

# Knowledge and Practice in English Medicine, 1550–1680

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## CHAPTER I

### *Setting the scene*

#### INTRODUCTION

This chapter gives the background and context to the rest of the book.<sup>1</sup> It sets out some of the basic findings of historical demographers on mortality and morbidity in early modern England (c.1550–c.1700). It then sketches in the wide range of medical provision patients could use as described by recent work in the social history of medicine, and discusses how medicine co-existed with the other healing main resource, religion. Finally, the texts that communicated medical knowledge and practice are considered. Most were written in English and this helped to create a literate medical culture that both recognised popular–elite distinctions and accepted that educated lay people and practitioners could share in a common medical culture.

#### LIFE AND DEATH

Our Clocks of Health seldome go true: those of Death more certaine than beleevd.<sup>2</sup>

Medical writers and practitioners in the early modern period lived in a world where disease and death were ever present, or so it seemed. Death was highlighted in the Christian teaching that emphasised the need to be constantly prepared for death. Illness was ‘the messenger of death’, and the devout declared that ‘every day shall be as my dying day’.<sup>3</sup> However, not all age groups were equally at risk of dying.

<sup>1</sup> And it should help those readers not already well acquainted with the recent social history of medicine in early modern England.

<sup>2</sup> Stephen Bradwell, *Helps for Suddain Accidents* (London, 1633), sig. A3<sup>r</sup>.

<sup>3</sup> Robert Yarow, *Soveraigne Comforts for a Troubled Conscience* (London, 1634), p. 406; Robert Horne, *Life and Death, Foure Sermons* (London, 1613), cited in A. Wear, ‘Puritan Perceptions of Illness in Seventeenth Century England’ in R. Porter (ed.), *Patients and Practitioners: Lay*

Death especially dogged the footsteps of the young. Early modern England had higher infant mortality rates than many Third World countries today, although those in continental Europe and Scotland were worse. Of a thousand babies born alive, around a hundred and sixty would be dead by the end of their first year. Life expectancy at birth in the period 1600–49 was 36.4 years; however, if childhood was safely navigated, then a long life was on the cards. Expectation of life for both men and women at age thirty was about another thirty years.<sup>4</sup>

Geography and social status helped determine an individual's chances of life. Towns and cities generally had higher mortality rates than the countryside. For instance, the parish of Hartland in Devon enjoyed the lowest mortality rates so far discovered in early modern England. Its infant mortality was below 100 and life expectancy at birth was more than 55 years; such figures were, as E. A. Wrigley points out, 'attained nationally only about 1920'. Hartland was relatively isolated, bounded on two sides by the sea, and far from major roads, its 1,000–1,500 inhabitants living in widely spaced houses and farms.<sup>5</sup> Cities and towns, on the other hand, had high density populations and housing, and were usually centres for trade and communication routes that also brought in diseases. In urban areas the lack of effective sewage disposal led to more illness than was the case in the less crowded countryside, and clean water supplies were less available in the towns. Morbidity and mortality flourished in such conditions. Small towns suffered worse death rates than their surrounding countryside. The populations of cities such as York, Bristol, Norwich, Newcastle and, most famously, London, were not self-sustaining and only the constant inflow of people from the countryside allowed them to grow.<sup>6</sup> However, some parts of the

*Perceptions of Medicine in Pre-Industrial Society* (Cambridge University Press, Cambridge, 1985), p. 64, and see pp. 61–70 generally.

<sup>4</sup> R. A. Houston, *The Population History of Britain and Ireland 1500–1750* (Macmillan, London, 1992), pp. 50–1; E. A. Wrigley and R. S. Schofield, *The Population History of England 1541–1871* (Edward Arnold, London, 1981), pp. 250–3; Michael Flinn (ed.), *Scottish Population History from the Seventeenth Century to the 1930s* (Cambridge University Press, Cambridge, 1977).

<sup>5</sup> E. A. Wrigley, 'No Death Without Birth: the Implications of English Mortality in the Early Modern Period' in R. Porter and A. Wear (eds.), *Problems and Methods in the History of Medicine* (Croom Helm, London, 1987), pp. 137–8.

<sup>6</sup> Wrigley, 'No Death Without Birth', pp. 136–7; R. A. Finlay, *Population and Metropolis: the Demography of London, 1580–1650* (Cambridge University Press, Cambridge, 1981), pp. 51–69.

countryside were unhealthy, especially the marshy and estuarine areas of the south-east of England where 'agues' or malaria and water-borne diseases flourished and infant mortality was as high as 250–300 per 1,000.<sup>7</sup>

Social differences showed themselves in the mortality statistics. The poor, who almost by definition lived in the unhealthiest parts of towns, fared worse than the rich. In the well-to-do central London parishes life expectancy was 35 years at birth, whilst in the poor densely populated suburban parishes it was almost a third lower and infant mortality was also higher.<sup>8</sup> Of a thousand live births in the period 1580–1650, 631 children survived to the age of fifteen in the wealthy parish of St Peter Cornhill, but only 508 in deprived Allhallows between 1570 and 1636.<sup>9</sup>

Expectation of life was almost identical for both sexes,<sup>10</sup> although women certainly faced the additional dangers of childbirth. If they experienced six or seven full-term pregnancies they ran a 6 or 7 per cent risk of death in childbirth. Maternal mortality caused up to 20 per cent of all female deaths between the ages of 25 and 34, and 11–14 per cent for women aged between 20 and 24 and 35 and 44, but these were the age groups when women's overall mortality, like men's, was relatively low.<sup>11</sup>

#### DISEASES

Given four hundred years' difference in the diagnosis and classification of disease, the diseases of early modern England are less easily identified and quantified in modern terms. Although the use of modern disease labels often hinders an understanding of how

<sup>7</sup> Mary Dobson, 'Mortality Gradients and Disease Exchanges: Comparisons from Old England and Colonial America', *Social History of Medicine*, 2, 1989, 265, and *Contours of Death and Disease in Early Modern Europe* (Cambridge University Press, Cambridge, 1997), pp. 176–7, and pp. 81–220 for mortality in general in south-east England.

<sup>8</sup> Houston, *Population History*, p. 50; Finlay, *Population and Metropolis*, pp. 107–8.

<sup>9</sup> Finlay, *Population and Metropolis*, pp. 171, 168, 107.

<sup>10</sup> Houston, *Population History*, pp. 52–3. There has been, in Houston's view, an inconclusive debate as to whether the female infants born to a family that already had a number of children were neglected and suffered a higher mortality than male.

