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Alison Montgomery

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Abstract

This thesis examines the relationship(s) between medicine, the body and societal codes of masculinity in England and Scotland between c.1640 and c.1780. It responds to the way in which the men in histories of post-1660 masculinity are often disembodied, and to the comparative absence of men's gendered experiences from the history of medicine. Its findings show that in both centuries the experience of being a man with a body that was the site of health and sickness was an open, candid, and often communal, one, inside and outside of the formal medical encounter. Thus, and on both sides of 1700, ill men had full freedom in the pursuit and acceptance of medical, familial and social assistance, while their physical suffering, and associated emotional distress, was met with sympathy. With their sick bodies the sites of honest self-examination and open discussion, it was in part this very public nature of their sicknesses that allowed men, as a gender and as individuals, independence and agency in their non-commercial health care. Indeed, later-seventeenth- and eighteenth-century men suffered no constraints in their ability to respond to the vulnerabilities of their bodies, even where this involved behaviours or attributes allegedly associated with women and femininity, or inconsistent with ideals of active, independent, masculinity.

These findings indicate, therefore, great continuity across the period 1640-1780, and not only in masculine ideals of and involving the male corporeality. There seems to have been significant consistency across time in men's social and medical experiences of both sickness and their pre-emptive preparation for it, and in an apparent collective self-confidence concerning their corporeal masculinity, their sex, and, possibly, even their sexual potential. Indeed, these sources suggest that seventeenth- and eighteenth-century men had a resilient sense of self-identity (and personal masculinity), conceptually separable from the corporeal body and its known fragilities.

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List of abbreviations

BL	British Library, St Pancras, London
CL	Chetham's Library, Manchester
DUL	Durham University Library Special Collections
NAS	National Archives of Scotland, Edinburgh
NLS	National Library of Scotland, Edinburgh
WL	Wellcome Library for the History of Medicine, London
RCP	Royal College of Physicians of London, London
RCPSG	Royal College of Physicians and Surgeons of Glasgow
RCS	Royal College of Surgeons of England, London

Spelling is modernized throughout and all years given as starting on 1 January. Unless otherwise stated, all places of publication are London.

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**Chapter 1: 'Made not born'? Bodies, being male, and the masculine experience in
English and Scottish medicine c.1640-c.1780**

This study examines men with bodies, the bodies that they lived with, and the relationships existing between men's bodies and their masculine identities and anxieties. Although recognizing that the distinction between the individual and the body is itself a site of historiographical contention, it focuses on men as social players, and on the body as that fleshy corporeality that such individuals had or owned (if such a relationship can, indeed, be termed one of ownership). It does so because the men featuring in many studies of post-Restoration masculinity are comparatively disembodied. The ideals they sought to attain are not ones rooted in contemporary understandings of the male corporeality, elevating a certain type of body, making gendered requirements of the flesh, or having physical repercussions. Even the eighteenth-century masculinity 'based on sport and codes of honor derived from military prowess' referred to by a history of the nineteenth-century English middle classes, and allegedly expressed through 'hunting, riding, drinking and "wenching"', is usually absent.¹ Indeed, according to Michèle Cohen, this physically demanding and physically dangerous behaviour was not the hegemonic, textually prescribed, masculine ideal, and it was not until the 1800s that 'a "martial" masculinity' emerged.²

Post-1660 'masculinity' has, therefore, generally been approached as something very different to early modern 'manhood'. As currently depicted, the relationship between

¹ Lee Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850* (1987), p. 110, cited in Michèle Cohen, "'Manners' Make the Man: Politeness, Chivalry, and the Construction of Masculinity, 1750-1830", *Journal of British Studies*, 44 (2005), pp. 312-329, citation at p. 312.

the body, manhood, and men's status was in *early modern* society a crucial, close, and yet not unproblematic, one.³ Elizabeth Foyster, for example, made notions of physical maleness and femaleness vital to her analysis of the 'constructing' of 'manhood', arguing that physical strength and a physiologically-explained superior reason were '[t]he two key "male" characteristics', crucial justifications of patriarchal power, and the basis of a 'manhood' that was both natural and 'nurtured'.⁴ For Foyster, early modern 'honor' and a manhood 'associated... with physical strength' were performed through bodily and psychological attributes. Problematically, however, this very performance put at risk not only the two strengths but also the identities, roles and reputations conditional upon them.⁵

However, for historians such as Philip Carter and Anthony Fletcher, at least one element of this notion of male status and identity disappeared after 1660. It was their very 'association with... violence' (or with 'elitism' or 'boorishness') that allegedly now caused the prescriptive literature to reject 'old style' 'manhood' and 'many existing forms of manly virtue', 'field sports' included.⁶ Indeed, according to Fletcher, 'physical fitness and training in physical courage' were already relegated to only 'passing' mention before the end of the seventeenth century.⁷ G. J. Barker-Benfield took this further, finding an entire reformist reaction against a late-seventeenth-century

² Cohen, "'Manners'", pp. 313, 321, 324.

³ E.g. Lyndal Roper, *Oedipus and the Devil. Witchcraft, Sexuality and Religion in Early Modern Europe* (London and New York, 1994), pp. 3-4, 107-124.

⁴ Elizabeth Foyster, *Manhood in Early Modern England. Honour, Sex and Marriage* (Harlow, 1999), p. 30. Similar claims are made in Anthony Fletcher, 'Manhood, the Male Body, Courtship and the Household in Early Modern England', *History*, 84, 275 (1999), pp. 419-436.

⁵ Foyster, *Manhood*, pp. 40, 80-81, 177-181.

⁶ Philip Carter, *Men and the Emergence of Polite Society, Britain 1660-1800* (Harlow, 2001), p. 1; Anthony Fletcher, *Gender, Sex and Subordination in England 1500-1800* (London and New Haven, 1995), pp. 328-330.

⁷ Fletcher, *Gender*, p. 332.

“macho” drunkenness, violence and promiscuity allegedly viewed as but exaggerated ‘representatives of male popular culture’.⁸

Instead, it is said to have been ‘politeness’ and its ‘notion of civility’ that from the late-seventeenth century onwards ‘represented hegemonic masculinity’.⁹ ‘Politeness’ was itself allegedly a variegated phenomenon, being modified, or added to, by notions of ‘sentimentality’ (or ‘sensibility’) in the mid-eighteenth century, and by ‘etiquette’, robust homosociality, and more domestic interests in later decades.¹⁰ Yet, the demands placed on this ‘polite’ ‘refined “gentleman”’ expected little of the body, at least as is visible in the secondary literature.¹¹ While ‘politeness’ itself is said to have ‘required self-control and discipline of’ the ‘body’ this, as currently discussed, rested in ‘genteel appearance’, ‘poise’, ‘deportment’, ‘dress and self-presentation’.¹² More physical elements of the body are mentioned only briefly, in ‘suggestions that cleanliness was necessary to avoid offence’, this being but the continuation of ‘a theme popular in... early modern advice literature’.¹³ Ultimately, the bodily non-offensiveness of ‘politeness’ appears to have rested in *masking* the possession of a physical body.

The existing historiography might, furthermore, suggest that it was primarily for ‘critics... of polite society’ that the peculiarly male and masculine body mattered.¹⁴ Not all explorations of ‘the anxiety over masculinity’, or discussions of contemporaneously

⁸ G. J. Barker-Benfield, *The Culture of sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago and London, 1992), pp. 47, 50.

⁹ Quotations from Cohen, “Manners”, p. 312, and Fletcher, *Gender*, p. 323.

¹⁰ Quotations from Carter, *Men*, p. 8, and Karen Harvey, ‘The History of Masculinity, circa 1650-1800’, *Journal of British Studies*, 44 (2005), pp. 296-311, quotation at p. 304.

¹¹ Quotation from Carter, *Men*, p. 1.

¹² *Ibid.*, pp. 61, 73, 166-167; Fletcher, *Gender*, p. 330; Michèle Cohen, *Fashioning Masculinity: National identity and language in the eighteenth century* (London and New York, 1996), p. 56.

¹³ Quotation from Carter, *Men*, p. 61.

¹⁴ *Ibid.*, p. 7.

perceived ‘effeminacy’, feature the body, even tangentially.¹⁵ However, it is historians’ emphasis on ‘the period’s fascination with effeminacy’ that suggests that more corporeal elements of the body could have been at issue, and this that raises the possibility that men’s real life bodies might have carried significance.¹⁶ As Carter has revealed, critics at least associated the ‘refinement[s]’ of ‘politeness’ ‘with physical and mental enervation’, and satirized the fawning male followers of such fashions as ‘self-professed “delicate beings”’ characterized by ‘physical weakness and over-susceptibility to illness’. Indeed, later in the eighteenth century negative ‘representations of men... with nervous illness’ became a similar target, now as evidence of ‘the effects of unregulated sensibility’.¹⁷ Carter’s was, however, an analysis of textual discourses, and these comments part of a discussion of the written depiction not of men’s bodies but of fops.¹⁸

Other works, coming from the histories of sex and gender more broadly, have shown that it was not only the ridiculed fop that prompted, or became the target of, eighteenth-century fears about ‘effeminacy’. Yet, those fears about the population at large, or its soldier class, that such studies reveal are also textually expressed ones, and again about set character types.¹⁹ The bodies that they uncover are similarly imagined, generalized, ones, and, indeed, representations constructed as a manifestation of abstract fears and criticisms that were only in part about bodies.

¹⁵ E.g. Cohen, *Fashioning*, esp. pp. 4-6, 40. Quotation from *ibid.*, p. 42.

¹⁶ Carter, *Men*, p. 11.

¹⁷ *Ibid.*, p. 151.

¹⁸ *Ibid.*

¹⁹ E.g. Karen Harvey, *Reading Sex in the Eighteenth Century: Bodies and Gender in English Erotic Culture* (Cambridge, 2004), pp. 144-145.

Consequently, how anxieties about national martial, sexual and reproductive vigour, or stereotypes and judgements of the kind allegedly levied against the fop, operated in society at large is something still to be considered. So too is the conflict that might, therefore, have been encountered by men caught between the competing demands of anti-‘effeminacy’, gentlemanly urban civility, and pre-existing bodily ideals of the kind discussed by Foyster. If the unfolding of those more abstract, textual, fears of physical decline or de-masculinization already uncovered by historians meant that real-life men, and men other than fops, were increasingly judged on their bodies, and on a perceived physical manliness lying in the vigour and invulnerability allegedly lacked by fops, this has yet to be uncovered.

There are, however, already analyses examining the representation of more corporeal, male bodies – those that were of ‘equivocal’ sex or masculinity.²⁰ Significantly, these have revealed how anxieties about patriarchal authority and entitlement moulded the depiction of those male bodies of which the sex or reproductive potential were ‘uncertain’, or suspected of being transgressive.²¹ Furthermore, they have done so not only for printed (medical, literary, cultural and legal) dialogues but also, occasionally, through manuscript sources, those created in impotence trials.²²

The bodies in this study are similarly representations of bodies, sometimes those of real-life individuals, sometimes of imagined groups, and sometimes of generalized male masses. Yet, they are frequently the product of dialogues specifically about very corporeal bodies, or about the men owning such fleshy bodies. They also come not only

²⁰ Quotation from Cathy McClive, ‘Masculinity on Trial: Penises, Hermaphrodites and the Uncertain Male Body in Early Modern France’, *History Workshop Journal*, 68 (2009), pp. 45-68, quotation at p. 45.

²¹ See *ibid.*, p. 64.

from print but also from manuscript sources. Thus, the thesis looks for a possible inscription of patriarchal anxiety within more routine representations (and expectations) of real-life men, both societally and within medical practice, and not only in bodies that were attracting attention for their sex or for their ‘virility’. However, its interest also extends to the bodily and medical experiences upon which such representations were built.

The experience of the body – and of having a body – is, indeed, an arena in which ‘the day-to-day complexities and pitfalls of achieving (and retaining) a gentlemanly identity’ have yet to be examined for the men of this period.²³ Consequently, this thesis examines whether there *was* a characteristic relationship between masculinity, men, and their bodies, in health and illness, between around 1640 and 1780. It asks whether those gentlemanly, refined, ideals of the ‘polite’ gentleman, or his ‘sentimental’ successor, with his more genuine emotionality, extended to the body too, and to the relationships and experiences contingent upon owning one. It also tests whether those bodily-related fears and stereotypes that such ideals allegedly prompted within printed productions also circulated in wider-society, and in day-to-day expectations and discourses.

The thesis also enquires, however, into the possible importance of the body as a source of gender identity in its own right. Thus, it explores whether men’s bodies, or their actions with and upon these bodies, had a place in ‘the terms by which commentators debated male behaviour’.²⁴ The body that it considers is one more corporeal than ‘polite’ masculinity’s performative veneer, and one existing beyond the ‘virility’, sexual

²² Ibid., pp. 53, 64; Edward Behrend-Martinez, *Unfit for Marriage: Impotent Spouses on Trial in the Basque Region of Spain, 1650-1750* (Reno, LV, 2007), pp. x, xi, 145.

