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Kathleen Marie Reynolds

Sickness in Correspondence: gentry letter writing and the subject of health
in eighteenth-century Yorkshire, County Durham, and Northumberland

Abstract

This study uses eighteenth-century gentry correspondence from Yorkshire, County Durham, and Northumberland to investigate how letter writers discussed sickness and managed medical treatments in the home. Letter writers went beyond expressions of concern and reassurances of good health in correspondence by providing details about the experience of falling ill, diagnosing conditions, choosing treatments, and caring for their sick relatives. The extent of household medical work in the eighteenth century is an understudied topic compared to earlier centuries. This thesis redresses the lacuna in research by analyzing caregiving, medical knowledge, and medical expertise to reconsider the structure of household medicine and the extent to which the household functioned autonomously during illness.

The chapters can be envisioned as a series of thematic concentric circles. Beginning with the bodies of letter writers and their families (Chapter Two), each chapter expands its focus to wider elements of household health and covers caregiving practices (Chapter Three) and medical knowledge (Chapter Four). Chapter Five justifies how the household could be a site of medical expertise which simultaneously paid for medical care by introducing a sociological model which allows for the coexistence of experts with differing but complimentary expertises. Interactions with paid practitioner are the subject of Chapter Six. This thesis also explores continuity and change in medical and gendered behaviour over the eighteenth-century. Arguments about domestic healing as a female activity are mediated by the clear interest and involvement of their male relatives, and the emphasis on coexistence and cooperation between genders. Mediating between the survival of medical practice, the change in medical theories, and the gradual decreasing interest in discussing caregiving practices through correspondence allows this thesis to position the eighteenth-century household between earlier histories of household medicine and the spread of hospital medicine in the nineteenth century.

**Sickness in Correspondence:
Gentry Letter Writing and the Subject of Health in Eighteenth-Century
Yorkshire, County Durham, and Northumberland**

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Thesis submitted for the degree of Doctor of Philosophy
Department of History, Durham University

November 2017

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This thesis is dedicated to the memory of Audra Bourque
and to the promising future of her grandson Ben.

It's fitting that the woman who helped me count my chickenpox
should have an important place in a thesis on medicine,
and I know you would want to share the moment.

You are loved and remembered.

Chapter 1 — Introduction

Illness was a subject of great interest to gentry correspondents in eighteenth-century England. Letter writers regularly expressed concern regarding the state of their recipients and made reassurances about their own health. They also provided details about the experience of falling ill, and caring for their sick relatives, and choosing treatments. The inclusion of information in letters on diagnosing illness, managing the sick room, and providing medicines was enabled because even severe diseases were managed in the home before hospital medicine became more widespread in the nineteenth century. Because early modern illness generally began and ended in the home, most families possessed a high level of skill and knowledge on medical matters. Illness required special attention to diet, to the temperature and cleanliness of rooms, and to the regulation of sleep. Early modern families took this further by frequently self-diagnosing and supplying homemade remedies, and managing the administering of treatments recommended by external practitioners.

Despite the extent of this medical work, Anne Stobart has noted that there has been little research on household health care activities and that historians make only general statements about the home.¹ The lack of interest in these subjects is particularly pronounced for the eighteenth century because most existing studies of family medical work focus on the centuries previous. My research extends the history of household medical practices into the eighteenth century. Visiting the subjects of caregiving, medical knowledge, and expertise, it studies the structure of household medicine and the extent to which the household functioned autonomously during illness. This thesis mediates between the household as a site of kinesthetic skills, knowledge, and a range of resources available to support families during illness. Illness is explored through letters exchanged between gentry families and their relatives and close friends.

Using correspondence emphasizes the position of the household within social and medical communities. Helen Berry and Elizabeth Foyster note that the household was “imbedded in a network of kin, friends, and neighbours”.² These relationships are reflected in both the networks through which familiar letters traveled, and the social scenes portrayed within correspondence. Although letter writing served a range of purposes, ranging from business to

¹ Anne Stobart, *Household Medicine in Seventeenth-Century England* (London: Bloomsbury Academic, 2016): 1.

² Helen Berry and Elizabeth Foyster, “Introduction” in *The Family in Early Modern England*, ed. Helen Berry and Elizabeth Foyster (Cambridge: Cambridge University Press, 2007): 11.

pleasure, this thesis focuses on a particular type of letters which were most likely to contain medical information: the familiar letters exchanged between family and friends. Clare Brant has observed that through expressive language and plain discourse, these letters projected an idea of familiarity, informality, intimacy, and spontaneity.³ Letters were compared to conversations, and attempted to evoke the presence of the recipient.⁴ Within these simulated conversations, Roy Porter has observed the “endless inquires after and information about health, and judgements upon various doctors” as well as the “detailed recommendations about particular cures and remedies, and advice about how to preserve or restore ones health” that can be found in letters between family and friends.⁵ The status of health as an ongoing concern meant that it was also commonly integrated into correspondence.

The household was the framing element of familiar correspondence and the primary site in which illness was treated. Domestic spaces have also been central to historiographic and historical narratives on identity and knowledge. Robert Shoemaker states that both the family and household were “units of central importance in English society”, and that the household in particular was the most common unit of economic production, the key environment in which children, apprentices, and domestic servants were socialized, and a political model in which the hierarchies of the household were seen to mirror obedience to the state.⁶ Other historians emphasize the symbolic significance of households. Berry and Foyster observe that the home “symbolized family honour and reputation”, and Tague comments that the household was understood as a “physical manifestation of a family’s status”.⁷ The household simultaneously existed as a haven from the pressures of public life, and engaged in the market to sustain family functionality. Blecourt and Osborne remark that current studies presume “a strict boundary between public market and private household and focuses on the former at the cost of the latter”.⁸ Examining household medicine, in which familial self-care frequently coexisted with the

³ Clare Brant, *Eighteenth-Century Letters and British Culture* (Basingstoke: Palgrave Macmillan, 2006): 15.

⁴ *Ibid.*, 21-2.

⁵ Roy Porter, “The patient in England” in *Medicine in Society: Historical Essays*, ed. A. Wear (Cambridge: Cambridge University Press, 1992): 102.

⁶ Robert Shoemaker, *Gender in English Society, 1650-1850: the Emergence of Separate Spheres?* (London: Longman, 1998): 87.

⁷ Berry and Foyster, “Introduction,” 12; Ingrid H. Tague, *Women of Quality: Accepting and Contesting Ideals of Femininity in England, 1690-1760* (Woodbridge: Boydell Press, 2002): 99.

⁸ Willem de Blecourt and Cornelia Osborne, “Medicine, mediation and meaning” in *Cultural Approaches to the History of Medicine: Mediating Medicine in Early Modern and Modern Europe*, ed. Willem de Blecourt and Cornelia Osborne (Basingstoke: Palgrave Macmillan, 2003): 3.

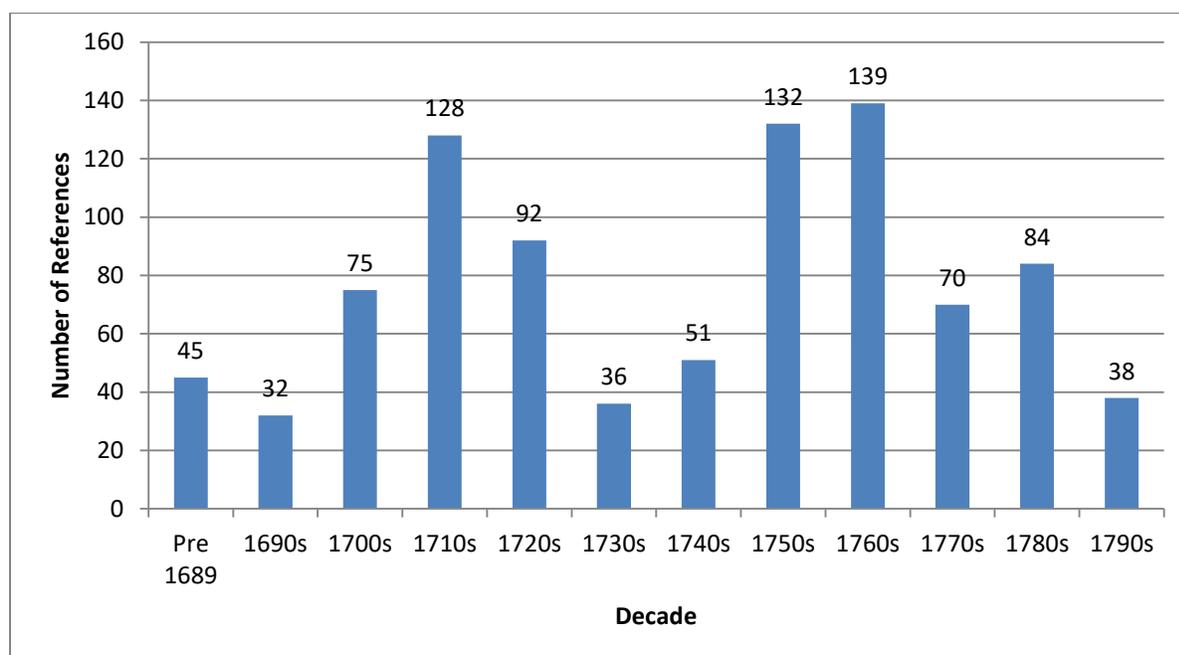
medical advice and treatments of external practitioners, reveals the inadequacy of separating the home from wider medical thought and work.

Gentry familiar correspondence in Yorkshire, County Durham and Northumberland is used in this study to investigate one way in which families in the eighteenth century discussed and managed health and sickness in their households. This approach will demonstrate the nature of medical work in the home by asking how household healthcare was defined, gendered, performed, and transformed between c. 1670 and 1800. Though the household is recognized as a central space in early modern health, histories of medical practice in the home usually terminate in the early decades of the eighteenth century. Complicating the issue further, eighteenth-century studies are divided by research into the reordering of gender roles, the significance of materialism for families, and medical histories which focus on the behaviour of paid medical practitioners. By investigating the eighteenth-century home as a site of medical work, this thesis unites these historiographic themes.

In fact, a history of medicine in the eighteenth century is enabled by the same elements which historians have used to characterize the eighteenth century as a period which was distinct from the high level of continuity in early modern medicine. Increasing literacy began to penetrate wider society, allowing for access to voices which would have been unheard in previous centuries. This reveals the dense networks of communication about ill health. Additionally, the rise of the medical and social theory of sensibility in the mid-eighteenth century produced new forms of self-interest and preoccupations with health which are complimentary to investigations of illness narratives in the seventeenth century. As well as contributing to the history of early modern households, this thesis remains aware of the many unique features that influenced how letter writers perceived their experiences of illness and their lives at home.

In order to approach the wide-reaching and constantly evolving subject of illness, this project has imposed a series of restrictions. First, it will focus primarily on the long eighteenth century, beginning when letter writers began producing correspondence frequently depicting illness in the 1670s and 1680s, and concluding in 1800 during the decline of substantial, lengthy references to medical work in the domestic space. As seen in Figure 1.1, the highest density of references to illness in this study were exchanged between 1740 and 1770, allowing a particular

Figure 1.1 – References to Illness in This Study’s Gentry Correspondence by Decade



theory. Within this century, the thesis focuses further on the familiar letter because of the tone of intimacy and the degree of information about the household which it contained. Finally, the families have been selected from Yorkshire, County Durham and Northumberland, which has allowed a comprehensive investigation of the family correspondence from fifteen families and in turn produced a detailed analysis of their regional context and the individual practices of each gentry family. Restricting the chronology, type of source, and geographic location has therefore made it possible to compile more definitive arguments about the type of medical information and skills which correspondence indicates that a family was expected to possess. It has also avoided presenting the households in this study as a timeless or universally “English” phenomenon by utilizing a regional case study, allowing for precise statements about the medical practices of the gentry of Yorkshire, County Durham, and Northumberland which form a more exact basis for further studies on national practices. This study does not seek to generally explain the experience of illness in the eighteenth century. Instead, the work produces a particular analysis of the management of familial health for a specific class of people in a specific time and place.

Household Illness Historiography

Dorothy and Roy Porter comment that “Health had to begin at home” in the early modern period. Self-care was a necessary household and social skill and domestic medicine allowed families to

take for granted that “everyday ills and spills” could be managed in the home.⁹ However, the paucity of detailed sources on private life has made it difficult to trace the experiences of performed household work and medical decisions. Early historiographic explorations of medicines in the domestic sphere were instigated as an attempt to recover a history of women and healing. As Mary Fissell has argued, this process has been complicated by the underdocumentation and undervaluing of women’s work.¹⁰ There has also been an emphasis on the preparation of medicines, including Elaine Leong’s analysis of collecting and testing recipes as a form of knowledge production within domestic spaces.¹¹ The preparation of medicines was a fundamental element of household caregiving. Complimenting historiography on recipes with more details about how households diagnosed and cared for sick relatives provides a more comprehensive view of medical capabilities in the home.

Histories of household work have traditionally had a strongly gendered perspective which followed the dictates of prescriptive literature which indicated that women should be in the home and perform medical work. As a result, historians have structured research questions around the “unspoken assumption that women’s healing was limited to the domestic sphere, and that it remained largely outside the commercial realm”.¹² The earliest studies on women’s medicine often emphasize universal expectations regarding women’s medical roles as part of the context for women’s paid medical work. Historians such as Lucinda McCray Beier and Doreen Nagy emphasize the expectations that women fulfilled a prominent role in providing care, particularly due to expectations that they would prescribe and nurse for those around them.¹³

There has been particular emphasis on the significance of noble or gentry women’s medical responsibilities, such as Linda Pollock’s description of the intersection of spirituality and medicine in the life of sixteenth-century gentlewoman Grace Mildmay, Susan Broomhall’s exploration of the role of female medical knowledge for French court life and elite women, and

⁹ Dorothy Porter and Roy Porter, *Patient’s Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 35-6.

¹⁰ Mary E. Fissell, “Introduction: women, health, and healing in early modern Europe,” *Bulletin of the History of Medicine* 82.1 (Spring 2008): 5.

¹¹ Elaine Leong, “Making medicines in the early modern household,” *Bulletin of the History of Medicine* 82.1 (Spring 2008): 145-168; Elaine Leong, “Collecting knowledge for the family: recipes, gender and practical knowledge in the early modern household,” *Centarus* 55.2 (May 2013): 82.

¹² Fissell, “Introduction,” 8.

¹³ Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London: Routledge and Kegan Paul, 1987): 5; Doreen Evenden Nagy, *Popular Medicine in Seventeenth-Century England* (Bowling Green: Bowling Green State University Popular Press, 1988): 2.

Alisha Rankin's description of the medical practices of sixteenth-century German noblewomen.¹⁴ Leigh Ann Whaley also devotes a chapter to "Motherly medicine: domestic healers and apothecaries" in her long history of early modern women's medical care.¹⁵ Such detailed studies often rely on a limited number of women because the survival of extensive source information is exceptional, and by studying a range of gentry families this study will compliment such research by establishing the extent to which families performed medical work.

Studying women as distinct from men in the home has persisted into recent historiography, including Edith Snook's argument that, despite her acknowledgement that men cared for their children, children's diseases were a particular area of knowledge and authority for women.¹⁶ Snook's arguments reflect the prioritization of female medical knowledge and spaces found in much of the literature on pregnancy and childbirth. For example, Adrian Wilson has claimed that childbirth was a female ritual from which men were almost universally excluded before the entrance of the man-midwife in the early eighteenth century.¹⁷ Daphne Oren-Magidor considers women to be "experts" on their diseases because their reluctance to discuss fertility problems resulted in a preference for self-treatment, disregarding the importance of ungendered familial support and the knowledge husbands could bring to a medical encounter.¹⁸ This implicitly endorses the narrative which saw women's bodies as "secret" and opaque, in line with the academic gynecological arguments, rather than a gender shared-area area of concern and cooperation.¹⁹

¹⁴ Linda Pollock, *With Faith and Physic: the Life of a Tudor Gentlewoman, Lady Grace Mildmay 1552-1620* (London: Collins and Brown, 1993); Susan Broomhall, *Women's Medical Work in Early Modern France* (Manchester: Manchester University Press, 2004); Alisha Rankin, *Panacea's Daughters: Noblewomen as Healers in Early Modern Germany* (Chicago: Chicago University Press, 2013).

¹⁵ Leigh Ann Whaley, *Women and the Practice of Medical Care in Early Modern Europe, 1400-1800* (Basingstoke: Palgrave Macmillan, 2010): 150-173.

¹⁶ Edith Snook, "'The women know': children's diseases, recipes and women's knowledge in early modern medical publications," *Social History of Medicine* 30.1 (2017): 4.

¹⁷ See Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770* (London: UCL Press, 1995) and Adrian Wilson, *Ritual and Conflict: the Social Relations of Childbirth in Early Modern England* (Farnham: Ashgate, 2013).

¹⁸ Daphna Oren-Magidor, "Literate laywomen, male medical practitioners and the treatment of fertility problems in early modern England," *Social History of Medicine* 29.2 (2016): 3.

¹⁹ For research on the subject of "women's secrets" and the female body, see Monica Green, "From 'disease of women' to 'secrets of women': the transformation of gynecological literature in the later middle ages," *Journal of Medieval and Early Modern Studies* 30.1 (2000): 5-39; Monica Green, *Making Women's Medicine Masculine: the Rise of Male Authority in Pre-Modern Gynaecology* (Oxford: Oxford University Press, 2008); and Katharine Park, *The Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006).

Monica Green has suggested that the emphasis on a biological basis for women's medical work has resulted in a lack of coherence in the history of women's medicine, inhibiting historians' ability to perceive gender as a changeable and historically-based cultural artefact, rather than static.²⁰ Emphasizing women's expertise and skills in a vacuum presents an uneven image of the lived experience of eighteenth-century women and also does a disservice to the ways in which families mediated both gender roles and relationships. Historians have offered reformed narratives which reflect the desire to place women's work and the domestic space in context by investigating both men and women's household roles and informal medical work. For example, Hannah Newton asserts in her study of the experiences of sick children and their families that "there appears to have been no clear gender division in the roles of parents as carers: fathers as well as mothers looked after their sick offspring", and Leanne Calvert has countered the narrative of childbirth as a female domain by proving that men were interested and actively involved in pregnancies.²¹ In addition, Lisa Smith has stressed not only that men had significant power in regulating household medical decisions, but that their interest in health was a fundamental feature of their masculinities.²²

Recent explorations of household health have also presented the involvement and cooperation of men and women. Olivia Weisser's work focused on the sick role, arguing that gender shaped both "comportment and communication" during illness, and emphasized the importance of sociability in the form of attention from men and women during illness.²³ Anne Stobart explores the nature of "self-help" and the series of economic constraints for seventeenth-century households through chapters on nursing, remedies, finances, kitchen physic, therapeutics, and chronic disorders.²⁴ Financial elements were necessarily part of the context of medical decisions, but were routinely absent from this study's correspondence which focused on general methods of falling ill and regaining health. This thesis responds to the image of

²⁰ Monica Green, "Gendering the history of women's healthcare," *Gender and History* 20.3 (November 2008), 509.

²¹ Hannah Newton, *The Sick Child in Early Modern England, 1580-1720* (Oxford: Oxford University Press, 2012): 4; Leanne Calvert, "'A more careful tender nurse cannot be than my dear husband': reassessing the role of men in pregnancy and childbirth in Ulster, 1780-1838," *Journal of Family History* 42.1 (2017): 22-36.

²² Lisa Smith, "Reassessing the role of the family: women's medical care in eighteenth-century England," *Social History of Medicine* 16.3 (2003): 340; Lisa Smith, "The relative duties of a man: domestic medicine in England and France, ca. 1685-1740," *Journal of Family History* 31.3 (July 2006): 247.

²³ Olivia Weisser, *Ill Composed: Sickness, Gender and Belief in Early Modern England* (New Haven: Yale University Press, 2015): 3, 184.

²⁴ Stobart, *Household Medicine*, 2, 5.

cooperation, influences of social expectations, and gendered division of the tasks between men and women within domestic spaces.

While the history of patient and caregiver behaviour is becoming more detailed, most historians choose to end their investigations in the early decades of the eighteenth century because of a perceived discontinuity or turmoil in the period. Both Hannah Newton and Anne Stobart focus on the seventeenth century as a time of dramatic upheaval in which lay beliefs about health and disease shifted.²⁵ This positive framing emphasizes the sufficient complexity of managing one century's changes. Works that incorporate the eighteenth century are often collected volumes or broad overviews, such as Hilary Marland and Margaret Pelling's *The Task of Healing*, Leigh Ann Whaley's *Women and the Practice of Medical Care in Early Modern Europe*, or Dorothy Porter and Roy Porter's *Patients Progress*.²⁶

In contrast, much of the work on the female body and household medicine in England terminates in the eighteenth century because of a perceived discontinuity or upheaval in the period. Olivia Weisser's study of the illness experience covers the period 1630-1730, which she states allows her to avoid the "conceptual shift" of the eighteenth century in which irritable, slackened nerves became more significant than obstructed or imbalanced humours.²⁷ Similarly, Sara Read concluded her study of menstruation in the "early part of the eighteenth century", citing the decline or waning of humoral medicine and the socio-cultural changes which effected medicine as the reason for her chronology.²⁸ Jennifer Stine's dissertation on recipe closets concludes with comments that household medicine was a story of discovering new treatments and disclosing old "secrets", and that while women had a role in this discovery, the genre was codified by the 1690s and women no longer had the same role or authority.²⁹ However, examining the descriptions of illness in letters reveals a remarkable degree of continuity both in

²⁵ Newton, *The Sick Child*, 7; Stobart, *Household Medicine*, 3.

²⁶ Hilary Marland and Margaret Pelling, *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands, 1450-1800* (Rotterdam: Erasmus Pub, 1996); Whaley, *Women's Medical Work*; Porter and Porter, *Patient's Progress*.

²⁷ Weisser, *Ill Composed*, 7.

²⁸ Sara Read, *Menstruation and the Female Body in Early Modern England* (Basingstoke: Palgrave Macmillan, 2013): 12.

²⁹ Jennifer K. Stine, "Opening closets: the discovery of household medicine in early modern England," PhD diss (Stanford University, 1996): 193, 216.

medical thought and practice which link the eighteenth century to an earlier period, rather than to the nineteenth-century which is characterized by the rise of hospitals and laboratory medicine.³⁰

Medical Beliefs

The eighteenth-century medical world was characterized by a complex relationship between the introduction of new ideas and practices and the continuation of traditional explanations and treatment.³¹ Humouralism had long been the most dominant and enduring medical system, necessitating the preservation of internal balance through moderation and preemptive care.³² Combining Galenic and Hippocratic medical theories, the model described human bodies as comprising of four internal, fluid “humours” of black bile, yellow bile, blood, and phlegm which, when balanced according to an individual’s constitution, produced a state of good health.³³ Humoural understandings of the body dominated the early-modern period because of the adaptability of humouralism as an explanatory model. Michael Carl Schoenfeldt accentuates “the seductive coherence” and “experiential suppleness” of humouralism.³⁴ Owsei Temkin suggests that the persistent success of humouralism can be found in “its having provided medical categories, like the temperaments, for relating the individual to health and disease”.³⁵

The explanatory malleability of humouralism complicates any effort to trace its elimination from medical theory. Temkin demonstrates that though Galenism was in its “afterlife” by the seventeenth century, “the fall of the Galenic science of medicine was not identical with the fall of the Galenic practice of medicine”.³⁶ Though scholarly medicine might have adapted to new theories, ideas about the body as fluid and understanding of medicines as working through purgation or having “hot” and “cold” influences were persistent. Helen King indicates that humoural understandings of the body existed “up at least the eighteenth century”,

³⁰ W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994): 218.

³¹ Silvia De Renzi, “Old and new models of the body” in *The Healing Arts: Health, Disease and Society in Europe 1500-1800*, ed. Peter Elmer (Manchester, Manchester University Press, 2004) 179; Continuity and change were particularly emphasized in Shoemaker, *Gender in English Society*.

³² Mary Lindemann, *Medicine and Society in Early Modern Europe, Second Edition* (Cambridge: Cambridge University Press, 2010): 13-19, 88.

³³ Helen King, *Hippocrates’ Woman: Reading the Female Body in Ancient Greece* (London and New York: Routledge, 1998): 34; Lindemann, *Medicine and Society*, 13-19, 88.

³⁴ Michael Carl Schoenfeldt, *Bodies and Selves in Early Modern England: Physiology and Inwardness in Spenser, Shakespeare, Herbert, and Milton* (Cambridge: Cambridge University Press, 1999)

³⁵ Owsei Temkin, *Galenism: Rise and Decline of a Medical Philosophy* (London: Cornell University Press, 1973): 178.

³⁶ *Ibid.*, 165.

and points to the preservation of humoral practices well into the nineteenth century in her discussion of bloodletting as a medical treatment.³⁷ Particularly when analyzing wider social understandings of medicine and healing in domestic spaces, then, humoralism is a fundamental explanatory system.

In the mid-eighteenth century, the theoretical emphasis on the movement of internal fluids was complicated by the model of sensibility's focus on the nervous system's control of bodily functions, and the way in which the relative sensitivity of nerves to stimuli influenced the behaviour of genders but could simultaneously result in sickness. Geunter Risse identifies a "momentous shift" in physiology and medicine in 1752, when Swiss physician Albrecht von Haller suggested that "irritability" was due to external influence, independent from the nervous system, and "sensibility" was the capacity to perceive these outside stimuli within the core of nerves.³⁸ It is unclear the extent or speed with which these ideas were accepted by wider society, but the gentry were particularly positioned to interpret new ideas because of their access to physicians and educational institutions. Physicians such as William Cullen, who Geunter Risse depicts as "Britain's foremost clinician during the second half of the eighteenth century" and a popular medical consultant, further theorized regarding the control of nerves over solids and fluids in order to manage the sensory stimulation from both the external environment and the brain.³⁹

There was a high level of continuity between the humoral and sympathetic systems. Medical practitioners and the lay population found both models useful. In the introduction to *Patients and Practitioners*, Roy Porter describes an "umbrella of shared knowledge" which contained "greatly overlapping, if not identical, cognitive worlds".⁴⁰ This shared landscape of medical beliefs is emphasized by historians such as Michael Stolberg, who claim that there was little cognitive dissonance between patients and practitioners. Most of the population was versed in medical theory because of its "simple basic explanatory framework" and "closeness to the

³⁷ Helen King, *The Disease of Virgins: Green Sickness, Chlorosis, and the Problems of Puberty* (London: Routledge, 2004): 22, 124.

³⁸ Geunter B Risse, "Medicine in the age of enlightenment," in *Medicine in Society: Historical Essays*, ed. A. Wear (Cambridge: Cambridge University Press, 1992): 161.

³⁹ Guenter B Risse, "Doctor William Cullen, Physician, Edinburgh," *Bulleting of the History of Medicine* 48.3 (Fall 1974): 338-9; Risse, "Medicine in the age of enlightenment," 163.

⁴⁰ Roy Porter, "Introduction" in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, ed. Roy Porter (Cambridge: Cambridge University Press, 1985): 14.

everyday experience of the body”.⁴¹ The transition between the models was also facilitated by structural similarity between humouralism and sensibility. Both models focused on the movement and blockages of internal, and thus invisible, mechanisms: fluids in humouralism and nerves in sensibility. Anne Digby asserts that therapeutics changed much less dramatically than epistemology, underscoring the degree of medical continuity.⁴² De Renzi takes this argument further, stating that while new systems explained the body in minute anatomical detail, the theoretical focus remained on the interconnectedness of the body. Along with the continued use of old remedies, the holistic perspective of the body was thus rarely challenged.⁴³

Discussions of the routes through which large sections of the population accessed and made use of medical knowledge are indebted to the work of Roy Porter, who pioneered the approach of “history from below” within the history of medicine through comments such as “medicine has never enjoyed full monopoly or police powers, and most healing, like charity, begins at home”.⁴⁴ By acknowledging that “managing and treating sickness remained very largely in the hands of the sufferers themselves and their circles”, while also being paying consumers, Porter exposed practitioners as actors within, rather than arbiters of the medical relationship.⁴⁵ Without scientific tests or medical imaging to reconstruct internal complaints, the early modern body was opaque and in such a context, as Blecourt and Osborne note, “a patient’s definition of illness is ultimately decisive”.⁴⁶ The authority of the patient was not always so absolute: wealth and gender both influenced the degree to which a patient could advocate for themselves, and Lisa Smith has shown the extent to which families were involved in the medical relationship of patients and their practitioners.⁴⁷ Though not assured, the patient narrative was fundamental in consultations. As Roy Porter notes, “he or she alone can render his or her ‘complaint’ into words” for the experience of a disorder.⁴⁸ Steven Shapin states that physicians acknowledged this narrative authority because it was necessary to trust in the reports of signs,

⁴¹ Michael Stolberg, “Medical popularization and the patient in the eighteenth century” in *Cultural Approaches to the History of Medicine: Mediating Medicine in Early Modern and Modern Europe*, ed. Willem de Blecourt and Cornelia Osborne (Basingstoke: Palgrave Macmillan, 2003): 92.

⁴² Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 69.

⁴³ De Renzi, “Medicine in the age of enlightenment,” 167.

⁴⁴ Roy Porter, “The patient’s view: doing medical history from below,” *Theory and Society* 14.2 (March 1985): 192.

⁴⁵ *Ibid.*, 182.

⁴⁶ Blecourt and Osborne, “Medicine, mediation and meaning,” 3.

⁴⁷ Smith, “Reassessing the role of the family”.

⁴⁸ Roy Porter, “‘Expressing yourself ill’: the language of sickness in Georgian England” in *Language, Self and Society: A Social History of Language*, ed. Peter Burke and Roy Porter (Cambridge: Polity Press, 1991): 278.

feelings, and the language of patients in order to effectively diagnose and suggest treatments.⁴⁹ Lay medical confidence was fundamental because even practitioners relied on an informed patient to make medical diagnoses and prescribe treatment.

Gender and Household Roles

The physical space of the household was central in defining family units. Arguing that historians' expectations of a "characteristically nuclear" family is an inaccurate representation of familial structures in the eighteenth century. Naomi Tadmor proposes the category of "household-family" as a new organizational category for analysis.⁵⁰ Instead of measuring families through kinship, household units were defined as persons living under the same roof and under the authority of the same householder, structuring the family through the boundaries of household government rather than blood.⁵¹ Envisioning the family in its contemporary context, through the structure of the household, incorporates servants and tenants, rather than simply family members. Anne Stobart takes a similar view, defining the household as "a group of people living together as a unit, rather than simply a physical space", including family members, resident visitors, and servants in the "household".⁵² The element of authority is significant in Lisa Smith's argument about the significance of family in patient decision-making, and particularly explains how legal and financial dependence on the head of household influenced the medical choices and purchases available to women in the eighteenth century.⁵³

Many of the arguments around the division of labour in the household have aligned with the concept of "separate spheres", a historical model popularized in the 1980s which proposed that the genders were restricted to mutually exclusive masculine "public" locations such as coffee houses, business, and political arenas, and the household as a "private" female space.⁵⁴

⁴⁹ Steven Shapin, "Trusting George Cheyne: scientific expertise, common sense, and moral authority in early eighteenth-century dietetic medicine," *Bulletin of the History of Medicine* 77.2 (2003): 280. Porter makes a similar point in "Expressing yourself ill 278.

⁵⁰ Naomi Tadmor, "The concept of the household-family in eighteenth-century England," *Past and Present* 151 (May 1996): 111.

⁵¹ Naomi Tadmor, *Family and Friends in Eighteenth Century England: Household, Kinship and Patronage* (Cambridge: Cambridge University Press, 2001): 22, 24.

⁵² Stobart, *Household Medicine*, 3.

⁵³ Smith, "Reassessing the role of the family," 330-331.

⁵⁴ Amanda Vickery indicates that Nancy Cott's study of early industrial New England linked the "woman's sphere" to a narrative of economic change and that Mary Ryan integrated an aspect of class making, resulting in the presentation of "the cult of true domestic womanhood" as a product of the rise of the middle class and a "vital

Amanda Vickery returned to the subject of “separate spheres” in her analysis of the “genteel” women of Yorkshire and Lancashire. She argues that if the distinction of “separate spheres” meant that women had to spend more time in the home while men had greater institutional recognition and reward, then the concept could be applied to “almost any century or any culture.”⁵⁵ Revisions to the model reflect that rather than two mutually-exclusive spaces, the division of public and private, can better be understood as a general description of the ways in which the lives and daily social behaviours of men and women were gendered.⁵⁶

Men had important roles in the home as heads of households, and women increasingly had opportunities for public action with involvement in religious sects, voluntary societies, and political pressure groups.⁵⁷ Within the rough division of labour, Ingrid Tague emphasizes that the “rough sexual division of responsibility was extremely permeable and often simply did not apply to the actual workings of the household”.⁵⁸ This thesis will engage with ideas about “gendered behaviour” to interpret how men and women could fulfill complimentary and occasionally overlapping medical roles. Men and women coexisted and cooperated in domestic spaces. Though their roles were generally defined by gender, most families were flexible in their actual division of labour.

Historians such as Barker-Benfield have related the rise of sensibility to another major change in the eighteenth century: the increasing popularity of consumerism. The household was central to commercial capitalism because sensibility helped to produce a vogue which penetrated the wider public, encouraging decorating the household to exhibit personal identity and politeness.⁵⁹ G.S. Rousseau observes that the interplay of social differentiation and the need to assert status through visible markers also fed back into the importance of illness to the Georgians: if illness was caused by irritated nerves and the gentry were the most sensitive class,

component” in its collective identity. “Golden age to separate spheres? A review of the categories and chronology of English women’s history,” *The Historical Journal* 36.2 (1993): 384.

⁵⁵ Amanda Vickery, *The Gentleman’s Daughter: women’s lives in Georgian England* (New Haven: Yale University Press, 1998): 7.

⁵⁶ Vickery, “Separate Spheres?,” 411. John Tosh, “The old Adam and the new man: emerging themes in the history of English masculinities, 1750-1850” in *English Masculinities, 1660-1800*, ed. Tim Hitchcock and Michele Cohen (New York: Longman, 1999): 227.

⁵⁷ Shoemaker, *Gender in English Society*, 315.

⁵⁸ Tague, *Women of Quality*, 99.

⁵⁹ G.J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago: University of Chicago Press, 1992), xxiv-v; John Brewer, *The Pleasures of the Imagination: English Culture in the Eighteenth Century* (London: HarperCollins, 1997): xvii-xviii.

then they would be ill more regularly and visibly than lower classes.⁶⁰ Some research has been made into the relationship between consumerism and medicine, including Anne Digby's comments that the early modern period saw the "growth of a secular and consumer society, in which health was increasingly seen as a commodity to be purchased like any other".⁶¹ Although the development of consumerism plays an important contextual role, this thesis does not aim to investigate the function of household economics in relation to illness. Because all the individuals analyzed were of a similar status, it allows this thesis to focus on the treatments and ideas which circulated within the gentry home.

While sensibility exhibited high levels of continuity with previous medical theories, the integration of the model into social and gender theory had a significant influence on the ways men and women were expected to behave. Men were still depicted in prescriptive literature and religious rhetoric as intelligent, courageous and bold, and considered to be "different and superior" to women, who were understood to possess "thinner, finer, and more delicate nerves" which lead to assumptions that female qualities were based on this higher level of sensitivity and emotion.⁶² In transforming gender relations from a hierarchy to a dichotomy, eighteenth-century discourses of gender posited that men and women were innately complimentary, and naturally suited to their perceived roles as husbands and wives.⁶³ Lawrence Stone claimed that, in part due to this new gender system, a new model of companionate marriage and affectionate relationships with spouses and children came to characterize eighteenth-century marriages. These arguments have largely been revised. For example, Linda Pollock has reflected on the affection parents had for their children, and Alan Macfarlane validates a long history of both individualism and spousal affection, contrary to Stone's claims, over several reviews and books. Yet, Stone's arguments have remained a starting point for many historians.⁶⁴ Changes to the perceived innate nature of men and women influenced their relationships and work.

⁶⁰ G.S. Rousseau, "Towards a semiotics of the nerve: the social history of language in a new key" in *Language, Self and Society: A Social History of Language*, ed. Peter Burke and Roy Porter (Cambridge: Polity Press, 1991): 227.

⁶¹ Digby, *Making a Medical Living*, 26.

⁶² Shoemaker, *Gender in English Society*, 20, 24, 25.

⁶³ Anthony Fletcher, *Gender, Sex and Subordination in England 1500-1800* (New Haven: Yale University Press, 1995): 291.

⁶⁴ Linda A. Pollock, *A Lasting Relationship: Parents and Children Over Three Centuries* (Hanover: University Press of New England, 1987); Alan Macfarlane, "Review of Stone, *Family, Sex and Marriage in England*," *History and Theory* 18 (1979); Macfarlane, *The Origins of English Individualism: the Family, Property, and Social Transition* (Oxford: Blackwell, 1978), Macfarlane, *Marriage and Love in England: Modes of Reproduction, 1300-1840* (Oxford: Blackwell, 1986); Berry and Foyster, "Introduction," 1.

As a result of the influence of sympathetic ideology on gendered behaviour, Joanne Bailey demonstrates how the “rhetoric of maternity became more intensely emotional”, casting women as tender, noble, self-sacrificing, and ever-nurturing.⁶⁵ The same narrative tightened the links between femininity and domesticity because most female roles were directly related to their labour in the household and for their families. Women in the new system were expected to be the mistress of the household, to guard their husband’s reputation, and emphasize their role as mothers.⁶⁶ Management of the household in particular was assigned positive values, because as Tague notes, the instruction to be housewives “were couched in terms of management of servants, not performance of domestic labour”.⁶⁷ Amanda Vickery indicates that there was a correlation between a neat home and a modest woman because the housewife’s virtues were displayed in the physical space of her household.⁶⁸ This link between the home and character of the woman emphasized chastity as an overwhelming female imperative which relied increasingly on a definition of women as sexually passive, whereas previously their arousal had been a fundamental aspect of reproduction.⁶⁹ Anthony Fletcher states that the “construction of femininity and woman’s imprisonment in an ideological straitjacket went hand in hand”.⁷⁰ At the same time the new order was seen as benefitting women, argues Tague, because “women were increasingly told that they were essential in upholding the moral order”.⁷¹

Fletcher argues that in parallel to the domestic identity of women, men were expected to demonstrate inner self-discipline, exhibited in acceptable patterns of carriage, demeanour, affability, speech, and deference.⁷² However, Joanne Bailey has contradicted this conclusion by identifying an increasing emphasis on parental love in eighteenth-century court cases. A man had to be a ‘good’ husband and father in order to be a fully rounded man, and emotional closeness was increasingly an indicator of effective parenting for both genders.⁷³ Introducing the concept of “oeconomy”, which Karen Harvey defines as “the practice of managing the economic and

⁶⁵ Joanne Bailey, “Reassessing parenting in eighteenth century England” in *The Family in Early Modern England*, ed. Helen Berry and Elizabeth Foyster (Cambridge: Cambridge University Press, 2007): 223.

⁶⁶ Fletcher, *Gender, Sex and Subordination*, 387.

⁶⁷ Tague, *Women of Quality*, 46.

⁶⁸ Amanda Vickery, *Behind Closed Doors: At Home in Georgian England* (London: Yale University Press, 2009): 298.

⁶⁹ Fletcher, *Gender, Sex and Subordination*, 93, 387.

⁷⁰ *Ibid.*, 395.

⁷¹ Tague, *Women of Quality*, 19.

⁷² Fletcher, *Gender, Sex and Subordination*, 332.

⁷³ Bailey, “Reassessing parenting,” 215, 219-20.

moral resources of the household for the maintenance of good order”, mediates between the perspectives of Fletcher and Bailey.⁷⁴ Domestic authority was fundamental to masculine identities because of perceived links between self-regulation, the management of the home, and behaviour in public life.

Amanda Vickery established the importance of oeconomy because maintaining a home was perceived to be a “precondition of respectability and gentility”.⁷⁵ Harvey emphasizes the practical benefits of oeconomy preparing men for public masculine roles by honing their skills in teaching and management.⁷⁶ Elaine Leong and Sara Pennell have presented the benefit of this model to health care by using “oeconomy” to link the management of households as financial units with broader circles of local and national economies.⁷⁷ Lisa Smith identifies one element of this self-management as the link between order and health: keeping a house in order kept it healthy, and a healthy home was well organized.⁷⁸ Men, therefore, had a range of reasons, ranging from personal affection to public reputation, to pay close attention to their households.

The emphasis on the relationship between medical thought and gender flows primarily in one direction in the historiography. The focus has been on how the concept of “nerves” influenced the behaviour of men and women, rather than how these new roles influenced the ways in which genders navigated household illness. Vickery gives medical work a prominent place. She argues that “the role of sick-nurse was long established, all but inescapable, and long enduring”, and that medicinal recipes remained important to female correspondence.⁷⁹ However, in Ingrid Tague’s analysis of female household management in the eighteenth century, she identifies a range of furnishing and management tasks, but mentions medical work only once when she notes that “for women in more old-fashioned families like the Harleys, this could include tasks such as potting eels and making medicines”.⁸⁰ The book’s index recommends that for medicine, the reader should “see science”, implicitly dismissing the importance of medical

⁷⁴ Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford: Oxford University Press, 2012): 22.

⁷⁵ Vickery, *Behind Closed Doors*, 298.

⁷⁶ Harvey, *The Little Republic*, 39-40.

⁷⁷ Elaine Leong and Sara Pennell, “Recipe collections and the currency of medical knowledge in the early modern ‘medical marketplace’” in *Medicine and the Market in England and its Colonies, c. 1450-1850*, ed. Mark Jenner and Patrick Wallis (Basingstoke: Palgrave Macmillan, 2007): 136-7.

⁷⁸ Smith, “Relative duties of a man,” 248.

⁷⁹ Vickery, *The Gentleman’s Daughter*, 154.

⁸⁰ Tague, *Women of Quality*, 128.

activity as a category of women's work.⁸¹ Illness was a regular presence in eighteenth-century gentry life, as indicated by the volume of references to health and sickness in familial correspondence. If gender roles were becoming more regimented and differentiated as a result of sensibility, then illness was one of the roles which could fall under the "tender" female boundary. The division of labour during illness will be a recurring theme in this thesis, particularly in examining the gender and familial identity of caregiving activities in the sick room in Chapter Two.

Families and the "Medical Marketplace"

When household medical skills were insufficient, families had the option to supplement self-help with the aid of external medical practitioners, a subject which will be explored in detail in Chapter Six. Dorothy and Roy Porter identify a spectrum of responses to illness, ranging from self-treatment, expert advice, and services while often utilizing multiple responses simultaneously.⁸² The coexistence of household medicine and paid medical work are emphasized again by Porter, who states that "personal and professional healing were essentially complementary rather than in competition".⁸³ Stobart comments that self-help and attendance were not mutually exclusive, but instead should be "considered on a continuum of obtaining medical supplies and using medical services".⁸⁴

Wallis and Pirohakul claim that during the long eighteenth century, there was "substantial growth" in the likelihood that the sick would seek medical or nursing assistance, and that most of this increase occurred outside of London.⁸⁵ Patients had a great deal of power within medical relationships, as suggested by Nicholas Jewson's concept of the "patronage based system", in which "by virtue of their economic and political predominance the gentry and aristocracy held ultimate control over the consultative relationship".⁸⁶ Jewson's arguments, particularly regarding the significance of the patient's illness narrative and the "general lack of agreement about the causes of illness and the effectiveness of therapies", have been extended to characterize early

⁸¹ Ibid., 251.

⁸² Porter and Porter, *Patient's Progress*, 11.

⁸³ Porter, "The patient in England," 114.

⁸⁴ Stobart, *Household Medicine*, 5.

⁸⁵ Patrick Wallis and Teerapa Pirohakul, *Medical Revolutions? The Growth of Medicine in England, 1660-1800* (London: The London School of Economics and Political Science, 2014): 515.

⁸⁶ N.D. Jewson, "Medical knowledge and the patronage system in eighteenth century England," *Sociology* 8.3 (1974): 382.

modern medical relationships more broadly.⁸⁷ Lisa Smith has modified interpretations of the interactions between practitioners and patients suggesting an “Illness Constellation Model” based on sociological research which acknowledges the role which families had in controlling finances, influencing choices, and monitoring illness and treatment, particularly in the case of female patients.⁸⁸

Finances and social status were only two elements in the “medical marketplace”, a term coined by Harold Cook and Lucinda McCray Beier to represent the network of practitioners competing for patients.⁸⁹ Instead of a formal or centralized system, the “marketplace” focused on patients, who selected services based on a number of features including their perceptions of their illness, cost, and availability, and practitioners, including physicians, surgeons, apothecaries, and the “irregular practitioners” who existed outside of licensing bodies such as universities and guilds but often provided similar services.⁹⁰ Jenner and Wallis have tracked the imprecision of the “medical marketplace” as a dramatic and descriptive category with co-existing definitions. These include using the “marketplace” as a counterpoint to the “domestic” space, as a commercial entity, or a structural description that emphasized the connections of medical content to the economic situation.⁹¹ The association of “marketplaces” with shopping acknowledges that patients and their families had multiple options during illness. This is particularly relevant for my research because letters evaluated a range of supplementary care. As well as the unpaid assistance of family and neighbours and payment in kind to local wise women or practitioners unaffiliated with formal methods of training, there was the option for financial exchanges of money for services from practitioners who identified themselves as being “professional”, such as physicians and surgeons. The household remains central in these negotiations, and the resources of the family and the household were a significant consideration when establishing the appropriate treatment path during illness.

⁸⁷ Ibid., 371.

⁸⁸ Smith, “Reassessing the role of the family,” 327-8.

⁸⁹ Harold John Cook, *The Decline of the Old Medical Regime in Stuart London* (Ithaca: Cornell University Press, 1986); Beier, *Sufferers and Healers*, 4.

⁹⁰ Beier, *Sufferers and Healers*, 4.

⁹¹ Mark Jenner et al., “The medical marketplace” In *Medicine and the Market in England and its Colonies, c. 1450-1850*, ed. Patrick Wallis and Mark Jenner (Basingstoke: Palgrave Macmillan, 2007): 1-7.

Sources

The decision to focus primarily on illness in letters distinguishes this thesis from much of the research on early modern health. The paucity of sources has led most studies of household medicine to utilize a range of information. Including a variety of sources has the benefit of providing a wider and more detailed image of medical practices. However, it also introduces problems when it comes to managing the biases and limitations of each type of source. The style of letters, diaries, and account books produced different and occasionally conflicting information, and emphasized different elements of household life. As Olivia Weisser has explained in relation to her investigation of illness narratives in diaries, writing was a key element of constructing experience, describing the process as an act of self-actualization and constitution, rather than a “clear reflection” of events.⁹²

Attending to the context of the source’s construction is a product of the cultural turn, which emphasizes the making of meaning through language, power, and the construction of categories.⁹³ Letter writers composed texts and filtered their experiences, and though this process was embedded in the everyday and took meaning from household roles, it was not a transparent representation of household life.⁹⁴ The extensive historiography on the structure, function, and conventions of correspondence, analyzed further in Chapter Two, frames investigations of how correspondence on illness played with and against the conventions of both letters and sickness.⁹⁵ Examining correspondence between family and friends is also important because of the vogue for corresponding with physicians and gaining medical consultations by letter in the eighteenth century.⁹⁶ It is possible to compare physician letters to familial letters to see the ways in which the audience influenced the type of medical information recorded. There is also a wider range of illnesses because personal correspondence included letters which did not have the length or

⁹² Weisser, *Ill Composed*, 5.

⁹³ Willemijn Ruberg, “The letter as medicine: studying health and illness in Dutch daily correspondence, 1770-1850,” *Social History of Medicine* 23.3 (2010): 492.

⁹⁴ *Ibid.*, 498.

⁹⁵ See for example Brant, *Eighteenth-Century letters*; Susan Whyman, *The Pen and the People: English Letter Writers 1660-1800* (Oxford: Oxford University Press, 2009); Lindsay O’Neill, *The Opened Letter: Networking in the Early Modern British World* (Philadelphia: University of Pennsylvania Press, 2015); Richard Maber, “Knowledge as a commodity in the Republic of Letters, 1675-1700,” *Seventeenth-Century French Studies* 27.1 (2005) 197-208; Leonie Hannan, “Women, letter-writing, and the life of the mind in England, c. 1650-1750,” *Literature and History* 22.2 (2013): 1-19.

⁹⁶ Wayne Wild, *Medicine-By-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam: Rodopi, 2006); Lisa Smith, “Reassessing the role of the family,” 327-342; for the French context see Robert Weston, *Medical Consulting by Letter in France, 1665-1789* (Burlington: Ashgate, 2013).

severity to necessitate practitioner intervention. Focusing primarily on the ways in which health was discussed in personal letter writing allows for greater precision in identifying the interaction of the discourses of the source, which dictated the style and content, with discourses of illness which displayed various types of medical information and skills.

The fifteen sets of gentry correspondence in this study are comprised of over nine hundred references to health and illness extracted from over five thousand letters. These references include over a thousand different ailments which are attributed to over one hundred causes of illness and over three hundred and fifty types of treatment.⁹⁷ The earliest is dated 1623 and the latest was written in July of 1799. Figure 1.2 shows the spread of correspondence by decade. The emphasis on the gentry is partially a result of source survival, because gentry families had the resources and space to preserve letters which have now been transferred to archives. However, as Chapter Two will argue, the gentry also provide an interesting case study because they had both the literacy and leisure to interact with medical trends, and often had the financial resources and contacts in order to select from the full range of practitioners and to travel to obtain medical care.

In order to build the most complete picture of the family accounts of health and illness in their letters, an effort has been made to obtain familial correspondence which encompassed the majority of the period, such as the Stanhopes of Cannon Hall (1651-1784),⁹⁸ the Chaytors of Croft Hall (1673-1790), the Robinsons of Horsfoth (1687-1782)⁹⁹, the Bosvilles of Thorpe Hall (1686-1778), the Salvin-Tunstulls of Croxdale (1700-1789), and the Listers of Shibden Hall (1688-1799)¹⁰⁰. These family collections are supplemented with smaller collections which still reveal the detailed attention to health in daily life. The first half of the century includes letters from the Claverings of Chopwell (1708-1726),¹⁰¹ the Grimstons of Grimston Garth (1623-1757), and the Vanes of Durham (1699-1767). The second half of the century includes the correspondence from the Carrs of Hedgeley Hall (1733-1793), the Fairfaxes of Gilling Castle (1721-1770), the Ponsonbys of Howick (1766-1795), and the Whartons of Durham and Old Park (1774-1789). Other collections, such as the Tempest family of Tong Hall or the Pearsons of

⁹⁷ For types of illness see Appendix III, for disease causes by decade see Appendix V and for types of treatment by decade see Appendix VI.

⁹⁸ See Appendix I(A) for the Spencer-Stanhope Family Tree.

⁹⁹ See Appendix I(B) for the Robinson Family Tree.

¹⁰⁰ See Appendix I(C) for the Lister Family Tree.

¹⁰¹ See Appendix I(D) for the Clavering Family Tree.

Figure 1.2 – Spread of Family Correspondence by Decade

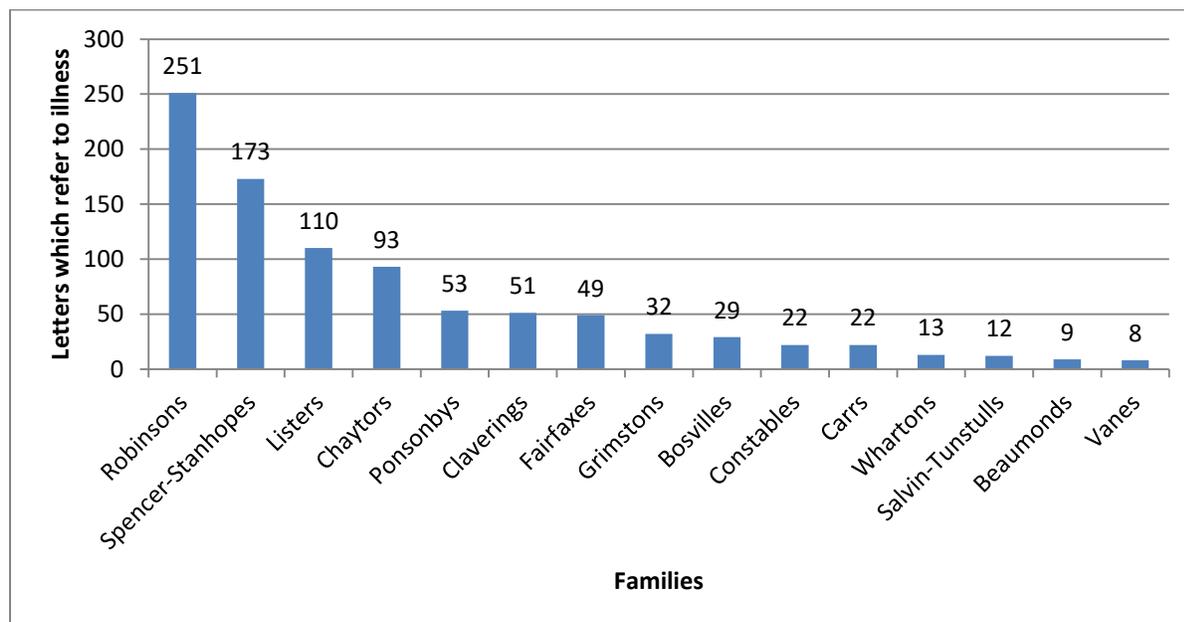
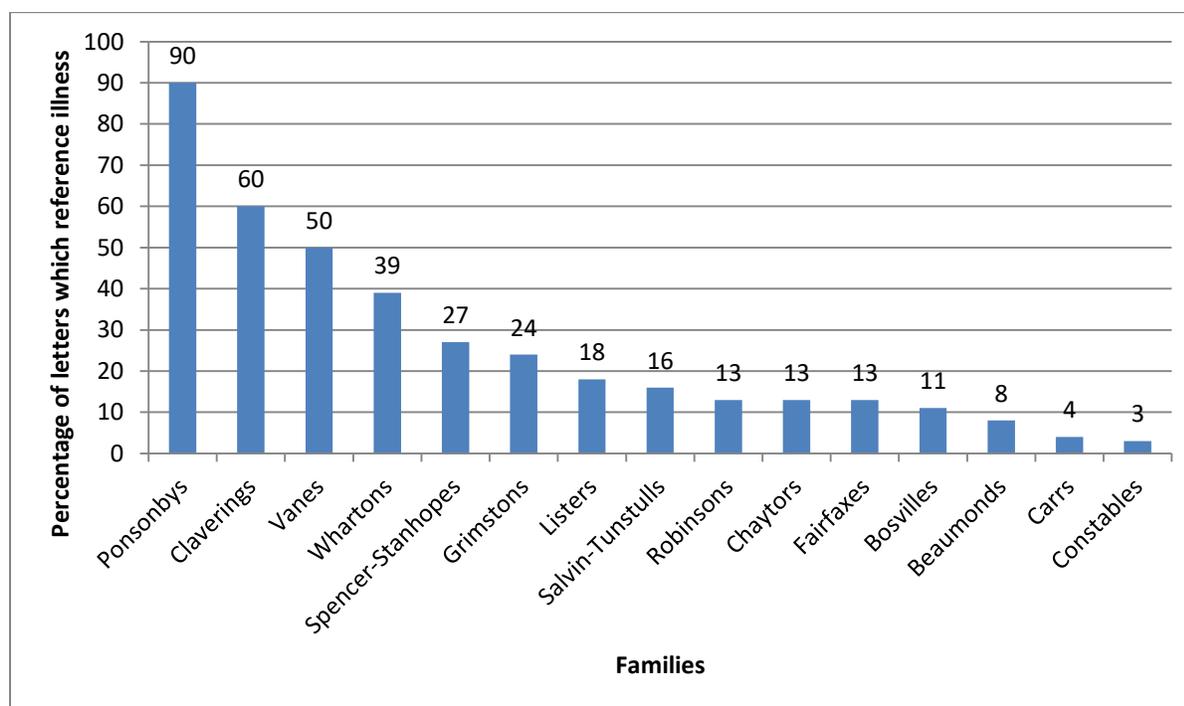
pre 1689	1690s	1700s	1710s	1720s	1730s	1740s	1750s	1760s	1770s	1780s	1790s	
		Claverings of Chopwell 1708-1726										
		Salvin-Tunstall of Croxdale 1700-1789										
								Ponsonbys of Howick 1766-1795				
								Whartons of Durham & Old Park 1774-1789				
		Carrs of Hedgeley Hall 1733-1793										
		Vanes of Durham 1699-1767										
	Grimstons of Grimston Garth 1623-1757											
				Fairfax of Gilling Castle 1721-1770								
	Beaumonts of Whitley Hall 1688-1741											
	Constables of Everingham 1663-1745											
	Bosvilles of Thorpe Hall 1686-1778											
	Robinsons of Horsforth 1687-1782											
	Chaytors of Croft Hall 1673-1790											
	Spencer-Stanhopes of Cannon Hall 1651-1784											
	Listers of Shibden Hall 1688-1799											

Yorkshire and Mountcross in County Cork, were surveyed and dismissed due to either a low number of family letters for the period, or due to low or undetailed references to health. Figure 1.5 maps the locations of family homes in this study.

Reasons for choosing to include illness in family letters will be discussed at greater length in Chapter Two, but it is necessary to briefly comment on the great variation in collection sizes that can be seen in Figure 1.3. Some collections appear more regularly because of the high volume of references to illness in the collection. The 251 references to illness represent less than ten percent of the 2000-plus letters in the Robinson family collection, and the Listers included news about illness in 110 of their 600-plus letters. The four largest letter collections, from the Stanhopes, Listers, Robinsons, and Chaytors, are significant in this study because the volume of letters related to illness emerge from their long chronological spans. The highest volume of references to illness can often be found in the shortest collections. This was the case when members of the household were regularly ill, as seen in the Clavering collection, which contained fifty-one references to illness in the eighty-five letters written from Ann Clavering to her cousin James. Illness was therefore present in sixty percent of her letters. The Ponsonby family was also unusually preoccupied with illness: of the fifty-nine letters in this collection, fifty-three referenced health and illness: ninety percent!

Other families, despite a long period of correspondence, appear to be regularly healthy or disinterested in illness: the makeup of the Constable and Beaumont families, both of which referred to illness in less than ten percent of their letters, will be discussed further in Chapter

Figure 1.3 – Family Collections' References to Illness in Letters

Figure 1.4 – Percentage of References to Illness by Family Correspondence Collection¹⁰²

¹⁰² The percentages in this chart are produced from data in Appendix II, which compares references to illness to the number of letters in each collection of correspondence.

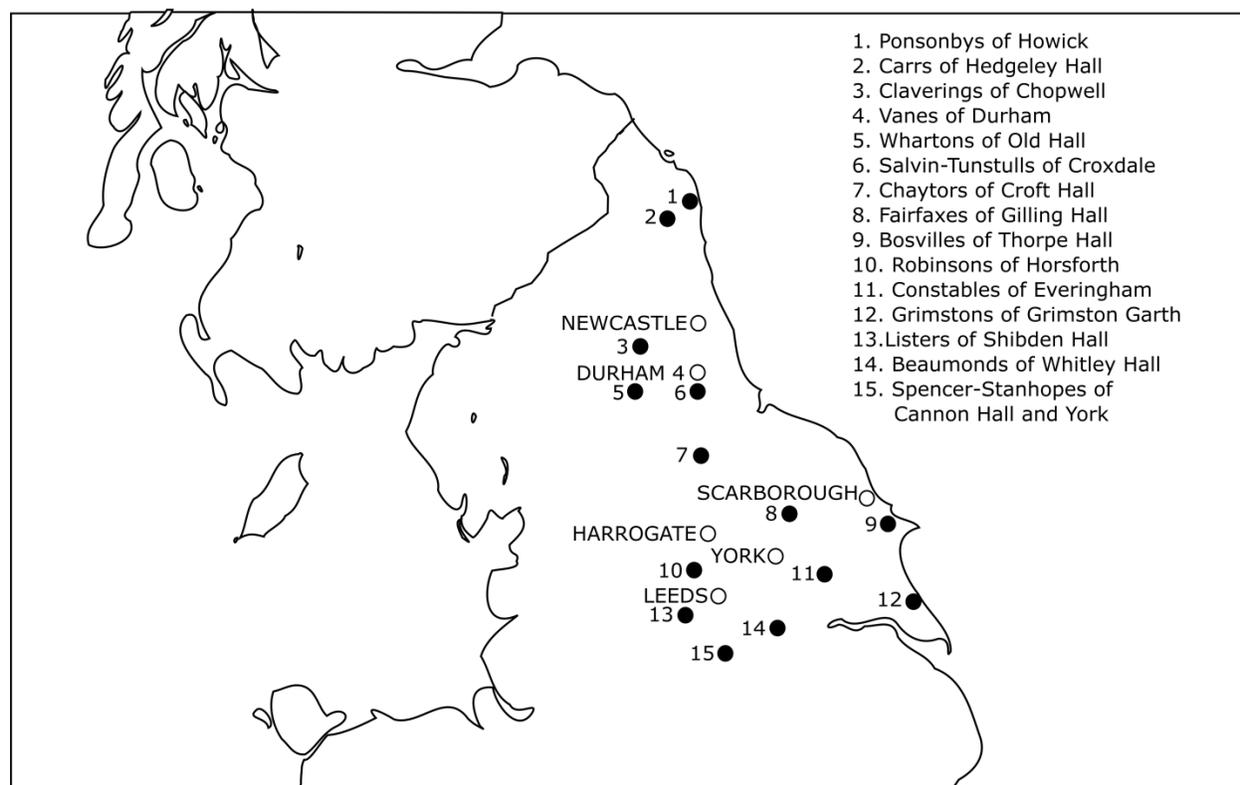
Two. The proportion of references to illness in correspondence in these four collections, between ten and thirty percent of the total letters by each family referencing illness, also reflects the makeup of the majority of collections in this study. Figure 1.4 demonstrates the high variation of references to illness in letters, ranging from ninety percent by the Ponsonbys to three percent by the Constables. In most cases, then, these collections reveal families who had a wide range of interests which *included* illness, rather than letters explicitly about illness which might be found in the collections of medical practitioners. As a result, they are more indicative of the way in which illness interacted with and was a part of daily gentry life in the three counties of this study.

The collections were selected based on regional restrictions. The Claverings, Ponsonbys, and Carrs had family seats in Northumberland, and the Salvins and Vanes were based in Durham. In Yorkshire, the Fairfaxes, Bosvilles, and Chaytors lived in the North Riding, the Grimstons and Constables in East Yorkshire, the Listers in West Yorkshire, and the Beaumonts and Stanhopes in South Yorkshire. The geographical scope of the families can be seen in Figure 1.5, below. The choice to perform a regional study is in response to the way in which most studies of early modern household medicine treat English household medicine as uniform, drawing examples from a range of counties in a way which emphasizes commonalities. The exception is Alun Withey, who includes household medicine in his investigation of medical practices, beliefs, and practitioners in early modern Wales.¹⁰³ In contrast, research into the range of practitioners available has emphasized not only the difference between the medical landscape in London and the provinces, but the distinct nature of medicine in particular counties.¹⁰⁴ It is necessary to focus on regions to reflect the specificity of medical resources in the area, as household medicine did not exist in a vacuum but instead interacted and coexisted with the paid medical care brought into the home. The availability of practitioners could thus have a deep impact on the type of medical work performed informally.

¹⁰³ Alun Withey, *Physick and the Family: Health, Medicine and Care in Wales, 1600-1750* (Manchester: Manchester University Press, 2011).

¹⁰⁴ See for example Irving Loudon, "The nature of provincial medical practice in eighteenth-century England," *Medical History* 29.1 (1985): 1-32. This subject will be analyzed further in Chapter Six. In addition, see project "The medical world of early modern England, Wales and Ireland, c.1500-1715," lead by Jonathan Barry and Peter Elmer (<http://practitioners.exeter.ac.uk/>).

Figure 1.5 – Map of Family Homes of Gentry Correspondents



Yorkshire, County Durham, and Northumberland frame a relevant case study due to the nature of the area as the “extremity of England” and as a border region with Scotland.¹⁰⁵ The regions would not have immediate access to London, the centre of medical thought and a city densely populated with a range of practitioners. Instead, immediate medical needs would be supplied by the smaller cities of York and Newcastle, with the potential to travel either south to London or one of the medicinal baths including Scarborough, Bristol and Bath, or north to Edinburgh and the newly flourishing medical community including practitioners such as William Cullen.¹⁰⁶ Focusing on a single region allows for a fuller picture of the activities of its resident families. The potential for a regionally distinct medical identity is explored in this context. Although financial freedom varied, the families in this study had a similar range of options in making medical decisions, and some even utilized the skill of the same practitioners. This common ground allows for a more detailed investigation of both familial idiosyncrasies and the choices shared by a range of families in the same situation.

¹⁰⁵ Helen Berry and Jeremy Gregory, “Introduction” in *Creating and Consuming Culture in North-East England, 1660-1830*, ed. Helen Berry and Jeremy Gregory (Aldershot: Ashgate, 2004.): 4.

¹⁰⁶ See for example Guenter B. Risse, “Doctor William Cullen.” The Cullen Project has also digitized Cullen’s medical consultation correspondence at <http://www.cullenproject.ac.uk/>.

This project focuses explicitly on gentry life, and as a result it does not deal with the “rise of the middle class” or the responses of lower classes to illness. This study focuses largely on medical practices and the types of knowledge which enabled letter writers to make diagnoses and suggest treatments in the domestic space, rather than the experience of the patient as displayed in correspondence. The scarcity of references to recipes and medical preparations in the letters of this sample has resulted in a wider emphasis on medical ideas and conversations. Finally, choosing to focus on correspondence necessarily means minimizing the use of a range of sources which could be used to present other images of household health care, including account books, diaries, and physicians’ case studies. When other sources are used, they are in support of or in contrast to letters rather than evaluated independently. This is a study of the way in which letters demonstrate household practice, rather than a comprehensive study of household and medical work.

Research Questions and Chapter Structure

This thesis asks a series of questions which test the parameters of the home as a site of healing. The chapters can be envisioned as a series of thematic concentric circles, beginning with the bodies of letter writers and their families. Each chapter expands then its focus to wider elements of household health by asking a large question about the nature of a particular element of medical practice which establishes the role of illness in letters and the medical routines, knowledge, and relationships of the household. Within each of these larger arguments, questions are asked both about continuity and change, the influence of wider historiographic themes, and about gender. For example, were the same treatments preferred throughout the period, and can any changes be mapped on the shifting medical paradigm? Were men and women equally involved in caregiving practices? Did the increasing popularity of sensibility result in different ways of describing illness or selecting treatments? Concurrently exploring the three, tightly inter-related themes of household medicine, gender, and change or continuity in each chapter allows this thesis to situate the household within the changing context of gender and medical thought. This study can thus form a bridge between the historiography of household medicine which terminates at the end of the seventeenth century, and the dramatic changes with laboratory and hospital medicine which became increasingly important in the nineteenth century.