<sup>11</sup> Houston, *ibid.*, p. 56, points out that a village of 1,000–1,500 population, of which a quarter were women aged 15–49, 'would experience only one maternal death on average every third year', and that higher female mortality should be balanced by higher male mortality in the same years due to occupational risks such as coal-mining in north-east England, etc.; also Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660–1770* (Harvard University Press, Cambridge, Mass., 1995), pp. 18–19.

diseases were perceived in the past (see chapter 3), they have been frequently employed to draw the demographic map of disease and death in early modern England, an enterprise that is self-consciously based on modern methods and categories. Acute infections undoubtedly accounted for many deaths. Gastro-enteric infections such as dysentery, typhoid, salmonella and 'fluxes' or undifferentiated diarrhoeas were prevalent, as were the respiratory infections of whooping-cough, diphtheria, scarlet fever, influenza, smallpox and typhus. Many of the very young were culled by these diseases, while smallpox was more deadly to children over two.

In addition, periods of very high mortality, or short-term mortality crises (defined as an average yearly mortality at least 10 per cent above the expected trend, or at least a 25 per cent rise in the monthly total above the trend, where often it rose above 100 per cent), produced enormous social, economic, cultural and psychological devastation. Between 1550 and 1750 England suffered thirty-seven periods of crisis mortality.<sup>12</sup> Plague, one of God's three arrows along with war and famine, was a major cause. After the initial pandemic of 1347–1351, when a third of Europe's population died, it continued to visit different areas in a series of epidemics. Death rates in the subsequent epidemics were lower but still high. In sixteenth- and seventeenth-century England at least 10 per cent of an affected population would die in a year in a plague outbreak; around a fifth of London's population died in the plagues of 1563, 1603, 1625 and 1665 (mortality was less in 1578, 1593 and 1638), whilst a third of the population of Norwich died in 1579 and even more in Newcastle in 1636 and in Colchester in 1666.<sup>13</sup> However, given that England was still a rural country and that plague was largely an urban disease, the overall national figures were lower.<sup>14</sup>

Another of God's arrows, famine, was less prevalent than in continental Europe where famine years were frequent up to the mid-eighteenth century. In England, crises of subsistence affected parts of the north and isolated areas of the south in 1596–8 and 1623–4, but after the mid-seventeenth century famine had largely left England. Agricultural innovations, for instance, no longer relying on one grain crop, the spring sowing of oats and barley to supplement

<sup>12</sup> Wrigley and Schofield, *Population History*, p. 333.

<sup>13</sup> Paul Slack, *The Impact of Plague in Tudor and Stuart England* (Routledge & Kegan Paul, London, 1985), pp. 14–16, 145–51; Finlay, *Population and Metropolis*, pp. 17, 112.

<sup>14</sup> Slack, *Impact*, p. 16; Houston, *Population History*, p. 55.

winter sowing, and the establishment of a unitary market for grain, helped eradicate large-scale starvation.<sup>15</sup> However, regular as opposed to extraordinary levels of starvation continued to be suffered by small numbers of the poor even in times of plenty.<sup>16</sup> Nevertheless, the poor suffered disproportionately from infectious diseases. Plague came to be associated with the poor and their living conditions (see chapters 6 and 7).<sup>17</sup> Typhus, which entered Europe at the end of the fifteenth century, was a disease of prisons ('gaol fever'), hospitals and armies, and also spread through the crowded slums of the poor. However, except for the impressions of contemporary observers, there is no precise data differentiating levels of morbidity between the rich and poor.

Apart from plague, it was the 'pox', which probably included modern syphilis, that had the greatest cultural and psychological impact, although its impact on mortality levels was small. Plague had been the great 'new' disease of the Middle Ages; in the Renaissance it was the pox (how it was understood and treated is discussed in chapter 5). Other novel diseases such as the 'English sweat,' which appeared in 1485, left after 1551, and may have been influenza, and a variety of strange fevers added to the uncertainty of a world already overfilled with familiar diseases.<sup>18</sup>

It was only in the period 1850–1950, when England and then the rest of Western Europe went through 'the demographic transition' from high to low infant and childhood mortality, that the major

<sup>15</sup> J. Walter, 'The Social Economy Dearth in Early Modern England' in J. Walter and R. Schofield (eds.), *Famine, Disease and the Social Order in Early Modern Society* (Cambridge University Press, Cambridge, 1989), pp. 75–128; Massimo Livi-Bacci, *Population and Nutrition* (Cambridge University Press, Cambridge, 1991), pp. 50–62.

<sup>16</sup> John Graunt, *Natural and Political Observations . . . Upon the Bills of Mortality*, 5th edn (London, 1676), p. 25: 'starved' was one of Graunt's 'accidents of life'; from the bills of mortality, which were compiled from the weekly returns by London's parish clerks of numbers of deaths and their causes, Graunt calculated that in fourteen years 51 people had been certified as dead in London due to starvation.

<sup>17</sup> Slack, *Impact*, p. 153, notes that by the seventeenth century the topography of plague was clearly biased towards the poor areas of London.

<sup>18</sup> Lloyd G. Stevenson, "'New Diseases" in the Seventeenth Century', *Bulletin of the History of Medicine* 39, 1965, 1–21; cf. also Henry Whitmore, *Febris Anomala Or, The New Disease that Now Rageth Throughout England* (London, 1659). There has been a recent debate on what the English sweat really was: A. Dyer, 'The English Sweating Sickness of 1551: an Epidemic Anatomised', *Medical History*, 41, 1997, 362–84; M. Taviner, G. Thwaites and V. Gant, 'The English Sweating Sickness, 1485–1551: a Viral Pulmonary Disease?', *Medical History*, 42, 1998, 96–8. J. R. Carlson and P. W. Hammond, 'The English Sweating Sickness (1485–c.1551): a New Perspective on Disease Aetiology', *Journal of the History of Medicine and Allied Sciences*, 54, January 1999, 23–54.

causes of death shifted from acute infectious diseases to the chronic degenerative diseases of middle and old age, and the expectation grew that only the elderly faced a real threat of death. However, in early modern England chronic illness was also present, though unquantifiable. Cancers, heart disease, arthritis, gout and paralysis could slowly and painfully handicap life, as could psychological conditions such as melancholy, and even conditions such as thrush, which today seem minor, could cause constant trouble for years.<sup>19</sup>

A question that springs to mind from the perspective of the twenty-first century is whether early modern 'medicine' addressed itself to the three great health problems that are apparent from the findings of historical demography: high infant and child mortality, the allied threat of infectious diseases and the higher mortality of the poor.<sup>20</sup> With the exception of plague, and to a lesser extent the pox, English governments did not initiate any action against diseases.

<sup>19</sup> See, for instance, Samuel Jeake of Rye who complained of oral thrush that lasted for many years: 'About this time I began to be troubled with a white pertinacious Thrush in the upper Jaw within side in the Mouth, which gradually slowly encreased, & all means I used proved ineffectuall. I could never be cured of it; but it was without pain, & not very much till 4 or 5 years after': Michael Hunter and Annabel Gregory (eds.), *An Astrological Diary of the Seventeenth Century: Samuel Jeake of Rye 1652–1699* (Clarendon Press, Oxford, 1988), p. 194. On madness see: Michael MacDonald, *Mystical Bedlam, Madness, Anxiety and Healing in Seventeenth Century England* (Cambridge University Press, Cambridge, 1981); R. Porter, *Mind Forged Manacles: Madness and Psychiatry in England from Restoration to Regency* (Athlone, London, 1987; Penguin, Harmondsworth, 1990).

