantial network of social relations, ethical and moral impulses should be included as forms of social power that influence a person's individual decision-making.

Research has shown that there were many modes of interaction between practitioners and the sick, in addition to the economic forces of the medical marketplace. For example, scholarship has since described the physically gruesome horrors and emotionally charged predicaments that faced both doctors and patients when they encountered disease.<sup>81</sup> Other modes of medicine involved caring for chronically ill patients, altruistic medical work in the cottages of the poor, and hours spent responding to patients' epistolary medical requests.<sup>82</sup> Moreover, power was not

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<sup>78</sup> Cook, *Decline of the Old Medical Regime*, 246; Harold J. Cook, "The Rose Case Reconsidered: Physicians, Apothecaries and the Law in Augustan England," *Journal of the History of Allied Sciences* 45, 4 (1990): 527-555.

<sup>79</sup> For a comprehensive study on medical advertising see, Elizabeth Lane Furdell, *Publishing and Medicine in Early Modern England* (New York: University of Rochester, 2002).

<sup>80</sup> Wear, *Knowledge and Practice in English Medicine*, 29.

<sup>81</sup> Payne, *With Words and Knives*.

<sup>82</sup> For studies on medical correspondence see, Wayne Wild, *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam and New York, Rodopi, 2006); Weston, *Medical Consulting in France*.

dependent on monetary transactions, which were often only the starting or finishing point and not the sum of the relationship. Arguably, salaried hospital doctors, court physicians and doctors at sea, as well as army doctors, those in household employment, and doctors who pursued medicine out of interest and not as a business, were only dependent on the medical marketplace in its most general and comprehensive sense.<sup>83</sup> Issues of patient power were also dependent on geographic location in places where the numbers of doctors could be lower and choice of doctor was not always an option.<sup>84</sup> These problems in methodological interpretation can potentially be resolved by conceptualising power as a widespread and inclusive network of far-reaching and thoroughly dynamic social relations.

One of the largest studies to specifically address the topic of power was Mary Fissell's study of eighteenth-century Bristol. Fissell described in detail how doctors became the unexpected beneficiaries of medical power when institutions such as the workhouse and the hospital became the norm.<sup>85</sup> This recognition of the structural power of medical authority characterised the doctors' gains in power as part of a wider movement that took place in conjunction with the eighteenth-century reformation of manners. Fissell argued that prior to the rise of institutions doctors were unable to instigate a privileged interpretation of illness above that of the patient,

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<sup>83</sup> For the variety of doctors employment roles see, Eric E. Gruber von Arni, *Hospital Care and the British Standing Army 1660-1714* (Aldershot: Ashgate, 2006); Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 2002); Elizabeth Lane Furdell, *The Royal Doctors, 1485-1714: Medical Personnel at the Tudor and Stuart Courts* (New York: University of Rochester Press, 2001).

<sup>84</sup> On Lancashire see, Jonathan Healey, *The First Century of Welfare: Poverty and Relief in Lancashire 1620-1730* (Woodbridge: Boydell Press, 2014); Steven King, *A Fylde Country Practice: Medicine and Society in Lancashire, 1760-1840* (Lancaster: Lancaster University, 2001).

<sup>85</sup> Fissell, *Patients, Power and the Poor*, 11.

therefore, the patient previously held power.<sup>86</sup> However, when power is re-conceptualised as a set of complex social relations, it becomes apparent that doctors had narratives of illness prior to the reformation of manners and the rise of institutions, which gave them medical power in a variety of circumstances. Their narratives differed considerably from patient narratives because they used Latin, and patients were often unable to understand the doctor's distinct and specialised medical terminology. Moving beyond power as individual agency can add to new areas of research in the social history of medicine.

The notion of patient power has not been overtly stated in some of the scholarship, perhaps because patient power is yet to be interrogated and remains ambiguous. Recent foci that touched on power relations have included gender and illness, the female patient, the sick child, epistolary studies and medical recipe collections.<sup>87</sup> They have all greatly furthered our knowledge of the doctor-patient relationship, however, a reassessment of the overall picture of how we understand power can enhance existing studies and create further contributions.

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<sup>86</sup> Fissell, *Patients, Power and the Poor*, 11.

<sup>87</sup> For varied aspects of the doctor patient relationship see, Stolberg, *Uroscopy in Early Modern Europe* (Farnham: Ashgate, 2015); Olivia Weisser, *Ill Composed: Sickness, Gender, and Belief in Early Modern England* (New Haven: Yale University Press, 2015); Churchill, *Female Patients in Early Modern Britain*; Newton, *The Sick Child*; M.A. Katritzky, *Healing, Performance and Ceremony in the Writings of Three Early Modern Physicians, Hippolytus Guarinonius and The Brothers Felix and Thomas Platter* (Farnham: Ashgate, 2012); Lisa Wynne Smith, "Secrets of Place: The Medical Casebooks of Vivant-Augustin Ganiere," in *Secrets and Knowledge in Medicine and Science, 1500-1800* eds., Elaine Leong and Alisha Rankin (Farnham: Ashgate, 2011); Alun Withey, *Physick and The Family: Health, Medicine and Care in Wales, 1600-1750* (Manchester: Manchester University Press, 2011); James Kelly and Fiona Clark, *Ireland and Medicine in the Seventeenth and Eighteenth Centuries* (Farnham: Ashgate, 2010); Andrew Cunningham, *The Anatomist Anatomis'd: An experimental Discipline in Enlightenment Europe* (Farnham: Ashgate, 2010); Lauren Kassell, *Medicine and Magic in Elizabethan London: Simon Forman, Astrologer, Alchemist, and Physician* (Oxford: Clarendon Press, 2005).

#### IV. SOURCES AND METHODOLOGY

Historical questions create their own context, which in turn influences the choice of sources and methodology. Accordingly, this thesis explores the doctor-patient relationship in seventeenth-century England by examining evidence relating to, or generated by, patients, medical practitioners and their sphere of associates. It employs the methodology of qualitative research, which is commonly used to show how human beings understood, experienced and produced their social world.

Qualitative research relies mainly on interpretation and analysis of primary source data, however, it goes beyond the meanings that were originally intended, to analyse societies as a whole. Sources for this project have been gathered from printed, digital and archival manuscript collections and include a wide range of historical material in the form of diaries, letters, pamphlets, broadsheets, recipe books, medical tracts and advertisements, doctors' case-notes and journals.<sup>88</sup> Old Bailey records and Quarter session records have been consulted, as crimes causing injuries often required the attendance of a doctor, and quarter session petitions show how the poor were able to access medical care. Additional sources have been located in the form of doctors' wills, apothecaries' accounts, and prison records.<sup>89</sup> Due to the revisionist nature of the thesis, some familiar characters from the seventeenth-century, both patients and

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<sup>88</sup> For diaries see, Patricia Pate Havlice, *And So To Bed: A Bibliography of Diaries Published in English* (Metuchen: Scarecrow Press, 1997); Robert A. Fothergill, *Private Chronicles: A Study of English Diaries* (London: Oxford University Press, 1974); William Matthews, *British Diaries: An Annotated Bibliography of British Diaries Written Between 1442 and 1942* (Berkeley: University of California Press, 1950); James Aitken, ed. *English Diaries of the XVI, XVII and XVIII Centuries* (Harmondsworth: Penguin Books, 1941); Arthur Ponsonby, *English Diaries: A Review of English Diaries From the Sixteenth to the Twentieth Century With an Introduction to Diary Writing* (London: Methuen, 1923).

<sup>89</sup> For example, Woodstreet Compter-debtor's prison records list medications given to sick prisoners. CLA/028/03, "Care of Sick Prisoners in Woodstreet Comptor," 1676-1721, LMA.

doctors, are freshly analysed. With each subsequent investigation these sources continue to yield new insights on power relations.

The analysis of historical documents generates tension between sources that have survived and those that are missing, or unimagined. Furthermore, the original intentions and meanings embedded in texts are never completely known. People made their own choices about what to include and what to leave out, and they followed cultural and literary conventions that influenced how they recorded events in their lives.<sup>90</sup> Accordingly, the sources have been used with caution and an appreciation of their limitations.

Non-medical material from diaries, pamphlets and secondary source historical sources provide a rich background with which to understand the doctor-patient relationship. However, this thesis is squarely focused on medical encounters and although the biographical details of individuals have been given consideration when they were available, such information does not always appear within the thesis. Medical sources have their own constraints, as participants in medical encounters rarely give full explanations of their thoughts or actions, and the sick did not always record a visit from the doctor. Diaries produce variable findings, depending on the severity of illness and the character and whim of the writer. The nature of chronicling illness ranges from a scant mention of being ill to recording every symptom and

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<sup>90</sup> See, Michelle Dowd and Julie Eckerle, *Genre and Women's Life Writing in Early Modern England* (Farnham: Ashgate, 2007); Paul Lobban, "Inhabited Space: Writing as Practice in Early Modern England," (PhD Thesis: University of Adelaide, 2001); Charlotte F. Otten, ed. *English Women's Voices, 1540-1700* (Miami: Florida International University Press, 1992); Elspeth Graham, ed., *Her Own Life: Autobiographical Writings by Seventeenth-Century Englishwomen* (London: Routledge, 1989).

listing all medications. When the course of illness ran smoothly and the medical outcome was pleasing, there was no need for a writer to record bland details. Much more likely to be recorded were the times when illness went badly and the experience was painful, or the treating doctor was unskilled. It is difficult to tell whether a doctor was involved in a case of illness when the sufferer only focused on his or her own experience. People also participated in malicious gossip about doctors in general, yet admired and appreciated their own doctors. Less available evidence of patient satisfaction, and more generalized criticism of doctors as a group, has resulted in an overly critical assessment of early modern doctors in general.

While diaries and other written materials indicate a variable level of education and literacy, records from the Lancashire quarter sessions have been utilized to gain insight into the medical care of the poor and uneducated. Quarter session petitions reveal how the suffering poor requested monetary and medical help from local magistrates. The Lancashire quarter session records also provide much needed information about the counties, as opposed to London. Several regional studies of medicine have been carried out, yet the similarities and differences between London and the provinces remain elusive.<sup>91</sup> For this reason, I have also drawn upon the Kenyon Family correspondence. The Kenyon family was well known in Lancashire and there is a substantial corpus of material, which contains

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<sup>91</sup> For example, Isla Fay, *Health and the City: Disease, Environment and Government in Norwich, 1200-1575* (Woodbridge: Boydell Press, 2015); Alun Withy, "'Persons That Live Remote From London': Apothecaries and the Medical Marketplace in Seventeenth- and Eighteenth-Century Wales," *Bulletin of the History of Medicine* 85 (2011): 222-247; Ian Mortimer, "The Rural Medical Marketplace in Southern England, c. 1570-1720," in Jenner and Wallis, *Medicine and the Market*, 69-87; Fissell, *Patients, Power and the Poor*.

many letters that refer to ill health and medical consultations.<sup>92</sup> It has been essential to use as comprehensive a body of evidence as possible to achieve viewpoints from all manner of participants involved in the doctor-patient relationship.

In addition to written materials representing the view of patients are the diaries, case notes and journals belonging to doctors. Doctors were increasingly recording the medical cases they treated and the medicines they prescribed.<sup>93</sup> Although historians have been more than ready to accept the patients' accounts and experiences of illness, they have been less ready to accept the doctors' accounts of treating illness, from a suspicion that medical practitioners portrayed themselves in the best light possible and talked up their cures. To reduce prejudice against the doctors' versions of events, the body of doctors' notes used here includes those notes that were obviously not intended for publication. These particular notes were written in a form that was not always presentable for a reader, sometimes being scribbled in shorthand or Latin. I also use doctors' published and public accounts of treating illness, as they came under a different type of scrutiny – from the contemporary reader and potential patient. The early archives of the College of Physicians have also proved valuable for understanding the viewpoint of a certain group of doctors; the physicians. Their attempts to control medical practitioners within London serve

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<sup>92</sup> DDKE “Kenyon Family of Peel Hall,” LRO.

<http://archivecat.lancashire.gov.uk/CalmView/Record.aspx?src=CalmView.Catalog&id=DDKE>

<sup>93</sup> For a detailed assessment of the nature and use of doctor's case notes see, Lauren Kassell, “Casebooks in Early Modern England: Medicine, Astrology, and Written Records,” *Bulletin of the History of Medicine* 88, 4 (2014): 595-625. Also see, Irma Taavitsainen and Paivi Pahta, eds., *Early Modern English Medical Texts* (Philadelphia: John Benjamins Publishing Co., 2010).



to illuminate many details of medical practice, more generally, in seventeenth-century England.<sup>94</sup>

Drawing on published medical material, in the form of medical texts and advertisements, indicates the types of treatments and cures that medical practitioners were offering to the public and the services that patients sought. Besides medical textbooks that collated a vast range of medical knowledge, medical case reports and papers from *Philosophical Transactions*, the Royal Society's journal from 1662 onwards, all demonstrate the state of seventeenth-century medicine and hint at its future direction. Broadsheets, pamphlets and almanacs greatly contribute to an understanding of how early modern people traditionally and culturally dealt with the issues surrounding medicine.<sup>95</sup> From secondary sources, like Ian Mortimer's study of probate records, we know there was a steady increase in the number of doctor-patient consultations over the course of the seventeenth century.<sup>96</sup> The implication from all these sources is that no matter how much the doctor appears to have been denigrated within early modern society, people kept on consulting them. Rather than focusing on one specific and limited source of material, this thesis has drawn on a wide range of medical material to gain an overview of the diversity of the medical landscape in seventeenth-century England. The following section outlines the framework of

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<sup>94</sup> "Annals of the Royal College of Physicians, Part I, 1518-1915," (Reading: Adam Matthews Publications, 1991), microfiche, Barr Smith Library, Adelaide. (Hereafter cited as *Annals*, RCP).

<sup>95</sup> For early modern pamphlets see, Margaret Healy, "Popular Medicine" in *The Ashgate Research Companion to Popular Culture in Early Modern England* eds., Andrew Hadfield, Matthew Dimmock and Abigail Shinn (Farnham: Ashgate, 2014), 309-322; Louise Hill Curth, *English Almanacs, Astrology and Popular Medicine, 1550-1700* (Manchester: Manchester University Press, 2007); Joad Raymond, *Pamphlets and Pamphleteering in Early Modern Britain* (Cambridge: Cambridge University Press, 2006). For almanacs see, B. Capp, *English Almanacs, 1500-1800: Astrology and the Popular Press* (Ithaca: New York, 1979).

<sup>96</sup> Mortimer, *Dying and the Doctors*, 204.

chapters, each of which examine aspects that show the vibrant, chaotic and dynamic nature of the early modern doctor-patient relationship.

## V. CHAPTERS

The thesis is divided into two parts with part one consisting of two chapters. The first chapter focuses on doctors and the second chapter explores the patient and the illness. Both of these chapters explore different types of power, and a range of other forces, which affected the understanding and behaviour of those within the early modern doctor-patient relationship. Part two of the thesis considers three further aspects of early modern medical interactions. In 1692 after a brutal skirmish with the Dutch fleet in the English Channel, a number of sailors were admitted to St. Thomas's Hospital, London. They received medical care for their injuries and were discharged after varying periods of treatment. The hospital treasurer asked the treating doctors to provide a list of sailors, with a brief comment indicating whether the medical outcome for each sailor was "cure, death, or otherwise."<sup>97</sup> The phraseology of "cure, death or otherwise" offers a simple representation of what actually occurred. Some patients were cured, some died, and some maintained a stable relationship with their medical practitioners as they managed ongoing or chronic illness. As such, they are three aspects of medical interactions that can be utilised to highlight forces within the social relational network, which make the

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<sup>97</sup> ACC/2866/001/001-008, "Papers Relating to Dispute Between the Governors of St. Thomas' Hospital and Their Physician, Richard Torless, and Surgeon, Thomas Elton, Concerning Their Dismissal For Receiving Payment For Treating Sick and Wounded Seamen At St. Thomas' Hospital," 1703, LMA. For an unrelated discussion regarding this event see, Gruber Von Arni, *Hospital Care and the British Standing Army*, 107.

doctor-patient relationship into a medical dynamic-equilibrium. Part two of the thesis, therefore, takes its lead from this seventeenth-century phrase and the last three chapters explore medical relationships in the light of cure, death or otherwise.

Chapter 1 explores the dynamic range of medical practitioners who offered their services to early modern patients. The chapter looks at the forces of reputational and structural power, and associated factors such as patronage and nepotism, which all served to situate practitioners within early modern hierarchies of medicine. Some doctors had large medical practices and no medical degree, while others had a medical degree but were not sanctioned to practise medicine by the College of Physicians. The tripartite system of medicine, a hierarchy of physicians, surgeons and apothecaries, overlaps in many areas and does not always account for practitioners who relied on patronage, nepotism or personal reputation, and it excludes “irregular” doctors<sup>98</sup> and those who were labeled as quacks by colleagues but who participated in medical practice in seemingly capable style with or without a degree.<sup>99</sup> Historians have described a panoply of medical practise, while some historians have lately footnoted their own definition of a doctor and what they mean by a professional or irregular practitioner.<sup>100</sup> In early modern sources, patients generally called their medical practitioners “Doctor” - whatever the doctors’ status

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<sup>98</sup> Pelling, *Medical Conflicts*; Margaret Pelling and Francis White, “Physicians and Irregular Medical Practitioners in London 1550-1640 Database” (London: Centre for Metropolitan History, 2004), *British History Online*. Accessed 26 September 2016.

<http://www.british-history.ac.uk/no-series/london-physicians/1550-1640>

<sup>99</sup> See, John Badger, *An Exact Catalogue of All That Have Taken The Degree of Doctor of Physic in Our Two Universities From The Year 1659 to This Present Year 1695, Publish'd For the Benefit of All English-men, Particularly to Inform the People Of London, Who Are Honest and Regular Physicians* (London, 1694).

<sup>100</sup> Churchill, *Female Patients in Early Modern Britain*, Ch. 1, n. 2, p.2.

might be – and university qualifications were a dubious marker of actual medical skill. Exploring reputational and structural power highlights the difficulties that patients experienced in exercising their power of agency by choosing a doctor.

Chapter 2 argues that illness constituted a dynamic and unpredictable social force, which dictated how the doctor-patient relationship functioned. Illness was much more than a trigger for beginning the medical relationship. It acutely disturbed the existence, the habits, the occupations and even the political schemes of those who were sick, drawing interest and attention from onlookers in both positive and negative ways. The gravity of illness dictated a patient's ability to act. Illness was not confined to the immediate bodily sphere of the patient but influenced a much larger web of social relations, which included doctors, families, carers, communities, and official bodies. The type and severity of illness determined the twists and turns that occurred throughout the medical encounter and it often produced vulnerable patients. This chapter explores the powerful forces that existed at the actual sites of decision-making around illness.

With a working knowledge of the powerful forces surrounding doctors, patients and illness, Part II of the thesis examines specific interactions within medical relationships. Chapter 3 explores the power to cure and throws new light on a more nuanced meaning of cure for scholarly consideration. It compares domestic medicine with the cures recommended by doctors. Even though patients and doctors used a similar pool of medical recipes and ingredients, the way in which they were presented distinguished who possessed medical authority, or *power-over*. However, in these overlapping spheres there was a scale of appropriate medical treatments that

often depended on the presence of medical authority. Patients could use domestic remedies in the early stages of an illness (or in the very late stages when nothing else had worked), but when illness became serious and severe they often turned to the doctor when seeking out who held the *power-to* cure.

Chapter 4 explores the doctors' power to read the signs of death. Doctors were often present at the patient's bedside when death was close, and they had recognised expertise in diagnosing and predicting death. The growing interest in anatomy made doctors knowledgeable on dying and death as they examined dead bodies for the medical secrets they yielded. The chapter also questions claims that early modern death was a peaceful and holistic process, where the patient died a natural death at home in a dignified manner, in the era of early modern bedside medicine. It raises the spectre of taphephobia – the very real fear of being buried alive - and it highlights a range of forces that created anxiety and fear, emotional forces that frequently accompanied patients who were faced with death.

Chapter 5 examines long-standing relationships between doctors and patients. Some patients were chronically ill and required a considerable amount of medical care. Such medical care necessarily required a different approach by all participants in the medical relationship. This chapter revisits and explores some well-known medical relationships to seek forces that played a role and which might have gone unrecognised in past interpretations that considered power to be patient agency. It argues that long-term illness often produced deep bonds between doctor and patient. As nuances in the relationship are explored the rich and diverse nature of individual associations comes to the fore.

The sources in this thesis are mainly limited to the later seventeenth century. The twentieth century has been noted as a juncture between pre-modern and modern medicine because of substantial improvements in treating disease. Consequently, early modern medicine can encompass three or more centuries; however, this period is far too long to make any generalisations about the doctor-patient relationship. A doctor practising in early sixteenth-century England might have made very different decisions from a doctor in the late eighteenth century, as the social relational forces during these periods saw significant changes in medical knowledge and practice. The seventeenth-century witnessed the development of chemical medicine and a decline in traditional Galenism. In mid-seventeenth century, the English Civil War brought changes in medical treatment via battlefield medicine. The Parliamentarians introduced pensions for those who were disabled, and for widows who had lost their husbands, thereby bringing new levels of medical and social support for wounded soldiers.<sup>101</sup> There was also a sharp increase in medical and other publishing after the Civil War, and the Restoration brought new and emerging interest in scientific pursuit under the patronage of Charles II and the creation of the *Royal Society*. Given the extent of these changes, my thesis will focus on the second half of the seventeenth century and will explore some of the multiple dimensions of the vast network of social relations that existed during that era.

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<sup>101</sup> Eric Gruber von Arni, *Justice to the Maimed Soldier: Nursing, Medical Care and Welfare for Sick and Wounded Soldiers and Their Families During the English Civil Wars and Interregnum, 1642-1660* (Aldershot: Ashgate, 2001).

## CHAPTER 1. Power Relations and Practitioners

On Monday 3 April 1620, a young William Lilly (1602-1681), unable to endure any country labour and told by his father he was good-for-nothing, departed Diseworth in Derby and headed for London to take up employment as a servant for Gilbert Wright; “a salt merchant known to Lilly’s father’s attorney.”<sup>1</sup> It took six days for Lilly to travel there on foot and on arrival he was provided with a new cloak and ate “good white bread” which he had never seen before.<sup>2</sup> He settled in and performed “all manner of drudgeries.”<sup>3</sup> Two years after his arrival Mistress Wright complained of a pain in her left breast. The small lump she found quickly increased in size and took on a reddish hue. Surgeons gave advice and ensuing treatments included “Pultises...Oils, Searcloaths, Plates of Lead, and what not.”<sup>4</sup> Further rapid growth of the lump followed. Painful and “noisesome” (smelly), it spread all over her breast and broke through the skin issuing a thin watery discharge. Lilly, the male servant of the house became his mistress’s medical attendant because “she would permit no Surgeon to dress it.”<sup>5</sup> But Lilly did much more than nurse her through her illness, getting out of bed two or three times in a night to dress the wound and change the “plaisters.” In 1624, shortly before her death, Lilly took a pair of “sizzors” and “cut

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<sup>1</sup> Patrick Curry, "William Lilly (1602-1681)," in *Oxford Dictionary of National Biography (ODNB)* (Oxford University Press, 2004). Accessed August 19, 2015.

<http://www.oxforddnb.com.proxy.library.adelaide.edu.au/view/article/16661>

<sup>2</sup>William Lilly, *The Last of the Astrologers: Mr Williams Lilly's History of His Life and Times from the Year 1602 to 1681 ed., by Katherine Briggs* (London: The Folklore Society, 1974), 8.

<sup>3</sup> Lilly, *Last of the Astrologers*, 8.

<sup>4</sup> Lilly, *Last of the Astrologers*, 11.

<sup>5</sup> Lilly, *Last of the Astrologers*, 11.

all the whole breast away...the Sinews, Nerves, &c” so that it appeared “mere Flesh, all raw, so that she could scarce endure any Unguent to be applied.”<sup>6</sup> She finally died, almost two years after the first appearance of the breast lump, when “a great cleft [broke] through the middle of her breast.”<sup>7</sup> Lilly went on to establish a career in astrological medicine and became famous for his astrological predictions.

Lilly was *not* a trained doctor but could not accurately be described as a quack, or one of the “vile people and unskillful persons without restraint, [who] make gainfull traffique by botching in Physicke,” a critique enunciated by physician John Cotta when referring to rival practitioners.<sup>8</sup> Lilly was a servant in the house, yet he was trusted over and above the known surgeons who had been consulted and whose treatment had been refused. Not only did Lilly protect Mistress Wright from the surgeons and provide nursing care, he also undertook the task of carrying out the surgeon’s job and was trusted to cause the least possible physical hurt. He was rewarded by confidence in his ability and he gained the gratitude of his mistress who intended to pay him handsomely for his efforts.<sup>9</sup> We cannot be sure what prompted the faith shown by Lilly’s mistress, but it appeared to come from her judgment of him as a person and not from a consideration of medical qualifications. Contrary to the tripartite hierarchy of medical practitioners, consisting of physicians, surgeons and apothecaries, Lilly’s story reveals that even though such hierarchies existed, it

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<sup>6</sup> Lilly, *Last of the Astrologers*, 11.

<sup>7</sup> Lilly, *Last of the Astrologers*, 11.

<sup>8</sup> John Cotta, *A Short Discoverie of the Unobserved Dangers of Severall Sorts of Ignorant and Unconsiderate Practisers of Physicke in England* (London, 1612), 8.

<sup>9</sup> Lilly, *Last of the Astrologers*, 11. (Mistress Wright gave him five pounds in ‘old Gold’ and then sent him to retrieve a further one hundred pounds from a trunk kept in a friend’s house, but when he got there he found no money because a kinsman of hers had taken it all away.)



cannot be assumed that they worked successfully in practice in seventeenth-century England. However accurate the historical knowledge is of social and cultural regulations, societies are often “too complex, too messy, and too indeterminate” for that historical knowledge to be taken as representative for the whole.<sup>10</sup> Social actors operated within complex social systems, creating relationships that were multilayered and networks that were multiplex.<sup>11</sup> The processes of such networks were driven by intricate dependencies and alliance formations between actors. The social alliance between Lilly and his employer overrode the reputational power of the attending surgeons.

Referring to groups of practitioners, such as *surgeons* or *physicians*, obscures how individual actors within the confines of each group behaved in their own socio-relational networks. Similarly, referring to the tripartite system of early modern medicine obscures how practitioner’s roles overlapped these categories or did not fit into this hierarchy at all. Ronald Sawyer’s 1986 thesis on the medical practice of clergyman-doctor Richard Napier (1559-1634), attempted “to get beneath the surface of the official tripartite hierarchy of medical practice” and he exposed “a different picture of officially sanctioned medicine than has hitherto been revealed.”<sup>12</sup> After studying Napier’s diaries, Sawyer found there was a “disjunction between the ideal

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<sup>10</sup> Robert Pool, Wenzel Geissler, *Medical Anthropology* (Maidenhead: Open University Press, 2005), 14.

<sup>11</sup> See Cohen R. Simpson, “Mutiplexity and Strategic Alliances: The Relational Embeddedness of Coalitions in Social Movement Organisational Fields” *Social Networks* 42 (2015): 42-59; Manuel Fischer and Pascal Sciarini, “Unpacking Reputational Power: Intended and Unintended Determinants of the Assessments of Actors’ Power” *Social Networks* 42 (2015): 60-71; Gonçalo Pereira, Rui Prada, Pedro A. Santo, “Integrating Social Power into the Decision-Making of Cognitive Agents” *Artificial Intelligence* 241 (2016): 1-44.

<sup>12</sup> Sawyer, “Patients, Healers, and Disease,” 55.

of the tripartite hierarchy and its reality.”<sup>13</sup> Besides Napier, large numbers of popular healers dwelt in the countryside and Sawyer found that the official licensing of practitioners was obscure and mostly immaterial to rural authorities.<sup>14</sup> Popular and official medicine was seen to be in “constant communication [and]...shared many structures of thought and action.”<sup>15</sup> Sawyer’s work demonstrated similarities between all categories of practitioners and cast doubt over the placement of physicians at the pinnacle of early modern medical hierarchy.

Scholars have found many similarities in medical practise amongst all types of practitioners. Not just restricted to Napier’s locality of the South-East Midlands, similarities have been found to exist between all levels of practitioner, to varying greater and lesser degrees, across the whole of England.<sup>16</sup> In 2009, Ian Mortimer’s work supported Sawyer, when he also found that “the tri-partite system has been shown to be a loose description of medical care.”<sup>17</sup> In addition, Rebecca Laroche commented on the inadequacies of this three-tier medical hierarchy when she pointed out “the tripartite division provides a system of repressive hierarchies that supports a narrative of the subjugation of women.”<sup>18</sup> With recognition that the tripartite system was not always an accurate description of medical practice, terms such as *medical marketplace* or *panoply* of medical practitioners have been more readily applied. Nevertheless, categorizing medical practitioners continues to present problems of

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<sup>13</sup> Sawyer, “Patients, Healers, and Disease,” 125.

<sup>14</sup> Sawyer, “Patients, Healers, and Disease,” 125.

<sup>15</sup> Sawyer, “Patients, Healers, and Disease,” 126.

<sup>16</sup> See Pelling, *Medical Conflicts*. 147. (Pelling suggested that similarities between profession and commerce brought physicians closer to the ‘irregulars’ they prosecuted and helps to explain why London apothecaries thought they were as good as the physicians.)

<sup>17</sup> Mortimer, *The Dying and the Doctors*, 210.

<sup>18</sup> Laroche, *Medical Authority*, 4.

interpretation and, as Wendy Churchill specified at the outset of her study on early modern female patients, her own interpretation of “professional” was meant to convey “paid medical practitioners” who practised medicine for a living and not any “organized group of practitioners which could claim a specialism or monopoly.”<sup>19</sup> That Churchill felt the need to specify what and who a professional practitioner was, indicates that present categorisations of practitioners remain ambiguous. These ambiguities can readily be attributed to the existence of societal and cultural power relations that took precedence over medical ability and contributed to reputational power.

This chapter examines how the reputations of medical practitioners within early modern England were affected by socio-relational power strategies and struggles. Evidently, patients employed all sorts of practitioners with and without prejudice and sometimes without prudence. While some practitioners were considered quacks, both then and now, many of them maintained viable medical practices and were recognized as competent doctors by their patients. Many physicians, on the other hand, were only admitted to the College of Physicians via patronage or nepotism. With an extensive range of early modern doctors to choose from, patients relied on instinct, listened to hearsay and took note of practitioner reputations. The first section of this chapter looks at socio-relational practices that conferred the title of physician. The second section shows how other practitioners, who were not condoned by the College of Physicians, could be raised to eminence

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<sup>19</sup> Churchill, “Introduction” in *Female Patients in Early Modern Britain*, n. 2, p.1.

within their medical sphere. The existence of a panoply of medical practitioners highlights the problematic nature of choosing a doctor in seventeenth-century England. It demonstrates that choice could be both a burden and a form of power for early modern patients. The difficulties of choosing a doctor, and the many factors that could make medical relationships a success or a disappointment, all serve to consolidate the relationship as one of dynamic-equilibrium. There was some element of lottery in choice of doctor and patients might die if they chose wrongly.

## I. PHYSICIANS

A closer look at practitioners within the category of *physician* can help to distance the idea of modern medical professionalism and thereby demonstrate greater understanding of the reality of choosing a doctor in seventeenth-century England. What has been considered as the early establishment of the medical profession began in 1518 with the creation of the College of Physicians, inaugurated by six doctors under the patronage of Henry VIII (1491-1547).<sup>20</sup> It is evident from accounts of the College's inception that there was an ongoing need for some form of control over the numbers of lay people who practised medicine that might prove harmful.<sup>21</sup> While the aim of its creation was to prevent deadly treatments by "cunning deceivers" it was

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<sup>20</sup> The six founding physicians were: John Chambre, Thomas Linacre, Ferdinand de Victoria, Nicholas Halsewell, John Francis, and Robert Yaxley. See *Munk's Roll*, 1; Clark, *A History of the Royal College*, 59.

<sup>21</sup> Clark, *A History of the Royal College*, 65.

also an attempt to distinguish physicians from the “rabble” of popular healers.<sup>22</sup> The College had jurisdiction over issuing licenses to doctors in and around London within a radius of seven miles. It had the power to examine the medical knowledge of anyone who offered cures and it responded to complaints from both colleagues and patients.<sup>23</sup> However, it proved ineffectual in dealing with the vast array of people who practised medicine and only produced “a very short casualty list for the hordes of illegal practitioners.”<sup>24</sup> It designated those who practised without one of its licences as “irregulars.” “Irregular” created an impression of wrongdoing; yet, a practitioner lacking a licence did not necessarily lack medical skill and education. Conversely, those who gained a licence or were admitted to College membership were not always proficient doctors, as we shall see. Although the College has been seen historically as the foundation that launched the medical profession, from a contemporary viewpoint it attracted criticism and failed to instigate a cohesive and effective system of medical organization, or create professional medical standards out of the chaotic milieu of practitioners.<sup>25</sup>

The 1518 charter of the College had declared that only those “deeply studied in Physick” should be allowed to practice medicine. An addendum to the charter in 1542 rephrased the wording and included those “who had knowledge and experience of herbs, roots and waters [to]...treat any outward sore, oncome, wound,

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<sup>22</sup> For a list of ‘rabble’ see, for example: F. H., *Beware of Pick-purses or A Caveat for Sick Folkes to Take Heede of Unlearned Phisitions, and Unskilfull Chyurgians* (London, 1605), B3.

<sup>23</sup> Clark, *A History of the Royal College*, 1.

<sup>24</sup> Clark, *A History of the Royal College*, 65.

<sup>25</sup> For an account of how the College’s authority declined during the century, see, Cook, *The Decline of the Old Medical Regime*.

apostemations, outward swellings or disease by means of any herbs, ointments, baths, poultices, and plasters.”<sup>26</sup> The words of the charter led to challenges because they inadvertently allowed all types of practitioners to continue medical practice, and, it failed to define exactly how a doctor could become “deeply studied in Physick.”<sup>27</sup> The act opened the door to anyone with medical knowledge and experience. This immediately included a large percentage of the population as most lay people had knowledge and experience of favourite remedies, which they shared with others.

Since the act raised questions about who was legitimately allowed to practice medicine, historians have produced differing interpretations of what the act meant and how it was received. George Clark, in his epic history of the College, thought the Act was “deservedly known as the Quacks’ Charter”, whereas R. S. Roberts saw the act as enabling “general medical practice [to belong]...in the hands of wise country people who were sound empirical practitioners protected by the Act of 1542.”<sup>28</sup> More recently, Ian Mortimer found difficulty in quantifying groups of practitioners in Canterbury because many of them “may have been...holders of medical degrees who did not have licences, failed applicants for licences, apprentices who did not serve out their whole term...licentiates of...the College of Physicians, or practitioners unrecognized in any official capacity.”<sup>29</sup> Mortimer difficulties with the terminology

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<sup>26</sup> Clark, *A History of the Royal College*, 86.

<sup>27</sup> See, Johannes Pontaeus, *An Argument Shewing that 'tis Impossible for the Nation to be Rid of the Grievances Occasioned by the Great Numbers Both of Quacks and Empirics in Law and Physick, Without An Utter Extirpation of Both: With Proposals For A New Constitution* (London, 1699), 2.

<sup>28</sup> Clark, *A History of the Royal College*, 86; R.S. Roberts, "The Personnel and Practice of Medicine in Tudor and Stuart England Part 1. The Provinces," *Medical History* 6, 4 (1962): 363.

<sup>29</sup> Mortimer, *The Dying and the Doctors*, 60.

typify the problems arising for anyone attempting to categorise the ranks of early modern medical practitioners. This endeavour has usually depended on practitioner qualifications and professional status, and has sometimes failed to account for the indifference towards medical officialdom that was rife among patients in seventeenth-century England.

There were many ways to create a career in medicine in seventeenth-century England, and acquiring a medical degree hardly took precedence over self-study or practical medical experience. Those who embarked on a medical degree found it could take over a decade, however, it was much shorter in practice.<sup>30</sup> It began with four years studying Arts, three years for a Master of Arts and a further four years to complete a Doctorate of Medicine. However, many practitioners began practising before they qualified, while others never bothered to qualify at all, yet set up in practise anyway, with or without a licence.<sup>31</sup> The content of the medical degree consisted of the study of Arts or Natural Philosophy, the foundation of which was the classical medicine of Hippocrates and Galen. This reliance on ancient medicine was becoming increasingly outdated in seventeenth-century England and College physicians eventually came to be known derogatively as Galenists.<sup>32</sup> Essentially, for

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<sup>30</sup> See, Phyllis Allen, "Medical Education in 17th Century England," *Journal of the History of Medicine and Allied Sciences* 1, 1 (1946): 115-143.

<sup>31</sup> See the case of Dr. Thomas Bonham, Harold J. Cook, "Against Common Right and Reason: The College of Physicians vs Dr. Thomas Bonham," in *Law, Liberty and the Parliament: Selected Essays on the Writing of Sir Edward Coke*, ed. Allen D. Boyer (Indianapolis: Liberty Fund, 2004), 127-149.

<sup>32</sup> See, George Acton, *A Letter in Answer to Certain Quaeries and Objections Made By A Learned Galenist* (London, 1670); George Castle, *The Chymical Galenist a Treatise Wherein the Practise of the Ancients is Reconciled to the New Discoveries in the Theory of Physic* (London, 1667); George Thompson, *Galeno-pale, or, A Chymical Trial of the Galenists, That Their Dross in Physick May Be Discovered With the Grand Abuses and Disrepute They Have Brought Upon the Whole Art of Physick and Chirurgery* (London, 1665).

the patient, a medical degree was no guarantee of the curative superiority of the physician.

Phyllis Allen argued that medical education in seventeenth-century England was a backwater compared to Europe.<sup>33</sup> Roy Porter pointed to differences between the seventeenth and eighteenth centuries when he unintentionally highlighted the deficiencies inherent in the English system and observed that “better training and education advanced medicine as a profession in the eighteenth century.”<sup>34</sup> Changes in medical education have been lost in the generality of the early modern period. One of the apparent deficiencies was the infrequency of anatomical lectures within the English universities. European universities excelled at the practical anatomy which better-equipped doctors to begin practising medicine.<sup>35</sup> Swelling numbers of English students travelled to study medicine at the continental universities.<sup>36</sup> Degrees could be acquired at Leiden, Padua, Paris, Montpellier, Basel or Heidelberg. Padua was described as “then the most celebrated school of medicine in the world.”<sup>37</sup> The medical philosophies and work of European physicians, Paracelsus (1493-1541), Andreas Vesalius (1514-1564), and Van Helmont (1579-1644), contributed to the enthusiasm that produced continued growth in European medicine. It was an

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<sup>33</sup> Allen, “Medical Education”, 118.

<sup>34</sup> Dorothy Porter and Roy Porter, *Patient's Progress : Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity/Blackwell, 1989), 122. See also: Roy Porter, “The Early Royal Society and the Spread of Medical Knowledge,” in *The Medical Revolution of the Seventeenth Century* eds., Roger French & Andrew Wear (Cambridge: Cambridge University Press, 1989), 272-293; Andrew Wear, “Medical Practice in Late Seventeenth- and Early Eighteenth-Century England: Continuity and Unity,” in French and Wear, *The Medical Revolution*, 294-320. Also see Geoffrey Holmes, *Augustan England: Professions, State and Society, 1680-1730* (London: Allen & Unwin, 1982).

<sup>35</sup> Allen, “Medical Education”, 117, 123, 125, 126.

<sup>36</sup> See Ole Peter Grell, Andrew Cunningham, and Jon Arrizabalaga, eds., *Medical Travel and Education in Europe, 1500-1789* (Aldershot: Ashgate, 2010), 3.

<sup>37</sup> *Munk's Roll*, 224.



Englishman, William Harvey (1578-1657), who arguably made the most significant discovery of the era; the circulation of blood. He had studied medicine in Padua under Hieronymus Fabricius (1537-1619) and yet his anatomical ideas received some criticism back home in England.<sup>38</sup>

The College of Physicians tried to establish medical standards, but while College members were particularly suspicious of foreign born doctors, patients readily consulted them. Even though study abroad was highly valued by many English practitioners, foreign born doctors engendered suspicion in those who felt threatened by foreigners who came to practice medicine in England. College concerns seemed to lie primarily with their own power and prejudice rather than ensuring safe treatments for patients, but this was due in part to the accepted epistemology of theory which took precedence over medical outcomes. James Primrose, a College physician, discredited foreign universities writing “there are few universities into which...abuse has not crept: Therefore in Italy and France the degree of Doctour procures not much respect.”<sup>39</sup> The College refused licences to many foreign nationals and discredited them as quacks. For the College, foreign doctors represented competition, while women and irregulars were especially singled out for censure. Many of them were dealt with like Doctor Boet, from the Low Countries, who was called in front of a College committee and criticized for behaving

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<sup>38</sup> See James Primrose, *Exercitationes, et Animadversiones in Librum, De Motu Cordis, et Circulatione Sanguinis Adversus Guilielmum Harveium Medicum Regium, et Anatomes in Collegio Londinensi Professorum* (London, 1630); Roger French, *William Harvey's Natural Philosophy* (Cambridge: Cambridge University Press, 1994), 114. For a recent biography of Harvey see, Thomas Wright, *William Harvey: A Life in Circulation* (Oxford: Oxford University Press, 2013).