Accordingly, Chapter Two begins with the subject of illness and the identity of the letter writers in this study. The emergence of a conversational tone which emphasized the experience of daily life provides a rich opportunity to explore the frequency and way in which illness affected household behaviours. By providing this context, the chapter establishes the validity of using familiar letters to understand the role of household health and medical practices. Chapter Three is a response to Mary Fissell's call to begin healthcare "at the bedside", focusing on the ways in which letter writers depicted caregiving activities.¹⁰⁷ Supervising the sickroom, monitoring patients, and choosing and administering medicine required medical knowledge in order to provide care effectively. The medical knowledge which informed good caregiving practices is the subject of Chapter Four, which analyzes both theoretical and experiential bases of knowledge and returns to the subject of the humoral and sympathetic model. Links between household medical knowledge and the wider medical landscape are made by comparing references to the cause and effective treatment of illness in letters with prescriptive medical literature and recipes.

Chapter Five links the subjects of caregiving and medical knowledge as fundamental components of an investigation based on Collins and Evans' sociological model of expertise. In this system, there is a spectrum of medical expertise which ranges from mastery of common social knowledge, to comprehensive understanding of the language and communicative norms of a field, to the ability to perform the skills of a discipline and to synthesize information and prior experiences to produce new results.¹⁰⁸ This chapter argues that multiple experts coexisted in early modern medicine, often with overlapping or complimentary skills. It thus offers a solution to the difficulty of identifying household medical work as "expert" while still acknowledging the ways in which these families acquired household care: the qualifications for household expertise differed from the qualifications for a physician or surgeon.

Chapter Six pursues the extent of household medical expertise by examining the cases in which families called upon external medical practitioners. Demonstrating the ways in which they managed the selection of external practitioners reinforces the fundamental significance of the household and its members in managing illness and selecting and evaluating the status or efficacy of selected treatments. Gentry families marshalled skills and knowledge to both adapt

¹⁰⁷ Fissell, "Introduction," 1.

¹⁰⁸ Harry Collins and Robert Evans, *Rethinking Expertise* (Chicago: University of Chicago Press, 2009).

the home for caregiving, and manage interactions with external practitioners to supplement and support household medical practices. Letter writing, family life, and illness in Yorkshire, County Durham, and Northumberland as the context of household medical expertise will be investigated in the next chapter.

Chapter Two — Illness in Eighteenth-Century Correspondence

In the fall of 1769, Walter Stanhope Junior sent a series of letters to his uncle apologizing that he was unable to return to his family in England because he was too ill to travel from Borne, France. The first letter, responding directly to John Spencer's request that Walter visit, explained that

here I have fresh occasion to be sorry that I can not pay an immediate submission to ye request in your last. A violent Fall upon my right Knee has, indeed not dislocated ye cap, but bruised & sprained all ye Tendons so violently that I fear it will be about three Weeks before I shall be able to travel.¹

However, ten days later Walter had a different explanation for his absence. Requesting that his uncle keep the contents of this letter quiet, Walter began,

Will you forgive me ye Pretence of ye lame Knee & I did not think it necessary that ye whole family should know my real Disorder, and herefore write this to you upon a detached Piece of paper, as you may probably have Occasion to show that letter. I had half an Inclination to have obeyed your summons, but ye Physician shook his head, and Mr Norton insisted upon my staying.²

Rather than immobility caused by a sprained knee, as he would have the rest of his family believe, Walter was forced to remain in Borne to undergo medical treatment. The reason for his secrecy was the nature of his sickness: Walter referred to it in other places in this letter as his “real Disorder”, “that condition”, and “the clap”. Walter had contracted a sexual disease on his continental tour and though he was willing to share this news with his uncle, with whom he corresponded regularly, he hoped to avoid having his illness be the topic of wider family conversation. Walter's narrative communication style evoked the image of his physician's activities for his reader, but he was also selective of his audience and aware of reading practices when he asked specifically that his “detached Piece of paper” be read only by his uncle.

These letters refer to an illness that was otherwise rarely mentioned in the correspondence on which this study is based. However, they are representative of the types of relationships and style in which letter writers preserved information about their health, as well as discussions and depictions of illnesses. This chapter will place the words of Walter Stanhope Junior in context within the eighteenth century's developing and expanding epistolary culture.

¹ SpSt/6/1/104 (Walter Stanhope Jr. to John Spencer, 02 October 1769).

² SpSt/6/1/104 (Walter Stanhope Jr. to John Spencer, 12 October 1769).

Prior to the eighteenth century, the difficulty of composing and ensuring the safe transport of letters made regular and detailed correspondence difficult. Changes to the postal service and letter-writing practices meant that by the second half of the century, Walter Stanhope Junior trusted that his letters would be delivered safely and read by his addressee, and was confident enough in the medium that he included the relatively personal information on the nature of his confinement.

Historians such as Clare Brant and Susan Whyman have examined the huge variety in the ways in which letter writers learned their craft, structured their letters, and tailored their messages to their audiences.³ This historiography has established that letters could create intimacy despite distance, serve as an educative tool, and help writers develop a sense of self. Additionally, letters have been used by historians such as Richard Maber and Leonie Hannan to explore social and political concerns, such as the significance of the seventeenth century “Republic of Letters” or how correspondence allowed women more extensive engagement in intellectual culture.⁴ These studies on epistolary culture are complimented by medical historians such as Wayne Wild, Lisa Smith, and Robert Weston, who have used letters to explore how medical correspondence between practitioners and their patients delineated medical relationships and rhetoric.⁵

Illness narratives were not, however, exclusively the domain of letters to practitioners. Willemijn Ruberg has remarked on the potential for personal correspondence to reveal attitudes towards illness.⁶ Her study focuses on theory, using the cultural turn to explain how Dutch letters were used to perform “emotional work” in processing and recording the experience of illness.⁷

³ See for example Clare Brant, *Eighteenth-Century Letters and British Culture* (Basingstoke: Palgrave MacMillan, 2006); Susan Whyman, *The Pen and the People: English Letter Writers 1660-1800* (Oxford: Oxford University Press, 2009); Lindsay O’Neill, *The Opened Letter: Networking in the Early Modern British World* (Philadelphia: University of Pennsylvania Press, 2015); Amy Harris, “This I beg my aunt may not know: young letter-writers in eighteenth century England, peer correspondence in a hierarchical world,” *Journal of the History of Childhood and Youth* 2.3 (Fall 2009): 333-360.

⁴ Richard Maber, “Knowledge as a commodity in the Republic of Letters, 1675-1700,” *Seventeenth-Century French Studies* 27:1 (2005): 197-208; Leonie Hannan, “Women, letter-writing, and the life of the mind in England, c. 1650-1750,” *Literature and History* 22.2 (2013): 1-19.

⁵ Wayne Wild, *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam: Editions Rodophi B.V., 2006); Lisa Smith, particularly “Reassessing the role of the family: women’s medical care in eighteenth-century England,” *Social History of Medicine* 16.3 (2003): 327-342; for the French context see Robert Weston, *Medical Consulting by Letter in France, 1665-1789* (Burlington: Ashgate, 2013).

⁶ Willemijn Ruberg, “The letter as medicine: studying health and illness in Dutch daily correspondence, 1770-1850,” *Social History of Medicine* 23.3 (2010): 492-508.

⁷ Ruberg, “Letter as medicine,” 502.

Despite increasing acknowledgement of the usefulness of letters as a historical source, there has been no extensive effort to compliment investigations of patient narratives in medical correspondence to physicians with investigations of English personal letters as sites of illness discussion. Personal letters are useful for accounts of illness, and reveal important aspects of that the perception and response to illness in the household.

The place of illness in eighteenth century letters will be analyzed in three sections. First, the conditions which created a new arena for discussing illness by producing what Whyman notes has been called the “golden age of letters”⁸ will be established. Second, the families who comprise this study will be examined to explore the types of correspondence relationships which produced narratives about illness. This section will also explore the gender of letter writers and the shifting patterns of communication throughout the eighteenth century. The final section focuses directly on illness, analyzing the range of illnesses depicted in correspondence, patterns of change throughout the decades of the eighteenth century, and the influence of the genre of correspondence on accounts of illnesses. Illness was an important element of the epistolary narrative, and such accounts can be used both to see how writers perceived illness in their life and communications, and to examine the household as a site of healthcare.

Developments in Epistolary Culture

The eighteenth century developed into the “golden age” of letter writing due to a series of expansions in the structures of both composing and sending correspondence. During this period, institutional and logistical resources matched cultural desires to enable and encourage a large portion of society to communicate by letter. Three large changes enabled the establishment of a culture that relied more heavily on letter writing than had been the case for previous generations: improved postal service, higher literacy, and new forms of fiction and narratives. These features each influenced the perception of letters and ultimately resulted in a cultural practice which Susan Whyman refers to as an “epistolary culture”, characterized by a command of the vernacular, ease with conventions, equipment, and language of letter writing, and a routine exchange of letters. How suggests that these changes created an “epistolary space” which

⁸ Whyman, *The Pen and the People*, 5.

provided “permanent and seemingly unbreakable links” between people and places.⁹ This vast epistolary culture made space for the greater inclusion of illness accounts.

Although letters were exchanged by privileged, literate members of society prior to the seventeenth century, there was no consistent postal service and the model lacked broad appeal and availability. Letters were exchanged privately via messengers or friends travelling in the correct direction, resulting in a high level of uncertainty regarding the privacy and receipt of correspondence and making continual correspondence difficult and unappealing as a recreational activity.¹⁰ Government desire to control the patterns of correspondence during the English Civil War (1642-1651) resulted in a government monopoly on and increasing stability of the postal service.¹¹ This centralization of infrastructure was complimented by improvements to turnpikes and roads, “even in the north”, and the addition of carriers and coaches to these routes.¹² Improvements to both the roads and the institutions which navigated them resulted in faster and more reliable delivery of letters.¹³ More effective and secure transportation meant an increased guarantee that the letters would reach their intended recipients, which in turn allowed letter writers to confidently include private information.

English citizens were able to take advantage of these improvements due to simultaneous improvements in literacy. Young family members were increasingly taught the significance of reading, writing, and specifically correspondence through “epistolary mentoring”, in which older generations taught their children through a combination of examples and expectations about form and content.¹⁴ The mentoring process was supplemented by the widening industry of letter writing manuals. These texts responded to and influenced conventions, providing guides to both style and content. One popular letter writing manual, *The Compleat Letter Writer*, first taught grammar, general directions, and style, then provided “miscellaneous letters on the most useful and common occasions” such as asking for advice and favours, courtship, and justification for failures to write.¹⁵

⁹ Whyman, *The Pen and the People*, 9-10; James How, *Epistolary Spaces: English Letter Writing from the Foundation of the Post Office to Richardson’s Clarissa* (Aldershot: Ashgate, 2003): 1, 4.

¹⁰ Whyman, *The Pen and the People*, 46, 64; How, *Epistolary Spaces*, 9.

¹¹ How, *Epistolary Spaces*, 12.

¹² Whyman, *The Pen and the People*, 13.

¹³ *Ibid.*, 58; How, *Epistolary Spaces*, 15.

¹⁴ *Ibid.*, 33.

¹⁵ *The compleat letter writer: or, new and polite English secretary. Containing letters on the most common occasions in life. Also, a variety of more elegant letters for examples, from the best modern Authors, on Business, duty, amusement, affection, Courtship, Love, Marriage, Friendship, &c. To which is prefix'd, directions for writing*

Manuals also are testaments to changing expectations for form. Linda Mitchell observes an increasing emphasis on communication skills in the early decades of the eighteenth century, noting that midcentury books on grammar and letter writing spoke to the expanded audience created by larger changes to epistolary culture.¹⁶ *The Compleat Letter Writer* provided advice on style, stating that its reader should

Write freely, but not hastily; let your Words drop from your Pen, as they would from your Tongue when speaking deliberately on a Subject of which you are a Master, and to a Person with whom you are an intimate.¹⁷

As well as following the model of conversation, a letter should be composed in “a short Stile and plain, strikes the Mind, and fixes an Impression”.¹⁸ The intention of these letters was a high degree of readability, rather than serving a function such as making a formal introduction or negotiating a business or political deal. Readability and regular connections were increasingly important because they enabled correspondents to engage fluently in an expanded social network. Complementing the rising ability and opportunity to safely exchange letters, the English had access to a “dynamic set of practices”, including writing, reading, interpreting, and responding to written communication. This created a network of shared connections and norms that stretched past what had previously been available due to geographical limitations.

When Samuel Richardson published *Clarissa* in 1748, his success was due in part to his central place in publishing, which allowed him to observe what publications people bought and respond to: the market was already producing a range of printed correspondence which grew and included a wider range of genders and authors in the eighteenth century.¹⁹ Richardson cemented the importance of epistolarity with *Clarissa*, in which the female protagonist preserved every element of life in correspondence. Novels in this genre centred around the experience of letter

letters, in an easy and proper Manner. Also, a plain and compendious grammar of the English tongue. With Instructions how to address Persons of all Ranks, either in Writing or Discourse; and some necessary Orthographical Directions; With a Spelling Dictionary, Of such Words as are alike in Sound, but different in Sense. Very useful to the English Scholar. And at the End of the Prose, some elegant Poetical Epistles, And various Forms of polite Messages for Cards. The Third Edition Improved. (London : printed for S. Crowder, and H. Woodgate, 1756) : 63, *Eighteenth Century Letters Online*. Gale Document Number: CW 113947581

¹⁶ Linda Mitchell, “Letter-writing instruction manuals in seventeenth- and eighteenth-century England,” in *Letter-Writing Manuals and Instruction from Antiquity to the Present: Historical and Bibliographic Studies*, ed. Carol Poster and Linda C. Mitchell (Columbia: University of South Carolina Press, 2007): 187.

¹⁷ *The Compleat Letter Writer*, 47.

¹⁸ *Ibid.*, 32.

¹⁹ Clare Brant notes that over 21000 items published in the eighteenth century had “letter” in the title. *Eighteenth Century Letters*, 1, 2; Whyman, *The Pen and the People*, 15.

writing and the benefits of awareness, encouragement, and manipulation of its associated skills.²⁰ Illness had an important role in this new narrative: Wayne Wild indicates that the integration of life and illness by eighteenth-century authors is particularly important in revealing the perception of medical rhetoric by society more broadly.²¹ Clarissa's experience of her extended illness and death is captured in detail in her letters, proving Richardson's adherence to doctrines of sympathy as he used illness as a model for manifesting her spiritual enlightenment.²² The success of epistolary novels reaffirmed the popularity of epistolary culture by presenting the nature of correspondence as simultaneously comforting, informative, and a site of personal development.

Space was increasingly important in the model provided by new letter writing techniques. As well as the physical space of writing in dining and drawing rooms or on tables and laps, letter writers created a mental space in which detailed accounts of their locations facilitated an exchange born of imagined intimacy.²³ Hannan and Barnes both note that part of the construction of this space was references to the physical space of the home, allowing an extension of the "conversation" metaphor by allowing a reader to envision their correspondent in context.²⁴ The rise of "epistolary space" changed how writers conducted daily life by providing a venue to test the boundaries of hierarchies and conventions.²⁵ It also allowed letter writers to correspond on matters "of no particular importance" and to write without the impetus of business or emergencies.²⁶

These changes allowed the rise of the "familiar letter", a style of communication which was noted for its "flexible, natural prose"²⁷ and conversational style. When Hugh Blair wrote in 1783 about letters "of the easy and familiar kind; when it is a conversation carried on upon paper, between two friends at a distance", he encapsulated the opinion of a range of eighteenth-

²⁰ Whyman, *The Pen and the People*, 165.

²¹ Wild, *Medicine-by-Post*, 243, 251.

²² *Ibid.*, 247.

²³ Leonie Hannan, "Making space: English women, letter-writing, and the life of the mind, c. 1650-1750," *Women's History Review* 21.4 (2012): 591, 598.

²⁴ *Ibid.*, 598; Diana Barnes, "Tenderness, tittle-tattle and truth in mother-daughter letters: Lady Mary Wortley Montagu, Mary Wortley Montagu Stuart, Countess of Bute, and Lady Louisa Stuart," *Women's History Review* 24.4 (2015): 572, 578.

²⁵ How, *Epistolary Spaces*, 5; Harris, "This I beg," 334.

²⁶ How, *Epistolary Spaces*, 5.

²⁷ Howard Anderson and Irvin Ehrenpreis, "The familiar letter in the eighteenth century: some generalizations," in *The Familiar Letter in the Eighteenth Century* (Lawrence: University of Kansas Press, 1966): 270.

century writers and letter writing manuals.²⁸ The same concept was endorsed in *The Compleat Letter Writer*, which recommended

When you sit down to write a Letter, remember that this Sort of Writing should be like a Conversation; observe this, and you will be no more at a Loss to write, than you will be to speak to the Person were he present; and this is Nature without Affectation, which, generally speaking, always pleases.²⁹

The idea of conversation suggested both the relationship between writer and reader, and a decrease in formality in correspondence. Like a conversation, these letters could encompass a range of subjects. Regarding content, *The Compleat Letter Writer* suggested that

As to Subjects, you are allowed in writing Letters the utmost Liberty: whatever has been done, or seen, or heard, or thought of, your own Observations on what you know, your Enquiries about what you do not know [...] and the more Variety you intermix, so as not rudely thrown together, the better.³⁰

This left a wide range of subjects available, from the content of reading or the composition of poems, to events in the household, to gossip or political news. Anderson and Ehrenpreis emphasize that this style of correspondence relied on the “possibility of a frequent, candid exchange between writers who trust each other”.³¹ Writing in a conversational style that acknowledged and encouraged emotional responses resulted in a different range of topics, including illness.

Families, Genders, and Patterns of Correspondence

The gentry were particularly well placed to take advantage of changes in the frequency, ease, and style of correspondence. The leisured lifestyle of the gentry allowed them to capitalize on increasingly quick and reliable postal routes and to engage in the new culture emerging around the novel, and their finances and access to credit provided the resources necessary to construct letters. Their combination of leisure and literacy also made the gentry particularly available for familiar letters, because they could easily acquire and converse about books, and were expected to perform social commitments that could form the foundation of a familiar letter.

²⁸ Keith Stewart, “Towards defining an aesthetic for the familiar in eighteenth-century England,” *Prose Studies* 5.2 (1982): 179.

²⁹ *The Compleat Letter Writer*, 46.

³⁰ *Ibid.*

³¹ Anderson and Ehrenpreis, “The familiar letter,” 269.

In addition to being poised to take advantage of the familiar letter, the gentry interacted with the genre differently when writing to each other than when exchanging letters outside their social group. This can be seen through an examination of the references to health in the same collections from writers of a lower class. For example, Charles Fairfax's preserved correspondence, dated between c.1720-1770, is largely split between letters from his daughter Ann, and updates from his London clerk, George Wilmot. When commenting on his daughter's health, Fairfax emphasized his involvement. When Ann was ill in Cambray in 1768, he acknowledged that she and her attending doctor should make medical decisions but added, "I shall goe to morrow to doctor Dealtry to acquaint him the contents of both your letters, and shall write to you again".³² In contrast, Wilmot referred to his own increasingly limited state due to gout in relation to his ability to communicate with Fairfax and effectively perform his business. One such letter from 1764 opened, "My Lord, I receiv'd Your Lordship's letter of the 12 Instant, and should have wrote Yesterday but that I had taken Physick", then recounted the extent of his illness to justify his silence before concluding that "I hope still to be able to wait upon Your Lordship, but cannt at present take Upon myself to say when I shall be able to do so".³³ The severity of his condition was used to justify his absences.

Lower class references to the health of their gentry recipients were characterized by a lack of reciprocity. Outside of justifications for failures to work or correspond, or expressions of desire for the health of the recipient and his family, lower class letter writers scarcely ever mentioned ill health. Although it was possible to initiate the intimate relationship indicated by familiar letters to strangers, historians such as Harris and Whyman emphasize the ingrained performance of hierarchy in epistolary culture.³⁴ The emphasis on narratives of daily life resulted in letter writers presenting detailed accounts of household health in correspondence. The creation of ease and honesty for such subjects was acceptable only among social equals, particularly family and close friends. The same intimate relationships rarely existed in inter-class relationships, and as a result a different style of correspondence characterized letters from the gentry families of this study and their business agents, tenants, or the poor who wrote to request charity. Collections such as the Constables and the Bosvilles had more letters from members of the lower classes, compared to families such as the Robinsons or Listers who corresponded

³² ZDV(F) VI 12/ (Charles to Ann Fairfax, 28 June 1768).

³³ ZDV(F) VI 12/163 (G. Wilmot to Charles Fairfax, 17 August 1764).

³⁴ Harris, "This I Beg," 334; Whyman, *The Pen and the People*, 21.

almost exclusively with relatives. As a result of the lower status of their correspondence partners, the Constable and Bosville collections had a low proportion of letters which referred to illness.

The familiar letters of this study's sample were primarily exchanged between members of the same class. The relationship between correspondents can be determined in almost sixty percent of the letters, and familial relationships dominate the study. Five different relationships comprised the category of families writing familiar letters, as seen in Figure 2.1. The most common pattern was siblings corresponding with each other. Often, as in the case of John Spencer and his sister Ann Stanhope, the correspondence was necessitated by the marriage and relocation of one of the siblings. When Ann married Walter Stanhope in 1749, she moved twenty miles north from the family home of Cannon Hall near Cawthorne to Leeds, where Walter was a woolen merchant.³⁵ The new distance and demands of running their households caused the siblings to transition from an in-person relationship to regular epistolary communication. Amy Harris establishes that sibling epistolary relationships were formed during youth as a place of experimentation and identity formation in the development of youth writing style, and the importance of these relationships is evident through the high survival of these letters.³⁶ Epistolary relationships between peers left numerous traces and persisted into adulthood. The sample for this study usually featured adult siblings.

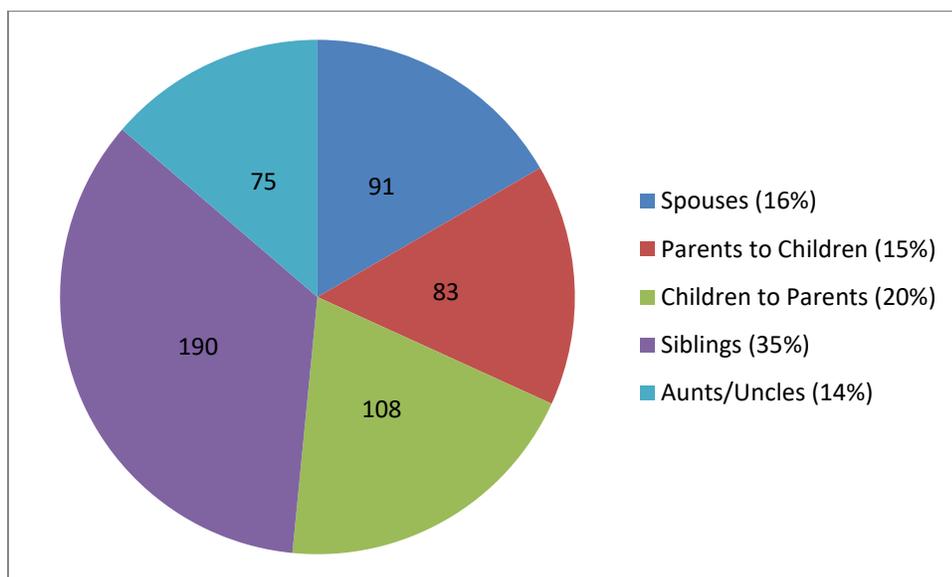
The second largest category was children writing to their parents. Many of these letters, such as the correspondence of Metcalfe and Thomas Robinson, Ralph and Harriet Carr, or Walter Stanhope, were composed while the children were either away at university in Oxford or Cambridge, or on their continental tours.³⁷ This group was complimented by the fourth large

³⁵ Hugh Owen, *Stanhope, Atkinson, Haddon and Shaw: Four North Country Families* (Printed for private circulation, 1985): 71. While Ann and John were the most regular sibling correspondents, letters were also exchanged between Mary Robinson and her brother and sister-in-law, the Aislabies, and between the Robinson children Metcalfe, Thomas, and Ann.

³⁶ Harris, "This I beg," 334.

³⁷ G. H. Hinchliffe chronicles how Metcalfe attended Queen's College, Cambridge, at the age of sixteen and, though unable to take a full Grand Tour because of the campaigns of the Duke of Marlborough against Louis XIV in France, he visited Paris in 1713 in "The Robinsons of Newby Park and Newby Hall," *Yorkshire Archaeological Journal* 63 (1991): 137. Metcalfe's younger brother Thomas was a scholar of Trinity College, Cambridge, and served as an ambassador to Paris and Vienna in the 1720s and 30s, as recounted by Hinchliffe in "The Robinsons of Newby Park and Newby Hall, part 3. Thomas Robinson, Baron Grantham (1695-1770) and his descendants," *Yorkshire Archaeological Journal* 63 (1993): 143-5. John and Harriet Carr's Grand Tours, first by John alone in 1788 and then with his sister Harriet in the hopes of curing her consumption in 1791, is the subject of A. W. Purdue's "John and Harriet Carr: A brother and sister from the North-East on the Grand Tour," *Northern History* 30.1 (1994) 122-138. Hugh Owen illustrates the life that Walter "Watty" Stanhope spent largely separate from his mother after his father's death in 1759 in *Stanhope, Atkinson, Haddon and Shaw*, 79-80. As well as attending Bradford Grammar School as a

Figure 2.1 – Relationships of Correspondents



category, comprised of parents writing to their children. Often parental letters were addressed to teenage children as parents such as William or Thomas Robinson, Ralph Carr, and Charles Fairfax traveled to London for business, or in the case of William Chaytor, imprisonment due to debts. Though this correspondence would likely be almost equal in practice, the survival of sources was higher for letters directed at home than to those of children in temporary lodgings. Clare Brant, Susan Whyman, and Amy Harris all observe the important role of intergenerational correspondence in familiarizing youths with the conventions of letter writing and society more generally. Parents both modeled letters and required that their children corresponded regularly.³⁸

A similar level of affection and interest in the health of household members can be found in spousal correspondence, which was frequently caused by the husband's travels for business or politics. Many of William Robinson's early letters to his wife contain a high degree of sentiment, as when he wrote around 1690 that "I hope yr breeding does not make you so sick as formely you cannot please me better, then taking solice sometimes how it goes with you, for you & yrs are really ye greatest objects of my thoughts".³⁹ Other spouses conveyed their affection through

child, Walter "Watty" Stanhope entered University College, Oxford, at sixteen and then attended Middle Temple to study law and visited Switzerland in 1770.

³⁸ Brant, *Eighteenth Century Letters*, 60; Whyman, *The Pen and the People*, 33; Harris, "This I beg," 336.

³⁹ WYL150/6001/4 (William to Mary Robinson, 26 December c. 1690).

nicknames, as when Ralph Carr referred to his wife as “my dear lass” in 1770.⁴⁰ Their emotional intimacy and a shared interest in household events made spouses ideal correspondents on the subject of health.

Outside the immediate home, aunts or uncles regularly corresponded with their nieces and nephews. These relationships usually paralleled sibling correspondence in the older generation. By the late 1760s, John Spencer had supplemented his letters to his sister Ann and brother-in-law Walter by regularly corresponding with their eldest son, “Watty”, who later inherited his land and combined the two families to become Walter Spencer-Stanhope.⁴¹ These relationships could also be less affectionate: Frances Bredall’s regular correspondence with his uncle Charles Fairfax in the 1760s focused on the money which Bredall owed.⁴² There was an added degree of voluntariness in these relationships: Watty did not write to all of the aunts and uncles who wrote to his parents, such as his father’s sister Hannah Atkinson or his mother’s sister Alicia Greame. He only exchanged letters with his uncle John Spencer. Writing to aunts and uncles showed the family connections which youths chose to make when they developed their own epistolary networks.

These patterns are particularly evident in the families who produced the largest volume of correspondence. The Robinson collection spans three generations, and is comprised almost exclusively of letters between members of the nuclear family. The earliest letters date to just after the marriage of William Robinson and Mary Aislabie in 1687, when William left his new wife to pursue a political career in London, then grew to include correspondence with their eldest son Metcalfe and fourth son Thomas.⁴³ Metcalfe died within days of his father, and the correspondence collection shifts to follow his youngest brother Thomas.⁴⁴ Thomas was very interested in the health of his children, perhaps due in part to the early death by miscarriage of

⁴⁰ ZCE/F/1/7/75 (Ralph Carr to Isabella Carr, 07 May 1770). Other examples of spousal correspondence include that of William Chaytor and his wife Peregrina during his imprisonment, and Walter and Ann Stanhope during his extended Bath trip, discussed further in Chapter 5.

⁴¹ Owen, *Stanhope, Atkinson, Haddon and Shaw*, 69. Walter Stanhope’s first wife Mary Warde and her namesake and niece regularly corresponded, and the children of Thomas Robinson exchanged letters with their aunt Ann Wortley.

⁴² For example, in ZDV(F) VI 12/151 Francis wrote “We have a great Deale owing to us, but Payments are so bad, yt money can hardly be raisd to get necessaries to subsit my poor Babes & Sickly Family upon,” and concluded in postscript, “I am in hopes to receive a little money next Month, if so, I’d be glad to pay your Lordship ye interest.” (c.1760).

⁴³ Hinchliffe, “The Robinsons,” 129.

⁴⁴ *Ibid.*, 138.

his wife Frances in 1750.⁴⁵ Intergenerational correspondence was also important for the Carr family, who preserved a high volume of correspondence from when their eldest son John Carr and daughter Harriet made a continental tour in 1789. The children had to skirt tense political crises, such as the 1793 France-Hungarian War, but it was the continued subject of Harriet's "troublesome cough" which was the most regular subject of their parents' concern.⁴⁶

The decisions to emphasize social and health news over revolutionary continental events is indicative of the nature of familiar letters: family news was explicitly prioritized over international events. A similar pattern can be seen in the smaller Clavering collection, in which Anne Clavering regularly wrote from her home at Chopwell to her cousin James of the Greencroft branch of the family, keeping him updated on gossip, family financial interests, and the health of her half-siblings Jacky, Betty, Margaret, Jane and Amelia, for whom both James and Ann acted as trustees after her father's death in 1702.⁴⁷

The Spencer-Stanhopes of Canon Hall preserved a wider range of correspondence between friends and distant relatives, directed primarily to Walter Stanhope and his wife Ann. As well as letters between the spouses, these letters contained news from Ann's brother John Spencer, and correspondence between the Stanhopes and their children while Walter Stanhope Junior was away for school. Similar patterns of sibling correspondence that developed into intergenerational letters can be seen from Listers of Shibden Hall. A large volume of correspondence was between siblings, such as the network formed by Mary Rose, Phoebe Wilkinson, and Samuel Lister, who, like the Spencer-Stanhopes, expanded to include correspondence between Jeremy's son James Lister and his aunts. The final large sample comes from the Chaytors' correspondence, exchanged during William Chaytor's imprisonment for debts due in part to his role in the "wrong side" of the Jacobite rebellion of the Fifteen.⁴⁸ Chaytor wrote to his wife, who remained in the north or traveled for her health, and as their eldest daughter Ann aged, she was included in the messages.

⁴⁵ Hinchliffe, "The Robinsons, part 3," 150.

⁴⁶ A.W. Purdue, *Merchants and Gentry in North-East England, 1650-1830: The Carrs and the Ellisons* (University of Sunderland, 1999): 220, 222,.

⁴⁷ Ann's political interests were sufficient enough to label her a "political commentator" in "Liddell, Ann (*hap.* 1686, *d.* in or after 1734)," J. M. Ellis in *Oxford Dictionary of National Biography*, online ed., ed. David Cannadine (Oxford: Oxford University Press), 2004, <http://www.oxforddnb.com/view/article/63016> (accessed September 14, 2017). See also ed. H.T. Dickinson "The correspondence of Sir James Clavering" (Gateshead: Printed for the Society by Northumberland Press, 1967): 1-2.

⁴⁸ Edward Hughes, *North Country Life in the Eighteenth Century* (London: Macmillan, 1940): 3.

With the exception of the Chaytors, these families had common reasons for traveling, and many family members spent at least part of the year in London. Berry and Gregory note that the north-east was perceived to be “at the extremity of England”, as distant from the dense London metropolis as it was possible to be before entering Scotland.⁴⁹ However, for the northern gentry this distinction was not a hindrance to their participation in national life, and the families of this sample were tightly connected to southern society. A.W. Purdue notes that despite a longer travel time, “the psychological distance was not commensurately greater [than today]. The Ellisons and their relatives took the three or four day journey on bumpy roads as a matter of course”.⁵⁰ These gentry families also had the resources to enable their traveling lifestyle because many were newly elevated. Edward Hughes identifies this change as a “double revolution” in which the old gentry, tightly related to the failing Jacobite cause, disappeared by the eighteenth century and were replaced by a new ruling class which took advantage of coal mining and its satellite trades.⁵¹ When taking advantage of opportunities to travel, these families used detailed written depictions of their spaces and experiences to facilitate the intimacy that had previously been gained by sharing those spaces and having conversations in person.⁵²

Gender

Although both men and women wrote letters throughout the eighteenth century in this sample of correspondence, male letter writers outnumbered their female peers in almost every decade of correspondence. The only exception was in the first decade of the eighteenth century, when equal numbers of letters were composed by men and women. The higher degree of equality in the early decades may be a result of early perceptions about the gendered nature of the familiar letter. Clare Brant suggests that the familiar letter was the one style in which women could be perceived as good writers because the style allowed their natural charms to be artistically displayed while simultaneously allowing the fulfillment of their social duties.⁵³ The increased number of male authors after the 1700s underline that familiar letters were no longer the preserve of women alone. The genre was increasingly used first in correspondence between women and

⁴⁹ Helen Berry and Jeremy Gregory, “Introduction,” in *Creating and Consuming Culture in North-East England, 1660-1830* (Aldershot: Ashgate, 2004): 4.

⁵⁰ Purdue, *Merchants and Gentry*, 76.

⁵¹ Hughes, *North Country Life*, XVIII.

⁵² Hannan, “Making space,” 598.

⁵³ Brant, *Eighteenth Century Letters*, 41-46.

men, being ideal to transmit information about the household and family life, and then by men amongst themselves as sociability and intimate friendships became more popular.

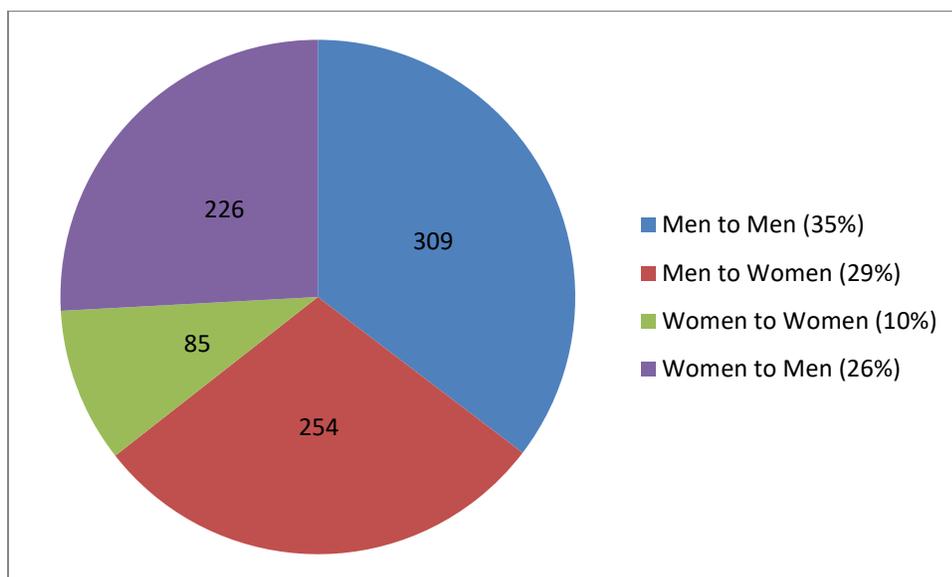
As well as the familiar letter being suited to the female temperament, gentry children in the eighteenth century had the basics of literacy instilled by their parents, and both genders benefitted by gaining competence in reading, writing, and particularly in correspondence.⁵⁴ This potential for education bears out in the surviving letters of women in this study's correspondence: consistent letter writers such as Anne Clavering, Mary Warde, Ann Stanhope, Miss Raine, and Therese Robinson wrote in a neat hand and packed their letters densely with household and social news as well as reflections on poetry and society more broadly. Rather than educational differences, the survival of male- over female- authored letters reflects a combination of the nature of eighteenth-century travel, and the preservation of sources. Managing household business, men had more reasons to travel away from the home, having letters delivered to temporary locations across England. Letters sent to the home had a higher chance of survival, as Diana Barnes suggests regarding the higher survival of letters from Lady Mary Wortley Montagu to her daughter during her continental travels.⁵⁵

Examining only the authors of letters leads to a picture of eighteenth-century correspondence which was dominated almost exclusively by men. However, when the genders of both letter writer and recipient are tabulated, women begin to appear much more regularly in correspondence. At first, they were largely recipients of male-authored letters, but throughout the century women gradually assumed a larger role as correspondents. Figure 2.2 tabulates the number of letters from men to women, men to other men, women to other women, and women to men. While men represent at least fifty percent, and as much as seventy percent, of letter writers per decade in this sample, including the gender of recipients results in a more balanced gender representation. In the 932 letters featuring references to illness, men remain dominant and wrote 689 letters (73 percent), but at least 565 letters (61 percent) involved women. This shows that women were far more active in correspondence than it might first appear, lending credence to the theory above that their letters simply had a lower survival rate. It also indicates that when compared to the high volume of male letter *writers*, that men were frequently writing to women.

⁵⁴ Whyman, *The Pen and the People*, 75 for her chapter on how northern farmers used correspondence, 12 for gentry relationships to epistolary educations.

⁵⁵ Barnes, "Tenderness, tittle-tattle," 571.

Figure 2.2 - Gender of Sender and Recipient of Correspondence



Examining the gendered relationships of letter writers by decade also reveals the changing use of correspondence by men and women through the eighteenth century. During the early decades of the eighteenth century, discussions of illness were largely between men and women. Indeed, in the 1710s sixty-eight percent of the illness letters were from men to women and a further twenty-seven percent from women to men, comprising the vast majority of the correspondence from the decade. The extent to which women were part of correspondence on ill health is demonstrative of their central role in family health. Men gradually become more confident and comfortable referring to their health and the health of their families to male correspondents. While men continued to write to women, after 1710 every decade was dominated by intra-male correspondence, including a peak of fifty-three percent of the letters exchanged in the 1730s. This may be a reflection of changing conventions in letter writing culture, which gradually emphasized greater casualness in letter writing.⁵⁶ Men appear to be taking advantage of this new level of freedom to incorporate personal matters into their correspondence.

Throughout most of the eighteenth century, women largely directed their letters to men. For example, during the 1720s women wrote thirty-one letters to men, but exchanged no letters with other women. This pattern began to change in the 1750s when women gradually began to exchange more letters with their own gender even as they maintained a regularly high level of

⁵⁶ Whyman, *The Pen and the People*, 21-22.

correspondence with men. Studying the change in the number of female letter writers between decades also reveals a general increase of female correspondents. Aside from the exceptionally high level of female correspondents in 1710, women represented a larger proportion of letter writers near the end of the eighteenth century than they did at the beginning, composing forty-four percent of the letters in the 1770s and 80s. These later eighteenth-century women were travelling away from home and creating female correspondence networks. Women were regularly involved in correspondence on sickness, but the parameters of appropriate female participation shifted to allow a more active approach in writing and in seeking relationships with distant friends and family through writing.

Converging improvements to epistolary culture enabled a greater desire and space for illness accounts and medical advice in correspondence. As determined in the the previous section, the relationships which comprised this study were largely familial, which influenced the desire for information and types of news that could be shared. This was an extension of the expectation that households would perform roles as sufferers and caregivers, including the mediation of medical encounters.⁵⁷ Because the peripatetic gentry did not travel as family units, their investment in family health was not necessarily paralleled by cohabitation and the opportunity to physically assist the sick. Illness narratives in familiar letters developed from personal experiences and the model of illnesses in epistolary fiction such as *Clarissa*, which signaled that illness was an important part of life which could be effectively recounted in letters. As Wayne Wild indicates, this genre also captured the social *Zeitgeist* that illness had both important effects on personal development, and reflected the morality of the sufferer.⁵⁸ The social, moral and physical importance of illness was captured in the expanded genre of letters.

Accounts of illness in this sample of sources thus were influenced both by the style of writing and the relationships of the correspondents. In *Ill Composed*, Olivia Weisser asserts that genre of seventeenth-century ego literature influenced how writers described their illness in gendered ways.⁵⁹ More than half of the women in her sample evaluated their sickness by observing the experience of others, based on their knowledge of health through household work, while men looked instead to their own prior experience and work lives to interpret their sick

⁵⁷ Olivia Weisser, *Ill Composed: Sickness, Gender, and Belief in Early Modern England* (New Haven: Yale University Press, 2015): 47.

⁵⁸ Wild, *Medicine-by-Post*, 11.

⁵⁹ Weisser, *Ill Composed*, 3.

Figure 2.3 – Women’s References to Their Own Illnesses Versus the Illnesses of Others

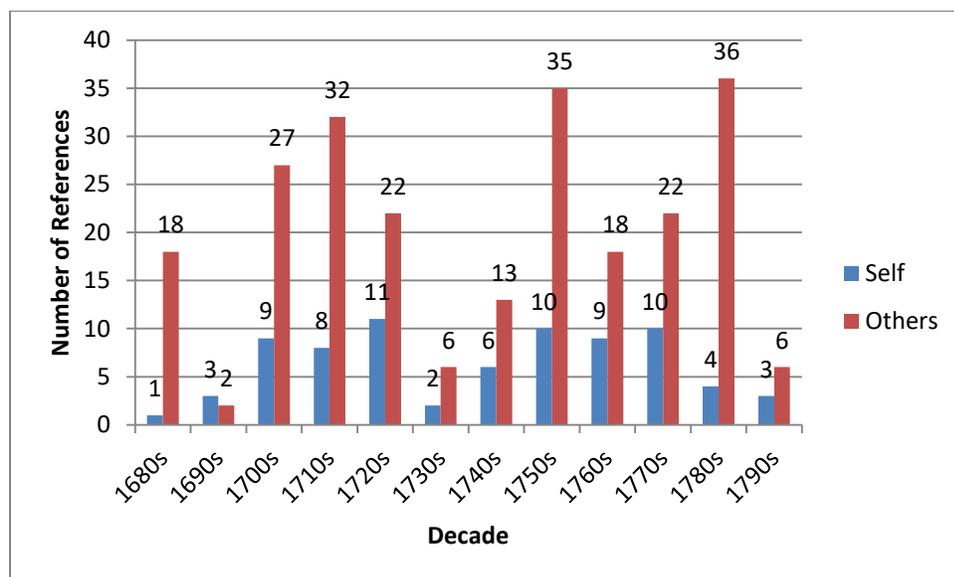
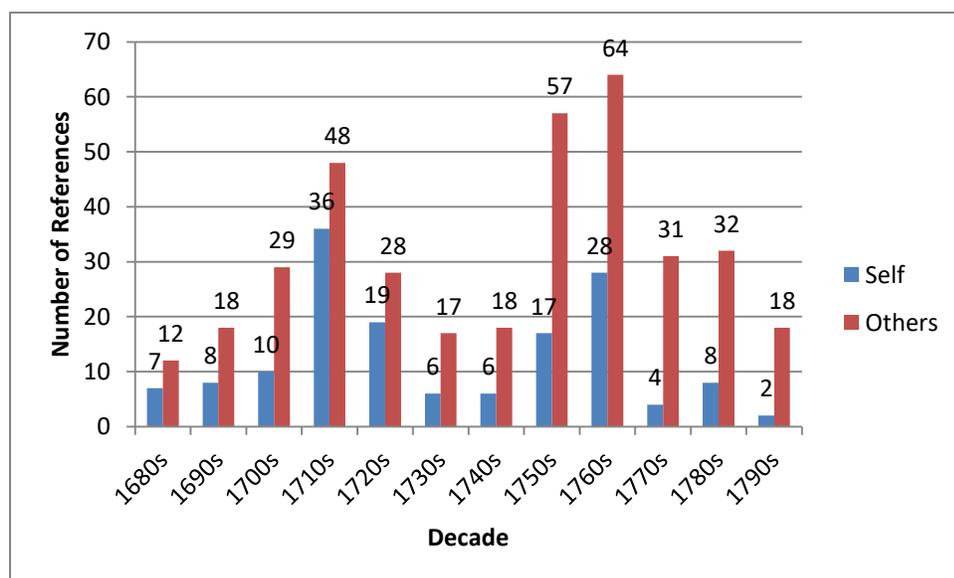


Figure 2.4 – Men’s References to Their Own Illnesses Versus the Illnesses of Others



body.⁶⁰ Weisser’s work on the gendering of illness raises questions whether illness accounts focused on the self, or the wider household. To measure the subject of illness accounts, I tracked both genders’ references to illness through the decades, noting if they referred to their own health, to the health of their reader, or to others in their household and neighbourhood.

⁶⁰ Ibid., 48, 53, 64.

For both genders, the vast majority of references to illness were questions or comments about the health of others. However, when the references to the self versus to others were compared within genders, men were slightly more likely to refer to their own health (in 29 percent of 523 cases, compared to women's 24 percent in 313 cases). For example, William Chaytor reported to his wife Peregrina and his daughter Ann in 1701 that "I gott only a little running cold at nose which is in a manner gone. I have a litle touch of gout in my toe but I thanke god it kept out of back and shoulder".⁶¹ There is no discernable, steady pattern of change for either gender, as can be seen in Figures 2.3 and 2.4. The absence of change in the perspective of letter writers exhibited a letter-writing culture that remained more interested in the bodies of others rather than of those of the writer.

An interest in the health of their recipients is indicative of the discourse of letter writing, which sought to gain information about distant friends and family. However, this interest in the bodies of others surpasses convention. Letter writers referred to the health of housemates and local family more regularly than their own health. They also inquired after the health of the reader and their family. Such information could depict members of the household, as when Mary Warde informed her aunt that she was dull because "my Papa is confined by a very bad fit of the Gout, & has not been down stairs, since Thursday last he has it in both Feet as bad as ever I Knew it". Letters also contained news on more distant relatives and friends such as Mary Robinson's report to her son Thomas while he was away at school that "yr bro: Jonny has put his elbow out of Joynt" in c.1720 or John Lister's news for his parents in 1726 that "My old friend Bold is in very bad Health, ye Physicians have almost given him up". Letters could even include commentary on high society illness, as when Anne Clavering noted to her cousin James in 1708 that "The Queen has gott ye Gout in her foot, wch misfortune has prevented Ms Temples marriage ye weel".⁶² The focus on surroundings and experiences gave letter writers the opportunity to reflect on health in their correspondence.

The gendered behaviours which so strongly distinguished Weisser's subjects are almost imperceptible in eighteenth-century letter writers.⁶³ The differing functions of eighteenth-century familiar letters and seventeenth-century ego-literature help explain this change. The key features

⁶¹ ZQH/9/14/9 (William Chaytor to Peregrina and Ann Chaytor, 27 January 1701).

⁶² SpSt/6/1/50 (Mary Warde to Mary Warde-Stanhope, 23 January 1738; WYL150/6006/II/13191 (Mary to her son Thomas Robinson, undated but likely c. 1720); SH:7/RL/39 (Rev John Lister to his parents, 15 May 1726); CLV 3 (Ann to James Clavering, 10 June 1708).

⁶³ See footnote 59, above.

of seventeenth century ego-literature were self-reflection and a desire to identify the works of God in daily life. God's will was inscribed on the body through illness, and so careful attention to one's own health could serve as a measure of salvation and a testament to moral character.⁶⁴ Familiar letters, on the other hand, were intended to satisfy a desire for novelty and curiosity, while simultaneously reviving and maintaining intimacy through distant companions through the sharing of news.⁶⁵ In this context, Stewart suggests, the goings on and domestic activities provided an important element of the substance of letters.⁶⁶ The intention was more social, as opposed to the emphasis on personal religion in the seventeenth century.

Illnesses

Within the generally outward-facing portrayals of illness in this genre, some references to health and illness appear to be adherences to convention more than general expressions of interest and concern in family health. For example, when William Chaytor opened a letter to John Robinson in 1785. "I heartily congratulate you and the family at Syon Hill on Miss Nevill's having got thro' the inoculation for the small pox in so favourable a manner", he was simultaneously fulfilling several epistolary conventions.⁶⁷ First, as Haggerty observed, one element of being a good correspondent, beyond the inclusion of news and personal opinions, was responding to all the enquiries and news of a previous letter.⁶⁸ Since many letter writers enquired about the health of their readers, there was an engrained cycle of confirmation of health by writers before proceeding to other matters. These conventions were an important response to the silences necessitated by correspondence which would take days to be exchanged. Though correspondents were highly conscious of the progress of time, unexpected silences created by missing letters or

⁶⁴ Weisser, *Ill Composed*, 47.

⁶⁵ Stewart, "Towards defining an aesthetic," 189.

⁶⁶ *Ibid.*, 183.

⁶⁷ ZQH/10/50/51 (William Chaytor draft reply to John Robinson, 09 April 1785). Similarly, William Robinson opened a letter to his son Metcalfe c. 1690 by commenting that "I got yrs this morning, am glad you are well at London." (WYL150/6002/21), Francis Chomeley concluded a letter to his cousin Charles Fairfax in 1721 with the report that "Yr Aunt Fairfax fell ill yesterday is hoped to be much better." (ZDV(F) VI 12/11), and John Lister informed his brother Jeremy that "I write these few lines to acquaint you that my Brother & I are in good Health hoping you are all the same." (SH:7/LL/157).

⁶⁸ Sarah Haggerty, "The ceremonial of letter for letter: William Cowper and the tempo of epistolary exchange," *Eighteenth-century Life* 35.1 (2011): 159.

delayed responses caused a high degree of distress.⁶⁹ A wide variety of letter writers comforted their readers and justified their delays through reports of their recent illness and recovery.

Reassurances of health were usually used to bracket a letter. A regular letter exchange might begin by thanking the reader for news of their health provided in their previous missive, or sympathizing with news of illness, as Chaytor did above. If a break in the pattern of correspondence occurred, the writer might begin by explaining and apologizing for delays by focusing on their ill health. For example, the opening sentence of Metcalfe Robinson's letter to his mother Mary, undated but from c.1710 while Metcalfe was at university in Cambridge, explained "I did not keep my word in writing to you last post, because I must have told you I was ill".⁷⁰ At the end of many letters, writers concluded with statements about their own health and the health of their families, as when James Lister concluded a letter to his sister Phoebe Wilkinson in 1775 that "the rest of the family are well, who join in all due respects to yourself" before his own respects and signature.⁷¹ When illness was mentioned in these ways, the writer rarely provided detailed information. The sections were intended to inform and assure their distant relatives about family welfare.

Beyond these conventions, the emphasis on daily life in familiar letters provides a strong resource for collecting information about illness in the eighteenth century.⁷² In order to investigate the most common identifications of illness in correspondence, I have divided over 1200 references to sickness into four larger categories: named illnesses such as gout, descriptions of sickness such as "very ill", illness identified by body parts like the leg and heart, and statements of health (Figure 2.5). There were more illnesses than letters which referred to them, because writers could include to the illnesses of several people in one letter, as when John Spencer labeled both his father's "ugly pain in the stomach" and their friend Mrs. Shuttleton's "very bad state of health" in a letter to his sister Ann Stanhope, dated c.1760.⁷³ Other correspondents labeled conditions using several terms, as when Ann Robinson (senior) recounted to her brother William around 1720 that her guest was delayed because of an injured foot because "if it is a strain, he may be here in two or three days, but if ye gout or Rheumatism,

⁶⁹ Ibid., 164.

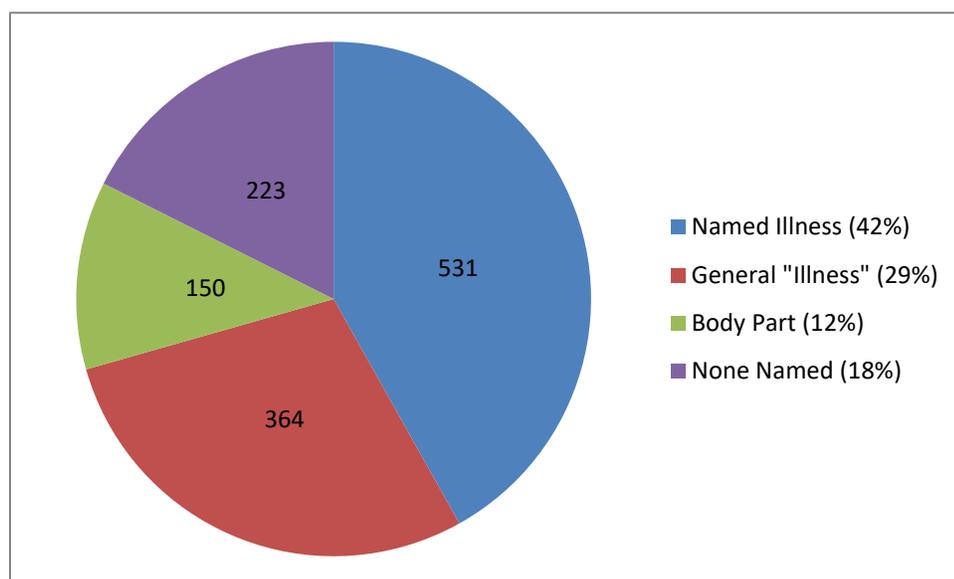
⁷⁰ WYL150/6004/5 (Metcalfe Robinson to Mary Robinson, 01 May c. 1710).

⁷¹ SH:7/LL/210 (James Lister to Phoebe Wilkinson, 09 May 1775).

⁷² See appendix III.

⁷³ SpSt/6/1/58 (John Spencer to Ann Stanhope, c. 1760).

Figure 2.5 – Descriptions of Illness



perhaps not this month”.⁷⁴ Whether talking about themselves, their friends, or their family, a variety of terms were utilized to recount illness to their readers.

The naming of specific illnesses dominated correspondence. Sixty-five different illnesses ranging from the omnipresent gout and colds to single incidents of gangrene, seizures, and stranguries. These named events represent over forty percent of references to illness in correspondence, proving that when letter writers were sick, they frequently felt comfortable sharing their diagnosis with their readers. Despite Roy Porter’s comments that eighteenth-century doctors were uncertain about diagnostic term because of the difficulty of “vocaliz[ing] one’s pains or verbaliz[ing] one’s body”, correspondents were confident in identifying the illnesses they experienced.⁷⁵ The subject of diagnoses will be explored further in Chapter 4. Across decades, named illnesses generally remained the largest category, representing around sixty percent of cases throughout the first half of the century, and then remaining around forty percent for the rest of the century. While there was a slightly higher chance that later writers would use descriptions of illness or health rather than naming a condition in the latter half of the eighteenth century, naming remained the preferred method of including an illness in a letter. The most popular named illnesses, gout and colds, were consistently present throughout the period,

⁷⁴ WYL150/6006/IV/16 (Ann Robinson to William Robinson, c. 1720).

⁷⁵ Roy Porter, “‘Expressing yourself ill’: the language of sickness in Georgian England,” in *Language, Self and Society: A Social History of Language*, ed. Peter Burke and Roy Porter (Cambridge: Polity Press, 1991): 281-2.

indicating that the nature of the illnesses experienced by writers did not drastically change over the century.

Writers also regularly referred to symptoms such as fevers, pain, and coughs, events such as childbirth and injury, and contagious diseases. Again, events such as contagious diseases were spread almost uniformly across the decades, despite the gradual inclusion of seven examples of inoculation after 1740. By the point at which these gentry families used inoculation, the process had been known in Europe since 1718, gaining popularity in England first, and was entering, according to Anne Eriksen, the “second stage” in which the method became “both safer, simpler, and less expensive” than before, allowing families to expose their children to infection at suitable times and in predetermined conditions. This allowed a milder form of smallpox and created immunity.⁷⁶ Most of the diseases in correspondence were regular or chronic conditions, with only smallpox deviating from this pattern in the most frequently referenced illnesses. Colds, fevers, and coughs were all regular conditions which were perceived to be influenced by season and temperature. Gout was a chronic and recurring condition which particularly predominant among the gentry. Roy Porter and G.S. Rousseau therefore also referred to the disease as one which traditionally hobnobbed in high society.⁷⁷ Letters which included illness referred most frequently to the diseases that regularly interrupted early modern life. This reflects familiar letters’ use of the content of daily experience as fodder for correspondence: regular events and regular diseases were acceptable subjects in the “conversations” of letters.

The second category features more general descriptions of illness that included fifty three expressions of general illness, encompassing terms such as “very ill”, “indisposed”, “poorly”, “attacked”, and “so bad”. Such accounts comprise almost thirty percent of the cases in this sample. While variations on illness, such as “very ill”, and “ill” were omnipresent in letters, there were also many single uses such as “dreadfully”, “not easy”, “ugly symptoms” and “uneasy”. When the use of descriptive terms is divided by decade, there is a high level of continuity: near thirty percent of references were imprecise representations, though the number rose as high as forty-four percent in the 1770s. In this category, a pattern of change can be seen by evaluating the use of the most popular terms such as “ill” or “disorder” through the decades.

⁷⁶ Anne Eriksen, “Cure or protection? The meaning of smallpox inoculation, ca 1750-1775,” *Medical History* 57.4 (2013): 518-27.

⁷⁷ Roy Porter and G.S. Rousseau, *Gout: The Patrician’s Malady* (New Haven: Yale University Press, 1998): 5.

In the first half of the century, most letter writers referred to their illness by specifically referring to the condition. When they represented their health generally, correspondents favoured variations on “ill” and “illness”, a term which comprised 35 percent of general descriptions of illness. “Ill”, “very ill”, and “illness” were the three most popular terms. These were followed by “disorder”, “indisposed”, and complaints. Appendix IV shows the chronological spread of these most popular terms, each of which represented at least two percent of the total references to illness. Variations on “ill” and “indisposed” dominated descriptions of illness through the 1720s, and there was only one example of “complaint” and two examples of “disorder” prior to 1730. Through the rest of the eighteenth century, uses of “complaint” and “disorder” became more frequent until they were more regular than “indisposed”, but “ill” remained consistently popular.

This shift signals a change in the perception of writers regarding the effects of illness on their lives. “Indisposed” is an ideal term to explain an absence from correspondence, it is a relational term which indicates that the indisposed person failed to perform one activity because they were occupied with another. Terms such as “complaint” and “disorder” speak more to an individual response to illness and how the body could be changed by the experience of sickness.⁷⁸ A writer who labeled their illness as a “complaint” depicted the extent to which pain and an inability to perform their regular routines was a personal inconvenience. “Disorder” took this concept even further, focusing on the absence of a regular internal state. The use of these personal terms is a reflection of the rise of sympathy in understanding medicine. Wayne Wild argues that the rhetoric of sensibility, which asserted that the nerves controlled general bodily function, lead to a rise in experiential accounts rather than the description of symptoms, and encouraged feeling, self-expression, subjectivity, and metaphors in illness accounts.⁷⁹ Sensibility allowed patients to look inwards and interpret the effect on their experiences due to changes in their bodies.

In the third category, almost twelve percent of the cases writers focused on the specific body part which was the site of their discomfort, referring most frequently to their heads, legs, and throats, but also labeling areas such as breasts, blood, lungs, faces and teeth, bowels, and

⁷⁸ During the early modern period, the terms were also euphemisms for menstruation and had much the same implications of bodily changeability. See for example Sara Read’s first chapter, “‘What a small excess is called *flooding*’: the language of menstruation and transitional bleeding,” in *Menstruation and the Female Body in Early Modern England* (Basingstoke: Palgrave Macmillan, 2013): 24-28; and Cathy McClive, *Menstruation and Procreation in Early Modern France* (Farnham: Ashgate, 2015).

⁷⁹ Wild, *Medicine-by-Post*, 10.

hearts. These cases were usually paired with an injury, as in Walter Stanhope Junior's false illness, when the injured tendons in his knee justified his absence from England. Headaches and sore throats, both key symptoms of colds and fevers, were among the most frequent body parts mentioned. Letter writers also referred to their legs and joints, which inhibited their mobility and were again linked to the popular conditions of gout and rheumatism.

Both humouralism and sensibility had a degree of imprecision when it came to assigning illnesses to body parts. For humouralism, this was because the fluids which regulated health could flow or stagnate in various areas, affecting the body holistically or moving illnesses from one part of the body to the other. This was the case when John Robinson apologized for failing to write to William Chaytor due to a "symptomatic gout flying about me for ten days" which confined him to bed.⁸⁰ The combination of "symptomatic" and "flying" in this case demonstrated an illness which was causing him considerable pain and inflammation, but also affecting multiple parts of his body as it "flew" from limb to limb. In sympathetic medicine, the explanation for the absence of body parts in illness narratives was that the doctrine favoured experiential accounts over symptoms.⁸¹ The body part was less significant than the effect that illness or injury had on its sufferer. Thus, while references to body parts remained throughout the period, they were never the emphasis of the diagnostic or descriptive techniques.

Finally, in order to effectively contrast references to either health or sickness, the fourth category contains letters in which no illnesses were named. Instead, this category is comprised of statements of health or comments about the receipt of treatment which do not specify the reason they were being treated. For example, an unsigned letter to Bridgette Bosville, possibly by her sister Mary in York, recorded that "I must own my self greatly Indetted to Sr Dealtrey whose skill in Physick, & Honesty in the application of it; I believe no one will offer to duplicate".⁸² These account for almost eighteen percent of the cases. The overwhelming frequency in which diseases *were* identified signals that letter writers were more likely to name their condition regularly, even repeatedly. Again, this is an indication of the importance of disease as something more than a convention of familiar letters. It was relatively rare to represent health generally, and the majority of letters in these collections did not mention either health or illness. It is clear that

⁸⁰ ZQH/10/50/51 (John Robinson to William Chaytor, 10 May 1785).

⁸¹ Wild, *Medicine-by-Post*, 10.

⁸² U DDBM/32/3 (unsigned to Bridget Bosville, 28 February 1750).

the decision to depict ill health was a conscious choice which responded to the interests of the parties involved in correspondence.

The specificity which characterizes the largest group of illness through naming conditions is an important indicator of the importance of illness in household life, and thus in the familiar letters exchanged by family and friends. Susan Fitzmaurice has argued for the minimization of the significance of illness, stating it is “not clear that knowledgeable advice is as an important ingredient of their association so much as sharing their experience of illness”.⁸³ She particularly maintains that the act of offering advice without knowing whether it would be accepted turned passive statements of sympathy into potentially active responses, which emphasized the writers’ interest in their reader and allowed them to play a role in the treatment.⁸⁴ However, simplifying inclusions of illness and advice to represent only attempts to facilitate intimacy underappreciates the function of familiar letter content that was designed to create intimacy and amusement. Dismissing illness also minimizes the significance of the knowledge and personal interest that was the foundation of inclusions of medical information.

The range and detail in writer accounts of household illnesses surpasses conventional methods. Instead, writers clearly valued naming conditions and providing information. By arguing that illness specifically performs the role of conventional content, Fitzmaurice is targeting one element of household narrative as being less about illustrations of life and more about attempts to simulate closeness. Instead, following her reductionist logic and appreciating the intention of the genre, all content in these letters would simply function as a replacement for the desired physical closeness. This overestimates the significance of convention in the genre. It is necessary to acknowledge that these elements of news can play multiple roles at once. The nature of correspondence, which was spaced out with silences and could be irregular or unreliable, was countered by descriptions of home which both entertained and performed a portrait of life which the reader could envision as if they were present.⁸⁵ Illness was a regular element of households, and correspondence relayed the disruption of regular routines by illness.

⁸³ Susan Fitzmaurice, *The Familiar Letter in Early Modern English: A Pragmatic Approach* (Amsterdam: John Benjamins, 2002): 99.

⁸⁴ *Ibid.*

⁸⁵ Hannon, “Making space”, 599.

Conclusion

Walter Stanhope's apologetic letter capitalized on a series of developments which explained and enabled his differing accounts of illness to his uncle. Changes to the postal system made more possible regular letter exchanges, allowing Walter to send a series of messages rapidly and trust that they would be received. High literacy was evident in his confident and descriptive style, and the narrative model of epistolary fiction was reflected by the personality and vivid nature of his account. Walter's account of his knee, and his more truthful update, were written as if in conversation to his uncle, in the style of the familiar letter. Changes to epistolary culture improved the dependability, capability, and appeal of letters, and gave correspondents increasing freedom to recount interesting events in their lives, from their social and intellectual pursuits to the daily experiences of health, sickness, and family life. Illness thus had a place in familiar letters which had not existed in previous forms of correspondence. In regularly describing the experience of their households, letter writers preserved the moments of sickness which disrupted routines and caused fear and fatigue in caregivers.

In this genre, there were distinct patterns in the correspondence partners who discussed illness. In cases when relationships between correspondents can be established, the majority of letters were written to family members who had departed from the home, and men in particular were likely to require household updates when they left their families in order to perform business in London. During the early decades these peripatetic men wrote primarily to women, but by the late eighteenth century men were regularly conferring about health with male readers. Women's correspondence increased in the eighteenth century, and developed from being largely towards male readers to creating a female epistolary network. Both men and women used familiar letters to consider health, but were much more likely to chronicle the health of family and friends than their own sickness. The fact that men and women produced similar narratives reflects how both genders were expected to adhere to the same conventions in composing letters.

Historians such as Clare Brant have observed that letters are not stable sources and must instead be explored for the diversity of their functions, content, and writers.⁸⁶ Willemijn Ruberg has responded to the inadequacy of using letters as a transparent description of household activities by emphasizing the cultural turn, in which historians explore the making of meaning

⁸⁶ Brant, *Eighteenth-Century Letter*, 25.

through language and the construction of categories.⁸⁷ Susan Fitzmaurice has taken this concept to its natural conclusion and contends that illness played only a conventional role in the familiar letter. Fitzmaurice claims that accounts of illness and offers of advice served only to equalize and continue correspondence. In her argument, advice was an expression of interest that served only to emphasize the intimacy of the correspondents. This argument both minimizes the extensive terminology marshaled to illustrate ill health, and how the genre generally had the same intentions of creating intimacy and maintaining conversations.

Illness has more relevance than simply asserting the existence of a relationship between writer and correspondence. The familiar letters of this study were designed particularly to replicate conversations between intimates, and to create a sense of shared space or to allow the reader to feel as if they were at the writer's home. Commentaries on household events were one important aspect of composing a familiar letter. Illness was in turn one significant element of the household narrative and an area of concern for both correspondents, and thus emerged regularly in letters. Regular interest did not, however, translate to referring to illness in every letter. Formulaic references to illness in letters can be distinguished from accounts of individual illness events. Most of the examples of illness defy this template, coming instead under other news about family life. If these inclusions are to be considered as conventional, they filled this role similarly to all other subjects, such as visiting friends, going to market, or the activities that filled an evening at home. Illness was one of many narrative elements which comprised the atmosphere of the familiar letter.