²³ Quotation from Carter, *Men*, p. 12.

²⁴ Quotation from *ibid.*, p. 9.

failure and castration that have most often brought the male's material body into cultural, gender and social history.²⁵ With this interest in a more physical entity, the thesis tests whether it was only in (allegedly sidelined) vigorous and martial ideals, or in a patriarchal status and 'manhood' allegedly contingent on sex and reproduction,²⁶ that the body was the creator, recipient, and product of masculine ideals.

Scholars have already asked something similar of a preceding era (whether one ending at 1600 or 1640) and of the seventeenth century, primarily in studies of printed literature, and by approaching instructions on healthy living as one of several types of interchangeable prescriptive writing. Alexandra Shepard, for example, used the English health-advice literature of 1560-1640 to reveal a close accord between medicine's 'ranking of different types of male body' and society's assumptions about men's varying entitlement to patriarchal status.²⁷ Yet, the historiography implies, these normative masculine codes underwent transformation soon after the endpoint of Shepard's study. As Shepard noted in a later historiographical review, '[a]s currently represented, the [English]men of the sixteenth and early seventeenth centuries and their counterparts in the late seventeenth century look like different species'.²⁸

Indeed, it is in explaining this alleged transformation that the body has occasionally been brought into narratives of masculinity after 1640 for something other than sexual

²⁵ Exceptions to the latter include Will Fisher, 'The Renaissance Beard: Masculinity in Early Modern England', *Renaissance Quarterly*, 54, 1 (2001), pp. 155-87; idem., *Materializing Gender in Early Modern English Literature and Culture* (Cambridge, 2006); Karen Harvey, 'Men of Parts, Shapes and Style: Men's Legs in the Eighteenth Century', unpublished paper delivered at EMBLazoned, University of Sheffield, 28 November 2008.

²⁶ As discussed in such texts as Helen Berry and Elizabeth Foyster, 'Childless Men in Early Modern England', in idem. (eds.), *The Family in Early Modern England* (Cambridge, 2008), pp. 158-183.

²⁷ Alexandra Shepard, *Meanings of Manhood in Early Modern England* (Oxford, 2003), p. 50.

²⁸ Idem., 'From Anxious Patriarchs to Refined Gentlemen? Manhood in Britain, circa 1500-1700', *Journal of British Studies*, 44 (2005), pp. 281-295, quotation at p. 282. It has been suggested that this is due to the different focuses of studies of the pre-1640 and post-1660 periods (the Civil War era being neglected).

and reproductive incapacity or incompleteness. In some texts, ideas about the body are said to have played a crucial role in facilitating the claimed transition from an early modern ‘manhood’ to a post-1660 ‘masculinity’.²⁹ Yet, (allegedly) new male bodies are not seen as the *basis* of new male norms, or given centre stage as an explanatory force. Nor are men and masculinity made the reason for the invention of new bodies.³⁰ In line with the concerns of the first histories of sex,³¹ it is changing understandings of the female by which historians explain an allegedly new gender system, and their application to new codes of male hetero- and homosexuality by which histories of masculinity make the revised notions of sex consequential to men.³²

For Fletcher, for example, it was ‘women's subordination’ that was ‘naturalised’ as a new notion of the nerve-based body emerged, and a ‘radically new construction of *female* gender that this [new physiological model] made possible’. Both, in this analysis, occurred over ‘the course of the period from 1660 to 1800’.³³ Thus, narratives such as Fletcher’s depict the adoption of new notions of sexual difference as being of social consequence long before the date at which Thomas Laqueur, one of the founders of the study of the history of the sexed body, saw sexed medical models as reaching fruition. For Laqueur, it was only towards the end of the eighteenth century that the dismantling of notions of bodies as gendered but not sexed was complete, and that the conceptual emergence of sexed bodies based on physical ‘incommensurability’ was

See *ibid.*, p. 287, and Harvey, ‘History’, pp. 296-311, esp. 309.

²⁹ As also noted in Harvey, ‘History’, pp. 305-306.

³⁰ See, for example, Fletcher, *Gender*, pp. 322-346, 376-400.

³¹ Londa Schiebinger, *The Mind Has No Sex? Women in the Origins of Modern Science* (Cambridge, MA, 1989), pp. 160-244; Thomas Laqueur, *Making Sex. Body and Gender from the Greeks to Freud* (Cambridge, MA, and London, 1990).

³² E.g. Tim Hitchcock and Michèle Cohen, ‘Introduction’, in *idem.* (eds.), *English Masculinities 1660-1800* (London and New York, 1999), pp. 1-22, esp. 6, 8-9.

³³ Fletcher, *Gender*, p. 293 (my emphasis).

about to begin.³⁴ It is argued in this study that if this alleged displacement of older ways of seeing bodies did have repercussions for men's attitudes towards their bodies, or for their bodily self-fashioning, these should have been becoming visible by 1780. The same might be said of any effects of the alleged sequence of transitions from a 'manhood' based on patriarchal household rule to Restoration libertinism, gentlemanly performative 'politeness', the sensitivity of 'sensibility', and, towards the end of the period, domestic 'tenderness'.³⁵

Shepard has already shown for pre-1640 England that medicine created *textually* a set of stock characters that meshed with social stereotypes of men of different kinds.³⁶ This was, however, an examination conducted through humoral guides, and historians have frequently claimed that humoral notions did not survive unchanged across even the seventeenth century. For Laqueur and Fletcher, and some medical historians, 'by the end of the seventeenth century' new intellectual movements had already 'radically undermined the whole Galenic [humoral] mode of comprehending the body'.³⁷ As the consequence was allegedly a 'radical re-thinking of basic bodily functions' this thesis examines the implications of such a transformation, if it did happen, for the potential application to the subsequent period of arguments similar to Shepard's.³⁸ It asks whether it was only in humoralism that medicine supported expectations about masculine behaviour and identities, and if it did this only in health-literature, as an expressly prescriptive genre.

³⁴ Laqueur, *Making Sex*, pp. 5-6.

³⁵ Harvey, 'History', pp. 297-305.

³⁶ Shepard, *Meanings*, pp. 47-69.

³⁷ Laqueur, *Making Sex*, p. 154; Fletcher, *Gender*, p. 287; Roy Porter, *Flesh in the Age of Reason* (London and New York, 2003), pp. 44-61.

The thesis is not, however, concerned only with medicine as a written project, or with ideals simply for the fact of their textual existence. Testing whether textual values can be shown to have existed beyond texts too, chapters 4 and 5 consider whether these were identities and ideal-types that men were adopting in real-life, and before the onset of sickness. Similarly, chapters 3, 4, 6 and 7 ask something similar of sick men. However, these chapters also try to examine the significance of such codes, asking whether these really were something that men were expected to attain, and not just a hypothetical ideal, known to be distinct from reality.

One of these ideals is ‘sensibility’, for historians have given the body varying significance to ‘sensibility’, and ‘sensibility’ varying importance in masculinity. While Barker-Benfield argued that the ‘restoration of a model of innate sexual difference’ was at the heart of the eighteenth-century ‘cult of sensibility’, it was not notions of the sexed or the ‘sensible’ (sensitive) body that he made the root of what he saw as concomitant new ideas of masculinity.³⁹ Nor was it medical ‘sensibility’s’ notion of nerve-based illness, its modeling of the male sufferer of hypochondria (a ‘nervous’ illness allegedly gendered as male), or its legitimization of male emotionality, by which he explained ‘the reformation of men’, or the delicacy of the ‘sensible’ male body in which he rooted the increasing urge ‘to avoid effeminacy’.⁴⁰

Similarly, while Carter touched on an (unsexed and ungendered) ‘nervous physiology’, an apparently non-gender-specific ‘hypochondria’, and even occasional men expressing their ‘delicate nervous physiology’, ‘sensibility’ – and the masculinity built upon it –

³⁸ Roy Porter, *The Greatest Benefit to Mankind. A Medical History of Humanity from Antiquity to the Present* (1997), p. 222.

³⁹ Barker-Benfield, *Sensibility*, pp. xix, xvii.

⁴⁰ *Ibid.*, pp. 104, xix, xxvii.

was in this analysis primarily a ‘reworking of... definitions of male refinement’, one emphasizing ‘genuine emotion’.⁴¹ If the phenomenon of ‘sensibility’ brought men at large a new way of experiencing – and expressing experiences through – the body, this is yet to be discussed. Indeed, while the alleged movement from ‘manhood’ to ‘masculinity’ has itself been depicted as a transition from performative social roles to internalized feelings, any effect that this might have had on men’s representations of, self-depiction via, or emotional relationships with, their bodies is still to be considered.⁴²

As Carter emphasized, ‘many’ of the participants in the ‘mid- to late-eighteenth-century development of a culture of sensibility’ were Scottish.⁴³ Scotsmen were also important in British medicine, although works by European authors of a range of contemporary and historical fames were also translated, abridged, published and plagiarized, British authors studied abroad, and medical ideas and languages pioneered by Europeans were soon absorbed into publications authored in both England and Scotland. Indeed, the English and Scottish worlds of medical publishing, education and practice were ever more integrated. Many texts had publishers or distributors in both capitals alike, and eminent Scots played a central role in London-based training and treatment. While it is often only English men who feature in histories of early modern ‘manhood’ and post-1660 ‘masculinity’,⁴⁴ Scottish and English men were exposed to the same bodily

⁴¹ Carter, *Men*, pp. 29-30, 91, 93, 192.

⁴² An apparent transformation summarized in Harvey, ‘History’, p. 303.

⁴³ Carter, *Men*, p. 8.

⁴⁴ None of the texts mentioned in a review of pre-1700 ‘Manhood in Britain’, for example, were about British or Scottish men. ‘Britain’ featured only in articles on colonization within the British Isles and male violence in Britain. See Alexandra Shepard, ‘Anxious Patriarchs’, pp. 281–295. Carter, *Men*, is one exception.

models, many of the same medical texts, and, as Carter demonstrated, a shared “‘culture’ of sensibility’ both medical and cultural.”⁴⁵

These bodily models, and the presumptions about men as social players that they might have incorporated, are analyzed in chapter 2. This is done, however, with a much wider definition of medicine than in the foundational histories of sex.⁴⁶ Some critics of this history of sex, or of its adoption by gender history, have gone so far as to claim that it is only in *non*-medical texts that ideas that might reflect those in ‘popular’ circulation can be accessed.⁴⁷ Others have argued that the models revealed by Laqueur and Londa Schiebinger were but ‘the products of high-professional debates’, and that the contents of ‘popular’ health manuals ‘clearly demonstrate’ that such ideas ‘were only very slowly adopted by the broader population’.⁴⁸ Yet, there was not just a single ‘elite’, ‘professional’, discourse, and a single ‘popular’ genre, let alone a single ‘popular’ genre that was uniformly outdated.

Instead, medical writing was highly variegated. Not even works expressly targeted at non-practitioners were automatically traditionalist, while texts ostensibly for professional use could themselves show a full range of progressiveness and technicality. Nor was there any simple, automatic, or even necessary, cleavage between the texts that practitioners and non-practitioners read. Certainly, non-practitioners were not confined to health manuals, or to those manuals of midwifery and generation used by historians

⁴⁵ Quotation from Barker-Benfield, *Sensibility*, p. xix.

⁴⁶ Schiebinger, *Mind*, pp. 160-244; Laqueur, *Making Sex*.

⁴⁷ Tim Hitchcock, *English Sexualities, 1700-1800* (Basingstoke, 1997), p. 49; Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven, CT, 2003), pp. 204-205; Karen Harvey, ‘The Century of Sex? Gender, Bodies, and Sexuality in the Long Eighteenth Century’, *Historical Journal*, 45, 5 (2002), pp. 899-916, esp. 902; idem., ‘History’, p. 305.

⁴⁸ Hitchcock and Cohen, ‘Introduction’, pp. 8-9. See also the discussion in Foyster, *Manhood*, p. 28.

to access ‘popular’ ideas of sex difference and reproduction.⁴⁹ Simultaneous or near-instant translation of texts written in Latin and other languages made even Continental ideas at the very forefront of medical research accessible to even the non-classically-educated book-buying public, as did the speedy percolation of their contents into other texts.

Medical literature was varied in other ways too, and lay readers were exposed to male bodies not only of varying degrees of novelty and technical sophistication but also of different types. To access some of the different ways of approaching the male body that might have been available to even non-Latinate contemporaries, chapter 2 mixes English-language English and Scottish texts with translations of European works. The authors vary in genre, originality, school of thought, contemporary prestige, education, and historical fame, and their subjects from health and domestic medicine, masturbation, and generation and midwifery to physiology, anatomy, pathology, hermaphrodites, natural philosophy and natural history. Using this mixed medical (and natural philosophical) source base – and occasional other materials – the chapter deliberately moves away from the current focus on the existence or absence of sex-unique reproductive organs. Instead, it examines the way that writers imagined, at different times and in different genres, those elements of the male body (and men with bodies) that they themselves selected.

