An Unusual Power: the rise and influence of medical doctors.

Stanley Wilkin



**Contents:**

**Chapter 1: The slow, imperturbable rise……Page 3**

**Chapter 2: Choice, Change, Conservatism in 17th Century European Medicine**

**Chapter 1: The Slow, Imperturbable Rise.**

**Introduction**

Throughout most of the modern era, identified as the past 200 years, professionals have been despised, and amateurism, associated with aristocratic sensibilities, seen as the desired state. Within my lifetime amateurs in sport were considered higher minded than professionals who earned their living playing, for example, cricket or tennis. In Britain, Fred Perry a tennis champion of the 1930s from a Northern background, was notoriously treated in a disrespectful manner by the prevailing tennis establishment and ostracised when he turned professional. Although it was a professional’s way of paying for home and family they were suspected of venality. In fact this position lasted only a hundred years and was a consequence of the British upper middle class colonising sport and forcing out the lower classes, in particularly the working classes. Foot racing by working class men was common in the early part of the 19th century with a number of records broken, bets made, and money accrued, but this area was colonised by upper middle class elements, the group with money and status who performed the majority of the country’s organisational tasks, with professionalism becoming taboo. This change occurred at approximately the same time that attitudes, fashioned by the demands of ruling vast swathes of the world as the Empire grew, and new notions of character, involving duty and sacrifice, were developed to efficiently run it. Concepts of personality are always contingent on the social and political priorities of the time. In the end, only football remained as a way of earning money through sporting acumen. Football provides another example of colonisation in that it has generally been assumed that the sport gained its modern rules and shape from the English public schools, such as Eton, the focus of the above traits, but recent research has shown that the rules came from northern English working men’s clubs, which effectively civilised the 1878 rules created by public schools.[[1]](#footnote-1) While this will be a sociological examination of professionalism, connecting the phenomenon to transmitted aristocratic traits, it will primarily concern the rise of medical professionals, examining how they acquired the enormous influence and power within present day society, which I describe as a colonising process. The imperatives of Empire were imitated within society. In this research I will make claims that although the renaissance changed and shaped European attitudes the discovery of the Americas was fundamental to other later changes, and it was upon that event that Europe obtained its later prominence.

Professionalism, particularly as exampled by physicians, developed as an organising arm of central government, a role it continues to play inhabiting selected ideas and behaviour. Usually it expresses similar values to residing governments and worldviews that ensued and ensure conventional behaviour and stasis. Physicians became closely related to the aristocratic elite that for centuries ran this country. This work will consider the medical profession, a multifaceted group, as inhabiting a peculiarly autonomous position within society, demonstrating controls that function outside of state parameters. The latter will be examined primarily through the anomaly of psychiatry that operates within a largely subjective, group-centred dynamic. In doing so, it will consider examples from Britain, France and the USA. This work will also argue that aristocratic mores have been assimilated by the profession, a strong belief in group and individual superiority and control of others. It will scrutinise the historical process. As this is an historical survey, until the 1880s, according to David E. Allen (Amateurs and Professionals, The Cambridge History of Science Vol. 6. The Modern Biological and Earth Sciences) the upper middle class followed only four occupations: armed forces, church, the respectable branches of law and medicine. These processes, whereby aristocratic attitudes were further transformed into professionalism, caused the absorption of many different methods of treating people, labelling others as frauds and criminals. This is not a Whig history of the medical profession and institutions, a story of natural progression, but will attempt to analyse the development of professional medicine in intellectual, social and ontological terms in which the quack for example is viewed as an outsider, the outlawed, and in which the physician, often with a fixed view of the world, has colonised both the past, present and future.

**Historical Process:**

From Tudor times physicians were the aristocrats of the medical world, a position acquired through their close association with the crown and the new learning that had emerged since the 12th century. Surgeons and Barbers formed a company in 1540, but apothecaries, who for several centuries made up the different medical experts, were incorporated in the Grocer’s Guild in 1605. Both remained much lower down the social and managerial scale and, of course, even today surgeons are known by the normal, everyday appellation and not Doctor. This reflected the social conflict of medieval times from which the western idea of the doctor emerged: an authoritative, managerial figure possessed of social status and power rather than inhabiting a laissez faire role based upon equal status with those they treat. [[2]](#footnote-2) In Europe, the physician’s social status was of the highest in the fledgling academia based upon, within a hierarchy, logic, natural philosophy and medicine.[[3]](#footnote-3) In *The Medical Renaissance of the Sixteenth Century,* Schmitt (1985) notes the unwillingness still of 16th century physicians to descend from theory to practise even though the original university medical instruction at Salerno had been more practical than theoretical. The philosophical elements of medical instruction bestowed upon physicians their humanist and high status credentials. As I will demonstrate, their position in society was not based upon effectiveness but from an evolving role that had roots in early Renaissance within the universities and, without changing knowledge-foundation, accumulated greater prestige as respect for ancient learning grew. In addition was the blood-taboo that relegated anyone who caused blood to flow to the level of craftsman (Gottfried, 1986). In the final conclusion, physicians were perhaps more intent on social status than cures, unless whatever cures they discovered advanced their social status.

While present-day doctors are commonly revered, viewed preposterously as self-sacrificing demi-gods, physicians from medieval times until the Late Renaissance in England, were sometimes viewed disparagingly. The general accusation was that doctors, as distinguished from lay healers, were little more than murderers out for gain (Gottried, 1986, pages 58-59). The difference between that approach and the idealised one of present is often clarified through the idea of scientific progress, knowledge of human biology and of viruses, but that immediately begs the question of why laud the messenger and not or not exclusively the discoverer. We do not after all laud teachers because of the subject matter they teach, that is we do not say the teacher of Socrates’s philosophy deserves the plaudits owed to Socrates for his apparently innovative ideas.

As will be seen (see above), the social status of physicians had nothing to do with the efficacy of their methods. The approach to illness, in particular plagues, owed much to the ancient Greek natural philosophers who preceded Plato, as well as to Aristotle. It too was based on observation of phenomena, with the same tendency to note one substantial event and extrapolate all observable consequences upon its effects. Where air or water as driving forces were observed in the ancient world, odour, always present with disease and corruption, was considered equally a driving force of other contingent consequences. Another philosophy and societal change were needed to turn theory into practice.

Although it is I feel necessary to record and analyse the history of physicians, this work does not take the usual position[[4]](#footnote-4)that by focusing on these individuals and groups it is possible to trace a unilinear scientific, medical approach. Although many medical historians no longer view scientific medicine as the only right kind, the general public still retains that belief, viewing medical doctors as icons and modern medicine as sacrosanct.

Even though medical doctors became more closely defined through licensing by the College of Physicians London, bishops and Oxford and Cambridge universities, the process towards this development lay in the medieval world. I have provided other social and political reasons: the growing commercial [[5]](#footnote-5)aspects of society, knowledge becoming a source of income, played its part. Academic medical practitioners can be found in the universities as well as within the clergy, exhibiting limited learning in the field. Prior to the 16th century, there were physicians throughout Europe quoting Galen, perceiving sickness in terms of odour (see above), corruption of the air, in a dangerous dynamic with humours. Again, in the medieval world astrology played a significant role as seen in John of Burgundy’s *Treatise on the Epidemic.*[[6]](#footnote-6) Those calling themselves physicians studied at the universities and attached themselves to members of the elite. Many of the ideas about sickness and medical treatment remained connected to ideas in the medieval world, and continued so until the 19 th century, drawn from the ancient Greeks via the Arab world. In fact, a case can be made that many medieval concepts remain with us but their names have simply been altered. In John of Burgundy’s treatise, above, plagues are observed as being caused by the will of God, odours or miasma, noxious vapours emitted from the earth, and the susceptibility of individuals understood through the concept of humours. Personality therefore played a significant part in the catching of diseases or of becoming ill. Odours were a conduit for disease not necessarily the only device. Sickness occurred for three reasons: sin, trial of faith and intemperance of passions, requiring mediation between the physician and priest. This cooperation, 16th century physicians did away with in their own practises. [[7]](#footnote-7)Treatments were taken from many sources, including the bible, and then as now becoming a doctor required feats of memory. But medicine was multileveled and included demons and witches as sources of sickness, with appropriate practitioners to treat each source. Community based healers, named Folk Healers, [[8]](#footnote-8)formed the largest group of healers, religious leaders formed another group and book-based university trained healers, or doctors, the third. In fact throughout the 16th and 17th centuries there were all manner of medical practitioners offering a choice of treatments, often working in other professions at the same time.

Universities emerged in the 12th century, with medicine taught at first informally, but by the 15th century Padua University had emerged as the most respected of the medical schools. Women had acted as physicians until the emergence of universities when, as these facilities were only for men, their involvement in academic medicine largely ceased although many remained as barbers, leeches, and apothecaries.[[9]](#footnote-9) Although women still played a significant part in medicine in an informal capacity up to the beginning of Victorian times, by the Late Medieval period they were increasingly marginalised from formal practise as a possible consequence of monopolising and colonial tendencies. Earlier, women, such as Margery Kempe (1993-ca.after 1438) and Hildegard of Bingen (1098-1179), had written respected books on medicine. In Europe, by the end of the 15th century women were actively hounded out of the profession. Two Dominican friars wrote *Malleus maleficarum*, connecting women healers with witchcraft. [[10]](#footnote-10)The treatments offered by academic physicians were largely fixed on the writings Avicenna (980-1037), or Ibn Sina (full name Abū ʿAlī al-Ḥusayn ibn ʿAbd Allāh ibn Sīnā ) based on Aristotle and Galen. Apothecaries and surgeons more often learnt their trade through formal apprenticeships[[11]](#footnote-11)usually of seven years followed by an assessment by an expert panel. Whatever form of learning was undertaken, medicine was clearly seen as a lucrative trade or additional employment.

Although this chapter will demonstrate that it was the Classic or Academic physicians that provided the status doctors largely enjoy today, after the worst of the plagues had subsided their star had apparently significantly declined. In England the Black Death had killed many physicians, medical teachers and authors, ensconced in the theories of the ancient Greeks and Arabs, which were at least 500 years old. Those that survived did so with shattered reputations. Physicians had no solution to the plague. According to Robert Gottfried[[12]](#footnote-12)it was at this point that surgeons came to the fore and partially restored the reputation of medicine. Their practical focus engendered respect, as success, in a limited fashion, as were their failures, was clear to the observer. Henry V recruited many surgeons for the wars in France, increasing both numbers and reputation. These individuals, returning from France, established in1423 the College of Medicine, and composed the ranks of the Fellowship of Surgeons. This represented the high point for surgeons for the following centuries as new ideas from Italy ensured physicians’ renewal of power and influence. The emergence of hospitals during the plaques aided physicians as they often found employment there, another means of evolving professionalism, gradually ousting clerics.