In addition to analyzing the circumstances in which letter writers referred to illness, this chapter has demonstrated the importance of specificity in the wide range of diagnoses and representations used. The majority of references to illness include a specific condition, indicating that understanding their own diseases and depicting them accurately for their readers was important to letter writers. Naming conditions was complimented by descriptions of ill health such as "confined", "very ill", and "indisposed". While naming illness remained consistent, these general labels for illness gradually shifted to reflect the significance of sensibility both socially and medically. As the eighteenth century progressed, correspondents were increasingly more likely to reflect on the effect which illness had on their lives, through terms such as "complaints"

⁸⁷ Ruberg, "Letter as Medicine", 492.

and “disorders”, than on the effect of illness on others, as when “indisposed” signaled that they were not able to complete external commitments.

Narratives of illness in letters were particularly possible in the context of the “golden age” of correspondence. The structure of family letters produced different records of illness than ego-literature, medical correspondence, recipes, or practitioner casebooks. They represented an attempt by writers to recreate consciously the style of conversations they could expect to have in person. Such letters preserve the incidents which letter writers felt were important and interesting enough to their readers to merit inclusion in the letter. Keeping in mind the illusory transparency of letters allows historians to shift the frame of reference slightly, from “what they did and knew” to “what activities and knowledge they considered important”, and how this prioritization influenced the actions of gentry letter writers. The familiar letter as a genre, the familial relationships which characterized correspondence, and the nature of illness in letters provide the foundation for further investigations into the medical behaviours of the writers’ households. Constructed personal epistolary narratives in eighteenth-century Yorkshire, Durham, and Northumberland allow a deep exploration of the concerns and behaviours of sick families which will be the subject of the next chapter.

Chapter Three — Caregiving Activities and Managing the Sickroom

In December 1782, Dorothy Bentinck, Duchess of Portland, wrote to her cousin, Louisa Ponsonby, regarding a matter of mutual interest. Louisa's previous letters had been characterized by a focus on family illness, but the most recent had delivered Dorothy more welcome news. Dorothy replied,

Your letter is rather comfortable than otherwise as it tell me that all your kindred have nearly recover'd their indispositions, it is high time, for you must have been long ago tired of that melancholy trade, nursing the sick.¹

Dorothy underlined the words “nursing the sick” to stress her statement. When this emphasis is combined with her reference to nursing as a “trade”, a term used in the eighteenth century to designate occupations such as surgery or carpentry which required high manual high skill but awarded lower prestige, her comment expresses one perception of the status and labour involved with caregiving.² Dorothy's reference to “all your kindred” noted that several members of Louisa's family were simultaneously or consecutively ill, and the comment that “you must have been long ago tired” suggested that it was Louisa who had acted as caregiver during these illnesses. Louisa's nursing role was dictated in part by social expectations that women should care both for relatives and in a wider charitable context, adding to the necessity of her caregiving role.³ Dorothy indicated that women in her family were acting as nurses, and that the role made considerable demands on their time and energy.

Though Dorothy named Louisa's activities “nursing”, she provided no context for the nature of the work or the medical knowledge and skill which caregiving necessitated. A survey

¹ Second Earl Grey 870/7/2. (Dorothy Duchess of Portland to Louisa Ponsonby, 5 December 1782). Emphasis in original.

² Samuel Johnson defined “trade” as “Occupation; particularly employment whether manual or mercantile” in *A Dictionary of the English Language in Which the Words are Deduced From Their Originals, Explained in Their Different Meanings*, third edition (1768). Margaret Pelling establishes “trade” as the opposite of the ideal position of “profession,” a “full time pursuit of some prominence or social significance,” and the control of a market in “Medical practice in the early modern period: trade or profession?” *Bulletin for the Society for the Social History of Medicine* 32 (1983): 27. Pelling also argues that trades were numerous and an “index of economic development” in contrast to the “culturally important but numerically insignificant” professions in “Occupational diversity: barber-surgeons and the trades of Norwich, 1550-1640,” *Bulletin of the History of Medicine* 56.4 (Winter 1982): 487. Surgeons were often labeled as a trade due to the training by apprenticeship and the necessity of manual work, in contrast to the efforts of physicians to be understood as a profession due to their academic training in universities and the intellectual rigours of their medical knowledge.

³ Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London & New York: Routledge & Keegan Paul, 1987): 4.

of the manner in which letter writers signaled caregiving activity provides some context for Dorothy's comments while establishing both how caregiving influenced household activities during family illness and the status of these activities in familiar letters. Examining the role of caregiving in familiar correspondence is important because in comments such as Dorothy's, caregiving was not necessarily a precursor to the inclusion of medical practitioners. Familiar letters are an underused source material which this study uses to provide a wider sample of caregiving activities than those mentioned in correspondence to physicians or practitioner case studies, in which household caregiving proved insufficient and necessitated the inclusion of the paid practitioner. Based on an expanded survey of eighteenth-century caregiving activities, this chapter establishes the extent to which anyone in the household provided care, and considers the fundamental role of gender in dictating who performed most of the medical work.

Identifying caregiving in historical sources is complicated because much of the work of caring for the sick occupied the ambiguous status of both necessary daily household tasks and fundamental elements of regulating the sick room. For example, the preparation of food was a daily activity which was modified to reflect special dietary needs based on the nature of illness. Similarly, historians such as Elaine Leong have revealed how recipe books and medicinal preparations shared skills with cookery while being a site of medical knowledge and authority.⁴ Caregiving was a natural extension of household work. The interrelated nature of caring and housework is further complicated by the degree to which daily life and the maintenance of health was medicalized by the common belief that the body was porous and vulnerable to external factors such as air, heat, and food. In their study on early modern Italy, Sandra Cavallo and Tessa Storey emphasize the extent to which letter writers were aware that managing different elements of the household in response to the "non-naturals" could influence the experience of health and illness.⁵ Managing changes to the daily life, diet, and environment of patients was a necessary element of caregiving, and this indistinct identity leads to difficulty in identifying nursing work.

While most histories of medicine acknowledge the importance of household caregiving as a fundamental element of medical work, they have largely neglected to examine these

⁴ Elaine Leong, "Collecting knowledge for the family: recipes, gender and practical knowledge in the early modern English household," *Centaurus* 55 (2013): 81-103.

⁵ Sandra Cavallo and Tessa Storey, *Healthy Living in Late Renaissance Italy* (Oxford: Oxford University Press, 2013): 57.

activities in detail.⁶ Hannah Newton devotes a chapter to caring for sick children in seventeenth-century England, but most research focuses on explicitly medical tasks in caregiving. For example, Alun Withey's chapter on "Care and the Welsh medical home" focuses on the preparations of medicines. Olivia Weisser also recognizes that "patients rarely recorded the particulars of their interactions with healers", and instead discussed models of the sick body and the availability of household remedies.⁷ Responding to the historiographic underrepresentation of the physical body of the patient, Sandra Cavallo and Mary Fissell suggest integrating the concept of "bodywork" into historical research. This term "enables us to start at the bedside of the sufferer, attending to the physical labor entailed in the care of the sick".⁸ The category incorporates a wide range of roles including caregivers, midwives, wet nurses, "watchers", and wig-makers.⁹ Expanding the definitions of medical work to incorporate the daily management of bodies provides both a clearer picture of the medical aspects of daily life and more opportunities for historians to explore the subject of health preservation and activities in the sickroom. Gentry families used medical knowledge not only to inform explicit medical tasks such as wound care and medicaments, but to understand the progression of sickness and manage a range of caregiving duties in the sick room.

Despite the interest in health and illness expressed in the gentry letters of this study, analyzed in Chapter Two, only seventeen percent of references to illness depict the actual practices of caregiving. Terminological ambiguity in the eighteenth century complicates investigations of caregiving practices. Letter writers used a range of caregiving descriptions including "caring", "attending", and the concept of "nurses" and "nursing". The absence of a simple expression of caregiving is reflected in historiographical discussions of these activities: Hannah Newton observes that seventeenth-century parents recorded "nursing", "sitting by" or "holding", "keeping", and "watching" their sick children. Anne Stobart also defined caregiving or nursing tasks in the seventeenth century as including activities linked with housework through

⁶ See for example Susan Broomhall, *Women's Medical Work in Early Modern France* (Manchester: Manchester University Press, 2004): 1-2; Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 35-6; Alun Withey, *Physick and the Family: Health, Medicine and Care in Wales, 1600-1750* (Manchester: Manchester University Press, 2011): 99.

⁷ Hannah Newton, *The Sick Child in Early Modern England, 1580-1720* (Oxford: Oxford University Press, 2012): 93-120; Withey, *Physick and the Family*, 99; Olivia Weisser, *Ill Composed: sickness, gender and belief in early modern England* (New Haven: Yale University Press, 2015): 11, 34.

⁸ Mary Fissell, "Introduction: women, health and healing in early modern Europe," *Bulletin of the History of Medicine* 82.1 (Spring 2008):10-11.

⁹ *Ibid.*

providing nourishment and hygiene, as well as supervisory tasks such as planning and reallocating the work of the sick person, and medical tasks as consisting of obtaining medicines and preparing special foods and dressings.¹⁰

Definitions of household caregiving can be read alongside the historiography on paid nursing, which highlighted similar roles. While the idea of “nursing” did not develop a distinctive professional meaning until the nineteenth century, the term was charged with definitions and expectations in the early modern period. Margaret Pelling indicates that in the mid-seventeenth century, the term began to shift from its origins in “wet-nursing”, the feeding of infants, to incorporate acts such as caring for the sick and tending the old and infirm.¹¹ This complex occupational identity is reflected in Samantha Williams’s comment that nursing work “encompassed skilled nursing and more general forms of care and help with practical tasks, such as washing”.¹² Rather than a profession associated with hospitals, early modern nursing used a range of tasks performed without compensation by families. Some women were paid to act occasionally as nurses, using many of the same skills and tasks as household caregiving.

Dingwall, Raffery and Webster assert that “the greater part of the care required by the sick involved some kind of assistance with activities of daily living that they were unable to carry out for themselves”.¹³ Similarly, Christopher Maggs characterizes nursing after 1800 as “providing care for those who are ill or suffering”.¹⁴ “Caring” was a fundamental element of nursing, potentially constituting a range of tasks for cleaning the patient, their bedding, and the room, making and serving food, and providing medical aid. Caring for the sick and performing the household tasks to support the sufferer’s household could be farmed out to paid nurses in cases where the family was not able to perform these tasks independently, or where they had the money to supplement their care by paying a nurse.

¹⁰ Newton, *The Sick Child*, 95; Anne Stobart, *Household Medicine in Seventeenth-Century England* (London: Bloomsbury Academic, 2016): 136-7.

¹¹ Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London: Longman, 1998): 189.

¹² Samantha Williams, “Caring for the sick poor: poor law nurses in Bedfordshire, c. 1770-1834,” in *Women, Work and Wages, c. 1650-1900*, ed. Keith Snell, Penny Lane and Neil Raven (Woodbridge: Boydell & Brewer, 2004): 149.

¹³ Robert Dingwall, A.M. Rafferty and C. Webster, *An Introduction to the Social History of the Nursing Profession* (London: Routledge, 1998): 6.

¹⁴ Christopher Maggs, “A general history of nursing: 1800-1900,” in *Companion Encyclopedia of the History of Medicine*, ed. W.F. Bynum and Roy Porter, vol. 2 (London: Routledge, 1993): 13; Dingwall,

Because of the indistinct nature of the caregiving element, historians of early modern paid nursing have divided nursing activities into “caring” as manual labour similar to household work, and “curing” using identifiable medical treatments. When defining paid nursing work, Dingwall, Rafferty and Webster point to the importance of the “basic assistance” of feeding and cleaning.¹⁵ Jeremy Boulton identifies the ambiguity of “curing”, because humoral medicine’s emphasis on the curative powers of lifestyle choices such as modifying diet and moderate behavior made it difficult to distinguish daily life and medical choices.¹⁶ Starting from Jennifer Hawker’s distinction between the work of “status carers” who cured using medical work, including acts of physic and surgery, and “basic carers” who watched, cleaned, and dressed the dead in eighteenth-century Dorset Parishes, Williams contends that there were no “paid carers” in eighteenth-century Bedfordshire. She concludes instead that nursing tasks were more “care” than “cure”.¹⁷ However, an examination of the caregiving terminology in correspondence establishes that the distinction between “care” and “cure is not applicable in gentry houses. In order to manage the sick room, gentry families supervised their patients and servants while also performing medical work such as providing medicaments and treating wounds. As a result, gentry caregiving was distinct from paid medical nursing because it necessitated medical knowledge and skills.

Both in historical sources and historiography, there is a tradition that defines caregiving as the sole remit of women.¹⁸ The narrative of female medical work discounts male discussion and participation in illness, and as a result distorts how women performed medicine alongside other members of their families and communities. In fact, as considered in Chapter Two, the entire family was interested in the subject of health. Recent historiography has also emphasized the extent to which men and women cooperated in illness. In particular, Margaret Pelling exposed the importance of women in the households of physicians, and Hannah Newton

¹⁵ Dingwall, Rafferty and Webster, *An Introduction*, 6.

¹⁶ J. Boulton, “Welfare systems and the parish nurse in early modern England,” *Family & Community History* 10.2 (November 2007): 136.

¹⁷ Williams, “Caring for the sick poor,” 166.

¹⁸ Linda Pollock, *With Faith and Physic: The Life of a Tudor Gentlewoman, Lady Grace Mildmay, 1552-1620* (Knightsbridge: Collins & Brown Ltd., 1993); Beier, *Sufferers and Healers*, 210-241; Doreen G. Nagy, *Popular Medicine in Seventeenth-Century England* (Bowling Green: Bowling Green State University Popular Press, 1988): 54-78; Leigh Whaley, *Women and the Practice of Medical Care in Early Modern Europe* (Basingstoke: Palgrave Macmillan, 2010); Alisha Rankin, *Panacea’s Daughters: noblewomen as healers in early modern Germany* (University of Chicago Press, 2013); Broomhall, *Women’s Medical Work*.

established that parents shared the duties of caring for sick children.¹⁹ Lisa Smith has been influential in indicating the involvement of men in household medical care by performing tasks that were both stereotypically masculine, such as interacting with practitioners and deciding the course of treatment, and feminine, such as the preparation and management of remedies.²⁰ An examination of the gendering of activities depicted in correspondence compliments Smith's research by proving the extent of cooperation and flexibility in gendering caregiving work.

This chapter evaluates the role and nature of caregiving in four sections. A consideration of caregiving terms illustrates the necessity of medical knowledge and skills in the sickroom and will contextualize the following analysis of caregiver roles and the extent of medical work. Caregiving roles are next explored in two sections, first focusing on caregiving in the home, and then the methods which families used to support their households such as visiting family or paid assistance. Finally, the fourth section readdresses the extent to which caregiving activities required medical knowledge and skills to perform supervisory care, administer medicine, and tend to wounds. Caregiving activities were fundamental in the home and necessitated extensive medical knowledge and skills in families' management of the sick room.

Descriptions of Caregiving

Dorothy's comments about Louisa's management of illness in 1782 exposed much of the context of caregiving activities while providing little detail on the work which took place in the sick room. Despite the regular reference to illness by the gentry letters of this study, less than twenty percent of correspondence outlined any caregiving work. Additionally, the terminology used was irregular. References to monitoring the sick represent twenty-four percent of caregiving accounts, followed by nursing and staying with the sick at eight percent each, and terms such as "sit up", "care" and "attend" had fewer than ten references each. However, the silence regarding the activities of the sick room and the terms which are used can be analyzed to explore the perception of letter writers on caregiving and of the duties that caregivers performed during familial illness. To study the degree of intimacy between families and sick bodies, this section begins with an answer to Fissell's call to investigate "bodywork", in particular by examining the

¹⁹ Margaret Pelling, "The women of the family? Speculations around early modern British physicians," *The Society for the Social History of Medicine* 8.3 (1995): 383-401; Newton, *The Sick Child*, 4.

²⁰ Lisa Smith, "The relative duties of a man," *Journal of Family History* 31.3 (July 2006): 238 and "Reassessing the role of the family: women's medical care in eighteenth-century England," *Social History of Medicine* 16.3 (2003).

activities of feeding, carrying, and cleaning the sick and their rooms. It then then considers the use of more general caregiving terms such as “sitting up”, “caring”, “attending”, and “nursing”. Finally, it looks at the letter writer’s perceptions of caregiving, if the tasks were seen as positive or negative, and what effect they had on a household.

Letter writers frequently implied that caregiving had been performed without defining either the activities or explaining who did the work. Caregiving activity was often only implied, which was particularly apparent in cases in which letter writers or their family were “confined”, had remained upstairs, or were “in bed”. Letter writers record restricted movement in thirty-five cases without making any mention of the identity of the persons who would have to provide care during confinement. Some cases were completely silent on the types of care received. For example, Marmaduke Tunstull wrote to William Salvin in 1781 that he “was confined near a fortnight with a cold & swelled face, but am thank God much better”.²¹ Even when letter writers did depict the support they received, it was often without identifying their caregivers. During a fit of rheumatic fever in 1770, Chris Shuttleworth recounted how “my Knees continue vastly swells and painfull that I am carried to bed by two”.²² Again, the “two” were unnamed and undescribed, but given the attention to attributing work to family members present, it is likely that they were servants. These figures directly interacted with sick bodies but were not identified by letter writers. Margaret Pelling has observed that “medical sources tend to be vague about those tending the sick” because their authors focus instead on the uncompliant nature of patients.²³ My study of letters will extend this perspective, exhibiting how letter writers took a similar approach in minimizing the discussions of caregiving work in the home.

The work of cleaning the sick room was almost invisible in correspondence. Regarding the contents of the bedroom, necessary changes of laundry were only mentioned twice in the

²¹ C277.9 (Marmaduke Tunstull to William Salvin, 19 December 1781). Similar references include Anne Clavering’s apologies for a late letter to her cousin James in 1708 with the explanation that she had “been confined to my bed great part of ye week, by a rash” (CLV 2); Miss Warde’s comments in 1738 that her letter was dull because “my Papa is confined by a very bad fit of the Gout, & has not been down stairs” (SpSt/6/1/50) and later, that her Aunt Fawcitt, discussed further below, was so fatigued by caregiving and grief that she was “confined to her bed in the utmost danger” in an undated letter (SpSt/6/1/50); Marmaduke Tunstall’s brother “being nine weeks confined to his bed & only able to sitt up a few hours a day” (D/Sa/C 78.8) and Frederick Cavendish reflected that he “was apprehensive that being confined in a chaise so long might not agree with” his sister Harriet in a letter to Louisa Ponsonby (GRE/870/10/2).

²² SpSt/6/1/110 (Chris Shuttleworth to Sister Stanhope, 01 June 1770). E. Stainforth also chronicled Mrs. Bastaid’s cold and injured feet in 1781: he noted that she “was yesterday out of airing, in a post Chaise, near two hours and no fewer by it,” leaving unmentioned the figure who transported her to the chair when she was unable to walk (WYL150/6040/12224).

²³ Pelling, *The Common Lot*, 199.

sample of this thesis. John Robinson's account of his confinement in 1785 recounted how gout "forced me to take my bed, where it has confined me ever since, except getting up a little this afternoon to have my bed made".²⁴ He did not make it clear who changed his bed, or the regularity of the action: like the accounts of confinement analyzed above, the focus was on his own body and health. Similarly, when James Lister commented on the final days of Mrs. Asked in 1775, he wrote that "she was brought very weak, & as thin as possible, for the last fortnight was confined to her Bed, only moving out till such time as it was made".²⁵ The person who changed the sheets was unmentioned, and their inclusion in the narrative of Asked's illness emphasized her state of incapacity rather than the labour of maintaining the sickroom.

When letters referred to modified diets, they also minimized the elements of preparation and delivery. Criticizing John Lister's siblings for their management of their sick child in 1754, David Hartley wrote that "It is a great Pity that your brother & Sister do not keep the Child to the Diet & Medicines that have agreed so well with him. The Preservation of his Eyes is of far more consequence than any present Pleasure he can have in eating".²⁶ Though he signaled the importance of appropriate diet in the health of their child, Hartley implied that this misstep was more in coddling the boy through allowing him to abandon his diet, rather than any error in food cookery. Alicia Greame also suggested medicinal foods which were "recokon'd very gt sweetner of the Blood" in a letter to her sister Ann Stanhope in 1784 before emphasizing that "I wish you would come here and let me nurse you".²⁷ While her suggestions would allow Stanhope to take steps in restoring her own health, Greame expressed that Stanhope's health would be better served by Greame's nursing abilities.

The invisibility of bodywork in correspondence was due in part to its ubiquity: because washing, eating, and other bodywork tasks related to caregiving were such regular and integral parts of the home, they were taken as assumed in correspondence. The absence of "bodywork" is thus due in part to the tone of familiar correspondence, which could take for granted some daily activities or actions, and instead focus on news and the stimulation of intimacy through sharing opinions. Another, related reason is that "bodywork" in caregiving demonstrated the division of labour inherent in gentry households. In the Welsh context, Alun Withey asserts that "women

²⁴ ZQH/10/50/51 (John Robinson to William Chaytor, 10 May 1785).

²⁵ SH:7/LL/217 (James Lister to Aunt, 17 December 1775).

²⁶ SH:7/HL/48 (David Hartley to John Lister, 29 October 1754).

²⁷ SpSt/6/1/123 (A.M. Greame to Ann Stanhope, 8 April 1784).

were generally expected to perform the mechanical aspects of care”, but the English gentry letter writers of this study apparently did not share the expectation that women would do both mechanical and medical work in the sick room.²⁸ Historiographic references such as Ann Stobart’s comments about the “lack of evidence of day-to-day activities [...] resulting in the frequent ‘invisibility’ of nursing” and Hannah Newton’s reference to nursing as an “essential, unchanging element” of caring for children reflect a similar perspective: the ubiquity of physical caregiving rendered it invisible.²⁹

Though letter writers did not emphasize the manual labour of the sick room, the terms used to indicate caregiving signal that families remained involved in the illness of their relatives. One of the features which differentiated caregiving behavior from other types of medical assistance seen in letters, such as recipes or medical advice, was the necessity of proximity. As a result, letter writers often provided care by “attending” or “sitting with” the sick. These terms implied that, unlike brief daytime visits, the family would persist in caregiving which disrupted the regular behavior and schedules of the family and continued past the point of ease. When reflecting on her sister’s injury after a fall in 1784, Mary Rose wrote to her uncle James Lister at Shibden Hall that “I hope my sister, wants for nather, atendance, nor advise”.³⁰ Though she contributed neither, her anxieties signaled the expectations about the support structure around an ill family member. A similar emphasis on supporting the sick was made by Anne Robinson when she portrayed the interactions of her her aunt and her sick sister, Fanny, during their extended trip to the Bristol waters in 1757. She wrote to her father that “Indeed I must say Mrs Aislabie does every thing that she thinks, will contribute to her health, or ammusement”.³¹ Despite this emphasis on an expansive range of support and service, neither woman was depicted as performing any manual labour or “bodywork”. In fact, Aislabie acted in the opposite direction: though she wanted to aid Frances’ health, she was most invested in keeping her entertained.

²⁸ Withey, *Physick and the Family*, 145.

²⁹ Stobart, *Household Medicine*, 157; Newton, *The Sick Child*, 95.

³⁰ SH:7/LL/256 (Mary Rose to James Lister, 20 January 1784). Ms Grimston also wrote to her brother Thomas in 1751 that she would prefer to treat him in person, concluding that “if you should not be so well as to come here, I will come to you” (DDGR/41/1/87). Hannah Knaplock wrote to Phoebe Wilkinson regarding the necessity of her houseguest Mrs. Banks’ travel to Buxton in 1754 that “Sister Betty as well as a servant must attend her” (SH:7/LL/135). Some letter writers also refer to the attendance of Doctors, as when Mrs Fawcitt “keeps her Bed & is attended by a Dr & Apothecary” in a letter from Phoebe Wilkinson to her brother Jeremy Lister in 1770. (SH:7/LL/183).

³¹ WYL150/6041/12254 (Ann Robinson to her father Thomas, 02 November 1763).

Attending a patient placed the caregiver in immediate proximity, allowing them to observe the symptoms and condition of the patient and respond accordingly.

Letter writers also used terms which more precisely indicated their tasks and closeness to sick bodies, such as “sitting up” with members of the household or friends. After the illness of one of her servants in 1710, Ann Clavering wrote to her cousin James how “my steward is upon ye Recovery, having had a pretty good night last night, yt before was terrible, his Papa & I satt by him for 3 hours in his nightgown he was so ill”.³² She shared the task with her steward’s nuclear family, and both presumably monitored the steward and were prepared to react to any change in his condition. Sitting up was in fact an activity of intense monitoring and required the sitter to watch the patient’s health and provide medical support and emotional comfort through the night. As a result, an effective sitter required medical knowledge in the cause and progression of diseases.

Sitting up could also be a method of providing comfort for a disturbed patient, as in Francis Bredall’s two references to his role in the illness of his friend Mr. Belasyse in 1768. He first observed that when Belasyse’s status grew dangerous due to a paralytic fit, the man “is never easy without me, & I satt up with him for these two nights part & am to do ye same this night & wish I may be instrumentall, in any shape to render him any Service”.³³ In a second letter, Francis confirmed the continuance of Belasyse’s status before reflecting again on his role in providing comfort and ease. He remarked that “as it gives him satisfaction, I think my Labour well spent, poor man, he is never easy, when I am obligd to leave him, therefore, am seldom from him”.³⁴ Notably, Bredall did not refer to any medical practices during his “sitting up”: allegedly, it was his presence alone which eased Belayse’s discomfort. The role of men in “sitting up” indicates that they had an important position in providing comfort for the sick.

Close proximity to the sick was also expressed with references to “caring”, as Anne Clavering reported to her cousin James that “my Aunt was yn very ill & under my care” in 1708, or when John Spencer reassured his sister Ann that he would manage the health of her son Walter during an outbreak of measles, concluding “You may be assured no Care shall be

³² CLV47 (Ann to James Clavering, 27 June 1710).

³³ ZDV(F) VI 12/ (Francis Bredall, 20 March 1768).

³⁴ ZDV(F) VI 12/ (Francis Bredall, 31 March 1768).

wanting, & yt I will sent or go to see him every day till he is well".³⁵ As well as caring in person, letters might desire "care" for their readers over a distance, as when "Geo Collingwood" updated his "Dr brother" on the health of his daughter in 1715, writing that "You may be assured she shall want no care or whatever wee can doe for her here".³⁶ Care could announce desires on the daughter's part, but when combined with "whatever wee can doe" Collingwood clearly intended a medical definition. Collingwood was assuring his family that their child would be well treated and attended during her illness. James Lister was wary of potential harm to Mary Rose's health while she assisted his aunt during her illness in 1775, writing that Rose should "pray take care of yourself, lest with too much Care & Attendance you make yourself ill".³⁷ Care had multiple meanings in this quote, both in terms of the effort and emotional attachment placed in the activity, and the combination of care and "attendance", considered below. Much like "attending", care signaled a level of attentiveness to the patient and their treatment. As a result, the action once again required a degree of medical knowledge in order to contribute usefully to discussions about the patient's illness and make decisions about medicines and the organization of the sick room.

The supervisory caregiving work of the gentry is epitomized in accounts of gentry families acting as nurses. As explained in this chapter's introduction, prior to the seventeenth century, nursing was not associated with "sick nursing", but instead focused on the role of nurse as support for infants and children: there was frequently no distinction between "wet-nursing" and "nursing".³⁸ In the eighteenth century, there was an increasing emphasis on "sick nursing" which emerged from "looking to" or "keeping" patients.³⁹ In correspondence, letter writers distinguished between the care of infants and sick family, and largely emphasized sick-nursing. Of the thirteen references to nurses or nursing, the only reference to nursing an infant can be found in Martha Lister's undated letter to James Lister, in which she recounted how the

³⁵ CLV 10 (Ann to James Clavering, 20 October 1708); SpSt/6/1/83 (John Spencer to Ann Stanhope, dated 27 February, likely c. 1760). Rose responded in August that "I have don my dwety (sic) to my sister to the utimost of my power, which she exprest my great care, and Tendernes to Her to the last." (SH:7/LL/214). Dorothy Duchess of Portland reassured her cousin Louisa that the cough following her daughters' measles in 1782 "with common care is seldom material at her age." (GRE/870/7/1)

³⁶ D/Sa/C 32 (George Collingwood to "dear Brother", 31 January 1715).

³⁷ SH:7/LL/213 (James Lister to Mary Rose, 18 July 1775).

³⁸ Montserrat Cabre, "Women or healers? Household practices and the categories of health care in late medieval Iberia," *Bulletin of the History of Medicine* 82.1 (Spring, 2008): 18-51.

³⁹ Williams, "Caring for the sick poor," 149; Boulton, "Welfare systems and the parish nurse," 127.

newborn's "Aunt is very fond of him, & nurses him almost continually".⁴⁰ The Listers indicated a situation in which family other than the mother provided care for an infant. The combination of the observation of the child's development, as he "comes on very fast", and the Aunt who "nurses him almost continually" in the letter suggests that this was nursing as in monitoring, providing physical attention, caring for and raising the child, rather than treating his ailments. His aunt's fondness is linked in this case to a willingness to act as nurse, spending time and effort on her nephew.

Most letter writers referred to their own activities and roles as nursing in narratives about managing and acquiring care. Ann Clavering wrote that she was "now turned Nurse with Dr Betty" during a case of Betty's chronic asthma in 1709.⁴¹ Ann called for external help, as will be considered later in this chapter, but emphasized her position in making decisions and monitoring her sister. Fathers could also assume the role of nurse, contrary to expectations that caregiving was a female task. Writing to his son and reporting on the health of his daughter Terese, who had breast tumours in 1763, Thomas Robinson remarked that "If I am not a good Doctor, I am at least a good nurse and an excellent Eccuyer".⁴² Though this comment was self-deprecating, it was indicative of a differentiation between the interactions between sick relatives and those in doctoring or nursing roles. While Robinson did not make it clear what tasks were entailed by being a nurse, differentiating "nurse" from "doctor" marked a distinction between the necessary medical knowledge imparted from an external source, and the type of role that he would fill in caring for his daughter. Robinson's example, situating himself between the advice of the doctor and the body of the patient, emphasized medical skills. As will be examined in Chapter Five, Robinson had to have the skill to interpret and apply the doctor's medical advice in order to nurse effectively.

The inconsistent and sporadic use of caregiving terminology limits any attempt to identify changes over time. However, the content and length of individual accounts did shift through the century. In the early decades, Anne Clavering, the Chaytors, and the Robinsons all provided detailed accounts of their caregiving activities. Clavering was the most prolific, referring to "nursing" three times and providing moment-by-moment narratives of several cases in which she cared for her sick half-sister, Betty. The Chaytors and the Robinsons similarly

⁴⁰ SpSt/6/1/132 (Martha Lister to Mr Spencer, undated).

⁴¹ CLV 27 (Anne Clavering to James Clavering, 08 November 1709).

⁴² WYL150/6041/12253 (Thomas Robinson to son, 17 June 1763).

focused on details. William Chaytor and his daughter Ann had protracted conversations about Ann's difficulties in managing her mother's nighttime fits of coughing and her diacodium dependency. William and Mary Robinson also exchanged specific reports on their health and the health of their children, including one account in which William labeled his daughter Ann as "a notable surgeon".⁴³ These families possessed not only a household interest in the sick room, but a belief that the information would be of interest to their readers.

The transition from detailed accounts of caregiving to brief, simple references to illness can be found by comparing the undated letters which William and Mary Robinson composed on caregiving activities in the early decades of the century at their Newby estate to those of their son, Thomas Robinson, regarding his own children in the 1750s. While Thomas evidently still performed caregiving, at one point referring to himself as "at least a good nurse and an excellent Eccuyer" in his acquisition of medical advice for his daughter Therese's breast lumps, later letters reveal that he had sent his daughter to live with his sister Ann Robinson and Aunt Mrs. Aislabie, who were the writers who actually reported on her health.⁴⁴ Generally, reports from this generation of the Robinsons focus more on the state of the patient than on the details of caregiving activities. The trend of referring to caregiving without defining activities continued through the final decades of the century. Though families such as the Ponsonbys continued to consider "that melancholy trade" and the health of a variety of family members, accounts contained none of the narrative elements of the Claverings or Chaytors.

Caregiving terms all shared a necessary proximity to sick bodies. While gentry letter writers did not perform manual work in the sick room, leaving such tasks to servants who were frequently underrepresented in correspondence, the analysis of nursing as an element of identity in section two, below, indicates that they did consider themselves to be fulfilling important roles in the sick room. Often, this work was supervisory, necessitating the monitoring of symptoms and the progression of the disease, and then making decisions about the type of care, the construction of the sick room, and the delivery of medications and other treatments. As a result of the aforementioned supervisory role, caregiving was also inherently medical. To some extent, then, this justifies the conflation of "caregiving" and medications performed by historians such

⁴³ WYL150/6003/14 (William to Metcalfe Robinson, 06 August, c.1710).

⁴⁴ See WYL150/6041/12255 (unsigned to "my dear brother", 20 November 1763) and WYL150/6041/12258 (Ann Robinson to "my dearest brother," 26 December 1763).

as Withey and Weisser, described above.⁴⁵ The gentry's ability to separate physical work from supervision is unique, however, and such an extensive division of labour would be difficult for lower classes who did not have the same number of servants. Focusing on gentry caregiving is indicative of the translation of medical knowledge into sick room activities.

Caregiver Roles

The changes to household routine brought by sickness could involve a range of family members, particularly those who cohabitated with the sufferer. In almost eighty percent of the references to caregiving, both men and women wrote about caring for people with whom they lived. Their immediacy and the necessity of preserving the household both contributed to this care. Cases at home include Anne Clavering's dispute with her neighbor and care for her sister in the early decades of the eighteenth century, H. Digby's alternating roles "between the state of an invalide, and a Nurs" in 1757, and Dorothy Duchess of Portland's sympathetic comments to her cousin Lousia that it was "high time" her nursery regained health in 1782.⁴⁶

Women dominated reports of caregiving, being more than twice as likely as men to assist a sick member of the household. This pattern was true of most caregiving activities, as seen in Figure 3.1, and women were more likely to provide care in every decade except for the 1750s and 1760s. In of these decades, men acted in just two more cases than women. The early decades of the century contained accounts of young, unmarried women who nursing their mothers. Nanny Robinson was labelled as a "surgeon" during her treatment of her mother Mary's leg, discussed further below.⁴⁷ She also nursed her father through his failing health until she married Thomas Worsley of Hovingham in 1733 shortly before her father's death in 1736.⁴⁸ Ann Chaytor was the only caregiver during her mother's nighttime battles with diacodium dependency in 1704.⁴⁹ However, the role of the unmarried daughter as caregiver

⁴⁵ See footnote seven above.

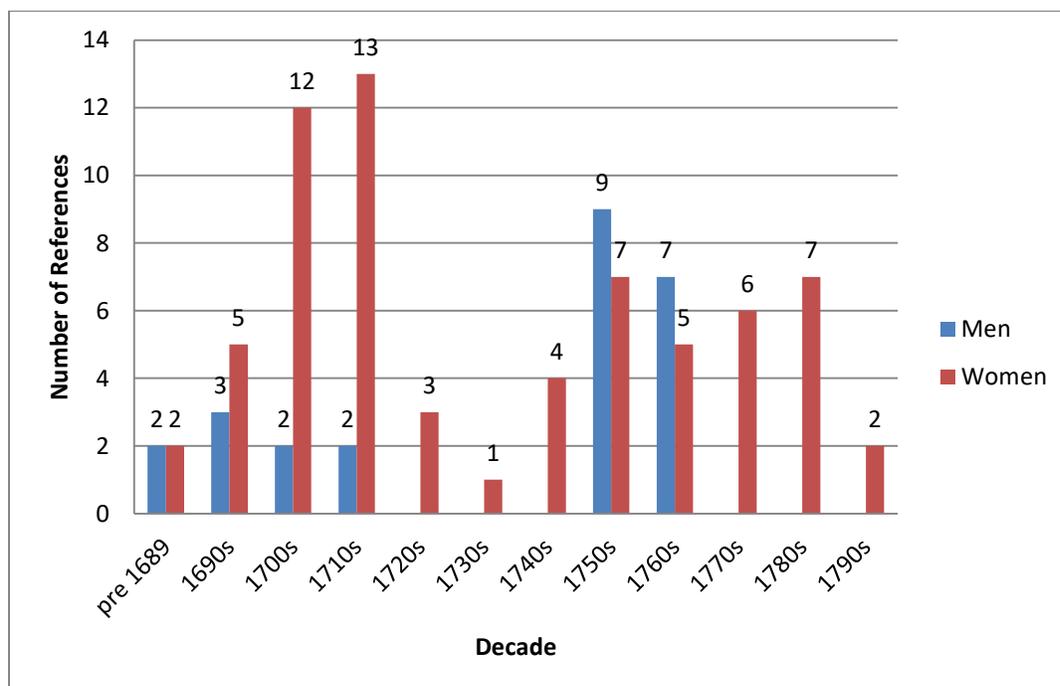
⁴⁶ CLV 10 (Anne Clavering to James Clavering, 20 October 1708); DDGR/41/1/69 (H. Digby to Thomas Grimston, 13 November 1757); Second Earl Grey 870/7/2. (Dorothy Duchess of Portland to Louisa Ponsonby, 5 December 1782). Emphasis in original.

⁴⁷ WYL150/6003/14 (William to Metcalfe Robinson, dated 06 August with no year but early eighteenth century).

⁴⁸ G. Hinchliffe notes Ann's fundamental role as household manager and caregiver after the death of her mother in 1720 in "The Robinsons of Newby Park and Newby Hall," *The Yorkshire Archaeological Journal* 63 (1991): 136 and "The Robinsons of Newby Park and Newby Hall, Part 3. Thomas Robinson, Baron Grantham (1695-1770) and his descendants," *Yorkshire Archaeological Journal* 65 (1993): 145.

⁴⁹ ZQH/9/15/104 (Ann to William Chaytor, 13 June 1704) and ZQH/9/15/104 (William Chaytor, draft reply to Ann circa 1704).

Figure 3.1 – Gender of Caregivers by Decade



vanished as the century progressed. This partly due to the nature of the sample: all the daughters who survived into adulthood also married and left the home.

Unmarried women became the wives and mothers who acted as nurses throughout the century. There is also some evidence that the letter writers and their families had incorporated a more aggressive rhetoric of maternity, as suggested by Joanne Bailey and Ingrid Tague.⁵⁰ The final decades of the century saw an increased reference to caring for children, rather than a range of patients. Letters gradually shifted to prioritize the importance of the relationship between the mother and her children. Despite the developing emphasis on maternity, sisters and aunts were the most frequent providers of care, representing twenty-seven and sixteen percent of caregivers respectively. The reports of female relatives supporting and caring for extended families may be a reflection of the sources, which failed to mention the daily caring activities of mothers. It could also be a response to the disruption of the household, when the incapacity of a sick wife/mother required external assistance. Sisters and aunts' efforts to supplement household caregiving exhibit a general division of labour in which women did perform most of the caregiving work.

⁵⁰ Joanne Bailey, "Reassessing parenting in eighteenth century England," in *The Family in early modern England*, ed. Helen M. Berry and Elizabeth A. Foyster (Cambridge: Cambridge University Press, 2007): 223; Ingrid H. Tague, *Women of Quality: Accepting and Contesting Ideals of Femininity in England, 1690-1760* (Woodbridge: Boydell Press, 2002): 19.

Men did appear in caregiving roles, though less regularly than women. The relative absence of male caregiving is significant given the density of male correspondence, and complicated by the piecemeal fashion in which men approached caregiving when compared to the strong pattern of female caregiver identities. Men were most likely to refer to caring for a friend or for their children. In the abovementioned case of Thomas Robinson, though he identified himself as a nurse, his active role in the health of his children was a result of the absence of a mother-figure in the household: his wife Frances has died in 1750.⁵¹ Similarly, Charles Fairfax's regular correspondence with his daughter Ann all dated after the death of his wife Mary in 1741. Caring for friends necessitated a similar obligation: men usually acted as caregivers when women were absent or in tandem with women. Despite this implicit pattern of caring in the absence of female caregivers, male involvement in the care of the sick was never labelled as exceptional or unusual, and there was no attempt by letter writers to justify men's reasons for involvement.

The acceptance of male caregivers reveals the fluidity of household roles revealed by recent historiographical research into masculinity. Authors such as Karen Harvey reject the simplistic "two sphere" system in which men were associated with public and women with private spaces, pointing instead to the "private" household as an important site of manly identity.⁵² Harvey indicates that men had overall management of the household, while women worked at a micro-level as a steward or deputy.⁵³ In their role as absolute managers, men could choose to become involved or support their "steward" wives as necessary. Lisa Smith demonstrates the participation of men in a range of medical roles beyond simply composing medical correspondence to physicians. Instead, she observes that "keeping one's household in order could keep it healthy" and that a healthy household was a signal of how effectively a man could manage his civic duties.⁵⁴ Health appears in these contexts to be a *household*, rather than a gendered responsibility even if women took on a slightly heavier burden of care than their male partners.

Both men and women acted in a largely supervisory role, watching the patient and making decisions as to their treatment, as determined in the previous section. This was a natural

⁵¹ Hinchliffe, "The Robinsons, Part 3," 150.

⁵² Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford: Oxford University Press, 2012): 138.

⁵³ *Ibid.*, 33-34.

⁵⁴ Smith, "Relative duties," 247.

extension of general household management. Men were the heads of household and women were domestic managers.⁵⁵ As a result of the gentry's supervisory role in the sick room, many of the elements of "bodywork" in assisting sick family members went unmentioned. However, sufferers still required fresh sheets, help regulating the temperature of their rooms through the management of fires, additional blankets, and windows, and the delivery of food, often adapted to their conditions. In cases of true confinement, particularly during dangerous fevers or after leg injuries or severe attacks of gout or rheumatism, patients also needed assistance in moving or cleaning themselves. Laundry and the preparation of food was the natural remit of servants, though managed by gentry women, and therefore would be unmentioned by letter writers except in exceptional cases.

When John Robinson rose only "to have my bed made" and Mrs. Asked similarly "was confined to her Bed, only moving out till such time as it was made", as seen in the previous section, it is very likely that servants were performing their usual cleaning roles in the bedroom. Amanda Herbert provides an insight into similar cases of inter-class co-operation and the shared use of household spaces.⁵⁶ Though the entire household worked together to prepare food and medicines, the gentry women performed the skilled and supervisory elements, while the servants performed repetitive, manual tasks.⁵⁷ Using the same division of labour, the gentry monitored the sick and the work of servants who performed the tasks necessary to maintain the sickroom and support the sufferer.

Some cases are explicit about how servants were drafted into managing the bodies of the incapacitated sick. Depicting the illness of both herself and her husband in 1770, Mrs. Shuttleworth recounted how she was "carried to bed by two" and that Mr. Shuttleworth "is still carried to his bed".⁵⁸ The demands of a sick household had the potential to physically affect servants to a greater extent than the family. While letter writers saw caregiving as fatiguing and upsetting, they also displayed how sickness disrupted family life and brought the family together around the body of the patient. When Mary Rose commented on her dullness in 1738, she added that she was "particularly so [because] my Papa is confined", indicating that her dullness and limited activities were a direct result of her father's illness. For servants, in contrast, sickness in

⁵⁵ Tague, *Women of Quality*, 46; Harvey, *The Little Republic*, 23.

⁵⁶ Amanda Herbert, *Female Alliances: Gender, Identity, and Friendship in Early Modern Britain* (New Haven: Yale University Press, 2014): 78.

⁵⁷ *Ibid.*, 89.

⁵⁸ SpSt/6/1/110 (Chris Shuttleworth to Ann Stanhope, 01 June 1770).

the home could exponentially *increase* their amount of labour. In addition to their work supporting a functional household and its healthy members, they also took on additional tasks to support the care of the sick. The modified diets, increased sheet changes, and attendance did not exempt servants from their ordinary duties.

The strong effect on servants who cared for the sick can be seen in the series of letters which Ann Stanhope composed about her servant John Harnass's illness and eventual death of influenza in 1782. In the first of three letters about her servant's disease progression, Ann wrote how "John's illness has took up much of my maid servants time, wch has thrown us a little out of sorts at present, & rather over hurried their spirits".⁵⁹ While she did not make explicit what elements of care have occupied the maids' times, she noted that the attendance of the sick was significant enough to disturb the normal routines of the household. In a later letter, the commitment was enough to disturb the maid's own health due to exhaustion, as "John's severe Illness, a long confinement, in breaks of her [the maid's] rest, sometimes read no week together, in not getting to her own bed 'till 12 or one' clock [...] was rather one hurried in her mind".⁶⁰ The requirements of attending John in addition to her own work had been so extensive that they disrupted the maids' health and made them seem "hurried" to a degree which drew comments.

The "hurried" state of Stanhope's female servants exhibits the difficulties and discomforts of adapting to and caring for sick family. Anne Clavering twice used the term "nurse" in relation to an ongoing conflict between herself and her neighbor regarding who had a higher level of medical expertise. In 1708, when Ann was away on the European mainland, her gentry male neighbor "came & insinuated himself so much into favor as to undertake to cure her [Ann's aunt] if she would throw off her nurses (wch were my uncle & self)".⁶¹ Two years later, Ann's neighbor appeared in another letter when the pair disagreed on treatment for Ann's cough. She wrote to her brother James that "my neigh or rather my Nurse, I find loves to make complaints".⁶² In both cases, the problem was who should be treated as an authority in neighbourhood illnesses. Ann and her neighbor clearly visited each other frequently enough to be aware of health issues and compete for patients, and the figure of nurse entailed regulating and gatekeeping the care of the patient. It could be a positive role, as when Ann called herself a

⁵⁹ SpSt/6/1/122 (Ann Stanhope to son, 15 August 1782).

⁶⁰ SpSt/6/1/122 (Ann Stanhope to son, 02 September 1782).

⁶¹ CLV 10 (Anne Clavering to James Clavering, 20 October 1708).

⁶² CLV 34 (Ann to James Clavering, 21 January 1710).

nurse, or an insult, when she associated her neighbour's attempts to regulate her own health through nursing.

Other letter writers did not attach the same level of voluntariness to assuming the role of nurse. While Clavering fought to maintain her status, H. Digby used the concept of nursing to describe a grim season in 1757 when they wrote to Thomas Grimston how "my Winter has hitherto pass'd between the state of an invalide, and a Nurs, I have had an extream bad cold, but my mother & Sis Digby the worst I ever saw". The combination of sickness and nursing lead them to comment that their reader "will excuse my dwelling so much upon self when you consider we see very little els".⁶³ The limitations and ill effects of caregiving could similarly be seen when Mrs. Cookson wrote to Mrs. Stanhope that she and her daughter were "sorry they cannot do themselves the pleasure of waiting on her tomorrow as Doctor Cookson is confined to his bed with the gout".⁶⁴ No mention was made of their own ill health; instead it was the illness of Doctor Cookson which changed the behavior of his family.

Using a relative's illness as an excuse for absence could also be a powerful tool to negotiate social obligations. Lady Fitzwilliam was frequently mentioned as unwell in the Ponsonby-Cavendish correspondence: Frederick Cavendish reported that the doctor considered her "an awkward case" in 1766 and Dorothy Duchess of Portland depicted Fitzwilliam as looking "pale & pinched ... I am afraid she never can be better, the only hope one can have about her, is that she may not grow worse".⁶⁵ Despite the acceptance of her generally poor health, Fitzwilliam remained active in the community until Dorothy wrote in 1784 how "Ld Fitzwilliam has been confined with a feverish cold, & the weather has been so bad that she [Lady Fitzwilliam] was very glad to stay at home & take care of him, but he is finally well again".⁶⁶ Acting as a caregiver was an appropriate excuse to retreat from public responsibility, while Fitzwilliam's own consistent state of ill health was not. Unlike cases in which the reader was reminded to care for themselves while caring for a patient, it was the action of caring that allowed Lady Fitzwilliam to remain in the home. Her role as caregiver was a more accepted justification than her role as sufferer.

⁶³ DDGR/41/1/69 (H. Digby to Thomas Grimston, 13 November 1757).

⁶⁴ SpSt/6/1/134 (Mrs Cookson to Mrs Stanhope, undated).

⁶⁵ Second Earl Grey, 870/10/3 (Frederick Cavendish to Louisa Ponsby, 10 March 1766); Second Earl Grey, 870/7/9 (Dorothy Duchess of Portland to Louisa Ponsby, 15 February 1784).

⁶⁶ Second Earl Grey, 870/7/9 (Dorothy Duchess of Portland to Louisa Ponsby, 15 February 1784).

Family members wanted the sick to be well attended, but they were also conscious of the potential repercussions for the attendants. Writing to his sister about the health of his nephew, John Spencer wrote that “The sooner he can safely be removed to Heresforth I should think the better, but you may be a little releasd from your strict an attendance upon him. If you confine yourself too much you will undo all you have been doing this summer”.⁶⁷ Caregiving during sickness could cause an illness or a relapse due to the high time and effort requirements. It could also influence the attitude of the home and access of healthy family members to events. Just as the Cooksons remained home when Doctor Cookson was confined, Mary Warde wrote in 1738 that “You know me dull at all times, & will not be surprized at finding me particularly so when you hear my Papa is confined by a very bad fit of the Gout”.⁶⁸ She did not make it clear what sort of work she had to do, but did directly link her dullness, and implied inactivity in the wider social scene, with her father’s confinement. Illness changed the rhythms of the home and restricted family from interesting activity. Her middle-aged father was bedridden, and she implied her continual attendance by adding later in the letter that “nothing certainly makes one so unfit for Business of any kind as seeing ones Friends in pain, it gives rise to the most melancholy reflections”.⁶⁹

Such narratives emphasized the encompassing nature of sickness and the care involved in treatment: a sick family member changed the behavior of the household, leading letter writers to reflect on and apologize for their dull lives. This could progress into distressed mental states, as mentioned in the introduction to this chapter, Dorothy Duchess of Portland offered her support to Louisa who “must have been long ago tired of that melancholy trade, Nursing the Sick”.⁷⁰ Nursing was highlighted as a fatiguing task which influenced the mood and health of the nurse, and it was a task from which Dorothy expected Louisa would be glad to be free. Hannah Knaplock similarly characterized her nursing experience when she talked about the care necessary for her friend Mrs. Wyserdale in 1754, whose rheumatic fever was so severe that “Her Apothecary advises to [the medicinal baths in] Buxton next month & if so Sister Betty as well as a servant must attend her wch will be a concern for us for when Temper meets with distemper

⁶⁷ SpSt/6/1/76 (John Spencer to Sister Stanhope, 10 September).

⁶⁸ SpSt/6/1/50 (Mary Warde to her aunt and namesake, 23 January 1738).

⁶⁹ Ibid.

⁷⁰ Second Earl Grey 870/7/2 (Dorothy Duchess of Portland to Louisa Ponsby, 5 December 1782).

nursing is a Tedious affair”.⁷¹ Similar to Anne Clavering’s account of sharing nursing her sister with a servant and the child’s nurse, Knaplock implied that Betty and a servant would work together to manage Wyserdale’s illness. Her emphasis was on the unpleasant nature of the task, implying that Wyserdale would be a bad patient due to a temper which had been exacerbated by her illness. The necessity of managing the emotions both of a confined family member and a fatigued nurse made caregiving a taxing activity.

Expectations that families, particularly sisters, aunts, and mothers, would help care for sick relatives created a system of household caregiving which had wide reaching effects. Women did represent the majority of caregivers, which supports the predominant historiographic assertions that women were responsible for health. However, critiques of the necessity of their work expose some of the complexities of the system. In referring to caregiving activities as “melancholy” and “tedious”, letter writers reflected on the repetitive and time-consuming nature of caregiving. It also had potentially deleterious physical effects, causing Ann Stanhope’s maids to become “hurried” in appearance in 1782 and potentially threatening her own health in another, undated letter to Stanhope from her brother. These criticisms, along with comments about the dullness of letters from sick households, reveal the inescapability of caregiving: it was not necessarily a chosen task, but an expectation of letter writers and their families.

External Assistance

Households were willing to extensively reorganize their daily tasks during illness, devoting family time to sitting with and supervising the sick and compounding the work of servants to support bodywork. Despite these adjustments, there were cases in which the combined household resources of family and servants remained inadequate for the care of sick relatives. In these situations, gentry families had the option to supplement the care provided in the household with both unpaid assistance from families and friends, and paid care from neighbourhood men and women. This section will analyze the offers letter writers and their families made to relocate in order to support sick relatives and their caregivers. It will also evaluate the type of paid labour which families employed, particularly in reference to hiring “nurses”. It will conclude with a consideration of the gender and status of those who offered or were paid for their help.

⁷¹ SH:7/LL/135 (Hannah Knaplock to Phoebe Wilkinson, 20 July 1754).

Letter writers and other members of the family made offers to travel and supplement household care with their own labour throughout the eighteenth century. This can be seen in Figure 3.2, below. James Lister relayed the support of his Aunt Fawcitt, who offered to come up if she could “be of any use or Service” in supporting his cousin Mary Rose in caring for her sick mother in 1755.⁷² As well as offering to support Rose, Fawcitt had been present for the death of Lister’s aunt Mrs. Asked in 1775. Reporting on Asked’s death, Lister commented that “Aunt Fawcitt has been mostly with her for these two Months past, & what with fretting, & being hurried there, has made her look very thin & ill”.⁷³ Fawcitt’s distress was a product of the supervisory elements of her work: the “fretting” implied an intellectual management, rather than a strained muscle. She remained to care for and support Mrs. Asked past the point of her own health. The portrayal of Fawcitt as physically altered as a result of “being with” Mrs. Asked is indicative of the centrality of her role, which taxed her so much that it caused her own illness. Repeated references to Fawcitt and indications of her responsibility and autonomy, which saw her caring up to the point of personal discomfort, imply that Fawcitt was seen by her family as particularly competent in caring for the sick.

Ann Peacock played a similar role in the Chaytor family. When Peregrina Chaytor was confined to the house with a severe purging in 1697, she complained to her husband that “the sooner Nanny Peacock had com wod have been the best for we have a want of her and I in perticuller”.⁷⁴ No mention was made of the work Peacock would perform, but Peregrina Chaytor’s emphasis on the urgency of her need for Peacock’s attendance suggests the performance of functions which were currently unmet in the household. Particularly given Peregrina’s persistent and debilitating cough, and the diacodium dependency which developed from its treatment, Peacock could have performed a number of roles both in managing the household and assisting Peregrina in her illness. Peacock appeared in a later illness as a patient, when William Chaytor sent his servant to his sick family in 1704 and had the man act as a nurse in William’s stead. He recounted to Thomas Gill how

my daughter being soe extream ill that wee feared shee would have dyed. Shee not recovering much strength from her late sorrow was seizd with the violent distemper of the

⁷² SH:7/LL/213 (James Lister to Mary Rose, 18 July 1755).

⁷³ SH:7/LL/217 (James Lister to his Aunt, 17 December 1775).

⁷⁴ ZQH/9/12/53 (Peregrina to William Chaytor, 19 August 1697).

season, vomiting and purging; Nanny Peacock was ill at the same time; and I sent Clarvaux to them who was nurse to them both.⁷⁵

Chaytor's emphasis was on the symptoms of his daughter's illness, placing her as the most important patient in his narrative. Given Peacock's role in supporting the family in an earlier episode, it is likely that she would have cared for Ann had she herself been healthy. In her stead, a male servant was evidently trusted enough to be close to all the members of the family. Chaytor stated that Clarvaux "was nurse to them both", therefore acting as the primary caregiver during his family's illness in place of both Chaytor and any other female relatives.

Chaytor's decision to send Clarvaux to support his family is one method by which letter writers overcame distance when expressing a desire to provide care for their family and friends. Families also expressed willingness to travel, or a desire to bring the patient to their own home. In an undated response to news that Ann Stanhope's "Inflamation is return'd into your Eyes", around the middle of the century, her sister Alicia-Maria Greame concluded with the statement that "I wish you would come here and let me nurse you, Do Dr Sisr make trial of a little change of Air, I would do every thing in my power for you".⁷⁶ This request came at the end of a letter which suggested a series of cures which Ann could try at her own home, but Greame implied that the care and support that she could provide in person would increase the efficacy of the medicaments she suggested. Men and women were equally willing to travel in order to support sick relatives and friends. These offers persisted throughout the eighteenth century and there were few cases per decade. Women were distinct in their willingness to *offer* care in conjunction to suggesting travel or inviting the recipients of their letters to visit them. Women such as Nanny Peacock, Aunt Fawcitt, and Ms. Grimston were also more likely to be positioned as providing an unlimited range of support and advice. The cases in this section have largely displayed female carers because women were more explicit and detailed about the care they offered.

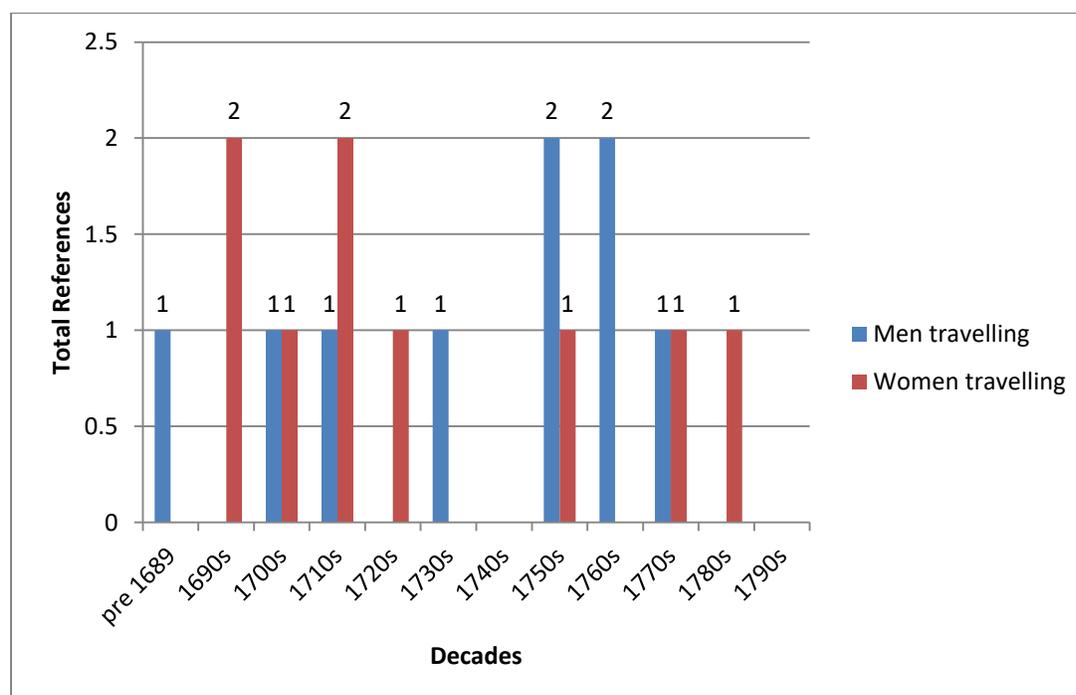
In contrast, when men suggested travel or moved to be near their sick families, they emphasized their desire to be close to the sick person and provide emotional support. For example, William Lister wrote to his brother Jeremy in 1736 that "I do suppose ere this thou hast heard of my design of Going to Virge on Acct of Tom being so much out of Health"⁷⁷ He

⁷⁵ ZQH/9/15/111 (William Chaytor to Thomas Gill, 31 August 1704).

⁷⁶ SpSt/6/1/123 (A.M. Greame to Mrs. Stanhope, dated 08 April).

⁷⁷ SH:7/LL/93 (William to Jeremy Lister, 23 December 1736).

Figure 3.2 – Men and Women Travelling to Care for the Sick



did not express his desire to care for or nurse his son, but instead signaled his desire for closeness. Men were also likely to record traveling in order to be with relatives whose health was poor or failing. When Mary Robinson described the lumps in her breast in the early decades of the eighteenth century, her husband William wrote to her urging her to travel from their home in Newby to York for a consultation and promising to return home to her.⁷⁸ Writing to his brother James about the failing health of their mother in 1751, Samuel Lister wrote that “If it please god ~~to continue her life~~ I could wish to be at Home before the [illegible]” before detailing funeral plans.⁷⁹ Whereas Aunt Fawcitt cared for Mrs. Asked for the two months leading up to her death, male relatives often arrived late to the sickbed. As well as displaying expectations of female caregiving, delayed returns by men was a result of their own gendered work. Occupied by business or politics, men did not have the same freedom to relocate in support of a sick relative.

When relatives were unable or unwilling to support household caregiving, families also brought in in paid assistance. Chapter Six will consider at length the relationship between families and medical practitioners, in which the medical knowledge of the household was supplemented with the skills and expertise of physicians, surgeons, or apothecaries. However,

⁷⁸ WYL/6001/58 (William to Mary Robinson, 24 April).

⁷⁹ SH:7/LL/122 (Samuel to James Lister, 1751). Strikethroughs in original text.

the caregivers employed to supplement family medical work had a much more uncertain identity. Although Margaret Pelling suggests that in the seventeenth and eighteenth centuries, nurses “may have come closest to having a visible occupational identity outside hospitals”, women did not necessarily act as nurses full time.⁸⁰ Caregiving also did not require the training of the formally recognized medical professions, and the work was unregulated.

In addition to the lack of a professional identity, the demographic of patients who received paid nursing care was distinct from the range of sick persons in correspondence. There is only one example of a nurse being named as providing care for a sick adult. Attempting to gain financial support from William Salvin of Durham in 1714, J. Bosh chronicled his employment of a nurse as part of his argument for the cost of maintaining the household of Margureite Salvin. Marguerite “has not been out of her chamber above thes four months and for above thes three weeks, quiet helples and cannot move out of her bed but she is moved and to keep a nurse and she is very chargeable besides”, was aged, and had to be “helpe as an infant”.⁸¹ Bosh asked for help due to the cost of supporting both her and his own family. This is a similar context to the isolated, sick poor of Bedfordshire analyzed by Williams.⁸² Salvin was alone and dependent on others for charity and care, and the absence of familial support necessitated hiring a nurse.

Marguerite Salvin’s isolation was unusual in familiar correspondence, which normally emphasized the lives of other family in the house. This irregularity also helps explain why sick nurses were largely absent from family correspondence: sufferers were not isolated, and did not require paid support. Williams observes that in Bedfordshire, there are cases in which daughters were paid to care for their mothers. Payment was necessary to allow a lower-class family to maintain support for their sick relatives.⁸³ Families asking for financial support in order to care for their own relatives establishes the low social status of both paid nurses and their patients. In an article on the role of nurses in the poor relief of St. Martin’s parish, Jeremy Boulton highlighted that fourteen percent of the parish expenditure went to nurses. These “multi-functional” figures explicitly “kept” and lodged the sick and the poor.⁸⁴ Because the gentry relied

⁸⁰ Pelling, *The Common Lot*, 201; Williams, “Caring for the sick poor”, 157.

⁸¹ D/Sa/C 36 (J. Bosch to “Sr,” 14 October 1714).

⁸² Williams, “Caring for the sick poor,” 155.

⁸³ *Ibid.*, 55, 154.

⁸⁴ Boulton, “Welfare systems and the parish nurse,” 137, 148.

on their existing staff of servants to fulfill the physical elements of caregiving, they did not need to hire sick-nurses.

Instead, the hired nurses in letters all assisted with childbirth and the health of children. Nursing was again linked to the exchange of funds when a writer to Marmaduke Constable advised in 1722 that “He has readily granted the sum ye mention, which I shall equally divide as from ye to the midwife, Nurse & Keeper”.⁸⁵ The distinction between the three roles was not made explicit, particularly for the “keeper”, but all three appear to be involved in the early stages of the infant’s life. Reporting on the pregnancy of his wife in 1753, John Spencer wrote how during her rapid labour, “we had ye Midwife & Nurse to call from their Beds at their own houses”.⁸⁶ Neither lived with the Spencers leading up to the birth, nor was it made explicit who the focus of the nurse’s care would be. However, given the significance of the link between “nursing” and breastfeeding which persisted through the eighteenth century, it is likely that both these nurses were brought on to care for the child, rather than directly supporting the midwife. The nurses were hired and brought in at the same time as the midwife, either to care for the mother during her labour or to immediately take responsibility for the new child.

Evidence of nurses who raised and cared for children between infancy and the onset of puberty is sporadic, but there are several cases which demonstrate that families shared the care of their children with hired help. When Anne Clavering’s younger half-sister Betty suffered from measles in 1709, Ann wrote an extended narrative to her cousin James detailing the progression of the disease and the methods the family had undertaken to care for Betty. This included a reference to the assistance of both a servant and a nurse. After Ann had “stay’d till ten at night by her, she was no better, My Servt & her nurse keeper sett up”.⁸⁷ The fact that the nurse keeper was referred to as *Betty’s* implies that the role was not contingent on illness; Betty’s nurse was likely a regular companion who was expected to increase her hours during illness. Pelling emphasizes the importance of childcare to the development of the seventeenth century “nursing” identity, commenting that the word had “nursery connotations to do with discipline, surveillance, custody, and upbringing”.⁸⁸

⁸⁵ U DDEV/60/84/VII (Unknown to Marmaduke Constable, 26 September 1722).

⁸⁶ SpSt/6/1/64 (John Spencer to Walter Stanhope, 19 February 1753).

⁸⁷ CLV 32 (Anne Clavering to James Clavering, 20 December 1709).

⁸⁸ Pelling, *The Common Lot*, 189.

Nurses who specialized in the care of children had a particular set of skills which were important because infants and children were perceived to have unique constitutions that benefitted from specialized care.⁸⁹ Children were predisposed to a range of illnesses, diagnosing their illnesses was difficult due to their lower ability to communicate, and treatment had to be mediated because their bodies were understood to be particularly vulnerable and sensitive, and thus required gentler, painless treatments.⁹⁰ A more ambiguous reference to nursing children was made in Mrs. Collingwood's letter to Ralph Salvin in 1714, in which she opened their letter with the statement that "Nurce tells me dr brothr that you are desirous to know the occasion of yr Daughters illness wch realy is beyond my judgement to inform you".⁹¹ No other mention was made to the role of this nurse, or why they suggested that a family member report on the health of the child rather than personally recount the progress of the illness.