At a basic level, chapter 2 asks whether a narrative reducing the eighteenth-century textual sexed body to the reproductive organs (or the skeleton or nervous system) tells

⁴⁹ E.g. Mary Fissell, ‘Gender and Generation: Representing Reproduction in Early Modern England’, *Gender and History*, 7, 3 (1995), pp. 433-456. See also Hitchcock, *English Sexualities*, pp. 49-52.

the whole story.⁵⁰ However, it also follows those studies that have revealed for *non*-medical discourses that it was not only female bodies that ‘were sites of construction and debate’, or capable of ‘having meanings ascribed to them’.⁵¹ With cultural anxieties about male bodies, and men, allegedly absent from the reproductive anatomies and physiologies that Laqueur used, this chapter examines whether other types of medical publications can reveal the existence and inscription of pressures and expectations.⁵² Thus, it considers to what extent medical writing beyond health-literature was the culturally isolated production suggested by critics. It also tests whether it was only emphatically prescriptive (and allegedly traditionalist) medical writing that embraced concepts and expectations coalescing with those that might have circulated socially. Ultimately, it asks if medical authors, and medical authors of different types, gave expression and backing to commonplace assumptions about masculine roles and attributes.

These findings have implications for the remainder of thesis. There are, for example, parts that look for evidence of those ideas also enshrined within textual constructs of the adult male body, and of the man within it, influencing actual identities and behaviours. As Karen Harvey discussed, historical masculinity has frequently been depicted as insecure, and the masculine ideal as frighteningly unobtainable.⁵³ Various historians have shown how the prospect of sexual failure and genital incompleteness in particular created alarm, both male and societal,⁵⁴ and an analysis of early modern French legal

⁵⁰ For the skeleton see Londa Schiebinger, ‘Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy’, *Representations*, 14 (1986), pp. 42-82.

⁵¹ Karen Harvey, ‘“The majesty of the masculine-form”: multiplicity and male bodies in eighteenth-century erotica’, in Hitchcock and Cohen (eds.), *English Masculinities*, pp. 193-214, quotations at pp. 193-194.

⁵² Laqueur, *Making Sex*, pp. 10-11, 19, 22, 193-196; Schiebinger, *Mind*, pp. 214-215.

⁵³ Harvey, *Reading Sex*, p. 125.

⁵⁴ See, for example, J. C. Mueller, ‘Fallen Men: Representations of Male Impotence in Britain’, *Studies in Eighteenth-Century Culture*, 28 (1998), pp. 85-102; Thomas Foster, ‘Deficient Husbands: Manhood,

medicine revealed the imposition of schematic genital requirements of male sex.⁵⁵ Consequently, chapters 3, 4, 6 and 7 examine whether there were also *non*-structural standards imposed by medicine that men's bodies could fail to achieve, or expectations that they risked falling short of that were societal rather than medical. It tests whether *non*-sexual, *non*-genital, elements of the male physicality also contributed to this allegedly anxious experience, or whether this was in fact an area of life in which masculinity felt more secure, and that serves as a counterbalance to the existing picture of anxious masculinity.

The study also argues that bodily experiences were an important element of men's lives in their own right too, and not just for how they confirmed or endangered a man's reputation for masculinity. '[B]odies lived, and lived beyond the imagination'. '[T]he... effects on the body of certain kinds of exercise', and '[t]he capacity of the body to suffer pain, [and] illness' were something 'more than discourse' and, consequently, perhaps 'themselves a source of 'subjectivity'.⁵⁶ As Foyster noted in 1999, '[t]he ways in which men experienced their bodies still remain little explored', and this study shares Lyndal Roper's interest in the gendering of bodily experiences, but experiences relating specifically to bodily suffering, or its cause or avoidance.⁵⁷ It aims to show that it is possible to write a history of the male body, and of one that is not just an ideal, but experienced and physical. With the body far from only a textual imagining, or 'representation' more broadly, subsequent chapters are concerned with bodies as literal, lived, fleshy entities, sometimes as made sense of, and sometimes as something felt,

Sexual Incapacity, and Male Sexuality in Seventeenth-Century New England', *William and Mary Quarterly*, 56, 4 (1999), pp. 723-744; Valeria Finucci, *The Manly Masquerade: Masculinity, Paternity, and Castration in the Italian Renaissance* (Durham, NC and London, 2003), pp. 30-35, 248-280.

⁵⁵ McClive, 'Masculinity', esp. p. 65.

⁵⁶ Roper, *Oedipus*, pp. 21, 3-4.

⁵⁷ Foyster, *Manhood*, p. 29 (talking of the way in which males imagined their difference from females).

dealt with, treated, or ministered to, a site of sickness, or the creator, physical target, or beneficiary, of various activities, relationships, and interactions.

This consideration of the lived body begins in chapter 3 with the specifically male body. This chapter tests how far the exclusively male, and specifically sexual, parts of this body dominated the male experience of sickness. Using manuscript records of surgical practice, combined with printed discussions of male genital disorders and their treatment, it asks whether belonging to the male sex created a characteristically (or even uniquely) male illness profile. Venereal disease and sexual problems are considered, but alongside other health problems in and from the genitalia, some of them characteristically or peculiarly male. By exploring the surgical account of the experience of problems in and from the penis, testicles and scrotum, the chapter also considers whether being male always meant a comparative freedom from physical distress of the severity and frequency that the womb was, and is, said to have caused females.

This chapter also considers some of the emotional distresses that might have accompanied physical trauma in the male sexual organs. It is the genitalia that historians have found to be the historical proofs and core of male sex, labelled a source of masculine anxiety, or identified as the cultural and anatomical centre of maleness, masculinity, and patriarchal privilege.⁵⁸ Consequently, surgical records of men's experiences of sexual and surgical penile, scrotal and testicular health problems are analyzed here for additional, medical, evidence that might support this wider picture of emotional and social investment, pressure, and subsequent anxiety. They are also

searched for suggestions that the experience of *illness* in or affecting the sexual organs was a further way in which being male, and having male sexual organs, was an anxious experience. However, the chapter also enquires into the frequency and prevalence of such sexual and medical problems. It asks whether these did happen often enough to create a characteristically male physical experience of the lived body, in line with that highlighted for 'women's health'.

Chapter 4 then considers the problematic male and man-owned body as an entirety. It looks at the male experience of problems across the body as a whole, and not just in its exclusively male parts, while adding elements of the experience of being ill not visible in practitioners' materials. The source base is enlarged accordingly. Although initially using case histories of the sort studied in chapter 3, these are expanded to include practitioners other than surgeons, and subsequently replaced by men's self-authored medical accounts, and those of their associates.

Consequently, chapter 4 begins with a statistical analysis of the complaints for which men were treated both before and after 1700. There are surprisingly few sets of records that appear to depict even a substantial part of a practitioner's patient base, and for even a short period of time. Far more are collections of 'select' and 'curious' cases (not always from their authors' practices only), and while there are abundant student notes recording those clinical lectures delivered in mid- and later-eighteenth-century teaching wards, these give no indication of ailments' relative frequency even in the hospital at large. The number of different practice records used to compile this statistical profile of the diagnoses given to men is, therefore, small, and the cases confined to pre-1730. All

⁵⁸ E.g. Edward Behrend-Martinez, 'Manhood and the Neutered Body in Early Modern Spain', *Journal of*

of the records are from England, and only one not from London, although this, from the West Riding of Yorkshire, depicts both rural and non-metropolitan urban communities. Yet, together they cover the early 1630s to late 1680s, and parts of the 1720s, and a range of types of practice. They also reveal over 800 diagnostic labels, in 565 cases. Indeed, this frequent use of symptomatic labels compensates for variations in the number of patients, and, furthermore, makes it possible to access the individual complaints that would sometimes be concealed by illness names.

These different kinds of practitioners – a surgeon, a physician, two hospital physicians, and a mixed practitioner – should ostensibly have encountered male bodies failing in very different ways. With all ‘Manual Operations... to remove the Diseases of the Body, by the assistance of the *Hands*’, ‘External Accidents’, ‘mechanical repairs’, and the skin officially ‘[t]he surgeon’s job’, it was in surgical manuals that urinary and ocular conditions, haemorrhages, injuries, ulcerations, venereal disease (‘classified partly as a disease of the skin’), swellings, hernias and ‘tumours’, and anal and rectal conditions, for example, were discussed.⁵⁹ By contrast, physicians officially focused, in England (and in medical theory), on the illnesses stemming from disrupted processes, treated by ‘internal Medicines’.⁶⁰ Contentiously, however, eighteenth-century physicians graduating in Scotland learnt ‘surgery, medicine and midwifery and were practising’, in both countries, ‘as general practitioners’.⁶¹ Many apothecaries were doing the same.⁶² In Scotland, furthermore, official medical bodies in Glasgow and (after

Social History, 38, 4 (2005), pp. 1073-1093; McClive, ‘Masculinity’.

⁵⁹ Paul Barbette, *Thesaurus chirurgiae...* (4th edn., 1687), p. 1 (original italicizations); Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680* (Cambridge, 2000), pp. 210-211; David Hamilton, *The Healers. A History of Medicine in Scotland* (Edinburgh, 1981, revised edition 2003), p. 59.

⁶⁰ Barbette, *Thesaurus*, p. 1.

⁶¹ Hamilton, *Healers*, p. 182.

⁶² In London unofficially, until ‘a bitter fight... in the seventeenth century’ (Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge, 1999), p. 216).

1657) Edinburgh were producing ‘surgeon-apothecaries’, trained in ‘both surgery and medicine’.⁶³

Officially, however, and in England at least, surgeons and physicians should have seen male bodies, and men with bodies, suffering because of their sex and gender in very different ways. If diagnoses of gendered illnesses *were* being made, or men’s lifestyles being found to have damaged constitutions or created sickness, it is, ostensibly, physicians only who should have been recording this. On the other hand, the record of men suffering the consequences of the constructions of masculinity that allegedly led them into promiscuity, violence and bravado should, officially at least, be confined to surgeons’ notes, alongside those men suffering because of their sex, or from their uniquely male parts, or in their sexual functions.

It is for this reason that the chapter combines the diagnoses recorded in the four separate practices. The resultant composite picture is used for an overview of the range and relative frequency of the problems for which men might have needed medical help, unobscured by professional divisions. This is itself significant, as a part of the male experience yet to be considered by historians of masculinity. Where the history of masculinity and studies touching upon masculinity have focused on men’s bodily problems it is primarily those that were sexual or in the sexual organs, mainly as problems of social status and social response, or in the stock character type of the male melancholic or hypochondriac.⁶⁴ While scholars from other fields have explored those tensions and uncertainties of men’s identities that were written into other kinds of

⁶³ Hamilton, *Healers*, pp. 59-62.

⁶⁴ Michael Stolberg, ‘An Unmanly Vice: Self-Pollution, Anxiety, and the Body in the Eighteenth Century’, *Social History of Medicine*, 13, 1 (2003), pp. 1-22; Mark Breitenberg, *Anxious Masculinity in Early Modern England* (Cambridge and New York, 1996), pp. 35-68, and other analyses of the

pathological or deviant male bodies, this is often an analysis focused on textual, and frequently literary, representations.⁶⁵ Consequently, where the health problems encountered by actual men, and recorded as being treated by practitioners, have been considered, whether alone or in comparative studies, this has tended to be the product of an initial interest in women's health, not in masculinity.⁶⁶ Chapter 4 offers, therefore, a reminder that the male experience of illness was never one confined to sexual, sexed, and gendered problems alone.

Moving to consultations-by-post, and a sample of those sent to the London-based Irish physician Sir Hans Sloane (1660-1753), the chapter then responds to calls for the consideration of “the social relations of gender”, and how manhood and masculinity ‘might have been experienced as an emotional state’ or ‘psychological experience’.⁶⁷ Comparing statistically the way in which sick men recounted their experiences with the accounts offered by their circles and practitioners, part two searches for the ‘ways in

construction of the melancholic or hypochondriac.

⁶⁵ E.g. David Katz, ‘Shylock’s Gender: Jewish Male Menstruation in Early Modern England’, *Review of English Studies*, 50, 200 (1999), pp. 440–462; John Beusterien, ‘Jewish Male Menstruation in Seventeenth-Century Spain’, *Bulletin of the History of Medicine*, 73, 3 (1999), pp. 447–456; Breitenberg, *Anxious Masculinity*, pp. 35–68.