<sup>39</sup> James Primrose, *Popular errors. Or The Errours of the People in Physick, Translated into English by Robert Wittie, Doctor in Physick* (London, 1651), 5.

“unjustly” to the College because he relied on a woman apothecary to produce his medicines.<sup>40</sup> Voicing the concerns of many members at a College meeting in 1631, Doctor Winston complained about the numbers of foreigners practising “amongst us on which account he thought they ought to be suppressed by every means.”<sup>41</sup> Englishmen, like Thomas Margetson who gained a degree at Montpellier on 10 March 1656 and another degree eight days later at the University of Orange, were readily admitted to the College, implying that it was not the foreign degree that was the issue, but the foreign origins of the recipient of the degree.<sup>42</sup> For the patient, foreign doctors represented “otherness” and satisfied some patients’ desires for an exotic cure.<sup>43</sup> Scores of doctors claimed clandestine knowledge of secret cures gained in foreign lands, and boasted of the excellent medical experience they had acquired during travel overseas. Foreign cures must have appealed to patients because such claims were prevalent in medical advertising.<sup>44</sup> Patients’ acceptance of foreign doctors included those practitioners that the College was unwilling to accept, thus demonstrating that patients were less concerned about medical hierarchies and more concerned with finding experienced practitioners who they thought might be able to cure.

The College required that foreign degrees should be incorporated at Oxford or Cambridge upon a doctor’s return from abroad; however, during the civil war

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<sup>40</sup> C12, 330, July 1632, *Annals*, RCP.

<sup>41</sup> C12, 330, February 1631, *Annals*, RCP.

<sup>42</sup> *Munk’s Roll*, 280.

<sup>43</sup> See, Alison Lingo, "Empirics and Charlatans in Early Modern France: The Genesis of the Classification of the "Other" in Medical Practice," *Journal of Social History* 19, 4 (1986): 583-683.

<sup>44</sup> See, Elizabeth Lane Furdell, *Publishing and Medicine in Early Modern England* (New York: University of Rochester Press, 2002), 38-39.

years it was political issues that influenced who could become a member of the College. In 1644 the vice-chancellor of Cambridge was concerned about the lack of students “in these troublesome times.”<sup>45</sup> Those who had incorporated their degrees at either Oxford or Cambridge withdrew them because of their political allegiance. Well-known English physician Thomas Sydenham (1624-1689) studied medicine at Oxford, “but left the university as soon as it became a garrison for Charles I.”<sup>46</sup> Sydenham eventually took his arts degree at Cambridge on account of the politics of his brother William, who worked for the Protectorate; a fact which “kept him (Thomas) out of favour with the court.”<sup>47</sup> William Munk refers to political interference when he cited the case of Edward Cooper. Cooper gained entry to the College in 1653 with no indication as to where he had obtained his degree and at a time when “degrees were regularly conferred especially on noted puritans.”<sup>48</sup> Robert Savorie was issued with a special licence by the College to “give him leave to practice with distracted people, and in some other particular maladies”, a caveat which suggested a lack of qualifications and perhaps some political influence, as he also gained entrance to the College in 1653 during the Interregnum.<sup>49</sup> Although a university degree was a requirement of the College, in some instances the degrees were conferred without the requisite study. In one case of nepotism, Thomas Prujean left Cambridge University without a degree and was welcomed into the College by

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<sup>45</sup> C16, 548, June 25, 1644, *Annals*, RCP.

<sup>46</sup> William Macmichael, *Lives of British Physicians* (London: Murray, 1830), 86.

<sup>47</sup> Macmichael, *Lives*, 90.

<sup>48</sup> *Munk's Roll*, 267.

<sup>49</sup> *Munk's Roll*, 266.

his father who was then President.<sup>50</sup> The seventeenth-century official classification of a doctor thus relied on socio-relational practices that did not always account for medical skill.

Royal and aristocratic patronage meant that practitioners rejected by the College under different circumstances, were reluctantly accepted. Power and influence was rife in the rarefied realm of the rich, where high status individuals employed doctors at whim. Even royalty undermined their own College of Physicians, by choosing practitioners for the interesting and novel cures they offered and their entertaining way of presenting them.<sup>51</sup> In 1609 James I created Leonard Poe royal physician and, although College members thought Poe was a quack, doubted his medical ability, and were reluctant to accept him, they were forced to do so by his patrons, the earls of Essex, Suffolk, Northampton and Salisbury.<sup>52</sup> A number of entries into the College record books indicate that the College committee thought it better simply to submit to patronage issues without causing trouble for themselves. On 7 December 1683 College annals reported, “On the reading of a letter from the illustrious Earl of Arlington, on behalf of Doctor Russell, for the College to refrain from further proceedings against him on the grounds of practising medicine contrary to the Statutes, it was decided to comply with this.”<sup>53</sup> Patronage issues often held larger sway than the College was able to combat and resulted in a mixed bag of physicians, some of who were advanced to positions they may never have held

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<sup>50</sup> *Munk's Roll*, 279.

<sup>51</sup> Thompson, *Quacks of Old London*, 86-89.

<sup>52</sup> On Leonard Poe see Clark, *A History of the Royal College*, 148; Dawbarn, “Patronage and Power,” 2 C62, 5 December 1589 onwards, v. 4, II, 1581-1608, *Annals*, RCP.

<sup>53</sup> C20, 21, December 1683, *Annals*, RCP.

otherwise.<sup>54</sup> The medical ability of its members, however, was not the only issue for concern. When fraudulent proceedings within the College came to light, the integrity of members at the heart of the College was called into question. On 13 May 1684 a *Comitia Extraordinaria* debated “an extraordinary [act of] embezzlement by Daniel Whistler, the recently deceased President.”<sup>55</sup> It seemed that deceitful practitioners of the type the College took pains to exclude could be found within its very own ranks.

Although College physicians strove to maintain control over other practitioners, it was a task they found increasingly difficult to achieve regarding surgeons and apothecaries, the other two thirds of the so-called tripartite arrangement of practitioners. William Copeman wrote in 1967, “Surgeons, however skilled, worked only to the physician’s direction and were considered as craftsmen of lowly status.”<sup>56</sup> More recently in 2007, Michael McVaugh disputed this when he found that the relationship between surgeon, Richard Wiseman and College physician, Walter Needham, was “a friendship...between the two men that carried over into practice and tended to break down occupational and intellectual distinctions.”<sup>57</sup> Surgeon Wiseman collaborated with more than forty London physicians during his career and the professional relationships he participated in were a display of mutual respect. There is evidence for a spectrum of rivalry and co-operation. Robert Frank’s study of clergyman Doctor John Ward revealed, “what practical anatomy Ward knew, and the

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<sup>54</sup> See, Dawbarn, “Patronage and Power,” 6, 10.

<sup>55</sup> C20, 25, 13 May 1684, *Annals*, RCP. Also see *Munk’s Roll*, 249; “Daniel Whistler (1618/19-1684),” *ODNB*.

<sup>56</sup> William Sydney Charles Copeman, *The Worshipful Society of Apothecaries of London: A History, 1617-1967* (Oxford: Pergamon Press, 1967), 34.

<sup>57</sup> Michael McVaugh, “Richard Wiseman and the Medical Practitioners of Restoration London,” *Journal of the History of Medicine* 62, 2 (2007): 125.

physiological experiments he carried out, were frequently linked with his friendships with...surgeons.”<sup>58</sup> Such relationships demonstrated that the designated scholarly boundaries of the tripartite system were crisscrossed repeatedly on numerous occasions. As one of many examples representing the patients’ point of view, Samuel Pepys’ divulged he regularly consulted his surgeon or his apothecary before resorting to a physician.<sup>59</sup>

Physicians were supposed to treat diseases that came from inside the body, while surgeons treated those that appeared on the outside; however, in actual practice this was not an easy distinction. There were many illnesses which were difficult to define as being either inside or outside the body, for example, when a fever and a rash was present the fever was thought to have emanated internally while the rash was visible externally. In addition, although the reputation of the surgeon portrays a bloody, gory and painful picture of early modern medical practice, the surgeon often suggested practical and useful procedures that brought welcome relief to the suffering patient.<sup>60</sup> In serious cases of breast cancer and of bladder stones, an operation by the surgeon could relieve a patient’s discomfort, if they were lucky enough not to die of infection. Samuel Pepys, again, recorded his thanks for survival after being cut for the stone; his gratitude taking the form of a yearly celebratory

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<sup>58</sup> Robert G Frank, "The John Ward Diaries: Mirror of Seventeenth Century Science and Medicine," *Journal of the History of Medicine* 29 (1974): 153.

<sup>59</sup> Samuel Pepys, *The Diary of Samuel Pepys: A Selection*, Selected and edited by Robert Latham and William Matthews (London: Penguin, 1985), 4 July 1661, 16 January 1663, 9 February 1663, 3 November 1663.

<sup>60</sup> For surgeons’ medical work see, Richard Theodore Beck, *The Cutting Edge: Early History of the Surgeons of London* (London: Lund Humphries, 1974).

feast.<sup>61</sup> In surgical cases, the surgeon was given due respect and cooperated with the physician when the need arose.

It was during the seventeenth century that the apothecaries obtained a charter freeing them from the Grocer's Company and from then on the apothecaries took the opportunity to be the physicians' closest allies or their worst enemies.<sup>62</sup> Apothecaries supplied purges, elixirs, boluses, clysters, plasters and tonics, and made up prescriptions for the physicians, however, from the patients' viewpoint they were frequently the first port of call for the sick to seek advice for remedies. The College summoned those apothecaries found to be dispensing medical advice and treatment, and reprimanded them. Apothecaries who were found to be charging patients a fee for attendance were trespassing on the territory of the physician. Physicians had obtained the right to examine apprentice apothecaries and to inspect apothecary shops, and the College annals detail numerous rebukes when physicians clashed with apothecaries over this right. The College's sought after prestige counted for little when on 8 November 1644 William Barker, a servant and apprentice of the apothecary Mr. de Laune, undertook the apothecaries' examination and was approved, but with his approval came the admonishment "to refer more carefully to our Pharmacopoeia and in future to conduct himself with more respect towards the physicians."<sup>63</sup> Apothecary Mr. Thomas came in for censure by the College when it was reported he had "slighted the Councells Warrant saying it was not worth three

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<sup>61</sup> Pepys, *Diary*, 21 & 26 March 1669.

<sup>62</sup> See Christopher Merret, *A Short View of the Frauds, and Abuses Committed by Apothecaries* (London, 1670).

<sup>63</sup> C16, 252, 8 November 1644, *Annals*, RCP.

skips of a Louse.”<sup>64</sup> Mr Glover was yet another apothecary who got into trouble with the College for “adding his own medicines and dispensing them in the hospital and elsewhere.”<sup>65</sup> Glover hit back at the College, accusing it of using unlawful clauses against apothecaries. He also pointed out that “phisitions maye [make] mistakes” also, thereby challenging the physicians supposed superior skills.<sup>66</sup> Glover thus indicated that physicians and apothecaries were treated differently, and indeed, College annals reveal a lack of respect on both sides.

The rivalry between apothecaries and physicians came to a head at the end of the century in the form of the Rose Case (1704), which saw a legal challenge by William Rose, an apothecary who attempted to establish his right to advise patients and prescribe medicines. Historians have previously thought that the Rose Case was a win for the apothecaries over the physicians, however Hal Cook interpreted the outcome as “rather than changing matters of medical practice, the Rose case confirmed the status quo. The physicians were trying to revive and strengthen legal prohibitions against the practice of those not licensed by themselves, prohibitions that had slipped away already.”<sup>67</sup> In other words, the physicians had little medical superiority over the apothecaries and it was common practice for apothecaries to advise and prescribe. John Ward mentioned “apothecaries in the smallpox, and such like diseases [who]...charge for attendance.”<sup>68</sup> College morale reached an all-time

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<sup>64</sup> C12, 312, 1631, *Annals*, RCP.

<sup>65</sup> C12, 349, 1631, *Annals*, RCP.

<sup>66</sup> C12, 350, 1631, *Annals*, RCP.

<sup>67</sup> Cook, "The Rose Case Reconsidered," 528.

<sup>68</sup> John Ward, *Diary of the Rev. John Ward, A.M., Vicar of Stratford-Upon-Avon, Extending from 1648 to 1679*, ed., Charles Severn (London: Henry Colburn, 1839), 106. (Hereafter, Ward, *Diary*).



low as physicians and apothecaries displayed personal animosities and literally came to blows in the street, as when Doctor Grent (apothecary), called Doctor Goddard (College physician), a “foole” and an “asse.”<sup>69</sup>

Further claims that dispute the medical superiority of the physician come via a variety of complaints, made for several reasons, by an assortment of seventeenth-century writers. John Ward jotted down in his diary several sayings about physicians, which were in current use. He wrote, “Some says too sharply of physitiens, that the sun sees their practice, and the earth hides their faults.”<sup>70</sup> He also wrote of a physician who told his patient: “Friend, thou hast two diseases, and whilst I kill one, the other will kill thee.”<sup>71</sup> He related a story of Doctor Bates who was “by some thought to be inconsiderate in his practice: itt is said he hath killd two ladies, my Lord of Bedford’s little daughter and my Lady Watton.”<sup>72</sup> Richard Baxter, the Puritan pastor who suffered from ill health most of his life, employed imagery of physicians in proverbial ways, stating, “A foolish friend is like an unskilful physician who will love you to death.”<sup>73</sup> And in the aftermath of the great fire of London the Verney family joked about the physicians who headed westwards “where they find so many more of their craft bereft of patients that they fear they shall be reduced to bleeding each other.”<sup>74</sup> There was a distinct lack of respect for early modern physicians and

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<sup>69</sup> C12, 355, 1631, *Annals*, RCP.

<sup>70</sup> Ward, *Diary*, 191.

<sup>71</sup> Ward, *Diary*, 181.

<sup>72</sup> Ward, *Diary*, 262.

<sup>73</sup> Richard Baxter, *The Practical Works of the Late Reverend and Pious Mr. Richard Baxter: The Fourth Volume* (London, 1707), 56. Also see Tim Cooper, “Richard Baxter and His Physicians,” *Social History of Medicine* 20, 1 (2007): 1-19.

<sup>74</sup> Margaret M. Verney, *Memoirs of the Verney family From the Restoration to the Revolution 1660-1696, Vol. IV* (London: Longman's, 1899), 395. (Hereafter cited as, *Verney Memoirs*).

patients were scathing or praiseworthy in their remarks about them depending on the physicians' manner, reputation and the usefulness of their individual medical practise.

Medical historian John Raach selected the case books of five physicians, from various areas of England, to explain exactly what early modern physicians did in their daily work. He argued that "to practise" meant a physician who was trained in medicine but who "saw only a few patients a day. It was not a hard life and [it] allowed practitioners a certain amount of leisure time to do with what they would."<sup>75</sup> Many seventeenth-century physicians fitted into this category of medical practice, but not all. As Sawyer's thesis on clergyman-doctor Richard Napier shows, there were some doctors who worked hard and supplied much appreciated medical care to their communities. Their workload suggests they may well have accrued more experience in treating people and hence could be better qualified than a College physician who had been to university but who partook in much leisure time, as ascertained by Raach. Meanwhile, the sick appear to have distinctly favoured practitioner ability over practitioner status and took a pragmatic approach towards seeking medical assistance.

As we have seen, examination of College membership shows anomalies, inconsistencies and failures in procedural management, which included bribery, nepotism and patronage, and other practices that can be described as corrupt. Margaret Pelling's study on the College's treatment of irregulars, which concludes at

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<sup>75</sup> John Raach, "Five Early Seventeenth-Century English Country Physicians," *Journal of the History of Medicine* 20, 3 (1965): 215.

1640, highlights many of these issues.<sup>76</sup> Recognising these differences in procedure, and viewing them as socio-power relations, helps to explain how patients discriminated between doctors. Reputation, political and religious prejudices, personal feuds, court politics and patronage, all played a part in the acceptance or non-acceptance of practitioners, aside from their medical qualifications. Patients who found a doctor they liked and whose treatments suited their medical needs disregarded issues that presented problems for the College. Patients were not seduced by College prestige but were mostly indifferent to it and patronised practitioners across a spectrum, from College physician, to irregular, to quack, calling them all “doctor.” Many doctors served out a worthy career in medicine and were greatly respected by their patients. The following section will examine how some of those practitioners managed to establish reputational power and social standing.

## II. THE PANOPLY OF MEDICAL PRACTITIONERS

Reputational capital was paramount in the medical hierarchy of seventeenth-century England, where the mechanisms for building trust greatly relied on word-of-mouth testimonies “from intimate conversation to the circulation of rumours in the marketplace.”<sup>77</sup> Historians have studied the importance of reputation in the early modern context and clearly demonstrated how it was linked to social identity, honour, status and gender.<sup>78</sup> Even so, they have been criticised for taking reputation

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<sup>76</sup> Pelling, *Medical Conflicts*.

<sup>77</sup> Elizabeth Horodowich, “Introduction: Speech and Oral Culture in Early Modern Europe and Beyond” *Journal of Early Modern History* 16: 4-5 (2012): 301.

<sup>78</sup> Faramerz Dabhoiwala, “The Construction of Honour, Reputation and Status in Late Seventeenth- and Early Eighteenth-Century England” *Transactions of the Royal Historical Society* 6 (1996): 201-

for granted “as an uncomplicated phenomenon... without probing precisely how or why” it directs and influences social behaviour.<sup>79</sup> Positive and negative reputational forces are thoroughly embedded in social relations, and context is important in finding out how these forces operated. Roy Porter pointed out the importance of social context when he wrote, “in short, the historical distinction between medical quackery and orthodoxy has been more social than scientific.”<sup>80</sup> Accordingly, this section examines why some practitioners are thought to be quacks, and how medical practitioners created reputational power despite being rejected by the College of Physicians.

The College of Physicians attempted to bolster its reputation by restricting its membership, however, practitioners outside the confines of the College drew on a range of strategies to bolster their own reputations and thus challenge the College’s power. The threat of censure from the College was not strong enough to deter those practitioners who were itinerant travellers and who escaped the district before any fraudulent behaviour could be detected.<sup>81</sup> The lure of a quick profit often proved enough incentive to sacrifice personal reputation. Deceitful medical trickery was documented in artworks, such as that by Dutch artist Jan Steen, who illustrated “a

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213; Pauline Croft, “Libels, Popular Literacy and Public Opinion in Early Modern England” *Historical Research* 68, 167 (1995): 266-285; Austen Saunders, “Lanhydrock’s Autobiographical Instillation: Books, Reputation and Habitat in Early Modern England” *Seventeenth Century* 29, 3 (2014): 223-240; Bernard Capp, “The Double Standard Revisited: Plebian Women and Male Sexual Reputation in Early Modern England” *Past and Present* 162, 1 (1999): 70-101.

<sup>79</sup> Christopher McKenna and Rowena Olegario, “Corporate Reputation and Regulation in Historical Perspective” in *The Oxford Handbook of Corporate Reputation*, eds., Timothy G. Pollock and Michael L. Barnett, 1, 2. Accessed 6/11/2016.

<http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199596706.001.0001/oxfordhb-9780199596706>

<sup>80</sup> “Cults and Quackery” s.v. in *Oxford Reference Online*.

<sup>81</sup> See Roberts, “The Personnel and Practice of Medicine,” 363.

curious form of quackery [that] prevailed in the seventeenth century.”<sup>82</sup> It depicted a quack treating a headache, or a case of madness, by making an incision and extracting a stone from the patient’s head.<sup>83</sup> The stone, of course, was hidden and readily produced at the right moment as evidence that the patient was cured.<sup>84</sup> There were also quacks who pretended to remove bladder stones by making an incision in the skin of the perineum, but producing the “bladder stone” from the quack’s sleeve instead of from the patient’s body.<sup>85</sup> French surgeon Pierre Dionis (1643-1718) wrote of surgical quacks he had seen operating on and exploiting patients suffering from hernias. They promised the male patient not to remove the testicle during the procedure, but did so, destroying the evidence by throwing it under the table “where it was devoured by a dog trained for the purpose.”<sup>86</sup> Evidently, many patients were duped by such practitioners, and their ilk have come to dominate the enigmatic definition of quackery. Such stories illustrate the lack of any code of medical ethics at the time, however, it could also be said that they constituted a code of ethics of their own.<sup>87</sup>

Although the terminology of quack was accurately used to describe the fraudulent, deceitful and unskillful practitioner, it was not always applicable to

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<sup>82</sup> R. F. Mould, *Mould’s Medical Anecdotes* (Abingdon: Taylor & Francis, 1984), 216.

<sup>83</sup> Image: Jan Steen, *The Quack Doctor* <http://www.dcscience.net/DeKwakzalver-JanSteen-1626-1679.jpg>

<sup>84</sup> Mould, *Medical Anecdotes*, 216.

<sup>85</sup> Anon, “Quackery in the Past,” 1258.

<sup>86</sup> Anon, “Quackery in the Past,” 1258.

<sup>87</sup> See Andrew Wear, “The Discourses of Practitioners in Sixteenth- and Seventeenth-Century Europe,” in *The Cambridge World History of Medical Ethics* eds., Robert Baker, Laurence B. McCulloch (Cambridge: Cambridge University Press, 2009), 379-390; Mary Fissell, “The medical Market Place, the Patient, and the Absence of Medical Ethics in Early Modern Europe in North America,” in *The Cambridge World History of Medical Ethics* eds., Baker and McCulloch, 533-539.

significant numbers of practitioners who provided useful medical help and advice to their patients. William Eamon saw the early modern period as a time when “ancient rivalry between learned physician and popular healers broke out with particular vehemence.”<sup>88</sup> Some practitioners used an allegation of quackery, or acting like a mountebank, as part of a campaign to discredit a competitor.<sup>89</sup> So besides being an accusation of medical deceit, quack was used to insult a colleague or rival practitioner of any status.<sup>90</sup> In some instances, quack was also used to describe those practitioners who plied their medical skills informally and without official licence, which is a completely different accusation from that of being deceitful and unskillful. It is hard to distinguish between practitioners who proceeded with bad treatments in good faith, believing them to be effective, and those who deliberately set out to defraud their patients. The protean nature of quackery has caused lingering confusion over who was and who was not a “genuine” quack or “respectable” physician, while a further and subsequent complication has been the changing approval of a variety of medications, which are thought to be valuable in one era and afterwards poisonous and harmful in another.<sup>91</sup>

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<sup>88</sup> William Eamon, "Physicians and the Reform of Popular Culture in Early Modern Europe," *Acta Histriae* 17, 3 (2009): 616.

<sup>89</sup> Eg. Richard Boulton, *An Examination of Mr. John Colbatch His Books...*(London, 1698), Preface.

<sup>90</sup> Porter, *Health For Sale*, 1.

<sup>91</sup> Eg. mercury, arsenic, antimony, see John Frith, “Arsenic – the “Poison of Kings” and the “Saviour of Syphilis”” *Journal of Military and Veterans’ Health* 21, 4 (Nov., 2016): 11-17; Catherine E. Thomas, “Toxic Encounters: Poisoning in Early Modern English Literature and Culture” *Literature Compass* 9, 1 (2012): 48-55; Erika Carroll, “Potions, Poisons and “Inheritance Powders”: How Chemical Discourses Entangled 17<sup>th</sup> Century France in the Brinvilliers Trial and the Poison Affair” *Voces Novae* 4, 1 (2012). Accessed November 2016.

<http://journals.chapman.edu/ojs/index.php/VocesNovae/article/view/330/709>

Periodically, endeavours were made to define quackery but meanings have constantly shifted and answers have remained elusive. In 1911 the *British Medical Journal* asked, “What is a quack?”<sup>92</sup> The author looked to Samuel Johnson’s 1755 dictionary and discovered it originally meant a mountebank who mounted a bench, sold salves and quacked about them at the fair. However, “in Johnson’s day it had already acquired a larger connotation”, distinguishing between pretenders with no knowledge and those who do have knowledge but use it in “an artful and tricky manner.”<sup>93</sup> In 1957 Dickson-Wright, surgeon and president of the Medical Society of London, stated to fellow members, “all through the ages...there has existed orthodox medicine at one extreme with quackery at the other.”<sup>94</sup> He recognised some gradation between the two extremes but his definition settled on “free-lance quacks with no training of any kind and never an organization backing them.”<sup>95</sup> This would have been a difficult requirement in seventeenth-century England when the College was limited to a select group of men who were restricted to London practice. In 1965, Eric Trimmer linked quackery with folklore because “they both spring from very similar evolutionary roots.”<sup>96</sup> Essentially, the meaning of quackery is closely linked to reputation, which can be established, maintained, repaired or demolished, depending on the social context within which it existed.

Practitioners came to medicine from a range of backgrounds. In addition to the university qualification, a medical career could be achieved through a medical

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<sup>92</sup> Anon, “Quackery in the Past,” 1250.

<sup>93</sup> Anon, “Quackery in the Past,” 1250.

<sup>94</sup> Dickson-Wright, *Quacks through the Ages*, 161.

<sup>95</sup> Dickson-Wright, *Quacks through the Ages*, 161.

<sup>96</sup> Eric J. Trimmer, “Medical Folklore and Quackery,” *Folklore* 76, 3 (1965): 162.

apprenticeship, self-study through book learning, and years of experience accrued in treating friends and acquaintances. Empirical knowledge was required to supplement university study, which was not sufficient on its own. During the early days in the career of Thomas Willis (1621-1675), Willis complained that he “had not found in books what might satisfy a mind desirous of truth” and took pains to “search into the living and breathing examples...sitting oftentimes with the Sick...carefully to search out their cases, to weigh all the symptoms.”<sup>97</sup> Experience, therefore, was a crucial element of medical practice and was sometimes considered to be the only requirement for proficiency. Thomas Sydenham, known as the father of English medicine and called the “English Hippocrates”, supported medical apprenticeship over book learning.<sup>98</sup> “Physick, says Sydenham, is not to be learned by going to universities, but ...is for taking apprentices... one had as good send a man to Oxford to learn shoemaking as practising physick.”<sup>99</sup> Sydenham’s remarks also highlight how medicine was affected by the social and religious rivalries of the English Civil War. Sydenham was a Parliamentarian and Oxford University was a Royalist stronghold, nevertheless, he spoke from first-hand knowledge as he studied at Oxford University for several years.

There were practitioners who concentrated their skill and experience in specialised operations, for example cutting for the stone, while others might

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<sup>97</sup> Thomas Willis, *Willis's Oxford Casebook (1650-52)* ed. Kenneth Dewhurst (Oxford: Sandford, 1981), 61. Also see Zoltan Molnar, "Thomas Willis (1621-1675), the Founder of Clinical Neuroscience" *Nature Reviews Neuroscience* 5 (2004): 329-335; S. Setti, Rengachary, et al, "The Legendary Contributions of Thomas Willis (1621-1675): The Arterial Circle and Beyond," *Journal of Neurosurgery* 109, 4 (2008): 765-775.

<sup>98</sup> See, Kenneth Dewhurst, "Thomas Sydenham (1624-1689)" *Medical History* 6, 2 (1962); P. Anstey, "The Creation of the English Hippocrates," *Medical History* 55, 4 (2011).

<sup>99</sup> Ward, *Diaries*, 241.



exclusively set broken bones. When Anthony Wood dislocated his elbow, he went to see an expert bonesetter who happened to be the local locksmith.<sup>100</sup> Even though contemporaries accepted their medical proficiency, these unqualified operators were also seen as quacks by others who sought to emphasise their own reputational status. Although countless practitioners had not attended university, rational explanation obviated that proficiency could be gained through experience. Patients endorsed this philosophy by patronizing those practitioners who lacked a university qualification but had a wealth of medical experience.

Doctor William Salmon (1644-1713) was a medical practitioner who treated the poor, advertised and supplied cheap medicines, and called himself “Professor of Physic.” His medical career began early when he was apprenticed to a mountebank, amusing audiences by tumbling through hoops, performing sleight of hand tricks and making speeches in praise of his master’s panaceas.<sup>101</sup> By 1671 he had established his own medical practice, waiting outside the gates of St. Bartholomew’s Hospital, London, where doctors who lacked an official licence found they were able to solicit patients who had been denied hospital admission.<sup>102</sup> Salmon became a rich and educated man who maintained a large classical library and published books on a variety of subjects, including medicine, surgery, mathematics and art.<sup>103</sup> He never acquired a medical degree and never became a member of the College of Physicians. Consequently, despite his successful medical career, some scholars have seen

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<sup>100</sup> Willis, *Willis's Oxford Casebook*, 42.

<sup>101</sup> “William Salmon (1644-1713),” *ODNB*.

<sup>102</sup> “William Salmon (1644-1713),” *ODNB*.

<sup>103</sup> “William Salmon (1644-1713),” *ODNB*.

Salmon as a quack doctor.<sup>104</sup> Historian, C. J. Thompson, devoted two pages to detailing Salmon's achievements, commending him as an "astute and clever man with considerable literary ability", yet he grudgingly prefaced his praise with "in spite of his quackery."<sup>105</sup> This demonstrates how the progression of more formal mechanisms of medical qualification overtook the early modern reliance on individual reputation.

There were many practitioners who challenged the College of Physicians' attempts to regulate them in a more formal manner. In 1695 Adrian Huyberts launched a public attack on the College, which highlighted the legitimacy of his own position as a non-College doctor and impressed upon readers his contempt for College authority, and his advocacy for patients. He stated his credentials: attendance at Trinity College, Dublin, an apprenticeship to an apothecary and a number of years study abroad where he had obtained a degree from Utrecht. He had been a doctor for thirty-eight years and possessed a licence to practice from the Archbishop of Canterbury. Huyberts declared that "good success in practice is the surest evidence of a man's learning and knowledge" and asked why, if the patient be sick, "he should not with freedom use what physician he believes can best cure him", thus indicating that such freedom was not readily available to everyone, partly because of College sanctions.<sup>106</sup> Both patients and practitioners believed in some degree of self-reliance concerning medical matters. A common excuse when hauled up in front of the

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<sup>104</sup> See, Thompson, *Quacks of Old London*, 126; Furdell, *Publishing and Medicine in Early Modern England*, 28.

<sup>105</sup> Thompson, *The Quacks of Old London*, 127.

<sup>106</sup> Adrian Huyberts, *A Corner-Stone Laid Towards the Building of a New Colledge (That is to Say a New Body of Physicians) in London* (London, 1675).

College was for a practitioner to say he was only treating his friends, and in cases of patronage, that he was only practising medicine in a particular household.<sup>107</sup> In one case, an apothecary named Mr Clapham was hauled up before the College for saying “that Mr. Turner (the patient) much despised phisicke and phisitians, yet relied upon him”, and Mr Turner “sayed Mr Clapham was his antient Apothecarye whose councill he used, and one that knew his bodye well.”<sup>108</sup> Mr. Turner clearly appreciated a close medical relationship with Mr Clapham and distrusted some of the methods and the reputations of College physicians.

Notions of quackery were a largely grey area that depended upon the subjective view. There are numerous examples of how medical practitioners have been casualties of the changing social interpretations of quackery. In 1911 an anonymous writer in the *British Medical Journal* put Sir William Read (*d.* 1715) at the top of a list of “Some Notable Quacks.”<sup>109</sup> The author quoted John Jeaffreson (1831-1901), who called Read “a botching tailor, and to the last a very ignorant man.”<sup>110</sup> Jeaffreson described Read’s patron, Queen Anne, as the natural prey of quacks because she suffered from weak eyes, while other versions of their medical relationship concur that Queen Anne was a gullible patient who was duped by Read’s charms.<sup>111</sup> However, Arnold Sorsby - a modern ophthalmologist - evaluated Read’s *Treatise of the Eyes* (1706) found the publication to be “the work of a careful

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<sup>107</sup> C12, 349 & 356, 1631, *Annals*, RCP. (When a doctor from Padua appeared in front of College examiners, he pleaded he had not come to practice, but to serve in the household of the Earl of Northampton.)

<sup>108</sup> C12, 322, October 1631, *Annals*, RCP.

<sup>109</sup> Anon, “Some Notable Quacks,” 1264.

<sup>110</sup> Anon, “Some Notable Quacks,” 1264.

<sup>111</sup> See, A. L. Wyman, “Baron De Wenzel, Oculist to King George III: His Impact on British Ophthalmologists,” *Medical History* 35, 1 (1991): 78-88.

observer and honest practitioner [an]...excellent summary of the teaching on the diseases of the eyes.”<sup>112</sup> Notwithstanding, Sorsby then went on to describe Read’s text as a “purely personal vainglorious rhodomontade...sung for the Benefit of the Publick”, and finished with a tinge of regret for “one who, though a quack and a mountebank, has been ranked by historians in the illustrious company of pioneer British Ophthalmographers.”<sup>113</sup> Once Read had been named a quack the label stuck and even when praising his accomplishments Sorsby followed the lead of others and continued to label him a quack. William Read’s self-promoting style was not socially acceptable by some of his peers or by subsequent observers, nevertheless, he managed to establish an exceptional reputation for his medical work.

William Read’s reputation has oscillated between one of ridicule and one of respect. Thirty years after Sorsby’s summation of Read, Gordon Jones wrote an article on quackery and admitted that Read was a skilled operator. Jones wrote with an air of reluctance, “it must probably be conceded that this quack was the best eye man in England.”<sup>114</sup> He also observed that “men like Read were often defended in the books of the time.”<sup>115</sup> Unlike Sorsby, Jones presented a view of Read taken from the contemporary evidence, which showed he was popular and esteemed by his patients. In fact, “he so impressed the government that Queen Anne knighted him...as a mark of her Royal favour.”<sup>116</sup> Read’s knighthood came from great services

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<sup>112</sup> Arnold Sorsby, "Sir William Read’s Treatise of the Eyes," *British Journal of Ophthalmology* 16, 6 (1932): 340.

<sup>113</sup> Sorsby, “Treatise of the Eyes,” 345.

<sup>114</sup> Gordon W. Jones, "A Relic of the Golden Age of Quackery," *Bulletin of the History of Medicine* 37 (1963): 230.

<sup>115</sup> Jones, “A Relic of the Golden Age,” 230.

<sup>116</sup> Jones, “A Relic of the Golden Age,” 230.

performed in treating and curing large numbers of the soldiers and sailors of England, free of charge. All these differing opinions on Read's legacy clearly show how a practitioner can fall in and out of the realm of quackery depending on current opinion. As recently as 2011, Hugh Ormsby-Lennon described Read as a quack who shamelessly hawked styptic water for sore eyes and, on the same page, suggested that perhaps we should not dismiss him so casually as he was a successful surgeon who relied on "manual skills of great speed and much dexterity."<sup>117</sup> From pioneer ophthalmologist to quack is from one extreme to the other and demonstrates the subjectiveness that is manifest in any discussion of medical ability.

Sir William Read probably never thought of himself as a quack. As Roy Porter pointed out, "a quack was [always] someone else."<sup>118</sup> Quackery was, and is, in the eye of the beholder. Read may have begun life as a tailor and then taken up a calling as a travelling mountebank, but by the end of his career he was warning others, "there are some Quacks that go abroad to Fairs and Markets on horseback, which were never bred to that practice, but were Tumblers, Rope-Dancers, and Jack-Puddings."<sup>119</sup> Read understood that people had little choice but to patronise all sorts of practitioners. It was accepted behaviour and all Read could do was advise caution in their choice of practitioner. Read's own definition of quackery was a person who prepared false medicines simply to cheat people out of their money.<sup>120</sup> Interestingly, his emphasis rests on the medicines rather more heavily than the purveyors. He

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<sup>117</sup> Ormsby-Lennon, *Hey Presto!*, 170.

<sup>118</sup> Porter, *Health For Sale*, 1.

<sup>119</sup> Jones, "A Relic of the Golden Age," 234.

<sup>120</sup> Jones, "A Relic of the Golden Age," 234.

complains of those who “counterfeit my Medicaments” and cheat the country with “bad medicines” and “make up false compositions” which are “not prepared properly.”<sup>121</sup> The only way to tell the difference between the physician and the quack was from the results of the medicines they administered. By then, it was often too late. Patients had to beware that the pleasant plausibility of the practitioner did not turn into deadly deceit. A patient’s failure to escape this outcome on occasions indicated the difficult choice they faced in determining which practitioner was genuine, and which one was not.

William Harvey obtained a medical degree and was acclaimed for discovering the circulation of the blood, yet his contemporaries thought that discovery “to be his Masterpiece” and were not sufficiently impressed by his general medical skill.<sup>122</sup> Anne Conway wrote about Harvey in a letter, opining “in the practicke parte of Physicke I conceive him to be to[o] much, many times, governed by his Phantasy...to have a Physitian abound in phantasie is a very perilous thing...diseases are very often suddaine...one ought to have a Physitian that should be governed only by his iudgement...”<sup>123</sup> Lord Conway wrote to his daughter-in-law, concluding that the best course of action was to choose a doctor who the patient approved of “for it is thought [that] to have a good opinion of the Physitian doth contribute much to the cure.”<sup>124</sup> The Conways consulted all types of practitioners

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<sup>121</sup> Jones, “A Relic of the Golden Age,” 234-35.

<sup>122</sup> Lord Conway, *The Conway letters: The Correspondence of Anne, Viscountess Conway, Henry More, and their Friends, 1642-1684*, ed., Marjorie Hope Nicholson, revised by Sarah Hutton (Oxford: Oxford University Press, 1992), 30. (Hereafter cited as *Conway Letters*).

<sup>123</sup> *Conway Letters*, 30.

<sup>124</sup> *Conway Letters*, 31.

and were famously the patrons of Valentine Greatrakes, known as *The Stroker*, invited over from Ireland in an effort to cure Anne's raging headaches, which she had suffered from for many years.<sup>125</sup> The Conway family took little notice of the qualifications of their practitioners and championed practitioners from the whole spectrum of availability.

William Atkins wrote and published a substantial treatise on gout that suggests he represented an acceptable alternative to physicians. His pamphlet gives an insight into the emotional pleas with which he attempted to persuade people that he was a legitimate practitioner, who was being hounded by the College for no good reason. In his view, it was not medical officialdom that dictated whether he could practice medicine, but his own powers of persuasion, which served to attract his clientele. Atkins writes of the "envious" people who "hated" his "speedy" cures; cures which "took away pain" and kept "the danger of life from the inward parts."<sup>126</sup> Atkins warned people about the "wicked" and "malicious" persons who put people in fear of his medicines.<sup>127</sup> He challenged the reader's ability to know if and when a person is dead by stating "I do verily believe that many people in England are buried alive" and suggested that only by consulting him would people feel safe and secure.<sup>128</sup> He exploited peoples' fears and drew on subtle coercion to influence and sustain his reputation. Atkins also cast a spotlight on his medicines, declaring what "incredible", "strange" and "speedy" cures his miraculous medicines performed, "the

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<sup>125</sup> *Conway Letters*, 244-308. (For more on Anne Conway, see Ch. 5., 197.)

<sup>126</sup> Atkins, *Discourse on Gout*, A2.

<sup>127</sup> Atkins, *Discourse on Gout*, A3.

<sup>128</sup> Atkins, *Discourse on Gout*, xi.

like hath not been known in our age.”<sup>129</sup> He astutely tapped into the patient’s yearning search for a cure. He did not need to explain how his medicine worked in a historical context where physiological knowledge was minimal. Medicines were “miraculous” and one had to believe in them. Atkins’ appeal for faith in his medicines exposes how vulnerable patients were encouraged to try new and perhaps risky cures. Atkins was at pains to persuade people that his medicines were not dangerous, and therefore, not quackery. To prevent people being wary of his medicines he pleaded for everyone to “love” and “help” each other by giving him a chance to perform his cures, which would “shamefully” put his critics to silence.<sup>130</sup> Atkins appeared to have had a successful medical practice, according to the list of patients’ names and addresses, their medical conditions, and the cures he performed while in their employ.<sup>131</sup> Atkins was a “first-rate empiric” who established reputational power within his sphere of medical activity.<sup>132</sup>

## CONCLUSION

Early modern patients paid little attention to medical hierarchy, taking their chances with all sorts of practitioners for a variety of reasons. Patient whim, practitioner reputation, experience of a practitioner, the specialist nature of the treatment offered, or desperation in the face of painful suffering and imminent death, were all valid

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<sup>129</sup> Atkins, *Discourse on Gout*, Preface.