The paid support which families identified as "nurses" was also almost universally gendered female. This built on expectations of the female identity as a caregiver in relation to children. The only exceptions to men acting as nurses generally are within families. Clarvaux supported his master's sister and daughter, and Thomas Robinson acted as "at least a good nurse" to his own daughter. Generally, when men supported the sick, it was in a more physical form than their female counterparts. Male help or servants were particularly used to carry the sick, both within the house or to chariots for airings. Anne Stobart similarly asserts that male care was associated with restraining and carrying the patient in the seventeenth century, and Williams identifies a similar pattern in paid male caregiving in late eighteenth-century Bedfordshire.⁹² The gender difference between paid male and female help in this study reflects wider patterns in household caregiving. In both cases, around two-thirds of the examples of caregiving are by women, and men largely providing support when women were incapacitated. Caregiving activities, both familial and paid, were thus not exclusively gendered, but did reveal expectations about appropriate types of work for men and women.

⁸⁹ Newton, *The Sick Child*, 32.

⁹⁰ *Ibid.*, 23, 64, 67, 70-71.

⁹¹ D/Sa/C 43.6 (C. Collingwood to Ralph Salvin, dated 1714).

⁹² Stobart, *Household Medicine*, 138; Williams, "Caring for the sick poor," 150.

Caring and Curing

The supervisory role of caregiving was central to the early modern definition of the nurse and essential to curing a patient. When families attended, sat up with, or nursed their relatives, they performed three complimentary roles. First, they monitored the sick for signs of improvement, decline, and the efficacy of treatment. This was largely a supervision of physical factors because, except for Peregrina Chaytor's diacodium addiction in 1704, all references to caregiving were in response to illness.⁹³ Second, they enacted the necessary organization of managing the attendance of external medical practitioners, administering prescribed treatment, and caring for the body of the patient. Finally, though implicitly, this supervision regulated the invisible labour of maintaining a sickroom, including the cleaning of the patient and bedding, regulating room temperature, and supplying food and drink.

Anne Clavering's detailed account of her young half-sister Betty's measles in 1709 is evidence of the interaction of different medical skills and decisions. Neither Anne nor the summoned physicians were able to confidently diagnose the child's condition. The account is unusual because it is so explicit, providing a strong sense of Anne's physical and emotional labour and decision-making processes during Betty's illness. Anne wrote,

...of Saturday night Betty did not rest her vomiting &c continued, she was so ill yt of Sunday morning ye Apo[thecary] came to me; told me some spott were come out & desired she might be removed with speed... in ye mean time ye Dor came & wn he went away told me he did not know wt it would prove, but if yt small pox it would be a very ill sort; so we wrapt her in blankets putt her in a chair & brought her to her new lodging, putt her in bed, still her Vs looseness continued, she complained of a violent pain in her head, a sore throat, her shortness of breath, sickness att her stomach, & extreamly [sic] cold tho her spots kept out yet no more appeared but were thick on ye flesh, by these circumstances ye may judge nothing had an effect. So ye Dr in ye evening gave us new perscriptions but told me her case was deplorable he would do what he could to serve her but—so he left us, ye apo[thecary] said if it proves ye Meazells she will be hapy, if ye Small Pox she must die. I stayed till ten at night by her, she was no better, my sevt & her nurse keeper sett up; it pleased God wt was last ordered had ye desired effect she slept will her malady seased but till Monday night ye Dr would not pas say what it was yn he said twas ye Meazell but yt her evacuations & her blister (wch I mentioned in my Steward letter) prevented there coming out so well as with Peggy. She now daily mends.⁹⁴

⁹³ ZQH/9/15/104 (Ann to William Chaytor, 13 June 1704). See also Appendix III for a complete list of illnesses discussed in the correspondence.

⁹⁴ CLV 32 (Ann to James Clavering, 20 December 1709).

During this extended account of the illness of her half-sister Betty, Anne Clavering referred to reviewing the illness with her doctor, the activity of keeping Betty warm and moving her to a better location, monitoring Betty's skin for "spots", and judging the effectiveness of the doctor's first prescription. She also "stayed till ten at night by her" until being replaced by "my sevt & her nurse keeper", and finally recounted how Betty's "malady seased [sic]" and her recovery began. Anne was present and active throughout the narrative as she interacted with practitioners, relocated and monitored Betty, and provided her own opinion on Betty's health. Her detailed observations were recorded in the letter and passed to her cousin. Despite the doctor, servant, the unnamed "nurse keeper", and the implicit involvement of an apothecary in preparing the medicines, Anne situated herself and Betty at the centre of the narrative.

The supervisory element of nursing became particularly apparent when letter writers reported how they monitored the illness of their patients. The act of watching was often central to their illness narratives. Hannah Newton has observed that nursing during this period was also referred to as "keeping" or "watching", emphasizing the monitoring of symptoms and the provision of emotional support to patients.⁹⁵ Nursing therefore involved observing patients for signs of decline or improvement. When Bryan Salvin depicted the death of Lady Mary on a Wednesday morning in an otherwise undated letter, he noted that "neither the Doctor, nor her Famaly I believe thought her in any Imediate danger the night before at Bedtime".⁹⁶ The family and the medical practitioner were given equal authority in his eyes. Though she had been "very ill this fortnight", their reading of the signs of her body and her responses to their presence had assured them that she had a level of health that was misleading. Both doctor and family had judged her health, and both had been wrong.

Anne Clavering presented a positive image of her role as night nurse when she sat up with her sick steward. In a letter of 27 June, 1710, Anne wrote,

my steward is upon ye Recovery, having had a pretty good night last night, yt before was terrible, his Papa & I satt by him for 3 hours in his nightgown he was so ill, they bled him & yt operation, wth a Prescription of his Drs yesterday morning, has not only took away ye pain in his side but given great hopes of him getting afoot again.⁹⁷

⁹⁵ Newton, *The Sick Child*, 95.

⁹⁶ U DDEV/60/84/25 (Bryan Salvin to Marmaduke Constable, undated).

⁹⁷ CLV 47 (Ann to James Clavering, 27 June 1710).

Anne shared the labour of watching, but distinguished herself in identifying her role as both monitoring and supervising. Unlike the extended statement about Betty's illness above, Anne did not move or tend directly to the patient. She was either present in the sick room or reviewed his course of treatment with the visiting practitioners to the extent that she could both summarize their activities and relate the treatment to its perceived effects. She attributed her servant's lessened pain and optimism at regaining mobility to the combination of an unnamed prescription and bloodletting. Families may not have been involved in the formal elements of treatment, which were provided in this case by the doctor and surgeon. However, this example of monitoring demonstrates the interaction of family nurses and formal practitioners in medical situations. The prescription was "of his Drs yesterday morning", implying that the doctor prescribed treatment but did not remain to manage doses or observe the effects. Anne and her steward's father, the only two who sat with the man, managed his treatment.

Sitting up could also be grueling and extensive. Francis Bredall commented that his work "goes a little hard wth me" when recounting how he had sat up to provide comfort to his friend Mr. Belayse for more than five consecutive nights in 1768.⁹⁸ Though he was willing to support his friend, sitting up still took a toll on him. This difficulty could be exacerbated by the behavior of the patient. One striking case of this can be seen when Ann Chaytor and her father began to discuss her mother Peregrina's diacodium dependency in 1704. Ann recounted how

The doctor and I had a sad bout with my mother last night about the diacodium and tho she beg'd as if it had been for life he possatively forbid it and charged me against it so I was forst to sitt up with her and intends to sitt up again to night for I dare not trust any body she is so earnest for it that they tell me they cant defate her. Tis a hard part I have to act every way but I'm resolved to go through with it and run the haszerd of being sick or any thing rather than se her ruin her self I've hoummerd her too long [...] The doctor orders syrup of cowslips or tea made of them and that is what I'm resolved if it be possable she shall keep to.⁹⁹

Peregrina's illness and William's imprisonment put their daughter Ann in the unenviable position of monitoring her mother's behavior on behalf of both the family and their doctor. Not only was she responsible for nursing and supervising her mother, who had a persistent bad cough, but the treatment Ann enforced was directly in opposition to Peregrina's desires. Ann had the support of the doctor, who was present for the "sad bout" with her mother, and her father also

⁹⁸ ZDV(F) VI 12/ (Francis Bredall to Charles Fairfax, 31 March 1768).

⁹⁹ ZQH/9/15/104 (Ann to father William Chaytor, 13 June 1704).

expressed his happiness at their plan through his letters. However, Ann made it clear that she was obliged to care for her mother alone at night. Unlike other cases of sitting up, Ann felt “forst” because she “dare not trust any body”.¹⁰⁰ The emotional burden of assisting her mother was coupled by an absence of physical support from friends, family, or servants.

Monitoring the sickbed frequently necessitated decision-making, as Lisa Smith has detailed. Families examined a range of medical options before they chose one and helped to enact the appropriate medical actions.¹⁰¹ This expresses a degree of knowledge and medical confidence on the part of these letter writers, as they both practiced medical care in the home and were conscious of the point at which their authority ended and a medical practitioner must be summoned. When Phoebe Wilkinson came home to find her brother ill in 1772, she wrote that “we imeadeatly (sic) sent for Dr H who order’d some working Physick wch has in a great measure taken off ye fever & pains in ye bones & head”.¹⁰² She evaluated the situation and determined that the appropriate course of action was to call in a paid practitioner.

Similarly, Anne Clavering recounted to her cousin in 1709 how she was away from home when notified of Betty’s asthma attack by a servant. She explained that “I sent for ye Dor but before either he or I could come she was well again”.¹⁰³ The transmission of information in this case seems to have several stages. Either Betty, a servant, or family member contacted Anne because Betty was having an asthma attack. Anne was the one who called the doctor. She did not give the location of any of the actors in the story, but the travel time for her to arrive at Betty’s location was long enough that Betty’s breathing was normal by the time Anne arrived. Similarly, the physician was too late to assist during the “fit”. It is particularly interesting that Anne was contacted rather than having the doctor summoned directly, indicating that she was seen by members of her household as the person who decided on the appropriate medical interaction or had control of the finances which determined what medical actions could take place.

As well as explicit evidence of the application of medical and surgical skills in tandem with caregiving, some letter writers implied medical knowledge through accounts of caregiving. Letter writers signaled the importance of managing diets to medical treatment. John Lister wrote in 1755 that “Dr Sydenham recommends bleeding or a low cool diet, we try the latter method, no

¹⁰⁰ Ibid.

¹⁰¹ Smith, “Reassessing the role of the family,” 330.

¹⁰² SH:7/LL/200 (Phoebe Wilkinson to James Lister, 30 August 1772).

¹⁰³ CLV 27 (Ann to James, 8 November 1709).

physic has been used & we wait for Time & Abstinence to affect a cure”.¹⁰⁴ The family consulted an external practitioner, but also chose the advice which seemed most appropriate to their family, opting for diet rather than surgery. Additionally, they demonstrated the medical and theoretical knowledge to translate the concept of a “low cool diet” to a practical set of foods which would be safe and beneficial for Lister’s nephew. William Robinson in particular lingered on the caregiving practices and interactions of women in his household. When his wife Mary had an injured and infected leg at the beginning of the century, he wrote in a letter to their son Metcalfe Robinson that “Yr sister (inserted above: Nanny) proves a notable surgeon, & housekeepr, & very diligent about her good mother”.¹⁰⁵ Nanny was taking on all the roles of caring in the household, particularly the dressing of wounds revealed by her father’s labeling her as a “notable surgeon”. Her caregiving was explicitly medical; Robinson made it clear that she was tending the wounds, not just monitoring her mother’s illness. The reference to surgery was striking. Although other letter writers refer to treating wounds, Nanny is the only person who is presented with the skill of a surgeon. This is indicative of her father’s perception of her exceptional skill and competence.

Families also revealed medical knowledge associated with caregiving when they made decisions on their family’s location and type of treatment. In a letter to Thomas Grimston in 1751, Phill Harcourt wrote how “poor Robin fall dangerously Ill of a Feavor, the weather was violently hott & I was afraid of Infection so remov'd thither, from whence I did prevent his being visited by any Regulars, & gave him Dr James' Powder”.¹⁰⁶ This medical knowledge worked on several levels: Harcott evaluated the effects of the climate, and supplemented the change with a popularly prepared medicine. A similar level of knowledge was implied when Thomas Robinson wrote to his son about the health of his daughter, Terese, who had a cancerous breast in 1763. Returning home to tend to her, Robinson wrote that “I carry with me full directions how to manage with her. Patience, great care, air & exercise will, the Doctor flatters himself & me, set her up”.¹⁰⁷ While the advice was from a physician, Thomas implied that it would be the family who actually managed her care. The physician was in the city and she was in the country, but Thomas Robinson had sufficient information to manage her treatment independently.

¹⁰⁴ SH:7/HL/49 (John Lister to David Hartley, 04 January 1755).

¹⁰⁵ WYL150/6003/14 (William to Metcalfe Robinson, 06 August).

¹⁰⁶ DDGR/41/1/11 (Phill Harcourt to Thomas Grimston, 28 June 1751).

¹⁰⁷ WYL150/6041/12252 (Thomas Robinson to son, 20 May 1763).

Comparing her eighteenth-century sources with the majority of work on the profession of nursing which focuses on the nineteenth century or later, Williams observes that nineteenth-century nursing functioned as a result of a rigid distinction between “care” and “cure”.¹⁰⁸ Jeremy Boulton observes that one of the difficulties of situating nurses as either “carers” or “curers” can be found in the ambiguity of the concept of “curing” because skilled nursing could contribute to health, as diet specialization was part of treating the sick.¹⁰⁹ The importance of regulating daily behaviours to ensure or restore health is shared by Cavallo and Storey, who assert that each non-natural had an important role in healthy life.¹¹⁰ The non-naturals of air, exercise, sleeping, food and drink, excretion, and emotions were ubiquitous to daily life but also fundamentally influenced the humours which directly controlled health. Hannah Newton’s chapter on convalescence, in particular, emphasizes the important role of non-naturals in restoring health and flesh while evaluating the process of recuperation.¹¹¹ Given the prevalence of humoralism well into the eighteenth century, as considered in the next chapter, any effort to distinguish “care” from health is therefore anachronistic. The distinction between “carers” and “curers” is even less relevant in the context of the eighteenth century home because of the division of caregiving tasks. Monitoring symptoms and the nature of the sick room were integral to the gentry identity as caregivers. As a result, there was necessarily an element of medicine in their regulation of illness.

In the sick room, family members simultaneously discussed and applied medical advice while supervising the range of caregiving activities. Within Harker’s division of nurses, then, families fell firmly into the role of “status carers”. Not only did they avoid the manual labour of caregiving, as demonstrated in the previous section, they also brought medical knowledge to the sickroom. To some extent, this justifies the conflation of “caring” and “curing” by historians such as Withey and Weisser. However, this chapter has demonstrated the need for a greater level of attention in differentiating caregiving activity from the preparations of medicines. Though they had similar goals, making clear the methods in which the gentry managed “bodywork” and

¹⁰⁸ Williams, “Caring for the sick poor,” 145.

¹⁰⁹ Boulton. “Welfare systems and the parish nurse,” 136.

¹¹⁰ Sandra Cavallo and Tessa Storey, “Conserving health: the Non-Naturals in early modern culture and society,” In *Conserving Health in Early Modern Culture: Bodies and Environments in Italy and England*, ed. Sandra Cavallo and Tessa Storey (Manchester: Manchester University Press, 2017): 10, 42.

¹¹¹ Hannah Newton, “‘She sleeps well and eats an egg’: convalescent care in early modern England,” in *Conserving Health in Early Modern Culture: Bodies and Environments in Italy and England*, ed. Sandra Cavallo and Tessa Storey (Manchester, Manchester University Press, 2017): 121-122.

servant labour provides a more nuanced picture of the experience of sickness. While most of the work which the gentry performed was supervisory, there are still places in which they reveal the extent to which sick rooms were modified in light of patient diagnoses and needs. Closer attention to bodywork, though it was not integral in these gentry letters, benefits historiographical narratives about illness experiences, and contextualizes the adaptations of skills and accommodations for illness made in homes.

Conclusion

Dorothy, Duchess of Portland's comments on the degree of effort which her cousin Louisa had exerted caring for the sick and celebrating the family's return to health is demonstrative of the ambiguous state of caregiving in familiar letters. Letter writers regularly referred to illness and confinement without providing details about the involved caregiving activity, but when caregivers were identified they worked to the point of personal fatigue. Gentry letter writers referred to themselves as the supervisory figure in the sickroom using terms such as "attendance", "caring", and "nursing" which emphasized their proximity to the sick. The restriction of gentry caregivers to supervisory roles was enabled by the structure of their households. Many of the caregiving activities in the literature on household health and paid nursing were modifications of the daily work performed in households. Illness increased the significance of heating rooms, laundering sheets and clothing, and cooking food. In gentry households, these were tasks which were largely managed by women and performed by servants.

Letter writers left unmentioned the tasks which they did not themselves perform. Similarly, they were largely silent on the lives of their servants in familiar correspondence. As a result of the emphasis on supervisory gentry work, the distinction between "care" and "cure" which has been applied to paid nursing is an inadequate model for household caregiving: the types of work that the gentry performed for the sick were inherently medical. This is particularly evident in the cases in which letter writers describe both caregiving and explicit medical work, such as the dispensing of medicines or the cleaning of wounds. Gentry caregiving was specialized both in terms of the status of their work and the medical knowledge required. Although Susan Broomhall has demonstrated the fallacy of perceiving caregiving work as "somehow unchanging", it is difficult to identify changes in the work of gentry caregivers in this

sample due to the irregular references and wide variety of terminology.¹¹² However, the value of caregiving as a subject in familiar letters did decrease through the century, shifting from detailed accounts of activities during illness in the early decades of the century to brief, undetailed references to illness such as Dorothy's in the 1790s.

The gender of caregivers is another subject which simultaneously demonstrated continuity and changed through the eighteenth century. The fundamental difference between male and female caregiving is evident in correspondents' critiques of caregiving activities. Only female letter writers detailed their responses to caregiving with words such as fatiguing, melancholy, and tedious. The expectation that women would work continually as caregivers is reflected in women's provision of the majority of care for their sisters, nieces, mothers and daughters. While unmarried daughters cared for their parents in the early decades of the century, mothers as caregivers for their children were increasingly referenced in the second half of the century, culminating in Louisa Ponsonby's management of her sick nursery. Compared to women, men had a higher degree of flexibility in their entry into caregiving roles and usually acted as caregivers when women were unavailable. Men were slightly more likely to be involved in the sickroom later in the century, supporting Joanne Bailey's argument that men increasingly were focused on being a "good" husband and father.¹¹³ This division of roles reflects the modified arguments about the "separate spheres", in which there was a rough and permeable division of labour between the sexes.¹¹⁴

The importance of medical knowledge and skills in the sickroom permeated gentry letters regarding their caregiving activities. Letter writers emphasized their observation of the sick with three complimentary roles. They monitored for signs of improvement, decline, or the efficacy of treatment, they evaluated and applied medical treatments, and they regulated the behavior of servants in the sickroom. In addition, references to caregiving often involved the application of specific medicine by the writer or their family, as when Nanny Spencer acted as a "surgeon" to her sick mother. Household medical knowledge and expertise allowed families to make the judgements about the behaviours of both the sick person and the family around them. This analysis of caregiving has revealed the extent to which medical knowledge informed even the

¹¹² Broomhall, *Women's Medical Work*, 2.

¹¹³ Joanne Bailey, "Reassessing parenting in eighteenth century England," in *The Family in early modern England*, ed. Berry and Foyster (Cambridge: Cambridge University Press, 2007): 223.

¹¹⁴ Tague, *Women of Quality*, 99.

most basic caregiving household activities. The next chapter will further explore displays of medical knowledge in correspondence, and the types of information with which they made medical decisions at the sick bed.

Chapter Four — Displays of Medical Knowledge

Following William Chaytor's imprisonment in Fleet Prison for outstanding debts in 1700, he exchanged a series of letters with his wife Peregrina and eldest daughter Ann in which the family displayed knowledge of subjects ranging from politics to health and social news.¹ In March of 1709, Ann wrote to William with detailed information on her current illness and plans for treatment. She began,

I write this day because I design to be blooded to morrow morning, my cough still continueing very bad. I have somtimes such a tickling that it makes me allmost [—] kink and often reach to vomitt but nothing comes up. Other times I get up in pleighm but the cough gives me such a soreness in my right side makes me very uneasy. I have had extract of malt and burnt brandy mixt with treackle with several such slaps to no purpose. I also anointed my stomach and the soles of my feet with brandy rubing it in several nights and I confess if bleeding do no good I shall grow a little serious.²

Ann's corralling of diagnosis, symptoms, and treatment exemplifies how letter writers understood and displayed medical knowledge in eighteenth-century correspondence. When Ann labeled her cough as worse than expected throughout the letter, she exhibited the ability to compare the symptoms with her own detailed knowledge of the usual progression of the ailment. She also considered the implications to her health if her cures continued to fail. Her detailed description of cures reflected Ann's possession of the extensive knowledge necessary to administer a series of remedies to herself, establish their lack of effectiveness, and decide on her next steps in seeking treatment.

Ann's evaluation of her illness is a demonstration of medical knowledge in familiar correspondence. This chapter analyses what types of medical knowledge informed discussions of illness in their correspondence, how the discussions were framed, and how personal medical information fit with other sources of knowledge as seen in recipe books and prescriptive literature. There are three points of investigation. First, this chapter will establish that letter writers had knowledge of a range of medical explanations for illnesses and choices of treatment. Second, it will discuss the relationship between correspondence and other forms of medical knowledge through comparisons with recipe books and popular prescriptive medical literature.

¹ *The Papers of Sir William Chaytor of Croft (1639-1721)*, ed. M.Y. Ashcroft, North Yorkshire County Record Office Publications No. 33 (January 1984): 7.

² ZQH/9/17/78 (Ann to William Chaytor, 22 March 1709).

Finally, it will relate these themes to issues of continuity and change in medical theory and practice throughout the eighteenth century.

The multiple definitions and elements of knowledge make it a complex area of study. For the purposes of the following discussion, knowledge will mean the information through which letter writers understood the cause of illness and selected a treatment. This definition combines elements from several historiographies, including Dorothy Porter and Roy Porter's stress on lay medical knowledge as a means of controlling the experience of illness through "devising strategies and making choices" about medical care and Andrew Wear's assertion that lay medical knowledge was constituted of "treatments, explanations, and advice".³ How such knowledge was acquired will be the subject of the first section, which shows how important the application of previous experiences was to understanding current illness. This chapter largely focuses on treatment and explanation as loci which were proof of medical knowledge. In order to identify the cause of an illness or justify a treatment, letter writers had to access information about sickness and cures as well as to apply it to their households.

Illness discussions in correspondence illustrate the communal nature of medical knowledge. Pamela Smith and Benjamin Schmidt have asserted that knowledge-making has a particularly "shared and collective nature".⁴ The character of knowledge-making is evident in the composition of correspondence because in order to communicate effectively, letter writers relied on shared knowledge to establish what their reader would find interesting or which further information they required. The familiar tone and air of intimacy which characterized familiar letters created a generous space in which letter writers described how illness was experienced and understood. References to illness display both what knowledge letter writers had and what knowledge was considered to be important or relevant. As a result, letters are an important source to explore the extent to which knowledge was shared between various members of a class.

Emphasizing a measurable element of knowledge in correspondence provides an entrance into the complex identity of knowledge. Additionally, its use by the lay population in the eighteenth century has received little attention in historiography. Andrew Cunningham and

³ Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 189; Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680* (Cambridge: Cambridge University Press, 2000): 2.

⁴ Pamela H. Smith and Benjamin Schmidt, "Introduction: knowledge and its making in early modern Europe" in *Making Knowledge in Early Modern Europe: Practices, Objects and Texts, 1400-1800*, ed. Pamela H. Smith and Benjamin Schmidt (Chicago: University of Chicago Press, 2007): 7.

Roger French contend that the eighteenth century has been “relatively neglected by English speaking historians of medicine,” situated as it was between the “scientific revolution” of the seventeenth century and the rise of laboratories and “scientific medicine” in the nineteenth century.⁵ In contrast, Wear terminated his study in *Knowledge & Practice in English Medicine, 1550-1680* in the late seventeenth century due to “a maelstrom of change that involved Helmontians, empirics, the critiques and innovations of Thomas Sydenham, the modernization of learned medicine by Thomas Willis and others, and institutional and educational transformations”.⁶ These two coexisting explanations justify the low volume of literature on medical knowledge and practice in the eighteenth century: either nothing happened compared to the bracketing centuries, as contended by Cunningham and French, or too much happened, according to Wear. In fact, this thesis reveals a narrative which mediates between the two views: while there were strong themes of continuity, the changes to medical models gradually modified the types of causes and treatments which letter writers preferred.

Inside the complex eighteenth-century theoretical landscape, historians have pointed to several areas of change over the eighteenth century which had the potential to affect the medical knowledge of letter writers. Expertise was increasingly viewed as fundamental to knowledge-making due to the new theory of scientific experimentation espoused by Robert Boyle and other members of the Royal Society of London. Pamela Smith describes how techniques of observation were used to constitute a system in which “intuitive, concrete, context-embodied experience,” or the action of actively witnessing, was an important assessor of truth and validity.⁷ These changes rippled through society, but prescriptive literature was intended particularly for the gentry and burgeoning middle class. Partly due to the shift from academic literature to experience in the process of obtaining knowledge, Cunningham and French assert that “every man became his own authority” during this period. Medical systems developed along with a model of the mechanistic body rather than having the body as the instrument of the soul. As a result, God became the “author of a regulated or rational world”.⁸

⁵ Andrew Cunningham and R.K. French, *The Medical Enlightenment of the Eighteenth Century* (Cambridge: Cambridge University Press, 2006): 1.

⁶ Wear, *Knowledge and Practice*, 5.

⁷ Pamela H. Smith, *The Body of the Artisan: Art and Experience in the Scientific Revolution* (Chicago, University of Chicago Press, 2004): 147.

⁸ Cunningham and French, *Medical Enlightenment*, 2.

The structure of medical theories also shifted in the eighteenth century when Galenism was increasingly destabilized by forays from new medical models.⁹ The changing relationship between medicine and religion was part of this large alteration. Porter and Porter explain how during this era, medicine “drifted from its cosmological moorings” and the popularity of magical and religious medical remedies declined.¹⁰ Tracing these changes can be difficult because, as Charles Rosenberg has suggested, assumptions about the function of the human body were “so deeply internalized that they demanded little systematic exposition; they were self-evident truths”.¹¹ Letter writers frequently did not espouse their reasons for ascribing a diagnosis or choosing a cure, but there are cases within this study’s source collection which establish preferred explanations for their experience of health and illness.

Evaluating the nature of relationships between a variety of authors of medical sources will allow this chapter to establish the extent to which medical ideas were shared. To this end, the study of medical information in letters will be complemented by and compared to two other sources: medical recipe books, and prescriptive literature which informed readers how to “be your own physician”. Two recipe collections for which there is a surviving collection of correspondence, the Carrs of Hedgeley Hall (1733-1793) and the Whartons of Old Park (1735-1789), are used to explore the commonalities between correspondence and medical recipes.

The prescriptive literature of this chapter focuses on publications which historians have described as the “most popular” of the early modern period, a title largely established by the number of reprints. The earliest text was Nicholas Culpeper’s *The English Physician, or, an astrologo-physical discourse of the vulgar herbs of this nation being a complete method of physick, whereby a man may preserve his body in health, or cure himself, being sick, for three pence charge*, first published in 1652 and republished into the modern period, in over a hundred editions.¹² The second text is John Wesley’s *Primitive Physick, or, An Easy and Natural Method*

⁹ See for example Owsei Temkin, *Galenism: Rise and Decline of a Medical Philosophy* (London: Cornell University Press, 1973); Wayne Wild, *Medicine-By-Post: The Changing Voice of Illness in Eighteenth Century British Consultation Letters and Literature* (Amsterdam: Rodopi, 2006): 10; Porter and Porter, “Medical Knowledge” in *Patient’s Progress*, 189-207.

¹⁰ Porter and Porter, *Patient’s Progress*, 193.

¹¹ Charles E. Rosenberg, “Medical text and social context: explaining William Buchan’s *Domestic Medicine*,” *Bulletin of the History of Medicine* 57.1 (Spring 1983): 22.

¹² Nicholas Culpeper’s *The English Physician, or, an astrologo-physical discourse of the vulgar herbs of this nation being a complete method of physick, whereby a man may preserve his body in health, or cure himself, being sick, for three pence charge* (1652) printed by Early English Books Online Editions; N.F.L. Poynter, “Nicholas Culpeper and his books,” *Journal of the History of Medicine and Allied Sciences* 17 (1962): 162.

of curing *Most Diseases*, first published in 1747 and republished in multiple editions.¹³ The third text incorporates continental medicine using Samuel-Auguste Tissot's *Avis au Peuple sur sa Sante* (1761), which was translated into English as *Advice to the People in General* by J. Kirkpatrick in 1765 and had print runs in a number of languages.¹⁴ Finally, inspired in part by the work of Tissot, William Buchan produced *Domestic Medicine, or the Family Physician* in 1769. The text underwent at least 142 separate editions.¹⁵ Although it has not been possible to determine whether the letter writers of this study had read these texts, or any medical didactic literature, the comparison is useful because it helps to estimate the circulation of such ideas across different media in the eighteenth century.

Recipe books and prescriptive literature are important sources of information on medical ideas. Elaine Leong proves that household recipe books functioned “alongside the rich offerings in vernacular medical print and household guides, provid[ing] readers with a framework of health-related knowledge”.¹⁶ Similar interactions between popular ideas and published texts can be found in prescriptive literature. Patrick Singy underlines the degree to which popularization influenced later publications of Tissot's *Avis*. The physician revised the text to respond to reader interests and gaps in medical knowledge identified in his medical correspondence practice.¹⁷ Rosenberg presents the “very familiarity of his ideas and language” as one of the reasons for the sustained popularity of Buchan's *Domestic Medicine*.¹⁸ Ginnie Smith approaches the issue of popularity from the opposite direction, contending that the conventionality and sustained demand for didactic literature suggests a powerful vernacular tradition, and could be a

¹³ John Wesley's *Primitive Physick or an Easy and Natural Method of Curing Most Diseases, ninth edition* (London, 1761); Porter and Porter identify the text as “the favourite, going through scores of editions” in *Patient's Progress*, 198.

¹⁴ Samuel Auguste David Tissot's *Advice to the People in General, with regard to their health, but particularly calculated for those, who are the most unlikely to be provided in time with the best assistance, in acute disease, or upon any sudden inward or outward accident, third edition*, trans. J. Kirkpatrick (London, 1768); Tissot names the multiple editions and languages of *Advice* in his preface, xxiii-vii.

¹⁵ William Buchan's *Domestic Medicine: or, a treatise on the prevention and cure of diseases by regimen and simple medicines, [...] the seventh edition, corrected*. (London: 1781), printed by Eighteenth Century Collections Online Print Collections; Rosenberg, “Medical text and social context,” 22.

¹⁶ Elaine Leong, “Collecting knowledge for the family: recipes, gender and practical knowledge in the early modern household,” *Centarus* 55.2 (May 2013): 82.

¹⁷ Patrick Singy, “The popularization of medicine in the eighteenth century: writing, reading, and rewriting Samuel Auguste Tissot's *Avis au peuple sur sante*,” *The Journal of Modern History* 82.4 (December 2010): 796.

¹⁸ Rosenberg, “Medical text and social context,” 31.

calculated appeal for readers by authors.¹⁹ This chapter tests if the ideas espoused by letter writers in their private correspondence are coherent with recipe books and prescriptive literature from the eighteenth century.

After establishing the commonalities of language and rhetoric, the following three sections will examine the situations in which knowledge was represented and used to make judgements about causes and treatments of illnesses. The first section introduces the contents and structure of the three types of sources through a summary of the illnesses discussed and an exploration of the method in which each source wrote about or displayed knowledge. The second section establishes the origins of this knowledge, discussing the writers' use of both experience and theory to explain their logic and decisions. The third section will analyze how this knowledge was used, first to make evaluations about the cause of illness, and second to choose a range of effective cures.²⁰ Letter writers' discussions of the causes and treatment of illnesses will be compared with the four prescriptive texts and two recipe collections. These themes will be drawn together into a study that considers how a range of letter writers, didactic literature authors, and recipe books dealt with one of the most regularly-referenced condition in correspondence: agues. Through their discussions of cause and treatment, letter writers exhibited a substantial amount of medical knowledge that was used to care for themselves and their families.

Displaying Medical Knowledge

Correspondence, recipe books, and prescriptive literature all provided opportunities for their authors or compilers to display and preserve medical knowledge. This section will analyze the features that differentiated displays of knowledge from general comments about illness. It then discusses medical knowledge in recipe books through an examination of the Wharton and Carr recipe books. Finally, this section will introduce the four main didactic books used in the following three sections, and analyze how authors of prescriptive literature presented themselves and their texts as sources of knowledge. Establishing the qualities and language of each text will

¹⁹ Ginnie Smith, "Prescribing the rules of health: self-help and advice in the late eighteenth century" in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, ed. Roy Porter (Cambridge: Cambridge University Press, 1985): 253.

²⁰ See Figure 4.2 and 4.4. Data for this section has been compiled in Appendix V for disease causes and Appendix VI for treatments.

facilitate discussions on the relationship between these texts through the remainder of the chapter.

Though many letter writers were confident naming a series of illnesses, as evidenced by Appendix III, they were less likely to indicate how they reached their diagnosis or made a decision about the appropriate cure. Instead, displays of medical knowledge as seen in explanations or justifications of disease causation and treatment represent only thirty-three percent of the mentions of illness in correspondence.²¹ The remainder of references are comprised of general statements about diseases, such as an update from Mrs. Parker in a letter from Hannah Knaplock to her friend Phoebe Wilkinson in 1754, “who tells me she has just got recover’d from a fever”.²² In this case, Mrs. Parker made no statements about the cause of the illness, its progression, or the sorts of treatments which lead to recovery, but simply transmitted information.

Men and women were similarly likely to display medical knowledge compared to the gendering of general references to illness. In the wider correspondence, men wrote sixty percent of the letters with medical content, while women wrote only thirty-four percent.²³ In contrast, when including specific information about diagnoses or treatment, men comprised nineteen percent of the references, and women represented fifteen. Within their genders, then, men made confident statements about disease cause and treatment in thirty-one percent of the cases, while women made similar statements in forty-four percent of their letters. Similar to the importance of women in caregiving, this is indicative of either a greater possession of medical information for women, or a higher investment in sharing and having their knowledge validated. It reveals a discourse which expected women to participate in the health of family and friends.

Statements about illness were differentiated from claims of knowledge by the language used and the extent of detail included. When revealing their medical knowledge, letter writers

²¹ For displays of medical knowledge in describing causes and cures, separated by both gender and decade, see Figures 4.1 and 4.3.

²² SH:7/LL/135 (Hannah Knaplock to Phoebe Wilkinson, 20 July 1754). Similarly, William Norton wrote to Thomas Gill in 1704, “I return you many thanks for your kind inquiry after our Health, my spous (sic) & little Boy has got a cold”. (ZQH/9/15/111). Barbara Stanhope commented to her brother in the 1720s that “And thank God I am better of my cold”. (SpSt/6/1/42). John Spencer was vague about both the nature of his sister Ann Stanhope’s illness and treatment when he wrote to her in c.1760 that “I heartily wish your Journey to London may be attended with all the advantages it at present seems to promise. Indeed I do not in the least despair of it, & hope to hear shortly of your perfect recovery”. (SpSt/6/1/58). B. Broughton was similarly low on detail when he reported business and social news to his friend William Chaytor, writing that when he went to attend the “captain” at Syon Hall, “He has been very ill indeed I find and attended by Sir J. Eliot. He is better”. (ZQH/10/50/51).

²³ It is not possible to identify the gender of the remaining six percent of letters.

rarely wrote that they “knew” information about the illness’s cause, progression, or cure. Instead, they outlined such ideas in the vocabulary of thoughts, beliefs, and sureties. For example, relating her fear of a relative’s health to her daughter-in-law Louisa Ponsonby, Elizabeth Cavendish testified in 1788 that “I am particularly uneasy as the kind of cough he's got I am sure he has had something as the kind before he has not the least cold or fever & feels perfectly well but has a horribly cough.” She then added the observation that it is “like my cough”.²⁴ This language was often combined with further details which revealed the personal knowledge which allowed writers to make such statements. Thompson tracked the progression of Thomas Grimston’s sick father in 1751, writing that “I thought him a very likely way to do well till Thursday last, when a severe Cold seized him which intirely took away his Appetite & brought on a Flux”.²⁵ The writer had made a judgement about the health of Grimston’s father, which was modified based on new information regarding illnesses which increased the risk to the father’s already poor health.

Recipe books were also texts in which families collected and discussed medical knowledge. Elaine Leong has determined that while recipe books were originally perceived as a female form of knowledge by historians, spouses and family members often collaborated in their composition.²⁶ The Wharton and Carr recipe books were both compiled in the late eighteenth century. The Wharton recipe collection contains seventy-three recipes on sixteen complaints, and is recorded in a small leather pre-bound notebook with uniform handwriting which matches with the handwriting in the correspondence from Mrs. Ann Wharton (nee Lloyd), indicating that the book was probably compiled in the second half of the century during her marriage to Richard Wharton. The Carr-Ellison recipe book, which contains forty-three recipes on twenty conditions, has a slightly different provenance, as it is primarily a set of loose letters and single pages from families, practitioners, and newspapers which have been directed to Mrs. Carr and bound together at an unknown later date.²⁷ Although both recipe compilers in this study most likely were women, either collection could have been used by a combination of family members in successive generations. The Wharton and Carr collections refer to a number of common complaints, such as gout, ague, jaundice, and coughs.

²⁴ GRE/870/8/3 (Elizabeth Cavendish (Ponsonby) to Louisa Ponsonby, 10 December 1788).

²⁵ DDGR/41/1/51 (Thompson to Thomas Grimston, 22 October 1751).

²⁶ Leong, “Collecting knowledge,” 84.

²⁷ I am greatly indebted to John Carr-Ellison for having granted me access to the Hedgeley Recipe Collection and other personal papers.

Compiling a recipe book was an act of preserving knowledge which necessitated active collection and testing in order to assure that collections were effective and readily available.²⁸ Leong presents manuscript recipe collections, which were exchanged, acquired, and evaluated by their collectors and readers, as “a main medium for the recording and transmission of information and knowledge”.²⁹ One sign of this process of transmission, which also functioned to validate the contained knowledge, was recipe attribution, in which a specific author or situation is recorded either in the recipe title or at the end of the recipe.³⁰ This is the case in thirty five percent of the recipes in the Wharton recipe book, which included comments such as “Dr Davidsons receipt for a cold”.³¹ The authors of recipes are signaled by the inclusion of “advise”, and labeled either as “by” an author or “for” a cure. The Hedgeley recipe book similarly concluded “For A Cough or Tending to Broken Wind” with “Lord Ravensworth Receipt from Lord Lonsdale”.³² Forty-four percent of the Hedgeley recipes were attributed to a source. These labels signaled that recipes had been proved by a trusted friend, serving as a marker of the relationship and a potential cure.

While the recipe book was inherently a depository of knowledge, the inclusion or exclusion of information speak to the recorder’s distinction between excluded, common knowledge and necessary, included information. In the Carr-Ellison text, there is little evidence of Mrs. Carr as a person who possessed, created or tested knowledge, as she instead compiled information which had been offered by other authors. It is also possible that the invisibility of Carr’s involvement was used as a memory aid rather than an area of experiment, and therefore required less revision on the page. The recipes frequently provide minimal information about how a recipe has been prepared or tested. In contrast, Ann Wharton’s active pursuit and modification of recipes is evident in conversational comments such as “Capt Smith advises to take off to cure wind in ye Stomack”.³³ Wharton also included advice on refining recipes such as “You may any time add a little of ye same liquor if you make it too strong at first. Ye old

²⁸ Elaine Leong and Sara Pennell define the process as a “ceaseless project of therapeutic and pharmacological ‘data retrieval’” in “Recipe collections and the currency of medical knowledge in the early modern ‘medical marketplace’” in *Medicine and the Market in England and its Colonies, c. 1450-1850*, ed. Mark Jenner and Patrick Wallis (Basingstoke: Palgrave MacMillan, 2007): 137.

²⁹ Leong, “Collecting knowledge,” 83.

³⁰ See for example Leong and Pennell, “Recipe collections,” 133.

³¹ WHA.88 – Wharton Recipe Book, p. 72.

³² Hedgeley Recipe Book.

³³ WHA.88 p .47.

receipt”.³⁴ The comments on modification are evidence of a process of active selection and revision for the recipes, rather than simply preserving knowledge as seems to be the case with the Carrs.

Unlike recipe books and correspondence, the didactic literature in this study was largely written by individual male authors who published to share their medical knowledge with the wider population. This process was facilitated in large part by the rise of print, combined with the increase in literacy that was discussed in Chapter Two. Nicholas Culpeper was a physician and popular author of *The English Physitian: or An Astrolog-Physical Discourse of the Vulgar Herbs of this Nation*, first published in 1652 and providing an alphabetical list of plants as well as definitions of the features and “virtues,” or medical uses, under each name.³⁵ John Wesley was a Methodist minister and empiric who supplemented his interest in the health of both the body and soul with the publication of *Primitive Physick, or, An Easy and Natural Method of curing Most Diseases* (1747), which was organized by disease, providing brief descriptions of illnesses before listing cures in the form of medical recipes which varied widely in length within the text, ranging from one to more than ten treatments.

Ginnie Smith identifies a change in the mid-eighteenth century which resulted in a new type of author who associated himself with reforming the medical institution from within.³⁶ This can be seen in the final two prescriptive authors: Samuel-Auguste Tissot was a notable physician in Switzerland, who capitalized on his thriving network of medical correspondence to produce and tailor *Avis au Peuple sur sa Sante* (1761), translated into English as *Advice to the People in General* in 1765.³⁷ William Buchan, the author of *Domestic Medicine, or the Family physician* (1769), had trained in Edinburgh, where he eventually became a member of the Royal College of Physicians of Edinburgh.³⁸ Tissot and Buchan created very similar texts. Rosenberg labels both works as “novel departure[s]” because they were the first to combine the genres of regimen and pragmatic cures.³⁹ Although Tissot focused primarily on acute disorders and Buchan widened his

³⁴ WHA.88 p. 89.

³⁵ N.F.L. Poynter, “Nicholas Culpeper and his books,” 162.

³⁶ Smith, “Prescribing the rules of health,” 263.

³⁷ Singy notes that there are about thirteen hundred letters of medical consultation that survive Tissot’s practice after his reputation was established in the 1760s, and labeled *Avis* as “certainly one of the greatest medical best sellers of the eighteenth century” in “The popularization of medicine,” 773, 776.

³⁸ C.J. Lawrence, “William Buchan: medicine laid open,” *Medical History* 10.01 (January 1975): 21.

³⁹ Rosenberg, “Medical text and social context,” 23-4.

focus with a comprehensive range of illnesses, both were organized by disease and contained information on diagnoses, regimen, and medical recipes.

Published medical texts needed to prove that they had the authority and knowledge to justify their purchase by their target audience, the laity. As Glaisyer and Pennell have proved, such books “made their claim to educate and inspire from the outset, and were constructed both textually and physically to achieve those goals”.⁴⁰ Didactic medical literature used rhetoric in their introductory sections to prove their command of medical information while also prioritizing the simplicity and accessibility of the text. Culpeper identified gaps in the contents of other herbals and their lack of explanations, commenting critically that reading the popular *Gerard’s Herbal*, first published in 1597, would “teach them just as a Parrot is taught to speak, an Authour Saith so, therefore ‘tis true”.⁴¹ Wesley also utilized the narrative of medical secrecy, critiquing physicians who were “Had in Admiration, as Persons who were something more than Human. And Profit attended their Employ, as well as Honour”.⁴² Tissot also criticized “the Manner of treating sick People in the Country,” offering his book as a replacement for bad regional practice.⁴³ Buchan argued that his text would share previously restricted knowledge, which was necessary because it was impossible that “men can be sufficiently upon their guard against diseases, who are totally ignorant of their causes”.⁴⁴ These texts all justified publication on the ground that previously available knowledge was insufficient and misused, and their new text would restore good medical practice.

Correspondence, recipe books, and medical prescriptive literature all made claims about the author’s knowledge. This was particularly evident for prescriptive literature, because physician-authors wanted to control the medical discourse and establish their position as central to medical knowledge. Authors therefore maintained that they provided information that had previously been hidden, lacking, or withheld from their popular readership. However, close readings of other types of sources reveal a similar bid for acknowledgement. The attribution in recipe books relied on a similar acknowledgement of the author’s authority when recipes were attributed to authors. Knowledge further permeated the text, however, because the very process

⁴⁰ Natasha Glaisyer and Sara Pennell, *Didactic Literature in England 1500-1800: Expertise Constructed* (Aldershot, 2003), 3.

⁴¹ Culpeper, *English Physician*, x.

⁴² Wesley, *Primitive Physick*, x.

⁴³ Tissot, *Advice*, 97.

⁴⁴ Buchan, *Domestic Medicine*, xxiv.

of creating a recipe book necessitated testing and comparing recipes. The final collection was proven by attribution and experience, and potentially useful: a ready store of medical knowledge. In correspondence, this occurred mainly through confident statements which evaluated the information and reached conclusions about diagnoses and the progression of illness. These sources, though distinct in their formats, therefore worked similarly and used comparable language to appeal for their acknowledgement as medical knowledge.

This process was not strongly gendered, nor does it appear that men and women used knowledge in distinctly gendered ways. Men could help compile recipe books, and women did write prescriptive literature.⁴⁵ Women were slightly more likely to make statements about their medical knowledge in correspondence and are often associated with recipe collections, but men also made diagnostic and treatment decisions about illness in correspondence and used recipe collections in the household. The language of medical knowledge was thus, if not identical, at least identifiable between the range of sources used for this chapter. The next section will discuss the foundations of these knowledge claims through examining how the sources used theory and experience to understand illness and treatment.

Experience and Theory

Demonstrations of knowledge in letters were characterized by additional details regarding the features of illness which lead to the current diagnoses or advice. There were two main methods of providing this context. First, sources could apply translated knowledge collected from past experiences to the current illness. Second, they could refer to medical theories which explained how the body worked, or could fail to work properly. This section will explore these two methods of creating knowledge and then conclude with some brief statements about the balance and overlap between the two sources of knowledge.

Experience had always been a significant element of medical self-care. Analyzing the process of “self-diagnoses and self-care” of the women in eighteenth-century Eisenach, Barbara Duden observes that women selected physical sensations such as “sensed,” “felt,” and “experienced” in reporting their illnesses to the physician Johannes Storch, and they often had a

⁴⁵ See Elaine Leong, “Collecting knowledge for the family,” 85; and Lisa Smith, “Relative duties of a man,” 248, 250.

sense of what treatment would be most effective for him to prescribe.⁴⁶ Duden reports how women sensed their bodies as understandable “only as the place of an experienced but invisible flowing”.⁴⁷ Experience was critical to this form of medicine, because internal disruptions could not be externally observed or measured. Historians have also debated the extent to which historical experience was gendered. Olivia Weisser claims that the lived experience of men and women resulted in men prioritizing personal experience while women compared their experiences to those around them and noted common symptoms and effective treatments.⁴⁸ Lisa Smith disputes the concept of gendered knowledge, contending that the gendered body was peripheral to the experience of illness because sickness was characterized by a shared belief in the constant movement of humours and the “uncertainty and incomprehension” of the experience.⁴⁹ As argued in Chapter Two, the letters in this study highlight the shared experience of sick men and women.

Experience also acquired new intellectual weight in the early modern period. Natasha Glaisyer and Sara Pennell establish the increasing prominence of “‘practical,’ ‘sensual’ empirical knowledge”.⁵⁰ Early scientific methods were performed in households such as that of the natural philosopher and member of the Royal Society, John Evelyn (1620-1706) and his well-educated wife Mary (1635-1709). The couple initially performed experiments at the same time and in shared spaces with cookery and distilling, and used the same skills and equipment. The processes became increasingly formalized and differentiated as men chose to gather to discuss experiments, gradually excluding women from the dialogue.⁵¹ How-to books were popular after 1700 because they attempted to make explicit processes which had previously been “secrets” due to their manual nature and the system of transmission between master and pupil.⁵² In place of the

⁴⁶ Barbara Duden, *The Woman Beneath the Skin* (Cambridge: Harvard University Press, 1991): 74, 83, 93.

⁴⁷ *Ibid.*, 107.

⁴⁸ Olivia Weisser, *Ill Composed: Sickness, Gender and Belief in Early Modern England* (New Haven: Yale University Press, 2015): 48.

⁴⁹ Lisa Smith, “‘An account of an unaccountable distemper’: the experience of pain in early eighteenth-century England and France,” *Eighteenth-Century Studies* 41.4 (2008):463, 470, 473.

⁵⁰ Glaisyer and Pennell, *Didactic Literature*, 7.

⁵¹ Francis Harris, “Living in the neighborhood of science: Mary Evelyn, Margaret Cavendish and the Greshamites” in *Women, Science and Medicine 1500-1700*, ed. Lynette Hunter and Sarah Hutton (Thrupp: Sutton Publishing Ltd., 1997): 199.

⁵² Smith, “Prescribing the rules of health,” 251. See for example William Eamon, *Science and the Secrets of Nature: Books of Secrets in Medieval and Early Modern Culture* (Princeton: Princeton University Press, 1994); or Elaine Leong and Alisha Rankin’s “Introduction: secrets and knowledge,” 55; and Pamela H. Smith, “What is a secret?” in *Secrets and Knowledge in Medicine and Science, 1500-1800*, ed. Elaine Leong and Alisha Rankin (Burlington, Ashgate: 2011): 49-50.

traditional emphasis on syllogism, authors and philosophers now accentuated the observation of nature alongside continual practice and the active accumulation of practice.⁵³

Gianna Pomata shows how the role of medicine was even more fundamental because of the significance of observational practices in the Hippocratic texts which were rediscovered in the mid-sixteenth century.⁵⁴ The importance of observing and sharing information, particularly for rare cases of illness, and presenting information in its unfinished state rather than presenting conclusive or systematic treatises, characterized the “late-Renaissance genre” of medical writings.⁵⁵ However, much like the formalization of experimentation from the Royal Society, Pomata marks an increasing prioritization of the “learned and experienced observer” which marked a boundary between scholarly and low-status healers.⁵⁶ Observation changed from the concept of custom, practice, performance or rite, to the idea of scrutiny and painstaking attention to an object or phenomena, and created a new expectation of how to interact with and experiment on nature.⁵⁷ The advocates for the new and more formalized form of observation attested that theirs was an art of specific skills, but this new method continued in parallel with the cause-and-effect experiences of the lay population and low-status healers.

The demonstration of experience by letter writers aligned with the traditional methods of comparing illness to previous events or the sickness of others. John Lister used prior experience when he explained to his parents that his bathing regimen was an effective means of preventing illness during an outbreak of smallpox in his Cambridge lodgings in 1724, because “I find by xperience [sic] for tho’ ye small-pox has been in my stair-case, yet I’ve escap’d,” indicating his knowledge that bathing in the local well helped to “preventing fever or any contagious distempers”.⁵⁸ The “xperience” was the acknowledgement that a current illness was avoided through certain actions. Experience informed by proximity to other sufferers in the household was

⁵³ Smith, *The Body of the Artisan*, 217.

⁵⁴ Gianna Pomata, “A word of the empirics: the ancient concept of observation and its recovery in early modern medicine,” *Annals of Science* 68.1 (2011): 22; Gianna Pomata, “Sharing cases: the observations in early modern medicine,” *Early Science and Medicine* 15.3 (2010): 201.

⁵⁵ Pomata, “Sharing cases,” 195-8.

⁵⁶ *Ibid.*, 231.

⁵⁷ Alan Salter, “Early modern empiricism and the discourse of the senses” in *The Body as Object and Instrument of Knowledge: Embodied Empiricism in Early Modern Science*, ed. Charles T. Wolfe and Ofer Gal (New York: Springer, 2010): 59. The increasing accentuation of interaction and scrutiny of nature and the creation of a scientific method have been treated in monographs such as Rupert Hall, *The scientific Revolution, 1500-1800. The Formation of the Modern Scientific Attitude* (London: Longmans, 1954); Steven Shapin, *The Scientific Revolution* (Chicago: University of Chicago Press, 1996); and Deborah E. Harkness, *The Jewel House: Elizabethan London and the Scientific Revolution* (New Haven: Yale University Press, 2007).

⁵⁸ SH:7/RL/22 (John Lister to his parents, April 1724).

also evident in writers' willingness to analyze the severity of a condition by comparing it to other experiences. When Anne Robinson diagnosed herself with gout in the 1720s in a letter to her brother John Spencer, it was because she had "my old pains in my stomach & feet &c, which I always thought ye Gout".⁵⁹ Though she does not explain what differentiated these symptoms from other episodes of pain, Anne's comments imply a thought process which distinguished between symptoms and accorded diagnoses.

Letter writers showed a willingness to compare their perception and the depictions of sufferers in order to make their own diagnoses. John Spencer diagnosed his sister Ann by letter in 1766 when he said that "I attribute the Fit you was served with to Cold & wind upon your stomach, I remember some years since being seized exactly in the same Manner".⁶⁰ Diagnosing others based on experience relied on the same comparative techniques as self-diagnosis, matching a list of described symptoms, with a list of personal prior illnesses. The same techniques were used to judge the potential efficacy of a treatment. To deal with her "v terrible scorbutic Complaint" in 1768, Chris Shuttleworth wrote to her sister Ann Stanhope that she would be "taking Moredants Drops by advice wth us I have found relief from them before, hope I shall do now".⁶¹ The previous success of the treatment was instrumental in the expectation of forthcoming relief, and it was this recollection of success that was named rather than any statement of theoretical function or reference to an external source of authority such as a practitioner. This type of comparison could rely strongly on personal illness: the diagnosis relied on internal sensations.

Experience was also a central element of familial recipe collections. In some cases, the prior uses of recipes were explicitly included. One page of the Wharton collection listed two recipes from Captain Smith. The second read "He also experienced hot milk well sweetened with hony taken in the morning to cure Rheumatism".⁶² The first letter in the Hedgeley collection opened, "If any hint I can give you, from my own experience in the treatment of Children can be condutive to the welfare of your lovely Babe, believe me very sincere, in saying it will give me

⁵⁹ WYL150/6006/IV/21 (Ann Robinson to brother, c. 1720). A similar case can be found in Ann Stanhope's letter to her son, in which she felt she had influenza because her "violent Pain in my limbs" was similar to an early symptom experienced by other sufferers. (SpSt/6/1/12).

⁶⁰ SpSt/6/1/76 (John Spencer to "my Dear Sister", 10 April 1766).

⁶¹ SpSt/6/1/76 (Chris Shuttleworth to Sister Stanhope, 21 April 1768).

⁶² WHA.88, p. 53.

real pleasure”.⁶³ Elaine Leong suggests the importance of “kitchen physic” as a treatment which preceded medical intervention in most cases, and presents a strong correlation between stored medicines and recorded recipes.⁶⁴ Recipes were recorded because they were seen as useful treatments, validated in previous practice either by the family or by a trusted friend.

All the authors of prescriptive medical literature justified the trustworthiness of their texts through their experience with the medicines and illnesses recorded within. Texts represented persons of skill, knowledge, and experience, which allowed the reader to enter into a conversation with the expert through reading the text.⁶⁵ This can be seen in Culpeper’s use of “Dr. Reason and Dr. Experience,” and Wesley’s consultation of only “Experience, common Sense, and the common Interest of Mankind”.⁶⁶ Tissot justified his book based on having acknowledged the condition of the poor and wanting “to serve, and to comfort them”.⁶⁷ Buchan explicitly advocated for experience and wrote that “the knowledge of diseases does not depend upon scientific principles as many imagine. It is chiefly the result of experience and observation”.⁶⁸ Both their experiences, and the expectation that the reader would use their experience to acknowledge the efficacy of the text, were critical in the presentation of prescriptive literature.

Emphasizing the necessity of experience as the basis of knowledge destabilized the prior education systems, which valued mastery of classical texts and theory. The decreased significance of theory was exacerbated by the absence of a singular medical model during the eighteenth century. While Owsei Temkin sees Galenism, with its balancing humours and permeable body, as in its “afterlife” by the eighteenth century, he acknowledges the remarkable staying power of Galenism due to its provision of medical categories which related the individual to health and disease.⁶⁹ Galenism survived in such beliefs as that the interior of the body could be influenced by external events, and the significance of internal movement to maintain health. During the mid-1750s, there was a shift which subsumed humoral theory and charted the rise of sympathetic medicine as a popularly accepted belief. Sympathetic medicine was a physiological

⁶³ Hedgeley Collection.

⁶⁴ Leong, “Collecting knowledge,” 133, and Elaine Leong, “Making medicines in the early modern household,” *Bulletin of the History of Medicine* 82.1 (Spring 2008): 167, 148.

⁶⁵ Glaisyer and Pennell, *Didactic Literature*, 13.

⁶⁶ Culpeper, *English Physician*, ix; Wesley, *Primitive Physick*, 11.

⁶⁷ Tissot, *Advice*, xxi-ii.

⁶⁸ Buchan, *Domestic Medicine*, 106.

⁶⁹ Temkin, *Galenism*, 124, 135, 173.

construct which affirmed the power of nerves to control bodily function.⁷⁰ The transition was largely superficial because the fluid “humours” were replaced with fluids moving within recently-discovered nerves.⁷¹ Letter writers, authors, and recipe compilers could pick and choose between a series of complimentary understandings of the medicalized bodies.

The rise of sensibility has been well documented from a social perspective, but is less represented in histories of medicine.⁷² To examine the transition between “humours” and “nerves,” I have compared uses of the two terms in correspondence across the eighteenth century. Letter writers explicitly refer to humours twelve times in the letter collections of this study, ten of which were in the first half of the century. These descriptions highlighted the internal fluidity of the body, as when William Robinson suggested early in the eighteenth century that in the case of his wife Ann’s infected leg “this swelling proceed in some measure, from that milky humour, which used to fall from yr breast”.⁷³ He demonstrated a Galenic understanding of the body by linking the injury to a previous ailment and explaining that the movement of the humour had caused a new illness. There is evidence that understandings of the body had shifted away from a directly humoral body by the second half of the century: after 1730 the term was only used twice in this sample’s correspondence. Similar internal movements can be found in L. Kennedy’s account of her sister who “constantly has A perpetual Blister, upon one of her arms, which she thinks keeps her breast well, and her voice clear”.⁷⁴ Though no mention of humours were made, the importance of continual evacuation for maintaining a state of health was one fundamental element of humoral theory, and proves a continued use of the treatments of the medical system even as the language was replaced.

In contrast, “nerves” were identified in only four instances in the correspondence, representing less than one percent of the descriptions of health. The earliest use was in 1740, when Dr. David Hartley informed his friend and frequent correspondent John Lister that he “was

⁷⁰ Wild, *Medicine-By-Post*, 10; Geunter B. Risse, “Medicine in the age of Enlightenment” in *Medicine in Society: Historical Essays*, ed. A. Wear (Cambridge: Cambridge University Press, 1992): 161.

⁷¹ Guenther B. Risse, “Medicine in the age of Enlightenment” in *Medicine in Society: Historical Essays*, ed. A. Wear (Cambridge: Cambridge University Press, 1992): 167.

⁷² See for example Paul Goring, *The Rhetoric of Sensibility in Eighteenth-Century Culture* (Cambridge: Cambridge University Press, 2005); Ildiko Csengi, *Sympathy, Sensibility and the Literature of Feeling in the Eighteenth Century* (Basingstoke: Palgrave Macmillan, 2012); and Stephen Gaukroger, *The Collapse of Mechanism and the Rise of Sensibility: Science and the Shaping of Modernity, 1680-1760* (Oxford: Oxford University Press, 2010).

⁷³ WYL/6001/58 (William to Mary Robinson, 24 April c. 1715).

⁷⁴ WHA 82 (L. Kennedy to Mrs. Middleton, 18 November 1787).

nervous” and prone to over examining himself and his symptoms.⁷⁵ The experience of being nervous and the irritation of nerves overlapped in sympathetic medicine. In both cases, the behavior was a display of the internal processes. By the 1790s, an apology sent to Mrs. Ponsonby by the Duchess of Marlborough excused the duchess from an event due to a “bad nervous headache”.⁷⁶ Marlborough referred to the nerves’ capacity to control bodily function when they caused the headache which incapacitated her. This shift from “humours” to “nerves,” with references which also crossed between the first and second half of the centuries, is indicative of the gradual shift occurring in medical rhetoric. While the nature and names of the diseases experienced remained consistent, the explanatory structure used in correspondence shifted to incorporate sensibility and its increasing accentuation on refined feeling. Nervous medicine did not completely replace humoralism, but was instead a new vocabulary which was used to explain the invisible workings of the body. Helen King establishes in *The Disease of Virgins that* rather than producing schismatic changes, explanations and treatments could survive multiple revisions of theory. Each new medical system simply emphasized different elements of the condition.⁷⁷

Both recipe collections and prescriptive literature were even more opaque in their relationship to theory. Theoretical opacity was a standing feature of recipes, which required readers to have the knowledge and the skills necessary to diagnose an illness and prepare the recorded recipe. Therefore, the authors and compilers of recipes rarely included explicit theory in their texts. The rising popularity of scientific experience caused prescriptive literature to restructure into a similar model, focusing on simple information and observable features. While the seventeenth-century *English Physician* utilized the theoretical underpinnings of astrology to explain the working of medicinal plants, Wesley, Tissot, and Buchan avoided establishing theoretical structures.⁷⁸ Wesley was particularly aggressive in this approach, criticizing the “abstruse and philosophical Manner” of previous authors and articulated the accessibility of his text to the lower classes.⁷⁹ Tissot and Buchan similarly avoided lengthy theory, choosing instead to combine the genres of regimen and pragmatic cures.⁸⁰ Within this context, Tissot referred systematically to humours including the a “livid and foetid thin Humour” which was a feature of

⁷⁵ SH:7/HL/21 (David Hartley to John Lister, 07 June 1740).

⁷⁶ GRE/870/5/2 (Duchess of Marlborough to Louisa Ponsonby, c. 1790).

⁷⁷ Helen King, *The Disease of Virgins: Green Sickness, Chlorosis, and the Problems of Puberty* (London: Routledge, 2004): 3.

⁷⁸ See for example Culpeper, *English Physician*, xii.

⁷⁹ Wesley, *Primitive Physick*, xi.

⁸⁰ Rosenberg, “Medical text and social context,” 23-4.

“an inflammation of the breast,” and also incorporated the fashionable language of sensibility, observing that pressure from too much blood in the brain “prevents or impairs the Functions of the Nerves”.⁸¹ Buchan similarly utilized the language of both humoral and sympathetic theory, sometimes simultaneously. When he commented on the destructive power of grief, he wrote that “the nerves relaxed [...] and the humours, for want of fresh supplies of chyle, vitiated”.⁸² This theoretical framework incorporated both models which understood the body as being connected by fluids, choosing explanations to fit the circumstance without strictly adhering to a doctrine.

Causes of Illness

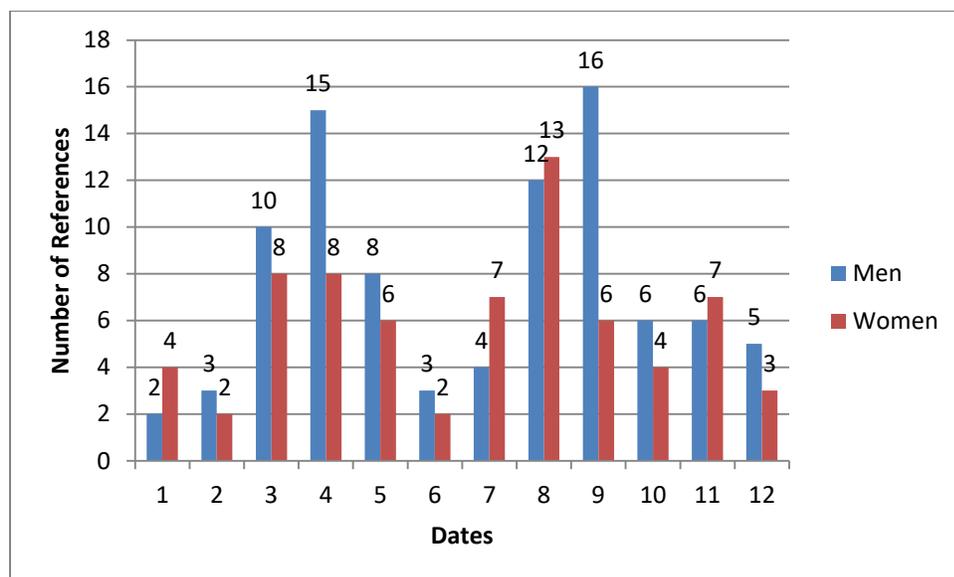
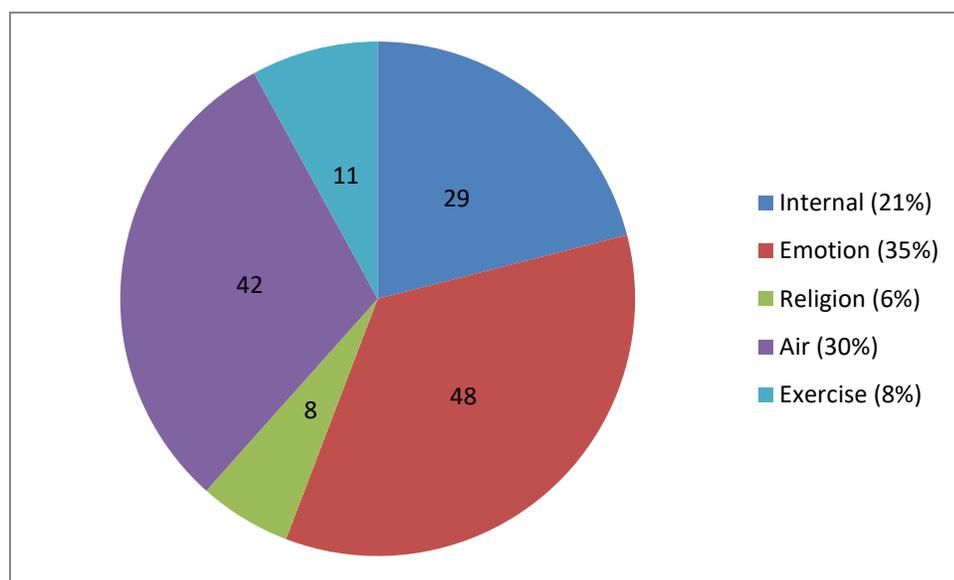
Letter writers had a range of explanations available for disease causation in the eighteenth century. They were slightly more likely to discuss the causes of their illness than they were to make confident statements about its treatment. Causes of illness represent fifty-one percent of the demonstrations of medical knowledge in this study. These references comprised seventeen percent of the total letters which referred to illness. Figure 4.1 shows that though women did describe the cause of illness, men were consistently more likely to make such statements in each decade after 1680. Men represented fifty-six percent of the total statements of disease causation. This image of a greater male tendency to ascribe causation changes when we compare the frequency of causal statements within each gender’s discussion of illness in Figure 4.1 to Figure 2.2 from Chapter Two, which broke down the genders of letter writers and their recipients. Men wrote 536 of the letters in this study, and disease causation appeared in ninety (seventeen percent). Women wrote 311 illness letters, in which seventy referred to disease causes (twenty-three percent). When reexamined in light of the wider gendering of letters, the male dominance of causes can be seen as a product of a greater volume of letters rather than a tendency of men to ascribe causes.