Another reason for the growing dissatisfaction with physicians was that by 1500 printers were publishing medical books, a third of all the books printed (Gottfried, 1986), in English rather than Latin, thus exposing the nonsense of many medical ideas which were largely unchanged from the 12th century. When their manuals and treatises were printed solely in Latin they could overawe the general population. Also, the lack of Christian ethics ( here understood as altruism, freedom from greed and largesse towards the poor) in physicians’ writings, and contracts between physician and patient or municipality and physician based upon remuneration, too created hostility, especially when compared to the behaviour of community healers who were soon to be dismissed as quacks.[[13]](#footnote-13) Shakespeare provides an overview of medical experiences, describing kind doctors in Macbeth and King Lear, fakes such as Dr Pinch in The Comedy of Errors, and Cerimon, a magician, in Pericles.

**Medical Competition:**

Before considering how academic medical practitioners began the long process of controlling or colonising the healing of sickness, I will look at their competitors and contrast the varied positions.

The healer was anyone in the community who could *‘expedite recovery from illness’. [[14]](#footnote-14)* This was implicit in English Common Law, although failure to bring about recovery could result in prosecution for felony. As medical licensing grew those without qualifications who based their practices on experience were labelled disparagingly empirics. The huge demand for medical services during the 16th and 17th centuries meant that licensed physicians had to compete with many different kinds of practitioners. Lay healers were accessible for most people. Most active physicians would not have had qualifications. Alongside those healers who employed recognisably modern techniques there were a number who employed magic. By and large, this resulted, especially in the countryside, in communal healing practices, very different from the organised, centralised form that developed incrementally from the 16th century onwards, consisting of empirics, unqualified people who treated by experience not learning. Although Alan Withey (History Today, Vol.63.issue 10) writes of practitioners travelling long distances throughout the countryside to treat patients, in fact this was probably only for invasive treatments or I suggest in advisory capacities. The medical choices open to people were not just from those licensed in one fashion or another but by many within the community. Practitioners appear to have come in many forms, from altruistic clergymen practitioners to upwardly mobile practitioners concerned mainly with remuneration. There was not the homogeneous quality to doctors there is today reading from the same manuals and reciting the same codes. Change to this market place free-for-all came about through parishes and councils contracting licenced practitioners when the need arose. Although it created less autonomy within the profession, it imposed external standards that functioned through market forces. Recent research (History Today: Vol.63 issue 10) has shown 14,000 medical practitioners in England by the 17th century, although many may have been supplementing incomes from other sources.

**Medical Colonisation:**

The disappearance of different forms of healing is the main concern of this chapter, reflecting on the centralisation of medicine and the eradication of all other forms of healing practitioners through the processes of illegitimisation. Gottfried (1986) identifies the corporate nature of medieval society as determining the development of medical institutions by the Tudor period, its effects evident today. The physicians he asserts required the corporate structure to protect their livelihoods, many of which operated locally. Such institutions were based on towns, and when fully established in London began to acquire their present corporate, monolithic nature. In order to fully comprehend this process termed colonisation, which I believe has continued without sufficient acknowledgement to the present day, this book will trace the political growth of doctors. The concept of colonisation considers doctors to have emerged from a medieval corporate structure that slowly swallowed up or dispelled other organised or laissez faire medical practitioners. In order to succeed, medieval corporates (guilds) embraced strategies of power. [[15]](#footnote-15)

Their livelihood and status depended on physicians convincing both the powerful and commoners of their greater medical knowledge, the superior exclusive nature of that knowledge and also of the inferiority of other forms of medical knowledge. While physicians propagated theirs through the idea that they were concerned for and protecting the king’s/queen’s subjects from unqualified medical practitioners, the lay practitioner, one not belonging to an organised body, claimed they were fighting against the learned physicians monopolisation of medical treatment. Andrew Wear in Medical Ethics in Early Modern England (1993, page 121) asserts that there were two approaches to medicine according to the power elite within early modern society. On one side were those who accepted physician’s claims and encouraged the law to be employed against quacks, and on the other those who were against monopolisation of medical treatment, and who could also see that some people had a talent for healing but could not, because of the expense, acquire qualifications.

**Thomas Linacre:**

The foundation of the modern English physician can reasonably be traced to Thomas Linacre who, after studying medicine in Padua, incorporated his degree at Oxford and Cambridge, and settled down to teach Greek and practise medicine. He made an improved translation of Galen from Greek to Latin, the language of scholars. After practising privately, and perhaps even attending Henry V11 he, upon the Tudor king’s death, became Henry V111’s personal physician. He had by then many influential patients.

Physician’s social and financial success depended upon who they treated and therefore access to the King or the aristocracy was the pinnacle for an ambitious physician. Nevertheless, physicians were prosperous and bourgeois, in the sense of individuals or groups concerned with profit and city-life. Did physicians, through association with the bourgeoisie, also constitute important members of an emerging middle-class, as they most certainly do now, providing a framework for the group’s beliefs and values? I would suggest not, as the middle-class traditionally bestow cultural benefits on society, and therefore constitute a later development. This paper takes the view that physicians were an urban phenomenon, by definition the bourgeoisie who defined success through money and status not solely through intellectual or artistic achievement. By the early 16th century the prosperity of doctors was considerable and spread widely throughout the profession (Gottfried, 1986, page 266-267). Although the concept of the medical market place in early modern Britain is now contested, nevertheless as medical colonisation grew, so the market-place expanded as often during the 15th- 17th century’s medicine remained part of the common good.[[16]](#footnote-16)Pills provide evidence of early consumerism, subject to the ease they could be bought and taken.

What evidence we have of his medical expertise shows that, probably alongside many early physicians, he was cautious and reluctant to prescribe (O’Malley, 1965). Erasmus describes being treated successfully by Linacre who instructed that a compound be prepared, made by an apothecary, and given to the great man. He was thereby relieved of a stone ‘the size of a walnut’. Physician’s compounds were made up of spices from the Far East, so probably had the constitutional effect that modern spices do in cleansing or appearing to cleanse the system. It is possible that the compound was obtained from those who were not licensed physicians, old women, housewives, knowledgeable neighbours or based upon their knowledge, because, as with many instances of medical triumph, it is anecdotal. I will consider this matter later. In 1511 he and his circle may have had a hand in persuading parliament to pass the Medical Act of 1511, limiting the practise of medicine in England to medical graduates of Oxford and Cambridge and those licensed by bishops. With five other prominent physicians, he urged Henry to found a college of physicians. The founding of the College of Physicians of London in 1518 placed the granting of licences and control of medicine within the hands of learned physicians who knew Latin and Greek. Those with a Batchelor’s Degree, gained after studying for four years, became a Licentiate but only a Doctor of Medicine, gained after fourteen years, could become a Fellow, or Candidate as there were few available posts. [[17]](#footnote-17)In 1599 these amounted to thirty Fellows and six Candidates. Wear (2000) provides a higher figure of 50 registered only in London. As the target of licenced physicians was the rich, the small numbers were of little consequence. Physicians, being highly learned, were taught Hippocrates and Galen, studied the classics in detail, and, at Oxford, dissected executed criminals. For their medieval forbears it had been one of the seven disciplines.[[18]](#footnote-18)In part, at this stage and later, it was important that physicians knew how to talk with the elite.

John Caius was born in Norwich in 1510 from a similarly privileged background to Linacre, who became even more adept in Greek and Latin, an equally convinced disciple of Galen and an opponent of Andreas Vesalius under whom he studied in Padua. Vesalius introduced anatomy into the student curriculum and successfully undermined the ‘*self-sufficiency of classical medicine.’[[19]](#footnote-19)* Although Caius further supported the College of Physicians, understanding perhaps its role in identifying what a physician was, that is learned in Greek and Latin and following certain mainly fixed treatments, he lived to see the belief in Galenic medicine eroded by new outlooks.

**What a physician was then:**

Our present hallowed conception of medical practitioners comes from this early period when important physicians were allied to the renaissance, still in its infancy in England. We call them humanist to distinguish these scholars from the medieval age, although it is difficult to see how they differed except in not ascribing sickness to supernatural sources. Like their medieval forbears successful treatment was based upon trial and error, with effective forms of treatment passing into the ownership of a particular physician. Although later the position of academic physicians, based upon Galen,[[20]](#footnote-20) would be attacked by others eager to explore alternative methods based upon independent observation of natural phenomena and of independent judgement not conditioned by long-dead Greek medical practitioners, which actually had its roots in medieval medicine[[21]](#footnote-21). Medieval medicine was seen as dependent upon superstition and folklore and needed desperately to be superseded. Recent research[[22]](#footnote-22) has indicated the efficacy of medieval medicine, and the work done in hospitals run by religious establishments. Even then, many historians of medicine concentrate on its academic practitioners as that is where information can be found. There is no justification in seeing the medicine of Linacre as an improvement. The only change was in the process of defining physicians as an exclusive body, who could control what and was not considered healing. With this came standard and agreed forms of treatment. In this changing world, commercial interests were paramount. A major difference between physicians and others providing a service, such as artists and craftsmen, was that physicians escaped being considered merely tradesmen through involvement with seats of learning. There is no clear justification for believing that professionalism at this stage was the natural response to the influence of greater empirical knowledge, as Linacre’s knowledge was no different from physicians of an earlier period. In addition, the influence of classical thinking and scholarship, urbanisation, Protestantism, the end of feudalism, with the assumption by professionals of the aristocratic traits of courtesy and gentlemanly conduct (Gottfried, 1986) and emergence of middle-class, were the forces behind the growth of individualism. Society as a whole became less concerned with martial skills and right of birth, but now included those with the intellectual skills to deal with the complexities of government. Central government required able bureaucrats. These humanist physicians tended to travel to Italy, Padua and Bologna, where the best medical schools were, for their medical training.

The setting up of a College of Physicians can arguably be seen as an assertion of exclusivity and scholarship, but certainly not of ensuring high level medical treatment. At this point, there is no reason to believe that they were more effective than their unlicensed and thereby unqualified practitioners. English medicine remained conservative compared to many areas of Europe. Although unlicensed practitioners have a poor reputation in the present, the division between the groups was of the learned and unlearned. Although the Medical Act of 1511 declared that only medical graduates from Oxford and Cambridge could practise medicine legally, licensed by Bishops, this was to prevent practice of medicine by the ignorant and superstitious, who posed a danger to the health and well-being of the nation. As licenced doctors then and later were very small in number and limited to large cities this legalisation of medical activity was perhaps more to do with changing understanding of scholarship, from theology to Renaissance concerns, of the rise of a class defined by scholarship, including Thomas More and Erasmus, and central control of knowledge and its practitioners. It certainly concerned class dynamics. If as O’Malley (1965, page 15) asserts it was about ‘*weeding out the unqualified’* and ‘*lead to an improvement in medicine practised legally’* it is extremely difficult to see how this benefited prospective patients. Far more rational is to see this as the attempt by an emerging middle class to obtain status and power siphoned from that of the crown. The limitations of medical instruction at the time suggest that a licensed physician knew Greek and Latin, used blood-letting, examining the pulse, and other authorised treatment, which often amounted to beneficial or equally possible injurious concoction of natural curatives. Those who engaged in similar activities, but knew neither Latin nor Greek, were likely to be accused of quackery. It was not medical efficacy that distinguished the many practitioners. The traditional Whig position is to point out the positive value for future scientific medicine, but this was a long way in the future, ignoring the absolutist tendencies already obvious within the profession. If we are to equate the above benevolence, then that trait was probably more evident in the unlicensed who also probably obtained better results.