<sup>20</sup> To argue that 'medicine' should have addressed itself to the demographic facts of death is also to misunderstand how those facts were changed. The demographic transition phase was largely due to a combination of public health measures rather than better medical treatments: better sanitation, clean water supplies, improved diet and working conditions. It was pushed through by political rather than medical action, though doctors were involved and there were some medical developments such as vaccination and the later discovery of sulphur drugs and antibiotics that were important for reducing smallpox deaths and maternal mortality. Moreover, it was not until the twentieth century that British governments envisaged the provision of universal health care through insurance schemes or from general taxation, which meant that for the first time the health of the different parts of the population came under government scrutiny. I. Loudon, 'On Maternal and Infant Mortality, 1900–1960', *Social History of Medicine*, 4, 1991, 29–73; Loudon, 'Deaths in Childhood from the Eighteenth Century to 1935', *Medical History*, 30, 1986, 1–41; Loudon, 'The Transformation of Maternal Mortality', *British Medical Journal*, 305, 1992, 1557–60; Loudon, *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality, 1800–1950* (Clarendon Press, Oxford, 1992); A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856–1900* (Clarendon Press, Oxford, 1993); A. Hardy, 'Smallpox in London: Factors in the Decline of the Disease in the Nineteenth Century', *Medical History*, 27, 1983, 111–38; S. R. S. Szreter, 'The Importance of Social Intervention in Britain's Mortality Decline c.1850–1914: a Re-interpretation of the Role of Public Health', *Social History of Medicine*, 1, 1988, 1–37 and 'Mortality in England in the Eighteenth and Nineteenth Centuries: a Reply to Sumit Guha', *Social History of Medicine*, 7, 1994, 269–82.

Further, they seem to have been blind to the young as a high-risk group, which is understandable as quantified mortality statistics did not exist, and in any case England appeared healthier than neighbouring France.<sup>21</sup> They could have made existing medical expertise and treatment more widely available, but only during the English revolution was such action envisaged and even then not at government level. Moreover, what action could they have taken? Pouring funds into medical research on infectious diseases? That would have been difficult in 1550 when, it was claimed, the best medical knowledge was to be found in the works of Greek and Roman medical writers, with 'research' lying either in the retrieval of that knowledge in its purest form or in its refinement. In any case, it was not until the later seventeenth century that the state, especially in France, supported medical research. The role of the state was limited to action against the contagious diseases of the plague and the pox where it initiated isolation and public health measures (plague being seen as both a contagious and an environmental disease). 'Research' by individuals searching for curative remedies did take place. However, there was a widespread realisation that in the absence of medical trials (see chapter 8) it was well nigh impossible to know for sure if a remedy was effective:

It is a great Question what does the cure, the Vulgar [the public] will tell you the last thing they took did the cure, as the last thing they did caused the disease; Some Physicians will ascribe it to the rarity and dearnesse, others to the variety and composition [of the remedies], others to the fitnessse and order [of the treatment] etc. others think it is not Physick or Physicians, but Nature being disburthened returns to her functions by degrees . . . And some adde, that it is not Nature but the God of Nature

<sup>21</sup> On attitudes to children see: L. Stone, *The Family, Sex and Marriage in England 1500–1800* (Weidenfeld & Nicolson, London, c.1977), especially pp. 64–81 on infant mortality; Linda Pollock, *Forgotten Children: Parent–Child Relations from 1500 to 1900* (Cambridge University Press, Cambridge, 1983); Philippe Ariès, *Centuries of Childhood* (Penguin, Harmondsworth, 1979). Medical treatises on infant health include: James Guillemeau, *Childbirth, or the happie delivrie of women. Wherein is set downe the gouvernement of women . . . together with the diseases which happen to women. To which is added, a treatise of the diseases of infants, and young children: with the cure of them. Written in French by Iames Guillemeau* (London, 1612); Robert Pemell, *De morbis puerorum, or, a treatise of the diseases of children; with their causes, signs, prognosticks, and cures. For the benefit of such as do not understand Latine tongue, and very useful for all such as are house-keepers, and have children . . .* (London, 1653); Gualtero Harris, *De morbis acutis infantum* (London, 1689); Walter Harris, *A treatise of the acute diseases of infants. To which are added, medical observations on several grievous diseases [and 'Of the venereal disease']*. Written originally in Latin by the late learned Walter Harris . . . Translated into English by John Martyn (London, 1742).

which heals us, and as the Proverb is, God heals, and the Physician hath the thanks.<sup>22</sup>

The diseases that affected the young and the poor were not the subject of any concerted campaign whether by medical practitioners, the government or the public. Medicine, as we shall see, was largely practised by individuals who were paid by individual patients, and their horizons were necessarily foreshortened. Medical institutions, the usual foci of concerted action, did exist but were few in number and membership. Moreover, though there were specialist practitioners for the pox, cutting for kidney and bladder stones, for eye problems and for setting bones, most practitioners were generalists rather than specialists. This is one reason why the question of medical research on the demographic fault lines of early modern England is misconceived though illuminating.

#### THE SICK POOR

A distinction has to be made between welfare and medical treatment. As part of the parish welfare support the poor sometimes had their treatment paid for them; and the English governing elite did concern itself with the welfare of vulnerable groups. For the young it set up charitable institutions such as Christ's Hospital in London, encouraged parishes to take care of foundlings through to apprenticeship, and took steps to protect apprentices from abusive masters.<sup>23</sup> The poor, especially, were the focus of attention by the English government and by some medical practitioners and writers. Christianity had originally given the poor a special status as chosen of God, the objects for charitable good works. In the early sixteenth century, they came to be differentiated as either undeserving and dangerous or the deserving, respectable, shame-faced poor: 'A faulte maketh necessitie, in this case of begging, in them, whyche might laboure and serve, and wil not for idlenes: and therefore not to be pitied, but rather to be punished. Necessitie maketh a fault in them,

<sup>22</sup> Henry Edmundson, *Comes Facundus in Via, The Fellow Traveller* (London, 1658), pp. 111–12; see A. Wear, 'Interfaces: Perceptions of Health and Illness in Early Modern England' in R. Porter and A. Wear (eds.), *Problems and Methods in the History of Medicine* (Croom Helm, London, 1987), pp. 240–3, 248–52 on uncertainty in medicine and on the early modern awareness of demographic facts.