<sup>130</sup> Atkins, *Discourse on Gout*, v.

<sup>131</sup> For more on Atkins see, Ch. 3., 114.

<sup>132</sup> James Caulfield, *Portraits, Memoirs, and Characters, of Remarkable Persons, From the Revolution in 1688 to the End of the Reign of George II Collected from the Most Authentic Accounts Extant* (London, 1819), B2.



reasons behind their choices. Patients picked from an array of doctors, who came recommended by hearsay and evidence of past cures, and there was no official code of medical ethics. Recommendations often depended on the reputational power of the individual practitioner rather than the qualification they held. Practitioners were as good or as bad as their last consult, and one man's physician was another man's quack. Doctors who were in conflict with the College of Physicians saw just as many patients as their adversaries in the College and sometimes had greater reputational power. Moreover, physicians were just as capable of doing harm or producing a cure as any other type of practitioner. As Anna Wierzbicka recommended, to be able to comprehend early modern "attitudes and emotions...we need to understand the meaning of words in which those earlier generations crystallised their own understandings."<sup>133</sup> In seventeenth-century England, patients frequently used the label "Doctor" as a mark of respect to practitioners who they witnessed providing medical care. Whether they were official or unofficial, formal or informal, if they laid claim to medical knowledge and provided a diagnosis, they were sought out and consulted by the sick.

The doctor-patient relationship was comprised of individuals who made each encounter unique. Any practitioner who was employed for medical advice and treatment belongs within the parameters of the doctor-patient relationship. It has proved difficult to set out exacting categories of practitioners because there were always exceptions and overlaps to the rule. Acknowledging the great diversity of

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<sup>133</sup> Anna Wierzbicka, "The "History of Emotions" and the Future of Emotion Research," *Emotion Review* 2, 3 (2010): 270.

medical practitioners, and the ways in which they could gain reputation through socio-relational forms of power rather than directly from medical qualifications, indicates the difficulties presented to patients when they came to choose who to consult. Patient choice of doctor, therefore, could be both a positive or a negative process, which depended on the socio-relational processes that underpinned how doctors gained popularity and for what reasons. Another factor that had serious and far-reaching effects on how the doctor-patient relationship functioned was the type and severity of illness, and the social and cultural attitudes towards how specific illnesses should be treated. The power of the early modern patient rapidly diminished as the severity of their illness increased. The next chapter will explore the power of illness and the undeniable vulnerability of the early modern sufferer.

## CHAPTER 2. Socio-Relational Power and Illness

Early modern historians of medicine have often linked illness and healthcare to poverty and poor relief.<sup>1</sup> While sickness and poverty are closely related, socio-relational power networks extended across the whole of early modern society, affecting the wealthy sick as well as the poor. Both individual and structural agents, whether rich or poor, effected or were affected by some form of socio-relational power. Some of the diverse social forces at play included jostling between doctors over reputational power, the manner in which local authorities and the judiciary exerted structural power, the ever-present impact and consequence of gossip, and various situational contexts surrounding illness, which incorporated age, status, gender, religion, and other factors.<sup>2</sup> The existence of a multiplex society ensured that the intentions, processes and outcomes of medical agency were always dynamic as they reinforced, challenged, or subverted existing power structures. This chapter explores the interface of power relations in the context of early modern illness. It considers the impact of illness on both the doctor and the patient and demonstrates

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<sup>1</sup> See Andreas Gestrich, Elizabeth Hurren and Steven King, eds., *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938* (London: Continuum, 2012); Kenin P. Siena, *Veneral Disease, Hospitals and the Urban Poor: London's "Foul Wards," 1600-1800* (Rochester: University of Rochester Press, 2004); Steven King and Alannah Tomkins, eds., *The Poor in England 1700-1850: An Economy of Makeshifts* (Manchester: Manchester University Press, 2003); John Walter and Roger Scholfield, eds., *Famine, Disease and the Social Order in Early Modern Society* (Cambridge: Cambridge University Press, 1989); Paul Slack, *Poverty and Policy in Tudor and Stuart England* (London: Longman, 1988); Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London: Longman, 1988).

<sup>2</sup> On gender, see Alannah Tomkins, "'Labouring on a Bed of Sickness': The Material and Rhetorical Deployment of Ill-Health in Male Pauper Letters" in *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938*, eds., Gestrich, Hurren and King (London: Continuum, 2012), 51-68.

how aspects of social power were embedded in medical decision-making. Exploring situational networks of power demonstrates that medical agency was not confined directly to the management of illness. It was part of a much larger uncertain and inconclusive process that indicates personal agency was not a reliable marker for transactions of power. Social networks and cultural traditions exerted influence over people's ability-to-act. The social complexities that were fundamental to doctors' and patients' agency are addressed in two sections for ease of analysis, however, the many ways in which they were interconnected cannot be overstated.

## I. ILLNESS AND THE DOCTOR

In 1674, a medical practitioner calling himself *Alius Medicus* composed a narrative about a consultation he undertook on 29 April 1669, to visit a ten-year-old girl who had fallen ill.<sup>3</sup> In his text he took issue with the diagnosis and treatment given by Mr. Frederick Loss, a doctor who had examined the patient and found symptoms of a pain in the side, a sore throat, difficulty breathing, a cough and spitting of blood. Mr. Loss diagnosed “a Pleurisie, whose external cause was by catching a cold, seeing that in a cold season late in the evening, she had gone forth a walking, with naked breasts, as is the manner of Noble virgins.”<sup>4</sup> *Alius Medicus* argued that the fever caused the pleurisy whereas Mr. Loss thought the pleurisy caused the fever.<sup>5</sup> *Alius Medicus* quoted part of a letter from the patient's mother who had written, “the day you bled

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<sup>3</sup> *Alius Medicus, Animadversions on the Observations of the Heidelberg, Palatinate, Dorchester Practitioner of Physick, Mr. Frederick Loss* (Westminster, 1674).

<sup>4</sup> *Alius Medicus, Animadversions on the Observations*, 45.

<sup>5</sup> *Alius Medicus, Animadversions on the Observations*, 53-54.

her, she was so ill, as I and all the Family despaired of her Life.”<sup>6</sup> She recalled that Alius Medicus had suggested a gentle purge and Mr. Loss “was very stiffly against it,” yet she consented to a purge because she was desperately worried for her child’s life.<sup>7</sup> The child eventually recovered and then offered her own reasons for why she had become ill, “an over-much heating of her Blood at Play, and drinking cold beer”, and both mother and daughter thanked Alius Medicus for his “very great Care of her.”<sup>8</sup>

The above story is a rare account that provides evidence of four different narratives concerning the same case of illness, albeit reported by only one participant in the proceedings. The narratives originated from two attending doctors, a mother and her sick daughter, and family members who were present in the background. It is an account of two doctors who vied with each other over the girl’s diagnosis and treatment, while the girl’s mother acted pragmatically in the face of her child’s illness. It shows how the presence of illness brought about a range of complicated issues that escalated well beyond the diagnosis and medical treatment. From this account, it is possible to observe the social ramifications of illness on the doctor and to demonstrate how socio-relational power played a vital role in the dynamics of any medical relationship.

Arguments between medical practitioners were a common occurrence when there were no explicit rules for explaining and treating early modern diseases. Both doctors accused each other of having “no Method or Reason” to their medical

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<sup>6</sup> Alius Medicus, *Animadversions on the Observations*, 88.

<sup>7</sup> Alius Medicus, *Animadversions on the Observations*, 89.

<sup>8</sup> Alius Medicus, *Animadversions on the Observations*, 89.

practise. Alius Medicus had reservations about bloodletting and preferred to use leeches in one so young, while Loss ordered the girl's cephalic vein to be opened as soon as he was consulted.<sup>9</sup> Their dispute produced a lengthy commentary by Alius Medicus who questioned Loss' interpretation that heat had melted the girl's humors and caused her illness. Surely, he stated, "if the Humors be melted by hot Air, then they were not melted before, and if not, how were they fluid and Humors? One would think that heat should rather dry up and consume moisture, than make it more fluid."<sup>10</sup> Clearly, there were different ways of interpreting illness and the ambiguity of this medical knowledge system led to numerous accusations and conflicts between practitioners.

Explanations of illness were heterogeneous and blended ancient medicine, humoral theory, chemical experimentation, and knowledge gleaned from anatomical dissection. These ideas merged with notions of astrology, magic, vital spirits and the passions, and were encompassed by a concentrated focus on regulating diet. College physicians generally followed the ancient humoral philosophy of Roman physician, Galen, whose own work was to an extent grounded in that of Hippocrates.<sup>11</sup> The ideas and practises of the doctors recognised as Galenists were, according to Michael Hunter, "dominated by bloodletting and other forms of evacuation."<sup>12</sup> Allen Debus observed that Galenists were always discussing "the imbalance of bodily fluids

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<sup>9</sup> Alius Medicus, *Animadversions on the Observations*, 48, 52.

<sup>10</sup> Alius Medicus, *Animadversions on the Observations*, 66-67.

<sup>11</sup> Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001), 2; Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), 80; Weston, *Medical Consulting by Letter*, 116.

<sup>12</sup> Michael Hunter, "Boyle Versus the Galenists: A Suppressed Critique of Seventeenth-Century Medical Practice and It's Significance," *Medical History* 41, 3 (1997): 323.

leading to disease.”<sup>13</sup> Debus conceded, however, that Galenist views cannot be neatly characterised as “ancient” and they certainly covered “a wide spectrum.”<sup>14</sup> This was also true of ancient medicine, as Helen King suggested that although the Hippocratic Corpus mentions the four humors of blood, phlegm, yellow bile and black bile, “many treatises ignore them and instead feature other fluids and other ways of accounting for disease.”<sup>15</sup> Ulrike Kistner described early modern medical metaphors of illness as generating “weakly sufficient causes...vaguely related to miasmata, humors and vapours.”<sup>16</sup> So, although humors and fluids were generally present in early modern doctors’ explanations of illness, they were too ambiguous to belong to a specific method of diagnosis and treatment, and their dubious effects were discussed in relation to myriad causes of disease.

Early modern practitioners had a talent for producing extremely vague narratives of illness, yet unreservedly championed their medical philosophies. In 1665 George Thompson (c.1619-1676), a chemical physician and follower of Van Helmont (1577-1644), launched a vicious attack on Galenists over their methods of phlebotomy and purgation. He attacked the prevalence of bloodletting, arguing that blood was not normally “cast out of the body by Nature, unless extimulated through

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<sup>13</sup> Allen Debus, “Chemists, Physicians, and Changing Perspectives On the Scientific Revolution,” *Isis* 89, 1 (1998): 73.

<sup>14</sup> Debus, “Chemists, Physicians,” 79.

<sup>15</sup> Helen King, “Female Fluids in the Hippocratic Corpus: How Solid Was the Humoral Body?,” in *The Body in Balance: Humoral Medicines in Practice* eds., Peregrine Horden and Elisabeth Hsu (New York: Berghahn Books, 2015), 26.

<sup>16</sup> Ulrike Kistner, “Illness As Metaphor? The Role of Linguistic Categories in the History of Medicine,” *Studies in 20<sup>th</sup> Century Literature* 22, 1 (1998): 21.

some exasperating and hostile matter.”<sup>17</sup> He suggested the chemical alternative of administering “*Volatile Alkali*, enriched with the specifick virtues of fit Concretes, capable to be circulated with the Blood into all parts of the Body.”<sup>18</sup> Thompson criticised the way Galenists relied on purgation, stating that its use “may be well compared to a Mad person, that in cleaning a foul house, casteth out with the filth some of the most useful Furniture.”<sup>19</sup> He promised his readers that his advice could “save thee from the jaws of untimely death” and argued that only chemical remedies could restore a person’s vital spirits to health.<sup>20</sup> Alius Medicus confessed that he was unable to understand the “Dichotomy of *Animal* and *Vital*...for all our Actions may be accounted *Animal*, since I cannot conceive what *Vital* is, if I abstract it from *Sense* and *Motion*, which belong to *Animal*.”<sup>21</sup> In this environment of medical uncertainty practitioners exaggerated differences as they tried to establish their individual reputations. Their failure to readily admit to any common ground created social biases that extended beyond the purely medical.

One of the differences created in the conflict over treatments was the social bias that existed between Galenical and Chemical physicians. In general, chemical practitioners believed the vital spirits were the cause of life and death, as once the vital spirit had taken flight at death, the body was “no longer capable of Disease or

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<sup>17</sup> George Thompson, *Galeno-pale: A Chymical Trial of the Galenists That Their Dross In Physick May Be Discover'd With the Grand Abuses and Disrepute They Have Brought Upon the Whole Art of Physick and Chirurgery, in Their Method Touching Phlebotomy and Purgation* (London, 1665), 49.

<sup>18</sup> Thompson, *Galeno-pale*, 51.

<sup>19</sup> Thompson, *Galeno-pale*, 59.

<sup>20</sup> Thompson, *Galeno-pale*, “To the Reader”.

<sup>21</sup> Alius Medicus, *Animadversions on the Observations*, 8-9.



Cure.”<sup>22</sup> Logically, then, it appeared that the vital spirit must have preserved the body in its natural state during life. Chemical physician William Bacon strongly asserted the role of the Vital Spirits as initiators and barometers of ill health.<sup>23</sup> When the Vital Spirits were disrupted in some way it could cause a “sudden degenerate into passions of different, nay, contrary effects, according to the nature of the irritative cause from without.”<sup>24</sup> There were a great number of internal causes and external accidents that might disrupt the vital spirit, “which either being enrag’d, transported or suppressed, frame[d] diseases accordingly.”<sup>25</sup> Bacon cited heat, acidity, acid and alkali as qualities manifest in this process and he explained how the vital spirits were nourished by food that created juices, which fermented into “morbifick matter” and caused acute disease. When the matter fermented slowly it resulted in chronic disease. Thus, although Bacon’s explanation of illness was connected with fluids and humors, it was primarily diet that played an important role. The dependency on diet as a cause of ill health enabled Bacon to criticise physicians and nurses who, thinking they were helping their patients by pressing them to eat, only fed the disease instead.

Bacon’s views, in turn, were criticised by John Case (1660-1700), who is usually described as a “quack”, presumably because he was an astrologer and despite evidence of “a steady and affluent clientele, many of whom were seeking a cure for the clap.”<sup>26</sup> Although Case also believed in the vital spirits and the benefit of good

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<sup>22</sup> William Bacon, *A Key to Helmont, Or, A Short Introduction to the Better Understanding of the Theory and Method of the Most Profound Chymical Physicians* (London, 1682).

<sup>23</sup> Bacon, *A Key to Helmont*, 5.

<sup>24</sup> Bacon, *A Key to Helmont*, 7.

<sup>25</sup> Bacon, *A Key to Helmont*, 7.

<sup>26</sup> “John Case (1660-1700)” *ODNB*.

nourishment, he differed from Bacon by asserting the importance of the four elements of fire, air, water and earth.<sup>27</sup> When these four elements became unbalanced they caused sickness, as when heat caused cholera and fevers and cold caused phlegmatic and moist humors.<sup>28</sup> However, in Case's religio-humoral synthesis, it was God who made man and the vital spirits, and the spirits worked for and against the body by altering the four Elements. Meanwhile, out of the watery element "arose Male in the Fiery Mercury and Female in the Watery."<sup>29</sup> It was a complicated and abstract theory not easily comprehended by the layperson, however, the simple message that emerged was "good Nourishment causeth Health...[and] good Air will revive the Vital Spirits."<sup>30</sup> What exactly constituted good nourishment and good air, however, still caused problems even when there was agreement over the diagnosis.

The presence of a disease created controversy between practitioners even when they concurred with a specific diagnosis. Gout, for example, had a range of interpretations that matched its unpredictable symptoms. Nathaniel Lomax claimed that gout was a disease of the head and nerves, while John Archer, author of the popular work, *Everyman His Own Doctor*, asserted that gout was a grievous pain in the joints caused by "acrimonious humor proceeding from the spermatick part of the blood," and was primarily a male disease.<sup>31</sup> Will Atkins, self-styled Gout-Doctor, cured male and female patients alike and made no mention of gout being a male

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<sup>27</sup> John Case, *The Wards of the Key to Helmont Proved Unfit For the Lock, Or, The Principles of Mr. William Bacon Examined and Refuted and the Honour and Value of True Chymistry Asserted* (London, 1682), 8.

<sup>28</sup> Case, *The Wards of the Key to Helmont*, 8.

<sup>29</sup> Case, *The Wards of the Key to Helmont*, 9.

<sup>30</sup> Case, *The Wards of the Key to Helmont*, 7.

<sup>31</sup> Nathaniel Lomax, *Delaun Reviv'd viz. A Plain and Short Discourse of that Famous Doctor's Pills, Their Use and Virtues* (London, 1680), 5; John Archer, *Everyman His Own Doctor* (London, 1671).

disease. Atkins maintained that gout proceeded from a conglomeration of humors in the affected part, which could appear as gout of the head, limbs, stomach, or bowels.<sup>32</sup> Scurvy diagnoses differed greatly between practitioners and was almost impossible to describe. Nathaniel Lomax wrote that scurvy had several shapes, being a distemper that “creeps into, and mixeth it self with all other diseases.”<sup>33</sup> Lomax had read other authors who had assigned “forty, some fifty, others seventy symptoms thereof,” which Lomax had no room to account for in his own description of the illness.<sup>34</sup> Another doctor and medical writer, Thomas Tryon, declared that scurvy was an “Epidemical” disease of the English that arose from eating too many contrary foods and too much flesh, which made the spirits “dull and heavy.”<sup>35</sup> John Archer described it as a putrification of the blood by which sundry diseases were bred.<sup>36</sup> Archer, who was physician to Charles II, admitted that it was common to fly to the sanctuary of the scurvy when no understanding of a disease was present.<sup>37</sup> His claim suggests that practitioners articulated diagnoses in order to appear knowledgeable and consolidate medical authority in the social network.

Social hierarchies were a fundamental component of early modern society.<sup>38</sup> In navigating the shifting theories of medical knowledge, practitioners were forced to rely on status, reputation and respect, to maintain medical authority. These were all dimensions of socio-relational power that emerged from interactions between people.

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<sup>32</sup> Atkins, *Discourse on Gout*, 6-7.

<sup>33</sup> Lomax, *Delaun Reviv'd*, 6.

<sup>34</sup> Lomax, *Delaun Reviv'd*, 6.

<sup>35</sup> Thomas Tryon, *The Good Housewife Made a Doctor* (London, 1692), 253, 254.

<sup>36</sup> Archer, *Everyman His Own Doctor*, 130.

<sup>37</sup> Archer, *Everyman His Own Doctor*, 129.

<sup>38</sup> See Braddick and Walter, *Negotiating Power in Early Modern Society*, 1 - 41. (see chap. 1, n. 17).

Status for the medical practitioner was an index of social worth that came from prestige or esteem in the eyes of others, especially patients. Because *Alius Medicus* needed to impress his version of events on readers of the pamphlet, the dedicatory epistle was addressed to a woman who was honoured and respected by “the whole country roundabout.”<sup>39</sup> It was dedicated to the sick child’s mother, the “Religious Vertuous, and Discreet Lady, Mrs. Elizabeth Moore of Spargrave”, whose husband Thomas was a Member of Parliament and Sheriff of Dorset County.<sup>40</sup> The dedication represented an appeal to political power and an attempt to consolidate an association that would gain the practitioner some social status that might move him upwards in the local medical hierarchy.

*Alius Medicus* described his medical opponent, Mr. Frederick Loss, as “an Elder Physician, and your [Eliz. Moore’s] older Acquaintance of many years standing,” however, he accused Loss of flattering these noble families and publishing *Observations* that were hardly medical but were more like “An Academy of Compliments.”<sup>41</sup> Mrs. Moore’s preference for *Alius Medicus*, who she thought “spake most Reason”, disrupted Loss’ status as elder physician.<sup>42</sup> One of the consequences of illness, therefore, was to diminish the accepted medical authority of an established practitioner in favour of a lower status practitioner who happened to generate a more favourable performance or medical outcome.

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<sup>39</sup> *Alius Medicus, Animadversions on the Observations*, A9.

<sup>40</sup> *Alius Medicus, Animadversions on the Observations*, A3; M. W. Helms, John P. Ferris, “Moore, Thomas (1618-95), of Hawkechurch, Dorset and Spargrave, Som.” *The History of Parliament* (London: Institute of Historical Research). Accessed November 2016.

<http://www.historyofparliamentonline.org/volume/1660-1690/member/moore-thomas-1618-95>

<sup>41</sup> *Alius Medicus, Animadversions on the Observations*, 12.

<sup>42</sup> *Alius Medicus, Animadversions on the Observations*, A9.

One of the factors that related to status was a practitioner's ability to use specialised language and medical terminology.<sup>43</sup> Whether it was the *synochus* of a continuing fever or the *hectique* of a fluctuating one, or the *morbifick matter* that caused disease, doctors prescribed *diaphoreticks* and *basilicons* to combat *plethorie* or *cacochymia* and the patient might be none the wiser.<sup>44</sup> Mr. Loss' ability to write Latin was scrutinised by Alius Medicus in order to subvert what appeared to be Loss' medical authority. He likened Loss' ability to speak Latin to several cases he had heard of when patients during a fever "Spake a Language never understood before, nor since."<sup>45</sup> He discredited Loss further by pointing out that it was only through a similar "Temperament of the Brain, whereby *Germans* do generally more naturally as it were write and speak Latin."<sup>46</sup> Alius Medicus employed social bias against this foreign doctor, calling him an "Alien Practitioner of Physick in England", "a petty schoolmaster at *Dantzick*", and one who slighted and slandered all English physicians.<sup>47</sup>

Medical writing was traditionally produced in Latin throughout the seventeenth century, however, this changed when Nicholas Culpepper (1616-1654), herbal practitioner, and William Salmon (1644-1713), self-titled Professor of Physick, each translated the College of Physicians' comprehensive and annually published medical manual, *Pharmacopoeiae Londonensis*, from Latin into the

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<sup>43</sup> See Anon, *The Quack's Academy*, 4,5,6.

<sup>44</sup> Diaphoretick: herbs that induce sweating/perspiration that helps to reduce fever cool the body and speed the elimination of toxins; Basilicon: Ointment of wax, pitch, resin, olive oil, & lard; Plethorie: corrupted blood; Cacochymia: corrupted humours other than blood. (Terminology sourced from the *Ward Diaries*.)

<sup>45</sup> Alius Medicus, *Animadversions on the Observations*, 77.

<sup>46</sup> Alius Medicus, *Animadversions on the Observations*, 77.

<sup>47</sup> Alius Medicus, *Animadversions on the Observations*, 2.

vernacular.<sup>48</sup> College physicians were slow to follow their example until the end of the century. A letter in 1691, signed by forty physicians from the Royal College of Physicians read, “we...faithfully promise to...write English directions to our patients.”<sup>49</sup> Alius Medicus insisted on writing his *Animadversions* in English because by writing in the “Mother-tongue” he would be better able to plead for “truth” rather than “learning”, thereby highlighting how different ways of communicating contributed to the mechanisms of socio-relational power.<sup>50</sup>

Historian, Michael Solomon described a literary phenomenon he termed “sickly reading” in which vernacular medical publishing served as “a type of palpable instrument” belonging to the doctor, which assuaged the anxieties of the sick reader, especially those who lived distant from any doctor.<sup>51</sup> The reader’s faith in the efficacy of the advice contained therein rendered it an extension of the physician who wrote it, making the doctor seemingly present at the patient’s bedside. In writing the text, the doctor began with a “rhetorical manipulation of the afflicted reader’s mind”, while the sickly reader approached the text in a highly motivated manner with an eye to restoring and preserving the body via the words contained within it.<sup>52</sup> Sickly readers crossed all boundaries of class, religion and geographical locality to form a group of people connected by illness and disease. The focus of

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<sup>48</sup> See, Nicholas Culpepper, *A Physical Directory, or a Translation of the London Directory* (London, 1649); William Salmon. *Pharmacopoeia Londinensis. Or, the New London Dispensatory. In Six Books Translated into English for the Publick Good; And Fitted to the Whole Art of Healing* (London: 1678).

<sup>49</sup> REGUC / ENV452, 1690, RCP.

<sup>50</sup> Alius Medicus, *Animadversions on the Observations*, A4.

<sup>51</sup> Michael Solomon, *Fictions of Well-Being: Sickly Readers and Vernacular Medical Writing in Late Medieval and Early Modern Spain* (Philadelphia: University of Pennsylvania Press, 2010), 3.

<sup>52</sup> Solomon, *Fictions of Well-Being*, 6

these popular texts, mostly written by doctors, was to generously furnish patients with the requisite knowledge to deal with illness, while simultaneously consolidating the doctor's medical authority.

Doctors' investigations of the sometimes grotesque and bizarre afflictions caused by illnesses gave rise to yet another genre of communication about illness; the medical case report. Papers in *Philosophical Transactions*, the journal of the Royal Society, demonstrated the growing importance of relating individual cases as empirical evidence, thereby accumulating greater knowledge of illness. Behind these narratives of illness lay an opportunity to make alliances that generated social power. In 1695, *Philosophical Transactions* published a paper on *Nephrotomy* containing information pooled from a number of practitioners.<sup>53</sup> The sum of its medical knowledge lay far beyond the comprehension of lay people. The author consulted well-known seventeenth-century medical figure Doctor Edward Tyson, and Doctor John Downes who was a physician at Christ's Hospital, London.<sup>54</sup> Dominicus Marchetti was named as the famous and experienced professor at Padua University who operated on Mr. Hobson, the English Consul at Venice, thus drawing upon Marchetti's fame and reputation. The author deciphered Latin texts, consulted the opinions of the ancients and collected all the available evidence so as "to advance the

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<sup>53</sup> Anon, "An Account of a Gentleman's Being Cut For the Stone in the Kidney, with a Brief Inquiry into the Antiquity and Practice of Nephrotomy," *Philosophical Transactions* 19, 215-315 (1695): 333-342.

<sup>54</sup> On Edward Tyson see Ashley Montagu, *Edward Tyson, M.D., F.R.S., 1650-1708, and the Rise of Human and Comparative Anatomy in England; A Study in the History of Science*. (Philadelphia: American Philosophical Society, 1943); Lawrence Kruger, "Edward Tyson's 1680 Account of the 'Porpess' Brain and its Place in the History of Comparative Neurology," *Journal of the History of Neurosciences* 12, 4 (2003): 339-349. (Doctor John Downes kept notes on the temperature and weather, see Gordon Manley, "1684: The Coldest Winter in the English Instrumental Record," *Weather* 66, 5 (2011): 133-136.)

Art of Healing”, in general.<sup>55</sup> The author’s knowledge was reinforced by the fame and reputation of respected medical practitioners in order to produce an authoritative medical narrative of illness. Collective knowledge shared and amassed in this way contributed towards improving the structural status of medicine as a developing profession.

Sometimes, the doctors’ unstable knowledge of illness forced them to limit or manage medical information in particular ways. One of those methods was secrecy. Historians, Leong and Rankin have argued for the centrality and importance of secrecy within early modern arenas of knowledge. Nowhere was it more important than in the field of medicine. Anything secret had an aura of numinosity surrounding it. Secrets were akin to religious mysteries, which were “revealed only to a chosen few.”<sup>56</sup> Secrets might be physical objects, technical knowledge, or trade secrets. The crucial function of a secret enabled the creation of a community that shared privileged knowledge. It allowed the holder to promise a potentially valuable result in a case of illness, or it could be used as “a device to entice.”<sup>57</sup> Secrets played a useful role even when they were revealed, as they were divulged for the good of the patient and “medical charity” served to enhance the reputation of the doctor. Or, they were given to young and inexperienced doctors to advance their medical knowledge.<sup>58</sup> Although secrets might appear as the prerogative of the so-called quack operator who was, supposedly, always out to trick their patients, doctors belonging to

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<sup>55</sup> Anon, “Being Cut For the Stone,” 334.

<sup>56</sup> Leong and Rankin, *Secrets and Knowledge*, 7.

<sup>57</sup> Leong and Rankin, *Secrets and Knowledge*, 9.

<sup>58</sup> Leong and Rankin, *Secrets and Knowledge*, 13, 14.



the Royal College of Physicians were also known to keep secret remedies, which were placed in a locked chest within the College building, or required to be revealed to College officers on admission to their ranks.<sup>59</sup> Secrets widened the gap between medical and lay authority, however, secrecy could also be used in the form of gossip to vilify others. Alius Medicus stated he had been highly incensed by Loss' use of "vilifying expressions" behind his back, and exposed what he saw as Loss' reliance on "private slanders" to inform people that Alius Medicus was no doctor and no scholar.<sup>60</sup>

Even though the outcome of any illness was of major importance in helping to determine the doctor's worth in the patient's eyes, practitioners appeared to be predominantly concerned with their reputation. Rather than collaborating and sharing any praise, practitioners continued to debate who was responsible for what particular treatment. Although Elizabeth Moore's daughter had been cured, Alius Medicus and Frederick Loss carried on arguing, each trying to maintain his reputation within the sphere of their social networks. Alius Medicus wrote that Loss' observations on the case were "wounding of my Reputation by his private whispers and now Public slander."<sup>61</sup> He accused Loss of producing "pompous false narrative" and generating a "plotted and studied piece of forgery."<sup>62</sup> Clearly, social networks of gossip were particularly dangerous to practitioners as "everyone is Judge in our case, and most commonly those that have the least knowledge have the greatest confidence if not

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<sup>59</sup> Clark, *History of the College*, 189.

<sup>60</sup> Alius Medicus, *Animadversions on the Observations*, 20.

<sup>61</sup> Alius Medicus, *Animadversions on the Observations*, 51.

<sup>62</sup> Alius Medicus, *Animadversions on the Observations*, 52.

impudence in their verdicts.”<sup>63</sup> This situation forced doctors to defend and attack each other in order to maintain their reputation, whatever the outcome of the illness.

If an illness resolved, doctors could be credited with skills they may not have possessed, as patients assumed the existence of valuable medical knowledge. An illness that was cured could increase the doctor’s reputation, while the death of a patient might contribute to the doctor’s downfall. Laurent Joubert wrote of doctors who failed to proceed correctly in the management of patients who were near death, yet, if a patient unexpectedly recovered the doctor was praised for bringing about “a remarkable cure, even a miracle, no less than if he had raised the patient from the dead or absolved him from death, into whose clutches he had already been condemned.”<sup>64</sup> On the other hand, a doctor who had done everything expected of him could encounter bad luck when a patient died. One patient might die and another recover simply because “the illness will be more vehement and the strength weaker in one than in the other.”<sup>65</sup> This predicament was clearly on the mind of Alius Medicus as he alluded to honest physicians who did all they could for a patient, yet were still thought of as obnoxious, even though they were ignorant of what their faults might have been, and, they were not given any chance to answer for themselves.<sup>66</sup> Building status and reputational power was a process that could easily go awry amidst the unpredictability of illness.

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<sup>63</sup> Alius Medicus, *Animadversions on the Observations*, B4.

<sup>64</sup> Laurent Joubert, *The Second Part of the Popular Errors*, transl. and annot. by Gregory David de Rocher (Tuscaloosa: University of Alabama Press, 1995), 119.

<sup>65</sup> Joubert, *Popular Errors*, 118.

<sup>66</sup> Alius Medicus, *Animadversions on the Observations*, B3.

When an illness turned out badly, and no competing practitioner was close at hand to take the blame, doctors were keen to lay responsibility for a bad outcome firmly with the patient. Doctors frequently pointed out that patients were their own worst enemies, and they readily blamed them for ignoring symptoms or displaying reckless naivety in their behaviour. Doctor Edward Tyson, Fellow of the College, wrote an account of a man who had been hit on the head with a quart pot in a quarrel. Tyson reported that he had died because he had “neglected the use of [medical] means, till at last he was forced to betake himself to his bed” and only then was Doctor Morton consulted.<sup>67</sup> Another case, described by Mr Bonavert, blamed a man who was troubled with a quinsy (sore throat), who “neglected any advice till he could hardly swallow any liquid” and was only relieved by Bonavert’s assistant using his finger to break the swelling in his throat and release a quarter of a pint of matter out of the mouth.<sup>68</sup> The implication was that patients should have sought help earlier at the onset of their illness.

There were other ways that practitioners shamed patients in the process of promoting their own reputations. *Alius Medicus* was scathing of Loss’ habit of naming his patients and supplying their age, wealth, trade and other salacious details that had little to do with their illness. He pointed out how young ladies who were presently unconcerned about the publication of their age might well regret it in future years, “especially if they not yet got Husbands, to have their age so easily look’d

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<sup>67</sup> Edward Tyson, “An Observation of One Hemisphere of the Brain Sphacelated,” in *Philosophical Transactions*. 19, 215-315 (1695): 535.

<sup>68</sup> Mr. Bonavert, “An Account of a Stone Bred at the Root of the Tongue” in *Philosophical Transactions* 20: 236-247 (1698): 440.

into, at every Booksellers shop.”<sup>69</sup> Women often attracted heavy criticism from their doctors. Alanna Skuse argued that women were characterised by their “foolish misjudgments” as they resisted doctors’ therapies, and she pointed out how medical outcomes generally “ended badly for the intractable patient.”<sup>70</sup> Alius Medicus, in his address to Mrs Elizabeth Moore, stated how he appreciated “you, that have a ladies skill in physic”, in a backhanded compliment that implied a ladies skill in physic was somewhat inferior to his own medical skill.<sup>71</sup> Thomas Molyneux M.D. accused all women who suffered from the stone: “truly, if Women in this case would but timely seek for help, they might with far less Danger and Pain be relieved of this torturing and lasting Evil, than they are delivered of a common Natural Birth.”<sup>72</sup> In October 1664 the mother of Louis XIV of France, Anne of Austria (1601-1666), consulted a doctor who declared that it was Anne’s own fault that she had breast cancer. “By eating whatever she wanted over the years and not following a regime of periodic bleedings and purgings she had inadvertently pushed her humoral fluids out of balance.”<sup>73</sup> The doctors’ narratives of blame were related to the course of the patient’s illness and were adjusted in response to its twists and turns. Alius Medicus believed that the unpredictability of illness brought forth emotions that were detrimental to the doctor and heaped shame on the practise of medicine. “Some of them are so self-conceited, envious, and covetous...[that] if the Patient dye, they

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<sup>69</sup> Alius Medicus, *Animadversions on the Observations*, 5.

<sup>70</sup> Alanna Skuse, *Constructions of Cancer in Early Modern England: Ravenous Natures* (Basingstoke: Palgrave Macmillan, 2015), 148.

<sup>71</sup> Alius Medicus, *Animadversions on the Observations*, A6.

<sup>72</sup> Thomas Molyneux. “Some Additional Remarks on the Extracting the Stone of the Bladder Out of Those of the Female Sex,” *Philosophical Transactions* 20, 236-247 (1698): 14.

<sup>73</sup> James Oleson, *Bathsheba’s Breast: Women, Cancer and History* (Baltimore: John Hopkins University Press, 2002), 20.

slanderously and privately suggest, that he took a wrong course, and killed him.”<sup>74</sup>

Blaming and shaming were emotional mechanisms inherent in all early modern socio-relational networks and the stressful presence of illness exacerbated their occurrence.

Social issues clearly affected early modern practitioners and dictated the way they practised medicine. The distresses of practising medicine were not confined to the physical management of illness but ranged across a social spectrum of issues that included reputation, the curse or boon of gossip, foreignness, social status, wealth, and the status of one’s friends and associates. Early modern social hierarchies could prove to be an obstacle to gaining status within medical practise. Status and respect needed to be earned and proved, however, the vagaries of illness placed sometimes insurmountable stresses on practitioners. Meanwhile, when doctors struggled with managing sickness, a broad and divergent range of socio-cultural factors lay behind the façade of patient agency.

## II. ILLNESS AND THE PATIENT

It is a truism that serious illness rendered patients dependent and powerless, however, ambulant patients with minor illnesses had to contend with social and cultural expectations that disrupted social relations and restricted behaviours. In 1623, John Donne caught “a contagious spotted or purple fever” that “hath taken

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<sup>74</sup> Alius Medicus, *Animadversions on the Observations*, B5.

away many of a good sortte as well as mean people.”<sup>75</sup> Donne could “impute it to no cause, nor call it by any name”, yet, he comprehensively described his illness and the disturbing symptoms it brought.<sup>76</sup> The threat of angry red spots, the imminent danger of his circumstances, and the belief he would die, all intensified Donne’s fear. His behaviour and emotional outlook changed markedly; illness made him miserable and pessimistic, forced him to take to his bed and disrupted his social relationships. He worried over how his friends and enemies would perceive him; “they conceive the worst of me now, and yet feare worse; they give me for dead now, and yet wonder how I doe.”<sup>77</sup> His emotions, or passions, responded seemingly of their own accord with “jealousies and suspitions, and apprehensions of Sicknes, before we can call it a sicknes...to presage that execution...to assist the sicknes.”<sup>78</sup> The illness that invaded his body caused his thoughts to turn against him. He experienced a loss of confidence in his previously healthy body, expressed in those “jealousies and suspicions” that invaded his mind, which, in turn, exacerbated his physical disease.<sup>79</sup> Donne was rendered weak and helpless and he worried over the social ramifications of his illness. He duly handed himself over to his doctors’ ministrations and let them shoulder the medical decision-making responsibility.

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<sup>75</sup> John Chamberlain, *The Letters of John Chamberlain* ed. N.E. McClure (Philadelphia: American Philosophical Society, 1939), 529.

<sup>76</sup> Donne, “Meditations” (See “Introduction,” n. 1, p. 2.)

<sup>77</sup> Donne, “Meditations.”

<sup>78</sup> Donne, “Meditations.”

<sup>79</sup> For more on Donne’s illnesses see Gerald L. Higgins, “Trust and Doubt: John Donne’s Perceptions of Physicians,” *Humane Medicine* 10, 1 (2010): 1-7; Mary Ann Lund, “Exploring Pain in John Donne’s *Devotions Upon Emergent Occasions* (1624),” in *The Sense of Suffering: Constructions of Physical Pain in Early Modern Culture* eds. Jan Frans van Dijkhuizen and Karl A. E. Enenkel (Leiden: Brill, 2009), 323-346; Kate Gartner Frost, *Holy Delight: Typology, Numerology, and Autobiography in Donne’s Devotions Upon Emergent Occasions* (New Jersey: Princeton University Press, 1990).

Whereas Donne was a deep thinker, sensitive and aware of his fate, others reacted to illness in many ways. Autobiographical narratives demonstrate that patient perspectives of illness were not only situated in religious, cultural, medical, and social contexts, but they were also influenced by personal circumstances and the spectrum of emotions. This section examines how patients' voices reveal a wide range of variable influences and responses to illness, which serve to demonstrate that medical outcomes were unpredictable within the dynamic-equilibrium of the doctor-patient relationship.

Historians have sometimes interpreted patient accounts of illness as evidence of patient power or agency. Mary Fissell argued that patients were powerful because they held "interpretive autonomy" when they described illness."<sup>80</sup> Linda Hunt explained how illness narrative "holds a potent constructive capacity, through which people find the power to resist and restructure."<sup>81</sup> In other words, articulating illness empowered patients and helped them to resist their doctors and reconfigure their new social status as a sick person. However, patient voices often describe the experience of pain and the detrimental social ramifications of illness. Descriptions of illness cannot be isolated as a signifier of patient power without considering other complicating aspects of the lived experience. No matter how the sick adjusted to their new circumstances, the social responses from healthy individuals surrounding them fluctuated uncontrollably between sympathy, empathy, concern, pity, fear, disgust, and even rejection. Patients might have appeared strong or resilient in their

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<sup>80</sup> Fissell, *Patients, Power and the Poor*, 35.

<sup>81</sup> Linda M. Hunt, "Strategic Suffering: Illness Narrative as Social Empowerment Among Mexican Cancer Patients," in *Narrative and Cultural Construction of Illness*, eds., Mattingly and Garro, 89.

actions as they faced disease, however, the situational context of their illness could have unforeseen social consequences that lay hidden beneath the guise of their agency.

Social identity could be constructed or demolished by illness. Historian, Anne Lear described how Alice Thornton (1626-1707) structured her suffering persona within the contextual confines of early modern religious, cultural, and social influences. Thornton drew on her experience of illness to construct “an intensely suffering yet humbly accepting and resigned Christian woman.”<sup>82</sup> However, Thornton experienced a barrage of episodes of ill health, including sixteen pregnancies, several of which ended in the deaths of her new born children. In the midst of one bout of illness she lost her hair, her nails – on both her fingers and toes, and her teeth grew loose and turned black.<sup>83</sup> During an episode of smallpox and in peril of her life, Thornton used this deathbed tableau “to slip in a nice compliment to her own potential Christian virtue,” and her childbirth experiences “gave her plenty of scope for the embellishment” of her persona as “a suffering mother.”<sup>84</sup> The torment endured by Thornton is underplayed by her seemingly powerful ability to create her own narrative, yet, the construction of her newly suffering persona came at a cost and demolished her previously healthy identity. In the context of the patient’s everyday life, therefore, the potential of illness to be disruptive and alter lives was

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<sup>82</sup> Ann Lear, “Thank God for Heamorrhoids! Illness and Identity in a Seventeenth-century Woman’s Autobiography,” *Women’s Writing* 12, 3 (2005): 344.