The idea of qualified and unqualified is not as certain as many might suppose. Qualified here means those attached to the two new universities and that traditional power bases of the age and the kind of knowledge, based upon class and authority, they asserted. To become qualified an individual required money, a suitably middle-class background, and connections. This has not substantially changed. Knowledge thereby becomes authenticated by wealth, status and power-as it still I suggest remains.

As we will see, medicine at this point consisted of many different competitive strands and it was this dynamism that the College of Physicians threatened in a successful attempt (although modern medicine is equally made up of various strands) to squash and in the process create a medical monolith of extraordinary power. Many competing forms of medicine were denounced as quackery, and the colonisation of sickness had begun by a group distinguished by their attachment to traditional authority and status within society. Although not used in such a way, and eventually to also be discredited, learning from mothers, grandparents or neighbours about curative natural ingredients is also to be qualified; learning and employing proven remedies equally is to be qualified. Apart from all the other issues tackled here, we also have a form of modern knowledge, one obtained through examination and certification.

Only in London did the physicians sue unlicensed practitioners for illegal practice. In 1663 physicians attempted to extend their remit throughout the country but the rights granted by Charles 11 were never confirmed by Parliament. The close connection of the college to the Crown caused it to wan as royal authority diminished towards the end of the seventeenth century. Verbally and via the written word physicians attacked unlicensed others who deigned to practice their craft for money, but as so many people during this period practised some kind of medicine physician’s attacks seem to be to do with preserving social status in the market place. The licensed physician was extremely expensive. As Roy Porter[[23]](#footnote-23)points out, there seems little difference during these earlier centuries in the effectiveness of licensed and unlicensed physicians. What difference there was appears to have consisted of learning, a knowledge of ancient Greek, Latin, Homer and Virgil. Of greater consequence to my later arguments is the invention of pills, which I suggest was and remains for marketable



purposes.

**Physicians’ viewpoint:**

Although I have looked briefly at medical treatment by licensed physicians, here I will consider it in more depth. Although in a competitive environment a physician could still make his name and fortune through a particularly effective cure. Physicians believed, after Aristotle, in the four qualities, hot, cold, moist and dry. Examination would confirm one or the other.[[24]](#footnote-24) The imbalance of humours was still widely accepted in the 17th century, although there were a greater variety of ailments recorded. In Late Medieval times there was also a considerable number of recorded ailments and greater knowledge of the human body.[[25]](#footnote-25) Diagnosis depended upon astrology and uroscopy. In the latter, a 12 hour sample of urine was collected from the patient in a glass flask and taken to the physician, who did not often get too intimate with the patient, for inspection. Not until later were physical examinations introduced. Treatment involved bloodletting and drugs, which were prescribed by a physician and dispensed by an apothecary. Drugs included theric, an antidote to poisons, galenicals, and animal products such as blood and bile.

Medicine seems to have gained its success through therapeutic methods not necessarily those of intervention in a similar fashion to the preventive medicine of today. Exercise, diet, freedom from stress, the creation of internal and external balance. Both licensed and unlicensed healers worked to the same end. Where academic physicians were concerned, what killed, also cost. Already a physician was distinguished by power, esoteric learning, background and social status. The efficacy of prescribed invasive treatments were already irrelevant and by the 17th century physicians had acquired a reputation for killing as well as curing.

‘*Trust not the physician;*

*His antidotes are poison, and he slays*

*More than you rob. ‘*

Timon of Athens: Act 4, Scene 3.

Only in the last century did that situation change in favour of cure. Nevertheless, surgeons seem to have had success with the everyday damages of life and both surgeons and physicians were able to provide excellent advice on preventing illnesses.

There have always been different approaches to medicine, but in Western societies these involved concerns of legitimacy, learning and authority. While medical historians tend to focus on licensed practitioners, they were just a small if powerful part of the overall picture. Most people may not have ever met a licensed practitioner but had regular contacts with other practitioners. Licensed physicians were concerned with the elite and usually had little concern with other elements in society. Also, effective remedies were done by those licensed practitioners, such as surgeons, further down the pecking order, not by physicians. Doctoring was different according to social status and habitation. Doctoring to the poor, to the rich, to urban patients and country patients was different as were the service deliverers. The growth of professionalism brought with it increasing degrees of homogenisation, as will be shown through the methods of colonialism. This section will look at this progression, connecting colonialist intentions with similar examples of power and superiority that occurred between western and underdeveloped countries during the same period.

**Elizabethan Medicine:**

General perceptions of sickness remain important in understanding treatments. This concerns medicine In Elizabethan England as well as today. In the 16th century the senses determined the nature of illness. The population as a whole was closer to the natural world than today thereby encouraging different viewpoints. For example, excrement was used in agriculture and medicines, with urine being used for bleach.[[26]](#footnote-26)European societies were still rural in the 16th and 17th century and therefore expressed certain conditions. There was considerable mobility, largely seen as threatening by the elite, which in France was vigorously and firmly responded to. As Foucault has noted, this informed our present understanding of sickness. Cleanliness may have declined since the medieval period due, in part, to the prevailing view that washing took away certain necessary protectives from the body. This development has been connected to the rise of syphilis. Throughout the 17th century there was a growth in street paving, with communal hygiene a matter for parish officials and individual homeowners (Pelling, page 23). The lack of organised public health was responsible for many illnesses. Dungheaps were located outside city walls and used for agriculture. The cities stank and as a consequence odour was still viewed as an important source of disease and a means of its cure. Anything that released foul odours (p 24) was seen as a source of disease. Nevertheless, these may have been only urban perceptions and not prevalent in the countryside.

As will be seen throughout this period was as in the past an active and effective lay medicine which involved competition and collaboration. It was community based, although not entirely, without the demands, money and individualism, of the growing professionalism of the College of Physicians London. Successful practices were shared and mainly conducted openly. Although professional or academic physicians existed, there were not many, and most of these had other occupations. Clergy, merchants and landowners practised medicine professionally.

Amongst the Academics, Galenism lost ground due to the practise of anatomy led by Andreas Vesalius (1514-64), see above, that tended to undermine the authority of the ancient Greeks and led to the notion of therapeutic effectiveness. This position was further developed by Paracelsus, a German-Swiss, who attacked classical medicine and advocated the use of inorganic substances in treatments. According to Pelling (1998), academic physicians, those of the College of Physicians London, had little to say about diseases and remedies. Changes in religious perception, the arrival of new plants and minerals from the Americas, also concentrated minds on what actually worked.

**Cultural perceptions:**

Changing perceptions caused different treatments to be applied. For example, Protestants saw sickness as linked to spiritual corruption with suffering perceived as a necessary part of a cure. Even by Victorian times, the medical opposition to anaesthetics was based upon the belief that pain was necessary for the soul. Treatment of the mentally ill, even today, has largely followed this pattern. High risk intervention, still employed today, is based upon earlier concepts of punishment of the ill or of the corruption within the individual’s body.

Medicine during this period was very different to present day treatments. It did not fit a process but was subject to competitive claims based on novel discoveries and assertions of authoritative knowledge. It was greatly influenced by the continent. Medicine consisted of astrology, traditional practices and religious attitudes. Diagnosis, based upon testing of a number of factors, remained unlikely. Bloodletting was commonly used, advice on diet, and on increasing or decreasing sexual activity. While early physicians were sufficiently altruistic in their approach, their attempts to help genuine, medicine was slowly taken from the hands of the community into the hands of those who claimed personal and group justification for the treatments they gave. From this point on, although it took time, medicine ceased to be a shared phenomenon based upon objective and subjective experience, thereby debate and discussion, but one colonised by a central authority.

**Social and economic change: custodial care, discipline, training, education and work**

State involvement in the provision of medical treatment came with Poor Relief , which had become a matter of national concern during the 16th century. This period provided identification of the poor in a way that is still with us, itinerant, lazy, abusing the system, but also helped construct public forms of medical care based on segregation, incarceration connected to lazar houses, constructed originally for lepers. The breakdown of master/servant relationships also contributed to the extension of state interest in local matters along with migration into the towns and cities.

**Vagrancy:**

From 1520 to 1640 the most pressing concern of government was that of vagrancy, or to re-categorise, mobility. John Pound[[27]](#footnote-27)asserts that vagrancy became widespread and organised. It became a problem for villages and towns. Consequently, urban centres began experimenting with methods of dealing with the problem, and with poverty in general. Medical treatment was employed to deal with the matter. Municipal authorities, epitomised by the Elizabethan poor laws of 1598 and 1601, and group charitable activities enjoined to limit the social effects of both.

Pound (1986) views begging as one result of recent warfare and of many armed and experienced ex-soldiers finding ways to survive without resorting to the humdrum existence of the average urbanite. Men who had previously been retainers of one lord or another gathered together in bands, equating vagrancy and criminality. This was partly solved by the provision of pensions to ex-servicemen in 1593, although many impoverished men who had not served in the army suddenly thereby claimed to have done so.

Another cause was the effect of an increasing population not met by increased employment opportunities. A situation exacerbated by the need for greater agricultural output, more efficient farming and the disposal of surplus labour. Landowners often turned their land over from agricultural usage to sheep farming, resulting in enforced enclosures, because of the greater profits accrued from the sale of wool and rising prices. With farm workers now dependent on wages and without owning land of their own more and more workers became subject to the vagaries of market forces. The nation’s growing dependency on the cloth industry, likewise susceptible to external threats, increased the chances of poverty and homelessness. Although some experts dispute the overall negative effects of economic change (Pound, 1986) there appears to have been increased mobility throughout this period. This may have been due to social and psychological factors, the mercenary quality of workers associated with wages, the resulting greater instability and the breakdown of traditional master/servant relationships.

It appears that the poor, temporary workers, returning soldiers, displaced rural workers, habitually congregated in urban areas. By the end of the Tudor period they often made up two thirds of a town. Of these, a number would be widows, many with children. In retrospect this seems a consequence of high populations, especially within a market force’s context where wealth is increasingly directed towards an elite, as a similar situation exists at the time of writing.

**Segregation:**

Before considering how municipalities dealt with these problems, I will consider methods already at their disposal, and connect that, where possible, with similar institutions and methods in the present day. The 16th and 17th centuries certainly provided the institutional and perceptual roots of social organisation in the present day. In order to evaluate these institutions and perceptions I will first look at incarceration as initially employed for leprosy sufferers and victims of the plagues.