⁶⁶ See, for example, the progression shown in Wendy Churchill, ‘Female Complaints: The Medical Diagnosis and Treatment of British Women, 1590–1740’ (unpublished Ph.D. thesis, McMaster University, 2005); idem., ‘Bodily Differences?: Gender, Race, and Class in Hans Sloane’s Jamaican Medical Practice, 1687–1688’, *Journal of the History of Medicine and Allied Sciences*, 60, 4 (2005), pp. 399–444; idem., ‘The Medical Practice of the Sexed Body: Women, Men, and Disease in Britain, circa 1600–1740’, *Social History of Medicine*, 18, 1 (2005), pp. 3–22, or in Lisa Smith, ‘Women’s Health Care in England and France, 1650–1775’ (unpublished Ph.D. thesis, University of Essex, 2001); idem., “‘An Account of An Unaccountable Distemper’: The Experience of Pain in Early Eighteenth-Century England and France”, *Eighteenth-Century Studies*, 41, 4 (2008), pp. 459–80; idem., ‘Fundamental problems: Gender and Haemorrhoids in Eighteenth-Century England and France’, unpublished paper delivered at EMBazoned, University of Sheffield, 28 November 2008; idem., ‘Representing Castration in Eighteenth-Century France’, unpublished paper delivered at SSHM annual conference, Durham University, 8–11 July 2010.

⁶⁷ BL, Sloane MSS 4075, 4077–4078, Hans Sloane consultations (late-seventeenth- to eighteenth-century). Quotations from Michael Roper, ‘Between Manliness and Masculinity: The “War Generation” and Psychology of Fear in Britain, 1914–1950’, *Journal of British Studies*, 44, 2 (2005), pp. 343–62, cited in Karen Harvey and Alexandra Shepard, ‘What Have Historians Done with Masculinity? Reflections on Five Centuries of British History, circa 1500–1950’, *Journal of British Studies*, 44 (2005), pp. 274–280, citation at p. 276; John Tosh, “What Should Historians Do with Masculinity? Reflections on Nineteenth-

which men constructed and thought about themselves'.⁶⁸ It considers whether medicine was another sphere in which gendered self-construction had to happen and, if it was, whether this was through the masculinity normative to the 'polite' gentleman or man of 'sensitivity', the stoic, courageous, anti-effeminate ideal, or an older 'manhood' of strength and reason.

Subsequent parts of the chapter similarly test whether masculinity might have shaped men's attitudes to sickness, or to specific complaints, and in this way created a peculiarly masculine experience of illness, anxious or not. Sloane's letters are supplemented by those received in the early 1780s by William Sinclair, a Scottish physician, and John Hope, president of the Royal College of Physicians of Edinburgh (1784-86).⁶⁹ A more detailed analysis is given of the way in which men made sense of their plights, now considered in its own right. The experience of sickness (or rather of men's representation of this experience) is then studied in a similar way, looking at how far male patients were aware of their physical vulnerability, what most distressed them, and to what extent this was the product of an interiorization of gendered social values and identities.

Chapter 5 also considers recorded causality. However, it moves from the medical self-representation of the sick man to the social identity and behaviours of the initially healthy man (allegedly) being made ill by his way of living. It also turns, where possible, to male deaths. Interested in both recreational and occupational cultures, it focuses on drink, venereal disease, violence, and health problems ascribed to work,

Century, Britain," *History Workshop Journal*, 38 (1994), pp. 179–202, cited in Shepard, 'Anxious Patriarchs', p. 289; Harvey and Shepard, 'What Have', p. 276.

⁶⁸ Quotation from Hitchcock and Cohen, 'Introduction', p. 1.

particularly in characteristically male occupations. The source base returns to practitioners' casebooks,⁷⁰ adding eighteenth-century, mainly Scottish, clinical lecture notes. The surgeon John Hunter's (1728-1793) later-eighteenth-century 'morbid anatomies' are also used, to access believed causes of death, and comparisons drawn with a small number of coroners' records.⁷¹ With the concern lying in the ascribed *origins* of the illnesses, injuries, and deaths, encountered by men, reference is also made to the criminal behaviours committed upon the men of later-seventeenth-century Middlesex, as revealed in a sample of sessional papers.⁷²

Constructing an illness profile from Sloane's Jamaican patient base, Wendy Churchill argued that typically gendered areas of both men's and women's lives could carry health risks.⁷³ However, this chapter is concerned with how often, for men, this actually happened. In one way its interest lies in whether or not men's behaviours left their physical mark on the body, and if these causes, the injuries or illnesses themselves, the medical processes that they set in place, and the body emerging out of these, somehow created a male and masculine body that was made rather than born. According to studies of modern men, after all, masculinity *is* bad for the health, and one eighteenth-century medical commentator even argued that masculine leisure and male jobs were proving *fatal*.⁷⁴ In testing these notions, the chapter ultimately considers to what extent the medical record confirms cultural, gender, and social historians' frequent claims about

⁶⁹ NAS, GD136/435, 436 Letters sent to William Sinclair (1778-1794 and 1778-1834); NAS, GD253/143/6, Letters sent to John Hope (1769-1786).

⁷⁰ English-only for the seventeenth century because of a relative scarcity of Scottish equivalents.

⁷¹ RCS, MS 0189/1/2, 'Records in Morbid Anatomy' (men's dated cases 1774-1802), John Hunter; RCS, MS 0189/1/3, 'An account of the dissections of morbid bodies' (men's dated cases 1755-1782), *idem*.

⁷² John Cordy Jeaffreson (ed.), *Middlesex County Records*, vols. 3-4 (1892).

⁷³ Churchill, 'Bodily Differences', pp. 413-415.

⁷⁴ Series Editor's Introduction, in David Frederick Gordon and Donald Sabo (eds.), *Men's Health and Illness: Gender, Power, and the Body* (1995), pp. vii-viii.

men's participation in a drink, bravado, and violence based male culture,⁷⁵ and about men as members of a patriarchal society and the subjects of gendered socialization.

Dangerous pleasures and hazardous work are not, however, the only way that masculinity is said to have led the men of the past to endanger their bodies. Western men have allegedly *traditionally* assumed an indifference towards their health and bodies, and have done so because of a form of masculinity that, sociologists claim, has long been hegemonic.⁷⁶ Today, the consequence of this same hegemonic masculinity is that

self-care practises have become culturally defined as “feminine”.

Denial of fear or vulnerability and men's late presentation to health services when they are ill, are important examples of this... [B]oys tend not to develop self-nurturing attitudes and behaviours in the same way that girls do... [and] men are slower to notice signs of illness, and... when they do,... less likely than women to seek help from a doctor.⁷⁷

This is said to happen because

[a] man who does gender correctly would be relatively unconcerned about his health... see himself as stronger, both physically and emotionally, than most women... think of himself as independent, not

⁷⁵ Roper, *Oedipus*, pp. 108-117; Shepard, *Meanings*, pp. 93-151; idem., ““Swil-bols and tos-pots”: Drink Culture and Male Bonding in England, c.1560-1640”, in Laura Gowing, Michael Hunter and Miri Rubin (eds.), *Love, Friendship and Faith in Europe, 1300-1800* (Houndmills and New York, 2005), pp. 110-130.

⁷⁶ Michael Kimmel, *The Gendered Society* (3rd edn., Oxford and New York, 2008), pp. 310-311.

needing to be nurtured by others... be unlikely to ask others for help...
spend much time out in the world and away from home... Face danger
fearlessly, take risks frequently, and have little concern for his...
safety.⁷⁸

The model man of the second quotation does seem to echo the strong and active, courageous and rational, autonomous, ideal discussed by historians of early modern (English) 'manhood'. This, furthermore, was not an ideal new to the 1640s, the starting point of this thesis. Histories beginning in the early-, mid- or later-sixteenth century have claimed substantial continuity from these points in time up to the mid- or late-seventeenth century, sometimes in this particular ideal and sometimes in the wider construct of which it was a part. These studies have also, however, identified a growing class-differentiation within English 'manhood', one that Shepard found underway by 1640 but which other studies date to the post-1660 (or post-1700) period, and explain by changes in the values elevated by 'polite' society.⁷⁹

Yet, there are also histories that suggest that it was not only in the 'working class' that elements of a male ideal shown to have already existed in the sixteenth century were still being upheld two centuries later.⁸⁰ Robert Shoemaker and Joanne Bailey have both argued that the early modern idealization of 'masculine assertiveness, courage, and physical agility' survived into and through the eighteenth century, although moderated (as with the expectation of violence), or supplemented by newer values (such as paternal

⁷⁷ Noel Richardson, 'Ireland: We must get the definition of "men's health" right from the start', www.emhf.org/index.cfm/item_id/101(European Men's Health Forum, undated).

⁷⁸ Will. H. Courtenay, 'College Men's Health: An Overview and a Call to Action', *Journal of American College Health*, 46, 6 (1998), pp. 276-290, quoted in Kimmel, *Gendered Society*, p. 311.

⁷⁹ Shepard, *Meanings*, p. 253; Fletcher, 'Manhood', esp. p. 436; Foyster, *Manhood*, pp. 208-218.

‘tenderness’).⁸¹ Consequently, chapter 6 asks whether a masculine ideal similar to that prevalent in modern society was having repercussions for men’s ability to manage their bodies echoing those found today. It continues chapter 5’s interest in the consequences for men’s bodies of gendered codes of necessary and permissible behaviour, and of any resultant self-construction as masculine. However, while chapter 5 asked how (and if) masculinity actively jeopardized bodies and bodily wellbeing by *creating* bodily plights, chapter 6 searches for evidence that cultural values influenced men’s pre-emptive protection of the body.

While there have been special issues of journals dedicated to men’s non-medical history, and other special issues or books on women and medicine, there are as yet none about men and medicine, whether a medicine domestic or purchased. Historians have not had the politicized motives to rehabilitate a historiographically neglected, and perhaps downplayed, male experience in the way that they have for women.⁸² Indeed, it is only very recently that there has emerged an interest in men’s domestic lives in general.⁸³ Consequently, chapter 6 considers whether it is possible to study men’s participation, as men, in (domestic) medicine, not for their nursing of others, but in taking care of their own bodies.

⁸⁰ Quotation from Foyster, *Manhood*, p. 217.

⁸¹ Robert Shoemaker, *Gender in English Society 1650-1850: The Emergence of Separate Spheres?* (Harlow, 1998), pp. 297, 304; Joanne Bailey, “‘A very sensible man’: imagining fatherhood in England c. 1750-1830”, from a forthcoming work. I am grateful for the opportunity to see this.

⁸² For women and medicine see *Bulletin of the History of Medicine*, 82, 1 (2008), Special Issue: ‘Women, Health, and Healing in Early Modern Europe’, esp. Mary Fissell, ‘Introduction: Women, Health, and Healing in Early Modern Europe’, pp. 1-17, esp. 1. For men in a non-medical context see *Journal of British Studies*, 44, 2 (2005), Special Feature on Masculinities. The way in which feminism created, and still drives, this interest in women and medicine is discussed in Monica Green, ‘Gendering the History of Women’s Health Care’, *Gender and History*, 20, 3 (2008), pp. 487-518; Hilary Rose, ‘Foreword. From household to public knowledge, to a new production system of knowledge’ (unpaginated), in Lynette Hunter and Sarah Hutton (eds.), *Women, Science and Medicine 1500-1700, Mothers and Sisters of the Royal Society* (Stroud, 1997).

⁸³ E.g. Karen Harvey, ‘Men Making Home: Masculinity and Domesticity in Eighteenth-Century Britain’, *Gender and History*, 21, 3 (2009), pp. 520-540. Amanda Vickery, *Behind Closed Doors: At Home in*

Lisa Smith has already argued that the construction of their patriarchal role prompted men to take care of not only sick offspring but themselves too.⁸⁴ This chapter asks if this was the only ideological force leading men to look after their bodies (or making them need *to be seen* as looking after these). Consequently, it begins by considering possible reasons and rationales behind men's desire to protect the body and preserve health. Thus, printed non-medical prescriptive texts are scrutinized for the commands issued to men, exploring whether didactic writers made masculinity directly relevant to the treatment of the body. In particular, it is asked if authors gave men, as men, any special reason or imperative to protect their bodies, or, indeed, actually furnished them with deterrents against being known to take care of themselves.

On the other hand, by comparing their messages with men's real-life actions, and apparent intentions, the chapter also tests the reliability of prescriptive texts as a source of insight into actual identities, behaviours and ideals. Frequently reliant on records left by men whose very record-keeping might suggest an atypical concern, or able to 'see' only sick men, often only as mediated through the practitioner, the historian of this period cannot access the thoughts and experiences of the masses. This chapter, therefore, attempts to find a source-base that might allow some provisional insight into the attitudes of at least a sample of men. This includes three diaries left by medically educated or practising youths and men, at the start, middle, and end of the period. These are analyzed for evidence of an interest in the healthy body and in the maintenance of health, a resultant involvement in health-promoting and body-protecting activities, and

Georgian England (London and Yale, 2009) made no mention of medical-related activities or possessions.

⁸⁴ Lisa Smith, 'Reassessing the role of the family: Women's Medical Care in Eighteenth-century England', *Social History of Medicine*, 16, 3 (2003), pp. 327-342.

the place given to such activities within at least the private self-images being constructed in these writings. The bulk of the analysis, however, focuses on male-compiled manuscript recipe collections and medical commonplace books, from across the period. Although also examined for men's ability to participate in domestic medicine, a crucial interest concerns what their contents reveal about men's *reasons* for equipping themselves with the resources by which to recover health, and how these relate to the ideals of masculinity presumed in medical instructions on health, or to the allegedly 'hegemonic' masculinities revealed in other studies.