<sup>83</sup> Alice Thornton, *The Autobiography of Alice Thornton of East Newton, Co. York* (Durham: Andrews and Co., 1875), 88.

<sup>84</sup> Lear, “Thank God for Heamorrhoids,” 341.



potent, and it might retreat without causing harm or leave people incapacitated in its wake.

So how did patients explain their illnesses and how did their explanations differ from the doctors? In general, patients pondered over any departures from their normal diet and deliberated over deviations from their habitual behaviours. Patients occasionally used humors to explain their illnesses, however, these explanations took a distinctly different turn from those of the doctor. While doctors used their medical and anatomical knowledge to explain the effects of “Alimentary” or “Excrementitious Humours” on internal bodily organs, blood, veins and nerves, patients talked of external hot and cold temperatures and mentioned abnormal weather events and social happenings.<sup>85</sup> Lay people often cited diet as a means of keeping healthy and they tried, sometimes unsuccessfully, to avoid rich food and strong drink. They also displayed a keen awareness of the need for exercise and fresh air, as when Ralph Josselin worried that cousin Benton had grown excessively fat, and a member of the Verney family wrote Captain Blarkes “died of fatt” because he never took any exercise.<sup>86</sup>

When patients requested bloodletting it is generally assumed their intentions related to humoral theory, yet bloodletting appeared to be an end in itself and very often had no association with the humors. Samuel Jeakes of Rye began his diary in

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<sup>85</sup> A. B., *The Sickmans Rare Jewel* (London, 1674), 9. Even when patients did not mention the weather, it can be discerned that weather had an effect on their health, as can be seen in Robert Hooke’s diary when the April weather seems to have cheered him up and he did not complain of bodily infirmities as often as he had done throughout the previous winter. See, Robert Hooke, *The Diary of Robert Hooke* eds., Henry Robinson, Walter Adams (London: Taylor Francis, 1935), 38-49. (Hereafter cited as, Hooke, *Diary*).

<sup>86</sup> Ralph Josselin, *The Diary of Ralph Josselin 1616-1683* ed., Alan Macfarlane (London: Oxford University Press, 1976), 94. (Hereafter cited as, Josselin, *Diary*); *Verney Memoirs*, 165.

1652 and detailed numerous incidents of illnesses experienced by family and friends during a span of over forty years, but he never once mentioned humoral illness until his penultimate entry on 26 Nov 1694. He wrote “very sore with a Cancerous humor, which brake out somewhat violently this week; having eaten away part of the gum; & was very painfull. But it pleased God somewhat to asswage the pain in 3 or 4 days.”<sup>87</sup> Jeakes, like other patients, was primarily concerned with his symptoms, how they progressed and whether they caused any pain. It is also difficult to find any association between illness and humors in the diary of Robert Hooke, who is known for obsessively recording every worrying symptom he experienced, on a daily basis.<sup>88</sup> Lay portrayals of the humors tended to ignore physical explanations of fluids, instead, depicting humors as characteristics that produced emotional turmoil, or heightened passions.<sup>89</sup> This distinction, from the doctors’ approaches to illness, was not straightforward and often conflated diverse explanations of humors and disease in order to suit social expectations and situations.

Olivia Weisser’s study on sickness and gender in early modern England showed that “passions” were a covert threat of illness “more prevalent...than historians have supposed.”<sup>90</sup> Indeed, the passions can readily be found in Izaack

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<sup>87</sup> Samuel Jeake, *An Astrological Diary of the Seventeenth Century: Samuel Jeake of Rye 1652-1699* ed., by Michael Hunter and Annabel Gregory (Oxford: Clarendon Press, 1988), 250.

<sup>88</sup> Robert Hooke, *The Diary of Robert Hooke, M.D., M.A., F.R.C.S., 1672-1680*, transcribed & edited by Henry Robinson & Walter Adams (London: Taylor Francis: 1935).

<sup>89</sup> See A. B., *The Mystery of Atheism* (London, 1699), 67. (“How incredible is it that all the People in the World, of the most distant Places, and the most different Humours, Interests, and Inclinations, should all agree together in framing this notion.”); A. B., *Some remarks Upon Government* (London, 1689), 20. (“The great and weighty Affairs of the Nation becomes subject to the passions and humours of a single Person.”)

<sup>90</sup> Weisser, *Ill Composed*, 83.

Walton's (1594-1683) *Life of John Donne*.<sup>91</sup> Walton referred repeatedly to the passions, suggesting that "love and anger are so like agues as to have hot and cold fits."<sup>92</sup> On one occasion, Donne's wife was seen to be so upset, prior to a visit by Donne to Europe, that "her divining soul boded her some ill in his absence."<sup>93</sup> She subsequently suffered a miscarriage while he was away, which was attributed to her constant yearning passion for him. Years later when she died, his friends were afraid that Donne would suffer from his passions as they wondered if "sadness for his wife's death, would...make his days few" and cause his bodily health to turn "evil...and of this there were many visible signs."<sup>94</sup> With the passage of time, Donne's sorrows moderated and his health improved, confirming that the passions had indeed been the cause of his illness.<sup>95</sup> Passions had the potential to disrupt the course of an illness and contributed to the dynamic nature of medical encounters.

The way the passions worked within the body in relation to humors, elements and vital spirits was not easily understood at the time. Historian, Stephen Pender described explanations by both medical and non-medical writers as "complex, often vaguely characterised, and frequently revised in the period, and we find equivocation everywhere."<sup>96</sup> Nevertheless, passions played an important though sometimes clandestine role in causing illness. Pender identified what he termed a "moral nosology" where early modern disease was classified by the way doctors and patients

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<sup>91</sup> Izaak Walton, *Lives of Donne and Herbert* ed., S. Roberts (Cambridge: Cambridge University Press, 1928).

<sup>92</sup> Walton, *Lives of Donne*, 11.

<sup>93</sup> Walton, *Lives of Donne*, 18.

<sup>94</sup> Walton, *Lives of Donne*, 31.

<sup>95</sup> Walton, *Lives of Donne*, 32.

<sup>96</sup> Stephen Pender, "Subventing Disease: Anger, Passions, and the Non-Naturals," in *Rhetorics of Bodily Disease*, ed. Vaught, 210.

felt the passions had caused or exacerbated illness.<sup>97</sup> Passions were observed to take hold of a person when government of the body was lacking. This raises the question of how much agency can be attributed to patients in cases where a disease was thought to exist because irrational passions had taken control of the body. A patient's ability-to-act did not clearly represent power in these cases but rather indicated that hidden processes were at work, which belied the appearance of agency.

Hidden processes can be detected through the tropes of fear, pain and torture figure that predominate and signify patient vulnerability. Corroborating Anne Lears' observations on Alice Thornton's religiosity, historian Jan Frans Van Dijkhuizen also found suffering to be a central idea in early modern English religious discourse, which encouraged physical pain to be constructed as "theologically and spiritually meaningful."<sup>98</sup> For instance, in Paris in 1651, John Evelyn witnessed a malefactor tortured on the rack and, with an element of confessional bias, related it to the suffering of Christ. The man's stomach was forcibly swelled with buckets of water to make him confess to a robbery, which he continually denied throughout his ordeal. Evelyn could not stay to watch the torture because it distressed him too much, but he remarked that the scene represented to him "the intolerable sufferings which Our Blessed Saviour must needs undergo" when he died on the cross.<sup>99</sup> Once illness was manifest, people likened their experience to the worst pains imaginable, ideas that were drawn from both religious and secular origins. The execution of felons on the

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<sup>97</sup> Pender, *Rhetorics of Bodily Disease*, 193.

<sup>98</sup> Jan Frans Van Dijkhuizen and Karl A. E. Enenkel, *The Sense of Suffering: Constructions of Physical Pain in Early Modern Culture* (Leiden: Brill, 2009), 189. Also see, James C. Truman, "The Body in Pain in Early Modern England," *Early Modern Literary Studies* 14, 3 (2009): 1-37.

<sup>99</sup> Evelyn, *Diary*, 15 March 1651.

streets of London made torture a familiarity and its association with fear and pain was a reference point of comparison. John Donne likened the symptoms of his purple spotted fever to being tortured on the rack and he may well have seen someone tortured, just as John Evelyn had in Paris.

In reality, both the fear of illness and illness itself were prevalent, almost palpable, and they regularly interrupted people's lives. Illness was a painful burden that intruded forcefully into people's habitual practices, affecting the welfare and security of their families and limiting the patient's ability-to-act. In 1667 an account of a condition thought by the sufferer to be "St. Anthony's Fire" began with "a little ache" which turned into a "pain" and then became "a constant condition of misery."<sup>100</sup> Another wrote I have much "weakness."<sup>101</sup> A third empathised with a friend that he "was seized by that distemper when I was young and for a long time was miserably tormented."<sup>102</sup> A wife writing about her husband's illness described a "violent" cold and pleaded support from friends to dissuade him from travelling to London. "Hee cannot travell but to the prejudice of his health which I very much feare at this tyme of the yeare" she wrote in her distress.<sup>103</sup> Clearly, people were afraid of illness, not just for the pain and suffering it brought, but also for the social disruptions it caused.

The hidden stealth with which illness crept up created difficulty in predicting the approach it might take. Personal experience and scattered hearsay provided

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<sup>100</sup> DDKE/9/38/3, 30 March 1667, "Letter from Charles Bostock", LRO.

<sup>101</sup> DDKE/9/40/23, 15 June 1669, "Letter from Robert Greinsworth", LRO.

<sup>102</sup> DDKE/9/41/72, 26 December 1670, "Letter from Oliver Edge", LRO.

<sup>103</sup> DDKE/9/55/68, 19 November 1682, "Letter from Eliza Hodgkinson", LRO.

cautionary tales, which were a constant reminder for people to take heed and protect their health. In 1697 Richard Edge of Lancashire hurt his heel and could not wear a shoe or travel on horseback because of the pain it caused him. When he first noticed it, he thought it would have “mended of itself and [he] neglected to take care of it”, but it deteriorated quickly and he was forced to see a surgeon to have it dressed.<sup>104</sup> Edge reported what the surgeon told him; “if I be carefull it will mend tho it may hazard my life for my leg swelling.<sup>105</sup> Beginning as a minor irritation, it turned from a seemingly harmless sore heel into a dangerous fever that threatened his life. Although he survived this time, it was a harsh lesson to learn, and one unlikely to present people with a second chance. However trivial the symptoms of illness might appear, uncertainty over their progression increased people’s fear of illness. Such tales of disaster and woe brought home the importance of looking after health, and they created expectations of behaviour that became social legitimations.

Accounts of illness can demonstrate how patients’ situations changed as they became dependent on their helpers. In April 1624, Robert Lawrence of Kirkby in Lancashire wounded himself in the knee with an axe, while he was at work. He continued ill into the following year when he was eventually and literally carted to his father’s house and lay “languishing...not able to move and turne him self in his bed from about Shrovetide Anno 1625...until Michaelmas the next following.”<sup>106</sup> Patients who were unlucky enough not to have any help from family or friends were at risk of being passed over to parish authorities. At the many Quarter Sessions all

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<sup>104</sup> DDKE/9/70/17, 6 March 1697, “Letter from Richard Edge”, LRO.

<sup>105</sup> DDKE/9/70/17, 6 March 1697, “Letter from Richard Edge”, LRO.

<sup>106</sup> QSB/1/26/52, 1625, “Examination of Robert Lawrence, knee”, LRO.

around the country, petitions contained evidence of reduced circumstances and hard times. Diagnoses found in the Quarter Session records were mostly succinct, variously naming people as mad, lame or destitute due to illness. It seems patients had little input or control over such descriptions, which were recorded by sundry parish clerks, and at the behest of magistrates. In 1698, Sarah Dylon asked the parish for help to evict her 105 year-old lodger, Francis Bromfield, who had become “noe ways capable of helping himself soe that he has become very troublesome.”<sup>107</sup> And in the case of Elizabeth Hurst, she was sent to Bethlem Hospital by her mother, via the parish, when her behaviour became “accordingly outrageous” as she ran about the “Fields and streetes night and day” threatening to wound her mother and “fire the house.”<sup>108</sup> Such accounts reinforce the unpredictability and severity of illness, which curtailed patient agency and restricted the ability of family members when they also could not cope with the far reaching ravages of illness.

Observations of patient agency have tended to overlook other participants who also had a say in the proceedings when someone was ill. Joining the cohort of the sick were family and friends who all passed opinion on what might be wrong with the patient, and they all recommended possible treatments. On 16 December 1680, Dorothy Lagoe wrote to a friend about her sick mother, who she was unable to visit at that time possibly because of bad weather in the lead up to Christmas. Dorothy related a variety of opinions given by other family members in regard to her mother’s illness. Her cousin, Anne Ashton thought the patient needed a cordial and

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<sup>107</sup> MJ/SP/1698/A010, LMA.

<sup>108</sup> MJ/SP/1699/07/013, LMA.

had asked Mr Mingshull to send one, but he had failed to do so, thus far. Dorothy approved of a cordial and suggested sack (wine), but specified it should be hot sack that had been burned. Additional siblings recommended anointing and rubbing the mother with blood; cat's blood would be best, but if they could not get enough then calf's blood or sheep blood would do. A male family member approved of the treatment with blood but warned not to use quicksilver first, as it would certainly kill her. Final encouragements were offered that the illness would surely mend when the weather improved and the frost retreated. In the meantime, Dorothy wrote, "your company will refresh her and your voice will do her good."<sup>109</sup> The whole family was involved in the mother's illness and each of them sought opinions from apothecaries, doctors, acquaintances and friends. Family members unable to attend the bedside all had their say and the only voice missing was that of the patient. While Dorothy's mother may have contributed to the discussion, the absence of her opinion amidst those of her kin demonstrates that illness was collaborative and the patient did not always have control over how their symptoms were articulated and what the best course of action was to ensure a cure.

Social friendships often overlapped between doctors and their patients and enabled a joint effort in the management of illness, which exposes the sometimes overlooked qualities of altruism, reciprocity and shared emotional support that belonged to medical relationships. In 1688 Lord Ashley-Cooper, first Earl of Shaftesbury, became dangerously ill with a suppurating hydatid abscess of the liver

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<sup>109</sup> DDKE/acc.7840HMC/391. 16 December 1680, LRO.



and was assisted by his friend John Locke. Locke was credited with organising an operation for Shaftesbury, who afterwards recovered but had to endure the indignity of a six inch silver tube left in situ in his liver, which drained fluid and was washed in wine every second day. Shaftesbury considered Locke his good friend and believed he owed his life to Locke's care.<sup>110</sup> Advice came as a welcome relief when a friend happened to be a doctor, but also when a doctor became a trusted friend after many years of medical care. Doctor John Symcotts wrote to a patient advising her in regard to a recent miscarriage. Although she had already consulted another physician, Symcotts gave his advice under the proviso that he knew her well through the "long experience I have had of your constitution from your childhood."<sup>111</sup> So, both patients' and doctors' participated in relationships that were full of persuasion, complaint, justification and co-operation on both sides. In other words, they demonstrate evidence of a medical dynamic-equilibrium.

Although patients offered their own suggestions about illness they frequently complied with the doctors' medical authority and granted them the last word. Lay people were often unsure what to do in the face of illness but the doctor was more likely to have seen similar cases of illness and was therefore able to claim knowledge and experience. A Kenyon family member wrote to her mother to discuss a cousin's "distemper" which they were at a loss to understand. The symptoms, she wrote, "will

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<sup>110</sup> John Locke, *John Locke (1632-1704) Physician and Philosopher: A Medical Biography, With An Edition of The Medical Notes in His Journals* ed. Kenneth Dewhurst (London: Wellcome Medical Library, 1963), 36-38.

<sup>111</sup> F. Poynter & W. Bishop, eds *A Seventeenth-Century Doctor and His Patients: John Symcotts, 1592-1662* (Streatley: Bedfordshire Historical Record Society, 1950), 17. (Hereafter cited as, Symcotts, *Diary*).

certainly be a rheumatism, a distemper very frequent here in the South.”<sup>112</sup> Her advice had come from “a Physic here of my acquaintance” and she related details of his methods of treatment.<sup>113</sup> She also offered to gather further opinions from the physicians in town and asked for the information to be passed on to Dr Briggs so “he may make what use of it he feel convenient.”<sup>114</sup> Although the writer offered an interpretation and diagnosis of illness, her information came from her medical acquaintances and Doctor Briggs was given the final say. In another letter, the writer alerted a patient to heed the doctor, as “he is the best judge.”<sup>115</sup> Although patients had the ability to participate in discussions over illness they frequently deferred final decisions to the expert opinion of the doctor.

When patients did have the final say regarding therapy, it was usually because the suggested treatment had frightened them and they were apprehensive it might be painful and increase their suffering. Adam Martindale of Lancashire (1623-1686) sought advice for a skin condition from three doctors but nothing they proposed satisfied him.<sup>116</sup> One doctor suggested waiting until his skin complaint cured by itself, even though he’d already suffered with the complaint for two years. Another doctor suggested using mercury, which Martindale knew was dangerous, and a third suggested a treatment that was too painful to contemplate. Whereas Andrew Wear saw Martindale’s refusal to accept these cures as a wielding of patient

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<sup>112</sup> DDKE/9/95/5, 4 July 1696, “Letter from Roger Kenyon to Mother”, LRO.

<sup>113</sup> DDKE/9/95/5, 4 July 1696, “Letter from Roger Kenyon to Mother”, LRO.

<sup>114</sup> DDKE/9/95/5, 4 July 1696, “Letter from Roger Kenyon to Mother”, LRO.

<sup>115</sup> DDKE/9/95/6, 1 April 1697, “Letter from Roger Kenyon to Mother”, LRO.

<sup>116</sup> Adam Martindale, *The Life of Adam Martindale Written by Himself ed., Rev. Richard Parkinson* (Manchester: Chetham Society, 1845), 21.

power, Martindale's refusal was simply the only way out of a predicament in which the choices on offer were unacceptable. Martindale eventually settled on a woman practitioner who sold him an herbal salve, which finally cured him. Fear and anxiety could be the dominant emotions for patients, families and friends dealing with illness, and on occasions they were forced, sometimes reluctantly, to adopt responsibility for the management of illness. The story that lay behind their agency was not always obvious.

Illness affected patients in numerous ways beyond its immediate bodily symptoms. Social expectations required the sick to behave in certain ways when they were ill. For some patients, their behaviour was scrutinised in public as onlookers judged illness to be a punishment for physical or spiritual misdemeanors, and did not hesitate to voice their views. When diarist Nehemiah Wallington heard that William Noy (1577-1634), Attorney General to Charles I, had become ill, Wallington immediately attributed it to Noy's role in the persecution of William Prynne, John Bastwick and Henry Burton in 1637. These three protesters were, by order of Star Chamber, punished for religious dissent and put in the pillory to have their ears cut off and their noses slit, and then publicly whipped. Wallington reported that after Noy had stood laughing at the spillage of their blood he "by the just hand of God fell a voyding and pissing out his owne" blood.<sup>117</sup> Noy had begun urinating blood and his servants found traces of it on his bed sheets. According to Wallington, Noy was so worried people would believe he deserved to be ill that he tried to conceal his illness,

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<sup>117</sup> Wallington, *The Notebooks of Nehemiah Wallington*, 124.

even from his physicians. Wallington recorded, “And hearing there that his disease of voiding blood was then publicly knowen and talked of in London, he was vexed at it that he fell out with his physicians and sarvants, rayling on them like a franticke man as if they had betrayed him and disclosed his secrets.”<sup>118</sup> The fear of how his illness would be interpreted by people, especially his enemies, led Noy to flee London in a haze of secrecy. Wallington’s diary entries highlight how illness could reduce a prominent figure to cower in shame and fear. Noy was thought to be fearful to consult a doctor in case his secret was known and discussed by his enemies. In his reluctant role as patient Noy was helpless to shape his own destiny. Wallington was a critic of Noy and interpreted his illness as punishment for cruelty and lack of forgiveness. His account demonstrates how a range of factors interfered with the progress of an illness and dictated the views of the community.

The power of illness to destroy lives and change the course of history has generally been commented on, however, the various emotions and attitudes surrounding illness could be far-reaching. William Noy was not only a victim of illness but also of the public contempt directed towards him. While Wallington and others expected Noy to repent quickly at the first sign of his illness, Noy had continued with his work “like a beast once mortally wounded proceeds on his former fury.”<sup>119</sup> Coincidentally, but significantly in Wallington’s view, Noy had drawn up the papers for the three men’s imprisonment on the very day he departed to take the waters at Tunbridge Wells to combat his ill health. Noy was dead not long after this

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<sup>118</sup> Wallington, *The Notebooks of Nehemiah Wallington*, 124.

<sup>119</sup> Wallington, *The Notebooks of Nehemiah Wallington*, 124.

trip and when the physicians opened Noy's body, besides apparently finding no blood inside him,

his false malicious hard heart with inward fretting and vexing was so consumed and shrunked up that it was like an old rotten leather purse or meer scurfe...his kidnies were as blacke as an hat his intrails all putered [putrid, EC] and his carkas as a miserable spectacle...his funeral...was so private that there were hardly gentlemen enough to carry him to his grave but that some came in by accident<sup>120</sup>

Besides demonstrating how Wallington perceived the appearance of morally corrupt internal organs, it also shows how William Noy's illness galvanised social and emotional reactions towards him and his behaviour. Noy's heart, the repository of his passions, was believed to shrink, to become old and rotten to match the rottenness of his conduct. Noy's illness engendered hatred, whereas popular and respected sufferers might have attracted sympathy in the onlooker. Onlookers focused on the illness just as much as the patient, noting its occurrence, its ravages, its power to punish immorality and its portentous omen of death. Not only did illness directly affect its victims, but it also aroused cultural and societal beliefs that could be used as weapons to destroy or accolades to praise. The sick patient was not well equipped

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<sup>120</sup> Wallington, *The Notebooks of Nehemiah Wallington*, 125.

to deal with illness and its wide-ranging effects. Being sick brought disadvantages that could heap scorn on the rich and powerful and humiliation on the poor.

## CONCLUSION

The presence of illness activated instability in medical encounters and strongly influenced people's agency in different ways. The dangerous volatility of illness placed doctors and patients at its mercy, creating fear and despair in its victims and obfuscation and panic in its healers. Both patients' and doctors' ability-to-act was often restricted to generating reactions and responses to its ravages, and in addition, they were forced to consider the social attitudes of a wide circle of influence that included families, carers and communities. The actions of individuals were diverse and complicated and they changed with each medical encounter and each social network. What appeared to be patient agency was not always what it seemed.

Inquiring further into how and why people acted in the way they did, the next chapter will explore both doctors' and patients' attitudes towards cure. Patients consulted doctors repeatedly, even after distressing experiences, and the ever-present urge to seek out a cure was an important component of the early modern medical relationship.

Part II

“CURE, DEATH OR OTHERWISE”

### CHAPTER 3. “Cure”: Why Doctor’s Claimed Cure, How Patients Judged Cure

A yearning for cure prevailed within most early modern medical relationships, however, determining whether cure had taken place was a subjective judgment that differed from one observer to the next, and notions of cure were often connected to socio-relational power. If a cure was not forthcoming, or treatments turned out badly, the consequences for the medical relationship could be dire. On the other hand, if a cure succeeded, the outcome was not only beneficial for the patient but it delivered plaudits to the doctors and boosted their reputations. Cure was a crucial factor that contributed to the dynamic nature of medical outcomes. This chapter explores what it meant to be ‘cured’ in early modern England, by asking why doctors claimed cure and how patients judged cure. The chapter is divided into two sections: “Doctor’s Cures” and “Domestic Cures.” Section one demonstrates that doctors had shifting principles of determining cure, which they might broadcast for self-promotion or hide from view to render them more effective in struggles with competing practitioners. Section two evaluates the claim that early modern patients possessed a shared understanding of medicine that gave them parity with their doctors.<sup>1</sup> The sum of evidence does not fully support a shared understanding of medicine, which can be better described as the existence of overlapping medical spheres.

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<sup>1</sup> See Weisser, *Ill Composed*, 32; Pelling, *Medical Conflicts*, 230; Lindemann, *Medicine and Society*, 11-12; Fissell, *Patients, Power and the Poor*, 16-17; Porter, *Patients and Practitioners*, 14.



## I. THE DOCTORS' CURES

One morning in 1694 a London minister arose to find his twenty-one year old son strangely afflicted with a disease that “took away his limbs and deprived him of the use of nature.”<sup>2</sup> Down to the tips of his toes he had no feeling and no strength to move his legs or his bowels. All he could manage was to lie weakly in his bed and endure the unfortunate ailment that had reduced him to so sorry a state. As he lay there, friends and relatives suggested remedies and methods of treatment, all of which were tried and proved futile. The doctors milled around advising and consulting with each other but none could discover the cause of the disease while time ran out and hopes for his recovery faded with each passing day.<sup>3</sup>

In desperation, the minister wrote to ask another medical practitioner to examine his son and pass opinion on his illness. Will Atkins did not possess a university degree, was not a member of the College of Physicians, and went by the title of *Gout Doctor*. He arrived promptly and got to work. In a matter of hours the patient felt a small improvement in his condition, after which came a sensation that enabled him to rise from the bed. He took some tentative steps and then walked cautiously around the room. Atkins diagnosed a “Convulsion on the Nerves and inward Parts, and by this means the Limbs were affected with a Palsical Disease that taketh away all strength.”<sup>4</sup> The patient’s strength increased during the next three to four hours and after a second visit, bringing other more suitable medicines for

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<sup>2</sup> Atkins, *Discourse on Gout*, 96.

<sup>3</sup> Atkins, *Discourse on Gout*, 97.

<sup>4</sup> Atkins, *Discourse on Gout*, 98.

convulsions, Atkins banished the disease altogether. The younger Meriton was perfectly cured at the end of four days and sufficiently recovered to be able to travel abroad two weeks later. Atkins was particularly pleased to have carried out the cure during the winter months, as dark damp days and cold frosty weather were well-known dangers that could compromise a patient's health.<sup>5</sup>

The above story demonstrated that early modern patients could be cured, though the source of the claim and the methods it describes attracts modern scepticism. Before beginning an analysis of early modern cure, it is pertinent to show how cure has been undervalued, as notwithstanding precise written evidence it is often difficult for the modern observer to believe that such cures took place. Evidential accounts describe diseases and cures that are now unfamiliar, with the result that early modern doctors have been ridiculed and past scholars were ruthlessly blunt in their assessments.<sup>6</sup> For example, Christopher Booth wrote that "England...was unwashed and unsavoury and much of its medicine was little better."<sup>7</sup> And in 1975, Guy Williams confidently asserted that eighteenth-century medicine was "seriously retarded", "primitive" and "ludicrous."<sup>8</sup> Lucinda Beier stated that "in the early modern period, whatever their hopes, people did not actually expect healers and medicines to cure them", yet evidence shows they continually sought out and shared information about cure.<sup>9</sup> Others have judged early modern

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<sup>5</sup> Atkins, *Discourse on Gout*, 98.

<sup>6</sup> For a critical view of medicine throughout the ages see, David Wootton, *Bad Medicine: Doctors Doing Harm Since Hippocrates* (Oxford: Oxford University Press, 2007).

<sup>7</sup> Christopher C Booth, *Doctors in Science and Society: Essays of a Clinical Scientist* (Cambridge: Cambridge University Press, 1987), 1.

<sup>8</sup> Guy Williams, *The Age of Agony: The Art of Healing c1700-1800* (Constable: London, 1975), 7.

<sup>9</sup> Beier, *Sufferers and Healers*, 5. Also see Eric J. Trimmer, "Medical Folklore and Quackery," *Folklore* 76, 3 (1965): 163.

practitioners by comparison to modern medicine. Both Ronald Sawyer and Andrew Wear pointed to a lack of medical technology as the reason for the doctors' inability to achieve convincing rates of cure.<sup>10</sup> The sum of these views imply that early modern doctors were deficient in a technology they could not possibly be aware of, and early modern people lacked hope for a type of cure they could not even imagine, thus demonstrating how difficult it is to dispense with hindsight.

While some critics were medically qualified and as such their opinions were heavily influenced by a comparison with modern medicine, social historians of medicine have often been unsympathetic towards early modern practitioners. Roy Porter proposed that the “louche cynicism of top doctors fed a lasting negative public view of the profession” fuelled by their “drunkenness, mercenariness, callousness toward patients [and]...sexual misdemeanours.”<sup>11</sup> He also suggested that early modern “physicians and surgeons grew rich beyond the dreams of their forbears.”<sup>12</sup> The views of Porter, Booth and Williams have endured until more recently when Robert Weston noted a “lack of scholarly analysis” of cure, with scholars often “skirting around” questions of the use and efficacy of therapies.<sup>13</sup> Scholarship has hardly yet discussed early modern notions of cure, tending to focus on either the invalidity of a cure from a medical viewpoint or on its economic status in the medical marketplace. Early modern understandings of cure were a composite of many

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<sup>10</sup> Sawyer, “Friends or Foes?” in *History of the Doctor-Patient Relationship*, ed., Kawakito, 50; Wear, *Health and Healing in Early Modern England*, 295.

<sup>11</sup> Porter, *Bodies Politic*, 138, 140,

<sup>12</sup> Porter, *Health For Sale*, 43.

<sup>13</sup> Weston, *Medical Consulting by Letter*, 162.

elements and the medical viewpoint was strongly influenced by the social circumstances in which it took place.

Of course, deceitful practitioners existed and were ridiculed by contemporaries, and their exploits in promoting dubious cures were widely proclaimed to the community. Thomas Brian published a pamphlet in 1637 warning people about the dangers of those who claimed knowledge of disease by observing patients' urine; an ancient practice that was becoming increasingly outdated at the time. He named a man called "Trigge, alias Markham" who lied to ignorant folk that he had gained a B.A. and later an M.A. at Cambridge.<sup>14</sup> Trigge claimed he was Master of a Hospital and a Fellow of the Royal College of Physicians and he pretended to speak Latin yet was only a shoemaker. Another practitioner seen as fraudulent was "Doctour George" who claimed to cure consumption but who also turned out to be a shoemaker living in Westminster. Brian named a third man, Donnington, who he criticised for burning children behind the ears when they had rickets.<sup>15</sup> These complaints were not only directed at the medical cure offered by the practitioner but incorporated details concerning their social standing, which added to their ill repute.

The breadth and scope of early modern remedies constituted a diverse assortment of cures. Popular modern interest has often focused on early modern cures that incite fascination and contain ingredients such as "a spoonful of white

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<sup>14</sup> Thomas Brian, *The Pisse-Prophet, or, Certaine Pisse-Pot Lectures Wherein Are Newly Discovered the Old Fallacies, Deceit, and Jugling of the Pisse-Pot Science* (London, 1637), 103.

<sup>15</sup> Brian, *The Pisse-Prophet*, 104.

dogs turd” or the entrails of a “running cock” pulled alive and then killed.<sup>16</sup>

However, some seemingly absurd components have turned out to have real medicinal effect, and some were merely traditional remedies that remained popular. Thomas Sherley’s 1670 translation of a Latin medical tract was a sincere appraisal of a popular medicine known as *scurvy grass*, a common remedy that was in regular use. But such well-known remedies were mentioned alongside wondrous plants from around the world that had strange properties. The “China rose” plant changed colour from purple to white, twice each day.<sup>17</sup> There was also a root from Judea that refused to be plucked unless sprinkled with women’s urine or menstrual blood, and a tree not unlike the Mulberry tree that walked away with two short and sharp feet when touched.<sup>18</sup> And, as Richard Sugg has shown, there was a great deal of interest and respect for corpse medicine, which was routinely accepted and had a long and illustrious history.<sup>19</sup> It is easy to see how these some of these cures have little credence in the modern era, but how were these cures presented in early modern times.

Advertisements were rife and designed to appeal to patients’ desires for cure. Many “irregular” and “unqualified” practitioners tried to make a living by promising

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<sup>16</sup> For an example of the popular response to past cures see Polly Russell, “Celebrity Plague Cures; The History Cook,” *Financial Times Weekend Supplement*, 13 October 2012.

<sup>17</sup> Thomas Sherley, *Cochlearia Curiosa: Or the Curiosities of Scurvygrass: Being An Exact Scrutiny and Careful Description of the Nature and Medicinal Vertue of Scurvygrass* (London, 1676), 1.

<sup>18</sup> Sherley, *Cochlearia Curiosa*, 5, 7.

<sup>19</sup> Richard Sugg, *Mummies, Cannibals and Vampires: The History of Corpse Medicine From the Renaissance to the Victorians* (Abingdon: Routledge, 2011); Richard Sugg, “Good Physic But Bad Food: Early Modern Attitudes to Medicinal Cannibalism and Its Suppliers,” *Social History of Medicine*, 19, 2 (2006): 225-240.

to cure a long list of diseases with one simple medical ingredient.<sup>20</sup> For example, Charles Blagraves' medical mixture, The Golden Spirit, was representative of assorted products that were advertised in seventeenth-century England. It was a derivative of Scurvy grass and Blagraves claimed his medicine could cure any "sudden distempers", "scurvy" and "obstructions."<sup>21</sup> It caused swarthy complexions to become fair and beautiful, cured the King's Evil, ulcers, dropsy, colic, gravel and greensickness. It cured a lost appetite, rheumatic eyes and blindness, small pox and unsavoury breath. It also killed worms, cured the itch and was a remedy for any type of headache. It could be bought in nineteen locations around London and although one bottle was enough for four purges for a grown man, and it could also be administered to women and children.<sup>22</sup> The acceptance that a single medicine could cure a broad range of symptoms shows how an itch or a headache could exist independently from any specifically named illness that might have caused the symptom. The difficulty for the patient lay in discerning exactly which "wonder drug" was acceptable and which should be avoided.<sup>23</sup> The wide range of choices put patients at a disadvantage and gave purveyors the opportunity to exploit the fears of the sick.

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<sup>20</sup> On medical publishing see; Furdell, *Publishing and Medicine*; Fissell, "The Marketplace of Print," in *Medicine and the Market*, ed., Jenner & Wallis; Louise Hill Curth, "The Medical Content of English Almanacs 1640-1700," *Journal of Medicine and Allied Sciences* 60, 3 (2005): 255-282; Joad Raymond, *Pamphlets and Pamphleteering in Early Modern Britain* (Cambridge: Cambridge University Press, 2003).

<sup>21</sup> Charles Blagrave, *Doctor Blagrave's Excellent and Highly Approved Spirits of Scurvey-Grass, Both Plain and the Golden Purging, Faithfully Prepared According to His Own Directions* (London, 1680).

<sup>22</sup> Blagrave, *Approved Spirits of Scurvey-Grass*.

<sup>23</sup> Alisha Rankin, "Empirics, Physicians, and Wonder Drugs in Early Modern Germany: The Case of the *Panacea Amwaldina*," *Early Science and Medicine* 14, 6 (2009): 709.

Cure was evident in textbooks, recipe books and other medical literature, commonly listed as “Cure for...” this or that ailment.<sup>24</sup> There was little to indicate how effective these cures were but evidence shows that cure was measured from an accumulation of medical knowledge and judgment over what is now called the patient’s quality of life. In 1680 John Fox was only to be paid for the cure of Robert Banns, when Banns could walk across a room without a stick.<sup>25</sup> Whether Banns was cured or not was a subjective measurement, and even if deemed to be cured he might still appear lame to some. Shifting notions of cure led to misunderstandings between doctors and patients and led one doctor to complain in 1587, of “ungrateful common people” who never gave any credit to the physicians’ care, only remembering and amplifying the doctors’ most insignificant mistakes.<sup>26</sup> What appeared to be a cure in the doctors’ opinion was obviously not matched by the opinions of his patients. This doctor’s complaint echoes down the centuries however, it does not explain why people returned repeatedly to seek cure from all types of practitioners.<sup>27</sup>

To engender trust within their own socio-relational networks, many practitioners used the practice of providing testimony. After having cured the younger Meriton, Will Atkins put his success to good use by promoting it to boost his public reputation for cure. In company with Meriton’s story Atkins published the names of thirty-nine other patients he had cured on previous occasions. Amongst

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<sup>24</sup> For recipe books see, *Wellcome Library Recipe Book Collection*.

<http://wellcomelibrary.org/collections/digital-collections/recipe-books/>

<sup>25</sup> P175/28/1, 1680, Kent History and Library Centre.

<sup>26</sup> Joubert, *The Popular Errors*, 263. Also cited in Steven Shapin, “Trusting George Cheyne: Scientific Expertise, Common Sense, and Moral Authority in Early Eighteenth-Century Dietetic Medicine,” *Bulletin of the History of Medicine* 77, 2, (2003): 266.

<sup>27</sup> See Carla J. Rotering, “Doctor Bashing Has Become a National Sport: How to Stop it,” *Physician* (25 July, 2013).

them was Mrs Ambrose at *The Bell* in Wood Street who was cured of a painful, tormenting disease that caused a swelling in her hand and wrist. Widow Hudson, who kept a coffeehouse in *Jewry Lane*, had long been afflicted with the gout and was now recovered, and Mr Hancock, a Counsellor at the lower end of *Arundel Street*, also received relief from Atkins in the extremity of his gout.<sup>28</sup> All thirty-nine people were described as cured and there is little evidence to conclude that these claims were false. Alongside the names of patients were written specific addresses and occupations. When plotted on a map of London the named patients fit neatly into a certain locality and were very likely to have been neighbours and friends, or at the very least, familiar faces to each other.

Atkins' success in curing people was therefore public and published knowledge. It is highly unlikely that it was fabricated within the vicinity of his own local community if he wished to maintain a living as a trusted practitioner; a status to which he laid claim. In addition, Atkins named Judge Advocate Jenkins who was a respectable local figure Atkins had cured of the dropsy.<sup>29</sup> A further ten men gave good testimony of Atkins' cures before the Right Honourable Sir John Fleet (c1647 - 1712), a well-known and respected governor of the East India Company who later became president of St Bartholomew's Hospital in 1705.<sup>30</sup> Other practitioners used the same method of promotion as Atkins. A Doctor James Foster provided a testimonial in 1663 that contained a list of all those he had cured.<sup>31</sup> And among those

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<sup>28</sup> Atkins, *Discourse On Gout*, 82-84.

<sup>29</sup> Probably Sir Leoline Jenkins who resigned from Secretary of State in April 1684 due to ill health. See "Jenkins, Sir Leoline (1625-1685)", *ODNB*.

<sup>30</sup> See "Fleet, Sir John (1647?-1712)", *ODNB*.

<sup>31</sup> D/1/14/1/1b/16, 1663, Wiltshire and Swindon Archives.



who recommended doctor Edward Stillingfleet in 1689, were the Mayor, Recorder, Aldermen and Common Councilmen of King's Lynn, who referred to the many cures Stillingfleet had performed.<sup>32</sup> So while there were some checks and balances, authenticity of cure was closely related to reputation and could easily be inconclusive. This process enabled patients to obtain some evidence of practitioner integrity but required a careful balance or weighing up of various factors. Sick and fearful patients were encouraged to avoid ignoring illness by testimonies that reassured them the doctor was their protector.

Part of Will Atkins method of self-promotion was to literally offer *himself* as evidence of cure, by sharing his own personal medical history and thus establishing a degree of medical authority through personal experience. He explained how he had amassed his knowledge in medicine from being a “diseased young man” just like the people he promised to help.<sup>33</sup> He had cured himself when he was young and since then had great success in curing others. Atkins emphasised the practical nature of cure, indicating the disease needed little or no causal explanation before proceeding with the treatment. To explain this reasoning he presented the analogy of a man who returned home to find his house on fire. “What would it signify”, asked Atkins, “for him to spend his time inquiring how it came about, and what was the cause, and while he is busy about that, his house is consumed when means was at hand” to extinguish the fire.<sup>34</sup> “Should this be counted wisdom? No, most will say this man is

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<sup>32</sup> MC 112/1 522x4, 1698, Norfolk Record Office.

<sup>33</sup> Atkins, *Discourse on Gout*, ix.

<sup>34</sup> Atkins, *Discourse on Gout*, 17.

a fool.”<sup>35</sup> Atkins’ metaphor gives insight into his conviction that the secret to cure lay in easing the symptoms, not eradicating the disease itself.