Michel Foucault[[28]](#footnote-28) places immense importance on the segregation of lepers within excluded communities, a policy employed as a response to the plagues that ensured the effective control of diseases. He viewed this as instrumental in the production of *Other*, a useful sociological term to describe societies discarded members who do not comply with the capitalist system. This practice he believes led to the construction of *mental illness* by authorities in order to control disenchanted elements within society. He points out that there were a number of leper colonies within England throughout the medieval period but of course the practice of isolating unwanted groups in England came much later than it did in France where it does appear to have been built into national perceptions. Foucault in addition notes how unwanted people were routinely driven outside of the city or town’s walls. The space within the walls was symbolically for working, settled populations. The segregation of groups, the separation in terms of both space and perception, created divisions between normality and abnormality.

Leper colonies in England were called Lazar Houses after the diseased beggar in a Jesus parable (Kelley, 2009). Once individuals were diagnosed with leprosy, often incorrectly, they were not allowed out again thereby predicting the arrangements in later mental institutions. As the disease was considered highly infectious lepers were avoided and rejected naturally occurred. By 1225 19,000 leprosaria had been built across Europe. A link between attitudes to lepers, regarded as dangerous, unclean, and undesirable poverty and madness is made through the incarceration of each group that became commonplace within European societies, usually under the auspices of the developing middle class who may have used such positions to define their professional and authoritative roles within society. Middle class professionals cleaned up the mess made by less agreeable types, keeping it away from aristocrats’ homes and clubs. This attitude can be found fully formed in the latter part of the 17th century.

Connected to Lazar Houses was the development of hospitals in England from places run by monks for wayfarers to stay to institutions that primarily looked after the sick. Later some hospitals were concerned only with the old or indigent (Sloan, 1996). In France, hospitals, also created and run by the church, were called *incurabili* as anyone entering such a place was likely to die. Nursing provided care rather than the delivery of possible cures. From these satisfactory attempts at care evolved the Bridewells where correction was instituted to control the immorality of idleness and non-production.

Although state medicine developed much earlier in Europe, as analysed below, the English counterpart emerged during the above period of social crisis and had more to do perhaps with social change and only later to do with virulent diseases like plagues and the French disease.

**Ideas of the ‘Poor’:**

The social and economic change that caused landless gentry to become urbanised, led also to a less structured supervision of the countryside, greater unemployment and vagrancy. This led to a greater number of illnesses amongst the poor. The migration to urban areas, with the differences in economy, one communal and the other expressed through group or individual economic attainment combined with wage earning resulted in a knife-edge economy, which greatly increased the number of poor. During the Tudor period prices rose fourfold. Beier[[29]](#footnote-29) has examined what he has called two variables: the appearance of great numbers of property-less persons and the authorities’ reactions to them. This occurred in both England and Western Europe. Although the authorities’ response was enlightened in some ways, assuming responsibility for a difficult phenomenon, they also defined and labelled the poor in a way that was to last within Western urban societies (see above).

By the Tudor period the poor had become a national problem, with a third to a half living in near poverty.[[30]](#footnote-30)As with any problem, where state action cannot supply an immediate resolution, analysis prevails. The poor can be divided up into settled and vagrant, although probably neither definition describes a static phenomenon. Under the poor laws the first were liable to poor relief, but, according to Beier, the second group were regarded and treated as criminals. In fact, urban societies for several millennium have demonstrated immense fear of mobile groups, often with justification. The rise in urban poor, whether settled or vagrant, can be located in the changing economy of the countryside, its breaking down into small holdings and subsequent dispersal of wealth.

**Medicine, the poor, social control:**

This period saw an increase in poor-relief but also of severe punishments for an increasing number of often petty misdemeanours. Idleness, usually the result of an inability to participate in the prevailing economy through social circumstances, itself became a crime deserving of the severest punishments (An Act Concerning Punishment of Beggars and Vagabonds of 1531, Statutes of the Realm, iii, 328). Although Norwich was not affected by the above economic and societal changes until late in the 16th century its practise of state medicine can be viewed as part of an attempt to control the situation of greater poverty, especially concerning the migrant poor. To keep people industrious and able to earn was the authorities’ civic duty. Although patronising in their approach, municipal authorities provided genuine help and assistance to the poor. Licences were employed to pay for treatments and the poor were aided in other ways, with scholarships for example (Pelling, 1998). Norwich authorities displayed admirable social conscience although we must bear in mind this was ameliorated by religious perceptions of ‘self-help’ and deserving, and whether or not the sick had residences. Municipal authority provided for sick poor children but largely because children then were an important part of the city’s economy.

There appear to have been a large number of medical practitioners during this period, which may have been due to the municipal provision of medical services, especially in larger urban areas. Mary Pelling (1998) has looked exhaustively at the records of Norwich, then the second richest city in England, with one of the best examples of state medicine in England, noting that the city officials demonstrated an understanding of the economic effects of sickness, using licensed doctors to enable the sick to return to work. As the poor did the essential physical labour, poor relief and state medicine was important for the local and national economy. The poor as a separate entity was emerging and identified through both poor relief and state medicine. The poor were not only to be looked after (Pelling, 1998. Pp 81-84) but also defined through the principles of Catholicism, Protestantism and Humanism, each of which emphasised improvement and change. Unlike the rich, the poor were often divided into the deserving and undeserving according to their place in the economy or attitude to it. The deserving poor were always those who worked. Again, such concepts have remained with us. Vagrants could be subjected to confinement, quarantine, forced labour or cure (Pelling 1998).

Pelling (1998, page 82) describes Norwich as instituting short term care that involved custodial care, discipline, training, some education and work. The poor were infantilised, requiring the intervention of enlightened authorities. Illness, poverty and morality were closely linked. To be poor, especially if a vagrant, was to be corrupt and immoral. Pelling (1998, page 97) describes a doctor contracted by the Norwich authorities to heal two boys, one of whom escaped to live in the streets. He was subsequently picked up and returned to the doctor but did not prosper and was thereby sent to Bridewell, see below. The other child suffered worse. What appears to have concerned the authorities is that the boys would pass from the doctor to residence in a home as apprentices, exhibiting thereby all the desired traits of domestication. In both cases this expectation failed to materialise.

While there were many admirable innovations in the Norwich Poor Relief scheme, in many ways there and elsewhere a war of attrition was begun by the urban authorities on the victims of economic change that deftly corresponds to later ruling manifestations. Houses of correction were set up to deal with the poor, definitions of which were labour based, if, for example, an individual was healthy and sturdy they should be working. Entertainers and peddlers too came under this dictate. According to Beyer (1983, page 31) the statutes of the period were to keep the sturdy in service under masters, a tradition now largely shunned. As a consequence Bridewells appeared, institutions to reform the idle, in which punishment and rehabilitation was linked to labour. In some parts of the country, settled poor were required to wear insignia, like the Jews during earlier and later pogroms. In such an environment, state medicine can be seen as a means of official control. Has that changed?

Medical care, based upon deserving and impotent poor, who the city wished to retain for their labour and who to punish, can be viewed as the re-assertion of authority in a civic not feudal fashion. It was in line with the ejection of unsuitable individuals or groups. From this period valuable citizenship and therefore normality became constructed upon settled home lives. Moving away from that ideal state indicated criminality and, reviewing Foucault, unproductive and therefore disturbed behaviour.

**State medicine:**

Whatever the connection between medieval forms of incarceration and later treatment of the mad and poor in society, models of state controlled medicine certainly did. Although public medicine formed in many ways, from the contracting of a variety of medical experts by municipalities within Europe, the statistical approach, developed in Milan by Catelano (d 1497) but employed by the Milan authorities as a method of identifying when plagues were likely to strike, thereby how best they could be controlled. Jacob Soll[[31]](#footnote-31) demonstrates that the pioneers of Florentine civic humanism connected medicine, politics and civil law, a model for much later developments in England. This method was used to minimise contact between ill and healthy and was at first in the hands of parish elders but then placed in the hands of the College of Physicians.[[32]](#footnote-32)Descriptions of illnesses began to be routinely collected as well as evidence that in matters of plague physicians were often passive witnesses, diagnosing illnesses through the narrative of victims and their families and through visible marks on victim’s skin, just barely useful in noting symptoms and causes of death.

While I have already suggested that municipals helped to create professional medical identity, the administration of plagues in Italy and later throughout Europe strengthened the public role and power of physicians. Collecting data certainly proved a decided move towards modern medicine, directed from the top of state hierarchies to control virulent diseases that destabilised states. Physicians therefore became, at this early stage, an arm of the state, which they remain still. Of interest in the development of my general theme, according to Roger French[[33]](#footnote-33)physicians only became interested in the management of hospitals when these institutions began to be identified with civic pride.

**Examination:**

Professionalism did not mean exactly the same as it does today, and the growth of professional doctors was locked into the social conflicts and competition of medieval and early modern times. Doctors, one of the most prosperous of the middle-class groups to emerge at this time, did not acquire wealth and status through the efficacy of their treatments but through their connection with high learning, use of Latin and Greek, corporate expertise, separating from other medical groups, the marginalising of cleric physicians and religious influence, and gradual distortion of community healing and healers into quackery and quacks. For example, at a later date, in the mid-17th century, Nicolas Culpeper contrasted the cheapness of his native god-given remedies, within the means of the poor, with the expensive, often exotic remedies of the Galenic physicians.[[34]](#footnote-34)

Although physicians were an urban phenomenon, their taking over management of hospitals from clerics, positions in royal and aristocratic households, increased their influence and control of society. Physicians were mainly intent on creating power and influence for their corporate, for as Leon Joseph of Carcassone commented: ‘*the learned physician is he who asks for a large sum of money and does not heal free of charge*.’[[35]](#footnote-35) While many other commentators may deny such overall self-interest, pointing to the effects of Christian altruism and concerns for the poor, as a group I believe the description remains valid. Although other medical practitioners, such as apothecaries and surgeons, competed in the medical market-place these groups were not quite so tainted by accusations of avaricious and self-interest. In the 17th century, as will be seen, changes in religious perceptions were to allow the already influential medical body to expel another rival, religion, from their growing monopoly of healing.

The assumed superiority of Academic physicians, a trait of many modern doctors, should not then or now delude us to the efficacy of their methods. Medical treatment is a contract, both visible and invisible, that requires both sides to engage in a pre-arranged role replete with psychological, almost magical, properties. For example, Erasmus immediately trusted Linacre’s integrity and expertise, necessary for a cure. The good doctor might have acquired his successful compound from the good woman next door or a cunning man in the next town. His apparent secretiveness testifies to any number of mysteries surrounding its discovery as well as the tradesmen’s desire to protect his goods.