The proportion remained consistent over the century, revealing stability in the discussions and understandings of illness by both genders. The identification of causes by eighteenth century correspondents is demonstrated in Figure 4.2, and the five types of causation can be divided into three umbrella categories which emphasize either internal or external causes. First, the smallest category was religious causation. The second and largest category was internal causes,

⁸¹ Tissot, *Advice*, 148.

⁸² Buchan, *Domestic Medicine*, 91.

Figure 4.1 – Men and Women’s References to Causes of Illness

Figure 4.2 – Causes of illness in correspondence⁸³

in which emotions, illnesses, or the invisible balances of the body were identified as the reason for sickness. Finally, letter writers also referred to the danger of external causes, focusing on the effects of the environment, their exercises and temperature. Due to the structure of recipe books, which only included curative information, recipes are largely absent from this examination of illness causation. Therefore, this section will concentrate on letter writers’ use and explanation

⁸³ A breakdown of references to causes made in each decade of the study can be found in Appendix III.

for different disease causes, comparing their reasoning and prioritization of causes with those of medical literature.

Religion was rarely selected as a cause of illness in correspondence after the first decade of the eighteenth century, representing six percent of the references to causes. Notably, there was only one reference to religious causes of illness after 1720. The only explicit reference to God's influence in causing illness occurred in 1674, when William Richardson wrote to Henry Chaytor that "It pleased God whoe is the disposer of all thinges since to visit your ladie with the small pox".⁸⁴ This marked a striking decline from the importance of providence in the seventeenth century.⁸⁵ The rapid decline of religious causation also contradicts the narrative of gradual secularization of medicine suggested by historians such as Michael MacDonald. Using the decriminalization of suicide through the eighteenth century as a model to explore the cultural change of secularization, MacDonald dismisses publications of concern about the absence of religion between 1700 and 1725 as "early alarums".⁸⁶ In fact, the rapid societal exclusion of religious narratives found in these publications correlates exactly with the early decline of religious cause for illness in gentry correspondence.

The remaining comments indicated God's ability to preserve health, as when William Chaytor wrote to his wife Peregrina in 1691 that "I hope God will blesse me with health [...]".⁸⁷ Religion had a similarly ambiguous position as a causal force in prescriptive literature. Culpeper acknowledged God very briefly as an unknowable creator when explaining his rationale for integrating astrology into his herbal, but only Wesley, the founder of Methodism whose work was motivated by his desire to support the sick poor, provided a religious framework for disease causation.⁸⁸ By the mid-eighteenth century, religion as a causal force was completely supplanted by social and behavioural causes. Neither Tissot nor Buchan used religion to explain illness.⁸⁹

⁸⁴ ZQH/9/3/22 (William Richardson to Henry Chaytor, 03 September 1764).

⁸⁵ Weisser, *Ill Composed*, 68.

⁸⁶ Michael MacDonald, "The secularization of suicide in England 1660-1800," *Past and Present* 111 (May 1986): 76, 80.

⁸⁷ ZQH/9/8/22 (William to Peregrina Chaytor, 7 August 1691).

⁸⁸ Culpeper, *English Physician*, viii; Wesley, *Primitive Physick*, 4-5.

⁸⁹ Porter and Porter identify the decline of religion and magic in medicine in *Patient's Progress*, 193. Similarly, Michael MacDonald claimed that medical causes for suicide were no longer supplemented by supernatural ones, leaving only physical or psychological explanations, in "The secularization of suicide," 85. According to Penelope J. Corfield, the secularization of medicine was a result of the wider shift to a "secular, or this-worldly, within a continuing but slowly attenuating Christian tradition" as a result of increasing religious pluralism and the

It can be difficult to differentiate between changing contexts and the individual beliefs and personalities of letter writers, but through evaluating letters from a wide range of families it is possible to identify points at which letter-writers widely agreed on the causes of illness. This was particularly the case when letter writers chose to look inward to understand the causes of illness: emotion was the largest category of causation and a regular feature of letters.⁹⁰ Emotions, also known as “passions,” were omnipresent and, as Lisa Smith explains, the body and mind were “inseparable,” with emotions having physical effects and often being perceived as symptoms of illness.⁹¹ Sandra Cavallo and Tessa Storey note that in seventeenth century Italy, despite confusion over the method by which “passions” influenced health, correspondence provides evidence that letter writers “widely accepted” the link between emotional turmoil and illness.⁹²

Emotions were dangerous because they were difficult to control: extreme or sudden emotions could be particularly disruptive for the body, and the difficulty of controlling emotions could therefore lead to unpreventable illness. The relationship between grief and illness was particularly significant in correspondence, such as when an unsigned letter, likely from Ann Stanhope’s brother John Spencer, recorded in 1784 that “my poor wife had received so sever a shock by the Death of her mother that she had not strength to go on with her pregnancy that she miscarried about ten days ago”.⁹³ The same concern regarding the danger of grief can be found in *Domestic Medicine*, where Buchan claimed that the emotion resulted in “the humours, for want of fresh supplies of chyle, vitiated”.⁹⁴ Letter writers responded to the potential physical dangers of negative emotions by reiterating the prophylactic ability of good cheer, which was particularly important for those who were sick or near the sick to avoid succumbing to illness. A series of recommendations for improving health were made by John Spencer in a letter to his sister Ann Stanhope in 1764. He wrote that she should

specialization of the clergy profession. Penelope J. Corfield, “‘An age of infidelity’: secularization in eighteenth-century England,” *Social History* 39.2 (2014): 229, 231.

⁹⁰ See Appendix III.

⁹¹ Smith, “Account of an unaccountable distemper,” 463.

⁹² Sandra Cavallo and Tessa Storey, *Healthy Living in late Renaissance Italy*. (Oxford: Oxford University Press, 2013):178, 189.

⁹³ SpSt/6/1/127 (unsigned to “my dear sir,” 31 January 1784). Similarly, in SpSt/6/1/50 (to Miss Warde, undated) news of a family member’s death affected an aunt so much that she was confined to bed. Anne Clavering argued that her irritation at poor legal dealings physically affected both her and her cousin in 1710 because “for my spleen & resentmt went yn so high, I must have communicated some of it to you”. (CLV 46).

⁹⁴ Buchan, *Domestic Medicine*, 91.

still endeavor to bear it as quietly as you can, & not be fretful or uneasy. Be seldom alone & always endeavour to get into chearful company; for I wou'd by all means have you avoid all pathick places wch will always throw yr spirits into an extraordinary Hurry.⁹⁵

The effect of emotions was made explicit in Spencer's suggestions of which activities and moods to seek, such as good company, or avoid, such as "pathick places".⁹⁶ When prescriptive literature mentioned emotions, it was with similar emphasis to that those found in correspondence. Detailing the significance of "the passions" in *Domestic Medicine*, Buchan noted that "there is an established and reciprocal influence betwixt the mental and corporeal parts," and Wesley agreed that "All violent and sudden Passions dispose to, or actually throw People into acute Diseases".⁹⁷ However, the threat of passions was ranked low in the concerns of prescriptive authors, who prioritize the regularity and significance of causes such as sedentary lifestyles and cleanliness and who included the passions only briefly near the end of the section on causes. In the case of Tissot, the subject was omitted completely.

Concern for movement within the body was also a preoccupation of the second largest category of causation: internal processes and the relationship between diseases. Most of the references to internal processes which caused illness relate to ideas of fluidity of symptoms in the body. In this way, the gentry of eighteenth-century England had similar experiences to their contemporaries in Eisenach, as analyzed by Barbara Duden, in which the interior of the body was "a sphere of surprising changeability".⁹⁸ Letter writers referred to movement in the form of humours or disorders "falling" from one part to the other. For example, William Robinson wrote to his son Metcalfe in the early decades of the century that he had left London because his wife Mary had "a humour fallen into her leg, which is broke, & very painfull when dress'd".⁹⁹ Not only did William understand his wife's illness in terms of humoral movement, he considered it serious enough to abandon his parliamentary duties in London to return home to Yorkshire and nurse her.

⁹⁵ SpSt/6/1/76 (John Stanhope to his sister, 11 October 1764).

⁹⁶ See also James Lister's concerns for Mary Rose's health while she provided care for an aunt in 1775 (SH:7/LL/213).

⁹⁷ Buchan, *Domestic Medicine*, 87; and Wesley, *Primitive Physick*, 21.

⁹⁸ Duden, *The Woman*, 107.

⁹⁹ WYL150/6002/24 (William to Thomas Robison, dated 19 July). Similarly, C. Collingwood reported to Ralph Salvin in 1714 that she hoped that "wth care we shall prevent ye humour falling on her Eyes or Lungs," in his daughter's case of scald head (D/Sa/C 43.3) and an unsigned letter in the Ponsonby correspondence contained news that Lady Tilby's prognosis was poor in 1789 because "some application to her heart, has thrown the disorder on her intestines & she is very dropsical". (GRE/870/2/4).

Prescriptive literature similarly asserts the importance of movement and dangers of the internal blockages characteristic of humouralism. Wesley warned of the threat of both costiveness, which “cannot long consist with Health” and obstructed perspiration, because each threw internal balance into disorder by literally and metaphorically causing blockages.¹⁰⁰ Tissot was similarly concerned with the stoppage of perspiration.¹⁰¹ Buchan utilized the elements of fluids and movement in the language of both humoural and nervous theory when he wrote that “Health depends on the state of the solids and fluids,” any disruption of which “necessarily impairs health”.¹⁰² Letter writers were utilizing similar claims about the structure of the body and the relation of movement and stoppages to health. Again, however, letter writers found this explanation more appealing than authors. Although blockage was a concern for both, the authors focused on more quantifiable symptoms, costiveness and stopped perspiration, while letter writers reported more nebulous movements.

When referring to external causes of illness, letter writers almost exclusively attributed their exposure to the environment, referring to air and temperature in thirty percent of their descriptions of cause. Both extremes of temperature could be detrimental. Hot air relaxed and opened the pores to potentially cause a loss of vital heat, and cold air constricted and hardened pores which prevented the discharge of waste and excess humours.¹⁰³ This threat was complicated because it was ubiquitous, and required constant attention to clothing and heating in order to regulate exposure to heat and air. Personal accountability is revealed in letter writers’ concern regarding air-based illness, usually attributing sickness to poor decisions which lead to overexposure to cold weather causing illness.

Phoebe Wilkinson reflected this belief in a letter to her brother James while he was in Scarborough in 1772. She depicted how their brother “is much better off this cold wch we imagine he got last Friday at ye funeral of Judith Oats, by sitting several hours in wett cloathes, on Saturday was very ill wth pains in his Limbs & head”.¹⁰⁴ The cold weather, combined with the wet clothing which exacerbated his condition, resulted in illness.¹⁰⁵ Letter writers’ awareness

¹⁰⁰ Welsey, *Primitive Physick*, 101.

¹⁰¹ Tissot, *Advice*, 28.

¹⁰² Buchan, *Domestic Medicine*, 72.

¹⁰³ Cavallo and Storey, *Healthy Living*, 71.

¹⁰⁴ SH:7/LL/200 (Phoebe Wilkinson to James Lister, 30 August 1772).

¹⁰⁵ Other events which occasioned illness included Peregrina Chaytor’s extended walks in “dirty nasty streets” dealing with dissenters (ZQH/9/15/85), Anne Clavering’s half-sister Betty going on an extended airing “wth out a

of the body's response to temperature is particularly striking because it tightly aligns with how Wesley, Tissot, and Buchan identified the threat of perspiration and its stoppage. Their comments were typified by Tissot's comment that the stoppage of perspiration "must occasion some dangerous Complaint. In fact this is one of the most frequent Causes of Diseases".¹⁰⁶

Some letter writers showed evidence of deep engagement with theories of causation, as when John Spencer criticized his sister in 1765 for her ignorance that "the skin's all over Porous, & full of little mouths [destroyed] & ingesting whatever Moisture comes upon it".¹⁰⁷ Spencer used theoretical language in his discussion of pores and, as discussed above in relation to emotion, and explicitly described the effect of good or bad emotions. He was familiar with the theoretical workings and experiential results of illness. The nature of the skin, and its relationship to both sweating and reacting to external moisture, was evident both in theoretical explanations and in wider comments about illness in correspondence. This is proof of a shared conception of the body's health and illness.

Exercise was related to the environment but was the second smallest treatment categories, comprising only eight percent of the total references to illness causes in this study. In some cases, exercise exposed writers to the elements, as when Ann Stanhope noted in 1766 that she "had overfatigued myself, wth too much Exercise, & it brought on a return of my feavourish complaint".¹⁰⁸ However, most exercise related ailments were injuries from activity, such as falling.¹⁰⁹ Neither the danger of overexposure to air through exercise or injury were present in didactic literature, which overwhelmingly assigned positive effects to exercise. Wesley considered "The Power of Exercise both to preserve and restore Health" to be "greater than can well be conceived," and assert the dangers of inactivity.¹¹⁰ Criticism of inactivity marked didactic medical literature as being very distinct from the opinions of letter writers, who never interpreted a lack of activity as a cause of illness. Exercise and inactivity were both rarely

hood, wch gave her Cold" (CLV 16) and Mary Warde's "whole tour of Ranelagh & Vauxhall by water," which again caused a cold. (SPSt/6/1/50).

¹⁰⁶ Tissot, *Advice*, 28. See also Wesley, *Primitive Physick*, ix; and Buchan, *Domestic Medicine*, 98.

¹⁰⁷ SpSt/6/1/94 (John Spencer to Ann Stanhope, 27 April 1765).

¹⁰⁸ SpSt/6/1/80 (Ann Stanhope to John Spencer, 3 June 1766).

¹⁰⁹ For example, see Ann Stanhope's account of how her friend Lady Lowther "open(in)g a wrong door, her foot slipt & she fell betwixt ye Joyce of a floor that was not laid, she hath arash'd her Thigh a good deal" in 1757 (SpSt/6/1/57). Annabella Wentworth reported that she "fell down stairs took all the skin of the tendon Achilles & hurt is, at the back of ye Ankle" in c.1778 (U DDBM/32/3). Ann Robinson wrote that a visit had been delayed in c.1720 because her son was "at present laid up with a swel'd lame foot, which he writes came upon him suddenly by taking a long walk" (WYL150/6006/IV/21).

¹¹⁰ Wesley, *Primitive Physick*, 5; Buchan, *Domestic Medicine*, 65, 317; Tissot, *Advice*, 7.

labeled as threats, particularly when compared to the dangers inherent to the body in air, emotions, and internal movement.

Methods of Treatment

The use of both experience and theoretical models has been evident in the explanations for illness analyzed above. Medical knowledge can also be perceived in the choices which letter writers made about treatments, which comprised forty-nine percent of knowledge displays and represented sixteen percent of the correspondence about illness. As with causes, men made a higher number of statements about treatment (fifty-three percent), but when the number of references within each gender's descriptions of illness is compared, the discussions of treatment were almost equal (twelve percent for men, thirteen for women). The pattern of gendered references by decade can be seen in Figure 4.3 below.

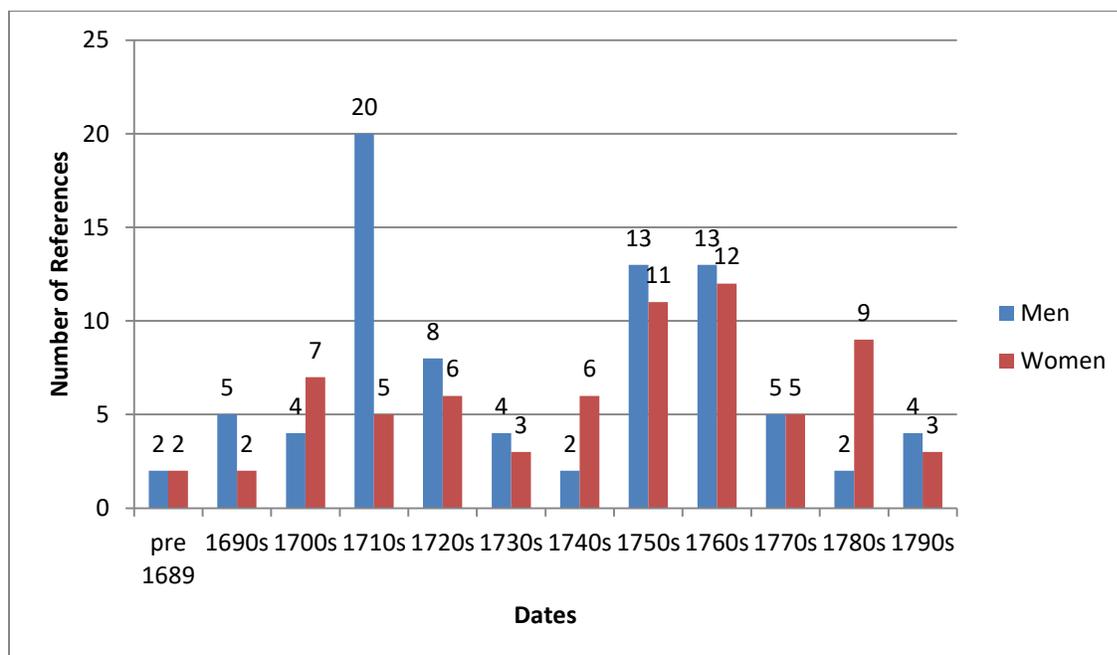
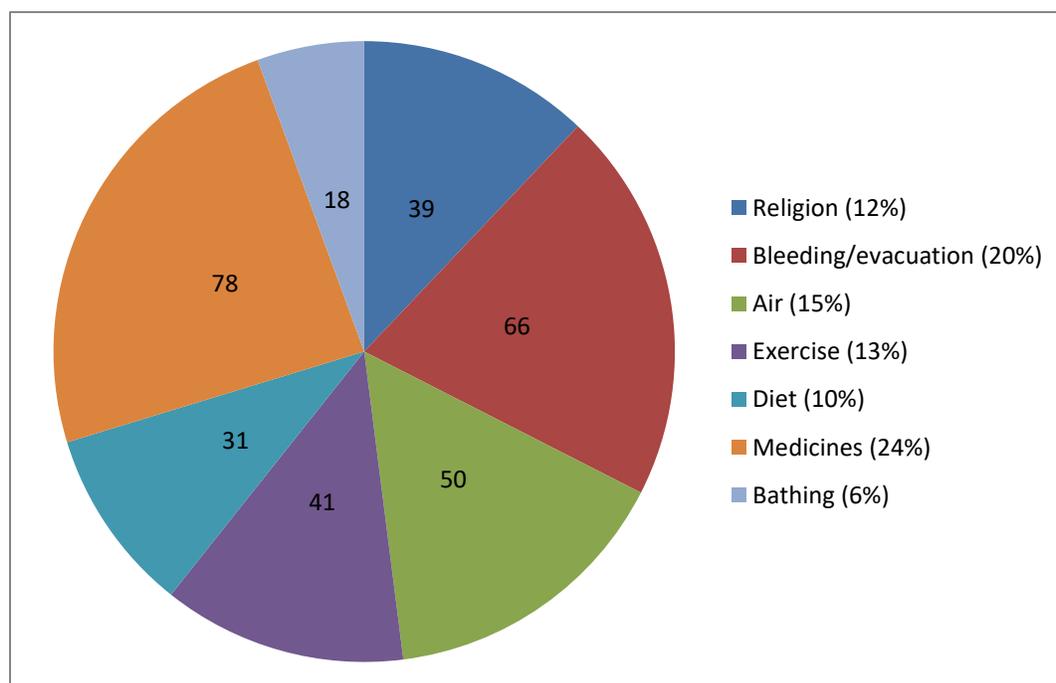
The even spread of references proves that all members of the family were invested in seeking out and evaluating treatments. While caregiving was an activity which was normally performed by women as part of their domestic duties, men were regular participants in the recommendation of treatment because it was an element of managing the entire household and maintaining family health.¹¹¹ There were seven types of treatments, as seen in Figure 4.4, which fall into three umbrella categories : first: rely on religion, second, to begin a course of medicines such as medicaments, bathing, or purging; and third to alter regimens. George Ponsonby expressed this trifecta in a letter to his sister-in-law Louisa in 1792 where he advised that she should use “that careful Diet, as much Air & Modern Exercise as she could take without fatigue”.¹¹² There could also be an overlap between these categories when letter writers thanked God for a cure received while bathing, or supplemented a medical prescription with a change of air or exercise.¹¹³

¹¹¹ Smith, “Relative duties of a man,” 237; Smith, “Reassessing the role of the family,” 330; Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford University Press, 2012):22.

¹¹² GRE/870/9/13 (George to Louisa Ponsonby, 5 June 1792).

¹¹³ Families used a variety of combined treatments. See for example the anecdote with which this chapter opened.” (ZQH/9/17/78). William Robinson wrote to his wife Mary in c.1715 that “I was let blood, & Kept my chamber, eat nothing but water gruel” for his sore throat. (WYL150/6001/24). Phill Harcourt thanked his friend Thomas Grimston for the use of his rooms in 1751 because during Harcourt’s son’s illness, “the weather was violently hott & I was afraid of Infection so remov'd thither, from whence I did prevent his being visited by any Regulars, & gave him Dr James' Powder, which in an almost miraculous manner with Gods blessing recover'd him”. (DDGR/41/1/11). G. Wilmot wrote to his employer Charles Fairfax in c.1760 that he “hope wth a Cool diluting regimen moderate

4.3 – Men and Women’s References to Medical Treatments

Figure 4.4 – Treatments for Illness in Correspondence¹¹⁴

exercise & this Good air,” his health would improve. (SpSt/6/1/109). When A.M. Greame offered to nurse her sister Ann Stanhope in 1784, she also suggested a series of treatments including blisters and foods which would sweeten the blood. (SpSt/6/1/123). References to a combination of diet, air and exercise, cited further in footnote 131 below, were particularly common.

¹¹⁴ References to treatment by decade can be found in Appendix V.

Despite the comparative rarity of references to religious cures, this type of treatment was mentioned in almost every decade. The references are almost all general and could potentially be rote comments, except for explicit references to the importance of religion made within the Catholic Fairfax family's correspondence.¹¹⁵ Ann Fairfax and her father Charles exchanged several letters in 1768 regarding the necessity of Ann submitting to God's will in her illness, including Charles' lengthy recommendation that she "resign your self to his Holy will, consider how many suffer much more, and lett me beg of you to submite to his holy will" before considering with extensive religious imagery of submission.¹¹⁶ Explicit religious language was absent both from recipe books and prescriptive literature, which largely focused on practical treatments. Even the Methodist John Wesley's comments that God's love "effectually prevents all the bodily Disorders the Passions introduce" were tempered by the emphasis on practical treatments in the body of the text.¹¹⁷ Both letter writers and medical authors focused on physical, experienced treatment processes.

Letter writers most frequently chose to select a medicinal treatment for their conditions, rather than a regimen or prayer. The preference for taking medicines was echoed in the composition of recipe books and prescriptive literature, which focused on making or selecting appropriate medicines. Despite the selection of medicines, letters rarely contained explicit information about the prescriptions which cured them. Drinking medicinal waters was the most popular type of medical treatment, ranging from imported or purchased treatments such as spa waters to household preparations such as varieties of tea. William Chaytor used teas to immediate effect during an illness while he was imprisoned for debts in 1701, noting that "by the help of sage tea I was able to write a pretty long letter before night".¹¹⁸ The prioritization of

¹¹⁵ Such comments include Elizabeth Rawdon's comments to her "deer nece" in c.1690 that "I am sore to heare my nece is so ill I pray God she may recoffer it and life to have joy of what she bring". (SpSt/6/1/13). John Spencer's comments to his sister Ann that "I am now I thank God, a great deal better" from an episode of gout in 1765 (SpSt/6/1/86). J. Robinson's comments to William Chaytor in 1767 when his children were being inoculated that "Pray God send them well and safe thro" (ZQH/10/50/51), or Mary William's comment to James Lister in 1771 that "I have been not very well in a bad cold, & sore throat, but am god bethank'd better". (SH:7/LL/190).

¹¹⁶ ZDV(F) VI 12/ (Charles to Ann Fairfax, 29 July 1768).

¹¹⁷ Wesley, *Primitive Physick*, xxiii.

¹¹⁸ ZQH/9/14/3 (William to Peregrina and Ann Chaytor, 17 January 1701). Most of the medicines were spa waters or other medicinal drinks. The Chaytors also had a small medicinal well on their property at Croft, and both regularly drank its waters: William both commented how he "long for a bottle of my spaw water" and informed a woman that if she drank it "it would cure her of the vapours" in 1701 (ZQH/9/14/100), and later that year Peregrina criticized her husband for sharing the water and her ale, asking him "if you doe not keep it till I com up as saveingly as can be what will becom of me for I must drink of it with wayter the twon drink not being good for me nether is botteld drink good for my wienddy body". (ZQH/9/14/122). C. Collingwood's report to her brother Ralph Salvin in 1714 of

simple medicines was supported by all four authors of the prescriptive texts. It is also evident in each of the recipe books, which contained multiple brief recipes included household ingredients, such as “For ye gout in ye Stomack. /// Boil half a handfull of tansie in half a pint of strong white wine, & drink ye decoction as hot as possible. It will remove ye pain in less than a quarter of an hour”.¹¹⁹ This treatment capitalized on the belief, shared by others such as Ann Robinson, that the symptoms of gout focused on pain and could be present throughout the body.¹²⁰ Despite the regular references to medicines, there was a diversification of treatment choices in the second half of the eighteenth century. Prior to 1750, medicines represented at least over twenty percent of the references to treatment, and this number dropped significantly after 1750, never again surpassing twenty-three percent.

The declining popularity of discussing medicaments is evident in the decreasing rate of including recipes in letters. This change is partially a result of the increasing diversification of treatments, particularly the greater references to regimen in the second half of the century. The absence of recipes from correspondence indicates that at the same time, recipe sharing was eliminated from the popular discourse of medicine. While families preserved treatments at home, they became more likely to suggest behavioural changes or spa visits than medical preparations. There are only sixteen letters which refer to the writer’s intention of including a recipe, representing twenty-one percent of the comments on medical treatment and 1.7% of the comments on illness in my collection of gentry letters. Fourteen of these letters (88%) were composed before 1755, and the final two letters which included a prescription were dated 1768.

All of the recipes in correspondence responded to news of an incident of illness in a previous letter, and were appended at the end of a letter which also discussed familial and social

the practitioners recommendations for his daughter’s scald head that “Isu (sic) in each armes & a purge once in five days & to drinck nothin but Sack mix’d wth the Germain spaw waters asses milke in the mornings & the wood tea in the afternoons; & to contineu, in this course of physick for some months,” which she evaluates to have “hitherto agreed extraordinary well wth her; so am in great hops that will make a perfect cure, in less time, then we imagined”. (D/Sa/C 43.6). Father Thornton depicted the treatment efforts of John of Berrington in a 1722 letter to Marmaduke Constable: Berrington had developed a sore after horseback riding and “has been already some time endeavoring what with diet drinks Tisans & Mercurial boluses to settle the swelling, but with no success”. (U DDEV/60/84/XVII). After his sister Ann finished taking a spa treatment in 1734, John Spencer wrote and asked “I would have you bring 6 bottles of Sulphur Water home, wch yr succellable Bottles will serve for”. (SpSt/6/1/50). Alicia Greame’s recommendations that her sister Ann Stanhope treat an eye inflammation in 1784 with “Cheese Whye, or Blew Milk Crack’d wth Vergimice is reckon’d very gt sweetner of the Blood, wch you are find of ye Spring Juicy- I woud let wthey be my Constant Liquor-“ (SpSt/6/1/123).

¹¹⁹ WHA.88 p. 58.

¹²⁰ Ann Robinson described “my old pains in my stomach & feet &c, which I always thought ye Gout” c. 1720 in a letter to her brother (WYL150/6006/IV/21).

news. For example, Mary Warde wrote two pages of news and a discussion of family events to her aunt Mary Stanhope in 1739 before appending a simple recipe “To Make Eye Water” on the third page.¹²¹ These recipes were brief and simple, as in the recipe collections of the Whartons and Carrs. In addition, recipes might be absent from archival collections because they were separated and preserved in a different area, as was the case for the Hedgeley Recipe Book. Despite the decline of recipes in correspondence, the Wharton and Hedgeley books exhibit that recipes were still being valued and collected in homes in the second half of the eighteenth century.

Letter writers also used the humourally-grounded treatments of bathing and bloodletting, sometimes in tandem, to effect changes on their bodies. Bathing was the second largest category after medicaments. Letter writers both depicted their bathing regimen, and disagreed on its practice.¹²² Bathing functioned by a combination of drinking purgative waters from the spa and regular exposure to the waters, either for the full body or the afflicted part, to the medicinal waters. Hot water would open the pores and allow purgation, and cold water would close the pores and create a closed system. Metcalfe Robinson dismissed the advice of his mother Mary in the early decades of the century, writing that “I don’t think you judge right of my case, when you advise me to try ye hot Bath again, for I’m satisfied the more I should use it [the bath] at this time of year, the harder I should find it even to get quit of my colds”.¹²³ The Hedgeley recipe book also integrated advice on bathing. Writing to “madam” on the subject of “Miss Carr”’s poor health, Charles Brown observed that if the Carrs observed a “change for the better” following Miss Carr’s consumption of Sulphur waters, he “woud then recommend her going into the warm bath occasionally”.¹²⁴

Similarly, purges, particularly bloodletting, had traditionally been a fundamental element of humoralism, used to purge “bad” or excess blood and restore internal balance. The process remained popular throughout the eighteenth century, though slightly less so in the later decades

¹²¹ SpSt/6/1/50 (Mary Warde to Mary Stanhope, 20 July 1739).

¹²² See Phyllis M. Hembry, *The English Spa, 1560-1815: A Social History* (London: Althone, 1990).

¹²³ WYL150/6004/7 (Metcalfe to Mary Robinson, dated 19 September). William Chaytor reported to his wife in 1701 that their friend Nancy Tullie “goes again for the bath to stay, she says, but a fortnight while he goes into the north, and sayes its for health and she will not take a servant to her”. (ZQH/9/14/114). David Hartley approved of John Lister’s bathing trip in 1742, writing that “I heartily wish you success at Scarborough both in bathing & drinking, & approve them both, at least to be tried”. (SH:7/HL/27). Martha Lister exhibited the regular use and knowledge of bathing when she wrote to her brother James that she had feared that her daughter “wou’d not find that benefit from change of Air and sea Bathing we wish’d and expected” in 1789 (SH:7/LL/274).

¹²⁴ Within the Hedgeley Recipe Book in a letter dated only “Friday morning five o clock”.

than in the earliest years of this study, while phlebotomy continued to be an accepted medical treatment well into the nineteenth century.¹²⁵ Responding to comments about a high level of head and eye disorders in Ann Stanhope's neighborhood in an undated letter, her sister Alicia-Maria Greame wrote that "Blisters either on ye top of the Head, or being the Ears, have been frequently prescrib'd, & have had the desird Effect [...] ye Discharge they make by laying on a long time I shoud imagine woud be of great service to you".¹²⁶ The volume of information provided by Alicia-Maria was likely partially a product of the regular illnesses which confined herself and her husband William to their home in Sewerby. The Hedgeley collection also used bleeding as a treatment without combining it with other practices, such as recommending "very quick Bleeding wt a leech or even wt the Lancett will be absolutely necessary as well as the continuing the use of purges & glysters" for an inflammation of the bowels.¹²⁷

The response of medical writers to bathing and bloodletting reveals a significant area of disharmony between the two types of sources. While letter writers frequented warm baths as regularly as they undertook cold bathing, prescriptive literature exclusively endorsed cold waters. Wesley commented that "Cold-bathing is of great Advantage to Health. It prevents Abundance of Diseases," and both Tissot and Buchan recommended cold baths in specific incidents.¹²⁸ The authors were equally critical of current bloodletting and purgative practices. For example, Tissot argued that "Infinite Mischiefs" were caused by early purgation.¹²⁹ Buchan endorsed bloodletting but claimed that it was a misunderstood practice, observing that "no operation of surgery is so frequently necessary as bleeding. But [...] very few know when it is proper".¹³⁰ The dispute then was not so much a difference between correspondents and authors as to the proper means of treatment, but a belief by authors that the practices were too complex or mismanaged by lay medicine, and instead should be left to practitioners. By teaching lay

¹²⁵ See Appendix IV for a chart of treatments by decade which shows that bloodletting represented at least ten percent of treatments in most decades. S. Helen King establishes how "green sickness" was attributed to the popularity of bloodletting for gynecological disorders into the nineteenth century in *The Disease of Virgins*, 125.

¹²⁶ SpSt/6/1/123 (A.M. Greame to Mrs. Stanhope, 8 April). Anne Clavinger also commented in 1710 that her frustration had agitated her to the extent that "almost apprehend yt might add to ye necessity of my loosing some of my giddy blood" (CLV 46). Commenting on the pleasure of Ann Fairfax's company to her father Charles, Helen Gascoigne noted that in 1768 Ann "was let blood the night before she received your Lordship's orders for her removal". (ZDV(F) VI 12). In 1770, Phoebe Wilkinson told her nephew James Lister that "loosing a little blood will be a means to cool you". (ZDV(F) VI 12).

¹²⁷ Hedgeley Recipe Book

¹²⁸ Wesley, *Primitive Physick*, 20; Buchan, *Domestic Medicine*, 428; Tissot, *Advice*, 428.

¹²⁹ Tissot, *Advice*, 57.

¹³⁰ Buchan, *Domestic Medicine*, 441.

readers how to identify the signs of illness, physician-writers also expected that this process would make clear the boundaries of lay medicine and exhibit the specialism and necessity of medical practitioners.

The modification of regimens comprised a significant category of treatment decisions, representing nearly a third of the comments letter writers made about treatment. This emphasis on regimen was also present in the prescriptive literature. Culpeper was distinct in that his text focused on herbs and their benefits, and therefore provided advice only on some elements of diet. Wesley, Tissot and Buchan each included sections which provided regimen advice. Wesley integrated a summary for rules of health “transcribed from Dr. Cheyne” in his introduction, and Tissot and Buchan devoted chapters to the benefits of good regimen. However, letter writers did not utilize the full range of regimen options. They strongly prioritized treatments which incorporated changes to air, exercise, and diet. Emotions were mentioned, as discussed above, but largely functioned as causal agents or within comments to maintain good cheer. Sleep and cleanliness, both of which were the subjects of chapters in Buchan’s *Domestic Medicine*, were largely absent from letter writers’ discussions of health. This proves that letter writers were making decisions about what types of regimen were most useful or beneficial, and discussing their choices and the efficacy of their treatment in correspondence.

Although the three elements of regimen interacted and were often referenced together, there was a difference in how commonly they were mentioned.¹³¹ The largest regimen treatment category was environmental. John Spencer’s comments in 1756 that “I hope he has nothing farther to do now than to take a little Cannon Hall Air to perfect his Recovery,” reveal two methods of airing: either the change of location, or simply going outside, often with gentle exercise.¹³² The desire to appropriately interact with air manifests concerns about the dangers of air expressed in the previous section. This exercise could be seen in comments such as Thomas Wentworth’s comment in 1736 that his indisposition was “almost quite removed by a short

¹³¹ Examples of the combined regimen references include G. Wilmot’s hope that the weather would hold so that his employer Charles Fairfax could “take a little Physick, but likewise to take the Air and use a little Exercise” (ZDV(F) VI 12/129). John Spencer recommended to his sister Ann Stanhope that “a regular Course of Medicines, Diet, Exercise &c with a due Proportion of Patiance & Perserverance” would restore her health in 1765 (SpSt/6/1/83). George told his sister Louisa that he believed their sister Harriet would be healed by “that careful Diet, as much Air & Modern Exercise as she could take without fatigue, frequent chance of Place, & every thing that could amuse & keep up her spirits”. (GRE/870/9/13).

¹³² SpSt/6/1/58 (John Spencer to Sister Stanhope, 17 September 1756).

ramble I took into Wiltshire, a much easier and better remedy than is to be found in any othecary's shop".¹³³

Exercise was explicitly and favourably compared to medicines, being both "easier and better". This was both an element of discourse and an acknowledgement that gentle movement had less impact on the body than the relatively harsh purgative medicines favoured in the early century. Finally, diet changes were the least frequently referenced, and often served to prepare the body for other treatments, as when Mrs. Collingwood wrote to her brother Ralph Salvin regarding his daughter in 1714 that "I'm sure she has not ate too onces of flesh & I think she's much better for it".¹³⁴ Medicine was made more effective by the food which supplemented it. Preparatory food was also one element of a recipe in the Wharton book, which recorded the advice "From [Captain?] Vane" that "Before you take any medicine for gravel or stone, it is good to use a smoothing diet for some days" with a list of suggested food items.¹³⁵ In this case, the body was made receptive by focusing on foods which "smoothed" because of their texture as soft and slippery. Didactic authors also made comments about the efficacy and benefit of the treatments. For example, Buchan observed that "No medicine is so beneficial to the sick as fresh air. It is the most reviving of all cordials, if it be administered with prudence".¹³⁶ John Wesley commented in his introduction that "The Power of Exercise both to preserve and restore Health, is greater than can well be conceived."¹³⁷ All four medical authors recommended food which was easily accessible and provided nourishment.¹³⁸

Case Study: Agues

Ague is an appropriate case study with which to reflect further on the accounts in which knowledge was used to understanding and treating illness. Also known as "intermitting fevers" because their primary symptom was regular intervals of fever, agues were one of the most common complaints in this sample of gentry correspondence. They were also seen as distinct from other types of fevers. For example, William Buchan stated that "No person can be at a loss to distinguish an intermitting fever from any other, and the proper medicine for it is now almost

¹³³ U DDBM/32/4 (Tho Wentworth to Thomas Hapnell, 23 November 1736).

¹³⁴ D/Sa/C 43.4 (Mrs. Collingwood to Ralph Salvin, dated 1714).

¹³⁵ WHA.88 p. 99.

¹³⁶ Buchan, *Domestic Medicine*, 59; and Tissot, *Advice*, 33, 35-7.

¹³⁷ Buchan *Domestic Medicine*, 109; Tissot, *Advice*, 75.

¹³⁸ Culpeper, *English Physician*, ix; Wesley, *Practical Physick*, xix; Tissot, *Advice*, 68; Buchan, *Domestic Medicine*, 47.

universally known”.¹³⁹ When recounting her summer at Great Cossingham in Norwich to her aunt in 1742, Mary Warde wrote that she had been bothered “with Fevers agues & other complaints”.¹⁴⁰ This indicates that agues were established as a specific illness which required different treatment than fevers, because although it shared many of the symptoms of other fevers, Warde detailed the two side by side, as separate incidents.¹⁴¹ Agues are one of the most regularly referenced diseases with a distinct identity, and therefore serve well for comparing discussions of one illness in a range of sources.

Agues were not necessarily severe: Buchan commented that, with the right regimen and location, “there is seldom any danger from allowing it to take its course.” However, a mistreated ague could develop into a more severe malady, such as Jaundice or a number of “slow wasting Fevers”.¹⁴² In addition to the comparisons made possible by references to ague by a range of letter writers, agues were one of the few diseases which also appeared in each of the sources used previously in this chapter.¹⁴³ The sources which have comprised the bulk of this chapter have been supplemented in this section by a further selection of prescriptive literature in order to evaluate the extent of shared understandings of diagnoses and treatments for ague. Comparing multiple sources in a discrete case study will provide a test case for the conclusions suggested in the previous sections of this chapter about the coherence of medical ideas across a variety of genres.

Letter writers referred to agues and intermittent fevers with varying levels of specificity in sixteen cases throughout the eighteenth century, but rarely provided a definition or list of symptoms for the illness. Instead, they emphasized the passage and successful cures of illness, as when John Lister wrote from Cambridge to his parents in 1728 that “I don’t imagine yt there’s any danger in my Illness but wt proper Means & a little Time will conquer, neither wd I have you be anyways uneasy, an Ague in Autumn is a little dangerous, but a spring-Ague is seldom so”.¹⁴⁴ This exhibited the belief stated by Tissot and Buchan twenty years earlier that the season

¹³⁹ Buchan, *Domestic Medicine*, 117.

¹⁴⁰ SpSt/6/1/50 (Mary Warde to Mary Warde-Stanhope, 26 September 1742).

¹⁴¹ Similar differentiations and separate treatments recommended for agues than other fevers occur in prescriptive literature.

¹⁴² Buchan, *Domestic Medicine*, 117-118. For Tissot’s argument, see *Advice*, 274-6.

¹⁴³ “Colds” had an uncertain diagnostic identity, and Tissot’s decision to omit chronic conditions further excluded many of the most frequently referenced diseases.

¹⁴⁴ SH:7/RL/59 (John Lister to parents, 06 April 1728).

affected the severity of the ague, and that summer agues were not dangerous.¹⁴⁵ Prescriptive literature was largely more explicit in definitions. Prior to the eighteenth century, authors focused on the internal features of the treatment. For example, Michael Etmuller explained agues as the “fermentation, and agitation of the blood and spirits”.¹⁴⁶ In 1728, Peter Shaw’s approach was indicative of a shift that would proceed through the rest of the eighteenth century which was characterized by a focus on external symptoms of shivering, heat, and sweats, rather than internal causes and highlighting the cyclical nature of the condition.¹⁴⁷ Decades later, Wesley, Tissot and Buchan offered similar evaluations of the disease.

Three letters present the belief that agues were potentially unthreatening, that personal constitution lessened the risks, or that simple treatments restored their health. For example, an undated letter to Marmaduke Constable chronicled how “the sharpness & purity of our air from an uninterrupted undulation preserves our Constitutions sound & vigorous”.¹⁴⁸ Metcalfe Robinson similarly underlined strong constitutions when he observed in the early eighteenth century that the family friend “poor Mr Franklands had been seiz’d this afternoon with a fit of the same sort of ague but I can’t fear it will have any ill effects upon him, he being more temperate in every thing, than any body I know”.¹⁴⁹ This correlates with the comments made by prescriptive authors about how some agues did not require treatment, but instead could be managed with patience and adaptations to regimen. Metcalfe Robinson later wrote to his mother from London, where he spent most of his time in the 1710s. He highlighted his social life with the attendance of a play and drives with friends before outlining how he “drank a spoonful of

¹⁴⁵ Tissot, *Advice*, 281; Buchan, *Domestic Medicine*, 121.

¹⁴⁶ Michael Etmuller, *Etmullerus abrid’g: or, a compleat system of the theory and practice of physick. Being a description of all diseases incident to men, women and children. With an account of their causes, symptoms, and most approved methods of cure, both Physical and Chivrgical. To which is prefix’d a short View of the Animal and Vital Functions; and the several Vertues and Classes of Med’cines. Translated from the last edition of the works of Michael Etmullerus, late Professor of Physic in the University of Leiptsich. A Book very proper for Families. The second edition, corrected and much improv’d.* (London, 1703): 168.

¹⁴⁷ Peter Shaw, *A New Practice of Physick; wherein the various diseases incident to the human body are orderly described, their causes assign’d, their diagnostics and prognostics enumerated, And the Regimen proper in each deliver’d; With a competent number of medicines for every stage and symptom thereof, prescribed after the manner of the most Eminent Physicians among the Moderns, and particularly those of London. The whole formed on the Model of Dr. Sydenham, and compleating the Design of his Processus Integri.* In two volumes. (London, 1726.)

¹⁴⁸ U DDEV/60/84/XV (unsigned, undated).

¹⁴⁹ WYL150/6005/7 (Metcalfe Robinson dated 29 September).

Stoughton in a pint of sage Tea & sweat all night” to cure himself of an ague, reflecting the popular concern in both lay and prescriptive discussions of illness for simple treatments.¹⁵⁰

When advocating for simple cures, medical authors across a range of sources recommended both internal and external treatments. In the mid-eighteenth century, it was very common, particularly in Culpeper’s but also in Wesley and Sarah Harrison’s work, to make use of local herbs. This included treatments such as Culpeper’s suggested use of broomrape, coltsfoot, and featherfew,¹⁵¹ Wesley’s recommendation of “yarrow, onions, or chamomile”,¹⁵² and Sarah Harrison’s advice that her readers drink a combination of onion, nutmeg, strong beer, and brandy when a fit came on.¹⁵³ The second type of treatment was external, and encompassed both hot and cold treatments. For example, the Wharton recipe book recommended in “a cure for an Ague” that the reader

Take a small quantity of black soap; About ye bigness of a large nutmeg, half a spoonful of pepper beat very small, a spoonful of aquavite, as much wheatflower as will make it into a stiff paste, mingle all these together, & put it into two little linnen bags & tye it hard to the coresh, chafting them well before with white wine vinegar. They must be laid on ye night before ye fits comes, & keep them on nine days.¹⁵⁴

Similar advice could be found in Lover of Mankind’s recommendation that Grounsel should be put in a bag and worn “on the Pit of the Stomach, renewing it two Hours before the fit”.¹⁵⁵ External treatments were also popular within the emerging school of hydrotherapy, and both

¹⁵⁰ WYL150/6007/3 (Metcalf to mother Mary Robinson, undated). G.H. Hinchliffe describes how after returning home from France in 1713, Metcalfe lived in the capital until his declining health caused him to return to Newby in the 1720s. “The Robinsons of Newby Park and Newby Hall,” *Yorkshire Archaeological Journal* 63 (1991): 137.

¹⁵¹ Culpeper, *English Physician*, 88.

¹⁵² Wesley, *Primitive Physick*, 30.

¹⁵³ Sarah Harrison, *The house-keeper’s pocket-book, and compleat family cook: containing above twelve hundred curious and uncommon receipts in cookery, pastry, preserving, pickling, candying, collaring, &c., with plain and easy instructions for preparing and dressing every thing suitable for an elegant entertainment, from two dishes to five or ten, &c., and directions for ranging them in their proper order. Seventh edition, revised and corrected.* Printed for C. and R. Ware, 1757), 2, <https://catalog.hathitrust.org/Record/009712888>

¹⁵⁴ WHA.88 p. 61.

¹⁵⁵ Lover of Mankind, *Nature the best physician; or, Every man his own doctor : Containing rules for the preservation of health and long life; from infancy to extreme old age. To which are added a collection of natural, simple and palatable receipts for the recovery of health, to those who are already afflicted with any of the various disorders incident to the human body, not only such as are easy to be purchased by persons of the lowest capacity; but proper for those in higher stations, who loath nauseous and unwholesome foreign drugs.* By A Lover of Mankind, who has made the study of the human constitution his principal employment upwards of twenty years[.]. (Dublin: Printed by James Hoey, Senior, at the Mercury in Skinner-Row, 1772):26 and printed in London (for J. Cooke, at Shakespear’s-head, c.1790), 24.

Wesley and Lover of Mankind recommending that the reader enter a cold bath before the fit began.¹⁵⁶

Despite the medical publishing narrative which suggested simple and local treatments, one course of treatment dominated medical discussions on ague: the new-world plant called “Peruvian Bark” or “Jesuit’s Bark”. In their accounts of treatment, letter writers were remarkably consistent in their recourse to this treatment. For example, in a letter to his son Metcalfe, William Robinson reported how “I am beginning again with ye bark, having had a return of my Ague”.¹⁵⁷ Of the seven cases in which a cure is named, six referenced Jesuit’s Bark or powder. The bark could be taken alone, as William Robinson had done, or in conjunction with other treatments, as in 1767 when Jame Robson described to Henry Vane how he remained in Durham because he was “not yet so recovered as to venture upon a London journey but hope the Bark with a little air and exercise will enable me soon to do it”.¹⁵⁸ The coherent preference for Jesuit’s bark establishes a contemporary relationship between fever and bark, analyzed by Woulter Klein and Toine Peters in the Dutch and French context.¹⁵⁹

The eighteenth-century letters in this study integrated a foreign, new-world product through the culmination of several decades of discussion and increasing confidence in the bark by medical authors. The references to using the bark occurred in correspondence as early as 1690. The bark was a product of increased availability of the treatment because, as Harold Cook contends, the Jesuit distributional monopoly of the bark was broken in 1670 and the product became both more affordable and more popular.¹⁶⁰ In late seventeenth-century prescriptive literature, such as John Archer’s and Michael Etmuller’s manuals, the bark was still dismissed as a treatment in favour of proprietary or local cures.¹⁶¹ The eighteenth century, however, saw increasing confidence in the bark, and by the 1730s, Peter Shaw and John Allen presented

¹⁵⁶ Wesley, *Primitive Physick*, 29; and Lover of Mankind. *Nature the best physician*, 26.

¹⁵⁷ WYL150/6002/20 (William to Metcale Robinson, 29 September).

¹⁵⁸ D/Lo/F 218(4) Jame Robson and comp. to Henry Vane, 20 January 1767).

¹⁵⁹ Woulter Klein and Toine Pieters, “The hidden history of a famous drug: tracing the medical and public acculturation of Peruvian Bark in early modern western Europe (c.1650-1720),” *Journal of the History of Medicine and Allied Sciences* 71.4 (2016): 4.

¹⁶⁰ Harold J. Cook, “Markets and cultures: medical specifics and the reconfiguration of the body in early modern Europe,” *Transactions of the RHS* 21 (2011): 133.

¹⁶¹ John Archer, *Every Man his Own Doctor. In two Parts* (London: Printed by Peter Lillicap, 1671): 137; Etmuller, *Etmuller’s abridg’d*, 187-8.

Jesuit's Bark as the most effective treatment for agues.¹⁶² Tissot and Buchan followed this trend and depicted Jesuit's Bark as a treatment which "infallibly cures these fevers".¹⁶³

Preference for Jesuit's Bark persisted through the remainder of the eighteenth century. However, later didactic literature and recipes also took care to articulate how Jesuit's Bark worked alongside the simple recipes of earlier authors. Sarah Harrison's five recipes for the ague included two uses of "Bark," to be mixed either with Snack-root and Wormwood, or with Honey and Maidiehair, along with her simple recipes outlined above.¹⁶⁴ Similarly, John Theobald's 1766 publication which provided a series of treatments based on "the best Peruvian bark powdered," which he called a "certain and infallible Cure".¹⁶⁵ The Hedgeley recipe also recommended using the bark, writing that the reader should

Prepare the Stomach by taking a Vomit / Jesuits Bark powdered 1 ounce / Salt of Wormwood 1 dram / Sulpher a 4 of ounce / A large Nutmeg grated / As much powdered ginger as will ly on a shilling. / Cinnamon [sic] cloves & mace of each a pennyworth powdered.

Mix them al into an Electury with teckle & take the quantity of Claret [inserted above: "or port"] after each dose begin to take it immediately after ye fit is off. / During the time, of your take it, eat no garden stuff drink no small bear or water; when all is taken rest 6 days yn take ye above quantity again as directed.¹⁶⁶

The Hedgeley recipe does not suggest using the Jesuit's Bark in isolation, as Buchan does in *Domestic Medicine*. Instead, the bark is one component of a detailed, multi-step cure which began before the illness and followed for several weeks after. The recipe featured primarily local or household ingredients, such as nutmeg, treacle, and claret, while also suggesting dietary and lifestyle modifications. Recipes produced later in the eighteenth century make use of Jesuit's Bark as a more effective ingredient than other herbs of a similar type, but also situate it within a landscape of necessary treatment. The final result was a preference for treatments which

¹⁶² Shaw, *New Practice*, 137; John Allen, *Dr. Allen's Synopsis medicinae: or, a brief and general collection of the whole practice of physic. Containing the Opinions and Judgements of the most Celebrated Authors, concerning Diseases, their Causes, and Remedies. With Most Cases in Surgery and Midwifery. To which are added, Some Observations very rare and uncommon: and a Curious Treatise on all Sorts of Poysons. In two Parts. Translated from the last edition, which is enlarged one third part, by a physician (London: printed for J. Pemberton, at the Golden-Buck in Fleetstreet, and W. Meadows, at the Angel in Cornhill, 1730): 12.*

¹⁶³ Tissot, *Advice*, 274; Buchan, *Domestic Medicine*, 119.

¹⁶⁴ Harrison, *The house-keeper's pocket-book*, 2.

¹⁶⁵ John Theobald, *Every many his own physician. Being, A complete Collection of efficacious and Approved Remedies, For every Disease incident to the Human Body. With Plain Instructions for their common Use (London: W. Griffin, in Catherine Street, 1766): 2.*

¹⁶⁶ Hedgeley Recipe book.

combined simple, foreign, and regimen practices in response to a recurring and potentially serious illness.

The various treatments for agues expose continuity and change in the understandings of diseases across the eighteenth century. Focusing on how agues were treated across a range of sources reinforces the conclusions of the previous chapters. The relative silence of letter writers on the causes and symptoms of ague indicate the preference for letter writers to discuss treatment over causes by a firm margin. The treatment of agues emphasizes wider themes in managing illnesses. Prescriptive literature, recipes, and letter writers in particular overwhelmingly preferred herbal treatments, and frequently offered a series of complimentary treatments which could be taken concurrently. The illness also offers an opportunity to trace the integration and increasing popularity of a new herb into medical thought. From the dismissive origins of Jesuit's Bark in the seventeenth century, the treatment grew in popularity across the century and was eventually and incorporated into household medicine through the Hedgeley Recipe Book. Agues demonstrate the complex relationship between changing medical ideas and the analysis of lay medical practice.

Conclusion

To make statements about the severity of her cough and the efficacy of a range of treatments, Ann Chaytor synthesized a range of information which she gained from experience and her expectations of how a healthy body would feel. She extrapolated this knowledge to evaluate a future course of treatment. Ann's confident marshalling of her symptoms and treatments typifies the interaction between the discourses of letter writing and medicine. Correspondence throughout the eighteenth century exposes a process of compiling, evaluating, and comparing sources of information. These examples include Ann Chaytor's evaluations of her symptoms and efficacy of treatment in 1709, Ann Stanhope's association of her exercise with "overfatigue" and the return of her "feavourish complaint" in 1766, and George Ponsonby's advocacy of diet, air and exercise in 1792.¹⁶⁷ Throughout the century, letter writers demonstrated that they understood why they were sick and how they made choices to become well again.

¹⁶⁷ ZQH/9/17/78 (Ann to William Chaytor, 22 March 1709); SpSt/6/1/80 (Ann Stanhope to John Spencer, 3 June 1766); GRE/870/9/13 (George to Louisa Ponsonby, 5 June 1792/).

The shared points of knowledge between correspondence, prescriptive literature, and recipe books manifest Smith and Schmidt's suggestions about the "shared and collective nature" of knowledge.¹⁶⁸ However, correspondence, prescriptive literature, and medical recipe books did not present identical discourses. While information was usually collective, the process of prioritizing and decision making varied. For example, though correspondents and prescriptive literature offered similar rhetoric on the dangers of bad air and the benefits of "taking the air," correspondents referred to this theme less regularly than the prescriptive literature which ascribed to it the highest importance. They were using similar logic to understand illness, but professional and lay perceptions found different methods more appealing. The same features can be found in the case of agues, in which the Jesuit's Bark gradually gained popularity and became instilled in popular treatment practice.

Compared to the strong elements of gendering in nursing in which women dominated the caregiving work despite evidence that men could and occasionally did care for the sick, both men and women demonstrated knowledge of the causes of illness and the appropriate methods of treatment. Medical knowledge was necessary both for caregiving, as established in the previous chapter, and in evaluating the health of the home and seeking external practitioners, as will be discussed in the next chapter. The types of knowledge also remained largely consistent throughout the century, despite historians' suggestion of the shift away from humoralism to sympathetic medicine in the mid-century. In particular, humoralism survived in explanations for illnesses such as the danger of air and emotions, which were both difficult to control and capable of influencing the internal balance of fluids, and in treatments such as bloodletting. The gradual change towards sympathetic medicine re-emphasized the significance of moderation and self-control which had been necessary in humoralism. As a result, letter writers increasingly recommended and practiced regimen-based treatments by taking the air, exercising, and modifying their diets as the century progressed.

Other methods in which illness was measured and evaluated had similarly subtle effects on the discourse of medicine in letters. Studying the varied rates of response of various sources to changes in theory and methodology reveals the inaccuracy of any polarizing statements about this century. Instead, some sources were more susceptible to changes, as when prescriptive literature became more descriptive than theoretical in light of the new usages of experience, or

¹⁶⁸ Smith and Schmidt, "Introduction," 7.

more interested in using multiple theories, as seen in the coinciding appearances of Galenic and nervous medicine in correspondence. Neither Cunningham and French's claim for minimal change, nor Wear's explanation of the increasing fragmentation of medical theory accurately capture the practices of the letter writers in this study.

The resulting balance of different sources, authorial decisions, and rhythms of continuity or change underlines the complexity of the landscape of eighteenth-century medical thought. The integration of the new theories could be traced to modifications in the language which described illness, as in the transition from labeling humours to nerves. However, the underlying context remained largely consistent across different types of sources and the same treatments were used under the new medical model. Evaluating the similarity between information contained in different sources is complicated by the range of intentions and the process of evaluating information undergone in multiple texts. The information compiled through experience and used to discuss cause and treatment could then be used to make decisions about the appropriate management of illness. Letter writers' use of medical knowledge and skills can be seen in their use of medical expertise. Managing illnesses in the home and controlling the process of acquiring practitioner assistance through medical expertise is the subject of the next chapter.

Chapter Five — Household Medical Expertise

In August 1757, Walter Stanhope had been at Bath for three months, taking advantage of the range of medicinal water treatments in order to alleviate the pain and swelling in his knees caused by gout. In a letter to his wife, Ann, he observed that his progress was not as thorough as hoped, and that he found himself “not near so stiff, but very weak”.¹ Ann responded that this piece of information

gives me great satisfaction to hear you amend, tho’ ‘tis but slowly, as to your being weak I think tis easily recounted for, yr frequent Bathing and staying in so long, must weaken any Constitution, and more considerably affect yours, wch has been brought so low by bad Health.²

This letter and the eighteen other surviving letters which make up the correspondence between Walter and Ann Stanhope whilst he was receiving treatment at Bath in 1757, are demonstrative of the medical expertise imbedded within spousal conversations about medical choices. Ann framed her arguments on the threat to Walter’s health around her personal knowledge about medical treatments and her husband’s own constitution.

Ann’s confidence in her own advice was striking because it was in conflict not only with Walter, but with Walter’s physician in Bath. Dr. Hartley had recommended that Walter “Bathe of Saturday and continue it 3 times a week” and “talkd of you staying 2 months there”.³ The negotiations between Ann, Walter, and their physicians are an example of the eighteenth-century gentry’s navigation of what Dorothy Porter and Roy Porter have referred to as “the rich, variegated and open-ended relationships” which constituted medical interactions that “could never have existed had lay people not felt competent to hold forth about their disorders and treatment”.⁴ This chapter explores the idea of medical “competence” in household letter writers as seen in families’ harnessing of medical knowledge and skills to act as medical experts.

Although medical knowledge and skill are evident in records of experience such as that of Ann Stanhope, households have rarely been discussed as a site of expertise. The reluctance

¹ SpSt/6/1/69 (Walter Stanhope to Ann Stanhope, 28 July 1757).

² SpSt/6/1/57 (Ann to Walter Stanhope, 02 August 1757).

³ SpSt/6/1/70 (Walter to Ann Stanhope, 16 June 1757). See also SpSt/6/1/70 (Walter to Ann Stanhope, 07 July 1757); SpSt/6/1/57 (Ann to Walter Stanhope, 13 July 1757).

⁴ Dorothy Porter and Roy Porter, *Patient’s Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 189-90.

among historians to include household practitioners in the category of “expert” is partially because of expectations that expertise should be readily identifiable by other groups. Eric Ash states that “experts should be distinguishable from common practitioners or artisans within a given field” and that “experts required some form of public acknowledgement, affirmation, and legitimization”.⁵ The emphasis on the public identity of experts has contributed to the historiographic emphasis on scientific, legal, and political expertise. For example, the involvement of women with “court experimentalism” is the subject of Alisha Rankin’s case study of Anna of Saxony’s medical experiments.⁶ Cathy McClive analyses the difficulties faced by female medical experts and the complexities of reading the female body in the French legal context, in which “experts were primarily a recognized body of venal officials.”⁷ Barbara Shapiro locates the foundations of expertise within early modern legal discourse.⁸ Physicians were similarly active in the legal system in London in an effort to convince communities that their ideas were of value and deserved acknowledgement.⁹

Pamela Smith’s reintegration of manual work and artisanal expertise into the scientific revolution questions the extent to which expertise is externally identifiable. The specialized skills and knowledge of artisanal expertise were not always visible, and different types of expertise are awarded different levels of acknowledgement.¹⁰ By focusing on the terms which define how expertise was created and used, we can observe the significance of expertise to the function of the early modern household, and particularly to medical interactions. Some historians have begun to include facets of household work as isolated incidents of expertise. For example, Elaine Leong and Sara Pennell display the importance of medicinal and cookery practices as sites of

⁵ Eric H. Ash, “Introduction: expertise and the early modern state,” *Osiris* 25.1 (2010): 9.

⁶ Alisha Rankin, “Becoming an expert practitioner: court experimentalism and the medical skills of Anna of Saxony (1532-1585),” *Isis* 98.1 (March 2007): 23-53.

⁷ Cathy McClive, “Blood and expertise: the trials of the female medical expert in the Ancien-Regime courtroom,” *Bulletin of the History of Medicine*, 82.1 (Spring 2008): 86-108.

⁸ Barbara Shapiro, *A Culture of Fact: England, 1550-1720* (London: Cornell University Press, 2000).

⁹ Margaret Pelling indicates that physicians’ aims and attitude, a form of civic humanism, were later codified into a “paradigm of professionalization” and that “physicians, of all practitioners, seem most caught up in problems of identity connected with gender” in “The women of the family? Speculations around early modern British physicians,” *Social History of Medicine* 8.3 (1995): 387; Harold Cook provides one of the foundational texts on the ways in which physicians fought for status in *The Decline of the Old Medical Regime in Stuart London* (Ithaca: Cornell University Press, 1986), as well as in “Policing the health of London: the College of Physicians and the early Stuart monarchy,” *Social History of Medicine* 2.1 (1989): 1-33. Physicians’ efforts to be publically acknowledged was also briefly discussed in Chapter Four in the context of medical didactic literature, and will be further explored in Chapter Six on the relationships between families and paid practitioners.

¹⁰ Pamela H. Smith, *The Body of the Artisan: Art and Experience in the Scientific Revolution* (Chicago: University of Chicago Press, 2004).

knowledge and authority.¹¹ Sean Takats has revealed that “practical experience coupled with theoretical knowledge of cooking” was the standard of judging cooks in eighteenth-century France. Specialized expertise in difficult cookery techniques was the primary feature by which potential cooks were judged.¹² This study links themes of expertise and household work by explicitly positioning household medical work in a similar category of expertise to that of paid medical practice.

Aside from the issue of external acknowledgement, expertise rested on responding to new situations and problems with the expert’s extensive and specialized knowledge and practical skills. This thesis has thus far considered the component parts of expertise; letter writers and their families possessed both medical skills, as seen in Chapter Three on caregiving practices, and medical knowledge, as was evident in the discussions of cause and treatments of illness in Chapter Four. Historians have also acknowledged that early modern “expertise” indicated tight links between proficiency and experience. Evan Selinger and Robert Crease suggest that expertise can be understood as having been “trained by experience or practice” and Eric Ash stating that expertise is “usually based at least in part on experience”.¹³ The significance of experience has been emphasized throughout this thesis, particularly in the significance of experience in letter writers’ descriptions of medical knowledge. Using the evidence of household medical activities established in previous chapters as a starting point, this chapter will show that letter writers used medical expertise both to care for family members and to ascertain appropriate treatments.

Demonstrations of expertise by letter writers will be explored through Harry Collins and Robert Evans’ sociological model entitled “the Periodic Table of Expertise,” in which different actors move along a spectrum of increasing competence from commonly shared, assumed points of knowledge, then to the methods of communicating expertise and with experts, and finally to

¹¹ See Elaine Leong and Sara Pennell, “Recipe collections and the currency of medical knowledge in the early modern ‘medical marketplace’” in *Medicine and the Market in England and its Colonies c.1450-c.1850*, ed. Patrick Wallis and Mark Jenner (Basingstoke: Palgrave MacMillan, 2007). 133-152

¹² Sean Takats, *The Expert Cook in Enlightenment France* (Baltimore: Johns Hopkins University Press, 2011): 24, 117.

¹³ Samuel Johnson’s *A Dictionary of the English Language in Which the Words are Deduced From Their Originals, Explained in Their Different Meanings*, third edition (1768) lacks a definition for expertise, but defines expert as “1. Skillful, addressful; intelligent in business. Prior 2. Ready; dexterous. Dryden. 3. Skilful by practice or experience. Bacon”. [<https://books.google.com/books?id=bXsCAAAAQAAJandpg=PT7> pg 361, accessed 02 Sept 2017] Evan Selinger and Robert Crease, *The Philosophy of Expertise* (New York: Columbia University Press, 2006): 1; Ash, “Introduction,” 5.

independently practicing expertise. In particular, this chapter utilizes two of Collins and Evans' categories of expertise: First, "contributory expertise," in which expertise is evident in direct statements and the demonstration of practical skills by the speaker. Second, "interactional expertise," in which a person displays a familiarity with the language of the expert which allows the speaker to explain, define, and justify the use of someone else's contributory expertise but did not possess the skills to personally apply the expertise.¹⁴ In the context of letters, the two forms of expertise distinguish between personally making medical decisions or providing medical care as performances of contributory expertise, while assessing and selecting the care of medical practitioners utilized interactional expertise.

Integrating a model which allows for the simultaneous existence of multiple experts with complimentary knowledge and skills provides a new framework of analysis which resolves the historiographic imprecision that surrounds the relationship between the household or lay experience and medical practitioners. Most historical debate has featured ungainly language which attempted to come to terms the factors which distinguished "lay knowledge" from "professional knowledge" while implicitly assigning primacy to "professionals".¹⁵ A recent example of the imprecise application of this term can be seen in Daphna Oren-Magiore's article on female independence from practitioners in relation to gynecological complaints, in which she states that "women were still considered experts on reproduction," without defining or interrogating what it *means* to be an expert.¹⁶ Instead, her argument relies strongly on structuring expertise as a binary conflict: women must have been reproductive experts, because it seems they did not consult men regarding their reproductive health.¹⁷ Collins and Evans' model suggests that female reproductive knowledge could lead women to be experts in the subject even if practitioners were also labeled as experts. The definition would be based internally on their skills and knowledge, rather than compared to any external source.