Easing a patient’s symptoms, therefore, was a primary feature of the notion of early modern cure. John Hall’s private medical notes contain many details about his patients’ illnesses and further reveal what constituted an early modern doctor’s assessment of cure. Married to Shakespeare’s daughter, Suzannah, Hall’s case notes demonstrate that cure was a common occurrence, and they confirm that it was not the disease itself but the symptoms of disease that primarily held the doctor’s attention. When Hall attended fifty-year-old Mrs. Beats of Ludlow who was “troubled with a great cough, *Asthma*, and grievous Pain in the Side”, Hall effected a cure after five weeks of intensive treatment, even though Mrs. Beats died shortly afterwards “but of what disease I know not.”<sup>36</sup> Hall relieved Mrs. Beats of her more troubling symptoms and therefore noted that she had been cured. This improvement in the patient’s condition was a minor triumph, or “cure” in this doctor’s judgment.

One of the reasons why the notion of cure necessarily rested heavily on alleviating observed symptoms was because medical practice relied mainly on visual, outward bodily signs. The pathology of internal diseases remained largely unseen and unknown and was simply referred to as unspecified “inward diseases.”<sup>37</sup> Hall related the case of Mrs. Lain, forty-nine years old, of Alveston, who was cured of a

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<sup>35</sup> Atkins, *Discourse on Gout*, 17.

<sup>36</sup> John Hall, *John Hall and His Patients: The Medical Practice of Shakespeare’s Son-in-Law* ed. Joan Lane (Stratford-upon-Avon: The Shakespeare Birthplace trust, 1996), 10-12.

<sup>37</sup> Gualtherus Bruele, *Praxis Medicinae, or, The Physitians Practise: Wherein are Contained all Inward Diseases From the Head to the Foot* (London, 1648).

“Pain in her Breast and great difficultly of breathing”, just before she died.<sup>38</sup> Hall’s attention was focused on Mrs. Lain’s outward bodily signs and being able to ease her suffering was paramount. Some of the medicines used by Hall were described by him as “excellent and worth gold” because they eased the symptoms even though Lain eventually died.<sup>39</sup> Another patient Mary Wilson, aged twenty-two, who was afflicted with “a Hectick Fever...a Cough, Obstructions of her Courses, and Weakness”, was cured by “sucking Women’s Milk and taking a cooling and nourishing diet”, yet she died the following year.<sup>40</sup> In all these cases, Hall justified cure because he helped to relieve uncomfortable and debilitating symptoms in his patients. He claimed cure when one set of symptoms were replaced by a different set of more serious symptoms, or when a short period of relief had preceded death. Even when a patient died, evidence of cure might still be found. In 1688, the Earl of Shrewsbury was injured in a duel and died three months later. His body was opened by “certain physicians and surgeons of good note...[who] certified that his wound was perfectly cured.”<sup>41</sup> Diseases that proved fatal often had little evidence to show for their existence, and early modern doctors had a difficult task to decipher the origins.

Nevertheless, attempts are often made to diagnose early modern disease from across the centuries. Retro diagnosis is tempting but can be speculative and prove futile in understanding early modern notions of ailments. One modern study examined twenty-two cases of dermatological diseases in John Hall’s practice, and

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<sup>38</sup> Hall, *Patients*, 32.

<sup>39</sup> Hall, *Patients*, 32.

<sup>40</sup> Hall, *Patients*, 38.

<sup>41</sup> “The Manuscripts of S.H. Le Fleming, ESQ., of Rydal Hall”, *Historical Manuscripts Commission, Twelfth Report, Appendix, Part VII.* (London: House of Commons, 1890), 55.

questioned Hall's claims of cure.<sup>42</sup> It questioned the cure of an "ulcerous cancer" on the leg of a thirty-six-year-old man, William Barnes of Treddington.<sup>43</sup> In the seventeenth century, cancer meant "growth", either growth of a tumour or an ulcer that ate away the flesh. Hall would not have been able to tell whether a cancer was benign or malignant until the disease had run its course (-as this modern distinction is only apparent at a microscopic cellular level). Supposing a poor prognosis for Treddington's cancer, the study noted that Hall did "not appear surprised by his patient's recovery" and suggested the so-called cancerous disease probably went unrecognised as a trauma with infection, which had been misdiagnosed as cancer.<sup>44</sup> However, with Hall's practical regime of washing the ulcer with various powders, "cast in hot Smith's Forge-water", and with repeated washing and covering with clean plasters, the patient would have felt better and Hall was able to produce a cure.<sup>45</sup> William Treddington was undoubtedly cured of what Hall recognised as cancer in the context of seventeenth-century medicine.

Hall improved the medical conditions of many of his patients. He was proficient in curing cases of scurvy and he treated his patients with various antiscorbuticals including watercress, brooklime, and scurvy grass. He evidently read many tracts on the disease and was visited by patients from as far as forty miles away. In addition, the effectiveness of his simple treatment for atopic dermatitis, using borage, saw him produce cures that have since been verified by scientific

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<sup>42</sup> Angel Fernandez-Flores, "On the Practice of John Hall in the Field of Dermatology in the 17<sup>th</sup> Century," *Clinics in Dermatology* 28, 3 (2010): 356-363.

<sup>43</sup> Hall, *Patients*, 152.

<sup>44</sup> Fernandez-Flores, *Practice of John Hall*, 362.

<sup>45</sup> Hall, *Patients*, 152.

evidence.<sup>46</sup> The steady stream of patients noted in Hall's case summaries was testimony to his medical knowledge, his ability to cure, and to his experience, popularity, and medical authority.

Some patients travelled long distances to seek out doctors and their cures, thus indicating the yearning for cure and a propensity to believe that observable symptoms signified the same disease. In 1627, Robert Butterworth, a woollen-webster from Castleton in Lancashire, was a very poor man with a wife and child to support. He was troubled with a grievous disease called the "canker...which began in his face about two monthes ago, and hath ever since growne worse and worse."<sup>47</sup> Butterworth humbly petitioned the local magistrates for help to keep his family supplied with food while he went to London to be cured.<sup>48</sup> His neighbour had previously travelled to London with the same symptoms and returned cured, to the delight of the neighbourhood. The doctor who had performed the cure had now promised to cure Butterworth. Even though Butterworth was responsible for his wife and child and beholden to the parish, such was his need for cure that he overrode these responsibilities and was prepared to walk all the way from Lancashire to London to visit the doctor. This was an example of how word of mouth and gossip combined with testimony was able to influence medical agency, and with no guarantee that a successful cure would be forthcoming.

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<sup>46</sup> BM Henz, S Jablonska, PC van de Kerkhof, et al. "Double-blind, Multicentre Analysis of the Efficacy of Borage Oil in Patients with Atopic Eczema," *British Journal of Dermatology*, 140, 4 (1999): 685-688. (A more systematic analysis of seventeenth-century herbal remedies is considered to be a worthwhile future avenue for scientific research see, M. Adams, et al, "Medicinal Herbs For the Treatment of Rheumatic Disorders: A survey of European Herbals From the 16<sup>th</sup> and 17<sup>th</sup> Century," *Journal of Ethnopharmacology* 121, 3 (2009): 343-59.)

<sup>47</sup> QSB/1/31/59, 1627, "Pass for Robert Butterworth", LRO.

<sup>48</sup> QSB/1/31/59, 1627, "Pass for Robert Butterworth", LRO.

Some of the cures and treatments the doctor performed appeared to be particularly brutal and required the patient to endure pain and discomfort before ease of symptoms occurred. The need to obtain a cure was a delicate balance that could cause problems for the doctor's decision-making. Daniel Turner carried out a traumatic procedure on a lady with a breast wound and although the prescribed treatment frightened her she later expressed her delight to him when she found herself cured. Turner needed to drain the breast wound because it was full of noxious fluids but the patient was reluctant to comply. Informing her that if she did not cooperate with what he proposed he would not attend her further, Turner gave her a second and a third chance but although she promised to cooperate she still withdrew in fear. In a clandestine attempt to drain the breast wound, Turner concealed his instruments up his sleeve and forced them quickly into the wound. After this, she was completely cured within the month and "fulsome in her praises of his medical skill."<sup>49</sup> Brutality was an ingredient of early modern cure that was accepted by patients. Patients' fears might cause them to reject their doctors, but patients were indebted to the doctor when a cure was bestowed. On the doctor's side, the fear of what they might lose in terms of reputation encouraged them to proceed with these brutal treatments, which they knew provided the best chance of cure and brought accolades.

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<sup>49</sup>Linda Payne, *With Words and Knives*, 95; On Daniel Turner see "Turner, Daniel (1667-1741)", *ODNB*; Philip K. Wilson, *Surgery, Skin and Syphilis Daniel Turner's London (1667-1741)*, (Amsterdam: Rodopi, 1999); Reginald Magee, "Writings of Daniel Turner and His Views on the Practice of Surgery," *ANZ Journal of Surgery* 73, 6 (2003): 438-442; Daniel Turner, *Apologia Chyrurgica: A Vindication of the Noble Art of Surgery* (London, 1695).

As well as temporarily alleviating patients' symptoms, some doctors performed lasting cures, particularly in the case of surgical cures. William Salmon, variously described as a "quack" and "medical empiric and author", was a critic of the College of Physicians who published many medical works and described himself as a practising Professor of Physic.<sup>50</sup> He wrote of the necessity "for a chirurgion to understand the medical part of curing" as those who did so were often more skillful than physicians.<sup>51</sup> While physicians learnt "one part of the Art", he wrote, surgeons were "Masters of the whole Art of Physick."<sup>52</sup> He believed that surgeons picked up or studied general medicine as they practised their trade. Surgeons were therefore more capable of providing holistic care for their patients. Physicians, on the other hand, were at a disadvantage because they could not perform surgical operations and often had to relinquish authority to the surgeon. Surgeons complained about physicians who tried to prevent them from working in both disciplines. Salmon became a rich and powerful individual able to challenge the College of Physicians' attempts to monopolise London medicine, and he used his observations on surgical cures to increase social bias against the structural power of the College.<sup>53</sup>

Patients and their families in hopeless medical situations found that recourse to surgical cures could indeed save lives. The emotions generated by the mechanism of a successful cure were a potent factor in a surgeon's favourable reputation. For

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<sup>50</sup> See "Salmon, William (1644-1713)" *ODNB*.

<sup>51</sup> William Salmon, *Ars Chirurgica: A Compendium of the Theory of the Practice of Chirurgery in Seven Books* (London; 1699), 2.

<sup>52</sup> Salmon, *Ars Chirurgica*, 2.

<sup>53</sup> See William Salmon, *Rebuke to the Authors of a Blew-Book, Call'd the State of Physic in London*, (London, 1699).

amputation, the equipment needed was a “Dismembering Saw” described by William Salmon as “a great and terrible Instrument” that should always be kept clean and ready.<sup>54</sup> One young boy, a lawyer’s son in Fetter-lane, London, injured his thigh in an accident with a heavy cart wheel and was under the care of several practitioners for many months. When surgeon Hugh Ryder visited him, the boy had suffered with diarrhoea for the last twelve weeks, looked like a skeleton, was at the end of his tether, and was lying in an appalling state; “From his Ulcers, and Fistulaes flowed a filthy matter, stinking beyond all comparison, his Heel stuck to his Buttock, and his Knee disjoined; for the head of the Tibia met not with the Os Femoris (which overhung it) by above an Inch, the Ligaments being all eaten asunder, by the matter there contained.”<sup>55</sup> Ryder immediately suggested amputation and the boy concurred, saying that if Ryder lent him the knife he would cut the leg off by himself. Meanwhile, the boy’s father wept miserably, while the boy’s mother was being delivered of a child in an adjoining room. The boy’s leg was amputated the following morning and Ryder paid tribute to him for not crying or making any complaint at the use of knife or saw. Ryder undoubtedly saved the boy’s life. The operation was done on Monday and by Thursday the stump was “very fair” and the boy was “very lively.”<sup>56</sup> In six weeks’ time he was perfectly cured and “grew very plump and carnous.”<sup>57</sup> The family had desperately sought assistance from numerous medical practitioners with little or no success and decreasing hope of cure, yet, despite their

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<sup>54</sup> Salmon, *The Practice of Surgery*, 6.

<sup>55</sup> Hugh Ryder, *New Observations in Surgery, Containing Divers Remarkable Cases and Cures* (London, 1685) 54.

<sup>56</sup> Ryder, *New Observations in Surgery*, 57.

<sup>57</sup> Ryder, *New Observations in Surgery*, 57.



predicament the parents did not stop seeking medical help and the eventual cure proved unambiguous and easy to recognise in this particular case.

Ships' surgeons like Hugh Ryder, Surgeon-in-Ordinary to His Majesty King Charles II, proved a necessary presence on sea voyages, performing useful medical procedures during and after a variety of adventures.<sup>58</sup> The ship's surgeon was the most medically authoritative person on board and their cures appear particularly skillful on occasions. These medical successes reinforce that cure was an imprecise formula that was thoroughly unpredictable. Ryder knew the value of reputation and made his cures publicly available to other medical men. Making alliances in this way increased the social power of surgeons and Ryder's cures were published, accordingly, in purposeful manner and written with a certain swashbuckling style. At war with the Dutch in 1665, Ryder related how an English sailor was struck on the head by a cutlass "from whence with two endeavours he could hardly pluck it forth."<sup>59</sup> The sailor managed to crawl into the hold and wait for treatment, whereupon, Ryder removed white matter and pieces of skull and dressed the wound with a "Stegnotick" medicine to stop the bleeding.<sup>60</sup> Ryder gave additional follow-up medical care, applying dressings and cupping glasses, and in six weeks "the Wound was cured, convenient bandage being fitly applied and greatly conducive to the Cure."<sup>61</sup> Years later the injured sailor was seen in Southwark appearing to have "great depravation and little right use of his sences", although, there are difficulties

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<sup>58</sup> See Richard Theodore Beck, *The Cutting Edge: Early History of the Surgeons of London* (London: Lund Humphries, 1974).

<sup>59</sup> Ryder, *New Observations in Surgery*, 3.

<sup>60</sup> Ryder, *New Observations in Surgery*, 4.

<sup>61</sup> Ryder, *New Observations in Surgery*, 3.

in interpreting this as it could point to a residual injury, or it might simply be a description of drunkenness.<sup>62</sup> Nevertheless, the patient had recovered beyond all expectation and was therefore considered cured. Ryder modestly admitted to help from God's miraculous blessing, but he had learnt that the possibility of cure should never be doubted, even in the worst cases.

Hugh Ryder's patients appeared to be thoroughly grateful for the care and cure they received. One patient, "the maddest I had ever yet beheld", wrote Ryder, was held down and given "a glyster", bleeding, cupping glasses, scarifications, a caustic to the head, and "a large eschar."<sup>63</sup> After this last treatment the man called Ryder to his side and "expressed himself joyfully" saying he was now perfectly well. One year later the patient again sought Ryder out to give him "a thousand thanks for my great cure of him."<sup>64</sup> Although Ryder is the author of these accounts, he was careful to authenticate them with recourse to important and respected figures, in the form of "the Learned Sir Charles Scarborough", who could be relied upon to inform anyone about the truth of the matter.<sup>65</sup> As we have seen, support from witnesses, either colleagues or (preferably) wealthy patrons, was a common method of validating cure.

Collaboration is now known to increase the structural power of a group, and early modern physicians and surgeons liaised with colleagues, reporting on successful cures and sharing them for the benefit of future patients and medicine in

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<sup>62</sup> Ryder, *New Observations in Surgery*, 6.

<sup>63</sup> Ryder, *New Observations in Surgery*, 16, 17.

<sup>64</sup> Ryder, *New Observations in Surgery*, 18.

<sup>65</sup> Ryder, *New Observations in Surgery*, 6. Also see "Scarburgh, Sir Charles (1615-1694)", *ODNB*.

general.<sup>66</sup> Surgeon Mr. William Cowper helped an injured man recover from an injury at work and then sent an account of his method of cure to the Royal Society. He operated on thirty-year old Thomas Wheatly, a carpenter who had severed “the Great Tendon, between the calf and the heel...after an entire division of it.”<sup>67</sup> Cowper sewed the tendon together despite reading contemporary medical literature that decried the procedure as hazardous and futile. Wheatly would probably have been lame for the rest of his life if Cowper had followed this advice. Instead, after sewing the tendon together, Cowper carefully attended to Wheatly’s leg, dressing it daily and supervising the healing process. He was pleased to report that within eight weeks Wheatly had “walkt from his Habitation in Witch-Street without Temple Bar, to Greenwich, to see a large whale that lay then on the Shore, and returned in a few Hours.”<sup>68</sup> Wheatly experienced minimal lameness and no impediment prevented him from carrying on with his work; two important measures of early modern cure.

There were multiple and dynamic pathways to cure and while some practitioners happily accepted all the praise for a cure others paid tribute to divine intervention and the power of nature. Gulielmus Fabritius Hildanus, a well-respected physician whose work was translated and published in London in 1640, wrote of many occasions “by which it appears, how wonderful the Almighty worketh

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<sup>66</sup> See, Gianna Pomata, “Sharing Cases: The Observations in Early Modern Medicine,” *Early Science and Medicine* 15, 3 (2010): 193-236; Pomata, “A Word of the Empirics: The Ancient Concept of Observation and Its Recovery in Early Modern Medicine,” *Annals of Science* 68 1 (2011): 1-25. On the role of collaboration increasing structural power of groups see Dacher Keltner and Robert J. Robinson, “Defending the Status Quo: Power in Social Conflict” *Personality and Social Psychology Bulletin* 23: 10 (1997): 1066-1077.

<sup>67</sup> William Cowper, “An Account of Stitching the Great Tendon, Between the Calf of the Leg and Heel, With its Union and Cure, after an Entire Division of it, With Remarks,” *Philosophical Transactions*, 21, 248-259 (1699): 153-160.

<sup>68</sup> Cowper, “Stitching the Great Tendon,” 258.

sometimes, and produceth admirable things in many men by his servant Nature.”<sup>69</sup>

The close connection between the structural powers of religion and medicine saw comparisons made between priests and doctors and the complexities of cure readily crossed these occupational boundaries. The priest generally took responsibility for the soul while the doctor looked after the body, however, sometimes the interrelations between religion and medicine obliquely assisted in overshadowing the doctors’ ability to cure. In 1694 a forty-year-old spinster, Lydia Hills, gave testimony that a miracle had cured and restored her from lameness. Her troubles began when she bruised her right hip in a fall, twenty-two years previously as she ran home in the rain.<sup>70</sup> She became “worse and worse by degrees, for Five Years”, lying in the hospital for one year and being treated by a number of surgeons who opened and cleaned the wound a number of times and removed pieces of foul smelling, infected bone.<sup>71</sup> In the ensuing years Lydia consulted several more surgeons for treatment, including a “Mr. Maschall” and a “Mr. Thomson,” but she remained sore and lame and walked only with the help of crutches, although infection had been kept at bay.<sup>72</sup> When Lydia heard of a young Frenchwoman who had been miraculously cured of lameness she began to think “If the Lord be pleased to work Miracles on others, he is able to do the same for me.”<sup>73</sup> She prayed continuously and “read of the miracles that

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<sup>69</sup> Gulielmus Fabricius Hildanus, *Litholtomia Vesicae: That is, An Accurate Discription of the Stone in the Bladder* (London, 1640), 80.

<sup>70</sup> Anon, *A Relation of the Miraculous Cure of Mrs. Lydia Hills of A Lameness of Seventeen or Eighteen Years Continuance* (London, 1696), 4. See also, Anon, *A Relation of the Miraculous Cure of Susannah Arch, of A Leprosy and Ptrysick* (London, 1695); Anon, *All Honour and Glory be Given Unto God Alone...The Great and Miraculous Vertue and Operation of the...Celestiall Stone* (London, 1658).

<sup>71</sup> Anon *Cure of Lydia Hills*, 5.

<sup>72</sup> Anon *Cure of Lydia Hills*, 8.

<sup>73</sup> Anon *Cure of Lydia Hills*, 8.

Christ did when he was upon the Earth.”<sup>74</sup> Abruptly, after eighteen years of torture and lameness, she decided to cast away her crutches and trust in God.<sup>75</sup> From then on Lydia did not use her crutches again and thereafter steadily gained strength in her legs. Seven men from her Church confirmed the miraculous cure that Lydia had longingly waited for.<sup>76</sup> Yet, was the cure the result of a miracle or was it due to the doctors’ work in removing infected shards of bone, or, was it simply the daring of a woman who just decided to try and walk without her crutches? Lydia’s doctors were pleased with her cure and supportive of her endeavours to publicise the miracle, some of them writing testimonials that confirmed Lydia had been cured. The doctors’ support for this miracle suggests that religion had the edge over medicine in this particular judgement on cure.

Doctors gave serious thought to the different ways that cures could be performed, hoping not to upset their patients and wishing to align with certain social conventions. Hildanus, in his pamphlet on the removal of bladder stones, advised how the stone may be cut out “without paine and danger to the patient.”<sup>77</sup> He suggested preparing the patient well by feeding them meat and drink to strengthen them, and purging any gross humors so that the cure would thrive and the “symptoms cause less molestation” for the patient.<sup>78</sup> One lady was described as a brave spirit after she refused to be tied down for the operation, claiming it was nothing to her after experiencing childbirth. She sat in a birthing stool for the procedure with the

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<sup>74</sup> Anon *Cure of Lydia Hills*, 9.

<sup>75</sup> Anon *Cure of Lydia Hills*, 15.

<sup>76</sup> Anon, *Cure of Lydia Hills*, 16.

<sup>77</sup> Fabricius Hildanus, *Litholtomia Vesicae*, 81.

<sup>78</sup> Fabricius Hildanus, *Litholtomia Vesicae*, 72.

doctor sitting on a low stool at her feet. The doctor reported that he “brought out the Stone, to the admiration of the by-standers; for though there were both men, and women present, yet neither any of them, nor I my selfe could perceive her naked body.”<sup>79</sup> It was deemed a successful operation, the doctor was pleased for not causing too much pain or loss of dignity and the woman quickly recovered and was thus cured.

Whether it was affected by social bias or conflict, religious or political allegiance, emotions or social customs, medical practitioners negotiated the cure of their patients with an eye to the relevant criteria. When Lord Berkley fell over with apoplexy in the gallery at Whitehall, his status required several doctors to work on him all night, applying hot fire-pans, administering Spirit of Amber and performing cupping on his shoulders. John Evelyn recorded the event in his diary and praised the doctors for their “miraculous restauration” of Lord Berkley.<sup>80</sup> On 10 April 1655, a report on the “pious care” of poor children in the city of London listed hundreds of children “under Cure at present, upon the Charge of the said Hospitall.”<sup>81</sup> These children were “cured”, given bursaries, and released to make their way in the world, in a social arrangement that demonstrated the importance of cure in early modern society. In 1700, David Abercromby wrote that only a “true physician” could understand the intricacies of time, place, temper of the patient and other circumstances, and only then was it possible to “cure the worst distempers, by not

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<sup>79</sup> Fabricius Hildanus, *Litholtomia Vesicae*, 85.

<sup>80</sup> Evelyn, *Diary*, 27 October 1675.

<sup>81</sup> Anon, *The 10<sup>th</sup> Day of Aprill 1655. A True Report of the Great Number of Poor Children, and Other People Maintained in the Severall Hospitals by the Pious Care of the Lord Mayor, Commonalty and Citizens of London* (London, 1655).

very odd, nor far-fetched Remedies”; a warning to patients and a slur on his competitors.<sup>82</sup> A significant number of early modern doctors could cure their patients, and even though cure was ambiguous, incremental, and subjective it was closely connected to the mechanisms of socio-relational power. The way cures were determined demonstrate how closely socio-relational power contributed to making each medical encounter a dynamic-equilibrium.

## II. DOMESTIC CURES

Domestic medicine, or popular medicine, are general terms used to describe cures administered in the household by laypeople. As Mary Lindemann pointed out, past scholars generally ignored domestic medicine and depicted doctors’ medicine as “scientific progress.”<sup>83</sup> After the 1970s this contrast lessened, however, dichotomies remained between “popular” and “elite”, and “orthodox” and “unorthodox” medicine.<sup>84</sup> More recently, scholarly consensus has argued for a shared understanding of medicine between doctors and laypeople.<sup>85</sup> It suggests that patients knew just as much medicine as their doctors, which was not always the case. Another way of describing the association between doctors’ cures and domestic cures would

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<sup>82</sup> Abercromby, *A Discourse of Wit*, 222, 223.

<sup>83</sup> Lindemann, *Medicine and Society*, 3.

<sup>84</sup> Lindemann, *Medicine and Society*, 11, 12.

<sup>85</sup> Lindemann, *Medicine and Society*, 12; Weisser, *Ill-Composed*, 32; Pelling, *Medical Conflicts*, 230; Waddington, *Introduction to the Social History of Medicine*, 81, 82; Elaine Leong and Sara Pennell, “Recipe Collections and the Currency of Medical Knowledge in the Early Modern “Medical Marketplace”” in *The medical Marketplace*, 136; Porter, “The Patient in England c1660- c1800” in A. Wear, ed., *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), 101-106.

be overlapping domains, as there existed a spectrum of domestic cure that intersected with doctors' cures but depended on factors such as social status, wealth, education, initiative, location, triviality or severity of an illness, and the availability of a doctor. The overlap of medical and domestic domains meant that in some cases the doctor had specialised knowledge that overrode patient agency. In others cases patients relied mainly on their domestic knowledge of illness to steer their own course. Sometimes there were no clear differences between practitioner and patient medical knowledge. Each medical encounter was dynamic because its outcome depended on the sum of the available medical input from agents in the surrounding social network.

Domestic medicine now has a distinct body of scholarship, while less attention has been paid to doctors' cures.<sup>86</sup> The dichotomy between the increasing analysis of domestic medicine and the apparent absence of interest in the cures used by doctors, strongly suggests that there were differences between them that prove contrary to a supposed shared understanding of medicine. It appears from the evidence that although recipe book ingredients closely resembled those recommended by physicians and apothecaries,<sup>87</sup> the most likely difference between

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<sup>86</sup> See, Elaine Leong, "Collecting Knowledge for the Family: Recipes, Gender and Practical Knowledge in the Early Modern English Household," *Centaurus* 55, 2 (2013): 81-103; Seth LeJacq, "Roy Porter Student Prize Essay: The Bounds of Domestic Healing: Medical Recipes, Storytelling and Surgery in Early Modern England," *Social History of Medicine* 26, 3 (2013): 451-468; Bruna Gushurst-Moore, "A Garden In Her Cups: Botanical Medicines of the Anglo-American Home, c1580-1800," (PhD Thesis, University of Plymouth, 2012); Elaine Leong, "Making Medicines in the Early Modern Household," *Bulletin of the History of Medicine* 82, 1 (2008): 145-168; Wendy Wall, "Just a Spoonful of Sugar: Syrup and Domesticity in Early Modern England," *Modern Philology* 104, 2 (2006): 149-172; Katherine Knight, "A Precious Medicine: Tradition and Magic in Some Seventeenth-Century Household Remedies," *Folklore* 113 (2002): 237-259; LeMar Riley Murphy, *Enter The Physician: The Transformation of Domestic Medicine 1760-1860* (Tuscaloosa: University of Alabama Press, 1991).

<sup>87</sup> Waddington, *Introduction to the Social History of Medicine*, 81.



domestic medicine and the doctor was the detailed and authoritative advice given by the university educated doctor.<sup>88</sup> Cook argued that a seventeenth-century medical degree supplied its medical students with the ability to think, judge, diagnose and advise on illness. Good judgment, character and reputation were demonstrable character traits that validated medical knowledge. They were vital measures of any doctor's competence in a process that saw positioning in the social network go hand in hand with the use of remedies.

In many instances, patients were more likely to ask the doctor for help when illness worsened, while domestic cure was for ailments that were relatively trivial and manageable. Lucinda Beier regarded domestic medicine as the first line of defence against illness.<sup>89</sup> In opposition to this claim, Seth LeJacq argued domestic cure was the last line of defence against illness.<sup>90</sup> LeJacq also argued there was an ongoing exchange between domestic and doctors' medicine, and doctors sometimes mediated their more brutal treatments by adopting the "gentler" techniques of domestic medicine.<sup>91</sup> All these scenarios are evident in the sources. For example, Lord Chesterfield self-administered a medicinal drink of burnt claret in an attempt to save his own life after the doctors could do no more to help him, thus using domestic

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<sup>88</sup> See, Harold J. Cook, "Good Advice and Little Medicine: The Professional Authority of Early Modern English Physicians," *Journal of British Studies*, 33, 1 (1994): 1-31.

<sup>89</sup> See, Beier, *Sufferers and Healers*, 129 ("Very often, people attempted to cure themselves and sought medical advice from relatives and friends before consulting healers.")

<sup>90</sup> Seth LeJacq, "Roy Porter Prize Essay: The Bounds of Domestic Healing: Medical Recipes, Storytelling and Surgery in Early Modern England," *Social History of Medicine*, 26, 3, 451 (Domestic medicine was "a last resort when practitioners had failed"); Seth LeJacq, "Butcher-Like and Hateful: Domestic Medicine and Resistance to Surgery in Early Modern England." Accessed May 2016. <https://jscholarship.library.jhu.edu/bitstream/handle/1774.2/34983/03251eja.pdf>

<sup>91</sup> LeJacq, "Bounds of Domestic Healing," 452.

medicine as a last line of defence against illness.<sup>92</sup> And the Verney family memoirs related how the Duke of Somerset's apoplexy was cured by wearing a piece of old cloth inside his slippers, after the physicians failed to cure him.<sup>93</sup> As a first line of defence, Richard Powers decided to soak his sore and aching feet in a basin of cow manure until he consulted the doctor who advised a different approach.<sup>94</sup> In another medical exchange, which demonstrates the overlapping nature of domestic and doctors' cures, Ralph Josselin took Syrup of Roses and evacuated nine stools.<sup>95</sup> When he called a physician to visit his child who was "full of phlegm", the physician also prescribed Syrup of Roses, yet with alternate advice and intention. On another occasion, Josselin sought reassurance from the doctor that he had treated his navel infection properly. More often than not, advice and reassurance from a doctor who possessed experience of cure proved to be a major difference between doctors and domestic cures.

Much of the evidence for domestic cure comes from the large number of commonplace and recipe books wherein remedies were transcribed.<sup>96</sup> Yet, as with any written source of this kind, there are problems in gauging whether the evidence represents an accurate picture of people's activities, or whether it represented an ideal for behaviour that was rarely undertaken. Moreover, cures were collected and recorded by all manner of people who would not, first and foremost, be linked to the domestic sphere. For example, Robert Mustow was a surgeon who kept a

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<sup>92</sup> LeJacq, "Bounds of Domestic Healing," 452.

<sup>93</sup> Verney Memoirs, 278.

<sup>94</sup> Symcotts, *Diary*, 37.

<sup>95</sup> *Verney Memoirs*, 473; Josselin, *Diary*, 112.

<sup>96</sup> See, WL, <http://wellcomelibrary.org/collections/digital-collections/recipe-books/>

commonplace book containing recipes and he transcribed many book titles he may or may not have read, which included a book on grammar, *Funerall Sermons*, *Scott's Discovery of Witchcraft*, *Practise of Physick* and *Cure of the Pox*.<sup>97</sup> Although Mustow kept a long list of consultative information to hand there is no evidence to show how frequently he drew upon it. Commonplace books, recipe books, letters and diaries, all produce considerable ambiguity over the assumed practice of domestic medicine.

Louise Curth has stated interpreted five main phases of medical production throughout history. The first phase took place in the sixteenth and seventeenth century, which she named “kitchen physic”, which denoted medicine made at home with natural ingredients.<sup>98</sup> Curth's second phase was the rise of commercialised medicine in the eighteenth century, and the third phase was the result of population growth that saw the emergence of specialised medical shops in the nineteenth century.<sup>99</sup> There is ample evidence to show that all three of these phases appreciably overlapped in seventeenth-century England. Patrick Wallis's discovery of Anthony Daffy's account books shows how a homely cure that originated in Daffy's family kitchen turned out to be a proprietary brand of medicine sold on a vast commercial scale.<sup>100</sup> Daffy's Elixir epitomises the crossover between domestic and commercial medicine. The existence of a great number of apothecary shops in seventeenth-

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<sup>97</sup> *Sloane Collection* 2117, 1663-1665, “Robert Mustow, Commonplace Book”, BL.

<sup>98</sup> Curth, *From Physick to Pharmacology*, 2.

<sup>99</sup> Curth, *From Physick to Pharmacology*, 2

<sup>100</sup> David Boyd Hancock & Patrick Wallis, “Quackery and Commerce in Seventeenth-Century London: The Proprietary Medicine Business of Anthony Daffy,” *Medical History. Supplement 25* (2005): 1-216.

century London is evidence for the convergence between domestic medicine and specialised medical shops.<sup>101</sup> Judith Woolf has described how some of these establishments were run by women from their own kitchens.<sup>102</sup> Alun Withey found that in seventeenth-century rural Wales, “apothecaries participated in broad and sophisticated networks of trade with London suppliers.”<sup>103</sup> Although apothecaries sourced local herbs to sell for domestic use they also sold exotic ingredients, which were prescribed by the doctor. When new and exotic drugs came on the market, such as Jesuit’s bark for fevers and agues, it was most likely the doctor who advised when and how to use them.<sup>104</sup> There was a mixed bag of cures available to suit all requirements and not the clear distinction between domestic and commercial medicine that has previously been articulated.

The way domestic medicine has been understood is influenced by the physical space in which it was practised. It takes its name from being made and administered in the domestic environment, yet doctors also practised medicine in the home, either their own establishment or that of their patients. There is increasing

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<sup>101</sup> See Patrick Wallis, “Consumption, Retailing, and Medicine in Early Modern London,” *Economic History Review* 61, 1 (2008): 26-53.

<sup>102</sup> Judith S. Woolf. “Women’s Business,” *Chemical Heritage* 27, 3 (2009): 20. Also see Patrick Wallis, *Medicines for London: The Trade, Regulation and Lifecycle of London Apothecaries, c.1610-c.1670*, (PhD Thesis, Oxford university, 2002). (Wallis shows apothecary shops were a fully commercialised sector, although, this fact did not prevent such shops being run from a kitchen-style establishment, nor does it exclude those shops that were run by women who may have taken over the business from their deceased husbands, as Judith Woolf demonstrated).

<sup>103</sup> Alun Withey. “Persons That Live Remote from London: Apothecaries and the Medical Marketplace in Seventeenth-and Eighteenth-Century Wales,” *Bulletin of the History of Medicine* 85, 2 (2011): 222-247.

<sup>104</sup> See, Francois Monginot, *A New Mystery in Physick Discovered By Curing of Fevers & Agues By Quinquina Or Jesuits Powder, trans. from French by Dr. Belon with Additions* (London, 1682); Sandra Knapp, “The Quest For the Jesuit’s Bark,” *Nature* 418, 6900 (2002): 820; Michael Adams, et al, “Malaria in the Renaissance: Remedies from European Herbals from the 16<sup>th</sup> and 17<sup>th</sup> Centuries,” *Journal of Ethnopharmacology* 133, 2 (2011): 278-288.

evidence of people lodging in the doctor's house for treatment, or staying in temporary lodgings while paid, domestic helpers nursed them for the duration of their illness.<sup>105</sup> Therefore, the physical space of domesticity is ambiguous and has not served as a reliable indicator of domestic medicine. The guiding principle of a medical dynamic-equilibrium includes all possible scenarios for the administering of domestic medicine and can promote a more accurate representation of the existence of multiple overlapping medical and domestic spheres.

Assumptions about gender have played a significant role in descriptions of domestic medicine, as it was commonly thought that women took charge of housekeeping activities within the domesticity of the home and kitchen. However, Alun Withey questioned this gendered perspective by suggesting that men, as well as women, played a vital yet underestimated role in domestic medicine.<sup>106</sup> Men collected medical remedies, swapped cures, gave advice to family members and displayed medical authority in their role as head of the household. Men looked after sick wives and gave medical advice to sons and daughters long after they had left home and married. Historians have increasingly included men as a feature of domestic medicine, pointing out the roles men took on as domestic caregivers.<sup>107</sup> For

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<sup>105</sup> Jeremy Boulton, "Welfare Systems and the Parish Nurse in Early Modern London," *Family and Community Health* 10, 2 (2007): 127-51; Jennifer Evans, *Early Modern Medicine Online*, Posted 27 March 2013, Accessed 24 March 2015.

<http://earlymodernmedicine.com/patients-practitioners-lodgers/>

<sup>106</sup> Alun Withey, Paper given at the "Historical Perspectives on the Family" Conference, Sheffield, 23 April 2010. Accessed 24 March 2015.

[www.academia.edu/653969/Physicking\\_the\\_Family\\_gender\\_and\\_domestic\\_medical\\_care\\_in\\_early\\_modern\\_Wales](http://www.academia.edu/653969/Physicking_the_Family_gender_and_domestic_medical_care_in_early_modern_Wales)

<sup>107</sup> Jennifer Evans & Sarah Read, "'Before Midnight She Had Miscarried': Women, Men, and Miscarriage in Early Modern England," *Journal of Family History* 40, 1 (2015): 3-23; L. Smith, "The Relative Duties of a Man: Domestic Medicine in England and France, ca. 1685-1740," *Journal of Family History* 31, 3 (July 2006): 237-256.

instance, John Cotton asked Doctor John Symcotts for “abstertive physic” for his wife, who, although she “finds herself well” was, in his opinion, in need of an evacuation three weeks after giving birth.<sup>108</sup> Monica Green has argued that since medieval times domestic medicine was not exclusively a woman’s role and women were just as easily administered to, as being the ones who administered to others.<sup>109</sup> So, it seems that the language of “domesticity” and “gender” can provoke erroneous assumptions that do not accurately portray the detail and dynamics of seventeenth-century medicine.

The women who did produce domestic medicines often came from wealthy landowning families, and their activities were regarded as a charitable social duty. The production of these cures frequently occurred on a large scale, as they supplied remedies to poor, sick neighbours in their community.<sup>110</sup> Elaine Leong examined the medical activities of Elizabeth Freke, one of many women who made medicines as a charitable pursuit.<sup>111</sup> As Leong highlighted, much of Freke’s medical production involved a lengthy process that required the use of stills and other equipment, as well as the employment of workers. Freke’s efforts at medical production were out of the financial range of most people, and her medical manufacturing exceeded the confines of what could be called household remedies. Many of the ingredients Freke used were pre-processed and bought from a supplier. So, although the production of

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<sup>108</sup> Symcotts, *Diary*, 12.

<sup>109</sup> See, Monica Green, “Women’s Medical Practice and Healthcare in Medieval Europe,” *Signs* 14, 2 (1989): 434-473. (Green challenges assumptions that a sexual division of medical labour existed in the Middle Ages).

<sup>110</sup> Eg., see Rebecca J. Anderson, “Lady Mildmay’s Modern Medical Cures”, *Reflections* 11, 2 (2011): 72-78.)

<sup>111</sup> Leong, “Making Medicines in the Early Modern Household”, 145-168.

domestic medicine or “kitchen-physic” may have occurred in individual kitchens, it was also linked to substantial manufacture of remedies.<sup>112</sup> The cure of Minister Meriton’s son, related at the beginning of the chapter, also exemplifies the overlap and convergence of domestic and doctors’ medicine. Atkins’ cure was neither exclusively domestic nor wholly the realm of the doctor. His gout medicine overlapped with the production of commercialised medicine. It was made from his own secret recipe mixed in batches at his house, its production assisted by his wife, and then it was advertised throughout London and sold commercially. Atkins activities typify the grey area that exists between domestic and official medical activity in early modern England.

Judging by the large number of pamphlets and books containing medical advice for everyman, poor people and ladies, industrious, diligent and rational men, and the rich, a great deal of domestic medicine was promoted and approved by doctors. Medical practitioner, Nicholas Culpeper, produced volumes full of herbal remedies for his readers, physician Edward Maynwaring recommended preventative medicines to the public, and medical writer Thomas Tryon stipulated dietary regimes and kitchen physic for treating disease.<sup>113</sup> In most of these tracts, in one way or another, doctors promoted the information presented within or were cited as authorizing its use. Each tract was either written by a doctor, endorsed by a doctor,

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<sup>112</sup> See Celeste Chamberland, “Partners and Practitioners: Women and the Management of Surgical Households in London, 1570-1640,” *Social History of Medicine* 24, 3 (2011): 554; Woolf, “Women’s Business,” 1-4.

<sup>113</sup> Nicholas Culpeper, *Medicaments For the Poor or Physic For the Common People...First Written in Latin, by that Famous and Learned Doctor John Prevotius, trans. into English by Nich Culpeper, Student in Physick and Astrology* (London, 1656); Everard Maynwaringe, *The Method and Means of Enjoying Health, Vigour, and Long Life* (London, 1683); Thomas Tryon, *The Good Housewife Made a Doctor, Or, Health’s Choice and Sure Friend...by Diet and Kitchin-Physick Only* (London, 1692).

gave recipes attributed to doctors, or promised to turn the reader into a doctor.<sup>114</sup> The doctors' medical authority was never more on show than in these books, and their sanctioning made domestic cure an acceptable alternative when no doctors were available. Indeed, Culpeper's recipe books asserted their usefulness not only for the sick poor, but "as necessary for the Rich, when they are upon a journey, if perchance they should feel sick when they are far from cities, and Apothecaries shops."<sup>115</sup> His recommendation indicated that the rich almost always preferred doctors' medicine, and it implied that for those higher up the social scale domestic remedies were deemed useful only as a temporary measure.