As in Europe and later in England, physicians began taking a supervisory role in the management of data and of hospitals the beginning of the modern scientific/managerial physician began to appear. Although municipal authorities had in many cases assumed directive control over medicine throughout most of Western Europe, with doctors merely contractees, continued control over wider state medicine was to release them from such tradesmen like subservience. In England, physicians did not serve as municipal health commissioners as they did on the continent, further restricting their influence. Margaret Pelling[[36]](#footnote-36) demonstrates that only a few doctors played a part in public life, which she suggests affected their masculine authority, but just as likely demonstrated the slow evolution of full professional status in England compared to the continent. Municipal authorities certainly helped increase the number of medical practitioners, as well as deciding who was to be treated and through the issuing of contracts what treatment was to be used. In turn, they pioneered a concept of normality, based upon urban ideals of domestication.

Of importance in the growth of medical influence is the definition of the poor as a group, identified also as itinerant and workshy, needing observation and incarceration. They were outside of productive stable urban groups, and often were seen as inhabiting space outside of urban centres. In fact, the *poor* were usually casualties of war, over-population, and social change.

**France:**

Any examination of French medicine must include the greater role played by royal doctors in forming an empirical political science, becoming not only the king’s physicians but his counsellors as well. The body became a motif connected to royalty, with the term ‘body of the king’ taking on state relevance. Royal doctors fashioned a new vision of the monarch as a practicing physician of the state, thereby conflating political and medical responsibilities. Notions of political and social corruption, visualised as corporal in nature, proliferated.[[37]](#footnote-37)

The state was henceforth seen as healthy or unhealthy, wounded or broken-a term used vicariously by a recent British Prime Minister when reviewing British society in a marvellous display of projected inadequacy and wishful thinking. The Royal doctors claimed that by examining the state a king could evaluate its humours, and so rule better. Soll (2002) demonstrates that the idea of examining institutions forensically was given utterance by Niccolo Machiavelli, postulating a political science, and taken up by successive political groups. In this fashion, politicians and doctors shared, and share, concepts of those they govern or treat that imply more than a common economic and social background. In France at least, state and medicine became both closely allied and aligned.

Historians have examined the growth of state involvement in health involving those subject to poor relief with particular reference to France from the 17th century and the United Kingdom from the 18th and the effects of the Enlightenment. The growth of institutional medicine is nevertheless only one aspect, albeit an important and long-lasting one. McHugh believes that institutionalised medicine in France grew out of Catholic Reform activism that insisted not only that the rich should be devout but also they must provide for the poor. Of course this belief was not new but can be located in the earliest Christian texts and had never died with Christian societies. The Jesuits, founded to check the spread of Protestantism, took up this ancient paradigm and employed it politically. As occurred later in British poor relief and prisons, poverty was blamed on flaws in individual’s characters and not seen as a social phenomenon or a chance of birth. The Jesuit’s sought to relieve poverty in order to keep or reclaim people for Catholicism.

This view of the religious beginnings of institutionalised care is in conflict with the belief that an absolute state initiated such care for its own ends. What occurred in France often seems in conflict with the market-forces development of medicine in the United Kingdom. In France, the crown assumed control of the Hotel Dieu De Paris, and Louis XIV’s 1662 Edict that authorised the establishment of hopitaux generaux in every town in the kingdom. This legislation, although the crown was intent on secularising the running of hospitals, was enforced by the Jesuits. By all accounts, this looks truly like the establishment of official uniform forms of medical care. In fact, the crown had taken a leading role in the formation of charitable health care from the 14th century onwards, assuming positions of patronage over a large number of hospitals (McHugh, p41). Treatment nevertheless remained in the hands of the religious. By the 16th century municipal governments had taken over the hospitals and few were run by religious orders.

**Control of social perception:**

The poor need to be identified. Apart from places set apart for lepers, the poor appear to have been largely beggars, often transient, who arrived in some localities from others. Many appear to have been refugees from famines or poor country conditions. The provision of poor hospitals may therefore have gone some way to create transient beggary, a particular group dependent on the state from those engaging in the ordinary processes of migration from one form of society to another. This group effectively changed its character when, in the late 17th century, with the increasing move towards internment, with in 1699 the crown demanded that all localities should imprison their poor.

The ‘*poor*’ were it seems a paradigm created by a nobility who then as later had little engagement with other sections of society. Then, as often now, power encouraged many positive characteristics to be applied to the powerful, wisdom and great maturity, while those without power were regarded as children requiring help and control. Many commentators have judged that as hospitals remained in control of the urban they served to exert control over the lower orders who they considered capable of creating instability within the growing state.

McHugh (p56) employs the term *cohesion of interests* to describe elite control outside of the occasional use of force to ensure order. This is done in a number of ways, one of which is the manner in which other groups are perceived in relation to self-serving paradigms of an elite. These are often developed through dichotomies. For example, the above, mature-childish or enlightened-ignorant, hard-soft, normal-abnormal, weak-strong. This work will demonstrate the use made of such dichotomies in modern medicine to ensure the prominence of physicians. Control of perceptions is an ancient tool of rulers from Sumer to the present day. In essence, power alters or reshapes reality in order to fit it in with the strategies of those who wield power, no matter how small, and provide machinations to enforce and sustain the restructured reality to such a point that people in general cease to notice the joins. In this instance, the political construction of sickness has to be itemised.

There is a difference, peculiar to the modern world, between self-designated illness and public illness, subject to the decisions of an elite expressed through variable authority roles. These can be intertwined as in the case of epidemics. Public control of sickness and the sick has grown.

The above can be seen as directly linked to urbanisation, but most of Europe remained rural, possessing a variety of environments and therefore of sicknesses and treatments. In England, as in France, a mobile population moved from country to town, and the difference between rich and poor appears to have increased. The Poor Law evolved to meet ‘*apparent threats to social and economic stability’,* in England as in France. As on the continent, famine was a reason for vagrancy, largely an urban phenomenon. In Tudor times starvation affected the population in 1557-59 and 1596-98.

In Tudor times medicine was known for its eclecticism, based upon different world views. An impetus in medical effectiveness appears to have come from the New World with its plethora of medicinal plants. Much use was also made of local flora to effect cures (Pelling, p35).

**Protestants:**

Although the role of Catholicism in poor relief has been noted above, many commentators associate its growth with the rise of Protestantism. Often poor relief in Protestant countries went hand in hand with social control and the idea of poor and deserving poor emerged as a method of limiting relief. In Protestant countries, welfare for the poor seems to have been linked to prevention of begging.

Medical treatment of the poor remained, unlike in Europe, laissez faire and un-institutionalised. Until recently, it was largely in the hands of voluntary agencies and therefore perhaps escaped the extreme authoritarianism of medical care elsewhere. Although it has generally assumed that there were few physicians in the 16th century in England, Pelling (1998) has produced evidence that in the larger towns there were a considerable number. Nevertheless, in England as in France, definitions of service delivery seems to have been entangled with religious and moral paradigms regarding the poor, creating the other so loved by sociologists. As in France, sickness appears connected to rootlessness and to work, that is the lack of, the suitability for, and the obtainment of. Sickness, the poor, moral instability and lack of work were closely connected as they were not with the rich and middle-class. Although the concern with its poorer citizens’ health was commendable it seems always to be defined through avoidance of poor relief and swift return to work and therefore independence from the municipality. This delivery, by and large, remained ad hoc. The number of practitioners to patients in Norwich has been assessed at 1:200, which reflects well with present times except for their different activity: barber-surgeons, surgeons, bonesetters, apothecaries, physician-surgeons and those of other trades involved in medicine. An eighth of these were at any one time employed by the city. Of these, in contrast to later practice, a third were women. Pelling (p 86) cites a woman surgeon and women managers of poor houses. There is little evidence of religious associations. Bonesetters appear to have received the highest remuneration, perhaps evidence of their relative success.

The ad-hoc nature of medicine was possible because knowledge of traditional remedies, particularly in the country, was open to a range of people within the population, and not dependent upon wealth and professional expertise. Healers could be one’s neighbour or aunt. Individuals could assume the authority to cure a number of illnesses, including smallpox to syphilis with local competition between villages and families as to who had the most effective medicine. Women were particularly involved in effecting cures and attending to a number of illnesses. Knowledge of and providing cures seems to have been part of being an efficient wife and mother. There is no reason to believe that these were any less effective than physician surgeons. Shakespeare, amongst other commentators, often associates doctors with money and not necessarily with the efficacy of their treatments.

**Chapter 2:**

**Choice, Change, Conservatism in 17th Century European Medicine**

This chapter will consider the development of the medical professions throughout the 17th century in order to provide understanding of the profession in the present. Then as now, contrary to popular belief, many of the theoretical and therapeutic interests of the profession separated it from the general needs of the populace and in effect its development was principally in the social and political arena. The growing attachment of medical practitioners to municipal authority and continued connection of physicians to courts, alone recommend such an approach. As the French kings played a crucial role in the formation of the different practitioner groups, the development of physician power in France was more clearly structured than during the same period in England and therefore that is why its development is considered here. In France, kings had assumed authority over the medical profession from the 14th century and thereafter royal decisions often determined professional outcomes. As seen above, physicians early identified with the state and other centres of power and influence. This chapter will also look at the emergence of modern science and its effect on medicine during the 17th century, holding that, contrary to belief and expectation, it had little practical effect on medicine. Medical understanding of illness remained based on humours, not on the mechanistic perceptions of Descartes and Newton, and prejudice against empirical approaches continued.

I will also introduce into the discussion the idea that medicine is not *quite* a science, although this matter will later be scrutinised in depth. Medical practitioners acquire much of their expertise from a supposed connection to science. On occasion doctors are referenced as scientists notwithstanding that most medical discoveries have emerged from outside the profession and that as a group physicians are noted for their conservatism. Drugs are perceived of as scientific remedies even though their use and effectiveness may not be clear cut. This alternative viewpoint may seem odd to present day readers brought up on this belief of medicine as all-conquering and beyond criticism, its success irrefutable. I propose that medical practise is both more complex and less successful than its supporters allow. Alfred E. Cohn[[38]](#footnote-38) suggests that medicine remains a craft, its practitioners applying outside theoretical knowledge to their subject matter, seen not only in the theories and practices of early modern physicians but also in present-day psychiatry, combined with practical knowledge from continuous testing and experience. Coln further examines the artisan nature of medical practice.

French physicians called their profession a science, although the term then referred to associations with academic learning, and constituted the historical authority of physicians. This connection defined the learned nature of the physician, their classical education based upon Galen, Aristotle and the apparent logic of their observational skills, perceiving patterns in illness that amounted to a clear design. Graduate physicians employed reason, over-confident analysis of cause and effect, to understand the sick individual. At this stage, medicine remains largely a social phenomenon with the therapeutic elements of medicine played out elsewhere. It was part of a discourse on the nature of authority and power, state control and class development. It is mainly referenced in medical histories because physicians had a public presence and were able to record their deliberations. Therefore this section will look at how French physicians protected and extended their power through Royal authority and the courts.