While chapter 6 explores how a sample of men negotiated their possession of a body that was potentially physically vulnerable, chapter 7 re-examines a topic considered in earlier chapters – men's negotiation of their possession of current sickness, or of a body that was sick. This is not, however, for that interest in the relationship between the specific natures of different ailments and the response of the owner of the body that is pursued in chapters 3 and 4. Similarly, in place of chapter 4's focus on men negotiating their sickness conceptually and psychologically, chapter 7 looks at their practical responses, and at the very public relationships and identities that these brought into play.

The male and the masculine are only slowly being absorbed into histories of sex and gender in medical care.⁸⁵ Lisa Smith considered the effects for both genders of an unequal distribution of financial autonomy, yet it is still only 'women patients' who are

⁸⁵ Where masculinity does feature in analyses of gender and sex in medicine it is often for the practitioner. See, for example, Margaret Pelling, 'Compromised by gender: the role of the male medical practitioner in early modern England', in Hilary Marland and Margaret Pelling (eds.), *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands, 1450-1800* (Rotterdam, 1996), pp. 101-133; Wayne Wild, *Medicine-by-Post. The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam and New York, 2006).

recognized as a distinct group to be courted by practitioners in a gendered way.⁸⁶

Consequently, this chapter considers the consequences of gendered behavioural codes for men's sick roles, and the way in which these might have shaped men's relationships with the (male) practitioners treating them, their ability to access this care, and their relationships with others. While it moves to reparative, primarily paid, body care, much of its interest lies in the interactions and negotiations *surrounding* the patient's use of practitioners' services. However, it certainly does not claim a separation between men's social discourses and networks and the discussions and actions occurring inside the formal medical exchange.

Using consultation letters, non-medical correspondence (primarily Scottish familial discourses), and, occasionally, practitioner records, chapter 7 asks how the fact of being sick, receiving medical care, and taking on the sick role might both have been shaped by and had consequences for those behaviours, identities and relationships (allegedly) demanded by society's model of masculinity. Part one, therefore, uses family correspondence to consider how sickness, and the associated costs and tensions, could have affected a particular male-male relationship, that between father and son. It also asks how the experience of sickness might have been shaped by the age- and gender-specific position of the male youth. The second part turns to the public world, mixing exchanges between family members, friends and colleague with clues found in consultation letters. On the one hand, it examines the implications for men's public gendered identities of the fact of sickness, and of the immobility and inactivity that being sick sometimes entailed. On the other, it asks if their membership of a society

⁸⁶ Smith, 'Reassessing'. For the latter see, for example, Wild, *Medicine-by-Post* (quotation at p. 12). The patients of earlier studies were ungendered (e.g. Dorothy Porter and Roy Porter, *In Sickness and in Health. The British Experience 1650-1850* (1998); idem., *Patient's Progress. Doctors and Doctoring in Eighteenth-Century England* (Stanford, 1989), p.13).

elevating autonomy as a proof and basis of masculinity did have to have consequences for men's sick-time behaviours and for their willingness to acknowledge weakness.

The third part similarly examines sick men's interactions with the men treating them. It suggests that it might be misleading to approach these as solely a professional, contractual, 'patient-practitioner relationship', or in isolation from the interactions, friendships, and eyes, of the wider world. Finally, part four searches the consultation letters for evidence of masculinity – especially one threatened by the fact of sickness – creating a peculiarly male and masculine sick role. It also asks if this masculinity thereby impinged on the care received, and, consequently, on the fate of the body itself. Of especial interest are the behavioural repercussions of the alleged movement from self-conscious self-control to the unguarded self-expression, and physical sensitivity, of 'sensibility'. Indeed, the specific circumstances of pain and physical distress are used to examine what the secondary literature suggests should have been a critical source of tension. For historians of 'sensibility', this new cultural trend allowed, and even demanded, 'a degree of emotion traditionally associated with women'.⁸⁷ Yet, according to Fletcher, the (English) conduct literature was still teaching as late as 1760 that the '[d]isplay of emotion... is always unmanly and womanish. Bearing pain if need be with manhood and firmness is a crucial aspect of male dignity. Tears, acceptable in women and children, were an unpardonable weakness in a man'.⁸⁸ This section tests whether the medical realm reveals any resultant conflict. However, it also considers whether it really was only with 'sensibility' that men were allowed to express distress in the face of suffering, and if the stoic ideals highlighted by Fletcher – and, as Barker-Benfield

⁸⁷ Carter, *Men*, p. 2.

⁸⁸ Fletcher, *Gender*, p. 366.

discussed, elevated by critics of “luxury” – really did put men under additional pressure.⁸⁹

As Joanna Bourke demonstrated a decade and a half ago, for a different period, context and source-base, the male body was not only a construct(ion) or representation. Bodies were something physical and lived, both in corporeal processes and social encounters.⁹⁰ This thesis takes a similar interest in the intertwining of physical and social experiences, the experiences that bodies underwent because of their owners, and men with typical bodies experiencing disruption.⁹¹ It also asks whether health, illness and medical care might be spheres in which to bridge that historiographical separation of masculine ideals and ‘representations’, men’s social history and ‘social relations’, and their emotional and ‘subjective experience[s]’, noted by other historians.⁹² Ultimately, it tests whether early modern ‘manhood’ and eighteenth-century ‘masculinity created peculiarly masculine ways of experiencing and responding to the corporeal body that was a site of health and sickness.

⁸⁹ Barker-Benfield, *Sensibility*, p. 104.

⁹⁰ Joanna Bourke, *Dismembering The Male: Men’s Bodies, Britain and the Great War* (1996).

⁹¹ Rather than those transgressive bodies of the hermaphrodite or castrato that have often attracted the attention of historians of this period.

⁹² Harvey and Shepard, ‘What Have’, p. 275.

Chapter 2: The male and the man in published medical writing

Introduction

In both 1640 and 1780, medical writers had a notion of what it was to be an adult male. To be an adult male was to have a specific body type, or specific types of certain parts and features. However, it was sometimes to have something else as well, and to have it as a consequence of this body type: to be (an adult) male could be to have a particular character, and sometimes also a particular social role and life, to be a particular type of man. This was not something constantly reiterated, in every text and every type of medical discourse, but there were authors subscribing to it in both 1640 and 1780.

To demonstrate this, the chapter begins with the different ways in which it was possible to approach the adult male in the mid- and later-seventeenth century. The first part looks at the male body as envisioned in a humoral (Galenic) framework, where it was the mixture of four different fluids (or humours) that determined health, appearance, and maleness or femaleness. While the exact fates of the humoral male and female have received comparatively little analysis, Thomas Laqueur seemed certain that humoral notions of male-female difference had collapsed by 1700. However, he mentioned this primarily to explain that allegedly new rooting of sex in the reproductive organs that was his own interest.¹ How male-female difference beyond the sexual organs (and perhaps the nerves and skeleton) was subsequently made sense of it, and if this wider difference still mattered, was not something discussed. Yet, for Londa Schiebinger, anatomists' and natural philosophers' 'view of female nature still (implicitly, even at

times explicitly) assumed the ancient theory of humors', even in the early eighteenth century.²

Part one of this chapter examines, therefore, the fate by 1700 of the humoral male as it existed beyond the reproductive organs. On the one hand, it asks whether the humoral way of approaching the sexed and gendered body outside of the reproductive organs was as uniform and consistent – between texts and across time – as histories of sex can imply. On the other, it tests claims that the effect of the 'Scientific Revolution' was nothing less than the demolition of the entire 'intellectual basis' of humoralism, and, by extension, that of its models of maleness and femaleness too.³ Part two then moves to some of the ideas about the male's reproductive nature visible in 1640-1700, but with different concerns to Laqueur and Schiebinger. Rather than examining how far male and female reproductive anatomy were seen as different to each other it looks at a non-structural element of male sexual nature, not to argue that the reproductive organs were yet to be sexed but to consider how far this more diffuse sexual nature was itself important to conceptualizing maleness. The role ascribed to the semen in the creation of the post-pubescent male is examined, as is the significance given to a non-anatomical 'virility' when defining maleness. The evolution of such ideas over the eighteenth century is then explored in part three, which asks if claims about the importance of the semen to and within the male body changed in response to later-seventeenth- and

¹ Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA, 1990), pp. 154-155.

² Londa Schiebinger, *The Mind Has No Sex? Women in the Origins of Modern Science* (Cambridge, MA, 1989), pp. 180-181.

³ Anthony Fletcher, *Gender, Sex and Subordination in England 1500-1800* (London and New Haven, 1995), p. 283.

eighteenth-century debates about its contents as a reproductive fluid, or to newer ideas of human physiology.

Following this, parts four and five test whether the rise of new approaches to human physiology and anatomy did result in the disappearance of those frequently external and enacted properties by which humoralism had in part delineated maleness. Although focusing on different parts (the reproductive organs and skeleton), Laqueur and Schiebinger both saw the eighteenth-century medical world as inventing bodies in which maleness and femaleness were rooted in anatomical structures. Michael Stolberg did something similar, locating the invention of sexed reproductive organs and skeletons in the 1500s, yet claiming that if ‘any decisive contribution’ to the creation of ‘modern’ sex happened subsequently it was in eighteenth-century ideas about the nerves.⁴

However, while some of the most fashionable and eminent texts of the early- and mid-eighteenth century did envision a nerve-based body, this was not true of all medical writers, even in the heyday of ‘the new mythology of the nerves’.⁵ The specifically male body was not in 1780, or at any prior point, one uniformly approached through its having nerves less irritable, muscles more elastic, and fibres stronger, than those of the female. Indeed, this chapter emphasizes the variety of approaches visible in medical writing at any one time. It examines to what extent, and how uniformly, there was any fundamental change in what various strands of medical writing chose to select as the definitive properties of the (adult) male, the forces seen as making (and threatening) them, the language in which these properties were described, and the principles by

⁴ Michael Stolberg, ‘A Woman Down to Her Bones. The Anatomy of Sexual Difference in the Sixteenth and Early Seventeenth Centuries’, *Isis*, 94 (2003), pp. 274-299, quotation at p. 299, n. 77.

which they were explained. Consequently, while part four explores the rise, and limitations, of a male body imagined through internal anatomy, the fifth looks at a complementary body, examining whether a humoral male, and the gendered values inscribed within it, might have survived.

Part i: The Humoral Male Body

In some ways it is difficult to find evidence of mid- and later-seventeenth-century medical thought having a notion of male nature that extended beyond the sexual organs. Literature on the maintenance of health promising '[t]he method and means of enjoying health' 'for different constitutions; ages; abilities; valetudinary states, individual properties; habituated customs, and passions of mind', and specific 'to every person', made no recognition of the male as a body type with its own 'constitution', 'passions' or 'properties'.⁶ While such manuals recognized females as having distinctive natural functions and needs, they were usually silent about a male body similarly made by nature.⁷ Even texts discussing the use of exercise 'as sutes... the Nature of each persons body' made no recognition of male nature giving men greater needs, or capacities.⁸

Yet, medical authors were not totally lacking a notion of the male (or the male beyond the sexual organs) created by nature, as born not made. The sexual organs were not the only body parts thought to have naturally a characteristic form in males, distinct from

⁵ Quotation from G. S. Rousseau, 'Towards a Semiotics of the Nerve: The Social History of Language in a New Key', in R. Porter and P. Burke (eds.), *Language, Self, and Society. A Social History of Language II* (Cambridge, 1991), pp. 213-275, quotation at p. 227.

⁶ Everard Maynwaringe, *The Method and Means of Enjoying Health....* (1683), title page.

⁷ For females see M. Flamant, *The Art of Preserving and Restoring Health...* (1697), pp. 93-96; Samuel Haworth, *A description of the Duke's Bagnio... and the medicinal vertues...* (1683), pp. 70, 102, 111; Sanctorius, *Medicina Statica: or, rules of health.... English'd by J. D.* (1676), ff. a5, a6, 165-7. See also idem., *Medicina statica: being the aphorisms of Sanctorius...* (5th edn., 1737).

⁸ Maynwaringe, *Method*, p. 139.

that normally found in females.⁹ Their comments varied in depth and technical sophistication, but anatomical authors who commented on, for example, the Adam's apple were not simply making metaphorical inscriptions of a deeper gender order, in a way never intended as a factual analysis of the corporeal.¹⁰ Instead, they stated that the male had a deep voice or an Adam's apple, that he had a deep voice because of the Adam's apple, or that he had particular attributes of the larynx and its component parts (and perhaps also that these had vocal repercussions).¹¹ While some observations were limited in anatomical detail, stating only that the '*Pomum Adami*, or Protuberant Part of the *Larynx*... in Men is much larger than in Women', authors of the same generation could and did make much more technical claims, arguing, for example, that it was formed by the '[t]he *Sheild Gristle*, called *Thyroides*', which 'buncheth out in the Throats of Men'.¹²

Not even the Adam's apple, with its obvious denotations, prompted British anatomical authors to make analogical or even tongue-in-cheek references to the patriarchal gender order, or to gendered virtues and faults. Many were silent about the Biblical tale of the Fall, and those who did mention it were simply explaining the origin of the name, 'from an *idle fable*, that part of the fatal Apple by God's judgement stuck in his Throat, and that this Cartilage being thereby distended was made to jet out, and the protuberance propagated to posterity. It is greater in Men than in Women'. This author, the Leiden-educated anatomist Thomas Gibson (1647-1722), preferred to refer to it as the 'part

⁹ For the sexual organs see the discussion of the penile and testicular muscles (with an account of the clitoris's difference to the penis) in John Browne, *A Compleat Treatise of the Muscles...* (1681), pp. 79-82.