Elizabeth Freke relied heavily on *Gerard's Herbal*, which came from a long tradition of English herbal texts that attributed little or no medical authority to women.<sup>116</sup> Rebecca Laroche found that women played no substantial role throughout the history of early modern herbals.<sup>117</sup> She argued that male writers of herbals used women as scapegoats for male anxieties and mistaken herbal knowledge. Male herbalists and physicians were uneasy about literate women readers who had access to herbals; nevertheless, they tolerated charitable gentlewomen over and above "poor" and "foreign" women, whose herbal usage often represented herbal abuse and

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<sup>114</sup> W. Cockburn, *Profluvia Ventris: Or The Nature and Causes of Looseness Plainly Discovered* (London, 1701); Hanna Wolley, *The Ladies Directory... With Rarities of Many Precious Waters; Among which, are Dr. Stephen's Water, Dr. Matthias's Palsie-Water... Approved of By the Ablest Physicians* (London, 1662); Anon, *Dr. Willis's Receipts and Cures For The Cure Of All Distempers... Collected Out of His Writings* (London, 1701); John Archer, *Everyman His Own Doctor*. (London, 1671).

<sup>115</sup> Culpeper, *Medicaments For the Poor*, B4.

<sup>116</sup> John Gerard, *Gerard's Herbal the Essence Thereof Distilled by Marcus Woodward, reprinted from the edition of Thomas Johnson, London 1636* (London: Howe, 1927).

<sup>117</sup> Laroche, *Medical Authority* 51-52.



witchcraft.<sup>118</sup> This jostling for medical authority went on among all types of medical practitioners and medical production, illustrating how dynamic seventeenth-century medicine was. Whether practitioners were men or women, lay or qualified, rich or poor, they all espoused medical knowledge and claimed medical authority over the sick.

In this medical culture of overlapping domains where the efficacy of cures and the skill of practitioners were highly subjective matters, social power see-sawed between household practitioners, doctors and apothecaries, and the patient was at the mercy of their perceived expertise. Similarities in the ingredients that comprised domestic and doctors medicine confirms the close relationship in which practitioners jostled for reputational power. A closer analysis of the medicine made in the kitchen of Elizabeth Freke reveals that it was somewhat inadequate for more serious cases of illness. Inventories of Freke's cure-alls turn out to be medicines such as *scurvy grass*, which was generally available for common ailments.<sup>119</sup> Time and again, Elizabeth Freke called in the doctor and had prescriptions made up by the apothecary, even though she was a notable producer of domestic medicine. She bought medical books written by doctors and collected recipes credited to doctors. She may have made medicines, but for personal and family medical matters she sought the doctor's advice. Freke's charitable remedies were generally for everyday ailments, and one of her stock recipes was for "surfit", or feeling full after a heavy meal. Domestic medicine undertaken by women like Freke did not challenge medical authority

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<sup>118</sup> Laroche, *Medical Authority*, 52.

<sup>119</sup> See Sherley, *Cochlearia Curiosa*.

because providing remedies was secondary to understanding the intricacies of medical diagnosis and prescribing the appropriate medical advice. Freke's kitchen-physic was always available to cope with various illnesses, but the distilled waters and cordial juleps she made could just as easily be bought at the apothecary. When illness threatened life it was the doctor who was recognised as medically knowledgeable, demonstrating the continuum of the doctor-patient relationship.

Seventeenth-century chronicler Richard Gough related many incidents of illness amongst his neighbours in the village of Myddle, revealing how people used domestic cures.<sup>120</sup> Gough, and the local characters he referred to resorted to a combination of magical, domestic, and doctors' cures, yet often reserved their respect for the authority and role of a good doctor who could cure. Gough made particular mention of Doctor Goddard who he singled out as being "the famous Doctor Goddard", implying the doctor's skill when it came to performing successful cures.<sup>121</sup> Even diarist Ralph Josselin, who was a devotee of domestic medicine, visited the doctor when he was able, if only to obtain confirmation that he was following suitable cures, whereupon he expressed relief on hearing that the doctor approved of his methods.<sup>122</sup> People swapped cures, recommended cures, became excited about cures and believed in cures, but they still consulted medical practitioners.

All sorts of people, both lay and medical, used domestic medicine. Scholars have cited this reliance on domestic medicine to support the empowerment of

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<sup>120</sup> Richard Gough. *History of Myddle* ed. David Hey (London: Penguin, 1981).

<sup>121</sup> Gough, *History of Myddle*, 246.

<sup>122</sup> Josselin, *Diary*, 163

patients and the empowerment of women in their socio-medical networks. Gianna Pomata agreed with Roy and Dorothy Porter in concluding, “illness was still substantially defined and controlled by the sick themselves.”<sup>123</sup> Yet, although patients could take responsibility for their own illness, and often did, it was not simply a matter of patient agency taking precedence over the doctor’s decision-making. Taking on the responsibility for one’s own illness depended heavily on the severity of the illness, perhaps the amount of money and help available, and a wide range of varied social circumstances. Domestic medicine did not only belong to the realm of the sick poor, but also to those who looked for a quick remedy for a manageable illness. Self-medication or domestic medicine was not a crucial indicator of patient ability-to-act that removed the doctors’ medical authority, instead, it reveals that the practice of medicine had a constant bustle and energy that teemed with varied choices and outcomes in a medical dynamic-equilibrium.

## CONCLUSION

In seventeenth-century England the possibility of cure depended on a range of social variables. Lucinda Beier observed that early modern people did not expect to be cured and did not expect medicines to make them feel better, yet evidence shows many of them were cured, to varying degrees. In expectation of cure, early modern people collected cures and wrote them down in recipe and commonplace books, which were kept in families for generations. With all the effort to pursue cures there

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<sup>123</sup> Pomata, *Contracting a cure*, xiii.

can be no doubt that they hoped to find the perfect cure. They colourfully reported the number of vomits endured, the number of stools produced and the amount of griping pains they experienced, frequently embellishing their accounts with explicit detail, obvious pride, a sense of wellbeing, and a belief that they had been, or could be, cured.

The social factors that impinged on the relationship between practitioner and patient included practitioner experience, patient agency, efficacy of remedy, the course of a disease, and the course of Nature. Importantly, patients continued to seek cure from practitioners even though previous treatments caused pain and dismay. There was always a chance that the doctor might be able to cure and patients were prepared to take that risk. They returned to practitioners to let their bodies be purged, poked and punctured, bathed and bandaged, scratched, scraped, burnt, blistered and bled. Doctors had something extra to offer that was different from domestic medicine, even if it was simply experience of similar cases of illness, with no guarantee as to outcome. The complex notion of early modern cure lies in its potential to alleviate symptoms in varying degrees; a process that was carefully judged in alignment with the intricacies of socio-relational networks of power.

## CHAPTER 4. “Death”: The Doctor’s Role at the Deathbed

The omnipresence of death intruded into the lives of many early modern people and although it was possible for people to be cured, death was a persistent and destructive outcome of any illness. Some scholars have stated that early modern death was simple and straightforward, a “sacred drama” in which medicine and doctors were marginal players.<sup>1</sup> In reality, death was not simple and straightforward. Early modern people had to contend with disease epidemics and the unpredictability of death, the ambiguous nature of the signs of death, and they had to navigate a variety of religious and magical beliefs about the body. Not least of all, taphephobia, the fear of premature burial, held grave terrors for the dying. Patients were often desperate when faced with death, so they turned to medicine and its practitioners for help.

This chapter focuses on the experience of death and its role in shaping understandings and lived experiences of medical relationships in seventeenth-century England.<sup>2</sup> The threat of death and the presence of death tested the agency and decision-making of all those involved, serving to both construct and limit the

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<sup>1</sup> Danae Tankard, “Defining Death in Early Tudor England,” *Cultural and Social History* 3, 1 (2006): 2, 4; Porter, *Bodies Politic*, 30, 125.

<sup>2</sup> On death in early modern times see, Phillippe Aries, *The Hour of Our Death*, trans. by Helen Weaver (London: Allen Lane, 1981); Ralph Houlbrook, *Death, Religion and the Family in England 1480-1750* (Oxford: Clarendon Press, 1998); Vanessa Harding, *The Dead and the Living in Paris and London, 1500-1670* (Cambridge: Cambridge University Press, 2002); Ruth Richardson, *Death, Dissection and the Destitute* (Chicago: Chicago University Press, 2000); Peter Jupp & Clare Gittings, eds., *Death in England: An Illustrated History* (Manchester: Manchester University Press, 1999); Julian Litten, *The English Way of Death: The Common Funeral Since 1450* (London: Robert Hale Ltd., 1991); Ian Mortimer, *The Dying and the Doctors: The Medical Revolution in Seventeenth-Century England* (Woodbridge: The Boydell Press, 2009); Julie-Marie Strange, “Death” in *The Oxford Handbook of the History of Medicine* ed., Mark Jackson (Oxford: Oxford University Press, 2013), 355-372; Claire Gittings, *Death, Burial and the Individual in Early Modern England* (Beckenham: Croom Helm Ltd, 1984).

possibilities for action. An exploration of the social impact of death can demonstrate how different strands of power influenced the agency of actors. The complexities of emotions also affected transactions of power, coalescing fear, trust, anger, sympathy, and compassion with social conventions, cultural traditions and structural powers within society. The range of any social network, and the forces that operated within it, varied considerably in each medical encounter. Doctors and patients appeared to have separate concerns when approaching and dealing with death, however, they frequently shared the similar aim of avoiding death, an aim which highlights the reciprocal dimensions inherent in exercising power. This mutualistic aspect of the medical relationship is often hidden when power is conceptualised as *power-over* another entity. Examining the ways in which early modern doctors and patients modified, disrupted or negated the social processes of dying shows how accepted social legitimations could change and be created anew.

## I. DYING IN EARLY MODERN ENGLAND

Scholars have thoroughly explored the rituals surrounding early modern death but little has been written about how the doctor-patient relationship functioned explicitly in regard to the dying. According to Philip Ariès, early modern death was the opposite of death in modern times.<sup>3</sup> He argued that as material life became an increasingly secure and protected phenomenon in western society, death began to be

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<sup>3</sup> Ariès, *The Hour of Our Death*, 28, 138.

seen as a “wild, alien and irrational” occurrence.<sup>4</sup> Ariès claimed that death in the modern era took people by surprise, as the patient did not always know they were dying and others could conspire to hide it from them. Also, dying was further hidden, as it occurred mostly in hospitals and hospices, out of sight and out of mind. When death did eventuate, bodies were concealed and removed to cemeteries on the outskirts of towns. In contrast to the death process in modern times, Ariès described death in early modern times as being “tamed.”<sup>5</sup> The ability to tame death was thought to come from a greater acceptance of death, an open deathbed with full knowledge of death, and final goodbyes to family, friends and neighbours, who were witnesses. The priest often attended and gave the last rites, the proceedings took place at home, and many people knew they were about to die so they could prepare for a good death. A good death meant attending to the soul and the body and tidying up one’s affairs for those left behind, and if the doctor predicted when death would occur people could proceed with their affairs.<sup>6</sup> An awareness that death was approaching was useful knowledge that conferred power and control, as it enabled the possessor of such information some degree of management over situational social relations. The social conventions surrounding death enabled doctors to occupy a position of authority and to advise when someone was dying.

The phrase “given up for dead by the doctors” is commonly found throughout seventeenth-century writings, indicating that doctors were often involved in deathbed

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<sup>4</sup> Joe Amato, “The Hour of Our Death by Phillippe Ariès; Helen Weaver,” in *Annals of the American Academy of Political and Social Science*, 460 (1982), 184-185.

<sup>5</sup> Ariès, *The Hour of Our Death*, 5, 28.

<sup>6</sup> William Perkins, *A Salve For A Sick Man, Or, A Treatise On Godliness in Sickness and Dying* (London, 1617), 86.

scenarios. According to Rebecca McNamara and Una McIlvenna, doctors were greatly concerned with grief—especially excessive grief, which was “regarded as a potentially dangerous medical condition”, and in which doctors played “a key role as social agents for setting the norms of grief.”<sup>7</sup> From Henry Savile’s correspondence we know that when Madame le Longueville was seriously ill she was “given over by her physicians.”<sup>8</sup> On 30 September 1600, the Earl of Ormonde was unable to travel because his wife was sick and “the physicians are hopeless of her recovery.”<sup>9</sup> On 2 August 1605, the Earl of Nottingham wrote there was no hope of life for his son as “the physicians say he cannot live.”<sup>10</sup> John Evelyn recorded there were six physicians at the bedside of Lord Ossory when he died, and on another occasion several physicians attended Evelyn’s servant, Humphrey, but were unable to prevent him dying from smallpox.<sup>11</sup> Doctors could not prevent death, but they could offer predictions concerning death. Early modern people recognised the unpredictability of death and condoned the doctors’ attempts to save the dying patient. Despite the patient’s ability-to-act, compelling evidence shows that doctors held significant degrees of both structural and reputational power when it came to managing death.

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<sup>7</sup> Rebecca F. McNamara and Una McIlvenna, “Medieval and Early Modern Emotional Responses to Death and Dying,” *Parergon* 31, 2 (2014): 5-6.

<sup>8</sup> Henry Savile, *Savile Correspondence. Letters To and From Henry Savile, ESQ., Envoy at Paris* ed., William Durant Cooper (Camden: Camden Society, 1858), 77, 79.

<sup>9</sup> *CSPD*, Ireland, March–October 1600 “Letter from the Earl of Ormonde to Lord Chancellor Loftus and the Council.” *State Papers Online*. Accessed 27 October 2015.

<http://go.galegroup.com.proxy.library.adelaide.edu.au/mss/start.do?p=SPOL&u=adelaide>

<sup>10</sup> *Calendar of the Manuscripts of the Most Hon. The Marquis of Salisbury, 17, 1605*, “Letter from the Earl of Nottingham, Lord Admiral, to the Earl of Salisbury.” *State Papers Online*. Accessed 27 October 2015.

<http://go.galegroup.com.proxy.library.adelaide.edu.au/mss/start.do?p=SPOL&u=adelaide>

<sup>11</sup> Evelyn, *Diary*, 210, 357.



Intense emotions surrounded the dying patient and the ever-present fear of death was to be found in published pamphlets that assisted the populace to face its inevitability. Pamphlets were typically religious in nature but all contained common themes regarding death; its power, its uncertainty and its inevitability. One pamphlet, *Death Triumphant*, held warnings of death's "particular stratagems and numerous regiment of Sicknesses and Diseases whereby he conquers and subdues all Mankind."<sup>12</sup> How could the sick muster arms against death when, "for power he is the most potent, for strength his is invincible?"<sup>13</sup> This sentiment was echoed by Abednego Seller in *A Funeral Gift* who wrote, "Strategems are in vain, for Death is so potent, and bears such sway that none can resist his invincible power."<sup>14</sup> Religious pamphlets contained many permutations of prayers suitable for the dying and the dead, as well as for those left behind who were fit and healthy yet feared death. There was a sombre prayer for "when we hear a Bell ring for a Person at the Point of Death" and a hopeful prayer for "ease in sickness or recovery out of it."<sup>15</sup> The agony of death was visible and the weekly visits to church reminded people of death as they passed the graveyard.<sup>16</sup> The structural power of religious belief was deep-seated in early modern society and greatly influenced how people responded to death.

Death was also described in secular pamphlets that used creative metaphors to show that death had an inherent power of its own irrespective of God and the

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<sup>12</sup> Andrew Jones, *Death Triumphant: Or, The Most Renowned Mighty, Puissant, and Irresistible Champion and Conqueror General of the Whole World Death* (London: 1674)

<sup>13</sup> Jones, *Death Triumphant*.

<sup>14</sup> Abednego Seller, *A Funeral Gift: Or, A Preparation For Death With Comforts Against the Fears of Death: And Consolations against Immoderate Grief, for the Loss of Friends* (London: 1690).

<sup>15</sup> Seller, *A Funeral Gift*, 146, 98.

<sup>16</sup> Gittings, *Death in England*, 8.

afterlife. Jeremy Taylor wrote, philosophically, of men as “bubbles” who “float up and down two or three turns, and suddenly disappear and give their place to others.”<sup>17</sup> While they lived they were “empty and gay...shining...like the image of a rainbow, which hath no substance, and whose very imagery and colours are phantastical.”<sup>18</sup> As such tracts demonstrate, it was not just religious concerns and a dread of being deposited in hell that cemented fears in regard to death. The reality of death in their midst reminded everyone, the sick, the carers, the doctors and any onlookers, of the fragility of life.

One popular ballad encouraged readers to be more accepting of death, and went a long way towards exonerating doctors from blame when they attended their dying patients. Reminding readers that doctors were only mortals, the ballad was a dialogue between a rich lady and a personification of Death who came to summon her away unexpectedly. Enjoying her prime of life, the lady suggested Death might alight on a more suitable character, such as those who suffered “in bitter grief”, those with “a hoary head and palsied joints”, or those “from whom all joy has fled.”<sup>19</sup> Instead of easing fears of death, the ballad reinforced the fact that death came uninvited and took away the most unlikely victims. Death insisted the rich lady submit, commanding her to “Prepare yourself to go; I’m come for you.” The victim’s response was to call upon the doctors for help:

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<sup>17</sup> Jeremy Taylor, *The Rule and Exercises of Holy Dying* (London: 1651), 1

<sup>18</sup> Taylor, *Exercises of Holy Dying*, 2.

<sup>19</sup> Anon, *The Great Messenger of Mortality, Or, A Dialogue Betwixt Death and A Lady* (London, c.1683-1700).

Ye learned doctors now exert your skill,  
And let not Death on me obtain his will!  
Prepare your cordials, let me comfort find'  
My gold shall fly like chaff before the wind!

But Death replied:

Forbear to call! that skill will never do;  
They are but mortals here as well as you.  
I give the fatal wound, my dart is sure,  
And far beyond the doctors' skill to cure.<sup>20</sup>

As the writer of the ballad revealed, those who were in fear of death instinctively turned to the doctor for help. Yet, as Death so callously pointed out, while doctors had some skills to cure they were insufficient when it came to healing the fatal wound of death. The ballad indicated that the patient's last thoughts, when faced with death, lay with how they might be saved physically, rather than spiritually.

Conflict between the structural power of the Church and the reputational power of doctors was apparent in 1617 when William Perkins, Calvinist minister, wrote that patients preferred to call the doctor before the minister. He bitterly complained,

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<sup>20</sup> Anon, *Death and A Lady*.

A thing much to be disliked, that in almost all places the doctor is first sent for, and comes in the beginning of the sickness, the Minister comes when the man is half dead, and is then sent for oftentimes when the sick party lies drawing on and gasping for breath, as though Ministers in the Gospel were able to work miracles.<sup>21</sup>

Perkins saw medicine as a useful means to gain health and avoid death, but he angrily lamented the patients' neglect of their souls and their preference for the doctor. During disease epidemics people forgot their souls as did diarist, Samuel Pepys (1633-1703), who wrote how dismayed he was to find there were no physicians left in Westminster during the great plague epidemic of 1665, and "but one apothecary left, - all being dead."<sup>22</sup> However, Pepys took this opportunity to allow himself "a cup of good drink" due to "my Physician being dead and Chyrurgeon out of the way whose advice I am obliged to take."<sup>23</sup> On the one hand, Pepys lamented the loss of the doctors, but on the other hand he took advantage of their absence, partaking of drink and going against their advice. His attitude encapsulated a mixed disposition. Love them or hate them, doctors wielded medical authority and patients were prepared to submit to them. Their presence was authoritative and their absence was license to behave badly. Besides Pepys, many others felt similar dismay at the apparent lack of doctors, with the result that the king

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<sup>21</sup> Perkins. *A Salve For A Sick Man*, 86.

<sup>22</sup> Pepys, *Diary*, 543.

<sup>23</sup> Pepys, *Diary*, 528.

was required to ask the Royal College of Physicians to offer medical advice to the public.<sup>24</sup> Although their medical remedies often proved ineffective against the plague, both individuals and the state continued to look to medical practitioners for help.

The doctors' skills in anatomy gave them an epistemological advantage over the layperson. Seventeenth-century medicine had begun to offer a more personalised and detailed working model of the body, as experimental medicine provided a rational grasp of the physiological changes brought about by death. Experimental operations were carried out on animals to determine, for example, how the lungs turned dark blood into bright red blood.<sup>25</sup> Because of this increased knowledge of the body, more attention was paid to bodily health during life and health gained greater importance than apprehensions over the fate of the soul. Just as the presence of the priest had been desirable at the bedside, so the doctors' presence increasingly became a necessary requirement.<sup>26</sup> Whether the doctor or the priest was the central figure at the deathbed depended on individual preferences that were influenced by cultural beliefs and social networks. As medical knowledge of death increased, new spaces for decision-making were constructed and old ideas faded.

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<sup>24</sup> See, *Certain Necessary Directions, As Well As For the Cure of the Plague, As Preventing the Infection...Set Down by the Colledge of Physicians by the King's Majesties Special Command* (London, 1636); *The King's Medicines for the Plague Prescribed in the Year 1604 by the Whole Colledge of Physicians...Generally Made Use of and Approved in the Years 1625 and 1636* (London, 1665).

<sup>25</sup> Locke, *Physician and Philosopher*, 14.

<sup>26</sup> See Mortimer, *Dying and the Doctors*, 204. (Mortimer's study of probate records from the south of England established that doctors saw dying patients much more frequently than was previously realised, in the latter half of the seventeenth century).

In an era when death was prevalent and the boundary between the living and the dead was fearfully blurred, some clung on to traditional ideas that lingered on through the seventeenth century. One of many varieties of corpse medicine recommended the sick person to touch the dead body of a freshly hanged malefactor, and even to drink its spilt blood or imbibe a potion prepared from its grinded bones.<sup>27</sup> The magical powers of corpse medicine brought the corpse to life, figuratively, by giving life to the dying. In similar manner, the bodies of murder victims were said to bleed afresh when touched by the murderer. In 1613 near Taunton, a man called Babb murdered a widow by stabbing her sixteen times after she refused his offer of marriage. The magistrate later exhumed the widow's body and summoned local people to come and touch the corpse, however, because Babb absconded from fear the corpse might bleed he was eventually brought to justice.<sup>28</sup> John Locke related a story of how the love of a father for his deceased son caused the son's body to bleed afresh from the nose every time the father approached the corpse.<sup>29</sup> As late as 1689, corpses might be arrested and kept captive until families paid the deceased person's debts.<sup>30</sup> The Roman Catholic belief in purgatory also blurred boundaries, keeping the dead in limbo so the living could pray for their salvation, although, how much impact this had in Protestant England is unclear. Telling the difference between life and

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<sup>27</sup> Sugg, *Corpses, Mummies and Vampires*, 84.

<sup>28</sup> George Roberts, ed. *Diary of Walter Yonge, Esq., Justice of the Peace, and M.P. For Honiton: Written at Colyton and Axminster, Co. Devon, From 1604 to 1628* (London: Camden Society, 1848), xiii.

<sup>29</sup> Locke, *Physician and Philosopher*, 129.

<sup>30</sup> Gittings, *Death in England*, 64.

death in this twilight world required special skills and doctors were increasingly called upon as experts.

Doctors were found carrying out post-mortems and supplying medical opinions to officialdom when deaths occurred. On 30 August 1694 William Walker was tried for fatally shooting a young girl in the stomach. Lydia Stockwell had entered his orchard at night to steal apples and Walker had shot his gun in her direction. A medical opinion was called for and the doctor described Lydia's wound as being three inches in depth.<sup>31</sup> Although he was sorry and said it was an accident, he was found guilty of manslaughter and punished by branding. Similarly, on 13 February 1656, Miles Sindercome, who had been sentenced to hanging, drawing and quartering for plotting to kill Oliver Cromwell, attempted suicide in his cell in the Tower of London. His guards found him almost dead and immediately called a doctor "who applied medicines to him; notwithstanding which, after he had continued in that condition speechless about two houres, he died."<sup>32</sup> An inquiry took place into Sindercome's death as it was thought he might have been poisoned. Yet, when the surgeons opened Sindercome's body, they could find no evidence. The Lieutenant of the Tower then called on "Sir Richard Napier, Doctor of Physick and Doctor Fern, Reader of Anatomy at Gresham College", to give their medical opinions.<sup>33</sup> They duly submitted written reports providing evidence of "some very violent and preternatural cause" of death.<sup>34</sup> Mr. Charles Stamford and Mr. Nicholas

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<sup>31</sup> *OBP*, "Trial of William Walker, 30 August 1694" (t16940830-33).

<sup>32</sup> Thomas Salmon, *Tryals for High-Treason and Other Crimes With Proceedings on Bills of Attainder and Impeachments, for Three Hundred Years Past*. (London, 1720), 374.

<sup>33</sup> Salmon, *Tryals For High-Treason*, 374.

<sup>34</sup> Salmon, *Tryals For High-Treason*, 375.

Brethers, Wardens to the Company of Surgeons, assisted them in their work along with Mr. Lawrence Lee, all of whom were described as “able and knowing persons in their profession”<sup>35</sup> Thus, officialdom called upon doctors to perform an administrative and bureaucratic role by examining wounds, performing post mortems and producing written reports containing evidence.

Doctors can also be found presenting official medical opinions within seventeenth-century courtrooms and their submission of evidence demonstrates they were the forensic experts of their day. On 13 December 1699, William Pheasant was accused of raping Deborah Wise who was not yet ten years old.<sup>36</sup> He had visited her dancing school three times and, on each occasion, he had bolted the door in the House of Office and sat her on his knee to give her pennies, sugar candy and oranges. Noticing that all was not right with the child, a nurse was called to examine the child’s body and found it “in great Disorder.”<sup>37</sup> An “Anatomical Doctor” was also called on and gave evidence that the girl had been “very much abused, and had lost her Virginity” and he “instanced divers reasons for it.”<sup>38</sup> After a relatively long trial that lasted eight hours, the defendant was found guilty and sentenced to death. The doctor’s evidence was crucial for the conviction in this case, demonstrating that medical evidence was vitally important in the early modern English courtroom and might send a defendent to their death.

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<sup>35</sup> Salmon, *Tryals For High-Treason*, 375.

<sup>36</sup> *OBP*, “Trial of William Pheasant, 13 December 1699” (t16991213a-1).

<sup>37</sup> *OBP*, “Trial of William Pheasant, 13 December 1699” (t16991213a-1).

<sup>38</sup> *OBP*, “Trial of William Pheasant, 13 December 1699” (t16991213a-1).



Acquittals based on the medical opinion of a doctor were also apparent. On 25 April 1688, Francis Brereton ran out of his lodging with his sword drawn and ran it straight through Edward Lawrence who happened to be passing at the time, killing him.<sup>39</sup> It was a random attack without any provocation, yet several people who were described as “persons of quality” testified to Brereton’s good character. Brereton was freed when the doctor specified that Brereton had been abstracted and much discomposed in his mind due to some ill-success in love and had become subject to “frensies and deliriums”, of which this incident was an episode.<sup>40</sup> On 8 December 1686, William Patience was indicted for mortally bruising and killing Joseph Holt who was assaulted on 13 August and languished until he died on 8 November. Patience was acquitted because the doctor testified Holt’s “Bruise was not any occasion of his Death, but that he died of a Natural Disease”, which was not specified.<sup>41</sup> And on 10 October 1683, John Derry was acquitted after being accused of murdering Thomas Robinson. Working together in a printer’s shop and arguing one day, Derry struck Robinson with the handle of a printer’s ball, “drawing blood by the stroak.”<sup>42</sup> Robinson was struck on 27 June and died on 23 August. Several doctors testified that Robinson had died of natural causes not related to the ‘stroak’, thereby acquitting Derry from any blame for Robinson’s death.<sup>43</sup>

The words and actions of many types of medical practitioners underscore the ways in which they navigated existing social legitimations by supporting or

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<sup>39</sup> *OBP*, “Trial of Francis Brereton, 25 April 1688” (t16880425-28).

<sup>40</sup> *OBP*, “Trial of Francis Brereton, 25 April 1688” (t16880425-28).

<sup>41</sup> *OBP*, “Trial of William Patience, 8 December 1686” (t16861208-1).

<sup>42</sup> *OBP*, “Trial of John Derry, 10 October 1683” (t16831010a-1).

<sup>43</sup> *OBP*, “Trial of John Derry, 10 October 1683” (t16831010a-1).

attenuating them, either deliberately or unintentionally. In a 1694 pamphlet, Will Atkins, *Gout-Doctor*, lamented the fact that many people still failed to call on the doctor *after* someone had died, declaring, “I do verily think that many people here in England are buried alive.”<sup>44</sup> Atkins challenged the accepted social legitimation that saw death as non-medical and he offered a new perspective that undermined existing practices. He advocated calling in an expert who could interpret the presence of death and he offered his own services. It might appear that he was touting for business, but mounting evidence of premature burial proved his plea to be a genuine concern. Since ancient times, doctors had saved people from premature burial. Asclepiades once stopped a passing funeral procession to look at the corpse and “carefully feeling every part, and discovering latent signs of life, he forthwith affirmed that the person was not dead” and thus saved him.<sup>45</sup> An Armenian soldier, killed in battle in ancient times, whose body was returned to his house for proper burial awoke after two days, just as he was laid on the funeral pyre.<sup>46</sup> And Pliny wrote of “those who have returned to life when they were about to be laid in the grave”, in his book of Natural History.<sup>47</sup> Tales of premature burial were widespread, and in seventeenth-century England there were enough of these tales to create widespread fears able to influence decision-making processes.

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<sup>44</sup> Atkins, *Discourse On Gout*, xi.

<sup>45</sup> William Tebb & Edward Perry Vollum, *Premature Burial and How it May be Prevented With Special Reference to Trance, Catalepsy, and Other Forms of Suspended Animation* (London, 1896), 325.

<sup>46</sup> Tebb, *Premature Burial and How it May be Prevented*, 325.

<sup>47</sup> Tebb, *Premature Burial and How it May be Prevented*, 326.

Citizens who failed to comply with prevailing social behaviours, or those who rejected them outright, were seen as subversive. One pamphlet described how, on a Friday night in 1661, near a London graveyard, neighbours thought they heard low moans and groans coming from a freshly dug grave where local butcher Lawrence Cordell had been buried earlier that day. By the time the local priest had sent someone by horseback to ask permission from the Bishop to investigate the noise by opening the grave, Lawrence Cordell was well and truly dead.<sup>48</sup> His landlady had found him lying comatose after a night he spent imbibing strong drink, and she buried him quickly so she could rent the room out to someone else. Neighbours warned her she was acting hastily but the landlady ignored their advice and went ahead with the burial. Dicing with death was evidently a risky business without a doctor at hand to advise. For her hastiness in burying Cordell, the landlady was carted off to Newgate to answer a murder charge. Her actions were castigated in public, thereby helping to establish what was socially improper and what was socially legitimate.

In the same year that Cordell was buried alive another story emerged of Dorothy Smith a poor labouring woman who, “troubled with a Megrin in her head”, fell into the fire and was rescued by neighbours. Four days later she fell down “stark dead” at twelve mid-day.<sup>49</sup> At six o clock that evening she was carried off in an open Church-coffin for burial. As she was about to be interred a gentleman standing at the

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<sup>48</sup> Anon, *An Exact Relation of the Barbarous Murder Committed on Lawrence Corddel A Butcher, Who Was Buried Alive at Christ-Church, Friday Last* (London, 1661).

<sup>49</sup> Anon, *Wonder Upon Wonders Or Strange News From St. Mary Magdalen's in the Borough of Southwark* (London, 1661), 2.

graveside “perceived her heart to leap under the sheet, so that immediately uncovering her face, she stared with her eyes as if she had been alive.”<sup>50</sup> Overnight, attempts were made by neighbours to revive her but it was all to no avail and she died for the second time, and was buried again the following morning. Will Atkins’ suggestion that people call on the doctor to diagnose death, proved to be sound advice and seventeenth-century England can be seen as a period of transition when doctors were beginning to consolidate their medical authority in relation to death.

Failing to call the doctor to diagnose death produced dire consequences for lay people, however, doctors had their own difficulties in determining death as they were fallible and they made mistakes. Flemish physician, Andreas Vesalius (1514-1564), famous for his anatomical observations in *De Humani Corporis Fabrica* (1543), once plunged a knife into a body prepared for anatomical dissection and “upon opening the breast, he saw the heart palpitating.”<sup>51</sup> Vesalius was sentenced to murder and was only rescued from his own death by the entreaties of his patron and supporter, the King of Spain. And in 1651, when Thomas Willis and William Petty were poised to open the chest of twenty-two-year-old Anne Green, lately hanged for murdering her bastard child, they were shocked to hear noises emanating from the corpse. Green was promptly rescued and wrapped in a warm blanket, and reprieved from further punishment on all accounts.<sup>52</sup> Although people expected the doctors’ knowledge of death to be superior to the layperson, doctors easily misjudged death’s

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<sup>50</sup> Anon, *Wonder Upon Wonders*, 2.

<sup>51</sup> Tebb, *Premature Burial*, 329.

<sup>52</sup> Anon, *A Declaration From Oxford, of Anne Green a Young Woman That Was Lately, and Unjustly Hanged in the Castle-yard; But Since Recovered* (London, 1651), 2; Richard Watkins, *News From the Dead* (Oxford, 1651), 2.

perilous approach and arrival. Nevertheless, the deathbed continued to claim a substantial share of early modern doctors' medical practice. So, how did doctors predict or determine the signs of death, and what exactly did they do when they arrived at the deathbed?

## II. INTERPRETING THE SIGNS OF DEATH

As the examples in the previous section suggest, defining death was neither a simple matter nor a definitive punctuation, but more a vague affair that hung in the balance. Death was a process that could begin during life and pass haphazardly through the body. When it finally appeared to have consumed each part of the body, signs of life might still be present in the form of a little warmth or a faint pulse. Sometimes death came slowly, other times death occurred instantly, accidentally, or unexpectedly. On occasions, death came close only to retreat against all expectations. People were naturally wary of doctors because of their close association with death but people also recognised that doctors were best placed to interpret the signs of death. The deathbed was a space for decision-making and a range of social priorities determined how agency was exercised. While doctors often dealt with the physical and medical signs of death, patients and their families took a more socially focused approach that helped to distinguish between what might be called a good or a bad death. The dying patient had minimal opportunity to exercise agency, and was limited to either displaying a psychological resistance to life and/or by formulating a will that gave

some control over life beyond death. Even then, such decisions were driven by social and cultural traditions that influenced or overrode personal agency.

How to interpret the signs of death was a subject that herbal practitioner, Nicholas Culpepper, deemed important enough to produce a publication listing all the signs of death in the sick body according to the medical aphorisms of Hippocrates. His publication and translation of the College's *London Directory* can be interpreted as a "domestic diagnosis of death" and written to empower the lay person to read the signs of death. Culpepper's work underlined the fundamental importance of being able to predict who would, and who would not, die. The desire to control death is evident in attempts to read its signs and manage its timing. Making a will was an attempt to control death through bequests and instructions that were to be enacted afterwards, and which invalidated the finality of death.

The first signs of death that Culpepper upheld were maxims pertaining to the art of astrology; "Leo or Aquarius impeded by the body of the Lord of the 5<sup>th</sup> or 12<sup>th</sup> houses, signifies danger of death" he instructed his readers, and "the Moon opposed to the Lord of the Ascendant at the beginning of a sickness if...retrograde or combust, shews bitter accidents will fall out to the sick."<sup>53</sup> Joseph Blagraves listed eight specific astrological signs of death in his publication, the eighth being "an eclipse of the moon in the acute, or of the Sun in Chronick griefs upon a critical day...showeth death, the nearer the afflicting Planets are to the earth, the worst."<sup>54</sup>

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<sup>53</sup> Nicholas Culpepper. *Semeiotica Uranica, or, Astrological Judgment of Diseases From the Decumbiture of the Sick...To Which is Added the Signs of the Life or Death by the Body of the Sick Party According to the Judgment of Hippocrates* (London, 1651), 138.

<sup>54</sup> Joseph Blagraves, *Blagraves Astrological Practice of Physic Discovering the True Way to Cure All Kinds of Diseases and Infirmities* (London, 1689).

John Edwards also looked to the heavens to interpret the signs of death, however, he provided an earthly caution, advising doctors that it would be near impossible to predict out of two people with high fevers who displayed the signs of death, which one would survive. It was “not possible for the Master of Medicks to forsee this”, even with astrological expertise.<sup>55</sup> All these accounts reflected the uncertainties of death and the ambiguity with which the signs of death could present. Indeed, interpreting death was such an ambiguous process that these authors resorted to supernatural signs rather than rely wholly on physical ones that were observable in living and dead bodies, but which proved to be thoroughly unreliable.

Strategies to capture control of death or have power over it were thwarted by chance casualties and fluke happenings that caused death to occur when it was least expected. In Rye, Sussex, Samuel Jeakes’ father cut his finger on “a little thorn” while weeding the garden and the tiny wound mutated into,

an intolerable pain in the last joynt of the middle finger...[that] became so excessive that it inflamed the whole arme, and the joynt gangrened in a dayes time...the swelling broke...in severall places, & a great deale of purulent matter issued out of it for severall dayes...he lost two joynts of the middle finger.<sup>56</sup>

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<sup>55</sup> John Edwards, *Cometomantia, A Discourse of Comets Shewing Their Original, Substance, Place, Time, Magnitude, Motion, Number...Whether Any Judgments Can be Made From The Observator of the Heavenly Bodies* (London, 1684).

<sup>56</sup> Samuel Jeake, *An Astrological Diary of the Seventeenth Century Samuel Jeake of Rye 1652-1699* eds., Michael Hunter and Annabel Gregory (Clarendon Press: Oxford, 1998). 202-203.

Although the family witnessed bodily signs that made them think he might die, Jeakes' father survived, minus a finger, only to become ill and die a few months later, catching the family unawares while they were still feeling grateful for his miraculous recovery.<sup>57</sup> Jeakes' experience confirmed the unexpectedness of death. His initial injury was trivial but brought him close to death, while his subsequent recovery was hampered by illness that brought a swift death. It was impossible to tell when death would come knocking and there was little opportunity to exercise agency in ways that would hasten or delay death.

It was obvious that besides astrological postulations, there was a vital need for more practical advice on reading the signs of death. Culpepper attempted to advise doctors how to proceed, but the advice remained ambiguous. He recommended to,

Advise with nature, and her two sons, Doctor Reason, and Doctor Experience; let him have some brains in his head and not all in his books; let the patient provide for a change, and make his peace with God, and set his house in order, and then hath he the lesse need to care whether he live or dye.<sup>58</sup>

Culpepper thus advised that doctors should err on the side of caution and predict the likelihood of death. The doctors' proper use of reason and experience would better

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<sup>57</sup> Jeake, *Diary*, 206-207.

<sup>58</sup> Culpepper, *Semeiotica Uranica*, 143.



prepare patients, because it allowed them to make the necessary arrangements for death in plenty of time. Reason and common sense also helped to prevent the doctor persevering with hopeless and painful cures when the patient was dying. If a cure did occur after a prediction of death, then its outcome was beneficial to both doctor and patient. The difficulty lay in being alert to the signs of death and acting on them appropriately.

Culpepper asserted that the only reliable predictor of death was Dame Nature, however, his description of the timeless Dame Nature was full of contradictions and no help to the mortal doctor. When met in the street, Dame Nature was,

a plaine homely woman in beggarly contemptible condition...truth written upon her breast...she is a virgin, a wife and a widdow...she hath no mony, yet is Mistris of the mines of India...she is alwayes everywhere and yet still with me: she is my Mother; shee's a woman and yet an Academick...<sup>59</sup>

In other words, Dame Nature was a paradox, capricious in the way she conjured illness, changeable in the way she influenced its course, and erratic when she presented the signs of death. How could any doctor communicate with her empirically? The dynamic vagaries of nature thus governed the doctor patient-relationship. Good and bad doctors fell afoul of Dame Nature or were rewarded by her, indiscriminately.

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<sup>59</sup> Culpepper, *Semeiotica Uranica*, 173-175.