**17th Century French Medicine.**

Plagues remained prevalent in Europe during the 16th and 17th centuries. Brockliss and Jones[[39]](#footnote-39) suggest that almost as many people died of bubonic plague during this period as during the more infamous Black Death of the 14th century. These regularly recurring diseases, not all bubonic, reached their highest point between 1628 and 1630. So devastating were these epidemics and pandemics that the state became directly involved in their control. At the same time other new virulent diseases appeared, such as typhus, due to the greater involvement of Europeans with the Near East, the greater occasion of scurvy, and, possibly, whooping cough. Until a period of more exact, state wide recording it remains difficult to know the progeny of diseases but many were the result of urban conditions, little fresh drinking water, and unsanitary disposal of human waste. The odour of dead bodies was prevalent. Close proximity to animals, for example the connection between cowpox and smallpox, encouraged new diseases to emerge. Unlike today, few people died of old age.

Perceptions of illness and disease are subject to change involving social ramifications. In the present world of a dominant NHS disease, illness has become physical or mental features that cause inconvenience. Stoicism is no longer preached as one of the determinants of character. Drugs are prescribed for a variety of real or imagined conditions without any genuine evidence of efficacy. Brockliss and Jones (1997) point out that in 16th and 17th century France skin infections, diarrhoea and vomiting were universal and probably not viewed as pathological. During this period, people did not see illness through the projections of scientific agencies (physicians, chemical companies), but through humankind’s pride, the incidence of behaviour coupled with divine mood swings-‘*The malady is too public to doubt that God is irritated with his people.*’[[40]](#footnote-40) For most people in the modern world, god has been reduced to the supervisor of the afterlife not the decider of who lives and dies.

The French physician’s claim to represent science mainly referenced their adoption of the ancient Greek physician, Galen (see previous chapter), who had married the observational methods of Hippocrates and Aristotle’s natural philosophy, which offered causal explanations of phenomenon. Galen linked disease to the body’s functions producing thereby a logical framework of sorts to justify diagnosis. As this resulted in medical physicians attempts to prove theory rather than adjust theory to the results of experience and experimentation, this clearly cannot be justified as a science in modern terms. Such an approach confirms power, and does not equate to a developing epistemology. In France, medical training was focused on Paris and Montpellier universities, which emerged at approximately the same time. The educative processes of both institutions mirrored that of the law, theology and arts faculties, being taught through lectures followed by oral exams and further examination through observation. The training, as already seen, was rigorous and lengthy. Licensing was performed by bishops and their representatives. By the 15th century Paris had become the more prestigious of the two.

During the 13th century colonisation of medicine by university trained practitioners was well underway, justifying their right to exclusive healing through the above scientific training and to the exclusion of full and part time healers who had not undergone university training. This development was given recognition by the church in 1220 and through royal warranty in 1271. Medical practitioners were henceforth distinguished by illegal and legal practice, not by efficacy. The physician’s unwillingness to engage in hands-on practice, as seen above, was part a consequence of their clerical calling, guaranteed the division of responsibilities see throughout Europe. While French medicine produced outstanding individuals, as viewed in the context of medical history not treatments, such as Jean Fernal, throughout the 16th and 17th centuries, when modern day science based upon demonstrable outcomes emerged, Galenic Science became sanctified by tradition and Catholic Church.

The medical science of this period was informed, as I will prove that medicine largely is, by theoretical knowledge obtained outside its own practice, not only with regards to its dependence upon Classical ideas. It concentrated on observation of phenomena and from that position sought causes without thereby utilising practical methods to resolve causes or effects. Physicians worked on the Aristotelian principle that bodies were composed of matter and form, the latter seen as a separate immaterial substance drawn out of matter. There was therefore a separation between body and these immaterial aspects of the body that required treatment. These could be regulated by individual behaviour.[[41]](#footnote-41) A physician dealt with balancing humours and not directly with the body, as modern medicine deals with intrusive bodies within the material human body or failures of specific parts of the body. The former is connected to concepts of soul, the other to concepts of species survival indifferent to god or morality. The physician’s reputation depended on correct identification of causes not on also curing them. State recognised medicine was already removed from close consultation and interaction with patients.

While the philosophical stance of western medical practitioners will be considered at length, an attempt will also be made to demonstrate that many cures came from elsewhere and only Euro-centricity separates medical developments in the Near East and further afield from that within the Christian states. There were numerous similarities between Ancient Indian and Western medicine going back to Classical Greece.[[42]](#footnote-42) Indian medicine tended to be absorbed by theories of the origin of disease, with an early historical belief in causation as regards individual behaviour, followed, as in Western medicine, by an epistemology concerned with observation and reasoning based on humoral theory. While the Indians called these three elements *dosas* or defilements they seem connected to Hippocratic and Galenic humours. In this system, disease came from outside and invaded the body or were inherited in some fashion or another. Indian medicine at this stage more closely resembled modern medicine than its Western counterpart, except in its belief in the workings also of divinities. Indian medicine, by the 11th century CE, had a concept of contagion. [[43]](#footnote-43) Traditionally Indian medical practitioners formally emerge in the 6th century BCE, exhibiting a concern with surgery. According to Dr Kutumbiah[[44]](#footnote-44)there were two systems of teaching, Brahmanical and monastic, although Dr Bhattacharyya (1995) raises doubts that it was quite so clear cut and suggests that the profession was open. As with religious training, a master was chosen as a teacher. As with Western medicine, an apprentice was expected to demonstrate character, including good manners, purity of mind, courage and endurance to pain. A medical student learned both theory (Sastra) and practice (Karma). Although a physician might be adept at practice, without the theory he remained a quack. There were a number of educational institutions where medicine was taught, including monasteries. Although Bramanical texts stigmatise physicians, they appear to have achieved considerable influence as part of state apparatus. In medieval times a number of educational facilities and hospitals were established for the training of physicians.[[45]](#footnote-45)Indian physicians, once qualified, attained disciples and often engaged nurses, establishing thereby surgeries. The economic basis of their profession is indicated by their wealth. As with Western medicine, practitioners emerged out of serious thought and hard study, but their understanding of disease and health does not seem to have permeated down into the masses who still believed in Karma and devils. Notwithstanding different societies and religious perceptions, Indian medicine seems to have been on a par with Western Medicine. Islamic medicine during the same time-period espoused many of the same concerns with science and the nature of diagnosis, but appears to have been more concerned with relationships with patients and their dependents. Western medical practitioners, as a corporate group, searched for exclusivity, to remove themselves from everyday considerations. This provided Western physicians with perhaps greater political energy, without competing with or being subservient to priests or other groups concerned with healing. Medical development in the West has often consisted of propaganda rather than cohesive investigation of performance and the recent triumph of western medicine has hidden potential and real disasters.

The idea that equilibrium equals health, and of course dis-equilibrium illness, would appear to have its roots in ancient Greek thinking, although in fact it has its roots in Near Eastern culture, where balance was seen as fundamental to the good life and is still evident in sayings such as ‘don’t drink to excess’ and in preventative medicine. Human behaviour was separated into naturals and non-naturals (human activity), with contranaturals, that is diseases. The four ancient elements of air, fire, water and air comprised the humours, which themselves possessed qualities: phlegm, cold and wet; black bile, cold and dry; blood, hot and wet; yellow bile, hot and dry. These allowed for the nature of responses to contranaturals combined with complexion and temperament, which reflected such things as age and sex. The body was seen as a *‘seething mass of fluids.’* (Lindemann, 2010, page 18). Alongside these ideas on the humours and balance were religious concepts on illness and moral corruption, although these were not consistently or necessarily generally held.[[46]](#footnote-46) As in the previous centuries, few patients relied exclusively on religious or secular healing but tried all that were available or, just as likely, together. Medical treatment was usually combined with expiation of sins and penance.

**Universities:**

By the turn of the 17th century there were a number of universities throughout France teaching medicine, often differentiated by religion. Toulouse faculty was Catholic, Caen Protestant. In the early part of the 17th century the foreign tour was an essential part of higher education. Milton for example travelled into Italy, an essential destination, and met the old Galileo while he was incarcerated at home by the Pope. For medical students the foreign tour, or *peregrination medica,* visiting centres of excellence was essential to the creation of prosperous careers. From c1500 to 1789 a succession of universities became the medical schools of choice. These included Padua in the 15th and 16th century, Paris in the 16th and Leiden and Edinburg in the 17th. The foreign tour neatly fits in with the importance of journeying to gain knowledge, returning to the original homeland to acquire greater status. Recently, student migration from Asia into Europe has met the same ends. William Harvey came back from Padua in 1602, equipped with anatomical skills. Foreign colleges operated as a finishing school for the sons of the growing middle-class, who had often obtained their riches in trade, establishing status and credentials.

Throughout the 16th and 17th centuries Galenic texts were referred to but not it seems fanatically. Paris lecturers began to reject Galen and focused instead on Hippocratic text, although very few of these are likely to have been written by Hippocrates, if, indeed, he ever existed. Notwithstanding, lectures in surgery and pharmacy were given throughout this period although pharmacy, anatomy and botany were not made compulsory until the time of Louis X1V. Throughout this time, a more dynamic approach to teaching emerged based on the development of textbooks written in the vernacular. Change was therefore evident, but outside of the normal educative processes of the main universities, amongst surgeons and through scientific investigation. Although by the early part of the 17th century Harvey had demonstrated the blood’s circulation, and Descartes had separated subject and object, medicine still largely kept to traditional ideas. Galen ceased to have untrammelled influence and there was an increased number of adherents of the Swiss physician Philippus Aurelolus Theophrastus Bombastus von Hohenheim, or Paracelsus, who died in 1541. A Protestant, probably inspired by Luther’s desire to reshape Christianity, Paracelsus wanted to reject Galenism and construct a medical science based upon nature. Although this seems eminently satisfying in so far as he gave credence to folk remedies, and sanctioned the belief that all creation was interrelated, a boon for later scientists, he advocated astrology and alchemy. Paracelsus held that diseases were the result of poisons invading the body, placing him closer, by ignoring individual behaviour, to modern concepts. His importance lies in his belief that the works of the ancients could be dispensed with and with his advocacy of minerals as part of a cure. In fact his focus on cures rather than diagnosis set him apart and lead to accusations of empiricism. Although few Paracelsians became medical graduates he appears to have influenced medical thinking, and during the 16th century Paracelsian remedies were being promoted by Montpellier.

Again, by concentrating on physicians it would be assumed that these represented a defined method of treatment and cure rather than representing social aspiration and change. If compared to folk or community methods physicians were still as likely to kill as cure, driven by theories that gave credibility to their authority but not their art or craft. Community methods relied upon natural and household substances that produced innumerable benefits, except of course in cases of wounding and wherever surgery was necessary.