¹⁰ Compare to Laqueur, *Making Sex*, p. 10, and Mark Breitenberg, *Anxious Masculinity in Early Modern England* (Cambridge, 1996), pp. 12-13.

¹¹ Thomas Gibson, *The anatomy of humane bodies...* (1682), p. 287.

¹² William Cowper, *The anatomy of humane bodies...* (Oxford, 1698), table one; Randle Holme, *The academy of armory...* (Chester, 1688), 'Throat' (original italicization). Some mentioned the Adam's apple

which sticketh out' from '[t]he first *Cartilage*', 'called... *scutiformis*, or Buckler-like; for within it is hollow, but without embossed or convex'.¹³ Translations of European works were similarly uninterested in endorsing the Biblical tale of the Fall, with its denotations of post-lapsarian male mastery. They too dismissed this explanation as something 'vulgarly believ'd', and focused solely on the structural anatomy.¹⁴

British authors gave greater and lesser emphasis to the Adam's apple's uniqueness to the male, some mentioning this as a point in itself, and others only in passing, in explaining the origin of the name. Yet, whether discussing the Adam's apple, other anatomical features of the male, and often even the sexual organs, their language was dispassionate and corporeal.¹⁵ There was certainly no repetition of that used by the Dutch Ysbrand Diemerbroeck (1609-1674), as translated by William Salmon, in claiming that 'because our... Parents fell through the Temptation of the Devil... to *Adam* was given a genital Member... like a Serpent, and to *Eve* a Member of Generation like the Serpents Den', 'the *Adamite*'s Serpent' being 'never at rest but when he is entering *Eve*'s Den'.¹⁶ Rather than 'indifference toward... secondary sexual difference', or a reliance on 'hoary images', anatomists were well aware of innate differences, throughout the body, separating males and females.¹⁷ The male did have physical, anatomical, and material characteristics that defined and identified it. While these were analyzed and explained with varying depths of causality and sophistication, writers were concerned with the accurate representation of the physical reality of the

but not the types of bodies it was found in (e.g. Alexander Read, *The manuell of the anatomy.... of the body...* (1638), p. 375).

¹³ Gibson, *Anatomy*, pp. 297-298 (first emphasis mine, other italicizations original).

¹⁴ Ysbrand van Diemerbroeck, *The anatomy of human bodies... translated by William Salmon* (1694), p. 367.

¹⁵ William Cowper, *Myotomia reformata...* (1694), pp. 30-35 (the testicular and penile muscles), 222-242 ('AN APPENDIX: *Containing a Description of the Penis and the manner of its Erection*').

¹⁶ Diemerbroeck, *Anatomy*, pp. 130-131 (original italicizations).

¹⁷ Schiebinger, *Mind*, p. 186; Laqueur, *Making Sex*, p. 25.

male body. The male body was not just a shell in which to write truths about the self within it, and the place of this self in the world at large.¹⁸

Nor was humoralism only about gendered abstract truths. While to be male was also to have the comparatively hot and dry humoral physiology of the adult male, this was to a great extent a system of making sense of observed, often very sensory, and often physical, properties. As Samuel Haworth ('student in physic') described in 1680, psychologically, to be an adult male was to have 'a more profound judgement than...the other [sex], and Wills... more stable and resolute'. However, the adult male was also defined physically, by 'the whole Structure of the Muscles [being] more compact and solid' (from a 'vehement Pulse and Respiration'), a 'strong and Man like Voice', and being more Hairy than females, 'in the whole Superfice of their Bodies'.¹⁹ Humoralism gave the adult male defining features on dual levels. The adult of either sex could be defined by its possession of a particular 'complexion' (for males, the disproportionate possession of hot and dry fluids). However, both the complexion and those properties that it explained functioned as a shorthand stand in, both for each other and for the resultant whole.

Authors approaching the sexes in a humoral way were not, therefore, interested solely in the physical. Haworth, for example, discussed the sexes in a chapter opening with a teleological explanation of why Nature had created the male and female that endorsed the gendered division of labour. His subsequent discussion of the male did, consequently, pick up on gendered social roles, claiming that the adult male's physical

¹⁸ Compare to Caroline Bicks, 'Stones Like Women's Paps: Revising Gender in Jane Sharp's *Midwives Book*', *Journal for Early Modern Cultural Studies*, 7, 2 (2007), pp. 1-27.

¹⁹ S. H. [Samuel Haworth], *Anthropologia or, a... discourse concerning man...* (1680), chap. XIII, 'Of the Sexes', esp. pp. 192-194.

vigour made him ‘robust and *more fit for Labour*’, in a chapter arguing both that this ‘nobler [male] sex’ had a characteristic ‘soul’ and that there existed male and female behavioural profiles.²⁰ For Haworth, there was a clear male mind frame, distinct from the female’s ‘[p]hantasia’, and itself the product of nature not culture, at least in the crucial characteristics that defined maleness and created the masculine character type.²¹

However, that authors also commented on social and psychological properties does not mean that there was no interest in the physical body in its own right, or that this was sidelined or artificial. Similarly, that ties were found between the definitive physical properties of the male and man’s gendered social role does not prove that (the) corporeality was seen as but a mechanism by which to explain gendered constructs about social roles and intellect. While historians have approached the notion of superior male heat as an ideologically charged claim of superiority *overall*, this heat was also being used as a way of making sense of very literal, observed, physical properties and differences. In one 1664 translation, for example, it was employed to explain not only why the male stomach was bigger than the female’s, but also why developed men but not undeveloped eunuchs, or pre-pubescent boys, became bald.²² Manuals of generation used male heat to explain other physical properties of the male too, ranging from his longer-lasting fertility to his leaner physical build. This heat also ran through Haworth’s entire description of the male, forming the basis of all of the characteristic and defining attributes – psychological *and physical* – of ‘The Male his Nature and Difference from the Female’. It did so because

²⁰ Ibid., pp. 190-191 (my emphasis).

²¹ Ibid., pp. 195-196.

²² Thomas Bartholin, ed. Nicholas Culpeper and Abdiah Cole, *Bartholinus Anatomy... the precepts of his father, ... modern anatomists... his own...* (1663), pp. 20, 128. Bartholin (1616-80) was a Danish physician-anatomist-physiologist-naturalist and drew on Caspar Bartholin (his father), *Institutiones Anatomicae* (Viteberg, 1611).

The Male (on whose Masculine Soul Nature hath conferred a Body in *Strength and Vigor* almost adequate to it) is of a hotter and drier Temperature than the Female; for... the Seed whereof the Male is generated, is of a hotter Nature than that whereof the Female; because... it descends out of the right Side from the... Vena Cava.²³

This might not have been the only way of conceptualizing the male's 'oeconomy' (physiology), or even the dominant way of doing so. Only rarely were express systems of humoral temperaments laid out in the second half of the seventeenth century, and in those that were produced the male and female had frequently disappeared.²⁴ Nicholas Culpeper's (1616-54) *Galens Art of Physic* (1652), for example, was dominated by the notion of heat, and of varying configurations of warmness/coldness and dryness/moistness. Yet, it not once mentioned the resultant male and female complexions, nor their difference in heat.²⁵ Nor did Culpeper allude to that Hippocratic belief in a hotter, male-generating, right-hand testicle that some others, including Haworth, were still using to explain this innate sexed difference in temperature.²⁶ Indeed, just two years after Haworth wrote, Gibson's highly derivative anatomy was claiming that such ideas about the testicles had been dismissed as 'obsolete', 'ridiculous fancies'.²⁷

²³ Haworth, *Anthropologia*, p. 192 (my emphasis). C.f. Anon, *Aristotle's Master-Piece...* (1697), p. 5; Thomas Chamberlayne [pseud.], *The Compleat Midwife's Practice...* (2nd edn., [London], 1659), pp. 38, 44, 81.

²⁴ E.g. John Archer, *Every man his own doctor...* (1671), pp. 4-6, 10.

²⁵ Nicholas Culpeper, *Galens Art of Physick...* (1652).

²⁶ Jane Sharp, *The midwives book...* (1671), pp. 12-13.

On the other hand, these were notions of male heat still available in 1680 to be used by Haworth. Indeed, Haworth was able to make these the entire basis of his account of the male, without any defensiveness, and to do so even though he was far from a diehard traditionalist. As his other chapters revealed, Haworth's whole understanding of heat was based on chemical languages and physiologies, he being part of that movement towards chemical rather than humoral models of the body that gained increasing strength in the second half of the seventeenth century.²⁸ Other chemists, laying out 'the true Principles of Natural Bodies', could be silent as to even the existence of the male and female.²⁹ Consequently, it is possible that humoral understandings of the male and its properties survived even amongst humoralism's critics, shorn, as in Haworth's account, of their lowest level of causality (the humours), yet not of the next (heat). Haworth's own synthesis certainly suggests that there were at least some members of a self-consciously modern strand of medicine who were not ready to abandon the old model of maleness and femaleness.

It might even be that, rather than disappearing, *some* humoral male-female differences were actually being made to be more insistent and clear-cut. Republications and translations of older works alluded to the beard, for example, as something most correctly or naturally seen on a male yet also found in masculine females, who by possessing a heat normally found in males subsequently aped some of their resultant properties. Accompanying these references to 'manly Women' (whose possession of a customarily male scale of heat 'their manly *voice*, and chin covered with a little *hairiness*... argue') were allusions to 'womanish men, which... we terme dainty and

²⁷ Gibson, *Anatomy*, p. 110.

²⁸ Haworth, *Anthropologia*, pp. 148-154.

²⁹ William Bacon, *A key to Helmont, or... the theory and method of... chymical physicians* (1682), p. 1.

effeminate'.³⁰ *Aristoteles Master-piece* (1684), for example, cited Lactantius (c.250-c.325 AD) as describing masculine females and feminine males produced by the seed falling on the wrong side of the womb. Should a male-producing seed fall on the cold, female-producing, left,

a Male Child may be gotten... resembling a Woman, viz...
fairer, whiter, and smother [than other men], not very subject
[as an adult] to have hair on the Body or *Chin*, long lank hair on
the Head, the *Voice* small and sharp, and the *Courage feeble*.³¹

Similarly, such translations of older works as *Bartholinus Anatomy* could claim that hair was found '[o]n the Chins of men but not of women' but then complicate this by reference to 'rare case[s]' of bearded 'Girl[s]', or to hairy non-menstruating women.³² Yet, there also existed later-seventeenth-century authors who seemed more confident of the exclusivity to the male of some definitive physical properties. This included Jane Sharp, a midwifery author who maintained many of the traditional humoral notions of male heat and, indeed, superiority. Linguistically at least, Sharp continued an older conflation of the male and female reproductive organs, yet she stated with confidence in this text of 1670 that the testicles of the latter 'are... colder and moister, and so is their Seed, and therefore women have no Beards on their faces because of the coldness of their Stones [testicles]'.³³ Culpeper's traditional exposition of the 1650s had done the same. By seeing both sexes as having 'testicles', the temperature of which shaped the

³⁰ [Ambroise Paré (1510-1590)], trans. Thomas Johnson, *The workes of... Ambrose Parey... out of the Latine* (1634), p. 27 (my emphasis).

³¹ Anon., *Aristoteles Master-piece, or, The secrets of generation...* (1684), pp. 24-25 (first italicization original, others my emphasis).

³² Bartholin, *Bartholinus Anatomy*, p. 128.

³³ Sharp, *Midwives book*, p. 62.

appearance, lasciviousness and sexual development of both alike, it conflated the male and female. However, it also separated the sexes at one point, stating confidently of the sanguine humoral complexion (the warm and dry ideal) that ‘if they be Men they have soon Beards, if they be Women it were ridiculous to expect it’.³⁴

Part ii: Virility, Semen and Male Character

There were, however, other elements of male character that were important in the seventeenth century. One of these was that conceptual association of adult maleness – especially in the male prime – with ‘virility’ enshrined in the shared etymological origins of *vir* (man) and *virilis* (virility). Indeed, there was still occasional use in the seventeenth century (and beyond) of such terms as ‘the virile member’ or ‘Membrum Virile’ (for the penis), or ‘the virile sex’, just as some texts explained the name ‘testicles’ by their having once been thought to be ‘a testimony of Virility or Manhood’ (thereby ‘witness[ing] one to be a Man’).³⁵

‘Virility’ was, therefore, one of the fundamental ways of defining adult males and adult maleness, and it was much more than a reduction of the male to his reproductive and sexual powers. Some dictionaries included male sexual nature in their definitions, describing ‘virility’ as ‘manliness, mans estate; also the *privy parts* of man’, or ‘mans estate, manlinesse; also *ability to perform the part of a man in the act of generation*’.³⁶

³⁴ Culpeper, *Galen’s art*, p. 52. Compare to claims that the differences separating male and female humoral bodies were frighteningly permeable in the early seventeenth century (Breitenberg, *Anxious Masculinity*, pp. 47-48).