In more precise terms, the manuals for discerning death sometimes provided the full gamut of physical signs that presaged a person's demise. These included external visible signs on the face and body, physical actions such as tumbling in bed and gnashing teeth, and other explicit signs that developed during particular types of illnesses. Fevers, for example, produced a variety of effects on the spittle, vomit, urine and excrements of patients. However, "verified by continuall experience that a fever terminates in death to one, and in life to another", Culpepper glossed over the fact that an accurate reading of the physical signs of death still relied on chance.<sup>60</sup> Doctor Theodore Turquet de Mayerne experienced great difficulties when he attempted to read the signs of death in a "Noble patient" with "disaffections of the Peritanaeum."<sup>61</sup> He found the patient in agony, seized by a vehement fever, with "frequent *Soundings*, *Nauciousness*, and loathing of Food, *heat* and *retention of Urine*", which were all sure signs of Death.<sup>62</sup> He discovered a tumour in the peritonaeum that was bigger than a "*Goose Egg*", yet, despite it becoming foul, ulcerous and gangrenous, the patient eventually recovered.<sup>63</sup> With lengthy and taxing treatments he was "snatched out of the Jaws of death, and emerg'd from an *Iliad* of Diseases", which happily, and unhappily, only left a recurrent and painful itching.<sup>64</sup> The signs of death had deceived in this case, however, the doctor appeared to have prolonged the patient's life with his medical interventions.

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<sup>60</sup> Culpepper, *Semeiotica Uranica*, 181.

<sup>61</sup> Theodore Turquet de Mayerne, *Medicinal Councils, Or Advices Written Originally in French by Dr. Theodore Turquet de Mayerne, Englished by Thomas Sherley* (London, 1677), 55.

<sup>62</sup> Mayerne, *Medicinal Councils, Or Advices*, 57.

<sup>63</sup> Mayerne, *Medicinal Councils, Or Advices*, 57.

<sup>64</sup> Mayerne, *Medicinal Councils, Or Advices*, 64.

Despite, or perhaps because of, the unpredictability of death, people were apt to call the doctor at the latest possible moment, well after there was any opportunity for treatment and often when the bodily signs of death had already presented. Doctor Thomas Willis's case notes tell of many late requests from patients who had misinterpreted the signs of death. On 19 March 1650, Willis was called to see a twenty-year-old youth who had suffered with rigors and a severe weakness that prevented him from standing or walking. He lay in bed for four long days with "intense fever, thirst, heat, continual wakefulness, and frequent delirium."<sup>65</sup> Willis was only called on the fifth day and delivered the prognosis that there was no hope of life, and the young man died that evening. Another man aged thirty-years-old was struck by unbearable pain in his side and was unable to move. He called in the local druggist who administered a "clyster" and placed fomentations on the affected part. Willis was only called in as a last resort, and when the patient was being moved onto his other side "he suddenly expired."<sup>66</sup> At post-mortem, Willis found that the man's lung and chest was "floating in a large quantity of water."<sup>67</sup> In yet another case, Willis wrote he was "summoned 'by chance' to attend a case of childbirth eleven days after the actual birth" even though the woman had experienced adverse symptoms on the second day and was now at risk of death.<sup>68</sup> Willis did not record whether the woman died or not, but in all of the above cases, people either ignored or did not act upon the recognised signs of death.

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<sup>65</sup> Thomas Willis, *Willis's Oxford Casebook (1650-52)* ed., Kenneth Dewhurst (Oxford, Sandford Publications, 1981), 99.

<sup>66</sup> Willis, *Willis's Oxford Casebook*, 118.

<sup>67</sup> Willis, *Willis's Oxford Casebook*, 118.

<sup>68</sup> Willis, *Willis's Oxford Casebook*, 96.

The appearance of sleep closely mimicked the demeanor of approaching death and made death particularly difficult to recognise. The difference between the two states proved mysterious and was a constant topic of discussion. Writing of sleep and death in the pamphlet *Death Triumphant*, the author soberly reminded readers “in sleep; our death, and in our bed a grave”, and advised, “prepare thyself as for the grave” when going to bed “remembering that many go to bed and never rise again.”<sup>69</sup> Some of the greatest medical minds of the age thought that “frequent turns of sleep” each night were like “so many previous Monitors of Death.”<sup>70</sup> In other words, every night’s sleep was a precursor and practice for death. The reason, essence and cause of sleep was as yet unknown, and when all spontaneous motions were seen to cease during sleep, bodies were compared to death because they were observed to “lye as [if] they were dead.”<sup>71</sup> The dreams and nightmares of sleep were linked to death and were thought to stir up spirits that wandered “like Spectres in a Church-yard, and Cause stupendious Apparitions of things.”<sup>72</sup> One question in the *Athenian Oracle* was “Why do physicians forbid us to sleep on our backs?”<sup>73</sup> Another question asked, “How does a fantasm or spirit strangle and stifle in sleep?”<sup>74</sup> The author’s answer cited the risk of apoplexies, frenzies and “the Disease called the night-mare.”<sup>75</sup> Dreams were believed to expose “the Naturall Temperament and Complexion and

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<sup>69</sup> Jones, *Death Triumphant*, 402.

<sup>70</sup> Thomas Willis, *Two Discourses Concerning The Soul of Brutes, Which is that of the Vital and Sensitive of Man...* trans by S. Pordage (London, 1683), 86.

<sup>71</sup> Willis, *Two Discourses*, 87.

<sup>72</sup> Willis, *Two Discourses*, 94.

<sup>73</sup> John Dunton, *A Supplement to the Athenian Oracle: Being a Collection of the Remaining Questions and Answers in the Old Athenian Mercuries, Intermix'd With Many Cases in Divinity, History, Philosophy, Mathematicks, Love, Poetry, Never Before Publish'd* (London: Andrew Bell, 1710), 218.

<sup>74</sup> Dunton, *Athenian Oracle*, 226, 236.

<sup>75</sup> Dunton, *Athenian Oracle*, 218.

the Secret Diseases of Persons” just as much as any bodily signs could during wakefulness.<sup>76</sup> All the answers to these anxious questions about dreams, nightmares and everlasting sleep led to death. Exactly how they were connected, and how the different states and signs of life and death could be interpreted was confusing, both in theory and in practice.

Laypeople participated in attempting to decipher the differences between life and death when they gathered at the bedside of the sick and dying. On Monday 25 June 1646, Elizabeth Jeskins, a 36-year-old housewife and cloth worker, felt a great heaviness oppress her, which she struggled to resist without success.

At first she did pretty well, and finding new employments she did begin to overcome it: but at the last - sleepe, with all its power sate heavy upon her eye-lids; and usurping all the faculties of her senses, did take her too soone in everlasting prisoner, and...about five dayes after did deliver her up to the hands of death.<sup>77</sup>

Jeskins slept for over one hundred hours before being overtaken by the sleep of death. During those long hours her distressed husband, in company with neighbours and onlookers, held a vigil at her bedside and attempted all manner of experimentations to test if she was asleep or dead. “How neare of kinne is sleepe to

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<sup>76</sup> Anon, “Of Dreams” in *A Rich Treasure the Knowledge Whereof is Useful, Profitable, Pleasant and Delightful, Treating 1.Of the Four Complexions, 2.Notable And Approved Medicines... 21.Names of Market Towns, With Divers Other Notable Things by Several Hands* (London: 1698), 120.

<sup>77</sup> Anon, *The True Relation of Two Wonderfull Sleepers* (London: 1646), 4.

death,” observed the author of the account, reflecting the view of many of his contemporaries and thereby exposing how a seemingly simple distinction could, in practice, cause such dire problems.

From the first approach of death until the final moments and the aftermath, every stage of Elizabeth Jeskins’ dying circumstance was troubled with doubt. After the appearance of two hours of sleep and household duties calling, Jeskins’ husband tried to wake up his wife. At first, relying on lay methods, he used “his tongue” to coax her awake and then his hand. Using “violence” he sprinkled cold water on her and placed a cold metal key in her mouth, “but no key could unlock her senses, and set them free from the tyranny of her tedious slumbers.”<sup>78</sup> He wrung her nose, pulling it again and again, and called for help to the neighbours who “used her roughly”, pinching her and administering liquid to her but no force could prevail to waken her.<sup>79</sup> This was common practice in determining early modern death. John Ward recorded that Lord Cherbury’s eldest son was found lying in the road in a pool of vomit and blood, after a night drinking, and all possible means were used to find life in him. Sneezing powder was put into his nostrils; they used “cupping and scarifying...to make him feel, but all to no purpose as he was perfectly dead.”<sup>80</sup> This vigorous treatment meted out to the comatose man and the similarly slumbering Jeskins was a socially legitimate method of forcing the signs of death to appear more clearly.

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<sup>78</sup> Anon, *Two Wonderfull Sleepers*, 4.

<sup>79</sup> Anon, *Two Wonderfull Sleepers*, 4.

<sup>80</sup> MS 6174, “Transcript of the Diary of John Ward 1648-1679”, WL.

With no apparent success forthcoming, Jeskins' husband turned to the doctors for advice about the significance of her unusual sleep, however, the case proved to be a difficult one. The doctors also thought she was experiencing some form of sleep and believed she might live, and they gave counsel that she should be bled from a vein in the nose. Accordingly, this was done by a surgeon who promptly bled her. The doctors believed she had an accumulation of humors in her head and attempted to release them, however, none of their treatments worked. Her husband found the counsel of the doctors "did not answer his expectation, for immediately after, she began to be cold, and one limb after another to suffer under the frozen hand of Death."<sup>81</sup> Dame Nature took her course and on this occasion the doctors were at a loss to prevent her death.

Following the doctors' departure from the Jeskins' household, the remaining spectators scrutinised Jeskins' every bodily sign denoting death with fervent curiosity. This was a vital component of determining whether her death would be socially acceptable. Some deaths were stigmatised when signs of immoral behaviour were detected, so Jeskins' neighbours used all their sensory perceptions to determine her faint pulse, her fading heartbeat, the dwindling capacity of "her Lungs to receive and returne the vitall Ayre" and any other signs that might prove useful for considered judgement.<sup>82</sup> Finally, after many hours "she became a Carcasse...to endure a following and a more deliberate corruption of her body in the Chambers of the Grave."<sup>83</sup> However, even with the evidence of death before them in the form of a

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<sup>81</sup> Anon, *Two Wonderfull Sleepers*, 6.

<sup>82</sup> Anon, *Two Wonderfull Sleepers*, 6.

<sup>83</sup> Anon, *Two Wonderfull Sleepers*, 7.

swelling and purging corpse, it was reported that gossiping tongues said her husband had buried her before she was dead. Not only were naive lay bodily observations unsatisfactory, but they were unreliable as proof of death. Even after Jeskins had died, uncertainty remained and the fear of premature burial was unmistakable in the circulating gossip.

In the absence of any satisfactory medical explanation for illness, speculation on the cause of death and the moment of death was rife. Lay conversation mainly discussed the personal and social circumstances of the dying and dead, whereas the doctors observed physiological signs and talked of diagnoses. In the case of Elizabeth Jeskins, every facet of her life was mused over by her neighbours. Her death was thought to be unusual because she was in the middle of her age and strength. Although inclined to be fat she was not gross or corpulent, she worked hard and did not sleep excessively. She was sanguine and so her spirits were more active, and because she had a strong constitution and a clear complexion, and there was no reason to believe that any inward disease had caused her death.<sup>84</sup> Yet, these outward signs that combined bodily and social indicators still failed to answer why she had died. Speculation was bewildering and lay interpretations could only go so far. The key to further answers in such cases was *post-mortem*.

Post mortem gave the doctors further opportunity to prove their expertise on death. An accident involving two scholars in a boat on the river at Oxford was proved after evidence was acquired via a post mortem. Several doctors, one of who

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<sup>84</sup> Anon, *Two Wonderfull Sleepers*, 7.



recorded the incident in a letter, examined the bodies and found scarring on the chest “of a deep blackish red Colour, not unlike the scorch’d skin of a roasted [sic] Pig.”<sup>85</sup> Nothing further could be discovered inside the corpse as it appeared sound, however, together with accounts of a violent thunderstorm and evidence of scorch marks on the clothes and body, the doctors confirmed their diagnosis that the Oxford scholars were killed by a lightning strike. A letter from Albertus Morton to Edward Conway on 6 June 1625, gave further confirmation of the doctors’ authority in determining the course of death. Morton had delayed his departure due to the death of Orlando Gibbons who died suddenly at Canterbury. After “opening the head” of Gibbons, the doctors avowed there was “no token of infection, and in the brain most apparent signs of lethargy.”<sup>86</sup> Although doctors could not always save their patients, post-mortem results enabled them to show their superior knowledge of death and its causes.

There were many cases when the doctors’ expertise in reading the signs of death was able to save the patient. One rainy windswept night when Doctor Thomas Willis was on his medical rounds he was forced to seek shelter in a country inn. The landlord asked him to visit a local father and son whose neighbours found them “distemper’d after a wonderful and miserable manner”, having been overwhelmed by “a most profound Sleep”, which had left them senseless in their beds.<sup>87</sup> In what can

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<sup>85</sup> Dr Willis, “A Relation of an Accident by Thunder and Lightening, at Oxford, May 12, 1666,” in *Philosophical Transactions* 1, 22, (1666): 222-226.

<sup>86</sup> CSPD, 6 June 1625 “Sec Morton to Sec Conway” *State Papers Online*. Accessed 27 October 2015. <http://go.galegroup.com.proxy.library.adelaide.edu.au/mss/start.do?p=SPOL&u=adelaide> (*Lethargy* denoted a medical term that indicated a morbid drowsiness, a sleep from which one cannot awake, although what the visible signs of this were within the brain is unclear).

<sup>87</sup> Willis, *Two Discourses*, 133.

only be described as skillful, Willis was able to declare that the cause of their sleepy lethargy was due to mistaking and eating the roots of henbane, thinking they were parsnips.<sup>88</sup> By pouring medicine down their throats, and “a Feather thrust down a great way, that made them vomit,” he was able to “excite their animal spirits” and deliver them from their “sleepy poison.”<sup>89</sup> The tale demonstrates the helplessness of the lay onlookers, who were unable to fathom the bodily signs displayed by the sleepy, or deathly, forms. While the doctors were unable to prevent Elizabeth Jeskins’ transition from sleep to death, a combination of knowledge and perhaps a touch of good fortune allowed Thomas Willis to save these two men from probable death.

Doctors like Willis, who combined common sense with reason and experience were lauded by their contemporaries for predicting and sometimes averting death when patients were convinced they were at death’s door. When Culpepper described the bodily signs of death, he included anecdotes that showed how some doctors were able to allay their patient’s terror of death. One of the “wisest physicians” he ever met was Doctor Butler of Cambridge. Discussing a case of the presage of death, Culpepper related how Doctor Butler’s “penetrating judgment” perceived that the cause of the man’s trouble was wind, whereupon he called for a rolling pin, got up on the bed “boots and all, not regarding the holland sheets; and fal[l]s to rowling the man’s belly with a rowling pin; the Patient’s fundament sounds an alarum, and certifies all the company that ease was a

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<sup>88</sup> Willis, *Two Discourses*, 133.

<sup>89</sup> Willis, *Two Discourses*, 133.

coming.”<sup>90</sup> After fearing death the patient was cured and reassured, and likely to recommend the doctor’s skills on future occasions.

When called to dying patients, doctors often displayed emotional power through their compassion, which expressed the doctors’ commitment to their patients’ wellbeing and developed patient trust. On 10 July 1689, Doctor Phineas Fowke (1638-1710) made a diary entry about a serious case of the *Iliac Passion*, now commonly recognised as a blockage in the bowel, which still has the potential to be deadly.<sup>91</sup> The doctor’s focus was on removing the obstruction by finding something “to pass down in this exigency.”<sup>92</sup> He conferred with fellow doctors, Sampson and Hulse, and tried smart pills, purging waters, stimulative clysters of oil, tobacco smoke, and friction to the abdomen by kneading the belly. Bloodletting had neither good nor bad effect and all treatment was in vain. Fowke was reluctant to use “the Bath” treatment because he had used it in his last case of *Iliac Passion* and although it had eased the pains, the patient had fallen into faintings and cold sweats, followed by death.<sup>93</sup> Previous experiences taught Fowke to modify present treatments. He had determined only to use the bath in future if the patient was in the early stages of the disease and still had some strength left. He knew the patient’s troubles had been caused by inflammation of the ilia, by its intrusion and constriction, and because he had seen inflamed bowels in former dissections. As the patient’s death appeared likely, he considered opening the abdomen to return the bowel to its straight passage,

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<sup>90</sup> Culpepper, *Semeiotica Uranica*, 165.

<sup>91</sup> See short biography of Fowke in *Munk’s Roll*, 427.

<sup>92</sup> WL, M2433, “Phineas Fowke, Diary & Notes.”

<sup>93</sup> WL, M2433, Fowke, *Diary*.

however, he was cautious about performing such a dangerous operation and decided to abandon this course. His experience had taught him that opium brought relief, quietness, rest and relaxation to the affected parts, which might enable further purgations to be administered. As he described the patient's painful symptoms, he felt the disease should be renamed *miserere mei*.<sup>94</sup> Unfortunately, such cases were often hopeless and no degree of knowledge and experience was guaranteed to cure the patient and prevent death.

Fowke's administering of opium to the dying patient is a key point in illustrating the divide between the activities and authority of medical practitioners and lay people. Opium was not always easy to come by for patients. When Hannah Allen was suffering from melancholy and wished to obtain some opium for her personal use, she sent her maid out to purchase some on her behalf. The maid visited several apothecary shops where the owners informed her they had none in stock. In other shops, the maid was told it was a dangerous ingredient and they would not sell her any opium. When she finally succeeded in buying it she was thwarted by the "maister of the shop coming in" who asked her what she had and then took it off her.<sup>95</sup> So although patients attempted to take charge of their own medical needs, they did not always have the ability to do so, and some medicines were informally restricted, being reserved for purchase and prescription only by medical practitioners. In this case it was not the practitioner but the shopkeeper who upheld and reinforced social legitimations surrounding the use of opium.

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<sup>94</sup> WL, M2433, Fowke, *Diary*. (*miserere mei*: have mercy on me, pity me.)

<sup>95</sup> Hannah Allen, *A Narrative of God's Gracious Dealings With that Choice Christian Mrs Hannah Allen* (London: 1683), 32.

On 22 April 1640, Lord Gerard Dutton wrote to the Earl of Essex with the unfortunate news that he was dying. “My physicians have shewed me the nearness of my end”, he wrote, asking Essex to intercede with the King on his behalf, to bestow the wardship of his son upon his wife. The physicians had predicted his death and he was able to set his final affairs in order. When doctors saw death coming they often informed their patients with obvious compassion, just as Thomas Willis told the friends of sixteen-year-old dying patient, Anne Mason, in February 1650.

“Practically despairing of her life, I conveyed to her friends the sad forecast that there was little or no hope left. I prescribed a soothing julep of water of treacle...then a rose cake, moistened with rose water and vinegar and smeared with oil of mace to be applied to her forehead and temples.”<sup>96</sup> Seven days later she expired.

People understood the difficulties doctors faced and accepted that the outcome of illness might likely be death. Robert Hooke related in his diary, philosophically, that when Lord Chester suffered from suppression of urine the doctors tried everything they could think of, including blowing into his bladder with bellows to dislodge a stone. Nothing they tried gave any relief to Lord Chester and he died, yet, when doctors opened his body in the ensuing days there was no evidence of a bladder stone to be found. The doctors made it known that he had probably died from opium and other medicines and Hooke did not attribute blame to the doctors, because such treatments were logical in light of Lord Chester’s illness.

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<sup>96</sup> Willis, *Casebook*, 90.

He had been sick and the doctors had simply tried to save him.<sup>97</sup> John Evelyn hardly thought to blame the doctors, even though they could do nothing to save his close friend, Mrs. Godolphin, in her final days as she lay dying after childbirth. In his sorrow, he merely regretted that nothing was found to save her.<sup>98</sup> Nor did Evelyn complain when the doctors failed to save his five-year-old son from dying of fever. Again, he merely regretted that they did not have the time or the opportunity to try something “artificial” after all “natural” means had been exhausted.<sup>99</sup>

Many accounts of death are noteworthy for the attendance of a doctor, even if their attendance simply produced letters that informed friends and relatives that the patient had been “given up for dead by the doctors.” With or without a doctor, interpretations of the signs of death were precarious, however, the doctors’ presence could assuage anxieties and provide reassurance or confirmation that the signs of death were definite. Doctors who were adept at predicting death had a greater chance of gaining respect and increasing their reputation, but even when doctors made mistakes they were not always blamed or thought to have erred. The prevailing attitude can be captured in the Latin phrase *caveat emptor*, or, buyer beware. Cited in William Noy’s book of Laws, it accompanied a clause that released blame from any servants who transported medicines from the practitioner to the patient.<sup>100</sup> The onus

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<sup>97</sup> Robert Hooke, *The Diary of Robert Hooke, M.D., M.A., F.R.S., 1672-1680* trans. & ed. by Henry W. Robinson, Walter Adams, with a foreword by Sir Frederick Gowland Hopkins (London: Taylor Francis, 1935), 14.

<sup>98</sup> Evelyn, *Diary*, 8 September 1678.

<sup>99</sup> Evelyn, *Diary*, 1-30 January 1658.

<sup>100</sup> William Noy, *Maxims in Law and Equity, Comprising Noy’s Maxims* ed., William Hening (London, 1824), 24, 51.

was on the patient to choose their doctor carefully; a demanding responsibility that could mean the difference between life and death.

## CONCLUSION

Early modern patients were limited in the way they could exercise agency when the spectre of death was present. Patients could only resist impositions of treatment or take control by justifying and embracing oncoming death. Meanwhile, doctors' experiences at the bedside of dying patients made them invaluable guides for reading the signs of death, predicting death, or possibly even cheating death. The constraints of pre-modern medicine and the high incidence of death made the doctor's advisory role at the deathbed unique to the early modern doctor-patient relationship. Although there could be rivalry between medical and social concerns regarding death, the desire of both doctors and patients to resist death demonstrates a mutualistic dimension to the relationship that eclipsed individual agency and promoted reciprocity. Strategies used to contain and control death depended on a mixture of the doctors' medical experience and the wishes of patients and their families, while the social interest in death and cultural ideas about what constituted a good or bad death further influenced medical decision-making processes. The strands of power that were present in social networks worked in interconnected ways that produced erratic outcomes. "Cure" and "death" were two outcomes at each end of the spectrum of illness. Both caused complexities that made the early modern doctor-patient

relationship multifaceted and dynamic. The next chapter will explore agency in the realm of long-term relationships and chronic disease, when patients were unable to be cured but were not immediately at risk of death. Long-term medical relationships enable a more detailed view of the processes of decision-making and the influences that lay behind choice and agency.



## CHAPTER 5. “Otherwise”: Managing Chronic Illness

In the context of the seventeenth-century phrase “cure, death or otherwise”, “otherwise” is understood here to represent any other medical outcome besides cure and death. In other words, it announces chronic disease and disability. Examples of chronic disease might be skin diseases, persistent gout, sporadic attacks of the stone, or recurrent and sinister coughs accompanied by general weakness. Disabilities included the blind, the lame and the mad. Medical outcomes that ended in cure or death were conclusive, and they have been used in the thesis to highlight how the concepts of power were inordinately more complex than simply observing agency when and where it occurred. This chapter uses three case studies to explore medical relationships in further detail to how socio-relational networks had a significant impact on the medical decision-making of individual patients. The medical histories of Richard Baxter, Anne Conway, and Richard Powers can all demonstrate that what appears to be individual agency was not simply a patient’s exercising of personal power, but a response that was influenced by greater competing forces within the immediacy of their personal social networks. Three alternative perspectives are supplied by using the male experience of Baxter, the female experience of Conway. The Symcotts-Powers correspondence has been chosen to extract a rare glimpse of ongoing interaction between a doctor and patient rather than the often one-sided accounts of medical relationships that are more commonly found. The medical experiences of these three subjects are testament to the influence of relational

contexts to enable and constrain, and to the dynamic nature of the early modern medical relationship.

## I. RICHARD BAXTER (1615-1691)

Richard Baxter was a Puritan Minister and religion was a significant factor that notably affected his views on medicine. Baxter melded an interpretive and curative medical framework that was largely driven by religious sensibilities and his belief in God. In Baxter's autobiography he provides his own version of seventeenth-century Puritanism and portrays his involvement in the English Civil War; confirming at least two factors that encroached upon his medical decision-making.<sup>1</sup> In studying Baxter's works, Tim Cooper pointed out that Baxter's writings were a rich source of information for the social history of medicine and disease although "no historian has brought these riches to the surface."<sup>2</sup> Cooper argued that Baxter's medical experiences affected his philosophy of Puritanism, however, it is argued here that it was Baxter's philosophy of Puritanism that forged his outlook on sickness, medicine, and its practitioners. While Cooper noted Baxter's "disapprobation" of doctors, his "disappointment" and "disillusionment" and his "dismal" views of them, it should be pointed out that Baxter can also be found praising his doctors and declaring his

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<sup>1</sup> On Baxter see Richard Baxter, *Reliquiae Baxterianae: Or, Mr. Richard Baxters Narrative of The Most Memorable Passages of His Life and Times Faithfully Publish'd From His Own Original Manuscript*, by Matthew Sylvester (London, 1696); Tim Cooper, *John Owen, Richard Baxter and the Formation of Nonconformity* (Farnham: Ashgate, 2011); N. H. Keeble, *Richard Baxter, Puritan Man of Letters* (Oxford: University of Oxford Press, 1982); Geoffrey Nuttall, *Richard Baxter* (London: Nelson, 1965); John Hamilton Davis, *The Life of Richard Baxter of Kidderminster: Preacher and Prisoner* (London: Kent, 1887).

<sup>2</sup> Tim Cooper, "Richard Baxter and His Physicians," *Social History of Medicine* 20, 1 (2007): 2.

appreciation and respect for their medical work.<sup>3</sup> Cooper further illustrated how “Baxter laid his soteriological emphases in different places at different times,” thus presenting clear evidence of Baxter’s fluctuating views and indicating how his medical encounters were influenced by varying social circumstances.

Scholars have considered Baxter mainly for his religious views rather than his medical experiences, with the result that many of his troublesome illnesses have either been glossed over or dismissed as hypochondria. Claims of hypochondria have come both from Baxter’s contemporaries and from subsequent historians.<sup>4</sup> Such verdicts ignore Baxter’s symptoms and suffering. Many of his symptoms were physically manifest and included diarrhoea, catarrh, cough, troublesome stomach problems, copious bleeding from the nose and bouts of measles and smallpox. He also suffered greatly from flatulence, headaches, insomnia, and excoriation of his fingertips, which were often raw and bloody and must have caused him great inconvenience as a writer. In later life during bouts of imprisonment for his religious views and his unlawful preaching, he complained of lameness and pain in his foot for a lengthy seven months and he spent almost eight years suffering with recurrent eye infections and cataracts. Baxter’s symptoms appear to have been physically troubling and it is unfair to see them dismissed as the ravings of a hypochondriac. Competing contemporaneous evaluations of Baxter’s medical complaints demonstrate how actors challenged and subverted existing power relations with alternative assessments of illness.

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<sup>3</sup> Cooper, “Richard Baxter and His Physicians”, 10-11.

<sup>4</sup> Geoffrey Nuttall, *The Puritan Spirit: Essays and Addresses*. (London: Epworth Press, 1967), 109; William Lamont, *Puritanism and Historical Controversy* (London: UCL Press, 1996), 42-43.

Baxter's doctors diagnosed him with *hypochondriack melancholy*, which can appear misleading as a criteria for today's understanding of chronic disease. In seventeenth-century England this diagnosis had a more ambiguous meaning than its name suggests, encompassing symptoms that were both physical and psychological. The varied combination of emotional and physical symptoms was difficult to diagnose and could be associated with "Nerves."<sup>5</sup> In medical texts of the day *hypochonriack melancholy* was described as a "sort of Cachexie that frequently reigns in our Northern Climates" or, in other words, a type of general ill health denoting emaciation of the body.<sup>6</sup> In its more severe form it had similarities with scurvy. Indeed, Baxter was originally given a diagnosis of scurvy, which continued for two years and was then dismissed in favour of *hypochondriack melancholy*. Baxter's symptoms of poor appetite and troubled digestion, an excess of wind and acid causing pain in the stomach with costiveness and "perturbation of the head", were all classic symptoms for the diagnosis.<sup>7</sup> The persistence of these symptoms understandably led many sufferers to endure the melancholy aspect of the disease, yet Baxter was pleased to record his thanks for never being overwhelmed by any real melancholy or having any "inordinate fancies" or "sinking sadness."<sup>8</sup> So, Baxter's symptoms were recognised as constituting ill health in early modern times. His symptoms could be severe at times and as they worsened he increasingly consulted his doctors.

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<sup>5</sup> Anon, *An Account of the Causes of Some Rebellious Distempers* (London, 1670), 39.

<sup>6</sup> Anon, *Some Rebellious Distempers*, 38. "Cachexie" - depraved state or bad habit.

<sup>7</sup> Anon, *Some Rebellious Distempers*, 38-39. "Costiveness" was constipation.

<sup>8</sup> Baxter, *Reliquiae Baxterianae*, 10.

Baxter experienced variable treatments and erratic medical outcomes throughout his life. The English Civil War interrupted Baxter's medical treatments and he rode back and forth from the front line to his doctors to receive treatment. In 1642 he left the Parliamentary garrison town of Coventry and "going to London was long under the Cure of Sir Theodore Mayerne", which he found greatly beneficial for his recovery.<sup>9</sup> Later, in 1645, Baxter temporarily left the Siege of Bristol after falling sick with a fever and immediately "rode six or seven miles back into the country and the next morning to Bath. Here, Doctor Venner was my careful physician; and when I was near to death it pleased God to restore me."<sup>10</sup> In 1647 at Worcester, Baxter was troubled with a further bout of ill health and again left his regiment to return to London to see Mayerne. Mayerne sent him to take the waters at Tunbridge-Wells for three weeks, although this time he did not meet with a successful cure and recounted that the visit rather "hastened his ruine."<sup>11</sup> Thus, some visits to the doctor improved his health and others made him worse. He accepted these outcomes with pragmatism and continued to consult his doctors.

Baxter's religious life taught him many lessons that seeped into his ideas about illness, medicine and doctors. When Baxter was only fifteen years old, God showed him the "folly of Sin", however, he spent "many years [in] doubt of my

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<sup>9</sup> Baxter, *Reliquiae Baxterianae*, 45. On Theodore Mayerne see, Hugh Trevor Roper, *Europe's Physician: The Various Life of Sir Theodore de Mayerne* (New Haven: Yale University Press, 2006).

<sup>10</sup> See, "Tobias Venner (1577-1660)" *ODNB*; John Aikin, *Biographical Memoirs of Medicine in Great Britain* (London: 1780), 280; Jean Dietz Moss, "The Promotion of Bath Waters by Physicians in the Renaissance," in *Rhetoric and Medicine in Early Modern Europe* eds Dr. Stephen Pender & Prof. Nancy S. Struerver (Farnham: Ashgate, 2012). Dr Tobias Venners' publications include: *The Baths of Bathe* (London, 1628); *A Brief and Accurate Treatise Concerning the Taking of the Fume of Tobacco* (London, 1621).

<sup>11</sup> Baxter, *Reliquiae Baxterianae*, 58.

Sincerity and thought I had no Spiritual Life at all.”<sup>12</sup> This mirrored his attitude to doctors; he doubted them at times, was shown the error of his ways, and then returned to them wholeheartedly to undergo further treatments. His struggles to reach an accepted state of faith enabled him to understand the medical struggles of doctors who found his case difficult. Rather than blame his doctors for not being able to overcome or cure his symptoms, he simply concluded that the diseases he had were probably incurable, especially after he read medical works confirming this opinion. He also blamed many of his medical problems on his own behaviour, such as travelling in cold snowy weather, eating too much fruit (particularly apples), and for his own error in setting too much store on eating garlic.<sup>13</sup> For periods of time he forsook his doctors unless he had an urgent symptom or pain that required attention. In general, just as Baxter departed and returned to God’s fold, he also repeatedly departed and returned to his doctors, and he had no qualms over their capabilities when he needed their advice. The setbacks in his religious life were comparable to setbacks in his medical experiences, but no obstacle hindered him in pursuing his religious and medical goals of obtaining a state of grace and a bodily cure.

Baxter could appreciate the difficulties of practising medicine because during his life as a religious minister, he combined his duties with a stint as a temporary medical practitioner.<sup>14</sup> After the Civil War ended he resided and preached at Kidderminster in Worcestershire and spent almost five years practising medicine, administering physic to parishioners, and to others who lived in the surrounding

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<sup>12</sup> Baxter, *Reliquiae Baxterianae*, 3, 5.

<sup>13</sup> Baxter, *Reliquiae Baxterianae*, 9.

<sup>14</sup> Baxter, *Reliquiae Baxterianae*, 83.

areas. Some mornings he awoke to twenty or more people waiting at his door for treatment. He related that with God's encouragement he had been able to endure this responsibility for some years, however, "fear of miscarrying or doing anyone harm, did make it an intolerable burden" and he never meddled with it again, instead procuring "a godly, diligent physician to come and live in the Town."<sup>15</sup> Baxter's religious and medical experiences went hand in hand, and for him both God and the doctor were inherently authoritative.

Although some of Baxter's medical decision-making might be interpreted as the wielding of patient power or agency, Baxter was both assertive and passive on different occasions, thus highlighting the usefulness of interpreting the relationship as a medical dynamic equilibrium. Baxter's occasional assertive decision-making occurred erratically and was interspersed with episodes of acute reliance on his doctors. For a number of years he took matters into his own hands and dosed himself regularly with the herb sage, using it for vague symptoms of weakness and sometimes finding it was better than some of the medicines he used from the physicians.<sup>16</sup> Eventually, after a period of reasonably average health, the good effects of sage failed him and he abandoned it. On several occasions and by his own wishes he ordered bloodletting and courses of purgation, but without any great success. Baxter openly documented his belief in the doctors' superior medical knowledge and his self-treatment was not necessarily a rejection of his doctors but was a

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<sup>15</sup> Baxter, *Reliquiae Baxterianae*, 84.

<sup>16</sup> For the early modern theoretical basis of using sage see, John Gerard, *The Herball, or Generall Historie of Plantes* (London, 1636), 766. (Among the many "vertues" of sage, it was "good for the head and brain and quickneth the sences and memory.")

supplementary or complementary addition to their treatment. Furthermore, his self-treatment occurred at times when his illnesses were relatively trivial and therefore manageable. When symptoms became serious he quickly returned to the doctors.

Baxter might have occasionally dictated his own medical remedies; however, just as he repaired his faith in God after a period of sin, he always renewed his faith in the doctors' advice. The even greater bodily weaknesses that ensued from the trials and errors with self-medication sent him back to the doctors again, some of whom voiced their dissatisfaction with his methods and pronounced he would be lucky to escape "dropsy."<sup>17</sup> Baxter's pattern of seeking medical help demonstrates that although Baxter had episodes of what might be described as agency or power, they were transient, fluctuating, and sandwiched between episodes of vulnerability and meek obedience. Baxter's medical association with his doctors was mercurial and it depended on his state of health and the state of his emotional and religious life.

Baxter's overlapping alliance between medicine and religion meant that social and relational contexts influenced him in ways that both constrained and enabled his behaviour. When Baxter consulted his doctors they frequently dictated Baxter's actions. Just as Baxter tried to ignore what he saw as his own depraved and earthly desires in his attempts to follow God, he also put aside concerns about his body in order to follow certain medical directions that he knew were adverse to his well-being. He listened carefully to his doctors' advice and followed their directions scrupulously. After consulting Mayerne and receiving a long course of physic, which

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<sup>17</sup> Baxter, *Reliquiae Baxterianae*, 58.



Baxter recorded did him some good, he explained how Mayerne had persuaded him to eat apples, “which of all things in the World had ever been my deadly Enemies.”<sup>18</sup> Despite his reservations, Baxter followed his doctor’s advice and obediently ate apples before his meat for the next two days, even though he knew they violently disagreed with his constitution. In consequence, he “fell into such a bleeding as continued for six days”, which along with his swelling legs caused the doctor to determine him a hopeless case.<sup>19</sup> On the advice of a friend, which demonstrates this patient’s compulsion to follow advice, Baxter then consulted Doctor George Bates (1608-1668), physician to Charles I, Oliver Cromwell and Charles II, who concurred so exactly with all that had been said by Mayerne that Baxter “ marvelled at their Concord” and promptly set upon a long course of purging that both doctors had independently recommended.<sup>20</sup> Baxter was thoroughly impressed with their advice, respected their suggested treatments and followed their prescriptions with vigour. Religious guilt for his errant behaviour was matched by the guilt he felt for doubting the advice of his doctors.

Baxter’s medical experiences were profoundly related to his religious beliefs in ways that shaped his medical decision-making. While doctors played an important role in his life, Baxter attributed most of his medical troubles and cures to the workings of God, who he saw as the higher power who controlled his world. For instance, Baxter believed he had only managed to avoid melancholy through God’s mercy. He also held that God had deliberately sent him his illnesses so that he could

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<sup>18</sup> Baxter, *Reliquiae Baxterianae*, 10.

<sup>19</sup> Baxter, *Reliquiae Baxterianae*, 10.

<sup>20</sup> Baxter, *Reliquiae Baxterianae*, 10.

practise gratitude during the times when he was well. More particularly, God had saved him from several equestrian accidents when he had narrowly escaped death, and God was responsible for curing his early inclination to gamble.<sup>21</sup> He believed that praying for God's help had once made a tumour in his throat disappear.<sup>22</sup> With God directing his every medical experience the appearance of Baxter's personal agency might be questioned and the structural power of early modern Puritanism seen as a major contributory factor in determining his actions.

The significant role that God played in union with Baxter's physicians saw Baxter frequently refer to God as a "healing physician", as he made comparisons between the medical work of doctors and the divine work of God.<sup>23</sup> He likened the Church to a hospital and depicted the minister as a physician of souls. It "ill becometh a preacher", he wrote, "to cast all the reproach of the Diseases upon the nature of Health, or on the Physician, or to expose...that weakness which he [the doctor] pittieeth them for and is about to cure."<sup>24</sup> Baxter thus reveals it was not the physicians' fault that they were unable to cure their patients; rather, the severity of the illness and the behaviour of the patient were factors that played a convincing role in the decision-making processes surrounding disease. He saw physicians as sympathetic towards their patients and noted their compassion as they did their best to cure. Baxter recognised that both religious and medical work was difficult and

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<sup>21</sup> Baxter, *Reliquiae Baxterianae*, 11, 12.

<sup>22</sup> Baxter, *Reliquiae Baxterianae*, 81.

<sup>23</sup> Baxter, *Reliquiae Baxterianae*, 81.

<sup>24</sup> Baxter, *Reliquiae Baxterianae*, 40.

hazardous, and his religious humility permeated his attitude towards doctors as he largely accepted them as his superiors in medical matters.

Baxter wrote his memoirs in his late sixties when he had accumulated a lifetime of religious conviction and gathered a store of advice to pass on to posterity. Chief amongst his observations was the “lamentable uncertainties in medicine, the poor world payeth for.”<sup>25</sup> He singled out the practice of anatomy as being the branch of medicine that had brought about the most improvements, yet he stressed “what a multitude of uncertainties remain.”<sup>26</sup> Writing on fevers, which he described as a common ailment that many suffered from, he declared he had never met a man who knew exactly what a fever was. All the years he had relied on practitioners of medicine had led him to finally understand “how little physicians knew.”<sup>27</sup> Nevertheless, Baxter described medicine as a noble art with physicians as its masters. The advice he passed on to his readers was to value those doctors who were “excellent men, who have...great reading and greater experience, and sober, careful, deliberating minds, and had rather do too little than too much.”<sup>28</sup> In contrast, he advised people to avoid doctors whose “heads are dull, or temper precipitant, or apprehensions hasty or superficial, or reading small, but especially [those] that are young, or of small experience.”<sup>29</sup> “Oh how much goeth to make an able physician!” proclaimed Baxter.<sup>30</sup> An able physician, then, was generally older and wiser and

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<sup>25</sup> Richard Baxter, *A Treatise of Knowledge and Love Compared in Two Parts: Part I. Of Falsely Pretended Knowledge, Part II. Of True Saving of Knowledge and Love* (London, 1689), Part 1, Ch. 6, 48.

<sup>26</sup> Baxter, *A Treatise of Knowledge and Love*, 48.

<sup>27</sup> Baxter, *A Treatise of Knowledge and Love*, 48.

<sup>28</sup> Baxter, *A Treatise of Knowledge and Love*, 48.

<sup>29</sup> Baxter, *A Treatise of Knowledge and Love*, 48.

<sup>30</sup> Baxter, *A Treatise of Knowledge and Love*, 48.

more experienced, being cautious and careful in their treatments. Significantly, there was a mixture of good physicians and bad physicians. Baxter's view of doctors mirrored his views on religion, and in his moderate approach he recognised how religion and medicine both involved struggles and setbacks that required perseverance and acceptance.