**Doctors at War:**

The conflict over supremacy amongst medical professionals in France was overt and volatile, leading occasionally to legal action, and, was often played out before the king. The growth of physician’s power thereby took a slightly different route in France, but nevertheless reached the same end. In France the physician’s lofty position was further enhanced by an expressed association with science, not just academia, and through an entrenched position within the universities. While in England physicians’ power was contingent on the views of the prevailing monarch, not all of whom were convinced by their arguments, and therefore conflict over status and power between physicians and surgeons was less intense, in France according to James William Barlow[[47]](#footnote-47)competition amounted to war.

In France the differences between physicians and surgeons appears to have resembled overt conflict fought out in the public domain within sight of Royal authority. The battlelines were drawn between physicians, surgeons and barbers. As in England, physicians had emerged from the clergy, and surgery from the inability of the clergy to engage in the shedding of blood. Surgeons were by nature an inferior class of men. An equally strong reason for physician’s rejection of manual activities was the connection between such activity and the lower classes. Physicians neededto be socially closer to the aristocracy. Considered mere mechanics, surgeons were excluded from the Faculty of Medicine.

In France, surgeons had long engaged barbers to aid them in their work. Over time they assumed more of the surgeon’s tasks until an edict of Charles V confirmed their right to apply plasters, ointments and to treat open sores. Thereby, during the latter part of the 15th century three powerful medical corporations existed in France; surgeons, physicians and barbers. The competition for clients was, according to Barlow (1914) fierce and made worse by the Faculty of Medicine that allowed barbers entry to their ranks, perhaps in order to undermine surgeons. The surgeons promptly took the Faculty of Medicine to court, which consequently legalised the standing of all three groups: a doctor could lecture on anatomy, but could not touch the body; a surgeon could perform dissection, with barbers present. The status quo was confirmed. In 1505 barbers were nevertheless admitted into the Faculty after passing an examination and agreeing not to practise surgical arts.

Although the surgeons continuously applied to the French kings for the right to be part of the university the Faculty each time barred their admittance by appealing to the authority of the Pope. In 1576 the surgeons attempted to gain admittance by force only for, after an unceremonious fist fight, the doctors to emerge again triumphant. Eventually, doctors and barbers quarrelled, as the latter attempted to increase their status, until, the matter was brought before Parliament, and the Court reduced them to their original status.

The physician’s fight for their privileges and status terminated in 1660 when the law courts decided against the surgeons, and the profession was effectively banned from involvement in university processes and formally amalgamated with barbers. Effectively, surgeons became ‘*the humble servants of the doctors*’[[48]](#footnote-48), not their equals as earlier in the century they had hoped.

Combined with protecting their status and professional power, French physicians, especially those who had graduated from the University at Paris exhibited disdain for recent medical and scientific discoveries, and even towards the end of the century could express belief in the infallibility of Aristotle. William Harvey published his book on the circulation of the blood in 1628, but even by 1672 it was argued against in the Faculty:

“*Circular motion, being perfect, belongs not to any but simple bodies, such as the stars; but the blood, being composed of four elements, is not a simple body. Ergo, circular motion is unsuitable for the blood. Moreover, if the blood circulates, bleeding would be useless, because the loss undergone by any organ would be instantly repaired. But it is impossible that bleeding can be useless. Ergo, the blood does not circulate*.” (Barlow, 1914, page 104).

Establishing again the superiority of theory over practice.

If Harvey’s proposition was true, this made nonsense of the Galenic belief in the separate functions of the venal and arterial system. New blood was not continually made in the liver, but venal blood flowed back to the heart and not to the extremities. Attacks on Galenic belief systems came also from the proposal of the Leuven physician Val Helmont that physiological and pathological changes were the result of chemical reactions, and the second, mainly by way of Descartes, that the body is a machine. But contrary to popular belief, Galenism survived and reason and evidence did not make inroads into medical thought as neither played much part in medicine of the day, rooted as it remained in social influence and power. Until the 19th century bloodletting remained part of a physician’s techniques, based though it was on an already outdated understanding of the human body.

The physician’s role remained to determine whether an illness was likely to be fatal or not and report the matter to someone in authority. As can be seen in the case of Erasmus, non-intervention was considered the correct approach, certainly given the confused outcome of medical procedures. Physicians observed rather than actively engaged in cures. [[49]](#footnote-49)As already noted, this was considered part of their superior status.

Although in Britain conflict between physicians, apothecaries and surgeons also continued it was of a nit-picking variety. Interfering or engaging in other’s expertise caused immense offence.[[50]](#footnote-50)Nevertheless, the period now under review constituted the medicalization of society, in which resorts to the medical profession became preferred to that of neighbours, family, magicians and religious personages. Moss and Peterson, (Ed)[[51]](#footnote-51)have reviewed changes in the approach to diseases through approaches to medicine in Shakespeare’s plays. Physicians offer advice, but it is usually sound.

**The growth of public medicine**

In France, by the 16th and early part of the 17th century, legitimised medical practitioners emerged as a powerful, legally recognised, corporative medical community[[52]](#footnote-52)headed by graduate physicians. This position did not reach deep into the societies of the time, it was after all a European phenomenon, but remained fixed to the elite. Nevertheless, medical power and influence, then and in the present, was a top down affair that only recently, driven by state medicine, has arrived to benefit at all the general population. The power obtained by the graduate physicians centuries ago, a mirror of aristocratic power and behaviour, has continued into the present in the guise of lordly consultants.

And yet medical developments had, as would often prove the case, little to do with medical practitioners but were in the growth of public health. The above acquired a more practical expression during the 17th century involving greater state involvement as the consequence of recurring plagues. In 1631 the *Parlement of Paris* established a health council. By 1660 royal administrators, intendants, had taken over the role of councils who later in the decade, with France again assailed by plague, established a cordon sanitaire around affected areas, localising the plague. Although public health began in Italy (Lindemann, 2010, page 199), French cities quickly followed. Surely the above author is right to note that administrative capabilities of states shaped communal health as much or more so than theories of medicine that invariably were wrong. In fact, whenever the state drove treatment and care, advances were often made. Although by the beginning of the 18th century plagues petered out, the use of quarantine may not after all have been the reason for its apparent containment. Also, there was a culture of flight before plagues, in that once it had appeared the rich would quickly leave a city or town. As Mary Lindemann[[53]](#footnote-53)points out, it would have been very difficult to stop everyone leaving if they wished to, many of the state apparatus developed much later, and therefore could not have affected matters, and that by the 17th century plagues did not arrive from outside Europe but were dormant in rats within Europe. She further suggests that the actual reason might have been alterations in trade routes and climate change. As in England, the authorities had realised the economic consequences of disease and the effect on manpower and overseas trade but unlike in England, which still engaged in an ad hoc fashion, public health became centralised under the king and his court. Physicians were employed only to manage central government policy. Concerns with military dominance under Louis X1V probably also encouraged central government involvement. Armies grew enormous during the 17th century culminating in the forces used by both the French, Germans and British in the early part of the 18th century. To sustain such armies, a healthy population was required.

Gathering statistics, a prolific and longstanding arm of epidemiology first noted in Italy and essential to present-day understanding of sickness, was exampled also by the London Bills of Mortality devised by John Gruant, a haberdasher and member of the Royal Society. The London Bills were a Table of Casualties for the period 1629-60, containing several non-specific terms. Certainly, this provided an initial step towards what is now seen as a truly scientific approach. The Bills of Mortality were formed from searchers, those detailed to discover the causes of a death. Usually such individuals had little formal medical knowledge, indicating that as yet the distinction between everyday medical knowledge and elite knowledge had yet to develop.[[54]](#footnote-54)Later, applying systematic methods, Percival Pott attributed scrotal cancer in chimney sweeps to their occupational exposure to soot and lack of hygiene. [[55]](#footnote-55)

The gathering of data on deaths warned of plague. In the 17th century it was understood that the poor were the most vulnerable, and many commentators asserted that this stemmed from moral and lifestyle choices. It was recognised that plagues moved from the poor communities in the richer communities. While the middle-class and aristocracy were seen as less contagious, and, of course, fundamentally more virtuous, the poor were seen on the one hand as requiring help and charity and on the other as dangerous. They were ‘*sluttishe, beastly people, that keepe their houses and lodynges uncleane, their meate, drinke, clothing most noisome, their laboure and travaile* immoderate’ (Wear 2000, page 283). The poor were linked to putrefaction, as was the plague. Constructs of the poor emerged from medicine as well as from concepts of societal structure based on work and residency. The data collected warned the rich of impending illness, allowing the aristocracy to flee, encouraged social control and discouraged the plague from being viewed as a shared experience.

In this fashion, medical practitioners became arms of the state, reflecting the economic and political aims of the French king where national interests were concerned. Control of plagues through containment became successful until the incidences of epidemics and pandemics considerably lessened.

**How people were treated:**

Catharine Knightprovides in *How Shakespeare Cleaned His Teeth and Cromwell Treated His Warts. Secrets of the 17th Century Medicine Cabinet (*2006, Tempus Publishing Ltd) an overview of treatments, both of the household recipes but also, in comparison, that of physicians. Her receipts are from original sources, often household books written down by wives or family members for the family group. These household books possessed a number of receipts for healing a variety of illness or simply providing advice. Coughs and colds, or cold *Rhumes* and *Flegms*, resulted in the provision of a variety of roots, herbs, alcohol and sweets serving as an expectorant with a high chance of success while for consumption a patient might be offered cooking ingredients. In *Rude physic for common soldiers* (Eric Sidebottom, 1977*)* it can be seen that many elements of 17th century society engaged in advising on or performing treatments. These community compounds fared well when compared with a judicious supply of well-washed snails, recommended by a Dr Gideon Harvey in a perhaps liberal interpretation of Galenic principles. Contrary to professional protestations, the physician’s receipts, composed of their remedies, may have been no different to household recipes. In early modern Europe, people did not go to the physician for a cure, but only the slim possibility of one, while also trying other remedies by other kinds of practitioners.

The community employment of herbs continued into the near-past and I remember them being advised by neighbours before the juggernaut of medical drugs swamped all other recipes and viewpoints. It is likely that their use is as responsible for aspects of modern medicine as the theories of the graduate physicians. Plants are useful in medicine because they contain alkaloids, which affect the nervous system. They can be carminative, good for digestion, expectorant, encourage coughing, stimulant, acting as tonic or aiding concentration, diuretic, stimulating production of urine, antiseptic, preventing infection. In fact most people today exist and subsist on one plant or another to accomplish daily activities and provide requisite moods. Medical drugs often provide a more dramatic form of these, if more dangerous and uncertain in their long term effects. Apart from this, many modern drugs are based on plants from the Americas and Asia, often synthetically reproduced.