¹⁴ Harry Collins and Robert Evans, *Rethinking Expertise* (Chicago: University of Chicago Press, 2009): 3.

¹⁵ Even recent studies which reconstruct ideas about what non-practitioners thought about medicine rely heavily on the role of the practitioner. Such studies include Wayne Wild, *Medicine-By-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam: Rodopi, 2006); Wendy Churchill, *Female Patients in Early Modern Britain: Gender, Diagnosis and Treatment* (Farnham: Ashgate, 2012); and Lisa Smith's "Reassessing the role of the family: women's medical care in eighteenth-century England," *Social History of Medicine* 16.3 (2003): 327-42.

¹⁶ Daphna Oren-Magiore, "Literate laywomen, male medical practitioners and the treatment of fertility problems in early modern England," *Social History of Medicine* (2016): 4.

¹⁷ *Ibid.*, 20.

Acknowledging the importance of medical knowledge in making decisions about appropriate paid medical care also breaks down the artificial division between “household medicine” and “external practitioners”. Andrew Mendelsohn and Annemarie Kinzelbach have shown the extent to which “commonality in diversity,” in which a common set of practices of “observing, inspecting, and reporting; weighing of diverse evidence and certifying or judging on that basis; reasoning to causal accounts of complex events in the physical and human world” were shared across early modern German court testimony about the body.¹⁸ Shared knowledge also characterized eighteenth-century medicine. Letter writers and their families made medical decisions based on what Porter and Porter describe as a spectrum of responses to illness, ranging from self-treatment to the acquisition of expert advice and services.¹⁹ This spectrum of response survives a re-envisioning of the medical marketplace, but the concept of “expert advice and services” requires further refinement.

Since the publication of *The Patient's Progress*, medical historians have widely accepted that patients could question or counter the expertise of medical, and that self-evaluation and the importance of self-treatment remained central throughout the medical decision making process. For Mendelsohn and Kinzelbach, the solution to the extensive sharing of knowledge is that “Expertise does not need ‘rethinking.’ It needs a rest”.²⁰ They claim that the inclusion of “lay experts” emphasizes the inadequacy of using “expertise” because the term relies on specialization, and that it is more effective for historians to focus on ideas of shared knowledge.²¹ However, this chapter exhibits the extent to which a range of different levels of expertise existed within families, and that letter writers with greater expertise often placed importance on their ability to translate medical skills and knowledge into practical assistance for their families. “Specialization” does in fact reflect the experience of various members of gentry families.

Rather than retiring expertise, it is necessary to integrate a more nuanced framework that allows multiple people to *simultaneously* be experts *in different ways*. Ursula Klein implies the necessity of describing a matrix of experts when she describes artisanal-scientific experts as “a

¹⁸ J. Andrew Mendelsohn and Annemarie Kinzelbach, “Common knowledge: bodies, evidence, and expertise in early modern Germany,” *Isis* 108.2 (June 2017): 277

¹⁹ Porter and Porter, *Patient's Progress*, 11.

²⁰ Mendelsohn and Kinzelbach, “Common knowledge,” 277. Their comment plays off Collins and Evan’s *Rethinking Expertise*.

²¹ *Ibid.*, 278.

distinct social figure – or a whole range of slightly nuanced figures” within Enlightenment discourse in France and Germany.²² Revising the discussion of medical expertise to acknowledge the coexistence of complimentary experts with slightly different skillsets allows for a more accurate understanding of the interactions between households and a range of potential medical options. Letter writers and their families had significant levels of skill and knowledge which comprised household care, and households remained repositories of knowledge even when they chose to consult external medical practitioners.

Acknowledging the role of expertise in gentry correspondence complements recent revisions on the concept of a “medical marketplace”. Mark Jenner and Patrick Wallis stress the usefulness of understanding early modern patients as “medically promiscuous” in relation to medical marketplaces because patients and their families were confident in their own ability to evaluate and interact with the options of the marketplace.²³ In order to effectively compare a range of practitioners, families had to marshal a range of information about the needs of the patient, the resources of the family, and the skills of the practitioner. This process necessitated evaluation both of the family’s medical resources, in the form of contributory expertise, and an ability to communicate effectively with practitioners through interactional expertise. The issue is complicated because of the various roles different family members could play in the pursuit of health. As Lisa Smith has observed, healthcare decisions were not a binary relationship between patients and practitioners, but instead was framed by a three-way relationship which included the patient’s family. Patient power was mediated by their medical knowledge and familial role, and women were particularly restricted by their subordinate relationships to husbands and parents.²⁴ Expertise was one of the variables, along with finances and gender, which influenced how families negotiated healthcare options. Situating the experience of illness and cure in a narrative of multiple types of expertise explains the coexistence of various members of the household who considered themselves experts and used knowledge-based expertise to interact with a practitioner.

This chapter revisits themes of experience, gender and medical knowledge within Collins and Evans’ model of expertise. Section one explains how the caregiving activities and medical

²² Ursula Klein, “Artisanal-scientific experts in eighteenth-century France and Germany,” *Annals of Science* 69.3 (2012): 303.

²³ Mark Jenner et. al., “The medical marketplace” in *Medicine and the Market in England and its Colonies, c. 1450-1850*, ed. Patrick Wallis and Mark Jenner (Basingstoke: Palgrave Macmillan, 2007): 13.

²⁴ Smith, “Reassessing the role of the family,” 327.

knowledge discussed in the previous two chapters form the basis of medical expertise in letter writers and their families, introducing Collins and Evans' sociological model of expertise in greater depth. Their two categories of expertise, the personal skills and knowledge of medical work in "contributory expertise" and the familiarity with the language of other experts in "interactional expertise," are explored in the following two sections.²⁵ Finally, section four looks at situations in which letter writers viewed themselves as experts, particularly in cases in which they came into conflict regarding medical decisions. Integrating interactional and contributory expertise into understandings of household medicine reveals how the knowledge and experiences of households dictated the complicated process of negotiating illness in eighteenth-century Yorkshire, County Durham, and Northumberland.

Demonstrating Expertise

This section will revisit elements of the previous chapters on illnesses, caregiving practices, and medical knowledge in order to establish how families built up expertise in managing household illness. Thus far, this thesis has revealed the complex and inter-reliant framework through which sick bodies, skills, and knowledge interacted in the household. The chapter on caregiving displayed the extent to which the supervisory caregiving activities enacted by the gentry were fundamentally reliant on their possession of medical skills and the knowledge to evaluate illness and the improvement of the sick body. Similarly, the knowledge chapter demonstrated that medical knowledge was most regularly associated with illnesses which had previously been experienced and managed within the home. Ubiquitous diseases such as colds and gout were managed with more confidence than rarer conditions such as seizures or hernias.²⁶ As well as utilizing medical knowledge in correspondence, letter writers also felt confident voicing their opinions in public venues. Roy Porter displays how the *Gentleman's Magazine* highlights "typical knots of interests" by lay readers, particularly including requests and exchanges for practical remedies. Replies were sent from other readers based on their prior experience and

²⁵ See Appendix VI for a breakdown of men and women's references to contributory and interactional expertise.

²⁶ Appendix II demonstrates the high volume of references to "common" illnesses and the rarity of dangerous or fatal conditions.

personal experience, not just from medical practitioners.²⁷ Families did not just collect medical knowledge; they applied it to themselves and their kin.

Self-care and household treatment were the first option available to sick people. However, historians have difficulties explaining how households could simultaneously be central sites of medical knowledge and also regularly utilize the help of external practitioners, while acknowledging the authority of both groups. Applying Collins and Evans' sociological model of a spectrum of expertise shifts away from the idea of expertise as a monolith, in which one definition of "expert" can be applied to a population in order to establish entrance into an expert group. The model also acknowledges that people could be experts in different ways: some letter writers made knowledge-based claims to expertise when they offered medical advice or explained illness, while others had a more practical and physical style which displayed medical skills through their caring for the sick and preparing treatments.

Collins and Evans also present a model of relational expertise, in which expertise is acknowledged due to knowledge, experience, and participation within a group, rather than retrospectively attributed by an authoritative group.²⁸ This model suggests that each individual contains a potential spectrum of expertise as well as the ability to refine skills and acquire knowledge to become an expert in a given field. The difference between realist expertise, in which expertise is understood as inherent and therefore existing whether or not it was acknowledged by others, and relational expertise which was characterized by acknowledgement of or comparison with others, can be understood by applying the model to the readjustments historians have made to the role of "quacks" in the medical marketplace. Physicians labeled nontraditional medical practitioners as dangerous and ineffective in an attempt to discredit financial competition and secure the status of physicians as the primary practitioners. However, these irregular practitioners had an important role in the medical marketplace, and the opinions of physicians neither controlled medical structures nor regulated which services were purchased by patients.²⁹

A realist model also allows historians to acknowledge that households had medical skills and knowledge which were similar to those of paid medical practitioners, while not completely

²⁷ Roy Porter, "Lay medical knowledge in the eighteenth century: the evidence of the *Gentleman's Magazine*," *Medical History* 29.2 (1985): 149.

²⁸ Collins and Evans, *Rethinking Expertise*, 2.

²⁹ See for example Roy Porter, *Health for Sale: Quackery in England, 1660-1850* (Manchester: Manchester University Press, 1989).

overlapping. This is important, because most households did not intend to be self-sufficient. They did manage most of the caregiving activities, as seen in Chapter Three, but they also focused their medical knowledge on the illnesses which were most likely to affect their homes and the treatments which had proved the most effective in the past. Households did not need comprehensive medical skills. Instead, they required the skills to manage a range of illnesses, and the knowledge to identify when an illness exceeded household knowledge, and then to select the treatment of an appropriate external practitioner. Being an expert in the types of medical knowledge and skills necessary for a gentry household was different than being an expert physician or surgeon, even though the knowledge models and treatments could be similar in each group.

Acknowledging the situations in which letter writers did not possess an extraordinary grasp of medical knowledge or define any particular skill establishes a baseline by which to investigate cases of household medical expertise. Throughout this thesis, distinctions have been made between rote comments and cases which display moments of medical knowledge and skills. Letter writers were most likely to make rote comments, such as when Therese Robinson reported in 1757 that their Bristol trip for her sister's illness, likely consumption, was beneficial and that "Sister Fanny continues better she has scarce any Fever and rode on horseback this morning".³⁰ These comments reveal a range of tacit medical information. Therese was able to compare her sister Fanny's health to previous days and conclude that she was improved, but did not have any stated involvement in the process and did not make any indication of its function. Evans and Collins refer to this competency within a wide range of expected social norms and information as "ubiquitous expertise". While necessary to function effectively in society, ubiquitous expertise was so common as to be considered mundane by members of the society.³¹ Similarly, most letter writers were familiar with a range of illnesses, as well as the action and appearance of bodies in sickness and health.³²

³⁰ WYL150/6030/13350 (Therese Robinson to her father Thomas Robinson, 03 April 1785).

³¹ Collins and Evans, *Rethinking Expertise*, 7.

³² Olivia Weisser emphasizes the extent to which illness was a "learned and patterned cultural exchange" and a complex social event defined by norms and behavior in *Ill Composed: Sickness, Gender, and Belief in Early Modern England* (New Haven: Yale University Press, 2015): 2. The idea of a sick role is also the subject of Janice Morse and Joy Johnson's *The Illness Experience: Dimensions of Suffering* (London: Sage Publications, 1991), and their concept of the "illness constellation model" has been used by Lisa Smith to explain the complex relationships between practitioners, patients, and families in "Reassessing the role of the family," 330.

Defining a baseline of ubiquitous expertise, in which the displays of knowledge were unsurprising, makes it possible to distinguish cases in which letter writers often surpassed ubiquitous expertise in cases of familial illness and medical advice. In these situations, their behaviour reflects the most exclusive type of expertise, which Collins and Evans term “contributory expertise”. This is refined skill in action, the type of expertise that has traditionally characterized professional groups such as scientists or physicians.³³ Ann Stanhope’s contributory expertise was evident in a letter to her brother John Spencer in the mid-eighteenth century, in which she wrote

with great thankfulness and Pleasure tell you, I hope in to gain ground of my Disorder, for these four Days past, I have not taken any one Medicinall thing, I find myself better without it, and therefore wish I could have thought so sooner but as its never too late to mend, I hope with a Cool diluting regimen moderate exercise and this Good air, I shall iSpirits.³⁴

Ann ascribed her newly improved health to her own medical knowledge, decision making, and performance of medical treatments. She both had evaluated the expertise of other contributory experts and found them lacking, in her dismissal of “Medicinall” things and physicians, and her own expertise shaped her evaluation and creation of an appropriate regimen and climate. The key was her active role in these choices. She was not transmitting or translating information; she was producing and utilizing her own knowledge.

In cases where the medical knowledge possessed by households, as seen in previous chapter of this thesis, proved insufficient, letter writers also had the skills to evaluate and select from a spectrum of experts, ranging from neighbours and relatives to practitioners, including physicians, surgeons, or a variety of nontraditional practitioners. Collins and Evans refer to this ability, situated between ubiquitous and contributory expertise, as “interactional expertise,” which is “expertise in the language of a specialism in the absence of expertise in its practice”.³⁵ Interactional expertise is gained through conversations with contributory experts which result in a familiarity with their skills, techniques, and methods of communication in those who lack the ability to personally perform the skills.³⁶ An interactional expert cannot *do* or *fix* things, only understand the problem that requires solving and identify an appropriate contributory expert.

³³ Collins and Evans, *Rethinking Expertise*, 24.

³⁴ SpSt/6/1/109 (Ann Stanhope to brother, undated).

³⁵ Collins and Evans, *Rethinking Expertise*, 28. Emphasis in original.

³⁶ *Ibid.*, 33-34.

Medical intermediary experts could describe illnesses to doctors, and explain the diagnoses and treatment back to the patient. Mastery of intermediary expertise was particularly evident in the gentry during the early modern period because, as Nicholas Jewson has contended, being of higher social status than practitioners meant that gentry patients had greater power in dictating the terms of medical interactions.³⁷ Correspondence to practitioners required a greater amount of detail in both the symptoms and methods of treatment. For example, George Ross' letter to his brother Mr. Lister in 1753 recounted the process of seeking treatment for his sibling,

I have talked to Dr. Armstrong with regard to your complaints: he still insists that you try the Bath water as a preliminary, and in the mean time to eat the lightest, but nourishing food, such as viper broth calf's foot Jelly eggs, chicken, and the use of milk as much as you please. No salt victuals. He desires to know if what he prescribed has answered the end proposed.³⁸

George Ross' role in this letter was intermediary, both sharing the prescription of the doctor with Lister and stating Dr. Armstrong's expectation of an update on the efficacy of the treatment. Ross was familiar with the language necessary for their physician to evaluate the condition of Lister without speaking to the patient directly. Ross also extracted the information necessary from Armstrong to enable a cure for Lister. In terms of medical skills, Ross was completely inactive; he offered no independent advice in this situation. Nevertheless, his role required a certain level of familiarity with medical knowledge and the social skills to effectively convey it between two parties.

The contributory expertise of household medicine and the intermediary expertise which allowed families to evaluate and translate the efficacy of external contributory experts were not mutually exclusive. In some cases, letter writers used their contributory and interactional expertise in concert. This was particularly apparent when families performed caregiving activities which complemented the medical advice of external practitioners. Describing the illness of their brother-in-law Mr. Greame in 1760, John Spencer recounts Mrs. Greame's response to the situation. He recounted how

poor Mr Greame had been violently afflicted for three or four days before I left Seweby with his Old Disorder. My Sister sent for Dr. Chaneley [or Chanebey] whilst I was there, he could not come but ordered a couple of Blisters to applied to his Ankles which had no

³⁷ N.D. Jewson, "Medical knowledge and the patronage system in eighteenth century England," *Sociology* 8 (1974): 376.

³⁸ SH:7/LL/130 (George Ross to Mr Lister, 04 September 1753).

effect; but my sister writes me word that since I left them they have applied two more which have made a copious discharge.³⁹

This situation includes the interaction of multiple types of expertise in one case. Mrs. Greame provided both interactional and contributory expertise in her role as her husband's caregiver. The interactional expertise was performed in evaluating the danger of the situation and summoning an external medical expert who had a different set of skills. Dr. Chaneley's contributory expertise structured the next steps, but he did not visit the patient or perform the treatment. Instead, it was again Mrs. Greame's skills which managed the treatment, applying several blisters and monitoring their efficacy. She had supplemented her own knowledge and skill with a doctor's advice, but maintained control of the sickroom.

Letter writers could make independent medical evaluations of patients and act as caregiver, while also sharing medical decisions with a paid practitioner. Mrs. Collingwood's description of the treatment of her niece by Mr. Fenwick is a case in which a letter writer might trust their own medical knowledge but still choose to supplement their care with the advice of a paid practitioner. Mrs. Collingwood wrote a series of letters to her brother Ralph Salvin in 1714, tracing the diagnosis and treatment of his daughter, who had scald head. Letters simultaneously indicated her judgement and the recommendations of the surgeon Mr. Fenwick, as when Collingwood evaluated the potential danger of the illness by commenting that

Mr Fenwick favou'd yr Daughter with a visit on Friday apprehending the hott weather might have made her breake out again, but he was mighty pleased to find it not so; and seems more assur'd then ever that the Cure will stand good, but at the same time says till shes a women she'll always have a little return of it more or less; so doubt she'll prove a very tender child but hope wth care we shall prevent ye humour falling on her Eyes or Lungs, wch is the onlly danger I fear, but as yett there is not the least appearance of either for she looks and is all respects as well as ever she was in her life.⁴⁰

Mr. Fenwick made regular visits to evaluate the girl's breakouts and recommend treatment for them. He also made judgements about her ability to be cured which Mrs. Collingwood judged relevant enough to be passed on to her brother. However, Collingwood also played an important role in her niece's treatment. After repeating Fenwick's observations, she indicated a shared responsibility for treatment, noting that "wth care we shall prevent ye humour," and then moving

³⁹ SpSt/6/1/58 (John to Ann Spencer, c. 1760).

⁴⁰ D/Sa/C 43.3 (C. Collingwood to Ralph Salvin, 1714).

to her independent evaluation of the situation by identifying the “only danger I fear”. While she allowed Fenwick to make decisions, she was intimately involved in the treatment and presented her opinion alongside the apothecary’s as to her niece’s health and recovery.

In a later letter, Collingwood reinforced the dynamic in which she accepted Fenwick’s advice and valued his opinions, but also emphasized her own conclusions in letters to her brother. When Fenwick recommended that the girl be moved to town so he could treat her more easily, Collingwood provided the update to her brother but concluded that

tis my opinion since you don’t value the expense of it, that tis much better for the Apothecary to attend her here; she’s thank God as to appearance very well and bothe eats and sleeps as well as ever she did in her Life. The breaking out is more in her body, then in her head; but was it not in the latter she wou’d not value it in the other, but I perceive Fenwick fears the humour is turn’d to what he call a scald head, if so twill be some time befor he’ll cure it; tho’ he fancys he can do it in another while wth constant adendance⁴¹

In this case, Collingwood politely disagreed with some elements of Fenwick’s recommendations and suggested that her brother reject the change of locations. This was largely based on the care she provided, as Collingwood recounted how the girl ate and slept well in Collingwood’s house. Collingwood relayed Fenwick’s diagnosis and the length of treatment, but she also asserted her own skills and the necessity of her involvement in the process. Due to the nature of caregiving, families were required to exercise judgement and skills even after calling in an external practitioner. As a result, contributory and interactional expertise frequently coexisted in an illness narrative as families negotiated between their own skills and the potential for external assistance. The following sections will explore the situations in which each type of expertise was most often required.

Contributory Expertise

When letter writers managed household illness, they were utilizing contributory expertise through their medical knowledge and diagnostic ability, and in their medical actions and recommendations. This expertise can be distinguished from ubiquitous examples through the degree of action on the part of the expert, and the independence of the decision. When letter writers made their own choices or performed medical work based on their knowledge, acting independently of other sources of knowledge, they demonstrated contributory expertise. This

⁴¹ D/Sa/C 43.5 (C. Collingwood to Ralph Salvin, 1714).

independence was fundamental, as expertise is self-supporting and self-sustaining, rather than parasitic.⁴² A contributory expert can rely on and develop their own knowledge and skills even in isolation and could then share their knowledge, while an interactional expert requires contact with a contributory expert in order to keep their knowledge and language relevant, and cannot teach another person the skills and knowledge of contributory expertise.

In Chapter Four, letter writers had a marked preference for particular causes of illness and types of treatment. This knowledge was largely based on experience. Families returned to explanations and medicines which had proved effective in the past and relating new illnesses to old complaints. Cases such as these, in which old experiences were applied to new illnesses, are evidence of contributory expertise through a synthesis of knowledge. For example, Martha Lister described the illness of their sister in a letter to James Lister in August 1789, stating,

I am also very happy to say I think my Sister better, these few Days past, she was frequently so very indifferent last Week that I began to be apprehensive she wou'd not find that benefit from change of Air and sea Bathing we wish'd and expected; at present I have greater hopes that the excursion will prove serviceable to her, in which I flatter myself I shall not be disappointed.⁴³

Martha commented that the family “wish'd and expected” benefit from the location, and that she had “greater hopes” that she was confident “shall not be disappointed”. This indicated that Martha had prior knowledge of the potential health benefits of the site, that she evaluated the positive changes in her sister’s health, and that she made a connection between the relocation and bathing and a continued improvement. The relocation to the coastal health resort of Bridlington in Yorkshire would change the type of air, a regimen treatment which was popular for eighteenth-century writers, as well as offer possible bathing treatments. There was no mention of physician input on deciding on the town, and given the willingness of the Listers to attribute treatments to practitioners elsewhere in the letter, their silence in this case implies that it was an independent decision.⁴⁴ This in turn suggests that they had knowledge of the benefits of that particular bathing location. Martha mentioned that they “wish'd and expected” benefit from the location, and that she had “greater hopes” that she was confident “shall not be disappointed”. She

⁴² Collins and Evans, *Rethinking Expertise*, 35.

⁴³ SH:7/LL/274 (Martha Lister to James Lister, 20 August 1789).

⁴⁴ The relationship of the families in this study to external practitioners is located in Chapter Six.

described a sense of her own accountability and confidence in the progression of their sister's illness.

Contributory expertise was frequently used to evaluate symptoms and the progress of disease. When William Robinson, then in London, wrote home to Newby and asked his wife Mary for a letter from their daughter Nanny in the early decades of the eighteenth century, it was because "I can depend upon her account of yr state of health, but all the world is shy of one another, My Dear Molly I am collicitory of yr welfare, pray do not blame me, for mine depends there on".⁴⁵ William's request for information was based partially on his mistrust of his wife's willingness to write about her own condition, which she minimized in order to avoid upsetting him. However, it also indicated that Nanny did possess the skills and perceptive ability to accurately convey the information. In this case, this quote was supported by other references in the correspondence to Nanny acting as a surgeon in cleaning wounds and providing medical treatment to her family.⁴⁶ Describing Nanny as a surgeon was particularly significant, as it was the only case outside of paid medical practitioners in which the term was used. The extent of the degree of practical skills employed by the girl lead her parents to recognize Nanny as a contributory expert. Both Walter and Mary relied on their daughter to transmit information that they would not exchange amongst themselves.

In addition to evaluating the health and improvement of their family members, letter writers used expertise to manage medical treatments in the home. This can be seen in both the specific recommendation of a treatment, and offers of assistance through either physical aid or a specific medical recipe. Providing care for family members, and the necessary skills for managing the sick room, required an extensive knowledge of illness which could be situationally adapted. For example, when Anne Clavering wrote to her cousin James in 1709 regarding the health of her charge and half sister, Betty, she used her own contributory expertise to place herself at the centre of a nexus of decision making and physical assistance. She wrote how

I am now turned Nurse with Dr Betty, who was well and wth me when yours came to hand, but yt morning I was sur she'd took one of her fits of her Asthma - I sent for yt Dor but before either he or I could come she was well again; so he ordered her a vomit. she continued well till above 4 a clock yt after noon and since yn has had little or no respite. I again smond ye Dr who upon seing her laid aside ye vomit and had her Blooded which he

⁴⁵ WYL150/6001/48 (William Robinson to wife Mary Robinson, dated only "17 April").

⁴⁶ WYL150/6003/14 (William Robinson to Metcalfe Robinson, 06 August with year unspecified): Robinson comments that "Yr sister [inserted above: Nanny] proves a notable surgeon, and housekepr, and very diligent about her good mother." Nanny's surgical prowess was also discussed in Chapter Three.

hopes will be of more use, some other things he's ordered her to take wch I hope may relieve but my sentiments are she'll not be cured.⁴⁷

Ann's contributory expertise is immediately apparent when she labels herself "now turned Nurse," assigning herself the active role in Betty's treatment. As discussed in Chapter Two, the nursing role played by gentry women was largely supervisory, and required monitoring the patient for worsening symptoms and efficacious treatment. Although Ann chose to call the physician to treat Betty's asthma, she also established herself as an expert by bracketing the physician's treatments and recommendations with her own judgement. Betty did recover, but continued to suffer from asthma, and as a year later Ann updated James that "Betty poor girl had last Sunday 2 violent fitts of her astmah but is now well again by ye help of ye Apothecary only".⁴⁸ Additionally, Anne's significant role in the sick room is made clear because the household called for her before the doctor. She was the one who judged severity and justified the expense of a practitioner even in an extreme situation in which the child was having "little or no respite". Ann emphasized how she interacted with her sister as a patient, and depicted herself as central to the activities of both caregiving and caring.

The role of the main caregiver as expert on the patient's illness and running of the household re-emerged in other narratives of household illness. When the patient was distant, an offer of aid might be made in a letter, as in James Lister's 1775 letter to Mary Rose, which read

Aunt Fawcitt desires to know whether she can be of any use or Service during my Aunt Illness; if you think she will do any good, and not make you more busy and troublesome, she will come up; but that as you think fit, as it is a long Journey; pray take care of yourself, lest with too much Care and Attendance you make yourself ill, but hope in your next to hear she is better.⁴⁹

There were two simultaneous claims to contributory expertise in this case: Aunt Fawcitt and Mary Rose herself. Lister, in offering to have Aunt Fawcitt attend the sickbed, suggested that Fawcitt had both the skills to assist, and a wider and more nuanced awareness of the realities of providing care. However, his emphasis on the optional nature of this trip, if Rose thought Fawcitt would not make her "more busy and troublesome" was indicative of Rose's own authority as

⁴⁷ CLV 27 (Anne Clavering to James Clavering, 08 November 1709).

⁴⁸ CLV 62 (Ann to James Clavering, 21 December 1710).

⁴⁹ SH:7/LL/213 (James Lister to Mary Rose, 18 July 1775).

caregiver. Mary Rose's contributory expertise was given primacy in deciding whether Fawcitt's expertise would supplement her own caregiving.

In lieu of travelling to care for a patient, letter writers could send tailored medical advice in the form of either suggestions for locations and regimen, or through the inclusion of medical recipes. In a letter to Mary Warde on 04 December 1745, C. Sellwood opened with the offer of assistance:

I am very sorry my dear niece Stanhope, has had any illness, but hope yr Looseness will be of great service to you, and so more towards a perfect recovery, then art could I think, and really hope, it will carry off ye sharpness in yr Blood wch has seationed will gr complaints, I pray God grant it, and sent you a perfect state of health, Yr receipt I am giving to write I had from Lady Northampton, she had it from Dr Rattclif I never knew it fail in a Looseness wheather in a lying In or at any other time, pray let me hear from you very often.⁵⁰

This account was followed by a recipe which was placed as a postscript in the letter. While the recipe itself originated with the physician, Dr Rattclif, it was by the point of writing several stages removed as it was applied to a new patient and a new case. Instead, the contributory expertise of Sellwood was the justification for sending the letter. She had evaluated the beneficial nature of a short period of 'loosness' in relation to the origin of Mary Warde's complaints: her "sharp" blood. Sellwood also emphasized her own experience with the treatment that she received from Lady Northampton, that she "never knew it fail" in a range of situations. Her experience was the deciding factor in justifying the treatment.

Experience was thus made explicitly important in cases of contributory expertise. Witnessing or having personally been cured was the measure through which a recipe was deemed useful in correspondence, and having been cured once by a recipe, an author was likely to recommend or mention it again later. This was the case in an unsigned letter, likely from Ann Stanhope, in early September of 1782, in which she wrote of the process through which she determined the most effective recipe to treat her condition. She wrote,

I was but poorly last week, whn a complaint in my Bowels, my Bror Stanhope does to me to take a little Chatant and ginger, but it did not relieve me, tho' I took it 3 mornrgs together, therefore this last week I had recourse to my old medicine Jalep and salts, wch has relieved me much.⁵¹

⁵⁰ SpSt/6/1/50 (C. Sellwood to Mary Warde, 12 April 1745).

⁵¹ SpSt/6/1/122 (unsigned, 09 September 1782). Jalep was an imported drug which facilitated defecation.

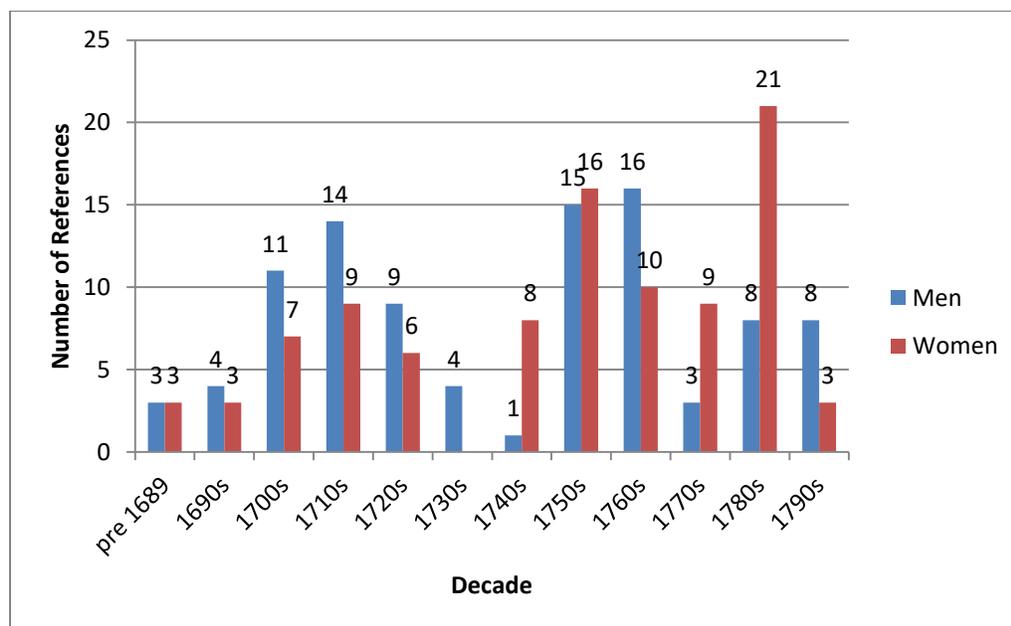
Ann had initially proceeded following her brother's advice, implicitly acknowledging his contributory authority, and had attempted to treat her bowel complaint with a simple recipe of his recommendation. Its failure was evaluated due to her persistent attempts to relieve her suffering, and when she had concluded that her bowels were not improving she switched to a more familiar treatment. Calling "Jalep and salts" her "old medicine" indicated that it was a treatment method which she had used to strong effect in the past, and indeed she linked it to her recovery in this case.

In several cases, both physical attendance and written advice were combined in contributory expertise. Responding to news of her brother Thomas Grimston's persistent cold in 1751, Ms. Grimston provided a detailed list of both medical treatments and regimen adjustments. She began,

I am very sorry to find you keep your Cold so long, if it is attended with a hoarseness, and haunny be not disagreeable to you let it be clarified, and take a little any hour of ye day, or a raw turnip sliced thin and sugar candy beat very fine, and laid between every layer, pewter plates, I have found the syrup from that excelent for a Cold, and a little small white wine, whey at going to bed, as you will not stir out of some dayes, to take fresh cold after a breathing sweat, if these prescriptions don't take place I have several more which must be done, if you shoud not be so well as to come here, I will come to you, if in my power to prescribe any thing that will due you service, none haveing your welfare more at hart, then us all here.⁵²

Ms. Grimston possessed a thorough knowledge of colds and potential treatments. In addition to specific medical preparations, she also suggested that her brother stay in bed to avoid a relapse. Having presented what she considered to be the most immediate treatments, Grimston also implied that she had further preparations to offer, and concluded with the suggestion that either she or Thomas should travel to each other so that she could care for him in person. This case typifies the ways in which letter writers could make independent claims to medical knowledge. Grimston made no reference to any other practitioner, but instead viewed herself as having a variety of treatments that would suit the situation. She went further in situating herself as a caregiver, implicitly arguing that she would also be more capable in that respect than any of Thomas' current housemates. Grimston argued through the letter that she had a range of medical competencies that could be utilized effectively in treatment.

⁵² DDGR/41/1/87(Ms. Grimston to Thomas Grimston, 13 December 1751).

Figure 5.1 – Men and Women’s References to Contributory Expertise⁵³

Both men and women regularly made statements about their contributory expertise throughout the century, as seen in Figure 5.1 above. Their emphasis on their own knowledge and skills represented seventy-four percent of the demonstrations of expertise, compared to a significantly lower proportion of references to interactional expertise. The regularity of references to this type of expertise was also relatively consistent, indicating that families maintained an interest in collecting and using medical knowledge throughout the period. Though men and women were similarly represented situations of contributory expertise, women were more likely to make comments about contributory expertise than they were to make comments about intermediary expertise, while men frequently referenced both.

The involvement of both men and women in medical decisions reflects the gendered division of labour demonstrated in both the caregiving and knowledge chapters, where women were overall more likely to perform caregiving activities and also more likely than men to make specific knowledge claims instead of expressing common knowledge. The effort of female letter writers to emphasize their medical expertise supports the historiographic assumptions of caregiving as female work encapsulated in comments such as Porter and Porter’s reference to the “natural domestic duties” of women, which have been explored at greater length in Chapter

⁵³ An expanded table of these references, particularly in comparison with interactional expertise, can be found in Appendix VI.

Three.⁵⁴ Describing caregiving as a facet of contributory expertise also reflects the style of caregiving performed by gentry families, which necessitated medical skills for the preparation of medicine and knowledge of the cause and progression of illness.

Including men in a study of household healthcare complicates the historiographical picture which has traditionally conveyed the image as a female duty because it reveals that men were also involved in making medical decisions and performing medical work throughout the eighteenth century. Men's contributory expertise was more limited to medical advice than medical skills, as reflected in their lower participation in caregiving and equal involvement in discussions of cause and treatment.⁵⁵ Focusing on the provision of information rather than practical skills aligns with the arguments of both Karen Harvey and Lisa Smith on the role of the male householder's supervisory role in healthcare and household management.⁵⁶ The more balanced view of gendered interactions with healthcare also modifies claims that women were singularly responsible for household health, and instead supports Lisa Smith's observations that household care required complex mediations of familial relationships. Gender roles influenced a patient's ability to act autonomously, and a range of both male and female relatives were involved in the decisions and practice of caring for sick relations.⁵⁷ Rather than a gendered binary, these relationships reflect Harvey's arguments about the absence of simple divisions of labour in the eighteenth-century home because men and women viewed the creation of a family as a joint venture.⁵⁸ Illness affected the entire household, and these experiences contributed to the knowledge and experiences of both men and women.

Interactional Expertise

Although healthcare took place largely in the home, the letter writers of this study, and their families, were confident about hiring external practitioners to support family resources. Lisa Smith observes that families were integral to patient interactions with practitioners, focusing on the degree of control with which families in general and men in particular influenced the care of

⁵⁴ Porter and Porter, *Patient's Progress*, 38. See footnote 14 in Chapter Three for further references to gendered caregiving.

⁵⁵ See Chapters Three and Four respectively.

⁵⁶ Smith, "Reassessing the role of the family," 330; Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford: Oxford University Press, 2012): 22.

⁵⁷ Smith, "Reassessing the role of the family," 329.

⁵⁸ Harvey, *The Little Republic*, 17, 25.

female relatives.⁵⁹ When they communicated on behalf of relatives, letter writers had to be able to effectively explain the symptoms and previous treatments, and also to use knowledge related to the medical marketplace to select a practitioner who had the appropriate skills and experiences. These communicative skills are indicative of what Collins and Evans label as interactional expertise: an encompassing knowledge of the *language* which characterizes exchanges of contributory expertise.⁶⁰ While contributory experts presented and acted on their medical knowledge, interactional experts did not have detailed medical knowledge or skills. Instead, families were familiar with the function of the medical community and the information necessary to make diagnoses. Interactional expertise acknowledges the extent to which letter writers were fluent in the shared language of medicine, particularly in humoral workings of the body, and in the types of information necessary for medical practitioners to make diagnoses and offer treatments.

Interactional authority was regularly used to mediate between sick family members and external physicians. Medical correspondence between sufferers and professionals was a valuable route for obtaining the medical expertise of practitioners.⁶¹ Direct communication by letter with a practitioner was very rare in this study's sample: it only contained thirteen letters from physicians. However, families' discussion of symptoms and disease progression were strikingly different from familiar letters. For example, when William Chaytor asked for details on his daughter Nancy's illness in 1701 so that he could present her letter to a local London physician during his Fleet Prison confinement, he received a detailed letter back. After Peregrina and Ann had disagreed over who could provide the most accurate summary of her condition, Peregrina proceeded to transcribe Nancy's lengthy comments for her husband, beginning,

Nancy is now pleast to let me giv you some account of her 1. The humor is moest trobullso in frostty weather and much alike at other times but in verry hott weather it will trobull more but not soe much as in frostt 2 the times of haveing them is not verry constant to the monuth being som times six or seven weeks 3. They doe not continue above 3 days and but ... [4] she is but littell trobelled with the whites ... 5. The colour is of a pale red and waterish but when she is blouded she has verry good blood and but littell serum in the blood". And "The humor seems to be betwixt the skin and fleshe a salt wayterish humor like tears when one weeps and you may remember that she uset to have sudden swellings or huffings up in her face and other parts which noe doubt was

⁵⁹ Smith, "Reassessing the role of the family," 329.

⁶⁰ Collins and Evans, *Rethinking Expertise*, 28.

⁶¹ See for example Lisa Smith, "Reassessing the role of the family;" Wayne Wild, *Medicine-By-Post*; and Robert Weston, *Medical Consulting by Letter in France, 1665-1789* (Farnham: Ashgate, 2013).

occasioned by this humor but she has been in a manner free from those sudden swellings this 2 years the swellings did not make the skin red but it continued much its natural colour she had no great swelling that she can remember of since she came from London the swellings would remove in 24 hours out of one part and move to another part.⁶²

The comprehensiveness of this description of health is unusual because of the precision of details and the inclusion of a range of symptoms. Nancy and Peregrina dated the earliest outbreaks and included the timing and length of incidents, located the complaint and provided a detailed account of the nature and texture of the “wayterish humor like tears”.

Doctors replied with a similar level of detail. Upon hearing in 1765 that Ann Stanhope felt that her current treatment at Buxton was insufficient, her brother John Spencer enlisted the assistance of a physician. The two men composed a letter together, first with Dr. Addington offering his suggestions at length, opening the letter with the comments that,

Madam, Mr Spencer has been pleased to read to me your sensible letter, in which you seem to despair of a Cure from the Bath at Buxton, and to wish to drink the water at Keddleston. I own, I have still very great Expectations from a continued course of tepid Bathing, and must entreat you not to drop it rashly. But if it should occasion any new and extraordinary symptoms, that may oblige you to drop it, give me Leave to dissuade you from Keddleston; the water of which spring is loaded with Sulphur, which is too hot for your constitution. I would rather advise you to be content with magnesia Alba at Night, and scarbo' water in the morning, and not to tamper any farther; tho' in case of considerable Head-ache, giddiness, or flushings, I believe it will be of service to you, to lose 7 or 8 ounces of blood from one of your feet, or to suffer leeches to be apply'd once, twice or thrice more, where they were several times apply'd when you was in town. This, madam, is the sum total of my advice to you, except Exercise; of which you can hardly have too much, provided you take it regularly, in fine weather, and do not carry it to a fatigue. If you was to take a very long journey, and change the air every day, as well as shake your Body with Exercise, it would be so much the better. But even a course of this kind ought not to be a Reason for your discouraging Magnesia and a cooling and opening Water.⁶³

Just as the Chaytor's letter had a high level of detail of the symptoms, Dr. Addington offered a comprehensive analysis of his plan for her treatment. Addington's recommendations compared the natures of the waters, which had been Stanhope's primary complaint. However, he also made several complimentary treatment and regimen suggestions, including bloodletting and exercise. Compared to the medical advice offered in the previous section by family and friends, Addington

⁶² ZQH/9/14/121 (Peregrina and Ann to William Chaytor, 07 August 1701).

⁶³ SpSt/6/1/94 (A. Addington and John Spencer to Ann Stanhope, 27 April 1765).

is both much more verbose and detailed. Even Alicia-Maria Grimston, who offered a series of recommendations for her brother's cold, confined her advice to several lines, while Addington wrote an entire page.

These letters replicated the process of a medical interaction, in which detailed patient narratives formed the major source for the physician's diagnosis. Wendy Churchill observes that in consultations, both parties placed a premium on accuracy and personal information and doctors encouraged their patients to expound upon details of their symptoms.⁶⁴ Correspondence preserved the level of detail which might be discussed at length in person, and the letters communicated information about illness to physicians in a different way to letters for their families and friends. Letters to physicians contained a higher level of detail, particularly on symptoms such as the pulse which were absent from familiar letters. While some medical authors, such as Tissot, provided questionnaires to guide readers in writing to medical authors, the letter writers of this sample largely presented information without references to external guidance. This is interactional expertise in action: while the families could not enact a cure themselves, they were sufficiently versed in the language of the external expert, the practitioner, to communicate effectively.

Letter writers preferred personal and face-to-face interactions when using interactional expertise in medical discussions. For example, George Ross "talked to Dr Armstrong with regard to your complaints" when he represented his brother Mr. Lister and relayed Dr. Armstrong's advice in 1753.⁶⁵ Ross had personally acted as the intermediary using his interactional expertise to establish a connection between Dr. Armstrong and Lister. He approached Armstrong with details of Lister's "complaints", which likely included a summary of cures attempted thus far. This letter appears to describe the relationship after the physician had already been contacted, as Armstrong "still" insisted on a bathing treatment, but supplemented this advice with recommendations for diet. Ross explained and defend Lister's condition and medical choices to the doctor, and also judged the benefit of Armstrong's advice before relaying it to Armstrong accurately. Both directions of this exchange relied on Ross' interactional expertise for understanding the parties' perspectives and respective knowledge.

⁶⁴ Churchill, *Female Patients*, 62, 65.

⁶⁵ SH:7/LL/130 (George Ross to Mr. Lister, 04 September 1753). The encounter is quoted at length in section one as a demonstration of intermediary expertise.

A similar interactional authority can be seen when B. Dutton opened a letter to Ann Stanhope in 1765 by referring to medical interactions, saying,

I saw Dr. Cookson on Saturday and conferred with him respecting you he was glad to hear the account I gave him and say'd you had taken the proper method of air and Exercise wch he did not in the least doubt wd have the desired Effect – Mr Wordsworth has not got any Scarbro' Water or woud have sent it by the Bearer whom I send on purpose with a Box wch came here yesterday- my wife begs to join in retender of your regards.⁶⁶

When Sutton “conferred” with Dr. Cookson, his report included an update on Stanhope’s health and the current treatment. He chose to relay back Cookson’s approval. Sutton was, however, acting against the will of Ann Stanhope: the postscript in a different hand, likely Sutton’s wife, added,

M Wordsworth has sent what you received from y Dr Cookson but as you sayd you woud take no more Medicines I imagine that they are of no use however I have sent them as you consered I woud⁶⁷

The wife’s account differed from Sutton because she both acknowledged Stanhope’s desire to avoid medicine and noted the inclusion of medicine in the letter’s package. This makes Sutton’s decision to emphasize that Cookson approved of the treatment, without any suggestion of further remedies, more striking. Sutton had utilized his interactional expertise to dismiss Cookson’s advice, likely based on Stanhope’s decision to “take no more Medicines”, as mentioned in his wife’s note. This is one of the rare cases in which the decision to omit information is visible in the letters. It is a reminder that interactional expertise did not only matter in terms of relating information accurately, but also applied to the understanding of relevance and filtering of information between two parties.

In more complex cases, interactional expertise was used to mediate the dense network of connections and possibilities which existed in the medical marketplace. When responding to a letter from Sir Marmaduke Constable about Bath in 1727, his unnamed friend referred to a wide range of physicians. He said,

I think your consultation of Dr Friend is very well, Especially as to my own case, since Dr Mead has had it before, and like entirely your consulting a Physician at the Bath, since as you say they should be the best acquainted with the effects of those waters, and Dr Huddleston says he knows the Doctor at Bath which yours mentions, and says he has the

⁶⁶ SpSt/6/1/91 (B. Dutton to Ann Stanhope, 24 June 1765).

⁶⁷ Ibid. Emphasis in original.

same good Esteem of him, as you mention to have in yours, and as you say you can procure us his opinion, I beg you will procure us that favour, in relation to both our cases, you have enclosed. Dr Huddleston's state of my wife's case more at large as you desired, with a word or two of my self, and says he can say nothing more fully, than what I have expressed in the inclosed state of my own case, which is a copy of that I sent to Dr Mead four years ago, and which I take the liberty to send you without Recopying, or correction since you desired my Answer as soon as possible (sic), and time would not permit me to do it⁶⁸

Though the intention of the letter was to have the friend transmit Constable's case to Dr. Friend, the letter referred to a range of practitioners. Constable had in the past consulted the eminent London physician Dr. Mead by letter, and attached a (now lost) copy of this description of his earlier symptoms. He emphasized the age of the Mead correspondence, but noted that his state was the same as it had been when he composed that letter. This was an element of interactional expertise that evaluated his health over an extended range of time, balancing the need for a rapid reply against the potential to create a more accurate summary of symptoms. However, he also referred to consulting Dr. Huddleston, who supported the accuracy of his enclosed account, and an unnamed doctor at Bath. This dense layering of the contributory expertise of physicians was characteristic of the "shopping" process available to sufferers in the "medical marketplace". Each new physician required the friend to use his own interactional expertise in evaluating their potential efficacy and comparing it to advice he had received in the past.

Recourse to multiple practitioners, and the process of navigating and evaluating their varying suitability, reveals the importance of interactional expertise. When obtaining the advice of physicians, there was no emphasis on the practitioner as the superior authority. This was in part due to the elevated social status of the letter writers in this study compared to their practitioners. However, Barbara Duden shows the extent to which female patients across social classes considered their perceptions of illness superior to physicians in eighteenth-century Eisenach, describing the physician Johannes Storch as "only a guest in the realm of self-treatment".⁶⁹ Given the individualistic nature of illness in the humoral system, all patients had a degree of power in controlling the medical interaction. Intermediary experts reported the case of the sufferer, and then returned with information provided by the physician, considered in turn

⁶⁸ U DDEV/60/84/31 (letter to Marmaduke Constable, 02 May 1727).

⁶⁹ Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany*. Cambridge: Harvard University Press, 1991): 76.

before it was either applied or rejected in favour of a renewed pursuit of assistance. Regarding an unstated contagion in near their home estate in the early eighteenth century, William Robinson wrote to his wife Mary,

I am sorry to hear Children dyes in ye neighboring towns pray doe not let squire Metcalf venture to Topclife during this contagion, I asked ye Doctor what was good to prevent infections, but I could not get any thing from him worth yr knowledge, I believe you are ye better doctor of ye two.⁷⁰

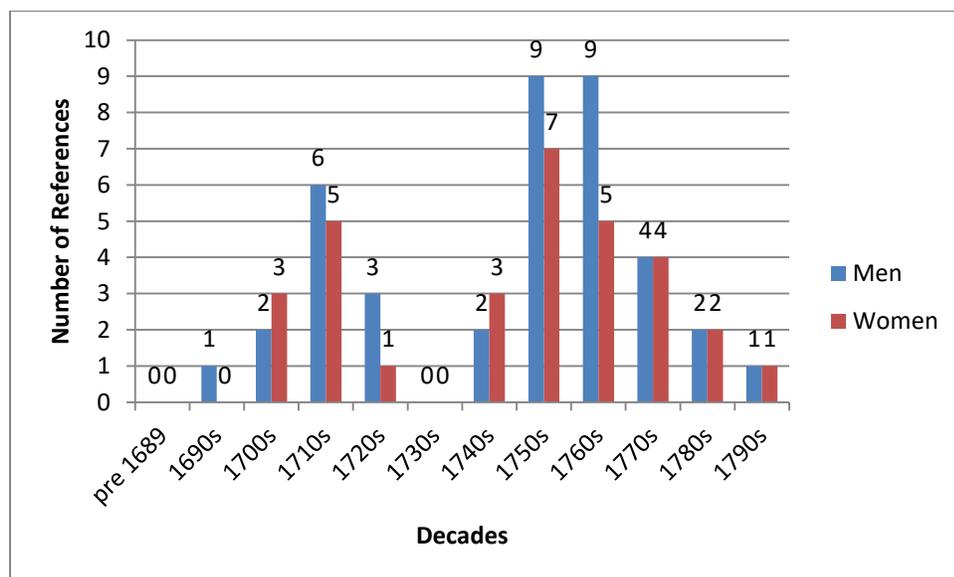
The severity of the “contagion” caused Metcalf’s parents enough distress that they sought a physician’s advice on preventative medicine. However, when Robinson used his interactional expertise to judge the efficacy of treatments and the confidence of the physician, he found both lacking. Reporting to his wife, he announced instead that there was no suggested treatment “worth yr knowledge” and that she was “ye better doctor of ye two”. This decision is very important in understanding the relationship of interactional expertise with the various contributory experts available. Readers considered and criticized the expertise of physicians in some cases, and could decide that the contributory expertise of family members was both less expensive, and potentially greater and therefore more trustworthy.

By focusing on these exchanges of information as an exploration of interactional expertise, it is possible to reassess and refine the role of family decision making in the “medical marketplace”. Historians such as Roy Porter, Lucinda McCrae Beier, and Harold Cook have established that families had a range of available medical options which they judged in relation to individual cases, then chose the most efficacious treatment based on a combination of factors which included finances, the perceived efficacy of the treatment, and trust in the practitioner.⁷¹ Applying the concept of expertise to this model emphasizes the high level of skill and knowledge that was fundamental in the performance of these decisions. Acknowledging expertise renders visible the degree of synthesis of decision-making factors.

Interactional expertise became increasingly significant as the century progressed. Whereas there was only one example of interactional expertise before 1710, letter writers increasingly referenced situations which required mediating the language of an external expert. Recourse to physicians and the expertise associated with this interaction were increasingly

⁷⁰ WYL150/6002/36 (William Robinson to Mary Robinson, dated 08 April).

⁷¹ For the foundational work on this model, see for example Porter and Porter, *Patient’s Progress*; Harold Cook’s *The Decline of the Old Medical Regime*; Lucinda McCrae Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London and New York: Routledge and Keegan Paul, 1987): 4.

Figure 5.2 – Men and Women’s References to Interactional Expertise⁷²

presented as significant in correspondence as the century progressed. The class of the letter writers in this sample increased the significance of their interactional expertise, as the families had the social connections and financial resources to evaluate a wide range of practitioners before deciding on the most appropriate form of treatment.

Men were significantly more likely to make statements about interactional expertise than women, as shown in Figure 5.2, and were usually the ones who sought out medical advice while they were away managing politics and business in London, relaying news between the capital and their families in Yorkshire and the North-East. Though women were never as likely to utilize intermediary expertise as contributory expertise, their numbers of medical interactions grew too. This is demonstrative of the division of medical roles in the household. As Lisa Smith has established, men were expected to ensure the financial, emotional, and physical welfare of the household, and did so particularly through summoning the doctor and deciding on courses of treatment because of their legal and financial control of the home.⁷³ Catherine Crawford indicates that the dominance of men as arbiters of paid medical care was enforced by the “patriarchal character of the common law,” in which women, children and servants were unable to contract for medical treatment. In lawsuits, men were positioned as refusing to pay for fees because they had denied their relatives the medical treatments, as well as mediating between the

⁷² An expanded table of these figures can be found in Appendix VI.

⁷³ Lisa Smith, “The relative duties of a man: domestic medicine in England and France, ca. 1685-1740,” *Journal of Family History* 31.3 (July 2006): 232, 238; Smith, “Reassessing the role of the family,” 531.

patient and practitioner in much the same process that Lisa Smith explored in the less emotionally charged context of medical correspondence.⁷⁴ Families were flexible and performed a range of roles, but due to social conventions, men were better positioned to more regularly negotiate interactions with external practitioners.

Identity and Conflict

Familial correspondence contained a high level of flexibility about expertise and the identity of decision makers. The difficulty of defining or mediating expertise can be seen in the existence of multiple claims for expertise in medical conflicts. Contributory expertise in medical matters was in fact a series of interrelated fields of expertise containing both members of the household and paid practitioners. As a result, illnesses in the home were often treated by experts who either agreed based on their personal experience or compromised based on evaluating the skills and knowledge of the other party. Contributory expertise and interactional expertise could be demonstrated by either gender, and both frequently appear within a unified decision on the part of families in selecting medical care. However, not all letters contained agreement. Dorothy and Roy Porter observe that “family medicine involved all the regular ploys of power and prestige, and the sick easily became pawns in domestic politics”.⁷⁵ Conflict in medical decision-making revealed the multiple situations in which expertise was located in the home. As a result of ongoing negotiations about diagnosis, skill and knowledge, there were multiple points in medical decisions where different parties had to come together and reach consensus on treatment.

The flexible system of decision-making could on occasion clash with individual perceptions regarding who should hold responsibility for decisions. Many of the most detailed accounts of healthcare practices in correspondence emerged when there was a disagreement about the most effective course of treatment. The nature of knowledge in the early modern medical system enabled such debates. As each person’s constitution was individual, there was no universally-approved treatment for illness; instead each treatment should be refined for the highest level of effect. The range of practitioners available emphasized this, as a different form of treatment could be received from a physician than from a surgeon. Each new engagement with

⁷⁴ Catherine Crawford, “Patient’s rights and the law of contract in eighteenth-century England,” *Social History of Medicine* 13.3 (2000): 397-8.

⁷⁵ Porter and Porter, *Patient’s Progress*, 41.

medical decisions required a new evaluation of the potential effectiveness and the authority of the players. As a result, conflict could appear at several levels of medical decision making.

Debates about the efficacy and appropriateness of treatment could occur between two household medical experts, as seen in the conflict of Anne Clavering and her neighbour. Anne Clavering's neighbour was never named or given an occupation in Anne's correspondence with her cousin James. However, he did emerge several times as her rival for medical expertise over her family members. In 1708, Anne complained to James that while she was away, her aunt's ill health

has so farr made an impression on him [the neighbour] yt hearing my Aunts cold was no better wn I was abroad he came and insinuated himself so much into favor as to undertake to cure her if she would throw off her nurses (wch were my uncle and self) ye shall be judge in ye fair proceedings have I not reason to complain.⁷⁶

The insult of her neighbour's involvement was intensified because it was much more than an intrusion to offer supplementary advice. He had stated that Anne herself was a poor nurse who her aunt had to "throw off". In so doing, he made statements which implied that Anne failed to possess contributory expertise, while Anne felt that she was an expert in her caregiving generally and her Aunt in particular. Anne appealed to her brother to support both her indignation, and her status as the household caregiver. This conflict of expertise was framed as the right to be the primary, or only, nurse for Anne's aunt. Here expertise was linked to acknowledgement: it was not enough to have medical knowledge and skill, Ann also wanted to be perceived by her friends and family as an expert based on her use of skills and knowledge in the past. Such acknowledgement would in turn emphasize her role in the family and mastery of caregiving skills which, as seen in Chapter Three, were largely gendered female.

Another dispute between the knowledge of a woman and other experts outside the home can be found in the anecdote with which this chapter opened. This case reveals a network of different experts. Ann Stanhope used contributory expertise in 1757 when she made judgments about her husband's constitution in her recommendations for changing his treatment. She wrote, "Bathing so very often, and sweats so profusely, as I'm told they do after it, will I fear weaken you in the end".⁷⁷ Countering her opinions was Walter, who argued based more on his intermediary expertise when he chose to adhere to his doctor's recommended treatments, which

⁷⁶ CLV 10 (Anne Clavering to James Clavering, 18 December 1708).

⁷⁷ SpSt/6/1/57 (Ann to Walter Stanhope, 13 July 1757).

involved multiple baths and pumping. Walter placed himself firmly in the role of the patient, supporting Hartley's treatment and using his personal experience to evaluate its success in comments such as how bathing "has agreed very well with me hitherto, for I have a very good stomach, and sleep like a sop".⁷⁸

Lisa Smith has elucidated how physicians were often consulted in order to provide support for the party with less influence in the familial relationship; her examples consisted primarily of women who tried to acquire the London physician Hans Sloane's support in their own opinions.⁷⁹ In the aforementioned case, both Ann and Walter referred to physicians' recommendations for treatment or analysis of Walter's ill health rather than making claims of medical expertise based solely on personal knowledge. They both would have *cause* to use their own knowledge as justification: Ann because women were understood to be the caregivers of the home, and Walter as the head of the family. Instead, both brought in physicians to support their rival positions. Walter recounted his stay through regular references to Doctor Hartley, including the a letter on 16 June which justified his long stay because

Dr Hartley is gott better he waited on me this morning, and gave me great encouragement (sic); he told me, he would not promise to make me sound again, but he doubted not making me useful sound again, and as well as most Gouty person am to take a little opening Physick to morrow, and to Bathe of Saturday and continue it 3 times a week.⁸⁰

Ann countered on 13 July with her concerns by first stating her own general knowledge of bathing and its potential ill effects, "Bathing so very often, and sweats so profusely, as I'm told they do after it, will I fear weaken you in the end".⁸¹ She then utilized the Yorkshire physician Dr. Maeler to support her position, writing that

Dr Maeler was so kind as call her a few days ago, to enquire after you, I told him how you went on, and that Dr Hartley talkd of you staying 2 months there, he sd he must be ye best Judge, as he see how you went on, but he himself, thinks Drinking the Waters too long, a very bad thing, for tho' they brace ye Stomach at first yet by too long continuance, they relax afterwards. By telling you this I don't want to hasten you Home, I only mention it that you may be upon your Guard, and not undoe what you've already done.⁸²

⁷⁸ SpSt/6/1/70 (Walter to Ann Stanhope, 07 July 1757) and SpSt/6/1/69 (Walter to Ann Stanhope, 28 July 1757).

⁷⁹ Smith, "Reassessing the role of the family," 337.

⁸⁰ SpSt/6/1/70 (Walter to Ann Stanhope, 16 June 1757). See also SpSt/6/1/70 (Walter to Ann Stanhope, 07 July 1757).

⁸¹ SpSt/6/1/57 (Ann to Walter Stanhope, 13 July 1757).

⁸² Ibid.

It was this combination of her own contributory expertise, based on her personal knowledge of Walter's constitution and the progression of his illness, and Dr. Maeler's advice which recurred in her 02 August letter, when Ann positions herself as an expert on Walter's constitution with the conclusion that Walter's constitution would be particularly ill affected by lengthy bathing.⁸³ Physicians were central to both narratives, functioning to argue both for continuity and for change in Walter's medical regimen.

When these two attempts to utilize the knowledge of physicians are compared, Ann is revealed to be in possession of a more developed medical expertise. Walter presented himself as an interactional expert, choosing to relate and perform the recommendations of Dr. Hartley's contributory expertise rather than relying on his own knowledge for making decisions. This distinction occurred as Walter obediently bathed and drank the waters and reported the results back to his physician and to his wife. Ann, on the other hand, used contributory expertise when she synthesized the medical knowledge of Dr. Maeler with her own in order to better muster her own argument for the care necessary to preserve Walter's health. She presented herself as having independent knowledge when she argued that bathing and sweats would weaken her husband, then found support in the medical construct provided by Dr. Maeler regarding the stomach and relaxation due to the waters. Ann was combining sources of expertise to influence her husband's behavior to what she considers a more amenable and successful plan.

A less subtle example of conflict was evident in the Ponsonby family, who in 1792 were embroiled in decisions about the most effective treatment for Harriet Ponsonby.⁸⁴ Harriet lived either with or near her sister Elizabeth "Lady Betty" Cavendish. Harriet was understood to have a nervous complaint, which her family considered to be exacerbated by Betty's own attitude. In 1792, George Ponsonby wrote to his niece Louisa that

Ly Betty seems as well as you hear, and poor Harriet as miserably as you have been told. (...). I am sure from my information, that her life must not be in the least danger, But I think Ly Betty's Melancholy will be her death. Her anxiety keeps down her spirits, when the thing to do her good would be to raise them, and to continue to make her forget herself, if any thing is proposed Ly Betty is sure to object, and says that can be as amusement to Poor Harriet, and does not consider that it is getting over so much time.⁸⁵

⁸³ Ibid.

⁸⁴ See Appendix I(E) for the Ponsonby family tree.

⁸⁵ GRE/870/9/14 (George to Louisa Ponsonby, 15 July 1792).

Lady Betty's melancholy depressed Harriet's own spirits, and George considered Betty's medical decisions to be detrimental to Harriet's health. In making this evaluation about the health and relationships of his sisters, George presented himself as a contributory expert who was more capable of understanding the situation than any of the women in his family. The essential problem was: who should provide care for Harriet. George complained that he was out of patience with the doctor, who was proving ineffective. Matters were exacerbated by the fact that Lady Betty and her sister Rachael "mind the nonsense he tells them". George situated himself and the doctor in the position of contributory experts, and his sisters as ill-informed interactional experts. They did not have the level of expertise to understand that the advice they followed was not effective or helpful. Betty's own incompetence was a subject of great distress to George, who complained that

Lady Betty does not seem to have the least conception of what is poor Harriet's complaint, seems to think that if she does not Get Better, she must owe it to Physicians and Medicines tho she owns none of them have done her the least good but that she has so many different complaints, whereas I believe that if the main one was to come right, all the rest would disappear of themselves.⁸⁶

His arguments about Harriet's health indicated that he considered himself to possess the expertise to diagnose her and evaluate her treatments. Indeed, he felt that he was more capable of identifying "poor Harriet's complaint" than Betty. However, this authority was tempered by his inaction. While George seemed to strongly believe that Harriet was suffering due to the treatment she was receiving, he also limited his complaints to Louisa rather than describing them to either Betty or Harriet. His medical expertise and judgment were not acknowledged by the women in his family.

Interactional and contributory expertise could also set letter writers against the medical establishment more generally when families recommended self-care rather than the assistance of paid practitioners. Some physicians played into this narrative by publishing books to assist those who, for financial or location reasons, could not immediately access medical services.⁸⁷ The debate also occurred in more informal venues; Roy Porter shows how the *Gentleman's Magazine* emphasized "self management and temperance of body and mind" and had a general, unspoken

⁸⁶ Ibid.

⁸⁷ See for example Ginnie Smith, "Prescribing the rules of health: self-help and advice in the late eighteenth century" in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, ed. Roy Porter (Cambridge: Cambridge University Press, 1985): 249-283.

assumption of self-care in its readership.⁸⁸ In self-management, an individual's knowledge of their own constitution and responses to illness was perceived to be superior to the contributory expertise of a physician. Sufferers had to decide whom they trusted most to make the correct decision, and who had more expertise on their own bodies and decisions.

The process through which a physician's expertise would be discarded in favour of the contributory expertise of oneself or a family member could be gradual. Physicians were frequently utilized and evaluated for efficacy before returning to self-care became the more appealing option. For example, in the early decades of the eighteenth century, Mary Robinson complained to her husband that her surgeon, Mr. Burbeck, suggested a trip from their home in Newby to Scarborough to mend "ye sizeness of my blood". She wrote to her son,

I am not for his advice because sometime agoe upon drinking it it did not pass well flew up into my head caus'd a flushing, and after yt an extream coldness and numbnes in my forehead and back of my head with beating and pain, which I never knew before, but often after, so it makes me a littel affraid to try again, however yr father woud have you ask yr Unkle Doctors opinnyon and whether tis proper as to my breast which I think keeps much at a Hand.⁸⁹

The contributory expertise that had lead Burbeck to recommend Scarborough clashed with Robinson's own knowledge based on her experience of bathing. She had previously tried the waters recommended by Burbeck, and found the treatment to be both very unpleasant and long lasting. In addition, Mary believed that the treatment had given her new symptoms which she "never knew before, but often after," linking the emergence and persistence of these symptoms to her bathing experience. Particularly considering that the swelling on her neck and wrist were unobtrusive symptoms, she was understandably unwilling to engage with extensive unpleasant side-effects. However, Mary Robinson's opinion was mediated by the recommendations of other members of her family. She had been advised by her husband and Metcalfe's father to pursue a second opinion from the uncle living near Metcalfe. Therefore, though they agreed to disregard Burbeck's recommendations based on Ann's prior experience that the treatment would be ineffective, the family still sought the advice of an external practitioner on an appropriate treatment.

⁸⁸ Porter, "Gentleman's Magazine," 146, 149.

⁸⁹ WYL150/6006/II/26 (Mary to son Metcalfe Robinson, undated).

John Spencer possessed a high level of confidence in his sister Ann Stanhope's ability to manage her own health. Reflecting on the possibility of a range of treatments during one of Ann's regular illnesses in 1766, Spencer expressed the belief that

For my own part I have a great confidence both in Dr Cooksons Honesty and Ability and I dare answer for him he will exert both in your Service, but after all, as I have often mentioned to you before, my dear sister must be her own Physician. If you will give way to your own Whims, or believe every hostume you see in the News Papers, or hear from a canting old Gossip, not all the Power of Medecine (sic) will ever be able to releive you, But I will say no more upon this subject, to a sensible woman I have everlaing wrote enough to a positive one nothing would be sufficient.⁹⁰

John's statement combined his belief that Ann needed to practice a higher degree of self-control and confidence in the medical knowledge she already possessed. His criticism of external practitioners, however, particularly focused on informal methods. While he considered Cookson to be an effective practitioner, he dismissed newspapers and gossips as forms of unregulated medical information. Still, he suggested that she was a "sensible woman" who could manage her own care. Ann therefore had to have the knowledge in order to maintain her own regimen and simple treatments. In other cases, as in Ann's conflict with Walter over the extent of his treatment, Ann had participated in medical conversations. John Spencer validated this involvement in encouraging her to exert control over her own health.

Another difficult relationship with a practitioner can be found in the undated correspondence of Annabella Wentworth, who wrote in the late decades of the century to her sister Diana Bosville about a delay in her departure from London due to an ankle injury. Annabella described how her attempts at a self-treatment based on her contributory knowledge had not progressed after ten days, resulting in a reorientation of her medical procedure:

I washed it clean with milk and water and put a rag with a little dip salve to keep it from sticking it grew better for 10 days then stop and could neither grow better nor worse. I sent for an Apothecary who has I think made it worse I shall houe been a fortnight under his hands next Monday I requested my took of his plaster put in some diacculum and it is better to day I intend going on Saturday.⁹¹

Despite accepting the apothecary's treatment, and therefore acknowledging his own contributory expertise, for a significant period of time, Annabella compared her experience under the

⁹⁰ SpSt/6/1/76 (John Spencer to Ann Stanhope, 10 April 1766).