In Baxter's measured opinion of medical practitioners, he did not attribute blame to them for the limitations of medicine, and he did not see them all as fraudulent characters. He recognised the abounding uncertainties within medicine and he understood its shortcomings. Baxter knew his illnesses were incurable and he had respect for the doctors' efforts on his behalf. He spent a lifetime consulting them and it was only on reflection, near seventy years of age, when he concluded that the physic he had taken over many years had probably been the ruin of his body. It was, therefore, not until the end of his life that he could look back and consider that the advice of the doctors may not have helped him on occasions. Earlier in his life at the height of his illnesses he showed a great deal of dependence on his physicians and would not have been able to do without them. With hindsight and maturity his opinions of their abilities changed. Baxter's medical adventures are an exemplar of the seventeenth-century doctor-patient relationship. They highlight how the appearance of patient agency was a complex feature of a multilayered social system in which actors occupied positions and made decisions that were driven by competing and often hidden influences. Richard Baxter chose a range of doctors and returned to consult those he liked and respected even when they had not cured him. The historical emphasis that has sometimes rested on the "power" of the early

modern patient, obscures a range of relevant factors, which in Baxter's case mainly constituted religion. Baxter's religious views greatly influenced his medical relationships making them collaborative but dynamic within the multilayered social settings of early modern England.

## II. ANNE CONWAY (1631-1679)

Lady Anne Conway's struggles with illness were principally affected by the socio-relational factors of gender and patriarchy. It is evident that the men in her familial and social spheres greatly influenced her medical management. Anne's medical choices were not simply the result of her own agency but often came about from capitulation to the insistence of others; others who recommended or warned against certain medical choices in equal measure. Marjorie Hope Nicholson, editor of the Conway correspondence remarked that Anne occupied herself with "feminine tasks", as "her sex forbade her any education" and she was married to Edward Conway at nineteen; - "as fortunate a choice as her relatives could have made."<sup>31</sup> Since being attacked with a severe fever at twelve years of age, Anne suffered with chronic headaches for the next thirty years of her life. Her continual headaches and bouts of pain were so "severe and mysterious" that besides the historical importance of her correspondence with philosopher, Henry More, she also became "a famous medical case."<sup>32</sup> Anne was prepared to take any advice and try any medical treatment that

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<sup>31</sup> Marjorie Hope Nicholson, ed, *The Conway Letters: The Correspondence of Anne, Viscountess Conway, Henry More, and Their Friends 1642-1684*, Revised edition by Sarah Hutton (Oxford: Clarendon Press, 1992), 5-6. (Hereafter cited as *Conway Letters*).

<sup>32</sup> Carol Wayne White, *Legacy of Anne Conway (1631-1679): Reverberations From a Mystical Naturalism* (New York: Suny Press, 2012), 6.

might relieve her headaches, and her family and friends, most noticeably the men in her life, eagerly assisted her in this endeavour. There were many occasions when she was desperate for help and at the mercy of the doctors.

Patriarchy and gender were two social influences that impinged on Anne Conway's ability-to-act. Hope Nicholson pointed out that on the one hand Anne was wife to a statesman, sister to an ambassador and Chancellor of England, while on the other hand, she was "vivid and eager girl", "suffering and gallant woman" and dearest friend.<sup>33</sup> This description clearly demonstrates the patriarchal realm in which Anne existed. Her husband held a position of power in the government. Her brother held significant political power in his government position, and he was also a doctor and member of the College of Physicians, an organisation that generally excluded women. Nicholson's description of Anne as "vivid and eager girl" and "suffering and gallant woman" reflects in part the stereotype of women in seventeenth-century patriarchal society. There were often tensions between Anne's overlapping roles as wife, sister and daughter, and these pressures were particularly evident when they surfaced within the realm of medical decision-making.

When Anne attempted to make her own medical decisions she was frequently dictated to, or overruled by her brother, John. John Finch was one of her staunchest allies but his medical advice to her was relentless. Anne's correspondence illustrates the pressure placed on her to comply with the clamorous medical directions that arrived routinely by letter. In 1652 John responded to a letter Anne had sent detailing

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<sup>33</sup> *Conway Letters*, 1.

a recent “Rheume” she was troubled with.<sup>34</sup> Spring was imminent and John began his letter with the hope that the following “warmth of the summer will cure you.”<sup>35</sup> John admonished Anne for drinking “too much small beere” and suggested she should cool her stomach by eating more fruit.<sup>36</sup> He also advised Anne not be *too* cool otherwise it would disturb her temper and bring on a fever or some other disease. He gave directives indicating the right kind of meat Anne should eat, variously making mention of mutton, veal, lamb and white fowl. He specified what time she must retire at night and how and when she should rise in the morning, “about 6 of the clock and walk abroad till seven, that houre of sweet [sic] being better in May and June than all the day after.”<sup>37</sup> He insisted “for my sake therefore have a little patience to undergoe these directions.”<sup>38</sup> No doubt his administrations were kindly meant and equally gratefully received; nevertheless, he was insistent in urging Anne to comply with his wishes.

John’s status as a doctor coalesced with his role as older doting brother and was a complicating factor in his relationship with Anne. It intensified the pressure on Anne to accept his advice. Most of John’s letters to Anne issued detailed instructions on her medical care from far afield. He attempted to supervise her behaviour, the foods she ate and even the type of glass she should drink from, writing “I had rather you would drinke beere out of an indifferent glasse than a Tankard.”<sup>39</sup> He attributed

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<sup>34</sup> *Conway Letters*, 62.

<sup>35</sup> *Conway Letters*, 63.

<sup>36</sup> *Conway Letters*, 63.

<sup>37</sup> *Conway Letters*, 63.

<sup>38</sup> *Conway Letters*, 63.

<sup>39</sup> *Conway Letters*, 64.

her ill health to her actions, citing “youre drinking of Tunbridge waters last yeare layd up store for youre distemper and your bad diet of fruit increased it.”<sup>40</sup> John Finch pressured Anne to behave in particular ways during her sickness. He blamed her illness partly on her own actions and warned her that it would be better “to worke youre cure without physick than with it if it can be done.”<sup>41</sup> All her brother’s directives lay behind Anne’s dealings with her doctors. Thus, when Anne voiced her opinion on doctors’ treatments or refused to comply with their orders, her apparent agency was most likely the result of coercion, gentle or otherwise, from other interested parties, such as John.

On one occasion, Henry More (1614-1687), Anne’s philosopher friend and mentor, wrote to inform Anne that he had revealed all the medical details of her illness to Doctor Ridsley in order to enlist the doctor’s help. Without her permission, More had already asked Ridsley to look into her case and he wrote to Anne to coax her to consult Ridsley. More added some medical recommendations of his own when he implored Anne to take fresh air and not to overheat her spirits, and to be patient in her “paine and affliction.”<sup>42</sup> He could not help but direct her to eat the kind of meat that “begets the finest and coolest blood, and to abstain from all gross food.”<sup>43</sup> In return, Anne thanked More for his concern and promised to consult Ridsley, whereupon More earnestly hoped that Ridsley’s physick would help her and requested she would send good news after all his efforts in engaging the doctor for

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<sup>40</sup> *Conway Letters*, 64.

<sup>41</sup> *Conway Letters*, 64.

<sup>42</sup> *Conway Letters*, 75.

<sup>43</sup> *Conway Letters*, 75.



her.<sup>44</sup> Henry's tutorship and friendship added a further dynamic to Anne's doctor-patient relationships, as Anne was seemingly obliged to undergo Ridsley's treatments in part to please Henry More. So not only was Anne desperate to relieve her headaches, but she was also compelled to consider and comply with the demands of the men she knew, all of who professed to know what was best for her and expected her to acquiesce to their wishes. Thus gender and patriarchy intruded into Anne's medical relationships and mediated any agency she might have exercised.

Anne was noticeably dependent on family, friends, acquaintances and doctors, to supply and discuss medical advice and to recommend other consultations and treatments. While Anne's brother, John Finch, sent liberal doses of advice in great detail that ran into pages, Lord Conway, Anne's father-in-law also advised her on medical matters. When she suffered from toothache, he wrote and told her to make sure she had "a very good physician" to deal with it.<sup>45</sup> He also influenced Anne by recommending physicians, discussing the merits of Doctor Harvey and voicing his approval of "Doctor Prudian's judgment."<sup>46</sup> Richard Baxter's doctor, Sir Theodore Mayerne, was also friend and doctor to Anne Conway.<sup>47</sup> When Mayerne realised he could do little to ease Anne's headaches, he called on various colleagues for assistance, demonstrating both that doctors frequently knew their limitations when faced with complicated illnesses, and that they consulted with one another when it came to difficult cases. When Mayerne asked Doctor William Charelton to

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<sup>44</sup> *Conway Letters*, 76, 77.

<sup>45</sup> *Conway Letters*, 29-30.

<sup>46</sup> *Conway Letters*, 31.

<sup>47</sup> See, Ch. 5, 185, n. 8; Ch. 4, 169, n. 62.

help, Charleton “refused to undertake the cure” promising to send someone who he considered would be better able to deal with Anne’s case.<sup>48</sup> In Anne’s case it was not the patient who was directly exercising medical decision-making but a combination of authoritative males, both kin and the medical fraternity, all vying with each other to do their best to take care of Anne.

Medical relationships customarily overlapped with familial and social relationships. While John Finch and Henry More were sending advice to Anne they were also dealing with medical troubles of their own. Finch was reduced by a severe quinsy and wrote to Anne with news that his doctors had pronounced him a dead man. He had undergone bleeding, cupping, glysters and purges and had thankfully received a late reprieve. During the span of his illness, his only care and comfort came from his doctor, who had sat up with him all night long.<sup>49</sup> However, the doctor who looked after Finch that night was also his friend and travelling companion, Mr. Baines. The lifetime friendship between the two men accounts for the devotion Baines displayed in his medical care of Finch. The story points to the different dynamics governing medical relationships and shows how friendship and respect played a significant role in many collaborative interactions between doctor and patient.

Meanwhile, Henry More exposed his fear of doctors when he was sick and weakened “partly by the spleen and partly by the scurvy.”<sup>50</sup> His episode of illness encapsulated patient emotions and revealed his attitude towards doctors, with his

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<sup>48</sup> *Conway Letters*, 20.

<sup>49</sup> *Conway Letters*, 90.

<sup>50</sup> *Conway Letters*, 90.

candid confirmation of a great fear of doctors and a strong reluctance to undergo treatment. With no accurate way to determine a doctor's medical knowledge, More was forced to gamble on the doctors with whom he dealt and guess at the level of skill they had attained. More explained his preference for only taking physic in emergencies, as he was unsure whether any doctor would be able to surpass his own medical knowledge. However, not having the time to investigate any particular doctor he was "constrained to submit my judgment to them that have skill and Experience in that Art."<sup>51</sup> More could choose his doctor but he did so with fear and uncertainty. While he worried over the calibre of his own doctors, he wrote to Anne with advice to stay cheerful and not "overheat your spirits with overmuch or too anxious thinking upon any thing...with humility and thankfulness to God."<sup>52</sup> His advice to Anne highlights the gender dynamic in medical relationships, and demonstrates a reliance on the structural power of religion to intervene when earthly solutions were found lacking. While admitting his own doubts about the efficacy of doctors and their medications, More evidently expected Anne to be reassured that God and her male kin and friends would secure the best medical assistance for her.

Rather than displaying an ability-to-act that equated to social power, Anne was clearly rendered vulnerable by her medical choices, due to the complexity of her social situation and the doctors' continual efforts to maintain their medical reputation within society. In February 1654, More wrote to her in outrage after hearing about her recent consultations with Frederick Clodius, son-in-law of the Dutch chemist

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<sup>51</sup> *Conway Letters*, 92.

<sup>52</sup> *Conway Letters*, 71, 75.

Samuel Hartlib. “This Clodius has moved my indignation above all measure...he is so mainly like a cheat, that I utterly suspect his skill...the things in your letter you allege against him are so foule and grosse...he is as accurs’d a Raskall as ever trod on English ground...a wretch.”<sup>53</sup> Henry More was angry that Anne had been on the receiving end of what he supposed was shoddy medical treatment. He wrote of “the money he has couzen’d you of” and the medicine given “that which is not good.”<sup>54</sup> Anne, it seems, had been treated with mercury and suffered some symptoms of mercury poisoning.<sup>55</sup> Anne’s vulnerability was complicated by the fact that the same doctor might just as easily cure a different patient and be seen as a reputable doctor. In the case of Frederick Clodius, he was appreciated by some and denigrated by others, making it difficult to sum up his worth. The unreliability of doctors was a factor that highlights the individuality and variability of medical encounters. The disappointments of medicine could polarise patient judgments depending on the outcome of a case and the circumstances surrounding it. This state of affairs forced patients to consider long-term medical relationships with a trusted doctor who became a friend, - if not already a friend beforehand.

Patients conflicting opinions over doctors were exemplified by Anne’s and Henry’s comments regarding the well-known physician, William Harvey. Harvey had been Anne’s doctor since childhood but had fallen out of favour as he aged and had little to offer that she had not previously sampled. Anne confided to More that she had “been extreemly troubled with a violent fit of the headache these 3 or 4

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<sup>53</sup> *Conway Letters*, 95.

<sup>54</sup> *Conway Letters*, 95.

<sup>55</sup> *Conway Letters*, 91.

dayes” and explained “all that Harvey hath hitherto done to me will discourage me from trying many more conclusions with him.”<sup>56</sup> In other words, Anne had exhausted the range of Harvey’s treatment and was still suffering from headaches; therefore she had no choice but to try another doctor. Harvey was by now suffering with his own ailments, being troubled greatly with gout. Anne was prepared to accept More’s suggestion and “make tryall” of Doctor Ridsley. She had heard good things about Ridsley and he came recommended by More, thus demonstrating that word of mouth was a routine method used to endorse doctors. Anne’s rejection of Harvey and her preparedness to try Ridsley points to the complexity of the medical dynamic, and to Anne’s dependence on the advice of her male friends and kin when seeking alternative doctors and new avenues of cure.

The types of medical treatments on offer demonstrate clearly how patients were at risk of being given false hope or duped. Anne consulted a range of practitioners from prominent physicians to infamous faith healers, without any cure or relief. Famous for his interest in the anatomy of the brain and ailments of the head, Doctor Thomas Willis recorded Anne’s case as hopeless.<sup>57</sup> Anne’s husband then summoned Valentine Greatrakes from Ireland, in the hope that Anne might be cured. Greatrakes was known to have a gift for healing people by “stroaking” and they flocked to him to be cured, many hundreds with apparent success.<sup>58</sup> Greatrakes also had his detractors who described his work as “*a Cheat*” and spoke for those who,

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<sup>56</sup> *Conway Letters*, 71.

<sup>57</sup> Thomas Willis, *The Remaining Discourses*, (London, 1681)

<sup>58</sup> Peter Elmer, *The Miraculous Conformist: Valentine Greatrakes, the Body Politic, and the Politics of Healing in Restoration Britain* (Oxford: Oxford University Press, 2013); Valentine Greatrakes, *The Great Cures and Strange Miracles Performed by Valentine Greatrakes* (London, 1666); Anon, *A Brief*

make horrid complaints of his undecent and intollerable handling of all their parts; of his pinching, rubbing, chafing, and lancing their Sores, of his inflaming of their blood and humours, and rendering many of them, by cutting them and other wayes, incurable<sup>59</sup>

Greatrakes was criticised for dealing mostly with women and children who, because of their gender were seen as weak and were thought to be “not capable of understanding how they were cured.”<sup>60</sup> Anne underwent Greatrakes’ treatment without success and with much disappointment. Eventually, Greatrakes was discredited, fell out of fashion and returned to Ireland. His efforts with Anne represented one of the more innocuous treatments she underwent, but other patients, more generally, were not so lucky and were supplied with dangerous treatments and suffered or died accordingly. Finding and undergoing a treatment that might turn out to be dangerous made medical choice and agency a precarious balance between life and death. Nevertheless, Anne was prepared to try several experimental treatments to find some relief. On one occasion, she travelled to France to undergo trepanning with a doctor there, who she had heard was particularly skillful in the operation. She was persuaded not to go unaccompanied, by the vehement entreaties of her brother.<sup>61</sup> She

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*Account of Mr. Valentine Greatrakes And Divers of the Strange Cures by Him Lately Performed* (Dublin 1668).

<sup>59</sup> David Lloyd, *Wonders No Miracles: Or, Mr. Valentine Greatrates Gift of Healing Examined* (London, 1666) 22.

<sup>60</sup> Lloyd, *Wonders No Miracles*, 28.

<sup>61</sup> *Conway Letters*, 117.

went and was accompanied by More, but the French surgeons refused the operation and instead opened “the jugular arteries.”<sup>62</sup> On another occasion, a letter mentioned her undertaking a trial that comprised the “experiment of water falling on your head”, from which she gained no relief.<sup>63</sup> Anne’s medical record is one of desperation, vulnerability, and obedience. Many of the decisions she took regarding doctors and treatments were not only dependent on the severity of her illness, but were swayed to the various medical fashions of the era.

When Anne’s agency appeared to come to the fore on a few occasions, the wishes of others quickly altered her intentions. Indeed, her gender required her to heed the advice of male family members and accept their chastisements. Her behaviour was frequently checked, for instance, when her brother criticised her suffering demeanour, writing,

I thinke that which is too much in you may be allowed in a man for though it may be no pleasant thing...to see a Woman strangely grave before shees fifty and has yeares fit for a madam is a great solacisme, as to see an old Madam of fourscore habited like a virgin of fifteen<sup>64</sup>

Yet despite such harsh comments, Anne was always appropriately solicitous to others in return, as befitted her gender. Henry More graciously thanked her for “that hope you give me of success in physic, that has been so unsuccessful to your

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<sup>62</sup> *Conway Letters*, 117.

<sup>63</sup> *Conway Letters*, 79.

<sup>64</sup> *Conway Letters*, 66.

Ladyship.”<sup>65</sup> More ended his letters to Anne with sentiments such as, “wishing you good success in your physic, and recommending you to Gods gracious keeping”, indicating they were both sufficiently aware of the unpredictable nature of medicine.<sup>66</sup> The letters of Anne Conway and Henry More reveal the ways in which early modern patients united to console one another as they lurched back and forth between eagerness and disappointment with each new treatment – with little sign of any cure.

Many of Anne’s medical treatments are now obsolete and have become almost entertaining outside their original context. Placed within their own context they reveal the experimental nature of medical enterprise, in which both patients and doctors had little choice but to appropriate when the need arose. Patients and doctors were ready and willing to share their medical experiences, test their new theories, and try new treatments. In Anne Conway’s case, her medical encounters were governed by the cultural mores of gender and patriarchy, which overrode or masqueraded as her individual agency. With each new patient came a different set of circumstances and a diverse array of factors that dictated how each medical experience played out. The third and final relationship that follows, between Richard Powers and Doctor John Symcotts, confirms the willingness of some patients to challenge treatments and argue with their doctors, establishing that medical decision-making was complex, unique, and specific to each doctor-patient relationship.

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<sup>65</sup> *Conway Letters*, 92.

<sup>66</sup> *Conway Letters*, 94.



### III. SYMCOTTS AND POWERS

The third medical relationship to be examined is that between Doctor John Sycotts and his patient Richard Powers. The surviving correspondence between them roughly spanned the years from 1636 to 1641.<sup>67</sup> It offers a rare insight into a long-term doctor-patient relationship and contains detailed prescriptions informing Powers how and when to take various medicines. The letters highlight the to and fro of medical relationships, displaying the sometimes argumentative and sometimes conciliatory attitudes of both participants. In the opinion of Frederick George Marcham, who transcribed the correspondence, the letters between the two men showed Powers to be “self-opinionated, querulous and argumentative, but he had a high opinion of Sycotts (who treated him patiently and persuasively).”<sup>68</sup> Powers, like Baxter and Conway, was clearly ill and required medical help. Sycotts managed the relationship by balancing the roles of friend, counsellor and medical expert. On the many occasions when Powers questioned the doctor about various medicaments, he usually acquiesced to taking his medicine and continued to ask the doctor for subsequent advice. Their relationship is highly representative of how many medical relationships were continually re-negotiated depending on how situational social relationships stood at the time.

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<sup>67</sup> Add MS 33464, “Letters to Richard Powers, of Ramsey, From His Physician, John Sycotts, With Prescriptions and Bills, 1633-1642”, BL.

<sup>68</sup> Sycotts, *Diary*, 20.

The communications between Symcotts and Powers confirm the blurred boundaries of a medical relationship that went beyond the purely medical and overlapped with friendship. Doctor Symcotts frequently addressed his letters “To my very loving friend Mr Richard Powers” and signed them with “your assured loving friend, John Symcotts.” The letters mainly dealt with Powers’ medical problems, therefore, they did not fully represent the social correspondence of friendship but rather signified a lengthy acquaintance born out of necessity. Powers confided detailed and personal information about his bodily symptoms, which included a dry mouth, fur on his tongue and pains in his neck, toe and finger. He also had swollen knees, often felt a great heat in his body and had a weakness of the stomach. Symcotts acknowledged Powers symptoms and interpreted them medically in his replies. When a treatment did not work Symcotts explained how it should have worked and guided Powers to other remedies. Symcotts combined his medical expertise with his humanistic manner in what can be described as a holistic approach to medical care but one that also weighed up local gossip and rumour, and paid attention to the medical reputations of other practitioners in the social network.

The death of one of Symcotts patients caused an upset that served to intensify the anxieties and emotions of both men. Powers, clearly fearing his own prescribed course of physic might elicit a similar outcome, wrote to Symcotts to ask about the treatment of the patient who had died. The doctor replied, explaining how he had prescribed a gentle vomit to clear the patient’s stomach, which would have

worked if “Nature had not been utterly spent in him.”<sup>69</sup> He reassured Powers that although the physic appeared as if it had accelerated the patient’s end, those present “might easily have judged whether he had had strength enough to take the vomit or not.”<sup>70</sup> As argued in previous chapters, the criteria for judging such matters was ambiguous and subject to competing explanations. Implying it was not his fault that the man had died, Symcotts further distanced himself from the misfortune by claiming that it was not God’s pleasure to keep the man alive and “therefore, I must be content his will be done, not mine.”<sup>71</sup> Symcotts answered the fears and uncertainties of his patient, and their relationship survived this potential breach of trust.

Whenever Powers questioned his doctor, Symcotts provided suitable answers that allayed patient concerns. Indeed, Symcotts often retaliated with vexatious inquiries of his own, thus exposing the alternations and counter balances of their relationship. Symcotts chastised Powers for trying to pick and choose between prescribed medical treatments, telling him they must be done to the letter or not at all. At other times, he instructed Powers to take his physic because “this season is not propitious to eradicate physic.”<sup>72</sup> Powers’ complaints increased on the advice of his neighbours, or by any gossip that was circulating, however, Symcotts often refused to back down, defending his medical judgment and reputation to the hilt. After consuming a particularly violent purge, Powers relayed complaints about its effect,

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<sup>69</sup> Symcotts, *Diary*, 39.

<sup>70</sup> Symcotts, *Diary*, 39.

<sup>71</sup> Symcotts, *Diary*, 39.

<sup>72</sup> Symcotts, *Diary*, 41.

only to be reprimanded by Symcotts who suggested Powers might rely on his own judgment of its effects rather than listen to “whatever your neighbours ignorantly talk against your physic.”<sup>73</sup> He was similarly dismissive of other lay attempts to diagnose conditions and evaluate medicines. When Powers described his trembling joints to Symcotts, the doctor corrected him on his description of that “which you call the Palsy.” Then again, Symcotts was not completely against lay advice, as when Powers reported his friends concern for his sore neck and Symcotts approved of their counsel. However, he would not accept that they were fully able to comprehend the situation, noting that “they were wrong in thinking it would affect the neck”, rather it would translate into the shoulder blade and might cause a palsy.<sup>74</sup>

In each exchange, Symcotts was careful to maintain his medical authority by challenging Powers’ domestic ideas about illness and medicine, and those of his friends. When Powers expressed a liking for a particular treatment of his own, Symcotts criticised his traditional medical remedies, writing “the ancient conceit of it is but a fancy” only to be found in almanacs and, “you did ill to give fuel thereto...I guess the pledging of others’ healths endangered your own.”<sup>75</sup> Powers was certainly able to voice his opinions and exercise agency; however, those opinions often constituted evidence of his own fears and uncertainties, which were usually allayed by reassurance from Symcotts. Powers clearly felt obliged to follow Symcotts’ more authoritative medical advice rather than trust his own power-to-act.

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<sup>73</sup> Symcotts, *Diary*, 20.

<sup>74</sup> Symcotts, *Diary*, 23.

<sup>75</sup> Symcotts, *Diary*, 25.

Demonstrating the reciprocity of their relationship, there were times when Powers needed Symcotts' medical help and times when Symcotts needed Powers' help. This was particularly the case when it came to maintaining Symcotts' medical authority and position in the local medical hierarchy. Powers occasionally asked other medical practitioners for their advice and when Symcotts became aware of this he wrote to Powers about one of these doctors. "For your Doctor his advice, I like it not; such rowelling, drawing and slabbering smells too much of his barber's shop from whence he went out Doctor."<sup>76</sup> In a subsequent comment that highlighted the alternate dependency and ascendancy of both doctor and patient in this long-term relationship, Symcotts cajoled Powers to "pray stop the rumour", after he had heard that "your Doctor there is much offended with me for inveighing against him."<sup>77</sup> In an effort to rise above a situation where he was seen to be bickering with another medic, Symcotts wrote of the other doctor "I think him worthy of contempt, not of opposition." The decision to write to Powers about this matter came from Symcotts desire to protect his medical reputation in the community.

Richard Powers was highly dependent on Doctor Symcotts' advice and respected his stature as a doctor, so he became very agitated when he had to deal with the doctor's assistant, Gervase Fullwood. Symcotts endeavoured to explain to his patient and friend that he was not always available to attend to Powers' needs, ending many letters explaining how busy he was after being called upon by others, writing in "extreme haste and can write no more now."<sup>78</sup> Powers obviously regarded

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<sup>76</sup> Symcotts, *Diary*, 28.

<sup>77</sup> Symcotts, *Diary*, 28.

<sup>78</sup> Symcotts, *Diary*, 26, 29.

Fullwood as an inferior individual in the local medical hierarchy. On the occasions when Fullwood wrote on Sycmotts' behalf, Powers was reluctant to take any of the recommended medicine and when he did, he was reticent to give praise for its effects. Fullwood always took care to preface his letters with "the doctor advises you to..." and "I have now at length spoken to the Doctor and he wishes you to...", so that Powers would more readily accept advice that he understood as having come from Sycmotts.<sup>79</sup> Fullwood's coaxing often failed miserably. Once, Fullwood took the liberty of sending some medicines of his own choosing and promised that "when the doctor comes I will show him your letter and if he thinks anything further requisite for you, you shall not want the best supply."<sup>80</sup> The medication Fullwood sent only brought complaint from Powers. "This physic put me to intolerable pain and gripings in my breast, back, stomach and sides...[and] made the top of my foot swell and to itch exceedingly."<sup>81</sup> He demanded, "the doctor must amend Fullwood's stuff" because "I had neither ease nor sleep...but lay in miserable torments."<sup>82</sup> When Sycmotts replied with alternative instructions, Powers happily returned; "This physic did me much good."<sup>83</sup> It appears this dose of medicine did him good because it was the doctor who prescribed it and not his assistant, Fullwood, thereby indicating Sycmotts' medical authority and the respect that Powers held for him and his advice.

The doctor was often kind and compassionate towards his patient and provided gentle and comforting remedies such as "to strengthen the brain I have

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<sup>79</sup> Sycmotts, *Diary*, 36.

<sup>80</sup> Sycmotts, *Diary*, 37.

<sup>81</sup> Sycmotts, *Diary*, 37.

<sup>82</sup> Sycmotts, *Diary*, 37.

<sup>83</sup> Sycmotts, *Diary*, 38.

prescribed a quilt of sweet powders to be worn continually, especially at night.” He displayed concern and sympathy for his patient by considering what might suit Powers’ emotional needs as well as his bodily needs. Symcotts was a busy man yet he made sure his patient was satisfied with his administrations. Occasionally, Powers complained about the cost of medicines and Symcotts argued with him “I much wonder you should yet so much question the dueness of 4s 8d...for the most part you deceive yourself.”<sup>84</sup> And so it continued back and forth and to and fro in this dynamic and shifting exchange.

Long-term medical relationships required mutual investment by both patient and doctor to enable the relationship to continue. Lucinda Beier interpreted Symcotts’ and Powers’ correspondence as patients knowing “a good deal about their own ailments” and taking “a large amount of responsibility in their courses of treatment.”<sup>85</sup> Their relationship was held up as an example of early modern patient power because Powers questioned Symcotts over prescribed treatments and argued over their efficacy.<sup>86</sup> While this is true to some extent, it only explains one aspect of their relationship and ignores others. When their relationship is interpreted as a dynamic-equilibrium, it is possible to recognise the many and varied factors at play that can be hidden by the display of individual agency.

There was a definite distinction between Powers homely and simple domestic medical remedies and Symcotts’ complex recipes and instructions. Although Powers

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<sup>84</sup> Symcotts, *Diary*, 34.

<sup>85</sup> Beier, *Sufferers and Healers*. 129

<sup>86</sup> Beier, *Sufferers and Healers*; Frederick George Marcham, “Letters of an English Physician in the Early Seventeenth-Century”. *Isis* 16, 1 (1931): 55-81, 57.

was particularly dependent on Symcotts advice, on the occasions that Powers resorted to self-treatment he was sometimes lucky, as when he “took green ginger and that expelled the wind in one day and did me more ease than all my physic.”<sup>87</sup> Symcotts responded to some of his homely remedies by criticism, advising to “drink nothing but cold milk, for hot beer is to you a poison”, and further cautioning, “what mischief bleeding might do, anyone may imagine.”<sup>88</sup> He also warned Powers “if you should rest upon strong scurvy grass ale you would soon see what a broken staff you leaned on.”<sup>89</sup> Symcotts’ prescriptions were particularly detailed and contained instructions such as steeping powders in a cool place in a stone jug for two or three days, drinking this or that mixture every morning and always taking warm broth afterwards. Powers had to mix and rub ointments and powders, applying certain ones to the temples, while others had to be gargled at four o’ clock every day. They were detailed treatments that Powers followed carefully and precisely.

The Symcotts-Powers correspondence brings to light the medical authority of the early modern doctor, rather than the agency of the patient. Even when agency can be observed on the part of Powers, Symcotts can be found justifying his own actions, explaining the intricacies of humoral medicine, giving detailed accounts of symptoms and diseases, and stating how cordials worked. He ridiculed, but occasionally congratulated Powers’ “ignorant neighbours”, condoned some of Powers’ medical thinking, and corrected his errant use of medical language. Powers deferred to Symcotts’ judgment on almost all occasions.

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<sup>87</sup> Symcotts, *Diary*, 37.

<sup>88</sup> Symcotts, *Diary*, 43.

<sup>89</sup> Symcotts, *Diary*, 43



## CONCLUSION

Long lasting doctor-patient relationships like those of Baxter, Conway and Powers, demonstrate that early modern doctors were genuinely valued for their medical advice. Chronic disease forced doctors to rely more heavily on their caring abilities than their curing abilities. Patients may have had the power-to-act at various stages of the association but, overall, the terminology of a dynamic-equilibrium can better express the machinations of the medical relationship and encompass all its salient features. In complex negotiations, initiated primarily by the existence of illness, social expectations and cultural conventions played out and influenced how the doctor-patient relationship proceeded. Relationships could last from childhood until old age. There can be little doubt that many patients, and the communities to which they belonged, generally appreciated the help of many different types of medical practitioners, but the representation of patient agency as patient power has ignored many of the factors that played a role in medical decision-making. The model of a dynamic-equilibrium has the potential to encompass a whole range of factors that are seen to be relevant to the doctor-patient encounter. This chapter has barely scratched the surface by suggesting that religion, gender, patriarchy, friendship, gossip, and reputation were some of the factors that influenced agency in ways that are not always observable but, nevertheless, played a significant role in determining the processes of early modern medical encounters.

## CONCLUSION

This thesis provides a new historical assessment of the relationship between early modern medical practitioners and their patients. The contribution to knowledge it makes is to present the guiding principle of “a medical dynamic-equilibrium” to replace the terminology of “patient power”. “Patient power” is a term that has often appeared in studies on early modern medicine, however, as conceptualisations of power have evolved, the phrase has become increasingly ambiguous. What exactly does *power* mean? If power was supposed to mean personal *agency* or an *ability-to-act* then such power should be attributed to patients and doctors alike. If it is meant to adhere to its pre-Foucauldian interpretation of dominance, or *power-over*, then doctors can also be found directing medical treatments and dictating their patients’ behaviour. The continuing use of the word *power* has proved limiting for explaining the reality of medical encounters, which were far more complex than such terminology implies. The totality of medical relations was full of light, shade, and nuance, and was influenced by many factors not directly related to individual power. The model of *a medical dynamic-equilibrium* can allow these wide-ranging social factors to assume their relative contribution in understanding the processes of medical relationships.

To highlight the many factors that impinged on the medical relationship, a new conceptualisation of power was articulated in the Introduction. Using major works in the field of power studies, a new conceptualisation of power was articulated, which was comprised of a complex labyrinthine network of social relations that recognised the influence of reputational power, structural power, and

their effects on the processes of decision-making. It also encompassed the forces of emotion, seen by some as the conceptual twin of power, as emotions clearly drive power relations in many ways. It also incorporated factors such as gossip and other communication processes, and the way social legitimations are engineered through suggestions and behaviours. This new conceptualisation of power highlighted the complexity of power relations and demonstrated that interpreting power simply as agency can prove to be thoroughly misleading.

The complexity of power and the inadequacy of the word “power”, which was now overburdened with meaning, prompted the introduction of new terminology, namely, “a medical dynamic-equilibrium”. It represents the many competing and opposing socio-relational forces in early modern society that all had the potential to influence medical decision-making in various ways. Power can no longer be explained as, or restricted to, straightforward agency, as the mechanisms of power relations are now seen to work in enigmatic and sometimes inexplicable ways. The early modern medical relationship was decidedly unpredictable and what might have been expected to occur in certain situations was not always what ensued. In other words, it represented a dynamic-equilibrium where outcomes were frequently uncertain and changeable depending on dynamic influences of socio-relational networks.

Chapters have each addressed particular features of the doctor-patient relationship that establish how social entanglements produced complexity within networks. The first chapter answered one of the claims at the core of patient power - that the patient’s ability to choose a doctor in the medical marketplace was a

representation of their power. It demonstrated that patients were at the mercy of doctors who might deceitfully portray themselves in ways that did not match their ability or practice, thereby contradicting what seems to be a straightforward claim that the ability to choose was an expression of early modern patient power.

Moreover, patient action did not solely drive choice, but was guided by how doctors advertised their own value and how medical reputations stood in the community. The obvious diversity of early modern doctors and the difficulties experienced by patients in selecting the best person to meet their requirements, demonstrates that choice was a liability that had the potential to cause harm. Portraying choice as simply shopping in the medical marketplace does not do justice to a matter that could prove the difference between life and death and required keen consideration.

Another important feature of the relationship to be examined was the effect of illness on the medical decision-making process. When the words and actions of severely sick patients are interpreted as patient power, little attention is given to their vulnerabilities, such as their inability to act while lying on the sickbed, their dependence on others and their emotionally crippling fear of impending death. The triviality or severity of an illness was a major factor that compromised those who were seriously ill or dying. The volatility of illness put both doctors and patients at its mercy, and the varied effects and circumstances it produced are important features of any medical relationship. How the fears of illness shaped the relationship between patients and their doctors needs further exploration and discussion, and can open up a new area of research to produce a richer understanding of the interface of power relations within medicine.

Thus, the first two chapters in Part I examined the fundamentals of the medical relationship, the doctor, the patient, and the illness. Three chapters in Part II followed an alternative thematic analysis, taking their cue from the seventeenth-century phraseology of “cure, death or otherwise.” Besides cure, death and chronic illness, the model of a *dynamic-equilibrium* readily embraces any topic relevant to the medical relationship, enabling researchers to examine diverse features of the doctor-patient relationship. The contributory findings from each disparate strand of inquiry have the potential to augment the overall model. For instance, the chapter on “Cure” found that cure had specific meanings that were particular to seventeenth-century culture and understanding. On an augmented level, this finding implies that early modern patients had good reason to consult their doctors when seeking a cure; therefore, patients were more reliant on doctors than previously supposed, and not quite as powerful as they have sometimes been depicted. Similarly, the chapter on “Death” demonstrated that doctors were more likely than patients to have the necessary skills to diagnose and predict death. The importance of the doctors’ role at the deathbed brings into focus how exposure to death shaped the understanding and lived experiences of medical relationships. An aspect that emerges from the sum of the two chapters on “cure” and “death” is that hindsight can sometimes be a problem in the social history of medicine when early modern medical experiences are emphasised by comparisons with modern medicine.

The final chapter “Otherwise” illustrated how participants relied on long-term medical advice when they suffered from chronic disease. The medical activities of Baxter, Conway, Symcotts and Powers, all demonstrate that individual medical

relationships were influenced by a range of socio-relational factors that ensured dynamic outcomes. Factors such as religion in the case of Baxter, and gender and patriarchy in the case of Conway, indicated how structural power within socio-relational networks could obstruct or quash individual agency. Symcotts' and Powers' exchanges implied a symbiotic medical relationship, where Powers needed Symcotts for medical help and Symcotts needed Powers to help maintain his reputation. There was complaint, persuasion, justification and cooperation, on both sides of this dynamic-equilibrium.

In every era, almost every facet of medicine requires equilibrium yet is dynamic. Medical treatments necessitate a fine balance between their harmful and beneficial properties. Palliative care depends upon balancing the quality of life with the time left to live. Doctors have to balance their communication skills with their medical abilities, because one without the other can result in misunderstandings and poor quality care. Parents need to balance the demands of the rest of the family with the requirements of a sick child. Patient satisfaction is often contingent on the amount of attention and the number of procedures given by the doctor, yet too much or too little of either can prove unsatisfactory. The new terminology of a medical dynamic-equilibrium can provide a common vision that enables researchers to account for all manner of themes and players within the medical relationship.

There are endless factors, themes and categories that can emerge from research on early modern medicine and the doctor-patient relationship. Original and innovative conceptualizations can help to build a substantial theoretical framework and provide synergy to the aims and outcomes of current research. While there are

always flaws in any design model, flaws can also lead to further understanding. As Sharan Merriam points out, qualitative research is mostly “holistic, multidimensional, and ever changing; it is not a single, fixed, objective phenomenon waiting to be discovered, observed and measured.”<sup>1</sup> This is evident in modern interpretations of the doctor-patient relationship, which have followed various models of interaction over the years. For instance, the *paternalistic* model of medical interaction sees the doctor dictate the patient’s treatment, while the *informative* model sees the doctor offer the medical facts while the patient decides what to do. In the *interpretive* model the doctor actively helps the patient to choose the best treatment, and in a *deliberative* model the doctor is the patient’s teacher and friend and takes into account the patient’s emotional as well as medical needs, in a holistic approach.<sup>2</sup> *Triangulation theory* is yet another complex model in which each of three participants in any medical relationship can make alliances in opposition to the third. For example, the sick person and a family member may oppose the doctor’s recommendations. This model continues the focus on power relations by continually recognising antagonism between participants and showing less sensitivity to altered circumstances and new developments that can engender teamwork.<sup>3</sup> All of these models relate to *power* of one sort or another, whereas the model of a dynamic-equilibrium recognises issues of power as agency but encompasses cooperation,

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<sup>1</sup> Sharan B. Merriam, *Qualitative research: A Guide to Design and Implementation* (San Francisco: Wiley, 2009) 213.

<sup>2</sup> Ezekiel Emanuel and Linda Emanuel, “Four Models of the Physician-Patient Relationship,” *Journal of the American Medical Association* 267, 16 (1982): 2221-2226, 2222.

<sup>3</sup> Johanna Shapiro, “Using Triangulation Concepts to Understand the Doctor-Patient-Family Relationship,” *Families, Systems & Health* 19, 2 (2001): 203-210. 204.

collaboration and reciprocity. In short, it demonstrates how medical relationships function in light of the full gamut of socio-relational networks and the inherent features that keep them circulating continuously.

Health researchers continue to discuss issues of patient empowerment; however, discourse over *power* is problematic, as it still mainly represents power as dominance. Calls for patients to receive the necessary knowledge, attitudes and skills, to make personal choices and participate in their own health care, are undermined by the vocabulary of power and empowerment. Using innovative language and devising alternative terminology can help doctors and patients to perceive themselves as working together and not in opposition to each other. In actuality, doctors and patients constantly work together, but the interpretative framework of power can frustrate their achievements by creating an atmosphere of “us and them.” Interpreting the doctor-patient relationship through the model of a medical dynamic equilibrium can be advantageous for past, present, and future studies, in all medical eras.



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