³⁵ Alessandro Massaria, trans. Robert Turner, *De morbis foeminei...* (1659), p. 11; Browne, *Treatise*, p. 80; John Pechey, *A... treatise of the diseases of maids...* (1696), p. 54; John Evelyn, *Numismata, a discourse of medals...* (1697), p. 287; John Marten, *Gonosologium novum...* ([1709]), p. 9; Adrian von Mynsicht, trans. John Partridge, *Thesaurus & armamentarium medico-chymicum...* (1682), pp. 133, 176; Diemerbroeck, *Anatomy*, p. 134; Peter Chamberlain [pseud.], *Dr. Chamberlain’s Midwifes Practice...* (1665), p. 5.

³⁶ T. B. [Thomas Blount], *Glossographia...* (1661), ‘virility’; E. P. [Edward Philips], *The new world of English words...* (1658), ‘virility’. All emphases mine.

However, the two concepts were sufficiently separated in medical writing for many authors to discuss male sexual capacities without any language of ‘virility’. Even manuals of midwifery and generation made little or no use of such a notion, whether discussing the anatomy and physiology of the male sexual organs, male puberty and marriage age, the causes and signs of lechery and fruitfulness, or penis size.³⁷

Similarly, where the term was adopted its meaning extended well beyond the sexual and reproductive. Indeed, while epistemologists tied being an adult male to a very holistic ‘virility’ it was overwhelmingly one that, for all its open-endedness, made no visible reference to sexual maturity, capacity or organs. The conflation with maleness and masculinity was certainly a strong one, dictionaries defining ‘virility’ as simply a self-explanatory ‘manhood’, or the ‘age of manhood’.³⁸ ‘Manhood’ itself was often left unexplained, even where used to define emasculation (‘taking away of Manhood, Effeminating’). Significantly, however, such authors associated ‘effeminateness’, the lack of ‘manhood’ (and, by extension, of ‘virility’), with ‘softness’ and ‘tenderness’, and used both ‘manhood’ and ‘manly’ as synonyms for being ‘stout’, ‘viridity’ (youth and vitality), ‘strenuity’ (‘activity, valiantness, nimbleness, *manhood*, stoutness’), ‘strength’, and having ‘fortitude’ (‘Valour, Courage, *Manhood*, stout... *manly*, manful, sturdy’).³⁹

In these cyclical definitions it was repeatedly the beard that was made the sign of manhood and manliness, and strength, sturdiness and courage that were singled out to

³⁷ E.g. Anon, *Aristotle’s Master-Piece*, pp. 4, 85-91.

³⁸ According to one author, ‘Young’ and ‘Ripe man-hood’ together encompassed ages twenty-two to fifty-six (B[lount], *Glossographia*, ‘ages’).

³⁹ P[hilips], *English words*, ‘emasculation’, ‘virility’, ‘mollitude’; B[lount], *Glossographia*, ‘strenuity’; John Wilkins, *An essay towards... a philosophical language* (1668), ‘fortitude’, ‘manhood’. All emphases mine.

be their bases. Although devoid of any express explanatory system, the strong, courageous, robust, bearded man with ‘virility’ was in essence a condensed version of the humoral male. Indeed, the humoral male itself was frequently lacking in any sexual or reproductive element, at least outside of manuals of generation. Nor were dictionaries the only genre to use the beard as the ‘signe of *virility*’, ‘a signe of Manhood... given by God to distinguish the Male from the Female sex... [and] a *badge of Virility*’.⁴⁰ Yet, those epistemologists who failed to tie ‘virility’ to anything anatomical consequently made no express association between this and male sex (the possession or ability to use the male sexual organs). Instead, they tied ‘virility’ to a masculine *gender*, and gave only occasional hints, in cyclical references to ‘viridity’ – ‘lustiness’ (joviality) or ‘greenness’, ‘*strength*, manliness’ – that these gendered virtues of character might have been envisioned as a product of male nature rather than of ‘education’.⁴¹

There were, however, discourses that did root these ‘signs’ of ‘virility’ in something physical. While Sharp had said only that it was the testicles that were responsible for the character (and wellbeing) of the adult male body, there were others stating that they had this effect through the semen. Indeed, the belief that the semen made the masculine features of the body, thereby making the male and the man, had ancient credentials. Although his *De Semine* does not seem to have been published during the seventeenth century, Galen (129- 216 AD) had recognized that castration caused animals to lose not only their sexual urges but also (in the words of a modern translator) their heat, strength,

⁴⁰ Thomas Hall, *Comarum akosmia the loathsomnesse of long haire...* (1654), p. 48; George Downname, *An apostolicall injunction...* (1639), p. 32; Giovanni Loredano, *Academical discourses...* (1664), p. 36. All emphases mine.

⁴¹ T. B., *Glossographia*, ‘viridity’; Elisha Coles, *An English dictionary explaining the difficult terms...* (1677), ‘viridity’, ‘cranny’ (my emphasis).

‘virility and, as one might say, their masculinity’.⁴² Nor was this a notion new to Galen. It was the established fact by which he supported another, contentious, claim.⁴³

Setting out to prove that the semen was produced inside the testicles, not their vessels, Galen had started with the consequences of removing the semen at its source, by castration.⁴⁴ The same subject lay at the forefront of the concerns of those seventeenth-century authors who commented on this substance’s significance to the specifically male body. The effects of the semen itself, in its presence, received little attention, with even manuals of midwifery and generation taking only a sporadic interest in the relationship between the peculiarly male body and the testicles (and without naming the semen itself). When Sharp discussed the reasons for the testicles being classed as organs ‘of the first rank’, again demonstrated by the effects of their loss, it was as much for their contribution to male health as for their responsibility for the masculine body or fertility.⁴⁵ However, not even this sympathy between the testicles and ‘the upper Parts... especially... the Heart’ was a common interest of anatomists or physiologists, nostrum advertisers or the writers of manuals of health, despite its therapeutic implications. The manner in which the semen made and then preserved the ‘manly’ body of ‘manhood’, with its signs of ‘virility’, was equally absent, except for where the topic was generation.⁴⁶

Nor did the rise of new chemical and mechanical physiologies mean that writers chose to approach the relationship between male health and the semen in another, more positive, way. One author of 1670, for example, advertising ‘chymical medicines’ and

⁴² Galen, trans. and ed. Philip De Lacy, *De Semine: Galen on Semen* (Berlin, 1992), pp. 122-123.

⁴³ *Ibid.*, pp. 122-123.

⁴⁴ *Ibid.*, pp. 123-129.

⁴⁵ Sharp, *Midwives book*, pp. 86-87.

claiming (with the chemists) that health and illness relied on ‘a mixture of divers Principles’ in the blood, still explained disease by mismanagement of the humoral non-naturals.⁴⁷ Thus explaining gout, he warned that

immoderate... Venery... weakens the Strength, hurts the Brain,
extinguishes Radical Moisture, and hastens old Age and Death;
the Sperm... being the only Comfort of Nature, which... lost,
injures a Man more than the loss of forty times that quant[it]y of
Blood...⁴⁸

Even this author thought that the most persuasive argument lay in the effects of a *loss* of semen. Furthermore, these were its effects for a specifically male sexual performance, not for male health or the masculinity of mind and body. Thus, even a writer who thought it fit to caution that the semen was nothing less than ‘the vital and principal Part of Life’ saw no reason to comment on its positive (non-sexual) effects, in its presence, simply warning that excessive intercourse ‘Exhausts the Stock, unfits Man for Wife’s good/, When moderately us’d holds long’.⁴⁹ Authors discussing the consequences of a permanent removal or absence of the *testicles* focused on a destruction of masculine ‘Strength, Activity and Vigour’, and ‘Reason and Judgement’, finding such men ‘Effeminate and Womanish, with squeaking Voices, [and] little or no Beards’.⁵⁰ Yet, and paradoxically, those writers considering a short-term depletion of the *semen* concentrated on very different effects. So too did those rare discussions focusing on the semen in its own right. Thus, five years later, in *The women’s*

⁴⁶ Bartholin, *Bartholinus*, p. 56.

⁴⁷ Air, food and drink, the passions, the excrements, motion and rest, and sleep and wakefulness.

⁴⁸ Anon., *An account of... rebellious distempers...* ([London?], 1670), p. 46.

⁴⁹ *Ibid.*, p. 46.

complaint against tobacco, a satirical depiction of female sexual appetites, the semen was again specifically male only. It was also again nothing less than ‘the Radical Moisture’ (that ‘fluent part of the Body... [necessary] for the preservation of it... borne with vs’ and ‘supplied by nourishment’), but was still seized upon only for its role in keeping men potent and fertile.⁵¹

There were, however, some authors who made such male and masculine properties as strength and courage – also attributes of the humoral male – the product of the semen. To some extent, rooting allegedly definitive male attributes in the semen, rather than in the testicles or heat, could make these more male-specific. After all, even authors who clearly made male and masculine features the product (in an unspecified way) of the testicles, which ‘give *strength* and *courage* to Mens bodies, as may be seen in gelded persons, who are changed well-near into Women, in their Habit of Body, Temperament, Manners, &c’, could erode this causal relationship instantly by adding that ‘[t]here are... manly Women, which exceed Men in *strength and courage*’.⁵² However, even explanations that rooted courage and strength in the semen directly were still not automatically claiming that these were attributes exclusive, or even properly exclusive, to the male.

By the end of the seventeenth century it was generally agreed in new works that only males produced a reproductive semen.⁵³ However, when ‘Dr. John Jones’ (1645-1709), physician and legal scholar, gave in 1700 one of the most comprehensive accounts of the male bodily effects of semen – as an analogy for the effects of opium – he did so by

⁵⁰ Marten, *Gonosologium*, p. 4.

⁵¹ Anon, *The women's complaint against tobacco...* (1675), p. 3; Robert Burton, *The anatomy of melancholy...* (Oxford, 1621), p. 20.

⁵² Bartholin, *Bartholinus*, p. 56 (my emphasis).

reference to a single '*semen animale*', present in both sexes.⁵⁴ Rather than seeing the male's semen as a specifically male substance, with unique effects, Jones moved indiscriminately between the effects of puberty and of semen, of semen both at puberty and during adulthood (generally *and* at times of arousal-induced abundance), and in males and females, seeing the sexes as undergoing identical processes, with parallel outcomes.

Jones did, however, make recognition of specifically male *creatures*. Thus, his discussion of the sixteenth and final property of the semen mentioned not '*semen animale*' but '*semen virile*' – male semen – as a cause of sexual urges and the remover of (male-only) impotence. Yet, it was not only in the sexual effects of semen that Jones singled out a specifically male body. He also seized on a sexed male psychology and physicality, one, like Haworth's male, revolving around a pairing of courage and strength (although here alongside the sexual).⁵⁵ Furthermore, Jones found these definitive core features to lie in the sex-specific consequences of a uniquely male substance (the '*semen virile*'). Both sexes were described as acquiring 'Courage' from the seminal '*Plenitude[s]*' of both intercourse and puberty, pubescent girls becoming 'Womanlike' and 'Modest and sheepish Boys' 'more *assured, bold, and*', significantly, '*Manlike*'. However, it was in reference to the specifically male version of semen, and this alone, that Jones added that "'tis my *Observation* that *Men* who breed most of the *Sem[en] Virile*, are generally, if not always, the most *Valiant*', in a merging of the animal, the human, gendered virtues, and comparison between men.⁵⁶ Whether the male semen had these effects because of some unique property, one shared with that also

⁵³ Laqueur, *Making Sex*, p. 38.

⁵⁴ Oxford Dictionary of National Biography; John Jones, *The Mysteries of Opium...* (1700), pp. 189-191 (original italicization).

⁵⁵ For Jones and male strength see below, p. 63.

present in the female, or simply as a fluid, was not discussed. Yet, Jones did presume a ‘manlike’ character, inherent at birth, seemingly inevitably reaching fulfillment on puberty, and only doing so because of the exclusively male semen.

As Jones thought that puberty made both sexes more courageous, but males even more so, this male attribute was a difference of degree only. However, it was one that happened not because of the possession of varying degrees of something else (as with humoralism’s heat) but because of a uniquely male component: no woman could be as ‘valiant’ as a man because no woman had ‘*semen virile*’. Thus, Jones made physical maleness, and the attainment of its signs, much more certain than did those who claimed that the male’s attainment of his proper features was a product of chance, determined entirely and solely by the side of the womb that he had happened to fall on as a ‘seed’. For these authors, there were some males destined even before birth to spend their entire adult lives denied of masculine bodies and characters.⁵⁷ In Jones’s text, men were more definitively, and even exclusively, male.