<sup>23</sup> Carol K. Manzoni, *Christ's Hospital of London, 1552–1598: 'A Passing Deed of Pity'* (Associated University Presses, London, 1995).

whiche wold labor and serve, but cannot for age, impotency, or sickenes, and therfore to be pitied and relieved.'<sup>24</sup>

Together with a new less positive view of the poor came new ways of funding poor relief. Across Europe, starting early in the sixteenth century in the Low Countries, towns and cities amalgamated charitable funds into single centralised 'common chests' for the poor. Charity became subject to secular regulation; face-to-face charity between individuals continued, though on a decreasing scale. In England, a series of Poor Laws, culminating in that of 1601, uniquely financed poor relief on a national level through rates collected and distributed locally by the parish. Treatment of the sick poor was sometimes contracted out. In Norwich a variety of men and women practitioners and former lazaretto keepers (leprosy having declined) were contracted to cure the poor, the aim being to get them back to work. London parishes often paid the poor to look after the sick poor as well as giving them money to pay for treatment and medicines from practitioners in the commercial medical marketplace.<sup>25</sup> However, only when one was completely penniless was any aid given.<sup>26</sup> Moreover, there had to be a perception that a person could not work, usually because of sickness or the infirmities resulting from old age, for relief to be given. Old age did not by itself make a person eligible for poor relief, though many recipients were old. Men and women were expected to work into very old age if they could. John Ward, the vicar of Stratford-upon-Avon between 1662 and 1681, who practised medicine and took a lively interest in the development of the 'new science' and in medicine generally, noted in

<sup>24</sup> John Caius, 'A Booke or Counsell Against the Disease Commonly Called the Sweate or Sweating Sicknesse' (1552) in *The Works of John Caius MD*, ed. John Venn (Cambridge University Press, Cambridge, 1912), p. 28. See Paul Slack, *Poverty and Policy in Tudor and Stuart England* (Longman, London, 1988); Robert Jütte, *Poverty and Deviance in Early Modern Europe* (Cambridge University Press, Cambridge, 1994). For a seminal essay on the topic see Natalie Zemon Davis, 'Poor Relief, Humanism, and Heresy' in Natalie Zemon Davis (ed.), *Society and Culture in Early Modern France* (Stanford University Press, Stanford, California, 1975), pp. 17–64. Barbara Harvey traces a negative attitude to sections of the poor back to the second half of the fourteenth century in her *Living and Dying in England 1100–1540: the Monastic Experience* (Clarendon Press, Oxford, 1993), pp. 30–3. I am grateful to Professor Nancy Siraisi for this reference.

<sup>25</sup> Margaret Pelling, 'Healing the Sick Poor: Social Policy and Disability in Norwich, 1550–1640', *Medical History*, 29, 1985, 115–37; Andrew Wear, 'Caring for the Sick Poor in St Bartholomew Exchange: 1580–1676' in W. F. Bynum and R. Porter (eds.), *Living and Dying in London, Medical History*, Supplement 11, 1991, 41–60.

<sup>26</sup> The sick poor often pawned their clothes to pay for treatment, and any money they had could be appropriated towards the cost of treatment before a parish released its money; see Wear, 'Caring for the Sick Poor', pp. 48, 50–51.

his diary: 'George Green, of Woodstock, 90 years of age, that will mowe and doe a good days work still', and 'Cripps, of Woodstock, 90 years of age, that works all the yeer as other men doe, hath as much wages; he is wondrous vivacious, and the last two very hard laborers all their time'.<sup>27</sup>

The poor often had to make do with the minimum of medical care. Thomas Fuller, the antiquarian, observed how in Cheshire, 'if any here be sick "they make him a posset [a hot drink of milk, mixed with beer or wine and sugar and spices] and tye a kerchieff on his head; and if that will not mend him, then God be merciful to him"'. But, he added, 'be this understood of the common people, the Gentry having the help (no doubt) of the learned in that profession [medicine]'. The Kent physician Robert Pemell wrote that the poor had to be their own doctors, and he and other practitioners published remedies that the poor could afford.<sup>28</sup> It was up to the individual practitioner whether to charge the poor less, as did 'Dr. Chamberlayne, the man midwife . . . his fee is five pound, yett I heard, if he come to poor people, hee will take lesse'.<sup>29</sup> However, ethical injunctions stressed the need for practitioners to be charitable: young surgeons were urged 'not [to be] to covetous for money, but a good demander, being good unto the poore, let the rich pay therefore'.<sup>30</sup> Nevertheless, organised charitable medical treatment

<sup>27</sup> John Ward, *Diary of the Rev. John Ward, A. M., Vicar of Stratford-Upon-Avon . . . 1648 to 1679*, ed. Charles Severn (London, 1839), p. 136. On Ward see Robert G. Frank, 'The John Ward Diaries: Mirror of Seventeenth Century Science and Medicine', *Journal of the History of Medicine* 29, 1974, 147–79. For a general discussion of old age and work see Margaret Pelling, 'Old Age, Poverty and Disability in Early Modern Norwich: Work, Remarriage and Other Expedients' in her book *The Common Lot. Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Longman, London, 1998); at pp. 140–3, she notes that elderly women when no longer looking after children often went back to work.

<sup>28</sup> Thomas Fuller, *The History of the Worthies of England*, 1st edn 1662, 2 vols, (London, 1811), vol. I, p. 190, quoting William Smith, *Vale Royal*, p. 16. Robert Pemell, *ΠΤΩΧΟΦΡΜΑΚΟΝ . . . Or Help for the Poor* (London, 1650), sig. A3<sup>v</sup>. Richard Hawes, *The Poor-Mans Plaster Box* (London, 1634), p. 10, took the material conditions of the poor into account: 'If the man faln or bruised be so poore that he hath no bed to sweat in, then annoynt him with this following [melted butter, parsley, rue or hearbgrace fried in the butter and strained], and set him for to sweat in horse dung up to the chin, and cover his head with hay . . . but it be neither cleanly, nor chargeable [expensive]'.<sup>29</sup>

<sup>29</sup> Ward, *Diary*, p. 107. Not all practitioners were so charitable. In 1659, for instance, the churchwarden of St Bartholomew's Exchange in London noted that in the case of Widow Hall, one of the pensioners of the parish who needed treatment for a fall, a broken arm and injured head, the overseers of the poor 'were also desired to mediate with Mr. Thicknes in her behalf who required £6 for her cure . . . but he would not abate any thing'; quoted in Wear, 'The Sick Poor', p. 51.