⁹¹ U DDBM/32/3 (Annabella Wentworth to sister Diana Bosville, undated but c.1780).

apothecary's treatment with her own medical experience and expertise and decided that his cure was not effective. She attributed her own decisions to the initial improvement of her leg, but acquired assistance when she stopped seeing improvement. The apothecary was given a fortnight to attempt a cure using a plaster, but Annabella considered this treatment to have made her worse. It was her own action, removing the apothecary's plaster and applying a new treatment to the injury, to which she attributed her successful cure. Patients could thus shift from giving primacy to their own expertise to those of others and later reacquire primacy, maintaining the contributory expertise necessary to evaluate the success of treatment throughout. Experience, in the form of successful cures, could bias writers to favour their own knowledge over the advice of practitioners. Letter writers desired treatments that were efficacious and agreeable: they wanted to see and feel progress with the minimum amount of discomfort. To that end, patients such as Annabella compared their own skills and knowledge to the advice of a practitioner, deciding whether their own expertise produced appropriate results and evaluating the efficacy or discomfort of the physician's treatment.

Letter writers and their readers, family and friends did not always agree on the causes of illness, appropriate treatments, or use of practitioners. As well as efforts to gain acknowledgement for expertise, the nature of the conflicts in correspondence reflects some of the changes seen in the use of contributory and interactional expertise. The three cases of conflict between experts show a move away from conflict between contributory experts, with Ann and her neighbour in 1710, to a mix of contributory and interactional expertise for the Stanhopes in 1757, and finally an emphasis on interactional expertise in George Ponsonby's judgement of his family in 1792. These cases also indicate the influence of gender on conflict and authority. Just as men were overwhelmingly more likely to engage the assistance of physicians using intermediary expertise, women were largely the figures who either declined or were advised to decline physician help. Seventy percent of the cases where authority was indicated through disagreement with physicians featured the opinions of women. Additionally, though men were more likely to suggest their correspondent "be their own physician," the person to whom they wrote was almost always a woman. This polarization of the association of individual expertise and external aid is a fascinating indicator of the process by which authority was gendered in the home. This may link to the larger issue of status and hierarchy: women had no guaranteed status

in society and their position was fraught outside the home, but they could effectively utilize expectations about their roles as caregivers and managers of the household.

Conclusion

Expertise was tightly related to the value which letter writers and their families placed on their medical knowledge and skills. This chapter has used the concept of expertise to link the ways in which letter writers talked about illnesses, their management of caregiving situations, and their understandings of medical causes, symptoms, and treatments. Utilizing Collins and Evans' model of expertise facilitates a more accurate explanation of how different sources of knowledge and medical skills interacted in the early modern period. While it can be useful to view medical knowledge on a spectrum in which lay and academic medical knowledge were dichotomies with a large grey area of interaction, the same model is inadequate for expertise. The qualities which defined expertise varied greatly between different types of experts: the knowledge to heal a leg wound differed from the knowledge to diagnose bad blood, and surgeons were expected to have different types of skills than physicians. Seen in this light, the knowledge and skills necessary to manage a sick household and treat family constituted a type of expertise, parallel to the paid medical professions and fundamental to early modern society. In order to manage health, families both had to possess independent skills and knowledge in the form of contributory knowledge, and the ability to effectively communicate and evaluate external practitioners in the form of interactional expertise.

Contributory expertise comprised the majority of references to medical skills and knowledge. Letter writers frequently made medical decisions based on their own knowledge, which they used to diagnose illnesses, inform their own medical treatments, make recommendations to their readers, and evaluate the efficacy of treatments. Contributory expertise was also present in the cases in which letter writers personally treated illnesses, ranging from caregivers such as Anne Clavering's management of the sick room to simple medical treatments recommended by John Spencer or Ms. Grimston. In cases where the knowledge of the household proved insufficient to manage an illness, letter writers proceeded to use interactional expertise to communicate effectively with practitioners. The language used in familial correspondence was very different from the prominent emphasis on detail and specific symptoms which characterized letters to practitioners. The ability of letter writers to navigate these two modes displays their

familiarity with the conventions and expectations of external practitioners, and could both translate household illness into institutional terms, and then decipher and apply the recommendations of practitioners. Letter writers also used these skills to compare practitioners, evaluating their efficacy and the relevance of their skills to the particular situation.

When distinguishing the features of contributory and interactional expertise, gender was a fundamental marker. Though both men and women made reference to their contributory expertise, women's preference for statements about contributory, rather than interactional, expertise is demonstrative of confidence in their medical knowledge and reflects their role as household managers and caregivers. The extent to which women emphasized their medical skills and knowledge supports the patterns displayed in Chapter Three, in which women were more likely to perform caregiving work, and Chapter Two, in which women's comments more frequently made reference to medical knowledge than nondescript references to illness. A study of expertise reinforces the importance which women placed on their own medical work, and how letter writers saw their female relatives as important sources of medical information.

Men did possess contributory expertise, in the same way that they supplemented the caregiving work of female relatives and made claims of medical knowledge, but they were most likely to take the role of acting as an intermediary between the household and external practitioners, and as a result utilized interactional expertise more frequently than women. This reflects their role as heads of the household, managing resources and ensuring the welfare of their families, as well as the legal realities of the eighteenth century: women, children and servants did not have the right to contract with a medical practitioner, and consequently the formal arrangements for medical cure went through their male relatives.⁹² There was flexibility in these roles in which men and women supported and supplemented each other's work, but the two types of expertise roughly mirror the division of gendered labour in the eighteenth century. Contributory expertise, performed largely in private within the family home, was frequently the purview of women, while the communicative skills necessary for interactional expertise were the domain of men who interacted with the wider community.

The relationship between expressions of interactional and contributory expertise shifted throughout the eighteenth century. In the early decades of the study, letter writers exclusively referred to situations which contained contributory expertise, but, as the century progressed,

⁹² Smith, "Relative duties," 232; Crawford, "Patients' rights," 396.

letters were more likely to include situations in which interactional expertise was used to make decisions about external medical practitioners. Contributory expertise did not vanish during this period; indeed, one of the densest networks of references to contributory expertise occurred in the 1780s during the medical conversations of the Ponsonby family. This indicates that families continued to value the collection and utilization of knowledge and skills based on experience. The growth of interactional expertise is, however, indicative of a partial shift away from household medical work as relatively independent and self-sustaining, to a household that relied on external services to support its knowledge and caregiving practices. If historical research ends in the early decades of the eighteenth century and resumes with the rise of hospital medicine in the nineteenth century, the process of transition which linked the two modes of health care is lost. Tracking the changes justifies the narrative associated with the increasing professionalization of practitioners, but it also moderates this view. The increasing emphasis on practitioner involvement did not lead to a proportional decline in household medical authority, but instead included a range of resources in preserving household health.

Retaining the language of expertise, contrary to Mendelson and Kinzelbach's suggestion of "resting" the concept in favour of a focus on shared knowledge, has allowed this study to differentiate between different types of experts, and different levels of expertise in each family.⁹³ When letter writers made arguments about appropriate treatments or practitioners, they were accessing their long experience with the process of being ill and the treatments which had proved effective in the past. It is possible to assign household medical worth its appropriate status by integrating a framework of medical expertise in which households existed in concert with the commonly acknowledged medical experts, such as apothecaries, surgeons, and physicians. Families did have medical expertise which frequently proved sufficient to manage illness, and when this front line of caring proved insufficient they transitioned to another important network of knowledge in order to select and communicate with external practitioners. Expertise was fundamental in helping families to define the parameters of medical knowledge in the home. Contributory expertise reflected their skills, and interactional expertise allowed households to effectively interact with the medical marketplace. The next chapter will follow the theme of interactional expertise and external practitioners by examining the depiction of relationships between households and paid medical help in correspondence.

⁹³ Mendelsohn and Kinzelbach, "Common knowledge," 277.

Chapter Six — The Role of Medical Practitioners in Household Health

During James Lister's medical treatment at Scarborough in 1769, he received a letter from his father Jeremy congratulating James on an improvement in his health before providing news and medical advice of his own. He wrote that

My Sister Wilkinson saw Doctr Hulme yesterday who enquired after your Health, and was surprised you are not returned from Scarborough, it being a cold place and the summer far advanced and if you should catch cold it would be worse for you than if you had not gone, so I would advise you to come home without further Delay.¹

This letter displays one method used by practitioners to integrate themselves into household dialogues about illness, and also indicates the degree of choice which families had in receiving and observing medical advice. Jeremy Lister's reference to Doctor Hulme is an example of the three-way medical relationship analyzed by Lisa Smith in which medical interactions were not only between a patient and their practitioner but also involved the opinions and influence of the patient's family.² In James Lister's illness, advice from a practitioner was acquired in person by his aunt Phoebe Wilkinson, who informed his father, who wrote to James. It also indicates the active role which many practitioners played in providing medical aid: no one in the family had asked for Hulme's advice, but instead he took it upon himself to ask Jeremy's sister for news on her nephew, then offered advice freely. The family subsequently evaluated the worth of his words, recommending against James Lister's sustained course of bathing at Scarborough, and decided it merited a letter to James from his father. The subject of medical practitioners reveals how family members used their intermediary medical expertise, explored in the previous chapter, to evaluate both the medical expertise and social relationship with a range of practitioners.

Acquiring the work of a medical practitioner did not necessitate the loss of power and autonomy for the gentry families in this study. Instead, families supplemented their own skills and knowledge with the advice and treatments of medical practitioners in cases where their own efforts were insufficient or the illness was unfamiliar. Interactional expertise allowed families to mediate relationships with a range of practitioners, and to communicate either in person, via an intermediary, or through correspondence. The occupational labels of physician, surgeon, and

¹ SH:7/LL/181 (Jeremy to James Lister, 11 September 1769).

² Lisa Smith, "Reassessing the role of the family: women's medical care in eighteenth-century England," *Social History of Medicine* 16.3 (2003): 327-8.

apothecary provided a rough guide as to the services each practitioner provided, but families individually examined the expertise of their chosen practitioner, and often selected different practitioners for different illnesses. As well as the exchange of services for money, relationships between families and their practitioners could be characterized by a degree of intimacy. This was particularly the case for families who maintained the services of a single practitioner over several years, even developing social relationships which involved dinner and conversations. Familial letters reveal the junction of sociability and medical advice in the eighteenth century.

A description of the relationships between letter writers and practitioners in familiar letters contributes to the existing literature on families and doctors in two ways. First, this investigation complements the existing historiography in asking to what degree paid medical care complimented the medical knowledge and skills of household health. As seen in Chapters Two and Three, letter writers felt confident diagnosing a range of illnesses, selecting treatments, and supervising the sick room. This chapter complements these themes by displaying how the selection of a practitioner was a necessary extension of household skill. Second, it provides a means of testing the efficacy of practitioner self-presentation, by comparing family descriptions of practitioners with attempts by physicians to acquire social and professional status. Physicians in particular emphasized their unique qualifications and skills while making a bid for increased social status. Integrating the opinions of letter writers helps evaluate the success of attempts by physicians to increase their influence compared to surgeons and apothecaries.

Correspondence reveals the extent to which the formation of relationships between practitioners and the community was an important factor in choosing medical help. Practitioners benefitted from remaining in a community and building up the relationships which could lead families to select one practitioner as a primary caregiver. Lane notes that “the majority of medical practitioners remained in the same community where they had built up goodwill and had established premises and a clientele”.³ These elements of goodwill were critical for the success of all practitioners: Nicholas Jewson contends that the medical relationship in the eighteenth century could be defined as “patronage based” because the financial power and approval of the patient was more significant than the authority of the practitioner.⁴ Anne Digby notes that “maintaining a practice was not only dependent on clinical skills and diagnostic acumen but also

³ J. Lane, “The medical practitioners of provincial England in 1783,” *Medical History* 28.4 (1984): 364.

⁴ Nicholas Jewson, “Medical knowledge and the patronage system in eighteenth-century England,” *Sociology* 8 (1974): 378.

on relationships with individual patients”.⁵ Margaret Pelling indicates that physicians were “the most ambitious, and the most anxious, in status terms” and therefore were invested in gaining recognition.⁶ In an effort to contrast their tight association with the “feminine” work of caring for the sick and the occupational label of “trade” based on the manual elements and close association with the female body, physicians had a particular onus to emphasize the intellectual nature of their work and to self-identify as a medical and social elite.⁷ Correspondence demonstrates the response of gentry families to some of the social overtures of their practitioners by forming relationships that transcended the medical relationship.

Regionalisms are an important factor in historical investigations of medical decision making. Anne Digby’s research has emphasized the regional differences in the number, diversity, distribution, and availability of practitioners.⁸ Much of the historiography emphasizes the increased amount of self-definition and space to practice for surgeons and apothecaries in the process: there were few legal or governmental definitions of the medical occupations, particularly in the provinces, which meant that a practitioner could base their medical work on the extent of their own skills and needs of their clients.⁹ As a result of the potential occupational ambiguity, Irvine Loudon suggests that occupational divisions are not a useful tool for understanding provincial medicine because practice was dictated by competition and

⁵ Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 176.

⁶ Margaret Pelling, “Politics, medicine and masculinity: physicians and office bearing in early modern England” in *The Practice of Reform in Health, Medicine, and Science, 1500-2000: Essays for Charles Webster*, ed. Margaret Pelling and Scott Mandelbrote (Aldershot: Ashgate, 2005): 85.

⁷ See for example: Ibid.; Digby describes physicians as a self-perceived medical and social elite, as a result of which it was “important [...] for them to be socially visible in *Making a Medical Living*, 170, 172; Irvine Loudon depicts the uncertain status of physicians between “trade” and “profession” in “The nature of provincial medical practice in eighteenth century England,” *Medical History* 29 (1985): 23; Peter Brown emphasizes the highly public identity of physicians, who wanted to be and be *seen* to be charitable, benevolent, and genteel in *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Palgrave Macmillan, 2011): 2.

⁸ Digby, *Making a Medical Living*, 11.

⁹ Dorothy Porter and Roy Porter outline how the traditional apothecary “abandoned his vulgar shop-counter and turned bedside-visiting into the most visible aspect of his craft” in *Patient’s Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 21; Roy Porter also depicted surgeons or surgeon-apothecaries acting as general practitioners in “The patient in England, c. 1660-1800” in *Medicine in Society: Historical Essays*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992): 93; David Harley identifies surgeon-physicians in north-west England in “‘Bred up in the study of that faculty’: licensed physicians in north-west England, 1660-1760,” *Medical History* 38.4 (1994): 415; Irvine Loudon focuses on surgeon apothecaries and their sense of commercialism in “The nature of provincial medical practice,” 1; Lane observes similar trends in her analysis of the Medical Register of 1783 in “The medical practitioners of provincial England in 1783,” 355; and Joseph Kett asserts that “surgeon” and “apothecary” were used interchangeably and that the difference between surgeons and physicians was “more a matter of prestige than function” in “Provincial medical practice in England, 1730-1815,” *Journal of the History of Medicine and Allied Sciences* 19.1 (January 1964): 17, 24.

opportunities, but that opportunistic factors such as temperament, personal preferences, familial background and training established the manner of practice.¹⁰ Additionally, isolation from a dense population of physicians, who were particularly located in medical spa centres such as Bath or the metropolitan capital of London, provided opportunities for northern gentry families to take advantage of obtaining medical advice by correspondence.¹¹ Letter writers could thus make choices about local versus distant medical advice, as well as the type of practitioner they wished to consult.

Selecting the appropriate practitioner required families to first use their own medical skills and knowledge to evaluate and attempt to treat their families, then to rate practitioners by a combination of skills, expense, and convenience in the “medical marketplace”.¹² The process was complicated by the convoluted relationships and competition between practitioners. It was not as simple as the “tripartite model”, which Dorothy Porter and Roy Porter depict as the propaganda ideal of “a professional pyramid lorded over by a closed clique of physicians” who would “look down on their distant cousins, the surgeons, who had trained for their primarily manual craft through mere apprenticeship.” “Lower still” were the apothecaries whose role labeled them as “a trade reeking of the counter.” They conclude by observing the inability of physicians to maintain control even at the beginning of the eighteenth century.¹³ Lawrence Brockliss has modified this model with arguments that there was a “growing discrepancy” between the reality of medicine “on the ground” and the theoretical structure of a “tripartite” system.¹⁴ Practitioners observed a high level of nuance within professions and modified their occupational labels based on additional training. “Irregular” practitioners functioned in the same market often without any formal medical training.¹⁵ The complex interaction between

¹⁰ Loudon, “Nature of provincial medical practice,” 1, 5.

¹¹ Wayne Wild, *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters* (Amsterdam: Rodopi, 2006); Smith, “Reassessing the role of the family,” 327-342; for the French context and the role of Tissot, see Robert Weston, *Medical Consulting by Letter in France, 1665-1789* (Burlington: Ashgate, 2013).

¹² See section four in Chapter One for further context of the concept of the “medical marketplace”.

¹³ Porter and Porter, *Patient's Progress*, 17-18.

¹⁴ Lawrence Brockliss, “Organizing, training, and the medical marketplace” in *The Healing Arts: Health, Disease and Society in Europe, 1500-1800*, ed. Peter Elmer (Manchester: Manchester University Press, 2004): 378.

¹⁵ Anne Digby reviews occupational differentiation within professions in *Making a Medical Living*, 25. For more on the relationship of physicians and irregular practitioners, see Roy Porter, *Health for Sale: Quackery in England, 1660-1850* (Manchester: Manchester University Press, 1989). For investigations of eighteenth century relationships between practitioners, particularly in provincial medicine, see footnotes 65-66 below.

practitioners is rarely visible in correspondence, but helps to inform methods used by gentry families to evaluate their medical care.

Acquiring the work of a medical practitioner did not necessitate the loss of power and autonomy for the gentry families in this study. In order to show how families maintained control over their illnesses while using the skills and knowledge of practitioners, this chapter proceeds in three sections. First is an exploration of the context in which the service of practitioners was acquired which examines the familial relationships between the writer and the patient, the number of practitioners per family, and the choice between consultations in person, via an intermediary, or through correspondence. The second section focuses on the variety of practitioners available through a study of the different medical occupational labels in correspondence, focusing particularly on the roles of apothecaries and surgeons in family health. Finally, the dense sample of named practitioners is used to explore the situations in which families retained the care of single practitioners, both from the perspective of the families and the self-fashioning attempts of practitioners. This chapter will analyse the extent to which paid medical practitioners interacted with the household, as well as how perceptions of the status and skills of practitioners influenced their inclusion in the narratives inherent in composing familiar letters.

Reasons for Calling the Practitioner

The gentry referred to practitioners in two hundred sixty-two letters, representing twenty-eight percent of the total correspondence of this study. When compared to the expressions of knowledge explored in Chapter Four, which were found in thirty-three percent of letters on illness, mentioning practitioners was slightly less common, indicating that letter writers preferred to refer to their own medical knowledge than to seek paid assistance. This perspective correlates with historiography about the significance of self-care.¹⁶ This section will illustrate the contexts

¹⁶ Porter and Porter claim in *Patient's Progress*, 8, that “the maintenance of health and the battle of disease remained essentially individual responsibilities”; Roy Porter indicates that sufferers could play “an active and sometimes a decisive” role in managing their health in “Lay medical knowledge in the eighteenth century: the evidence of the *Gentleman's Magazine*,” *Medical History* 29.2 (1985): 138. The subject is also addressed in a wide range of literature on the history of medicine, particularly in relation to household health and medicine preparation, including Alun Withey, *Physick and the Family: Health, Medicine and Care in Wales, 1600-1750* (Manchester: Manchester University Press, 2011); Olivia Weisser, *Ill-Composed: Sickness, Gender and Belief in Early Modern England* (New Haven: Yale University Press, 2015); Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London: Routledge and Kegan Paul, 1987): 4.

in which paid practitioners appeared in the familiar letters exchanged by gentry families. It will outline the illnesses, relationships of writers with patients, and process of interacting with practitioners throughout the century. In particular, it looks at the preferences letter writers displayed for the context of the medical interaction, emphasizing the continuing significance of the home even as external medical aid was solicited.

The number of men and women who used the services of practitioners is almost exactly equal in this sample of correspondence: one hundred and seventeen women and one hundred sixteen men as patients. Within this equal gender spread, letter writers obtained the care of paid medical practitioners for fifty-one different conditions and seventy-seven cases of unnamed illnesses which included situations in which correspondents only mentioned that a practitioner attended, and where that they attended someone described as being “ill”.¹⁷ Choosing not to identify a condition implied that it had been the subject of an earlier conversation, such as when John Spencer wrote to his sister Ann Stanhope in 1765 that he was “extremely sorry to hear you are still upon the complaining order”.¹⁸ The assumption of shared knowledge allowed letter writers to focus on the new information and details of the practitioner, rather than revisiting symptoms and diagnoses.

When recording named illnesses, letter writers mentioned the intervention of practitioners primarily in serious or unusual cases. Sufferers of cancer, smallpox, consumption, paralytic fits, or convulsions would fall outside of the range of usual illnesses treated in the home, and also had a higher likelihood of fatality. However, mundane illnesses also required the treatment of practitioners. Illnesses which were unusually severe or persistent, such as gout, leg injuries, coughs, sore throats, and fevers could also see families acquiring care outside the home. Compared to the density of references to gout, colds, and coughs in the total sample of correspondence, practitioners were only called in twenty-eight percent of the cases for gout, nine percent for colds, and seventeen percent for coughs. The supportive role that practitioners could play supplemented the self-care practices named in previous chapters. The majority of regularly occurring illnesses could be handled using the household contributory expertise defined in the previous chapter, but cases which were exceptional or particularly dangerous required external aid.

¹⁷ General statements about “illness” rather than naming a condition has been discussed in Chapter Three, see also Appendix II.

¹⁸ SpSt/6/1/94 (John Spencer to Ann Stanhope, 27 April 1765).

As well as accessing the services of a single practitioner for a variety of illness, most families also used the care of a variety of practitioners. In over two hundred letters on illness spanning a century, the Robinsons referred to eighteen different practitioners including regular letters from William Robinson's brother Dr. Janered Robinson in the first half of the century, sustained treatment of Mary Robinson's leg injury in the early decades of the eighteenth century by Mr. Birbeck, Dr. Heberden's advice on Therese Robinson's breast lumps in 1763, and Mr. Hawkins' bleeding of Thomas Robinson in 1767. William and Metcalfe Robinson were both chronically ill, William with gout and Metcalfe with deafness and a range of complaints which eventually contributed to his death by suicide in 1736 when he was overwhelmed by the combination of his own ill health and the pressures of estate management after his father's death.¹⁹

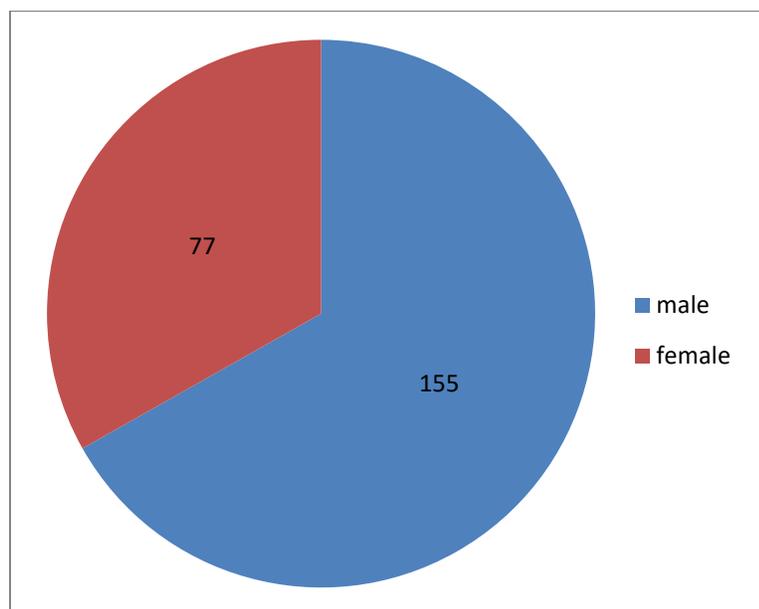
In some cases, as will be established in greater detail in a later section, the Robinsons relied on a particular practitioner for a sustained period of time, or consulted the same practitioner over several years. Similarly, the Stanhope family used the services of seventeen practitioners over more than one hundred fifty letters between 1651 and 1784, including Dr. Chambers' bathing recommendations in 1757, extended medical advice from Dr. Cookson, and Dr. Rainstick's care of Ann Stanhope's servant John Harness during his final illness in 1782. Only one family referred to a single practitioner: the Armytages consulted only Dr Armytage.²⁰ Given the shared surname, it is possible that they were availing themselves of the aid of a relation. The willingness to select different practitioners based on the time, illness, and locations indicates that families continued to take advantage of the "medical marketplace", changing their practitioners based on a nexus of reasons including the practitioner's prior successes, the nature of the illness, and the location of the patient.

Men made more references to practitioners than did women, as seen in Figure 6.1, representing sixty-seven percent of the references. This can be explained in part by the higher number of male letter writers in the sample, and when adjusted for this factor the difference is much smaller. Twenty-eight percent of the male references to illness included practitioners, and twenty-four percent of women. The majority of references to practitioners were for family use: with one hundred eighty two cases representing seventy-eight percent of the references.

¹⁹ G. Hinchliffe, "The Robinsons of Newby Park and Newby Hall," *The Yorkshire Archaeological Journal* 63 (1991): 138.

²⁰ DD/WBC/81 (John Armytage, recipient unknown, 24 March 1705).

Figure 6.1 – Men and Women’s References to Paid Practitioners



However, there remains a sizeable category in which writers utilized the care of their friends and local famous figures, particularly for those in London who had access to the latest fashionable news.²¹ Generally, however, the descriptions of practitioners followed the relationship patterns of correspondence.

The closest focus was on personal care, in which men referred to acquiring a practitioner’s aid forty times and women referred to their own treatment slightly more than half as often as men. The comparative self-interest of men may be a result of different concerns about the effects of extended illness: Olivia Weisser notes that though women’s sickness required adaption of the household, men’s work affected their income and thus had wider-reaching consequences.²² The sick role in turn affected the content of a familiar letter, in which there was an expectation of providing a narrative that simulated intimacy through recreation of daily life.²³ Depicting the care of other members of the household was also popular. Letter writers

²¹ Both William Chaytor and Bess Cavendish reported on social news and illness in their letters to northern family members.

²² See for example, Olivia Weisser, *Ill Composed*, 47; Alun Withey, *Physick and the family*, 123; and for some of the sociological perspectives see for example Jens Lachmund and G. Stolberg, *The Social Construction of Illness: Illness and Medical Knowledge in Past and Present* (Stuttgart: F. Steiner, 1992): 28. Ann Stobart also explains the necessity of reallocating the tasks of sick family members in *Household Medicine in Seventeenth Century England* (London: Bloomsbury Academic, 2016): 157.

²³ See the discussion on the function of familiar letters in Chapter Two, particularly p. 8, based in part on Leonie Hannan, “Making space: English women, letter-writing, and the life of the mind, c. 1650-1750,” *Women’s History Review* 21.4 (2012): 591, 598.

Figure 6.2 - Men's Relationships to the Patients of Paid Practitioners

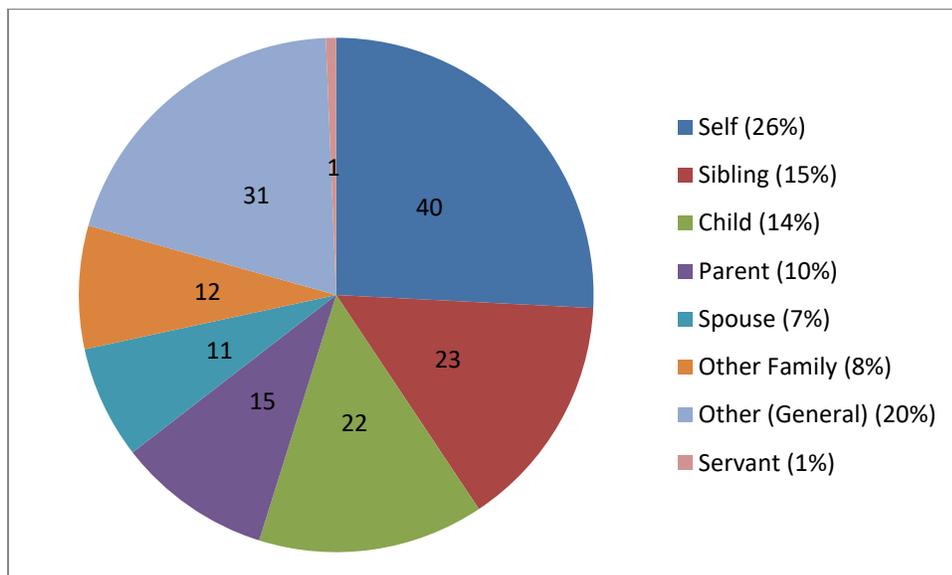
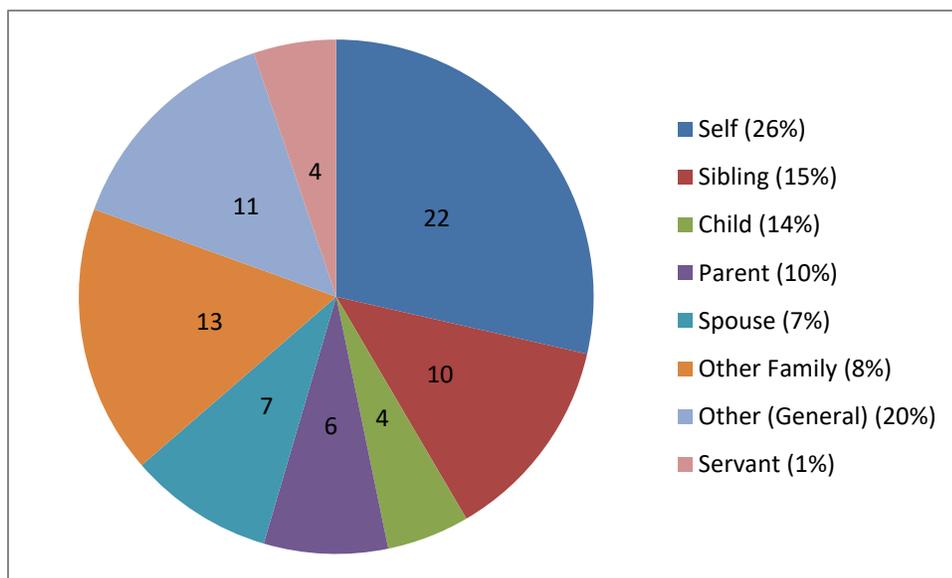


Figure 6.3 - Women's Relationships to the Patients of Paid Practitioners



particularly commented on the health of siblings, children, parents, and their spouses. In this category, the health of children was a significant contribution, which compliments Hannah Newton's research on the importance of caring for the sick and a familial willingness to pay for

their medical care, contrary to older historiographic narratives which dismissed the health of small children.²⁴

Figure 6.2 displays how men were more likely to position themselves as having acquired medical care for their families, representing seventy percent of the descriptions of siblings, eighty-four percent of children, seventy-one of parents, and sixty-one percent of spouses. The strong emphasis on men as the intermediary between families and caregivers supports Lisa Smith's claims about men's management of contacts with external practitioners for family health.²⁵ Because of the increasing emphasis on "oeconomy", the heads of households were expected to manage the large financial elements, as well as playing roles in caregiving and presenting knowledge, as has been explored in previous chapters.²⁶ However, studying healthcare reveals that it was not only men who organized care for their wives, children, and servants.

Women actively sought paid care for a range of relationships, albeit in less dense numbers. Figure 6.3 shows the spread of female familial references. In addition, there were two relationships in which women were more likely than men to depict themselves acquiring the services of a practitioner. The first situation was servants. For example, Anne Clavering sat up with her steward in 1710 and Ann Stanhope sought a range of practitioners when her household suffered from influenza in 1782.²⁷ Women also dominated inquiries about the health of nieces and nephews, making eighty-seven percent of the references to their medical care. Compared to men's focus on the household and kin, women's emphasis on servants and the children of siblings reflects a division of labour which saw women exerting their medical expertise in managing smaller elements of the household, while men acted for the family in interacting with external and financial elements of care.

²⁴ Hannah Newton, *The Sick Child in Early Modern England, 1580-1720* (Oxford: Oxford University Press, 2008) challenges the perceptions of Roy and Dorothy Porter. In *Sickness and in Health: the British Experience 1650-1850* (London: Fourth Estate, 1988); Linda Pollock (*A Lasting Relationship: Parents and Children over Three Centuries* (Hanover: University Press of New England, 1987); and Anthony Fletcher, *Growing up in England: the experience of childhood, 1600-1914* (New Haven: Yale University Press, 2008) in *The Sick Child* (Oxford: Oxford University Press, 2012): 11.

²⁵ Lisa Smith, "The relative duties of a man," *Journal of Family History* 31.3 (July 2006): 232.

²⁶ *Ibid.*, 238.

²⁷ CLV 47 (Ann to James Clavering, 27 June 1710) and letters from Ann Stanhope to her son Walter on 22 July, 15 August, 02 September 1782 in SpSt/6/1/122 and /125.

The process of communicating information between the sufferer and practitioner also reflects Lisa Smith's "three-way medical encounter" model.²⁸ The negotiation between Nancy Chaytor and her parents, William and Peregrina, during her 1701 illness is particularly demonstrative of the potential for complex familial involvement in illness. Nancy had been troubled with her complaint for an extended period of time, with episodes lasting "six or seven weeks", by the time her mother Peregrina composed a letter on Nancy's health to her father. William Chaytor was in debtor's prison in London, and used the opportunity to consult local physicians for his own health and on behalf of his family. Mary's letter opened with a complaint about Nancy's willingness to have her mother as intermediary, writing, "I must thank you for your care and the doctor for his advise but your daughter is too nice for she says she cud answer the doctors queries to him self better than to you". Several lines later, Nancy had decided that her mother's account would in fact suffice as a medium for her symptoms and "is now pleast to let me giv you some account of her".

Peregrina recorded Nancy's account of the "salt wayterish humor like tears when one weeps" that was affected by the time of the month and caused skin swelling and spots. Nancy concluded the letter in her own hand, reporting that the "cruel itching houmer" had been restricted to her hands for the summer and itched when it swelled. She also referred to the diagnoses of two local doctors, that "Doctor Anderton's oppinion that the swelling was caused by a windy blood and Mr chambers thought it both wind and [?]rechtine".²⁹ Smith's emphasis on the involvement of family could not be more apparent than in the case of Peregrina writing on behalf of her daughter, sending her letter to a husband who would in turn act as an intermediary for a physician. Nancy's effort to control her illness account is evident in her chafing at her mother's involvement, but ultimately both parents participated in the conversation about her symptoms and the acquisition of practitioner care.

Regardless of their relationship with the patient, nearly sixty percent of references to practitioners involved an in-person consultation. In almost half of these cases, it can be further established that the consultation occurred within the patient's home. When acquiring the care of distant practitioners, intermediaries acting in person represented thirty-six cases, compared to

²⁸ Smith, "Reassessing the role of the family," 327.

²⁹ ZQH/9/14/121 (Peregrina to William Chaytor, 07 August 1701).

only eighteen cases of letters from practitioners in this sample.³⁰ The decision to favour face-to-face interactions above medical letter writing is particularly striking in the case of the Robinsons and William's brother Dr. Tancred Robinson, referred to in letters as "unkle doctor".³¹ Of the nine references to acquiring Tancred's advice, only one letter, circa 1715, included advice directly penned by the doctor. Even in this case, his advice was included on the third page of a letter from William, not mailed independently.³² Instead, medical questions were directed to William when he was in London for business or to their son Metcalfe during his Cambridge education and subsequent move to London. For example, Mary Robinson wrote to Metcalfe that "yr father woud have you ask yr Unkle Doctors opinnyon and whether tis proper as to my breast which I think keeps much at a Hand".³³

Correspondence between the Listers and David Hartley was similarly limited. John Lister and Hartley corresponded directly regarding the health of Lister's friends and family between 1730 and 1755.³⁴ Although the content of a letter could be shared or the correspondence read by multiple people, the conversation it contained was directly between two people. The personal relationships between the Robinsons and for Lister and Dr. Hartley typify the communication between the gentry and distant practitioners in this collection. Despite the opportunity for medical correspondence, families preferred to send information to a representative who would then interact in person with the practitioner. This may have been due to the convenience of having a live representative, who could ask questions, seek clarification, and provide additional information at a pace which would be impossible by post.³⁵ Additionally, the gentry of the eighteenth century north-east was peripatetic, and willing to travel to find the best treatment.³⁶ Cases such as Walter Stanhope's trip to Bath saw families exchange their home physician for a

³⁰ See <http://sloaneletters.com/> and <http://www.cullenproject.ac.uk/> for digitization projects for the two physicians.

³¹ G.H. Hinchliffe chronicles how Tancred achieved his doctorate in 1685, became a Fellow of the Royal Society in London, and was appointed Physician in Ordinary to George I in "The Robinsons of Newby Park," 136. See also G.S. Boulger, "Robinson, Sir Tancred (1657/8-1748), physician and naturalist" in *Oxford Dictionary of National Biography* (Oxford University Press online edition: May 2010) <http://www.oxforddnb.com/view/article/23873>. Last accessed 18 November 2017.

³² WYL150/6001/58 (William and Tancred Robinson to Mary Robinson, 24 April c.1715).

³³ WYL150/6006/II/26 (Mary to Metcalfe Robinson, 14 May).

³⁴ For example, amid letters focusing on philosophical discourses, Hartley responded on 18 January 1753 to John Lister's description of the illness of a local boy with the advice that "I have known some very great Disorders of the Eyes cured by the Diet of Bread, Milk and Lime Water, with mercurial Purges, and wd advise in the Case you mention a Trial of it after the following manner" (SH:7/HL/47).

³⁵ As Chapter Two stated in section 1, while the infrastructure of correspondence was greatly improved by the eighteenth century it could not replicate the speed of conversations in person.

³⁶ Discussed in chapter 2 of this thesis. See also A.W. Purdue, *Merchants and Gentry in North-East England, 1650-1830: The Carrs and the Ellisons* (Sunderland: University of Sunderland, 1999): 76.

local practitioner, valuing the advice of Dr. Hartley over the updates from practitioners at home in Anne's letters.³⁷ Families clearly valued immediacy in their relationships with practitioners.

Range of Practitioners

Letter writers used a variety of terms to refer to practitioners in their correspondence. As seen in Figure 6.4, most of the references were to men who were employed in the formal medical professions: doctors, surgeons, and apothecaries. In forty-two percent of the cases, letter writers labelled their practitioner by occupation, rather than name. References to the services of “the doctor”, “a doctor”, “my” or “his doctor”, or “the doctors” dominated the category, composing eighty-two percent of the references to unnamed practitioners.³⁸ The remaining two levels of the traditional “tripartite” division of practitioners were barely represented in correspondence. Apothecaries were referenced in only four percent of the cases, and surgeons comprised only three percent of the references. The heavy preference for doctors found in correspondence drastically undermines current historiography about the changing patterns of development for medical professions in the eighteenth century.³⁹

When describing the acquisition of paid care for illness, the largest category of unnamed practitioner was “the doctor”, who was called for a variety of complaints or concerns. While it has not been possible to comprehensively determine if those referred to as “doctors” by letter writers possessed the university qualifications to validate their titles, investigations of named doctors reveals that the occupational labels in correspondence were largely accurate.⁴⁰ These cases began with the premise that the reader would know which person was meant by “doctor”. Most doctors were summoned to the house, such as when Ann Chaytor recounted to her father in 1704 how “The doctor and I had a sad bout with my mother last night about the diacodium”.⁴¹ Her cooperation with the practitioner was typical of medical interactions, particularly given the frequency of inviting doctors into the home. In serious cases, the expertise of a collection of practitioners might necessitate the simultaneous advice and care of multiple practitioners, such as when Sam Hapnell reported to Thomas Hapnell that their father was near death in 1730 and that

³⁷ Walter Stanhope's bathing journey was the opening anecdote of Chapter Five on medical expertise.

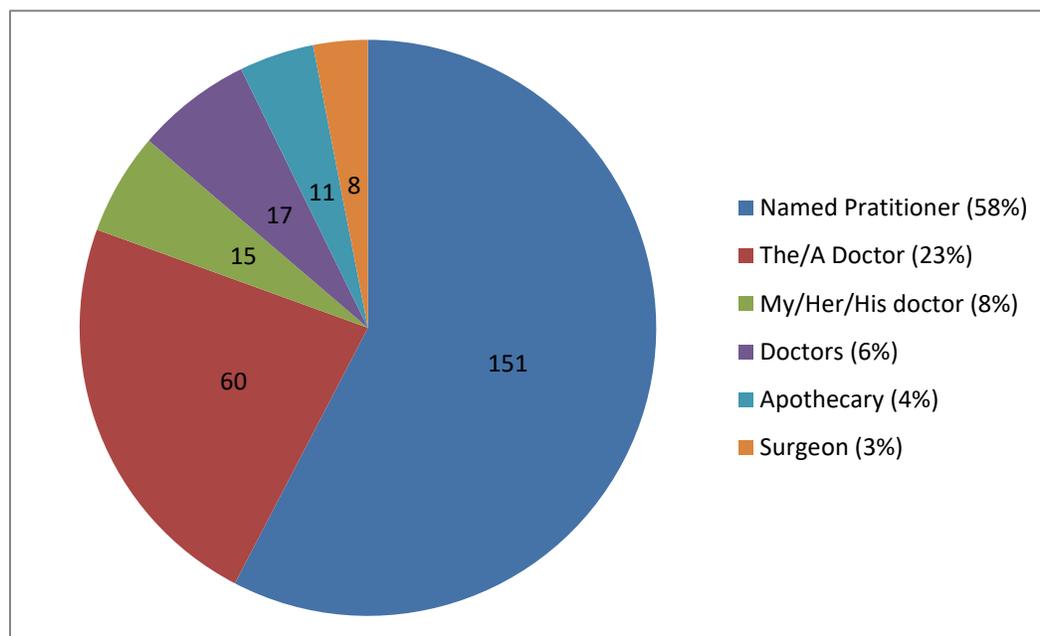
³⁸ For references to practitioner by decade, see Appendix VII.

³⁹ See footnote 9 above.

⁴⁰ The identity of several doctors is detailed below, particularly in footnotes 80-88.

⁴¹ ZQH/9/15/104 (Ann to William Chaytor, 13 June 1704).

Figure 6.4 – References to Practitioners



“The Doctors have not the least hopes of his recovery”.⁴² “Doctors” or “Physicians” were also used to represent the general state of medicine when letter writers expressed criticism. Writing to his sister Ann Stanhope regarding the health of London around 1760, John Spencer indicated that “there was never more Employment for the Physical tribe” and reminded Ann that “you can employ no worse Doctor, than yourself”.⁴³ Self-care was contrasted directly with to the quality of work by physicians in general.

The eighteenth century saw a shift away from proprietary comments such as “my doctor” or “her doctor”. When G. Dawson diagnosed himself with the vapours in 1701, William Chaytor outlined how “he sent for his doctor who put a probe in his mouth”.⁴⁴ After reflecting how he had been ill advised in trying the baths in October early in the eighteenth century, Metcalfe Robinson informed his mother that “My Doctor is for having me go into Italy and come home well in summer”.⁴⁵ However, the number of references decreased after the 1720’s, and there was only one reference to “his doctor” after 1760.⁴⁶ In its place, the frequency of references to a named practitioner rose. This seems to indicate a greater reliance on particular practitioners, and

⁴² U DDBM/32/4 (Sam to Thomas Hapnell, 22 May c.1730) see also an unsigned and undated letter’s comment that the writer “has consulted the Doctors is put into a new course of Physick” in WYL150/6006/IV/5.

⁴³ SpSt/6/1/58 (John Spencer to Ann Stanhope, c.1760).

⁴⁴ ZQH/9/14/50 (William to Peregrina and Ann Chaytor, 27 March 1701).

⁴⁵ WYL150/6004/13529 (Metcalfe to Mary Robinson, 04 October c.1710).

⁴⁶ GRE/B70/4/2 (unsigned to Louisa Ponsonby, c.1790).

an increase in their status in the eyes of their gentry patients. Rather than an interchangeable doctor, late eighteenth-century practitioners were recognized to have individual identities.

Apothecaries were scarcely referenced in correspondence about ill health, they were never referenced more than three times in a decade and were completely unreferenced in several decades. This silence raises questions about the sourcing of medical materials, since Chapter Three showed how letter writers generally chose to treat themselves with medicaments but made few references to acquiring these resources. Reporting from Cambridge in 1728, John Lister informed his parents that he had an Ague and “shall have to pay ye apothecary’s bill”.⁴⁷ It was slightly more common for letter writers to portray apothecaries dispensing advice rather than medicine. Anne Clavering reported that her half-sister Betty was “now well again by ye help of ye Apothecary only” after several violent fits of asthma in 1710.⁴⁸ Hannah Knaplock wrote about the health of her guests in 1754, describing how after Mrs Wyersdale contracted a rheumatic fever, “Her Apothecary advises to Buxton next month”.⁴⁹ The emphasis on medical advice in these references reveals the rise of the apothecary as a type of “general practitioner” who expanded his original role from dispensing medicines to offer medical advice as well, cutting the physician out of relationships with patients.⁵⁰

It is difficult to supplement these numbers through identifying apothecaries in the category of named practitioners, particularly for those who were expanding their practice into diagnosing and prescribing medicine. Determining the best treatment for Ralph Salvin’s daughter and her scald head in 1714, C. Collingwood implied that the girl was best treated in her home because “since you don’t value the expense of it, that tis much better for the Apothecary to attend her here”, mentioning only “Mr. Fenwick” in the other cases.⁵¹ Other cases are similarly ambiguous. It is possible that Asham was an apothecary in 1778 when he treated Mrs. Trevely’s gout and rheumatism because Lady Rachel notes that Trevely “will not have a physician”=, and when Mr. Biscoe attended with “the doctor” to prescribe medicine for Peregrina Chaytor’s

⁴⁷ SH:7/RL/59 (John Lister to his parents, 06 April 1728).

⁴⁸ CLV 62 (Ann to James Clavering, 21 December 1710). Metcalfe Robinson also acquired an apothecary for his servant c.1710 (WYL150/6004/13526).

⁴⁹ SH:7/LL/135 (Hannah Knaplock to Phoebe Wilkinson, 20 July 1754). Walter Stanhope also consulted an apothecary when trying to establish the severity of his father’s illness in 1767, see SpSt/6/1/90.

⁵⁰ See footnote 9 above.

⁵¹ D/Sa/C 43.5 (C. Collingwood to Ralph Salvin, 1714).

chronic cough in 1703, it is likely that he was acting as an apothecary who created the soothing draught.⁵² However, any other apothecaries who stretched their roles remain invisible.

As the smallest category referenced, surgeons were similarly underrepresented in correspondence. Letter writers referred to consulting “the” or “a” surgeon in only three percent of the cases. Francis Bredall mentions that his cousin was “left behind under ye Care of a Surgeon, having scalded his legg” in 1770, and “the surgeons” reassured James Lister’s brother in 1775 that his wound was healing appropriately.⁵³ Surgeons were also mentioned in reference to two operations to remove cancer, from Mrs. Farrer in 1779 and Miss Pett in 1798.⁵⁴ In these cases, surgeons were acting at the full extent of their skill in interventions, caring for dangerous wounds and even operating. However, there is a striking absence of the more routine care surgeons could supply. In particular, though Chapter Four established that bloodletting was one of the most frequently mentioned medical treatments by letter writers, most comments indicate only the treatment without referring to a surgeon or naming a practitioner. The disparity between referencing a treatment and making explicit the practitioner who performed the procedure implies that the work of surgeons was being sought, but not acknowledged or described in correspondence.

It is possible to expand the category of surgeons slightly by including references to named surgeons. When Mr. Bullcock operated on Mrs. Pett in 1799, he was referred to as a retired surgeon specializing in “cancerous cases”, and Mr. Blondell, referred to by William Robinson as “a famous surgeon”, was recommended to treat Metcalfe Robinson’s hernia in 1715.⁵⁵ Several other practitioners can be identified as likely surgeons given the nature of their care: Mr. Hawkins bled Thomas Robinson in 1767, and consulted on the treatment of Ralph Carr’s “Spot upon my Nose” in 1770; and Mr. Kelway provided advice on opening issues, which were small wounds or blisters intended to redirect or drain humours or blood, in the early decades of the

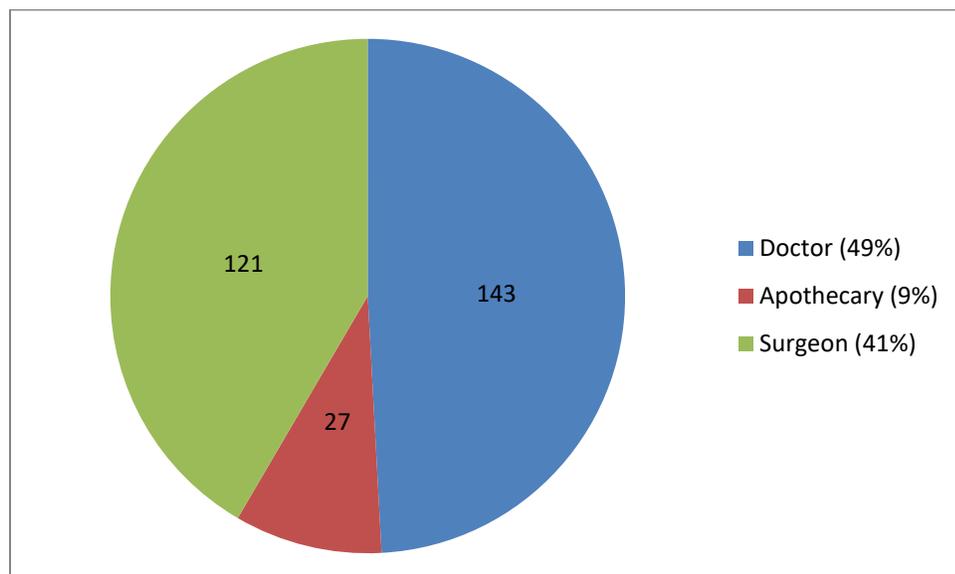
⁵² U DDBM/32/3 (Lady Rachel to Thomas Pershall, 15 August 1778); ZQH/9/15/83 (Ann to William Chaytor, 26 August 1703).

⁵³ ZDV(F) VI 12 (Franc Bredall to Charles Fairfax, 21 April 1770); SH:7/LL/216 (James Lister to Mary Rose, 30 October 1775) and SH:7/LL/217 (James Lister to his aunt, 17 December 1775).

⁵⁴ SpSt/6/1/121 (unsigned letter to “Sister Stanhope”, 22 March 1779); SH:7/LL/303 (Margaret Stoven to Martha Lister, 13 August 1798).

⁵⁵ SpSt/6/1/121 (unsigned letter to “Sister Stanhope”, 22 March 1779); WYL150/6001/83 and WYL150/6001/85 (William to Mary Robinson, 31 March 1715). Additionally, Mr. Birbeck dressed Mary Robinson’s leg and was referred to as “an honest and able surgeon” by William Robinson in an undated letter (WYL150/6001/59).

Figure 6.5 – References to Practitioners, Adjusted to Include Named Practitioners and References to Medical Activities



century.⁵⁶ The work of these surgeons ranged from the mundane elements of bloodletting and skincare which characterized much of early modern surgical work, to heroic surgical interventions, which required operations for serious internal conditions such as cancer and hernias. When these named practitioners are included, the number of references to surgical care rises to twenty two cases, more than tripling the number of references. Adding the sixty-six cases of bloodletting further inflates these numbers and creates a new total of 121 references to surgical work. The updated proportion of surgeons, apothecaries, and physicians can be seen in Figure 6.5. This means when surgical *work* is included with the naming of practitioners by profession or title, surgeons were used almost as often as physicians and much more regularly than apothecaries.

The heavy emphasis on “doctors” reflects the nature of this study’s sample because the gentry made medical choices that reflected their status and willingness to spend money. Though many members of the gentry were actually in debt in the eighteenth century, there was a level of consistency in the commitment to medical care across the class. This is particularly evident in comparing two families of very differing fortunes: the Chaytors and the Robinsons. William Chaytor (1639-1721) inherited the family estate at Croft in 1665 and was made a Baronet in 1671. Unfortunately, along with his lands, William had also inherited his father’s substantial

⁵⁶ ZCE/F/1/7/75 (Ralph Carr to “my dear Lass,” 07 May 1770); WYL150/6041/12291 (Therese Robinson to “my dear Brother,” 08 September 1767); WYL150/6001/83 (unsigned and undated).

financial debts: he was arrested in 1700/01 for his debts and served time in Fleet prison in London.⁵⁷ Though he and his wife Peregrina had thirteen children, there was no surviving male issue at the time of his death and the baronetcy became extinct. William Robinson's ascension almost directly mirrors Chaytor's decline. Robinson supported the coronation of the Protestant King William III and Mary II when they replaced Mary's father, the Catholic James II/VII. He was created a baronet in 1690, and was elected first as Member of Parliament first for Northallerton, then York in nine successive parliaments.⁵⁸ His success continued through the next generation: his second son Tancred inherited his baronetcy and his fourth son Thomas was a member of the diplomatic corps and was elevated to the Lords as Baron Grantham after serving as Secretary of the Southern Department in 1754.⁵⁹

Despite the different trajectories of these contemporaries and the resulting disparity in their financial freedoms, the Chaytors and Robinsons made very similar medical decisions. The eldest daughters in both families acted as caregivers: Nancy Chaytor nursed her mother Peregrina through her final illness, and Nanny Robinson was labelled in an undated letter from William Robinson as a "notable surgeon". However, both families also paid for medical aid. During his imprisonment, William Chaytor and his family consulted two doctors and one practitioner who was either a surgeon or apothecary. In a similar period of time, the Robinsons consulted multiple practitioners. Both families sought assistance for serious illnesses: the chronically ill Robinson family hired Mr. Birbeck to manage Mary's leg wound and consulted a range of practitioners for Metcalfe's hernia, while practitioners assisted Nancy Chaytor in the treatment of her mother Peregrina's illness, likely consumption, in 1703. While the Robinsons relied heavily on surgeons, the Chaytors invested more per medical encounter given the higher rates of physicians. Their emphasis on comparatively expensive practitioners demonstrates the importance of medical care to the family.

Although the Chaytors had more constrained economic circumstances, they continued to make the same decisions as their wealthier counterpart regarding payment for medical assistance. This exhibits the relationship that the gentry had with finances and status in the eighteenth century. Particularly within the credit culture of England, it was possible to sustain a quality of

⁵⁷ *The Papers of Sir William Chaytor of Croft (1639-1721)*, ed. M. Y. Ashcroft, North Yorkshire county record Office Publications No. 33 (January 1984): 5, 7.

⁵⁸ Hinchliffe, "The Robinsons of Newby Park and Newby Hall," 127, 129.

⁵⁹ G. Hinchliffe, "The Robinsons of Newby Park and Newby Hall, Part 3. Thomas Robinson, Baron Grantham (1695-1770) and his descendants," *The Yorkshire Archaeological Journal* 65 (1993): 143, 151.

lifestyle that did not correspond to personal savings. In fact, the maintenance of such a lifestyle was often a financial drain because families were obligated to maintain multiple homes and support their tenants and neighbours. Good health was an equally pressing obligation to the appearance of status, and Irving Loudon has shown that the decision to pay for medical care, even if it was expensive, was made throughout the social spectrum.⁶⁰ Even without wealth, in the extreme case of debtor's prison, the Chaytors were willing to spend money on medical treatments.

The extent to which gentry letter writers record acquiring the services of doctors contradicts the historiographic consensus on the makeup of medical professions in provincial England. In Anne Digby's analysis of the financial aspects of the medical professions, physicians' private practice focused on the elite, while general practitioners treated a wider socio-economic range.⁶¹ The instability of the tripartite system allowed practitioners to adapt their skills to the market without corresponding precisely to occupational labels.⁶² Professional lines were also blurred by movement between the three occupations. David Harley asserts that there were increasing options to acquire certification by graduating from Scottish universities and thus acquiring the title of "doctor" which had previously been largely restricted to medical graduates from Oxford and Cambridge.⁶³

As a result of these processes, which made identifying the status of practitioners uncertain, there was a degree of opportunity for self-labeling which may conceal the identity of some of the practitioners in these letters. For example, the Robinsons refer to "Mr. Birbeck" in most of the letters in which he treats Mary Robinson's leg and offers advice on her cancerous breast in early 1700, but Mary tells her son Metcalfe that "my Dr always tells me news, when he dresses my Leg" and later reports to her son Thomas that she was "confined to my Chamber, and under Dr Burbecks hands".⁶⁴ Both Mr. Fenwick, who treated Ralph Salvin's daughter in 1714,

⁶⁰ Loudon, "The nature of provincial medical practice," 1.

⁶¹ Digby, *Making a Medical Living*, 170.

⁶² Loudon dismisses medical divisions as not useful because practice was dictated by competition and opportunity in "The nature of provincial medical practice," 1; Kett identifies an accelerated process of merging professions and emphasizes a need to focus on function over nomenclature in "Provincial medical practice in England," 17; Harley claims in "Bred up in the study of that faculty," 402, that as a result of the flexibility shown for recognizing a range of skills in ecclesiastical court licenses, the tripartite system is inadequate in analyzing medical professions in this period.

⁶³ Harley, "Bred up in the study of that faculty," 400-402.

⁶⁴ WYL150/6006/II/40 (Mary to Metcalfe Robinson, 08 August, c. 1720?) and WYL150/6006/II/45 (Mary to Thomas Robinson, 31 August of the same year).

and Mr. Ford, who treated Frances Robinson in 1758, could have been either surgeons or apothecaries, as no distinguishing details of their treatments were made clear.⁶⁵

Despite the degree to which historians have identified occupational uncertainty in the medical professions, an evaluation of the types of medical practitioners described in letters indicates a preference among the gentry letter writers of this sample for acquiring the care of those they considered to be doctors.⁶⁶ Beyond physicians, references to practitioners and their services were related directly to the status of the practitioner and the difficulty of their service. Bloodletting, a routine practice which could be applied at home or by a range of semi-skilled practitioners, did not require the naming of a practitioner, as their competence was only in question in a case where the procedure went wrong. However, in more delicate operations such as tending a long-lasting wound, as when Mary and William Robinson exchanged a series of letters regarding the performance of Mary's surgeon, Mr. Birbeck, on her leg injury around the beginning of the eighteenth century, the identity of the practitioner mattered. Additionally, a name allowed the reader to investigate the practitioner and evaluate their skill more thoroughly, or to associate the practitioner with previous treatment, be it efficacious or poor. As will be discussed in the next section, doctors in particular were actively involved in cultivating a reputation and relationships which attracted the attention of gentry patients.

The disparity between the conclusions of this study and other scholarly work done on provincial practitioners is partially due to a difference in sources: historians of provincial medicine such as Kett, Lane, and Harley have focused on licensing or lists of practitioners, which are comprehensive and rarely reflect the patient-base of each practitioner.⁶⁷ Instead, the distribution of practitioners found in this sample of correspondence are a closer match to the arguments of Mortimer and Digby about the increasing diffusion of practitioners away from dense urban populations such as London.⁶⁸ The preference for physicians, indicative of the high

⁶⁵ See footnote 76 for a list of references to correspondence featuring Fenwick, and footnote 78 for Ford.

⁶⁶ See Figures 6.4 and 6.5 above.

⁶⁷ While Loudon uses a range of sources from a provincial record office in his exploration of the practices and financial and social status of practitioners" in "The nature of provincial medicine," Lane's study examines the 1783 *Medical Register* in "The medical practitioners of provincial England" and David Harley focuses on licensing procedures in "Bred up in the study of that faculty".

⁶⁸ Ian Mortimer identifies this change beginning in the seventeenth century in both "The rural medical marketplace in southern England c. 1750-1720" in *Medicine and the Market in England and Its Colonies, c.1450-1850*, ed. Mark S.R. Jenner and Patrick Wallis (Basingstoke: Palgrave Macmillan, 2007): 82; and his book on the subject, *The Dying and the Doctors: the Medical Revolution in Seventeenth-Century England* (Woodbridge: Royal Historical Society: Boydell Press, 2009); Digby, *Making a Medical Living*, 170.

status of physicians in the eyes of the gentry, was partially an element of the decision making process of patients and their families. It also indicated how the style of letter resulted in the presentation of different information. The distinguishing features of surgeons and apothecaries, who provided routine external care and dispensed medicines, generally merited less acknowledgement than the care of doctors. The next section will contextualize the increasing naming of physicians through a consideration of their conscious efforts to increase their occupational status and build relationships with the gentry.

Continuing Relationships with Practitioners

Letter writers' references to practitioners reveal the range of situations in which families could test, evaluate, and exchange multiple treatments in order to establish the most efficacious treatment. The emphasis on naming practitioners allows for more detailed investigation into the patterns of selecting care by tracing repeated references and investigating the historical traces of the practitioner. In some cases, the extent of medical relationships may be disguised by unnamed references to practitioners and, as mentioned above, letters often referred to treatments such as simple medicaments or bloodletting without mentioning a practitioner. As a result of the pattern in which named practitioners were normally doctors, this section focuses on that sector of the medical market. However, the choice to name a practitioner was itself a significant marker of the relationship between gentry families and paid medical assistance.

Correspondents were most likely to refer only once to a named practitioner, making thirty-eight single references in this study. These one-off references were often reports on the health of people outside the family, which were already generally more brief and infrequent than descriptions of health inside the home. For example, family members might refer to a practitioner only once for a successful cure, such as when the Salvins "stuck by Dr Bave, we all like him very well and he gives us all hopes that we may receive considerable benefit by the waters" in an undated letter from c.1720.⁶⁹ Single references to a practitioner were usually brief and low on detail. More detailed accounts of practitioners can be found for the twenty-four practitioners who had multiple appearances in correspondence. These ranged from ten practitioners who appeared twice, including men such as the professor of physic at Cambridge,

⁶⁹ U DDEV/60/84/32 (Bryan Salvin to Marmaduke Constable, c. 1720).

Dr. Plumtree, who treated one of the Robinson sons for colick in 1756, to the eleven references to Mr. Ford as he supervised Frances Robinson's bathing treatment at Bristol in 1757.⁷⁰

In seven of the cases in which a practitioner appeared multiple times in correspondence, it was because the writer was updating family on an ongoing condition. Mr. Birbeck was primarily associated across ten letters by the Robinson family because of his work tending a sore on Mary Robinson's leg beginning in 1690, and though he consulted on a breast lump and recommended travel for blood complaint, this advice was mentioned in conjunction with his continued wound treatment.⁷¹ He offered additional advice because he was already in the home. Ralph Salvin and his sister C. Collingwood granted primary care of Salvin's daughter to "Mr. Fenwick of Morpeth" beginning in 1714, remaining with the practitioner although his prognosis varied widely between optimism and the expectation that a cure could not be expected until adulthood.⁷² The most dramatic case of a single practitioner interacting with familial involvement in treatment was when Thomas Robinson arranged to have his three daughters sent to Bristol in 1757 in the hopes that the well there would treat Frances Robinson of a range of symptoms which his sister Ann Pelham summarized as "chilliness, Feaver, and sweats".⁷³ Mr. Ford was on site to supervise Frances' treatment and contributed three of the eleven letters, which were otherwise from her sisters or aunt, that related Fanny's treatment and expressed optimism for her cure.⁷⁴ Practitioners who provided repeated care for one illness were more

⁷⁰ WYL150/6027/13644 and WYL150/6027/13646 are from H. Thomas and B. Porteus at Cambridge to the Robinsons, both dated 22 February 1756. The Robinson letters from Mr. Ford have been cited in footnote 78.

⁷¹ WYL/6001/58 (William to Mary Robinson, 24 April) and WYL150/6006/II/26 (Mary to Metcalfe Robinson, 15 May, year unspecified).

⁷² D/Sa/C 43.3 to D/Sa/C 43.7 are from Mrs. Collingwood, D/Sa/C 32 from her husband; D/Sa/C 10 from Salvin's brother Wiliam Clopton.

⁷³ Given Frances' symptoms and the popularity of Bristol as a treatment for consumption (Digby, *Making a Medical Living*, 214), it is likely that Frances had consumption and ultimately succumbed to her illness before December of the same year.

⁷⁴ Ford is referred to in WYL150/6022/14578 (Rob Roper to Thomas Robinson, 18 June 1752), WYL150/6030/13348 (Frances Robinson to her father Thomas, 03 April 1758), WYL150/6022/14544 (unsigned to Thomas Robinson, 15 June 1758), WYL150/6039/12208 (Thomas Robinson to his son Thomas, 15 June 1758), WYL150/6030/13329 (Terese Robinson to her father Thomas 18 June 1758), WYL150/6030/13330 (Ann Pelham to her brother Thomas Robinson, 22 June 1758), WYL150/6030/13331 (Ann Pelham to Thomas Robinson, 27 June 1758), WYL150/6022/14584 (Harriet Roper to Thomas Robinson, 28 June 1758), WYL150/6022/14579 (Frances Robinson to her father Thomas, 29 June 1758), WYL150/6039/12210 (unsigned to Thomas Robinson, 29 June 1758), WYL150/6030/13332 (Thomas Robinson to his daughter Frances, 09 July 1758), and WYL150/6030/13333 (Frances to Thomas Robinson, 09 July 1758). He is the author of three letters to Thomas Robinson: WYL150/6030/13351 (14 April 1758), WYL150/6022/14571 (29 June 1758) and WYL150/6030/13343 (07 July 1758), WYL150/6030/13332 (Thomas Robinson to his daughter Frances, 09 July 1758), and WYL150/6030/13333 (Frances to Thomas Robinson, 09 July 1758).

likely to be identified as surgeons, whose work naturally targeted the slow healing of skin complaints and wounds.