Simples were plants used alone, both in household and community medicine but also in that of physicians and apothecaries. Paracelsus advised on their use and modern chemistry has confirmed their efficacy. Madness was dealt with through the use of purgatives. I will later consider how on occasion modern treatments have the same roots as their ancient counterparts. Most treatments were benevolent in their effects even if they rarely cured, and there seems little distinction between physician’s advice throughout the 17th century and household receipts. Still, especially in England, physicians represented just one of several medical practitioners, and had not yet assumed exclusive rights to healing.

Galenic and Paracelsian practitioners agreed in their attacks on ‘herb women’ and other community healers and methods of healing, based it seems on their lack of knowledge of humours. What did they know when they applied them wrong? And yet, at the time, so widespread was community healing that many people would have agreed instead with Robert Burton: ‘*Many an old wife or country woman doth often more good with a few known and common garden herbs than our bombast Physicians with all their prodigious, sumptuous, far-fetched, rare, conjectural medicines*.’[[56]](#footnote-56)Where community medicine was acknowledged it was as the lowest point of a hierarchical tree, of which physicians inhabited the very top (Wear, 200).The difference between the two groups, notwithstanding the innovations made by physicians as evidenced by early forms of rhinoplasty (Lindemann, 2010, page 133), was organisation, authority, power and the tendency to propagate their shared views through writing. The literate tradition of the physicians continually asserted its superiority through aspects of communication, i.e. classical references that belonged outside of medicine.

Disdaining the qualities and characteristics of others is a condition of colonisation. At the same time that physicians were lambasting community healers, while appropriating their methods, they wrote equally disparagingly about the medical practitioners of distant, foreign lands while praising the medicinal qualities of their plants. Far Eastern medical practitioners were merely barbarians who should be relieved of their cures and given to Western Europeans who were best able to employ them. In fact, not only is this the viewpoint of the coloniser but also of the merchant who thinks of medicine in terms of profit. Medicines from the Americas, such as guaiac used for the pox, brought a fortune to the Spanish government. The entrepreneurial pursuit of medicines can be linked to the colonising tendencies of European states in the pursuit of spices from the 15th century onwards,[[57]](#footnote-57)during which Europe’s wealth increased dramatically. Conspicuously, as I will later consider, demotion of community medicine occurred simultaneously with the exclusion of women, who played a central role in employing and propagating the treatments, from medicine.

1. Sanders, Richard. How Football was Born. History Today. Vol.63, issue 10 [↑](#footnote-ref-1)
2. Gottfried, Doctors and Medicine in Medieval Europe. 1340-1530. Princeton University. 1986 [↑](#footnote-ref-2)
3. Schmitt. Ed. Wear, French, Lonie. The medical renaissance of the sixteenth century. Cambridge University Press, 1985. [↑](#footnote-ref-3)
4. English Almanacs, Astrology and Popular Medicine: 1550-1700. Hill Curth. Manchester University Press. 1988. [↑](#footnote-ref-4)
5. Ed. Faith Wallis. Medieval Medicine. A Reader. University of Toronto Press. 2010. [↑](#footnote-ref-5)
6. Ed. Faith Wallis. Medieval Medicine. A Reader. University of Toronto Press. 2010.Page 423 [↑](#footnote-ref-6)
7. Ed. Faith Wallis. Medieval Medicine. A Reader. University of Toronto Press. 2010. Page 86. [↑](#footnote-ref-7)
8. Kate Kelly. History of Medicine: The Middle Ages 500-450. 2009 [↑](#footnote-ref-8)
9. Doctors and Medicine in Medieval England 1340-1530. 1986. Page 263 [↑](#footnote-ref-9)
10. Kate Kelly. The History of Medicine. The Middle Ages. 500-1450. 2009. Facts On File, Inc. [↑](#footnote-ref-10)
11. Alan Withey, A National Health Service. History Today. Vol.63 issue 10. [↑](#footnote-ref-11)
12. Doctors and Medicine in Medieval England 1340-1530. Princeton University Press. 1986. [↑](#footnote-ref-12)
13. Ed. Wear, Geyer-Kordesch, French. Doctors and Ethics: the Earlier Historical Setting of Professional Ethics. Rodopi. 1993.pages 110-111. [↑](#footnote-ref-13)
14. English Almanacs, Astrology and Popular Medicine: 1550-1700. Hill Curth. Manchester University Press. 1988. Page 15. [↑](#footnote-ref-14)
15. Gottfried, Robert S. Doctors and Medicine in Medieval England 1340-1530. Princeton University Press. 1986. [↑](#footnote-ref-15)
16. Jenner, Wallis. The Medical Marketplace. Ed. Jenner, Wallis. Medicine and the Market in England and its Colonies, c. 1450-c.1850 [↑](#footnote-ref-16)
17. A.W. Sloan. English Medicine in the Seventeenth Century. Durham Academic Press. 1996.page 2. [↑](#footnote-ref-17)
18. Ed. Faith Wallis. Medieval Medicine: A Reader. 2010, page 86. [↑](#footnote-ref-18)
19. Margaret Pelling. The Common Lot. Longman 1998. Page 33. [↑](#footnote-ref-19)
20. C.D. O’Malley. English Medical Humanists University of Kansas Press. 1965 [↑](#footnote-ref-20)
21. Ed. Faith Wallis. Medieval Medicine. A Reader. University of Toronto Press. 2010. [↑](#footnote-ref-21)
22. Vivian Nutton. Medieval medicine. Metascience 2010. 19: 83-85. [↑](#footnote-ref-22)
23. Quacks. Tempus publishing, 2000, page 127. [↑](#footnote-ref-23)
24. Sloan, English medicine, [↑](#footnote-ref-24)
25. Ed. Wallis, Faith. Medieval Medicine. A Reader. University of Toronto Press. 2010. [↑](#footnote-ref-25)
26. Pelling, Margaret. The common lot. Sickness, medical occupations and the urban poor in early modern England. Longman. 1998. [↑](#footnote-ref-26)
27. Poverty and Vagrancy in Tudor England. Longman, 1986. [↑](#footnote-ref-27)
28. Madness and Civilisation. A History of Insanity in the Age of Reason. 1961. University Press, Cambridge. [↑](#footnote-ref-28)
29. The Problem of the Poor in Tudor and Early Stuart England. Methuen. 1983. [↑](#footnote-ref-29)
30. Beier, 1983, page 5. [↑](#footnote-ref-30)
31. Healing the body politic: French royal doctors, history, and the birth of a nation 1560-1634. Renaissance Quarterly 55.4 (Winter 2002) p1259 [↑](#footnote-ref-31)
32. Carmichael, Ann C. Epidemics and State Medicine in Fifteenth Century Milan. Ed. French, Arrizabalaga, Cunningham, Garcia-Ballester.Medicine from the Black Death to the French Disease. Ashgate, 1998. [↑](#footnote-ref-32)
33. Medicine before Science. The Business of Medicine from the Medieval Age to the Enlightenment. Cambridge University Press. 2003. Page 152. [↑](#footnote-ref-33)
34. Ed. Wear, Simon, Geyer-Kordesch, French. Doctors and Ethics: the Earlier Historical Setting of Professional Erhics. Rodopi. 1993 page 113. [↑](#footnote-ref-34)
35. Ed. Wear, Simon, Geyer-Kordesch, French. Doctors and Ethics: the Earlier Historical Setting of Professional Ethics. Rodopi. 1993. Page 59. [↑](#footnote-ref-35)
36. Ed. Scott Mandelbrote. The Practice of Reform in Health, Medicine, and Science.1500-2000. Essays for Charles Webster. Ashgate, 2005. [↑](#footnote-ref-36)
37. Jacob Soll Healing the body politic: French royal doctors, history, and the birth of a nation 1560-1634.Renaissance Quarterly. 55.4 (Winter 2002) p1259. [↑](#footnote-ref-37)
38. Medicine and Science. Reprinted from the Journal of Philosophy, Vol.XXV, no. 15, July 19, 1928,403. [↑](#footnote-ref-38)
39. The Medical World of Early Modern France. Clarendon Press. Oxford. 1997. [↑](#footnote-ref-39)
40. Cited in Favre, La Mort, 72. [↑](#footnote-ref-40)
41. Brockliss, Jones. The Medical World of Early Modern France. Clarendon Press. Oxford 1997. Page 113. [↑](#footnote-ref-41)
42. S. K. Bagchi. The Interaction and Dissemination of Knowledge. Ed. Juthika Maitra. Medical Science in Ancient India. Centre of Advanced Study in Ancient Indian History and Culture University of Calcutta. 1995. [↑](#footnote-ref-42)
43. Kenneth G. Zysk. Does Ancient Indian Medicine Have a Concept of Contagion? Ed. Conrad/WujastykContagion: Perpectives From Pre-Modern Societies. Ashgate 1988. [↑](#footnote-ref-43)
44. Ancient Indian Medicine. Orient Longmans. Revised 1969. [↑](#footnote-ref-44)
45. Dr Amitabha Bhattacharyya. Early Indian Society: Medical Education and Medical Profession. Ed. Maitra. Medical Science in Ancient India. 1995. [↑](#footnote-ref-45)
46. Mary Lindemann. Medicine and Society In Early Modern Europe. Cambrisge University Press, 2010. Page 15. [↑](#footnote-ref-46)
47. Doctors At War, Studies of the French Medical Preofession circa the 17th Century. London David Nutt. 1914. [↑](#footnote-ref-47)
48. Barlow, Doctors At War, Studies of the French Medical Preofession circa the 17th Century. London David Nutt. 1914. Page 62. [↑](#footnote-ref-48)
49. Traister, Barbara Howard. “Note Her A Little Further”: Doctors and Healers in the Drama of Shakespeare. Diseases, Diagnosis and Cure on the Early Modern Stage. Ed. Moss and Peterson. Ashgate. 2004. [↑](#footnote-ref-49)
50. Furdell, Elizabeth Lane. The Royal Doctors 1485-1714. Medical Personnel at the Tudor and Stuart Courts. 2001. [↑](#footnote-ref-50)
51. Disease, Diagnosis, and Cure on the Early Modern Stage. Ashgate, 2004. [↑](#footnote-ref-51)
52. Brockliss, Jones. The Medical World of Early Modern France. Clarendon Press. Oxford. 1997. [↑](#footnote-ref-52)
53. Medicine and Society in Early Modern Europe. 2010. Cambridge University Press. 2010. [↑](#footnote-ref-53)
54. Andrew Wear. Knowledge and Practice in English Medicine, 1550-1680. Cambridge University Press. 2000 [↑](#footnote-ref-54)
55. John D Potter. Epidemiology informing clinical practice from bills of mortality to population laboratories. [www.nature.com/clinical](http://www.nature.com/clinical) practice/onc. 2005 Vol2 No12 [↑](#footnote-ref-55)
56. The Anatomy of Melancholy. 1621. [↑](#footnote-ref-56)
57. Andrew Wear. Knowledge and Practice in English Medicine, 1550-1680. 2000. Cambridge University Press. [↑](#footnote-ref-57)