<sup>30</sup> William Clowes, *A Briefe and Necessarie Treatise, Touching the Cure of the Disease Called Morbus Gallicus* (London, 1585), fol. 42<sup>r</sup>.

for the sick poor was not provided until the end of the seventeenth century when the London College of Physicians set up a charitable dispensary. Despite the Christian ethic of the charitable care of the sick, the learned or university-educated physicians especially were viewed as expensive and uncharitable. Remedies for the poor were not only composed of cheaper ingredients than those for the rich (see chapter 2), but the poor were excluded from expensive medical expertise, as one puritan minister and physician advised in the time of plague: 'Let the rich seeke for the godly, wise and learned Physician . . . And let the poorer sort with good advise and counsell (if they can have any) use Master Phares medicines in his short but learned Treatise of the Pestilence, which hee wrote of purpose for the benefit and comfort of the Poor'.<sup>31</sup> Because of the ethic of charity the poor were provided with some medical help that they would not otherwise have enjoyed, but on the whole they were not the object of concerted medical attention, with the exception of Paracelsian and Helmontian physicians (on this, see chapters 8 and 9).

#### MEDICAL PRACTITIONERS

It would be a mistake to think of medical provision only in terms of the commercial medical marketplace and its expensive end at that. Many would have agreed that 'All the Nation are already Physitians, If you ayl any thing, every one you meet, whether man or woman will prescribe a medicine for it.'<sup>32</sup> Social historians of medicine in the past fifteen years have confirmed that medical expertise was widespread across society.<sup>33</sup> Lay medical practice was centred on the family. Patients often treated themselves, and the women members

<sup>31</sup> Henry Holland, *An Admonition Concerning the Use of Physick* (London, 1603), p. 53. The charitable care of the sick was taught by Christianity as one of the six (later seven) corporal works of mercy based on Matthew 25.35–6: 'For I was an hungred, and ye gave me meat [food]; I was thirsty, and ye gave me drink: I was a stranger and ye took me in: Naked, and ye clothed me: I was sick and ye visited me: I was in prison, and ye came unto me.'

<sup>32</sup> Nicholas Culpeper, *A Physical Directory Or a Translation of the London Dispensary Made by the College of Physicians* (London, 1649), sig. A2<sup>v</sup>.

<sup>33</sup> See, for instance, the essays in Roy Porter (ed.), *Patients and Practitioners* (Cambridge University Press, Cambridge 1985); Roy Porter and Dorothy Porter, *In Sickness and in Health: the British Experience 1650–1850* (Fourth Estate, London 1988), and *Patient's Progress: Sickness, Health and Medical Care in England 1650–1850* (Polity Press, London 1989); Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Longman, London, 1998); Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol* (Cambridge University Press, Cambridge, 1991).

of the family especially were the sources of medical knowledge and treatment. Relatives, neighbours and friends also acted as medical advisers. Charitable gentlewomen, clergymen and their wives treated the poor and provided an informal medical service, which some of the learned physicians saw as a threat and which medical reformers in the 1640s took as the prototype for utopian schemes of nation-wide medical provision organised around ministers.<sup>34</sup>

Practitioners who offered cures for money ranged from village wise women or white witches, who were 'in every village, which if they be sought unto, will help almost all infirmities of body and mind', to the expensive physicians at the top end of the medical market.<sup>35</sup> In villages and towns, midwives, usually women who had children and had trained with another midwife, provided medical expertise during births. Only in the last third of the seventeenth century did male midwives or surgeons begin to manage first difficult and then normal deliveries; previously, they had been called in only in desperate situations to extract the dead foetus, though the midwife might do that in any case.<sup>36</sup>

Empirics, mountebanks, herbalists, astrologers and uroscopists offered their services either as itinerants or from fixed locations. They advertised themselves as cheaper than the physicians.<sup>37</sup> In the

<sup>34</sup> Charles Webster, *The Great Instauration: Science, Medicine, and Reform, 1626–1660* (Duckworth, London, 1975), pp. 246–323.

<sup>35</sup> Robert Burton, *The Anatomy of Melancholy*, 1st edn (1621), ed. Floyd Dell and P. Jourdan-Smith (Tudor, New York, 1948), p. 382. Alan Macfarlane, *Witchcraft in Tudor and Stuart England* (Routledge & Kegan Paul, London, 1970), p. 120 confirms Burton, stating that in the county of Essex no village was more than ten miles from the services of a white witch.

<sup>36</sup> Doreen Evenden, 'Seventeenth Century London Midwives: Their Training, Licensing and Social Profile' (Ph.D. thesis, McMaster University, 1991); Hilary Marland (ed.), *The Art of Midwifery: Early Modern Midwives in Europe* (Routledge, London, 1993). For the later seventeenth century see Wilson, *The Making of Man-Midwifery*.

<sup>37</sup> It is difficult to provide an accurate assessment of the fees and costs of medical treatment. A physician's visit to a patient usually cost between ten shillings and a pound. Some physicians made fortunes, others died in penury: Harold J. Cook, *The Decline of the Old Medical Regime in Stuart London* (Cornell University Press, Ithaca, 1986), pp. 58–9. Empirics might charge two shillings for a bottle of medicine, but as unlicensed practitioners they also contracted with patients to cure them. For instance in 1607 Elizabeth Googe complained that 'Moore of Knightsbridge had accepted twenty shillings of her to restore her to health but after forty days of an ordinary diet and frequent purging, she felt no relief'. In the same year 'Doughton, a surgeon, was accused by Mr. Flud, an attorney, because he had made an agreement with him to cure his wife for the sum of twenty pounds . . . but he had done nothing to earn the reward . . . for after a month or two she relapsed into that madness from which she formerly suffered'. In 1640 James Trikey was accused of giving 'Mrs Smith a powder against the stone in the bladder for one whole month . . . he took 15 s[hillings] as a fee and was to receive 3 l [pounds] afterwards'. Clearly, charges for a cure varied enormously; often the money was paid before the cure and on its completion. The method

eyes of the university 'learned' physicians the only other legitimate practitioners apart from themselves were the surgeons and the apothecaries. The physicians viewed them as subordinate and believed that they should be forbidden to practise internal medicine, which the physicians claimed as their own. In reality, not only did lay people, empirics and others constitute important medical resources despite vitriolic attacks on them by physicians and surgeons, but the occupational distinctions set up by the physicians were often ignored. Surgeon-physicians and apothecary-physicians, such as the Exeter apothecary William Dove, who in 1580 was licensed to practise medicine and surgery, were common in the provinces well before the set-piece debate in London in the later seventeenth century as to whether apothecaries could practise medicine (see chapter 9). Moreover, the distinction between barbers and surgeons was frequently broken in London and was non-existent elsewhere in the country.<sup>38</sup>

Numbers of practitioners are difficult to estimate. London attracted them, as the city's large and expanding population (70,000 in 1550, 200,000 in 1600, 575,000 in 1700) provided a ready supply of buyers for the remedies of empirics, and its wealthy citizens could afford the fees of the physicians who 'usually flock up to London (for there is the money)'.<sup>39</sup> The increasingly central role of London in the national economy also meant that patients from the provinces came to the capital to consult physicians and surgeons. Pelling and Webster calculated that in 1600 London, with a population of 200,000, was served by 50 members affiliated to the College of Physicians, 100 surgeons and 100 apothecaries, and a further 250

of payment indicated that a measure of success was expected. However, few charged 'a featherbed cover' which 'a woman called Pople' did in 1599 for a cure. *Annals of the College of Physicians* in the typescript transcription and translation by the Royal College of Physicians (abbreviated as *Annals*), 2, fol. 193a; 2, fol. 199b; 3, fol. 207a; 2, fol. 140a.