Rapid, repeated references to doctors were rarer. During his friend Robinson's severe fit of gout and headaches in 1774, William Chaytor corresponded with Dr. Brownrigg about the symptoms and treatment, and Ann Stanhope had Dr. Rainstick make multiple visits during an outbreak of influenza in 1782.⁷⁵ Rather than a single discrete illness, repeated references to doctors usually were an indication of a sustained relationship over a number of years and illnesses. Some of the most extensive examples of sustained correspondence reveal the benefits of having a doctor in the family. Both the Listers and the Robinsons repeatedly solicited advice from doctors with whom they were related or close friends. Tancred was a particularly useful resource for William and Mary Robinson because he was a London-based doctor, allowing them to access new advice from the capital despite their preference for receiving medical treatment at or near their home in Yorkshire.⁷⁶ These connections paid off when Metcalf Robinson contracted smallpox while on his continental tour and was referred to the "very able Physician Sgn Baglion" by his uncle.⁷⁷

Kinship was not the only reason for sustained relationships. The relationship between the Stanhopes and Dr. Cookson spanned two decades beginning in 1765 with a sibling debate about Cookson's efficacy when John Spencer writing that "My dear Sister much mistakes in thinking I should be displeas'd with her consulting Cookson; on the contrary (lost) must wish he may be of Service to (lost) bless the healing Hand be he who he will".⁷⁸ The collection includes one letter from Cookson himself, which includes his advice on the consumption of sea and spa water during Ann Stanhope's trip to Scarborough and shows that he was a resource of the family as late as 1771.⁷⁹ The introductory anecdote of this chapter, in which Dr. Hulme integrated himself into the medical care of John Lister, is the first of five references to the doctor in letters from 1769 to 1789.⁸⁰ Hulme played both an active role by recommending bleeding for Jeremy Lister,

⁷⁵ ZQH/10/50/51 (Dr. Brownrigg to William Chaytor, 17 December 1774, and William Chaytor's draft reply to Robinson). SpSt/6/1/122 and /124 are from Ann Stanhope to her son Walter on 29 June and 22 July, 1782).

⁷⁶ See footnote 31 above for biographical information on Tancred Robinson.

⁷⁷ WYL150/6005/9 (Metcalf to William Robinson, 03 January 1705).

⁷⁸ SpSt/6/1/58 (John Spencer to Ann Stanhope, 19 June 1765).

⁷⁹ SpSt/6/1/88 (J Cookson to Ann Stanhope, 09 July 1765); SpSt/6/1/77 (Walter Stanhope Jr. To Ann, 26 January 1771). The subject of this letter was news which Walter had gained from Cookson on the health of his father.

⁸⁰ Hulme is likely either Nathaniel Hulme, M.D., born near Halifax Yorkshire, or his brother, who practiced in Halifax. See the *Dictionary of National Biography*, vol. 28 (New York MacMillan: 1885) p. 201.

<https://archive.org/details/dictionaryofnati28stepuoft>. Last accessed 17 November 2017.

and gave passive advice and succor to family friends.⁸¹ An even longer medical relationship was formed between the Ponsonbys and Dr. Warren, who consulted along with Dr. Denman on the health of Lady Fitz in 1766, and was still the hope for a return of family health when he consulted with Harriet in 1792.⁸² Warren's role in Harriet's health was particularly contentious, and George Ponsonby commented in 1792 how "Warren I believe to be an uncommon Good Physician, and at the same time I am satisfied, is a perfect master of the farcial part of the Profession". Despite this, Warren remained a preferred source of medical advice in the family.⁸³

One practitioner appeared in multiple letters from the correspondence of several families in the second half of the eighteenth century. Dr. John Dealtry, originally based in York, had a practice that encompassed several counties of Yorkshire.⁸⁴ The Bosville family consulted Dealtry as early as 1750, when a letter to Bridget Bosville stated that "I must own my self greatly Indetted to Sr Dealtrey. whose skill in Physick, and Honesty in the application of it; I believe no one will offer to duplicate".⁸⁵ The family was still consulting Dealtry fifteen years later.⁸⁶ In the same period, Dealtry was suggested as a practitioner to Walter Stanhope by his brother-in-law John Spencer, who wrote in 1752 that "as I have the greatest confidence in dr Dealtry I wish you would call him in to your assistance".⁸⁷ Dr. Dealtry went on to give sustained medical advice to the Stanhopes throughout the decade. Charles Fairfax and his daughter Ann also consulted with Dr. Dealtry over the course of a decade beginning in 1760. During Ann's continental bathing regime, Charles wrote that he "went yesterday to York to acquaint Mr Dealtry with the content of your and Mr Bolton letters, who seems to be much concerned that the Watters have not had there desired success".⁸⁸ Dealtry was depicted positively in multiple roles. His visits comforted

⁸¹ SH:7/LL/267 (James Lister in 1788); SH:7/LL/274 (Martha to James Lister, 20 August 1789).

⁸² Dr. Warren was likely Richard Warren, one of the physicians for George III (with whom Elizabeth Cavendish was close friends). See *The Dictionary of National Biography*, vol. 59 (New York Macmillan: 1885): 423 <https://archive.org/details/dictionaryofnati59stepuoft>. Last accessed 18 November 2017.

⁸³ GRE/B70/9/13 (George to Louisa Ponsonby, 05 June 1792).

⁸⁴ U DDCV/x1/199/9 contains a document entitled "Lease for a year: Ralph Creyk of York esq. to John Grimston of Kilwick esq. and John Dealtry of York doctor of physic" dated 24 December 1771 from the Papers of Crust Todd and Mills, Solicitors, of Beverly. Dealtry's area of practice extended from several kilometres north of York, with the Fairfax family at Gilling Castle, to the Stanhopes at Horsforth, near Leeds, and down to the Bosvilles of Darfield in South Yorkshire.

⁸⁵ U DDBM/32/3 (unsigned to Bridget Bosville, 28 February 1750).

⁸⁶ U DDBM/32/3 (Mrs. Marsh to "Madam", 02 November 1765).

⁸⁷ First introduced in SpSt/6/1/57 (John Spencer to Walter Stanhope, 07 March 1752), Dealtry recommended that Walter Stanhope make the bath trip which was explored in Chapter Five.

⁸⁸ ZDV(F) VI 12 (Charles to Ann Fairfax, 30 January 1768).

the sick Bosvilles, his advice on bathing practices was respected by the Fairfaxes, and the Spencers and Stanhopes recommended his care above that of other practitioners.

Families in this study confidently maintained relationships with practitioners throughout challenging illnesses and across the years, but they did not rely on only one practitioner. In some cases, they solicited multiple practitioners, as when John Spencer recommended that his brother-in-law-Walter Stanhope consult Dr. Dealtry as well as Dr. Milner during Walter's illness in 1752.⁸⁹ This could also be a necessary combination of skillsets, as when William Robinson suggested that his wife Ann "loose not a minuts time in getting ye best advice immediatly of Mr Birbeck and Dr Prescot" on her breast tumour or Ann Chaytor's use of both "the doctor and Mr Biscoe" in her attempts to contain her mother's diacodium dependency in 1703.⁹⁰ Particularly due to their freedom to consult multiple practitioners simultaneously, there was a decreased emphasis on dismissing practitioners in the letters of the gentry examined in this thesis. This was likely due to a combination of convenience and perceived efficacy of treatment, with families choosing to continue the service of a practitioner who seemed to be able to stabilize or improve the health of their sick relative rather than repeatedly searching for new medical aid. New practitioners were associated with last-ditch attempts in fatal cases, as when Ann Stanhope's servant supplemented the care of Rainstick in 1782 with the advice of Dr. Crowther and underwent heroic treatment including being "Bled wth leeches, Blister'd, Cataplastm'd on his feet, but wth out relief, from any one concation" before dying.⁹¹

Knowledge about a practitioner's history and training formed one element through which families judged the suitability of care. In order to choose to maintain the services of a medical practitioner, or to choose when their work was insufficient and select a new practitioner, letter writers had to use the knowledge and expertise which have been established in previous chapters. Roy Porter has claimed that the "world of medical discussion and information seems inclusive and comprehensive rather than rigidly stratified", and that lay contributors to the *Gentleman's Magazine* considered their own experience to be of similar value to the advice of physicians.⁹² The variety of approaches which correspondents used to select or combine the skills of various practitioners is indicative of the confidence family members felt in their own medical

⁸⁹ SpSt/6/1/57 (John Spencer to Walter Stanhope, 07 March 1752).

⁹⁰ WYL150/6001/43 (William to Mary Robinson, 12 July); ZQH/9/15/83 (Ann to William Chaytor, 26 August 1703).

⁹¹ SpSt/6/1/122 (Ann to Walter Stanhope Jr., 15 August 1782).

⁹² Porter, "Lay medical knowledge," 146, 150.

knowledge. The strong preference for consulting physicians and exchanging reports on the practice of practitioners on distant sick relatives emphasizes this point. Letter writers positioned themselves to evaluate paid care constantly, adjusting the network of practitioners which they accessed in light of their perception of patient needs and the efficacy of various treatments.

The desire to know practitioners well enough resulted in a high preference for practitioners of local origins. This extended past the preference for those practicing in the writer's town: Although all chose to live in London, David Hartley, Tancred Robinson, and Nathaniel Hulme represented thirteen percent of the references to named practitioners and were all born in Yorkshire and relocated later in life. This means that families continued to capitalize on local connections when they did obtain more distant care. Practitioners also cultivated and valued extended relationships by offering unsolicited advice, as in this chapter's opening anecdote about the dangers of late summer bathing or when Ann Stanhope similarly passed on news from their local doctors during Walter Stanhope's time at Bath in 1757.⁹³ They were motivated to maintain these relationships for both financial and social reasons: interactions cemented their attempts to self-fashion as more sociable than surgeons, apothecaries, or irregulars, while also increasing the likelihood that they would come to mind during a future illness.

Physicians were particularly invested in this effort, because they were in an uncertain position between "profession" and "trade", in which their work was closely associated with uncouth manual labour, but they identified themselves by their academic training and desired an elevated status.⁹⁴ Brown outlines how physicians in York avoided associations with "trade by creating the Doctors' Club in 1781. The club was populated by both practitioners and other significant members of the community and central to the exchange of social knowledge which helped practitioners participate in society.⁹⁵ Some doctors in the correspondence also succeeded in cultivating personal relationships outside of the medical interaction. For example, Dr. Armstrong wrote to George Ross that "I am sorry to be disappointed of the pleasure of an interview with you to day, for I was in hopes you would have dined with us at the Long Rooms."⁹⁶ Metcalfe Robinson similarly recounted that "my Father made me one visit of 6

⁹³ SpSt/6/1/57 (Ann to Walter Stanhope, 13 July 1757).

⁹⁴ Loudon, "The nature of provincial medical practice," 29-30.

⁹⁵ Brown, *Performing Medicine*, 23, 28-31.

⁹⁶ SH:7/LL/133 (John Armstrong to George Ross, 11 June 1754).

minutes & the Doctor another of many” while he was sick in the early decades of the century. In these interactions, medical advice was absent in favour of social relationships.⁹⁷

The increased recognition of physician status was also necessitated by the popularity of the culture of sensibility. As Rousseau asserts, a range of doctors responded specifically to the new language of nerves and the increasing emphasis on illness as a signifier of refinement, including Cheyne, Sydenham, and Cullen.⁹⁸ The penetration of sensibility through medical, social, and cultural fields enabled physicians to receive the acknowledgement of status which they had sought for the past centuries. Letter writers acknowledged the social elements of their relationships with practitioners. Mary Robinson wrote how “my Dr always tells me news, when he dreses my Leg”, situating the practitioner not only as an authority on health but also as an important source of information during the period in which she was unable to enter society due to her injury.⁹⁹ Margaret Carr passed on the compliments of Dr. Lawrence to her father in 1733, focusing not on his medical skills but his life and housing when she wrote “He is not got into a house yet. I beleave he will find he will not have every thing so convenient as he had att Newcastle, but I beleave it is ambition”.¹⁰⁰ When detailing Dealtry’s visit to Mrs. Bosville in 1765, Mrs. Marsh emphasized how “after staying with her two hours, [he, the doctor] left her with a handsome compliment”, which placed the focus on his personal interaction and extended attention, rather than his medical advice.¹⁰¹ Practitioners were depicted as providing more than a service and contributing elements of sociability while treating their patients. This is indicative of a measure of success for their efforts to simulate social connections with the gentry.

This sociability was not a complete equivalence, and not all the doctors in correspondence were characterized in friendly terms. Doctors who made social overtures stimulated a closer relationship with gentry families and obtained their double goal of regular work and an improvement to their perceived social status. From the perspective of the gentry letter writers, who included in their correspondence practitioners who had performed roles that exceeded medical care and were invited to dine with the family, there is further significance. The conventions of familiar letter writing maintained the desirability of a narrative that simulated

⁹⁷ WYL150/6004/24 (Metcalf to Mary Robinson, c.1710).

⁹⁸ G.S. Rousseau, “Towards a semiotics of the nerve: the social history of language in a new key” in *Language, Self and Society: A Social History of Language*, ed. Peter Burke and Roy Porter (Cambridge: Polity Press, 1991): 240.

⁹⁹ WYL150/6006/II/40 (Mary to Metcalfe Robinson, 08 August).

¹⁰⁰ ZCE/F/1/1/10/3 (Margaret Carr to “honoured sir,” 03 January 1733).

¹⁰¹ U DDBM/32/3 (Mrs. Marsh to “Madam” Bosville, 02 November 1675).

personal interactions. The inclusion of information about daily lives and the news of friends followed from the goal that a letter should be like a conversation. In their distinct preference for naming practitioners, letter writers were choosing to include paid medical help in the narrative of their lives in a more visible way. Their intimacy with doctors meant that families had regular and immediate access to medical advice, and the social setting increased the likelihood that they could receive informal medical advice. When Ralph Carr had dinner with Mr. Hawkins, he was able to bring the conversation around to his own health and gained Hawkins's opinion that "he thinks nothing of this Spot upon my Nose".¹⁰² Unlike servants, who were generally unmentioned in letters but functioned as a crucial role in maintaining the household, these practitioners were perceived as significant enough to be named. An important element of this was the sociable connections that practitioners made with their letter-writing patients.

Conclusion

Practitioners constituted a significant number of the references to ill health, appearing in just under a third of letters mentioning illness. Within these sources, a series of patterns emerge which reveal the methods in which families preferred to solicit paid medical assistance. Families were acquiring care equally for men and women, but men were presented by both male and female letter writers as having an active role in acquiring practitioners both for self-care and for the care of members of their families. This complements current historiographical assertions that men were the heads of household, particularly illustrated by Lisa Smith in family letters to medical practitioners. Families also showed a general preference for consulting a range of practitioners, even if they had a relationship with a particular practitioner such as the Ponsonby's extended relationship with Dr. Warren, or if they had a practitioner in the family: the Robinsons consulted at least seventeen different practitioners despite being related to "uncle doctor" Tancred Robinson.

Families also preferred to speak to a practitioner in person, either having the practitioner consult with the patient and their family directly, or having medical conversations through a family member or friend close to the practitioner. This avoidance of medical-letter writing, which has been characterized as a popular method to acquire the care of famous physicians, is significant. It indicates the degree to which families wanted to control the medical interaction, as

¹⁰² ZCE/F/1/7/75 (Ralph Carr to "my dear Lass," his wife, 07 May 1770).

a live consultation allowed for a more equal interaction with the potential for immediate refinement of information or for asking of additional questions. Letter writers chose between or combined the service of several different practitioners in order to further control medical interactions. This is evidence of the extent to which the medical knowledge which informed household caregiving extended beyond the boundaries of the home. Letter writers were not only evaluating illnesses and causes, as demonstrated in Chapter Four, but also scrutinizing the skills and efficacy of practitioners depending on the situation.

Within the process of selecting a practitioner, the most dramatic theme was the strong preference for doctors, who represent over half of the direct references to practitioners. This was in part due to the nature of the sources: gentry families also had the funds and mobility to seek their practitioner of choice, even if they were constrained economically like William Chaytor, and physicians presented themselves as a medical elite. With enough business, a physician could even buy land and become a member of the gentry. However, a closer evaluation of practitioner descriptions reveals how the medium of letters influenced the inclusion of practitioners in gentry life. In the cases of surgeons, in particular, it is evident that there are cases in which families received surgical care, such as bloodletting, but did not make a reference to or name the practitioner who provided the service. Apothecaries are even more difficult to identify because reference to medicine does not mean that apothecaries were consulted, since families could also produce their own medicines or approach non-traditional practitioners. Therefore, the relationship between mentioning a practitioner, versus the implication that they provided care, seems directly related to the status and difficulty of procedure. Surgeons who performed operations on hernias or cancers were frequently named, while treatment for routine injuries was simply mentioned, and the work which contributed to bloodletting was rendered invisible in the narrative.

Doctors, surgeons, and apothecaries who appear over multiple letters have also been found to have different relationships with families. Surgeons and apothecaries were more associated with repeated references to one condition, appearing over a series of letters in one year and then vanishing completely from the correspondence. In contrast, doctors were more likely to be referenced over a period of time extending to decades, and to offer advice on a range of medical conditions. This is partially a result of their active effort to cultivate relationships and their self-fashioning as higher status practitioners. Doctors were found in correspondence visiting

or passing family on the street and asking questions about sick relatives, and then offering unsolicited medical advice. It was in their best interest to form this medical relationship, which served both to differentiate themselves from the label of “trade” and to provide a steady income and a series of recommendations to other families. The preference for doctors was also indicative of the culture of sensibility, which tightly linked the experience of illness with the refined nerves of the upper class and therefore required increased medical aid to support the ailing gentry body.

Cultivating relationships over time had an unusual result on descriptions of named doctors compared to other practitioners. As Anne Digby noted, one of the results of sustained service was that physicians became close to the families, “friendly rather than intimate in nature”.¹⁰³ From the perspective of the families, this shifted their role as a source of information from paid labour to be acquired to a more accessible form of medical information. Doctors were called in specific circumstances, but their care was also strongly based on their personal relationship to the family and to how their work was known and evaluated by families. As a result, practitioners’ advice was presented in a way which is similar to the medical advice offered by friends, acquaintances, and distant relatives who used their familial contributory expertise to justify their involvement in new illnesses. While doctors were not friends, they also were not completely divorced from the household. They were worth mentioning in correspondence because they were active within the family’s world, rather than introduced as an authority to be brought in. Although they treated conditions outside the purview of family medicine, there is very little evidence that families considered consulting a physician to be a break from their own medical knowledge and care. Instead, interactions with these practitioners was understood to be an extension of family medical knowledge, remaining under the control of the family as a resource to be tapped, rather than as a statement that the skills of the home had failed and that the household had to be opened to external influence and advice.

¹⁰³ Digby, *Making a Medical Living*, 177.

Chapter Seven — Conclusion

Letter writers incorporated the subject of illness in a number of ways. They bracketed letters with news on family health, offered detailed medical advice to their readers, and vividly recounted the strains of being ill and the challenges of managing the domestic healing space. Within this spectrum, each family in this study had a distinct relationship with illness. Anne Clavering was passionate about her nursing skills in her role as guardian of her half siblings, particularly Jacky and the asthmatic Betty. Charles Fairfax's deep interest in his daughter Ann's health likely originated in the deaths of seven children and his wife, Mary, in 1741: she was the last surviving member of his family. The chronic ill health of most of the members of the Robinson family, including William's gout, Metcalfe's deafness, Frances' consumption, and the breast cancer of both Mary and her granddaughter, Therese, led to a high volume of letters and regular expressions of concern. The Lister correspondence displayed a strong series of relationships with practitioners, including John Lister's close friend David Hartley. William and Ann Stanhope regularly corresponded with their siblings, particularly Ann's brother John Spencer in Cannon Hall and her sister Alicia-Maria Greame in Sewerby, about both the cause of illness and potential medical treatments based on the experiences of those around them. Despite the range of experiences across the century, there were patterns of continuity in the expectation of the provision of care, understandings of medicine, and concern for the maintenance of health characterized in each family's letters.

The extent to which families felt it necessary to include indications of their medical knowledge and skills in correspondence reveals the inadequacy of considering eighteenth-century medical history as separate or distinct from the sixteenth and seventeenth centuries. The intrusion of the medical model of sympathy, which historians have claimed led to the final decline of humoralism and therefore represented a schism in medical understandings of the body, is in fact part of a long history of the interactions of medical models with popular beliefs.¹ Just as Paracelsianism in the sixteenth century and Helmontianism in the seventeenth century were introduced to the lay population but failed to change fundamental understandings of bodies or

¹ Olivia Weisser, *Ill Composed: Sickness, Gender and Belief in Early Modern England* (New Haven: Yale University Press, 2015): 7; Sara Read, *Menstruation and the Female Body in Early Modern England* (Basingstoke: Palgrave Macmillan, 2013): 12; Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680* (Cambridge: Cambridge University Press, 2000): 5.

use of the humoural system, sympathetic medicine complimented existing understandings of the body with new explanatory language.² While each medical model suggested new theoretical underpinnings, the early-modern understanding of the body and illness retained an emphasis on a porous body which was influenced by both the movement of internal forces and the intrusion of external stimuli. As a result, a healthy body needed constant attention to balance and moderate behaviour in all aspects of life. In order to achieve these practices, household medicine did display strong continuities on independent management of health and illness, selecting simple medicines and monitoring the environment of the patient without necessarily acquiring paid assistance or the medical expertise of a trained practitioner.

The household was a fundamental space of medical work. Chapter Three proved that the majority of descriptions of caregiving activities occurred in the home. Letter writers cared for their housemates or offered to travel to the homes of sick relatives to support them during their illnesses. The household often also remained the site of care when seeking the assistance of external practitioners: Chapter Six exhibited how relatives in London or in the south at universities were used as intermediaries to solicit medical advice which could be transmitted by letter back to the family home. Because medicine was long established as a household matter, it serves as a point of continuity within which changes in ideals of domestic femininity and relationships between the household and wider society can be explored, as analyzed in each chapter and summarized below in the section on gender. The household framed experiences of daily life. The effect of illness on daily domestic patterns, by restricting the motions of patients or applying new roles to their families, is an important element of the history of the home.

Familiar letters which included illness accounts were almost exclusively directed towards close family members, particularly siblings or parents. Additionally, the sufferers were largely kin within the household and had a particular interest in immediate family: parents, siblings, children, and spouses both exchanged letters about illness, and were the subject of illness accounts. The prioritization on kin in the household is surprising given Naomi Tadmor's argument regarding the importance of "household-families," which included everyone who

² See the discussion of humoural medicine in the "Medical Beliefs" section of the Introduction, and particularly Wear, *Knowledge and Practice in English Medicine*; Silvia De Renzi, "Old and new models of the body" in *The Healing Arts: Health, Disease and Society in Europe 1500-1800*, ed. Peter Elmer (Manchester, Manchester University Press, 2004) 179; Owsei Temkin, *Galenism: Rise and Decline of a Medical Philosophy* (London: Cornell University Press, 1973): 165

cohabitated and shared an authority figure rather than just nuclear families.³ Letter writers clearly demarcated between their kin and their servants when it came to the regularity with which health updates were provided. This included both situations in which the healthy members of the household were specified, and in the references to illness and treatment.

Out of the hundreds of references to illness in the correspondence sample to which this doctoral thesis had recourse, there are fewer than ten descriptions of sick servants. The invisibility of servants may be a result of the fact that servants had less ability to disrupt their daily schedules with minor illnesses such as colds, while the gentry could devote time to experiencing and recording their experiences with illness. Studying the gentry therefore establishes the extent to which families could perceive and manage illness and incorporate periods of confinement. These families also travelled to specialized medical locations such as Bath and Scarborough, and solicited assistance ranging from the advice of family and friends to paid medical practitioners, particularly physicians. Comparing the gentry's records of illness with sources composed by other classes exhibits the extent to which employment influenced the types of medical decisions open to particular individuals.

As well as establishing the privileged medical position of the gentry, focusing primarily on correspondence has shaped the image of domestic medicine in this study. A centralized postal service, inexpensive paper, and high levels of gentry literacy allowed families to communicate more extensively and in a less formal style. Letter writing conventions also shaped the type of information included in correspondence, though the familiar letter became more flexible in style as the century progressed. The strongest arguments regarding the effect of letter writing discourse on the inclusion of medical information have been made by Susan Fitzmaurice. She asserted that medical conversation in letters was an attempt to facilitate intimacy through sharing an experience, rather than exhibitions of the importance of knowledgeable advice.⁴ However, Chapter Two has proved that medical references often exceeded the category of rote or formulaic comments. Instead, letter writers preferred to refer to specific illnesses in most cases, and complimented the naming of illnesses with detailed accounts of their experience of falling ill. Letter writers' understanding and management of illness also reveal the integral role of medical

³ Naomi Tadmor, *Family and Friends in Eighteenth Century England: Household, Kinship and Patronage* (Cambridge: Cambridge University Press, 2001): 22, 24.

⁴ Susan Fitzmaurice, *The Familiar Letter in Early Modern English: A Pragmatic Approach* (Amsterdam: John Benjamins, 2002): 99.

knowledge in their epistolary discussions. The primary features of familiar letters, which simulated conversations and had the imagined interests of the reader in mind, also reveal the role of illness in the daily lives of writers: sickness and familial management of the sick room were considered to be interesting and important enough to be included in letters. This indicates that not only did families possess medical knowledge and skills; they also valued these traits.

Medicine in the Home

Illness necessitated both a change in the behaviour of the sufferer, and an adaptation of their families to support and treat the sick. Despite the regularity of references to illness, caregiving activities have proved to be a more elusive subject in correspondence. In the majority of situations, letter writers refer to their illness without making reference to any kind of medical care, even when describing the sick as confined or bedridden. This silence was likely derived from a simultaneous focus on news of the patient, and the understanding of caregiving activities as ubiquitous. This study has contended that the nature of caregiving terminology in gentry correspondence can help explain the relative invisibility of manual caregiving work. When letter writers attended, cared, nursed, and sat up with sufferers, their management of the sick room accentuated monitoring the work of servants and administering medical treatments. Part of the reason for their silence on caregiving more generally, then, was that supervisory roles overlapped with regular domestic management by elite women. The narrow definition of gentry caregiving tasks modifies claims that caregiving was a universal practice: class was very much an element of the division of labour.

Supervising the sick necessitated medical knowledge. Monitoring the patient's improvement or decline and managing their treatment meant that families had to know what a healthy body looked like, how most diseases were expected to progress, how to distinguish when an illness fell outside the bounds of household skill due to its acute or chronic nature, and what results should be expected from treatments. References to caregiving often recounted not only being close to the sick, but performing minor surgical or medical procedures as well. In addition, it is evident that some families in this study continued to prepare basic remedies well into the eighteenth century, and would administer medicine even if it was originally prepared by an apothecary. Supervisory caregiving was thus necessarily intimately interwoven with the medical knowledge of the household. Gentry caregivers monitored the mundane daily tasks which were

the purview of their servants, even as the sick room increased the workload demanded for cleanliness and specialized cooking. As a result, skilled tasks were performed by gentry letter writers, who also recorded their work in their letters, while the work of servants was obscured and unmentioned in correspondence. The division of labour in the family sick room has emphasized the importance of being more explicit in investigations of bedside medicine, because rather than a monolithic, ubiquitous subject, caregiving was a collection of roles which could be combined or delegated depending on the situation.

The reliance of gentry caregiving on medical knowledge indicates that in order to help sick family members in the household effectively, letter writers had to be familiar with understandings of how the body worked, what caused illness, and which treatments proved to be most efficacious. Their continual application of medical knowledge reflects comments by Roy and Dorothy Porter about the “umbrella of shared knowledge” in which both paid practitioners and lay populations had similar understandings of illness.⁵ Through comparing letters with recipe collections and popular, frequently published books of medical prescriptive literature, it has been possible to add detail to this image of continuity between “lay” and “professional” or “institutional” knowledge. Within this binary, “lay” knowledge could be purely experiential for servants and lower class people who were illiterate and had low access to resources, or more developed and theoretical for the gentry who could read and interact with published, formal medical literature. Letter writers generally observed similar symptoms and used expectations that cohered with the models presented in prescriptive literature and the recipes in both published and manuscript medical books.

The high level of continuity from early eighteenth-century humoralism to late eighteenth-century sympathetic medicine displayed in Chapter Four establishes how a changing medical model had little influence on descriptions of illness in correspondence. G.S. Rousseau persuasively presents the social benefits of the sympathetic model for the gentry whose sensitive nerves served as a marker of their refined and superior status. However, there were few cases in which the language of nerves was integrated into either the cause or treatment of illness. This is a result of the fundamental similarities between humours and nerves: both involved the influence of internal fluids on the body, though the context changed from four humours which dictated

⁵ Roy Porter, “Introduction” in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, ed. Roy Porter (Cambridge: Cambridge University Press, 1985): 14.

health and constitution, to an “unseen spirit within the hollow tube” of the nerves.⁶ Rousseau suggests that “the myth of the nerves” as a tool which was quickly accepted to differentiate classes and explain behaviour incorporated illness, because it did not necessitate a change in the description or experience of illness in gentry correspondence.⁷

Instead, letters, prescriptive texts, and recipes all shared in ideas that were largely influenced by humoral medical theory that management of the internal flow of the four humours and a moderate lifestyle were important contributors to health, and all made regular references to the use of medicaments as a form of treatment. Therefore, Pamela Smith and Benjamin Schmidt’s argument that the expertise of tradesmen consisted of a “shared and collective nature” of knowledge can be applied with similar accuracy to the relationship between correspondence and other written sources of knowledge.⁸ Even though medical ideas were collective, letter writers regularly stressed the significance or efficacy of different causes and treatments. There was a particular attention to internal causes in correspondence. Emotions were understood to have the power to affect physical health, particularly necessitating an attention to positive attitudes and care around the experience of grief and anger. The interrelationship of different parts of the body and the understanding of the bodily interior as largely fluid also influenced understandings that one illness could both affect other parts of the body, and move from place to place by “falling,” “rising,” or “flying.” Internal causes were in turn managed largely by treatments taken internally, in the form of a wide range of medicines. The attention to regimen, so strongly endorsed by eighteenth-century prescriptive authors, was increasingly integrated into letters: rather than simply consuming medicines, families in the second half of the century recorded their exercise habits and relocated for better air. Letter writers compared popular knowledge to their own experiences in order to determine effective treatments.

Experience was fundamental in the acquisition of both skill and knowledge. Past illnesses were regularly compared to the conditions of letter writers in order to inform their diagnoses and ideas for efficacious treatment. As Chapter Four highlighted in particular, letter writers engaged more extensively with their medical histories, making only rare explicit references to medical

⁶ G.S. Rousseau, “Towards a semiotics of the nerve: the social history of language in a new key” in *Language, Self and Society: A Social History of Language*, ed. Peter Burke and Roy Porter (Cambridge: Polity Press, 1991): 226.

⁷ *Ibid.*, 245.

⁸ Pamela H. Smith and Benjamin Schmidt, “Introduction: knowledge and its making in early modern Europe” in *Making Knowledge in Early Modern Europe: Practices, Objects and Texts, 1400-1800*, ed. Pamela H. Smith and Benjamin Schmidt (Chicago: University of Chicago Press, 2007): 7.

theory. Using the memories and information collected by experience in order to respond to new situations was largely the subject of Chapter Five, which suggested the use of a new model with which to understand the complex lived experience of household expertise. Historiography has struggled to situate household medical authority and management, which had a high level of skill and knowledge, within a context in which most households also outsourced medical treatment by hiring a range of medical practitioners.⁹ Rather than viewing expertise on a hierarchy, it is more effective to understand medical work as a spectrum of coexisting, differing but overlapping medical expertises. The expectations for effectively managing medicine in the home were not the same as the types of medical knowledge gained by physicians in academic settings, and also differed from the apprenticeship-based manual expertise of surgeons or apothecaries. A household could have medical experts who managed a wide range of illnesses; still, it could also call a practitioner in situations which were outside the bounds of their experience.

Household medical work, then, actually required multiple forms of expertise in order to manage household illness and determine which practitioners and treatments were appropriate for illnesses which exceeded their experience. Collins and Evans' sociological model distinguishes a spectrum of expertises, from "ubiquitous" which was commonplace and shared by societies, to "interactional" which displayed the ability to interact with other experts using their specialized skills, and "contributory," the ability to use knowledge and skills to respond to new situations and develop further skills and knowledge.¹⁰ Managing household illness is a form of contributory expertise, encompassing both the caregiving activities and the management of the sick room analyzed in Chapter Three and the forms of medical knowledge which were used to diagnose illness and decide on treatments analyzed in Chapter Four. These skills coexisted with interactional expertise, and criticism of practitioners was unusual except for the advice to "be your own physician," analyzed in Chapter Five. Interactional expertise allowed families to evaluate a range of practitioners for suitability based on their skills, pricing, and previous successes, and then again to determine if the recommended treatment was appropriate and efficacious.

Interactional expertise was also of increasing importance throughout the century. The fundamental significance of this skill was determined in Chapter Six, in which families made

⁹ See discussions in the "Families and the "Medical Marketplace" section in the Introduction above.

¹⁰ Harry Collins and Robert Evans, *Rethinking Expertise* (Chicago: University of Chicago Press, 2009).

choices about which practitioners to use. It was also evident in the choices letter writers made to describe care in correspondence and to refer to practitioners by name rather than title. The gentry strongly preferred physicians, indicating that their elite status distinguished their preferences from the results of historiographic surveys which incorporate a range of patients. This explains the disparity between the gentry selection of “doctors” and the historiographic narrative of flexible job labels and the rise of the “general practitioner”.¹¹ While Anne Digby suggested that provincial families were more likely to acquire the services of “the medical fringe,” gentry letters indicated a marked preference for the work of physicians.¹² This was a result of the status of the practitioner and their treatment because, as Chapter Six exhibited, families regularly referred to routine medical services such as bloodletting and acquiring medicines without acknowledging the aid of a practitioner. The silence again is indicative of the discourse of letter writing, including routine medical treatments such as bloodletting with other regular features of the household, such as the content of meals or the schedule of sleep and wakefulness, which did not merit regular depiction.

The decision to include or exclude information was important: excluding the names of some practitioners indicated that letter writers were choosing to minimize their professional relationships with practitioners who performed lower status work. The effect of status is accentuated by comparing cases of silence to situations in which practitioners were frequently named. Throughout the eighteenth century, letters increasingly included a named practitioner rather than a general label such as “the doctor” or “my doctor.” Where possible, these names have been traced and it was established that overwhelmingly, named practitioners were physicians. Chapter Six revealed that the increasing significance of interactional expertise and naming practitioners through the period was both a recognition of the efforts from physicians to participate in culture and sociability, and an indicator of the respect families paid to practitioners. The increased use of interactional expertise was also a product of sensibility because the increasingly sensitive nerves of the gentry produced more regular illness and required the support and services of physicians.¹³ By providing a name rather than just an occupational label,

¹¹ See for example the discussion of flexible occupational identities in provincial medicine in Chapter Three’s section on the “Range of Practitioners.”

¹² Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 21.

¹³ Wayne Wild, *Medicine-By-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters* (Amsterdam: Rodopi, 2006): 10.

correspondence indicated the practical and social relationship between gentry families and their medical practitioners.

The gentry in this sample, who lived in Yorkshire, County Durham, and Northumberland, seldom distinguished their medical practices from other counties. Letter writers preferred to deal with familiar faces, using either local practitioners or soliciting the services of London-based practitioners who had been born in their home county. Despite the preference for local aid, letter writers and their families were willing to travel for the best advice and treatment, or to have distant relatives act as intermediaries for practitioners. However, the direction of travel was almost universally southern. This is interesting given the liminal status of these northern counties, which were almost equidistant between two of the dominant medical capitals of the period: London and Edinburgh. The Scottish medical community was vibrant in the early modern period, producing such thinkers as William Cullen, who wrote extensively on the importance of diet and the dangers of “pathological nerves,” the obstetrician William Smellie, and George Cheyne, who was renowned for his dietary advice.¹⁴ Regardless of the products of Scottish medical educations, letter writers made no reference to soliciting the service of Scottish practitioners, and they never traveled north. Instead, they preferred London, which offered social and political experiences as well as a range of medical services. Status evidently came into play when evaluating the locations of medical care as well as the practitioners.

Gender and Change

Although both genders were deeply interested in household illness, the situations in which men and women were most likely to record their own participation are indicative of differences in the general division of medical labour. Although men wrote a higher number of letters, women were more likely to include medical knowledge and skills in the letters they wrote: they located themselves as central to caregiving practices in the sick room, were more likely to include recipes in correspondence, and infused letters with medical knowledge. As a result of this deep involvement, Chapter Five contends that women can frequently be labelled as contributory

¹⁴ For Cullen see for example, Guenter B. Risse, “Doctor William Cullen, Physician, Edinburgh,” *Bulletin of the History of Medicine* 48.3 (Fall 1974): 338-9. For Smellie see John Peel, “Smellie, William (1697–1763),” in *Oxford Dictionary of National Biography*, online edition ed. David Cannadine (Oxford: Oxford University Press, 2004), <http://www.oxforddnb.com/view/article/25752> (accessed November 16, 2017). Steven Shapin discusses Cheyne’s work in “Trusting George Cheyne: scientific expertise, common sense, and moral authority in early eighteenth-century dietetic medicine,” *Bulletin of the History of Medicine* 77.2 (2003): 338-350.

medical experts. To some extent, that the eighteenth century did maintain expectations from earlier centuries that women would manage the health of the home.¹⁵ Women's active pursuit of medical information was one element of their gendered role as household managers because caring for the sick fell in a similar category as purchasing consumer goods and raising children.

However, men regularly wrote about illness, particularly in expressing their opinions about the cause of illness and inquiring after familial help. In contrast to women's work in the sick room, men were much more involved than their female housemates in the tasks which mediated between the household and the outside world. These conclusions complement and expand on the arguments of Lisa Smith regarding the essential role that men played in household health. Karen Harvey and Amanda Vickery both explain how the public identity of men relied on self-management and that this skill was practiced and refined through the management of the home.¹⁶ Smith extends these conclusions by observing that good health, which had its basis in physical and emotional moderation, therefore established that men were effectively managing their home.¹⁷ This thesis provides further support for Smith's conclusions by determining that men were more likely to be involved in acquiring the services of external practitioners than they were to be active as caregivers. Men largely used medical knowledge and expertise to supervise and support the work of other members of the household and in the form of intermediary expertise during interactions with paid practitioners.

While women were more likely to be caregivers and men were responsible for the majority of interactions with external medicine, there was flexibility in the gendering of medical tasks. Knowledge was shared collectively, though men were more likely to explain causes and women to emphasize treatments. Letters contained no narratives on gendered knowledge or expertise. In addition, roles which were usually performed by men or women were also undertaken by the opposite gender: men in this sample were active in a third of the references to caregiving, particularly in the middle of the century, and women used interactional expertise to

¹⁵ Mary E. Fissell, "Introduction: women, health, and healing in early modern Europe," *Bulletin of the History of Medicine* 82.1 (Spring 2008): 8; Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London: Routledge and Kegan Paul, 1987): 5; Doreen Evenden Nagy, *Popular Medicine in Seventeenth-Century England* (Bowling Green: Bowling Green State University Popular Press, 1988): 2.

¹⁶ Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford: Oxford University Press, 2012): 148; Amanda Vickery, *Behind Closed Doors: At Home in Georgian England* (London: Yale University Press, 2009): 298.

¹⁷ Lisa Smith, "The Relative Duties of a Man," *Journal of Family History* 31.3 (July 2006): 248.

evaluate the care of external practitioners in a third of their references to illness. The division of household tasks was not a subject of letters in this sample, despite the explicit division of labour advocated by prescriptive literature and the implicit division evident in the ways in which men and women managed roles in the medical marketplace and sick room respectively. Crossing the implicit lines of gender roles was never positioned as exceptional or unusual. Gender roles and gendered spaces were flexible. While the activities of caregiving were loosely gendered, both men and women were interested in illness and performed medical work in the home.

Historians have maintained that the culture of sensibility in the later eighteenth century significantly changed expectations of gender roles. For women, this produced the ideal of a chaste, domestically-minded wife, and for men a model of heightened self-control and intellectualism.¹⁸ This increasing codification of illness and definition of the home as a female space are largely absent from correspondence, and instead the adaptability of medical gender roles persisted throughout the period. Explicit references to the household as a woman's domain can be perceived in the changing tone of women's relationship with caregiving activities. As the century progressed, women increasingly commented on the difficulty and oppressive nature of their role in the sick room, compared to accounts in which women volunteered or defended their role as nurses in the early decades of the century. This increasing sense of displeasure and obligation may be a result of expectations that women should be deeply involved and invested in the lives of their families. The culture of sensibility attempted to regulate the roles that each gender performed and how they felt about it. The pressure to perform as a dutiful wife, mother and caregiver was evident in the changing accounts of the sick room and increased the strain of an already-demanding medical role.

Men remained active in letter writing about medicine, particularly in expressing concern for their children, throughout the period. More frequent affectionate comments in letters may a result of the evolution of the discourse of correspondence. Susan Whyman observes the eighteenth-century development of an expectation of informality and a colloquial tone, which were increasingly established by 1781.¹⁹ However, the persistent interest men had in the health

¹⁸ Anthony Fletcher, *Gender, Sex and Subordination in England 1500-1800* (New Haven: Yale University Press, 1995): 93, 332; Ingrid H. Tague, *Women of Quality: Accepting and Contesting Ideals of Femininity in England, 1690-1760* (Woodbridge: Boydell Press, 2002): 19.

¹⁹ Susan Whyman, *The Pen and the People: English Letter Writers 1660-1800* (Oxford: Oxford University Press, 2009): 22; James How, *Epistolary Spaces: English Letter Writing From the Foundation of the Post Office to Richardson's Clarissa* (Aldershot: Ashgate, 2003): 341.

of their relations cannot be solely attributed to letter writing form. As the century progressed, men felt more confident in discussing illness with other men, rather than confining their comments to female relatives. This confidence is indicative of a growing sense that it was appropriate for men to converse about ill health, and is also paralleled in the importance of soliciting external aid, a practice which was largely managed by men. The men in this study were clearly becoming more integrated with household health beginning in the 1740s. This validates Joanne Bailey's arguments that sentimental theory encouraged men to demonstrate parental and familial love rather than rationality and restrained disengagement with household life.²⁰

Continuity and Change

During the eighteenth century there was a high degree of continuity in medical beliefs, and the changes introduced in the transition from humouralism to sympathetic medicine were very subtle. The comparison of medical terminology in Chapter Four determined that letter writers were more likely to make reference to "humours" in the first half of the century, and that "nerves" emerged after 1750. Similarly, Chapter One displayed a change in letter writers' references to illness through a gradual increase in general descriptions such as "very ill" over named conditions. Attention was also paid to the external effects of the body on lifestyle, rather than personal changes. Increasingly affirming the effects of external causes relates to the replacement of humoural with sympathetic medicine. While humoural medicine necessitated an inward view in which each individual tried to achieve a balance of four humours, sympathetic medicine focused on the nerves as a site which was influenced by external stimuli. The theoretical prioritization of sensitive nerves meant that the body was vulnerable to changes outside the body. Additionally, sympathetic theory and illness as represented in popular literature increasingly focused on the moral and social implications of illness, rather than the personal effects. Unlike than the deep theoretical break posited by historians' decisions to terminate studies early in the eighteenth century described in the Introduction, then, the method of understanding the body was largely continuous despite some minor terminological changes.

²⁰ Fletcher presented emotional distance in *Gender, Sex and Subordination*, 332, while Joanne Bailey emphasized the importance of parental affection in "Reassessing parenting in eighteenth century England" in *The Family in Early Modern England*, ed. Helen M. Berry and Elizabeth A. Foyster (Cambridge: Cambridge University Press, 2007): 215.

The most significant difference between seventeenth and eighteenth century medicine can be found in the rapid disappearance of providence and religion from medical explanations. While histories of the seventeenth century stress the importance of religion in understandings of illness, extensive narratives about religion are almost entirely absent from the correspondence in this study after 1720, except for the Catholic Fairfaxes in the 1760s and 1770s. The secularization of medicine was one element in the transition from divine intervention to observable events and mechanistic explanations across English society.²¹ Secularizing medicine also began the process of applying a system in which preventative medicine could be more extensive: without the random influence of divine causation, it was behaviour that caused illness. Excluding religious explanations, there was a high degree of theoretical continuity throughout the century. Letter writers continually chose to assert the internal experience of health and illness, indicating that emotions and the internal flow of humours or nervous fluids could cause sickness or restore health. When selecting treatments, families diversified their medical decisions as the century progressed, moving from a strong preference for medicines to an integration of regimen. This change can be seen in the expansion of the long-popular concern for air to become the *trifecta* of “air, exercise, and diet” as well as traveling to spa locations.²²

As well as becoming more grounded in observable phenomenon in line with the development of empiricism, this study also identifies a gradual decrease in the amount of medical information contained in letters. Caring for the sick in the first decades of the eighteenth century depicted the involvement of the letter writer in the sickroom with a high level of detail. Early accounts were often at least a page long, detailing the familial struggles against chronic illnesses and concern for each other and the health of younger members of the family. In contrast, later in the century the level of detail on the mechanics of caregiving was lower and letter writers favoured briefer anecdotes and more frequent references to illness without reference to caregiving. Recipes in correspondence followed the same trajectory: though families continued to collect recipe collections, as exhibited in the late compilation dates of both the Hedgeley and Wharton recipe books, recipe recommendations were omitted from

²¹ Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989): 193; Michael MacDonald, “The secularization of suicide in England 1660-1800,” *Past and Present* 111 (May 1986): 85.

²² Sandra Cavallo and Tessa Storey explain that the air was increasingly significant over the sixteenth century in Italy, with a similar emphasis on heat and the threat to pores that can be seen in the eighteenth-century correspondence of this study. See: *Healthy Living in Late Renaissance Italy* (Oxford: Oxford University Press, 2013): 71.

correspondence during the second half of the century. Similarly, Chapter Six analyzed how letter writers were increasingly likely to refer to practitioners by name, which acknowledged the significance, status, and skill of physicians who were involved in their lives. This trend towards lower amounts of information in a variety of facets of medical discussion in correspondence indicates that the gentry were less interested in recounting their medical work, even if they did continue to care for family members in the home.

The gradual modification of including medical information in letters is encapsulated in considerations of medical expertise. Chapter Five established that contributory expertise necessitated extensive medical knowledge and skills, and that the ability to communicate effectively with medical experts was interactional expertise. During the first decades of the century, letter writers were most likely to recount how their families actively performed medicine or offered medical advice, and examples of contributory expertise dominate. As the century progressed, it became increasingly likely that correspondence mentioned familial activities of interactional expertise in their selection and evaluation of external practitioners. Though contributory expertise characterized most examples of expertise throughout the period, interactional expertise gradually became a fundamental skill.

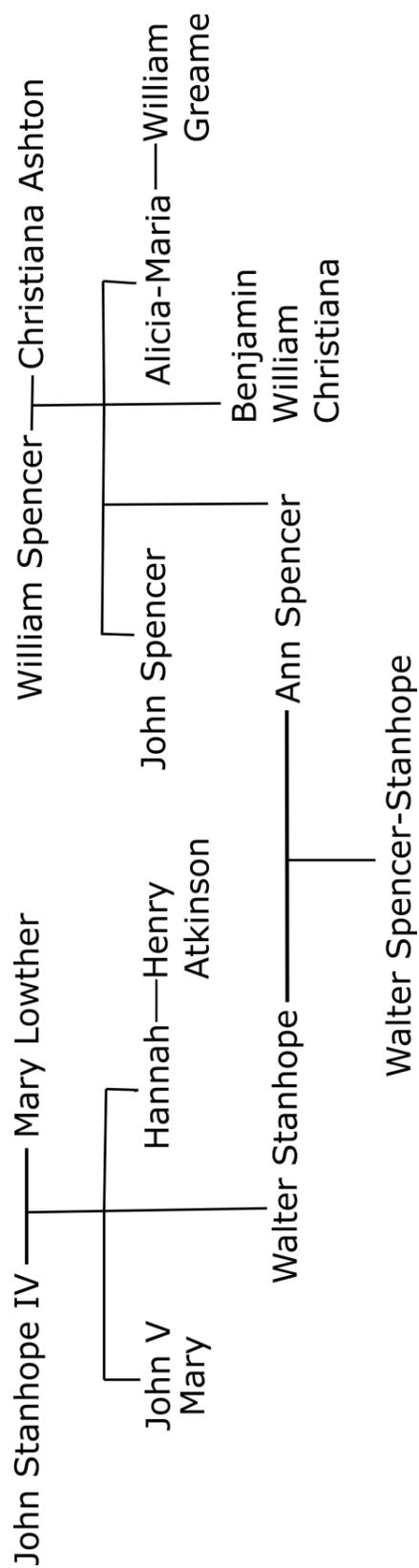
This slow and incomplete transition helps to situate the eighteenth-century medical household between the degree of autonomy and range of skills in early modern lay medicine, and the expansion of practitioner control, including the relocation of serious illness from the household to the hospital, in the modern period. The process of conceding authority to practitioners is visible after 1750, and would escalate in the nineteenth century.²³ The gradual silencing of personal medical action and the corresponding surge in acknowledgement of physicians are early indications of a transition away from household authority that would culminate in later centuries' specialized, technical practitioner language and the hospital as the primary site of care.

The household was a fundamental and vibrant site of medical labour and knowledge throughout the eighteenth century. Despite the slow and subtle process of decline in the autonomy of the home, many of the large theoretical and social changes of the eighteenth century

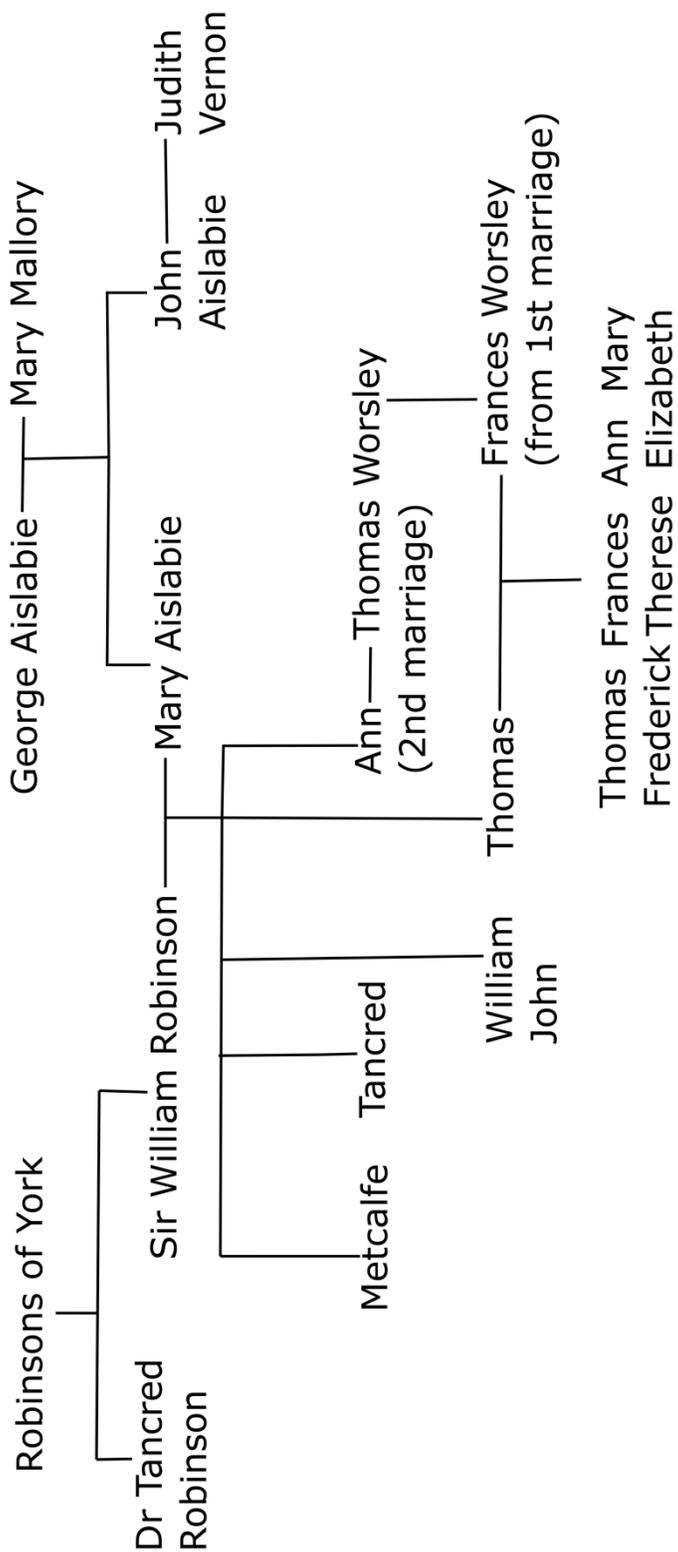
²³ W.F. Bynum asserts in *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994): xi, 218, that “in terms of concepts, institutions, and professional structures, the medicine of 1900 was closed to us almost a century later than it was to the medicine of 1790” because of the importance of science in the diagnostic methods of hospitals and community practices of preventative medicine.

had only minimal impact on the performance of medicine. The continuing activity of men and women indicates that sensibility's suggestion of a separation of female domestic space and male public behaviours was not fully acknowledged. Similarly, the fundamental features of humouralism, which stressed internal balance and the effect of both internal and external stimuli on the body, also gave structure to sympathetic medicine, though the explanatory labels changed. Caregiving work necessitated supervisory skills and medical knowledge throughout the eighteenth century, and the experience of providing care helped to inform later medical decisions and understandings of illness. The gradually increasing involvement of practitioners did not correlate with a decreasing sense of medical expertise in the home. Eighteenth-century household medicine was a site of slow transition, and simultaneously a key element of the long, continuous history of illness and domestic spaces which significantly shaped the lives of gentry families in Northumberland, County Durham, and Yorkshire.

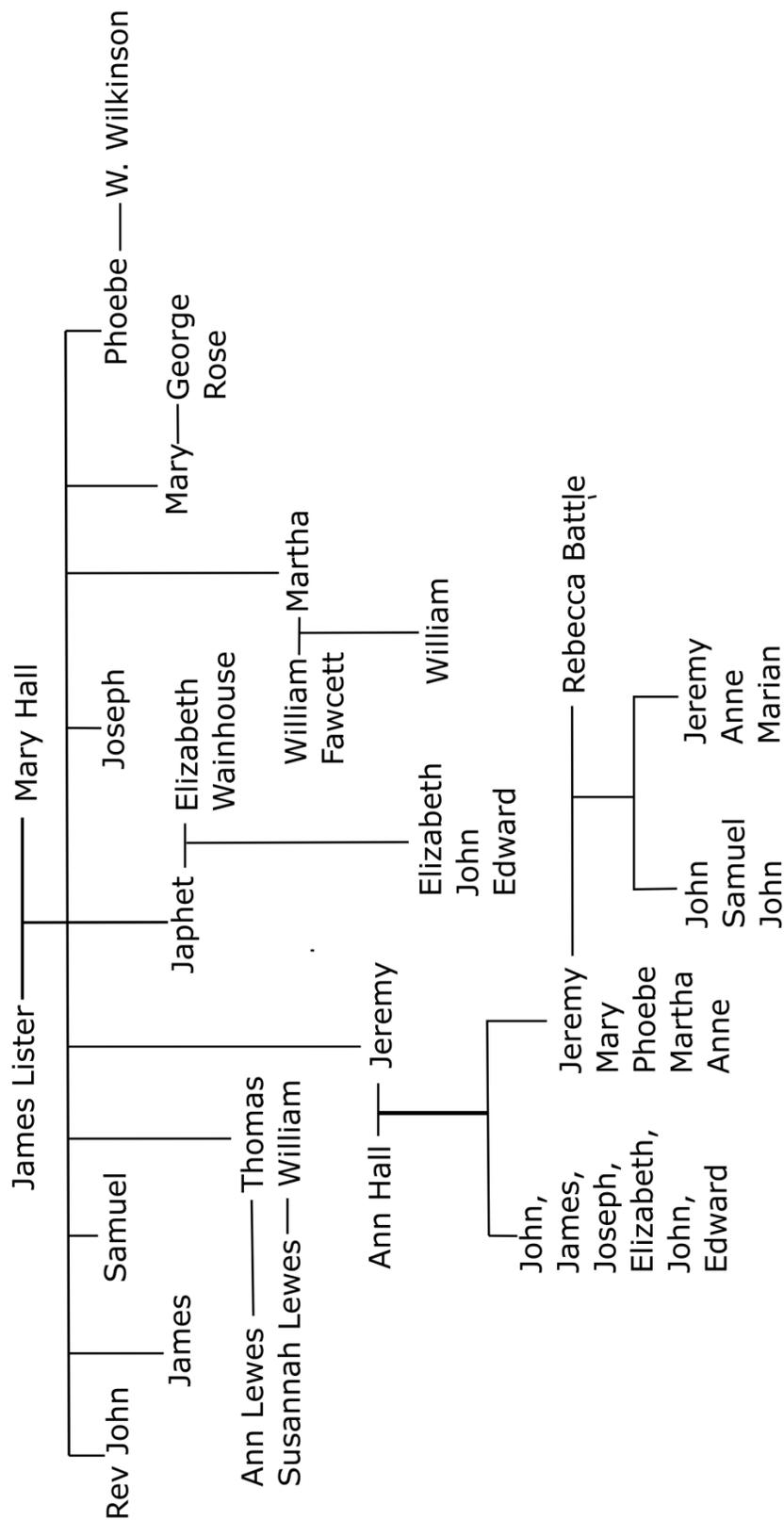
APPENDIX I (A) — Spencer-Stanhope Family Tree



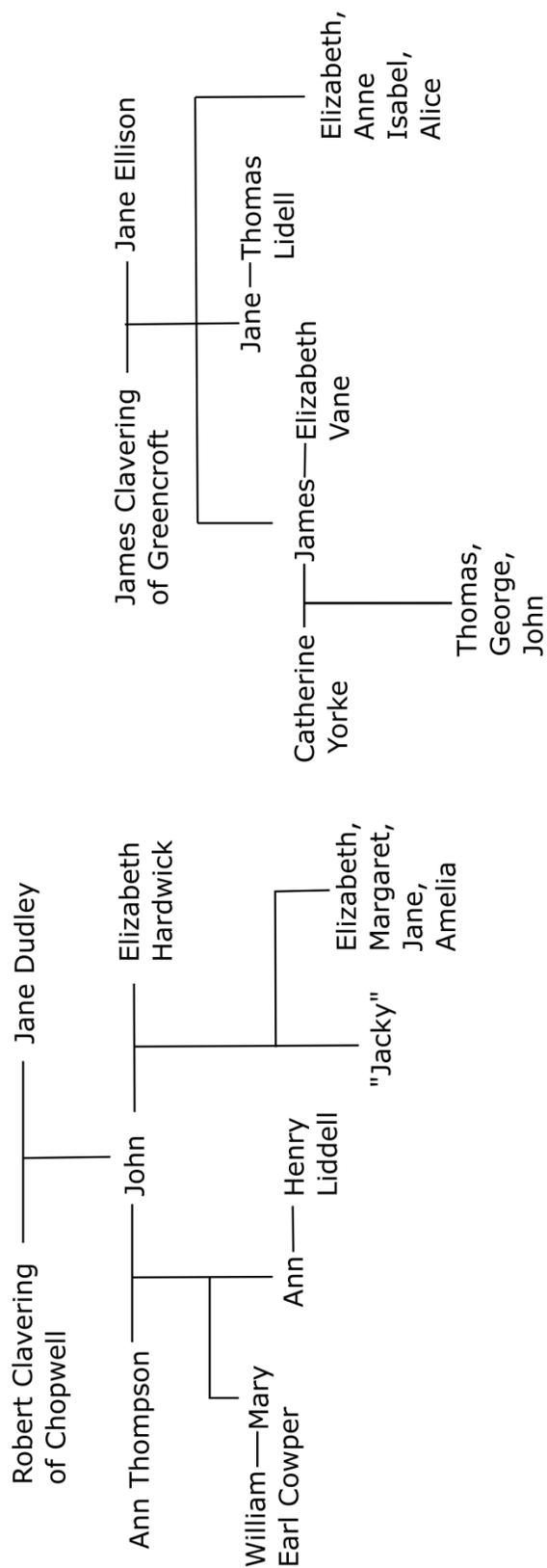
APPENDIX I (B) — Robinson Family Tree



APPENDIX I (C) — Lister Family Tree



APPENDIX I (D) — Clavering Family Tree



APPENDIX II — Breakdown of Family Correspondence Collections

FAMILY	REFERENCES TO ILLNESS	NUMBER OF LETTERS	PERCENTAGE REFERENCING ILLNESS
Beaumont	9	109	8%
Bosville	29	258	11%
Carr	22	507	4%
Chaytor	93	720	13%
Clavering	51	85	60%
Constable	22	700+	3%
Fairfax	49	386	13%
Grimston	32	131	24%
Lister	110	600+	18%
Ponsonby	53		
Robinson	251	2000+	13%
Salvin-Tunstall	12	76	16%
Spencer-Stanhope	173	650+	27%
Bosville	29	258	11%
Vane	8	16	50%
Wharton	13	33	39%

APPENDIX III — Total Descriptions of Illness

DESCRIPTION	NUMBER OF USES	PERCENTAGE OF CATEGORY
Total number of descriptions to illness and health	1268	(100)
(A) No named illness (statements of health or general comments on receiving treatment)	223	17.6
(B) Total Descriptions of Illness	1045	82.4
(B1) Named Illness/Event	531	41.8 (of total descriptions)
Cold	82	6.4 (of named illness)
Gout	64	5.0
Fever	56	4.4
Cough	30	2.4
Smallpox	24	1.9
Ague; Pain	19	1.5
Childbirth; Rheumatism	18	1.4
Lame/Crippled	15	1.2
Weak/lack of strength	13	1.0
Asthma; Tumour/Lump	9	0.7
Innoculated; Wound	8	0.6
Measles; Pregnancy	7	0.55
Consumption; Gripes; Humour; Inflammation	6	0.4
Scurvy; Fits; Scorbutic; Swelling	5	0.39
Deaf; Fatigue; Infleunza; Paralysis; Purging; Stone	4	0.3
Jaundice; Miscarriage; Scarlet Fever; Surfeit; Vapours; Windy	3	0.2
Accident; Colic; Contagion; Convlusion; Dizziness; Dropsy; Looseness; Palsy; Shortness of Breath; Stroke	2	0.15
Depressed; Disabled; Gangrene; Green Sickness; Hernia; Impostume; Leprosy; Milk Sick; Perspiration; Phlegm; Piles; Plague; Quinsey; Seizure; St Anthony's Fire; (STD); Stranguary; The Whites; Urinating Pain	1	0.1

(B2) General Illness	364	28.7 (of total descriptions)
Ill	46	3.6 (of general illnesses)
Very ill	37	2.9
Illness	35	2.8
Disorder	29	2.3
Indisposed	28	2.2
Complaints	26	2.1
Out of order	18	1.4
Distemper; State of health	14	1.1
Not well	13	1.0
Confined	9	0.7
Extremely ill	8	0.6
Sickly	7	0.55
Poorly	6	0.4
Infirm/Infirmary; Sick	5	0.39
Affliction; Ailment; Bad Health Condition; Sickness	4	0.3
Dangerously ill; Unwell; Worse	3	0.2
Attack(ed); Bad/Ill way; Disease; Ill Health; Melancholy; So Bad; Sore	2	0.15
Case; Danger; Difficulty; Discomposed; Distracted; Dreadfully; Far From Well; Giddy; Infection; Malady; Misfortune; Not Easy; Operation; Out of Health; Severe Illness; Sufferings; Ugly Symptoms; Uncertain Health; Uncomfortable; Uneasy; Violently Ill; Want of Health; Welfare	1	0.1
(B3) Body Part	150	11.8 (of total descriptions)
Head; Leg; Throat	18	1.4 (of body parts)
Eye; Skin	16	1.3
Joints; Stomach	9	0.7
Breast	7	0.55
Blood	6	0.4
Lungs	5	0.39
Face; Side; Teeth	4	0.3
Feet; Nerves	3	0.2
Arm; Back; Ear; Heart	2	0.15
Bowels; Hip	1	0.1

APPENDIX IV — Referenced Causes of Illness by Decade

Dates	Religion	Emotion	Internal	Air	Exercise	TOTAL
Pre 1689	2	3	3	-	-	8
1690s	1	-	1	-	-	2
1700s	3	5	-	7	-	15
1710s	1	6	7	7	2	23
1720s	-	1	3	3	2	9
1730s	-	3	-	3	-	6
1740s	-	2	3	1	2	8
1750s	-	6	4	5	2	17
1760s	1	8	2	11	1	23
1770s	-	2	1	3	1	7
1780s	-	9	4	2	1	16
1790s	-	3	1	-	-	4
TOTAL	8	48	29	30	11	138

APPENDIX V — References to Medical Treatments by Decade

Dates	Religion	Medicines	Evacuation & Bleeding	Bathing	Air	Exercise	Diet	Total
Pre 1689	1	2	1	-	-	-	-	4
1690s	2	3	4	1	2	-	1	13
1700s	4	15	11	3	2	-	3	38
1710s	4	12	15	11	3	3	6	54
1720s	4	7	5	5	3	1	3	28
1730s	2	5	-	1	1	2	-	11
1740s	-	5	3	1	3	1	4	17
1750s	3	13	6	15	7	17	5	66
1760s	15	7	10	13	16	12	7	80
1770s	2	3	4	4	4	3	1	21
1780s	1	6	5	6	7	1	-	26
1790s	1	-	2	8	2	1	1	15
TOTAL	39	78	66	68	50	41	8	373

APPENDIX VI — Men and Women’s References to Expertise by Decade

DATES	Contributory	Interactional	Total
Pre 1689 (total)	6	-	6
Men	3	-	3
Women	3	-	3
1690s (total)	7	1	8
Men	4	1	5
Women	3	-	3
1700s (total)	18	5	23
Men	11	2	13
Women	7	3	10
1710s (total)	23	11	34
Men	14	6	20
Women	9	5	14
1720s (total)	15	4	19
Men	9	3	12
Women	6	1	7
1730s (total)	4	-	4
Men	4	-	4
Women	-	-	-
1740s (total)	9	5	14
Men	1	3	3
Women	8	3	11
1750s (total)	31	16	47
Men	15	9	24
Women	16	7	23
1760s (total)	26	14	40
Men	16	9	25
Women	10	5	15
1770s (total)	12	8	20
Men	3	4	7
Women	9	4	13
1780s (total)	29	4	33

Men	8	2	10
Women	21	2	23
1790s (total)	12	2	14
Men	8	1	9
Women	3	1	4
TOTAL	192	70	262
Men	96	39	135
Women	95	31	126

APPENDIX VII — Descriptions of Practitioners

DATES	Apothecary	Surgeon	The/A doctor	My/her/his doctor	Doctors	Named Practitioner	Total
Pre 1689	-	-	-	-	-	-	-
1690s	-	-	1	-	1	3	5
1700s	1	1	11	3	2	9	27
1710s	3	-	16	6	-	19	44
1720s	1	1	7	2	5	10	26
1730s	-	-	-	-	1	3	4
1740s	1	-	1	-	3	10	15
1750s	1	1	5	2	-	38	47
1760s	2	1	6	1	2	27	39
1770s	1	2	6	-	1	14	24
1780s	1	1	5	-	1	10	18
1790s	-	1	2	1	1	8	13
TOTALS	11	8	60	15	17	151	262

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