<sup>38</sup> Fundamental are: R. S. Roberts, 'The Personnel and Practice of Medicine in Tudor and Stuart England Part I. The Provinces', *Medical History*, 6, 1962, 363–82, esp. 369, and 'The Personnel and Practice of Medicine in Tudor and Stuart England Part II. London', *Medical History*, 8, 1964, 217–34, which discusses the attempts by London surgeons and apothecaries to practise medicine. See also: Margaret Pelling and Charles Webster, 'Medical Practitioners' in Charles Webster (ed.), *Health, Medicine and Mortality in the Sixteenth Century* (Cambridge University Press, Cambridge, 1979), pp. 165–235; Margaret Pelling, 'Medical Practice in Early Modern England: Trade or Profession?' in Wilfred Prest (ed.), *The Professions in Early Modern England* (Croom Helm, London, 1987), pp. 90–128.

<sup>39</sup> Finlay, *Population and Metropolis*, p. 51; Anon., *Lex Talionis Sive Vindictae Pharmacoporum: Or a Short Reply to Dr. Merrett's Book; and Others, Written against the Apothecaries . . .* (London, 1670), sig. D4<sup>r</sup>.

mainly unlicensed practitioners (of whom 60 or slightly fewer were women), not including nurses and midwives. This gives a ratio of one practitioner for every 400 of London's inhabitants, though not every practitioner made a living solely from medicine. In Norwich, which in 1575 had a population of 17,000 at the most, they found a minimum of 73 practitioners, of whom 37 were surgeons or barber-surgeons, many of whom also practised physic or medicine, plus 12 apothecaries, 10 women practitioners, 6 practitioners of physic, 5 university-educated physicians and 3 undetermined, giving a ratio of one practitioner to every 250 or so of the population. Small towns such as Ipswich and King's Lynn had 24 and 15 practitioners respectively in the second half of the sixteenth century.<sup>40</sup> In urban areas at least, England was well provided with medical practitioners. In the countryside, wise women, lay people and the resources of the local town could be drawn upon, whilst a surprising number of licensed medical practitioners and men with medical degrees lived in country areas, though whether they all practised is less clear.<sup>41</sup>

The place where most people were ill was the home. After the Reformation many hospitals were abolished, though a few like St Bartholomew's in London survived or were refounded;<sup>42</sup> but even in the Middle Ages, when hospitals were thick on the ground in England, they did not dominate the medical world as they did in the twentieth century. Hospitals had looked after abandoned children, the poor and vagrants as well as the sick; it was not until the nineteenth century that treatment of the sick became the sole duty of the hospital, and only in the twentieth century did they become the power houses of clinical research and essential to medical careers.

In addition to the patient's house, there were also available small-scale domiciliary facilities for the ill. Sometimes this was an inn near to a practitioner's house. Nursing homes or small informal hospitals were also used for treatment and convalescence. For instance, when Thomas Brockbank caught smallpox in 1691 while a student at Oxford, he was cared for in a nurse's home: 'I sent for my apothecary Hopkins and he told me the smallpox were appearing on

<sup>40</sup> Pelling and Webster, 'Medical Practitioners', pp. 182–8, 225–7; also R. S. Roberts, 'London Apothecaries and Medical Practice in Tudor and Stuart England' (Ph.D. thesis, University of London, 1964).

<sup>41</sup> John H. Raach, *A Directory of English Country Physicians 1603–1643* (Dawsons, London, 1962); see the criticism of Roberts, 'Personnel and Practice . . . Part I', 364–5.

<sup>42</sup> Nicholas Orme and Margaret Webster, *The English Hospital 1070–1570* (Yale University Press, New Haven, 1995), pp. 147–66.

my face. I desir'd him to get a nurse for me which he did, and he accompanied me to her house . . . I grew very ill.' As he recovered, he 'was removed from my old quarters (widow Tipler's in Coach and Horses lane) to Henry Clinches in St. Clements for airing [a change of air was considered beneficial in recovering from illness] where I stayed 1 month at 12/- [shillings] the week. Here I purged and was cleans'd and lay on great expenses.'<sup>43</sup> As well as students far from home care, there were groups like soldiers, sailors, travellers, migrants and those seeking specialised or expert medical care in the metropolis who could not be looked after at home. Nursing homes, embryonic hospitals, catered for their needs. One such was the home of Ellen Wright in the London parish of St Botolph without Aldgate. From at least 1588 to 1599 she took in a variety of sick people and pregnant women, whose presence, either because they were delivered or died there, was recorded by the parish.<sup>44</sup> Surgeons also took patients into their houses or lodged them nearby if they were far from home and needed prolonged treatment (see chapter 5).

The fact that the most serious of illnesses were usually treated at home and the small-scale and specialised nature of semi-institutional care for the sick confirm the individualistic, one-to-one nature of early modern English medicine, centred on transactions between single patients or their families and single practitioners. In such a setting it made sense for medical knowledge to be accessible to lay people as well as practitioners, whereas today institutions like hospitals, the state or professional organisations claim to assess medical expertise and practical skill on behalf of patients.

There were no nation-wide medical institutions. The London College of Physicians, founded in 1518 along the model of the Italian city colleges of physicians, and the London guilds of barbers and surgeons, which were formally united in 1540, were limited to the metropolis. Like other trades, the provincial barber-surgeons,

<sup>43</sup> Thomas Brockbank, *The Diary and Letter Book of the Rev. Thomas Brockbank 1671–1709*, ed. R. Trappes Lomax (Chetham Society, Manchester, 1930), pp. 36–7, 39. On small hospitals or homes for the mad ('mad-houses') see A. Fessler, 'The Management of Lunacy in Seventeenth-Century England: an Investigation of Quarter Sessions Records', *Proceedings of the Royal Society of Medicine*, Section of the History of Medicine, 49, 1956, 901–7; William Parry-Jones, *The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (Routledge & Kegan Paul, London, 1972). A number of Oxford apothecaries seem to have taken the ill into their homes; see T. D. Whittet, 'The Apothecary in Provincial Gilds', *Medical History*, 8, 1964, 245–73, at 258.

<sup>44</sup> For details, see Wear, 'The Sick Poor', 57–8.

who might include physicians, had their own guilds, as in Norwich and York.<sup>45</sup> London apothecaries were members of the Company of Grocers until 1617 when the Society of Apothecaries was established. In the provinces apothecaries either had their own guilds or were part of a composite guild.<sup>46</sup> The training of apothecaries and barber-surgeons was by apprenticeship. Physicians, if they had gone to university in England, would have had to study medicine based on classical sources for seven years after taking their BA and MA degrees. However, after taking an arts degree in England they could go abroad to Italian, French or Dutch universities and acquire an MD degree in less than a year, sometimes in weeks or months on the completion of a brief thesis. Practical medical knowledge was often gained by working with a more experienced physician. Practitioners who had not gone to university or who were not licensed (see below) also often acquired their knowledge by a process of informal apprenticeship. In the latter category, for instance, was Francis Roe alias Vintner. When accused in 1639 of undertaking to cure a woman suffering from 'tympany' (a kind of dropsy or accumulation of water or air in the abdomen), he told the College of Physicians that he had been a student at Cambridge and that 'hee had been instructed in physicke from a boy by his father meaning Mr. Vintner the Emperick'.<sup>47</sup>

Licensing of medical practitioners existed, but was not universal.

<sup>45</sup> Pelling and Webster, 'Medical Practitioners'; Margaret Pelling, 'Occupational Diversity: Barbersurgeons and the Trades of Norwich, 1550–1640', *Bulletin of the History of Medicine*, 56, 1982, 484–511; Margaret Barnet, 'The Barber-Surgeons of York', *Medical History*, 12, 1968, 19–30.

<sup>46</sup> Whittet, 'The Apothecary in Provincial Gilds', 245–73; Juanita G. L. Burnby, *A Study of the English Apothecary from 1660–1756*, *Medical History*, Supplement 3, 1983, 12–13, 15–16, 59–60.

<sup>47</sup> *Annals*, 3, fol. 203b. On unlicensed practitioners and education see Margaret Pelling, 'Knowledge Common and Acquired: the Education of Unlicensed Medical Practitioners in Early Modern London' in V. Nutton and R. Porter (eds.), *The History of Medical Education in Britain* (Rodopi, Amsterdam, 1995), pp. 250–79. On medical education: Cook, *Decline*, pp. 49–52; A. H. T. Robb-Smith, 'Medical Education in Cambridge Before 1600' in A. Rook (ed.), *Cambridge and its Contribution to Medicine* (Wellcome Institute for the History of Medicine, London, 1971), pp. 1–25, and 'Medical Education at Oxford and Cambridge Prior to 1850' in F. N. L. Poynter (ed.), *The Evolution of Medical Education in Britain* (Pitman, London, 1966), pp. 19–52; Robert G. Frank, Jr, 'Science, Medicine and the Universities of Early Modern England: Background and Sources', *History of Science*, 2, 1973, 194–216, 239–69; Gillian Lewis, 'The Faculty of Medicine' in James McConica (ed.), *The Collegiate University*, vol. III of *The History of the University of Oxford* (gen. ed. T. H. Aston) (Clarendon Press, Oxford, 1986), pp. 213–57; Peter Murray Jones, 'Reading Medicine in Tudor Cambridge' in *The History of Medical Education in Britain*, pp. 153–83; also the sections on European medical education by Olaf Pedersen and Laurence Brockliss, in H. De Ridder-Symoens (ed.), *A History of the University in Europe* (Cambridge University Press, Cambridge, 1996), vol. II, pp. 452–5, 609–20.

The London College of Physicians had a membership of fellows, candidates and licentiates who were admitted by examination, whilst the barber-surgeons and apothecaries granted the freedom of their guilds after apprenticeship and examination. From 1511, bishops could license physicians, surgeons and midwives, and although an Act of 1523 gave the College of Physicians the duty of examining all physicians throughout England, the College was unable to enforce the right except in London. Bishops' licences were usually granted on the strength of testimonials from former patients and worthies in the community. Given the lack of a uniform system of licensing, the geographical limits of the licensing bodies, as well as the constant legal challenges which resulted in the authority especially of the College of Physicians to regulate and prosecute unlicensed practitioners draining away in the seventeenth century, it is not surprising that not only were there many practitioners who were unlicensed, but that there was no rigid uniformity in medical knowledge and practice.<sup>48</sup> This also reflects the nature of English law, which had few national enforcement agencies. Although judges from London travelled on assize circuits through the country to dispense national norms of justice, the apprehension of criminals was left to the victims of crime and to local lay officials such as the constables and justices of the peace. Such local and devolved powers are also characteristic of medical regulation. Moreover, English common law, with its piecemeal approach based on precedent, and its hostility to the codifying tendency of the continental Roman law tradition to legislate systematically for all possibilities, was not the instrument to create a uniform legal framework for medical practice. The parts of continental Europe, especially Spain and southern Italy, that regulated a variety of medical practitioners through the tribunal of the Protomedicato, had more uniform and comprehensive systems of medical regulation, even if they were not universally applied.<sup>49</sup>

<sup>48</sup> For the legal basis of the College of Physicians' powers, see G. Clark, *A History of the Royal College of Physicians* (2 vols., Clarendon Press, Oxford, 1964 and 1966). Cook, *Decline*; Cook, 'Against Common Right and Reason': The College of Physicians versus Dr Thomas Bonham', *American Journal of Legal History*, 29, 1985, 301–22; Cook, 'The Rose Case Reconsidered: Physicians, Apothecaries, and the Law in Augustan England', *Journal of the History of Medicine*, 45, 1990, 527–55. The court and the nobility also often intervened on behalf of empirics and further weakened the College's ability to police medical practice, on which see Clark, *College of Physicians*, vol. I.

<sup>49</sup> J. T. Lanning, *The Royal Protomedicato. The Regulation of the Medical Professions in the Spanish Empire* (Duke University Press, Durham, 1985); D. Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester University Press, Manchester, 1998); Gentilcore, 'All that

The overall impression of English medicine in the sixteenth and seventeenth centuries is of a large number of different kinds of practitioners. Those who made a living from medicine were often in fierce competition with each other. The College physicians and barber-surgeons had institutional rules that limited competition between members: they were enjoined not to poach patients from each other and advised on how to make a joint consultation without bad-mouthing each other in front of the patient.<sup>50</sup> These were, however, minor obstacles to the flow of free market competition that dominated medicine.

#### THE MEDICAL MARKETPLACE

Historians have fitted the different kinds of medical practitioners into a model that they have only recently created: the medical marketplace. It has been a very useful virtual space for placing disparate groups of practitioners together on an equal footing. Quacks and empirics were condemned by the learned physicians and it is the latter's hostile writings that largely survive. As a result, the historical evidence creates bias and distorts the reality, which was that empirics provided cheap medicines for many, though how many is impossible to know. Placing in the medical marketplace physicians, surgeons and apothecaries, the three occupational groups which had institutional identities and claimed to be superior to other practitioners, makes it easier to recognise that, like their hated enemies, the empirics, they were also driven by financial competition.

However, a note of caution is necessary. The medical marketplace model was conceived by historians in the mid-1980s at the time of Reagan and Thatcher and reflects these politicians' ruthless free

Pertains to Medicine": "Protomedici" and "Protomedicati" in Early Modern Italy', *Medical History*, 38, 1994, 121–42; Gentilcore, "'Charlatans, Mountebanks and Other Similar People': the Regulation and Role of Itinerant Practitioners in Early Modern Italy", *Social History London*, 20, 297–314; Gentilcore, 'Il regio Protomedicato nella Napoli spagnola', *Dynamis*, 16, 1996, 219–36. See also Esther Fischer-Homberger, *Medizin vor Gericht. Gerichtsmedizin vor der Renaissance bis zur Aufklärung* (Hans Huber Verlag, Berne, 1983). Ethical-legal writings were absent in early modern England, whilst the Canon and Civilian law traditions of continental Europe encouraged them as, for instance, Pauli Zacchia, *Quaestiones Medico-Legales*, 3rd edn (Amsterdam, 1651); D. Johannis Bohnii, *De Officio Medici Duplici Clinici nimirum ac Forensis* (Leipzig, 1704). Also A. Wear, 'Medical Ethics in Early Modern England' in A. Wear, J. Geyer-Kordesch and R. K. French (eds.), *Doctors and Ethics: the Earlier Historical Setting of Professional Ethics* (Rodopi, Amsterdam, 1993), pp. 98–130.

<sup>50</sup> Clark, *College of Physicians*, I, pp. 284–5, 414–6; A. T. Young, *The Annals of the Barber-Surgeons of London* (Blades, East & Blades, London, 1890), p. 119.

market ideology, which, such is the influence of the present on historical writing, shaped the thinking and behaviour of even the most left-wing of historians.<sup>51</sup> As with modern free market ideology, the medical marketplace model can be overemphasised. It stresses economic imperatives and discounts the cultural forces that shaped medicine, especially religion, the most powerful ideology of the time. A free market attempts to expand to fill all possible niches, and yet dying, as is discussed below, was not medicalised but continued to be managed by religion. Similarly, the members of a free market know no ethical constraints or charitable impulses in the search for profit, but that was not always the case with early modern practitioners, as the concern with the poor and the example of the Helmontians, discussed in chapters 8 and 9, especially demonstrate. The medical market model is also inappropriate for understanding lay medicine, where, if any transactions occurred, they were social rather than economic. Moreover, it tends to take attention away from the cognitive and practical aspects of medicine. How practitioners perceived disease and how they treated it have been downplayed by historians intent on exploring the variety of the medical marketplace, though they have related medical theories and practice to competition for patients.<sup>52</sup> Despite these caveats, the model of the medical marketplace together with the destruction of the Whig view of historical progress has helped to make available for study, groups, topics and sources which had been ignored or condemned as wrong, superstitious or unimportant by historians.<sup>53</sup>

#### RELIGION

One important topic ignored until recently was the relationship between religion and medicine. Just as free market economics today

<sup>51</sup> One of the first historians to use the term (health economists may have anticipated them) was Harold Cook in his admirable *Decline*; Roy Porter used the concept to good effect in his *Health for Sale: Quackery in England 1660–1850* (Manchester University Press, Manchester, 1989).

<sup>52</sup> See the influential paper by the sociologist N. Jewson, 'Medical Knowledge and the Patronage System in Eighteenth-Century England', *Sociology*, 8, 1974, 369–85. Also C. Rosenberg, 'The Therapeutic Revolution: Medicine, Meaning, and Social Change in 19th Century America' in J. Walzer Leavitt and R. L. Numbers (eds.), *Sickness and Health in America: Readings in the History of Medicine and Public Health*, 2nd edn (University of Wisconsin Press, Madison, Wis., 1985), pp. 39–52.

<sup>53</sup> For instance, the patient, the poor, quacks, midwives, religion, witchcraft, diaries and autobiographies.

is the driving ideology of globalisation by multinational corporations and the justification of American economic power, so religion in the sixteenth and seventeenth centuries was the ideology that justified wars between nations and shaped public and private morality. It is not surprising, therefore, that religion should have penetrated also into the area of medicine and illness. It did so in two ways: it took on the role of medicine by explaining why disease occurred and by offering healing through prayer and repentance; and it arrived at a *modus vivendi* with physicians and their remedies and allowed secular medicine to exist without much interference.

Christianity was from its beginning a healing religion. Christ, as a sign of his divinity, had healed the sick in body and mind, and the early Church Fathers and later writers used the image of Christ the Physician, and constantly employed medical metaphors in religious teaching. Christianity was concerned with both spiritual and physical healing. The Latin word *salus* came to mean salvation, but salvation also meant health: 'God's word worketh marvellously unto the health of them that believe. And therefore in the word of God it is called the word of health, or salvation.'<sup>54</sup> God also caused illness; he was a destroyer as well as a healer. The Fall of Adam and Eve brought disease into the world together with death.<sup>55</sup> English Protestants, especially Calvinists, added to the sense of original sin the view that illnesses were also God's punishment for their own present-day sins. Illness became a sign of God's providence, a running commentary on an individual's or, in the case of plague, a community's behaviour. It was a rod or punishment and a warning, or it could also be a trial of one's faith as it was for Job.<sup>56</sup> However,

<sup>54</sup> The early English Protestant writer, Thomas Becon, *Prayers and Other Pieces of Thomas Becon*, ed. F. Ayre for the Parker Society (Cambridge University Press, Cambridge, 1844), p. 490. On early Christianity and medicine see D. Amundsen, 'Medicine and Faith in Early Christianity', *Bulletin of the History of Medicine*, 56, 1982, 326–50; also G. Ferngren, 'Early Christianity as a Religion of Healing', *Bulletin of the History of Medicine*, 66, 1992, 1–15.

<sup>55</sup> On the dual nature of God see, for instance, Samson Price, *Londons Remembrancer for the Staying of the Contagious Sicknes of the Plague . . .* (London, 1626), p. 6; Theodore de Beze, *A Shorte Learned and Pithie Treatize of the Plague* (London, 1580), sig. A4<sup>v</sup>: 'Sinne in deede wherewith we are all borne infected, and from which all this dying commeth, by a certayne spiritual infection not without the decree of God, is conveighed and spread into all Adam his posteritie.' Burton, *Anatomy of Melancholy*, p. 114: 'the cause of death and diseases, of all temporal and eternal punishments, was the sin of our first parent Adam, in eating of the forbidden fruit, by the devil's instigation and allurements'.

<sup>56</sup> Andrew Wear, 'Puritan Perceptions of Illness in Seventeenth Century England' in R. Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society* (Cambridge University Press, Cambridge, 1985), pp. 55–99 and 'Religious Beliefs and Medicine in Early Modern England' in H. Marland and M. Pelling (eds.), *The Task of Healing: Medicine*,