Part iii: Semen and the Male Body in the Eighteenth Century

The mid-seventeenth century discovery of its ‘animalcules’ had transformed the analysis of the semen as a reproductive material.⁵⁸ However, in neither century was there any revolution in the role given to this substance outside of its reproductive function, and as something integral to, or creating, the male body and its maleness. The underlying explanatory frameworks sometimes changed (as with one author’s *claim* to approach glandular secretions through ‘mechanical, hydrostatical, and hydraulic laws’)

⁵⁶ Jones, *Opium*, pp. 189-191 (all italicizations original).

⁵⁷ Above, p. 41.

⁵⁸ See, for example, George Adams, *Micrographia Illustrata...* (1746), pp. 95-99.

but there was no visible transformation in ways of approaching the semen itself.⁵⁹ There was, therefore, no radical change in understandings of the production of semen, the sophistication of this knowledge, or authors' interests and purposes in considering it. Thus, when an 'Eminent Physician' set out in a 1729 health manual to justify old men's abstinence it was through a notion of semen remarkably similar to Galen's. Furthermore, although his discussion of the effects of a loss of semen said nothing about male heat, this author continued the association of the male with superior heat in his discussion of wet-nurses, claiming that 'a Woman, who has brought forth a *Son*, has more internal Heat', it being 'communicated' from him.⁶⁰

This author also maintained the old (fairly unspecific) association of the semen with the radical moisture. As in many earlier texts, he focused on the effects of a loss of semen only, explaining how replacing that ejaculated 'consumes that fat and unctuous part of the Blood' 'necessary to recruit their radical Moisture', and of which 'there is never too much, since it wastes continually'.⁶¹ The short-term effects of an individual loss were also noted, although only to state that "[t]was not without Reason, that they believ'd formerly, that a *Wrestler* had submitted' to lust 'when he fought with less *Courage*'.⁶² No effort was made to explain this latter repercussion through the author's account of the production of semen, which itself said nothing more sophisticated than that 'the fat Part of the... Blood, is carry'd to the Parts that serve to Generation', to be 'chang'd in the spermatick Vessels' into something 'whitish'. If not ejaculated, it 'nourishes these Vessels, as well as the other Parts' originally formed from semen. Sharp, in the

⁵⁹ Richard Russell, *The oeconomy of nature...* (1755), p. 2.

⁶⁰ Anon., *The nurse's guide... An essay on Preserving Health...* (1729), p. 31 (my emphasis).

⁶¹ *Ibid.*, pp. 124-126.

⁶² *Ibid.*, pp. 125-126 (first italicization original, second emphasis mine). C.f. Galen's discussion of 'Olympic Athletes' who were, consequently, castrated (Galen, *De Semine*, p. 124).

seventeenth century (in more detail and technicality) and, significantly, Galen and (in part) Aristotle had said the same.⁶³

Almost thirty years later, the guide to the glandular secretions (1755) produced by Richard Russell (1687-1759), M.D., showed a very different understanding of the body created by the semen. Unlike the Eminent Physician (and, indeed, many of his predecessors), Russell was not interested in the effects of semen in its loss only, or for sexual functioning. In contrast to Jones, furthermore, he saw the semen as a substance uniquely male.⁶⁴ For Russell, the semen was vital to (and a major determinant of) men's health, was a major source of their sicknesses, and was so by its presence. Furthermore, this uniquely male substance made the male distinctive in two ways. On the one hand it turned the boy's body into the adult male's, and created its characteristic features. On the other, Russell claimed, there existed a sex-unique (and age-specific) illness profile, and one explained by a uniquely male substance, one acting as a determining source of health and sickness unique to this sex.⁶⁵

Ultimately, however, the male was still being described and defined by his superior strength and robustness, dually external and internal, just as Haworth had made claims about both the male's build and his blood vessels and muscular structure.⁶⁶ Here, Russell argued that 'it plainly appears, that muscular force is increased by the blood's saturation with the *semen masculinum*', which amplified the elasticity and strength of the vessels, pressurization of the fluids, and native heat.⁶⁷ As in Jones's text, however,

⁶³ Galen, *De Semine*, pp. 109-110; Sharp, *Midwives book*, pp. 6-9, 54-56.

⁶⁴ Richard Russell, *Oeconomia naturæ...* (1755); idem., *Oeconomy*, p. 1. Jones is discussed above, pp. 47-49.

⁶⁵ Idem., *Oeconomy*, p. 1.

⁶⁶ Haworth, *Anthropologia*, p. 194.

⁶⁷ Russell, *Oeconomy*, pp. 101 (original italicization).

this work of 1755 still saw differences between the male and female as a matter of degree. The process happened in both sexes during the adult prime – because of the male semen and the female menses – but more so in the male. The adult male’s ‘texture’ was ‘firmer and stronger than that of the female’ because, consequently, women (and eunuchs) retained a relative ‘weakness, softness, or laxity of the solids’. Others were making similar points at the same time, likewise claiming that it was males who were the most prone to gout, and this because the female fibres were ‘more weak and lax’.⁶⁸ The old dichotomy of male strength, robustness and hardness, and female ‘softness and delicacy’, was thus maintained. It was, furthermore, now made to have health repercussions.⁶⁹

Russell, and others, had reduced both the male and his characteristic states and experiences at every stage of life to his internal physiology. Russell had, moreover, condensed the physiology itself to a substance – and potential – *innate* to the male. He was not, however, dehumanizing this body, or detaching it from the man and the way in which he lived. On the contrary, by rooting the causes of male disease inside the internal structures of the male body Russell was naturalizing what he insisted was the proper male lifestyle. Their robustness meant not only that males were more capable of exertion but that

the firmness... given to their habits, by the [seminal] secretions
set on foot at puberty, to enable them to undergo fatigue, and all
the laborious tasks to which they are destined... *lays them under*

⁶⁸ Ibid., pp. 145, 139; J. N. Stevens, *An essay on the diseases of the head...* (Bath, 1758), p. 89.

⁶⁹ Russell, *Oeconomy*, pp. 125, 139, 145.

*a necessity of performing... labour, or of paying the fine... so dangerous... it is to run counter to the institutions of nature.*⁷⁰

As the 'glandular secretions' that maintained male health by keeping the fibres in their proper male state 'cannot be... performed... without... fatigue', all 'sedentary' men – 'the studious', 'artificers', and all 'whose occupations confine them to an inactive life' – would, it was claimed, pay the price.⁷¹ Russell was simply applying a newer, more technical, and more uniquely male, explanation to the much older idea that men were made sick by 'sedentary' living.⁷²

Nor was Russell hesitant to draw out the social implications of this claim. By using the semen's visible external effects in animals to prove speculative claims about its internal effects in humans, and echoing Jones in moving between the animal and human, Russell naturalized these necessary masculine roles even further. He also extended the scope of male nature, making the condition of the male's body, and his illnesses, throughout the entire lifespan peculiarly male, and these, and the maleness of his body, the product of a uniquely male substance. Yet, there was no uniform approach, even when explaining a characteristic male tendency to certain illnesses. Not all mid-eighteenth-century authors rooted even the properties of the male 'fibres' in the semen. The long account of the fibres and their varying 'Elasticity' given in James Makittrick Adair's (1728-1801), *M.D., guide to the different predispositions to illness* (1772), for example, said nothing about sex, let alone the semen.⁷³

⁷⁰ *Ibid.*, pp. 125-126 (my emphasis).

⁷¹ *Ibid.*, pp. 126-127.

⁷² The meaning of 'sedentary' when used in reference to men is discussed below, p. 155.

⁷³ James Makittrick Adair, *Commentaries on the principles and practice of physic...* (1772).

Consequently, that chapter on age-related predispositions plagiarized (with heavy trimming) from Russell was the only one in Adair's lengthy text to acknowledge the semen. As in Russell's original, ageing was approached as glandular changes and a hardening of once lax solids, yet now without mention of even sexed characteristics in solidification. Although retaining more discussion of menstruation, all but one of Russell's references to the semen and its effects were shorn. The sole remaining comment, given in a description of puberty, stated that '[i]n males, the semen makes considerable changes to the body', these unspecified changes producing plethora, testicular swelling, 'and a variety of consequent complaints'. Even here it was argued that the female had 'similar complaints', presumably because these were not processes and products unique to the male.⁷⁴ Russell's elevation of the healthy male rustic disappeared entirely, and while Adair retained the claim that sedentary men would be in worse health than sedentary women, it was without any reference to the solidity of the male fibres, or, indeed, to anything male. It was now explained solely by the female, and by what Russell had identified as her health-giving evacuations.⁷⁵

Adair did continue to represent lifestyle as a cause of men's illnesses. This was, however, elsewhere in the text, in a part and context totally separate from this discussion. It was also for a way of living very different to the inactive, indoors, occupations seized on by Russell, and for consequences and dangers totally unrelated to the maleness of men's bodies. Practising at the fashionable health resort of Bath, Adair later wrote of the health needs of 'the 'indolent' and 'studious', and attacked 'fashionable diseases'.⁷⁶ However, it was not indolence that he found hazardous in

⁷⁴ Ibid., p. 74. Russell was mentioned only as the source of one quotation (ibid., p. 76).

⁷⁵ Ibid., pp. 80-81.

⁷⁶ Idem., *An essay on regimen, for the preservation of health...* (Air, [1799]); idem., *Medical cautions, for.... invalids...* (Bath, [1786]).

masculine culture in 1772. Instead, it was in part that gendered division of labour that Russell had made the basis of male wellbeing, here for the dangerousness of male occupations. Russell had argued that distinctive behavioural threats to men's health existed only because of a distinctive male physiology. Adair, by contrast, made culture the cause of a specifically male morbidity in its own right, without it needing to act in conjunction with, or upon, a physiology that was male.⁷⁷

Indeed, of all of the body types that Adair constructed the male was unique in having his health said to be so dependent upon the person within it, and on lifestyle rather than something 'drawn by the hand of nature'.⁷⁸ However, he also made maleness and masculinity of body much less certain and automatic, or natural, than in Russell's analysis. Thus, Adair's exposition of the different nerve-based 'temperaments' described men of the 'irritable temperament' as 'effeminate', 'delicate' and 'of very delicate habits', 'delicacy' having been central to Russell's definition of the female, and long associated with both women and 'sedentary' living.⁷⁹ Indeed, these 'effeminate men' shared the properties of Russell's pre-pubescent boy, and, with '[m]uscles and limbs more slender', white skin, small veins, a quick, weak, pulse, and 'muscular flesh less firm and elastic', were the very opposite of Haworth's humoral male.⁸⁰ Although exacerbated by such factors as 'a luxurious way of life without exercise', the '[p]rimary cause' of this 'temperament' was, furthermore, 'hereditary disposition'.⁸¹ For Russell, the uniquely male semen had automatically made males masculine, and men had become internally and externally effeminate only by defaulting on a physiologically

⁷⁷ Oxford Dictionary of National Biography; Adair, *Commentaries*, p. 82.

⁷⁸ Adair, *Commentaries*, p. 49.

⁷⁹ *Ibid.*, p. 65.

⁸⁰ *Ibid.*, p. 64.

⁸¹ *Ibid.*, pp. 65-66.

necessary, masculine, lifestyle. For Adair, an author almost entirely silent about the semen, the effeminate body could be natural to males too.

Yet, when texts did give the semen an explanatory role the resultant features were not approached in a way radically different to seventeenth-century understandings of sexed characteristics. Although generally seen in the eighteenth century as a uniquely and essentially male substance, the semen was not universally depicted as a substance affecting the male body, and men's health, in unique ways and for unique reasons. Russell, for example, had replaced Jones's two semens by an expelled menses and a semen (secreted inside and outside), but given these identical functions and effects, both during and after puberty.⁸² Indeed, it was not only menstruation that served in this analysis as the semen's interchangeable equivalent, but breastfeeding and parturition too.⁸³

Nor, furthermore, did this conflation of the male and female secretions disappear in the second half of the eighteenth century. John Anderson (c.1730-1804), M.D., sometime physician to a 'General Sea-bathing Infirmary', for example, reduced them even further in 1787.⁸⁴ His 'remarks' on 'evacuation' initially made the semen something that determined the health of the body primarily as an evacuation (as with the humoral fluids) rather than through qualities of its own. The evacuation produced health and simply took (for unspecified reasons) different forms in the male and female, an excessive evacuation of semen or its too-long retention making the body ill just as did those of the menses. However, the loss of semen also affected male health in exactly

⁸² Russell, *Oeconomy*, pp. 92, 121.

⁸³ *Ibid.*, p. 9.

⁸⁴ John Anderson, *Medical Remarks on Natural, Spontaneous and Artificial Evacuation...* (1787). C.f. the title page of the third edition (1796). He is not to be mistaken for the professor of natural

the same way as did a homologous female *sexual* secretion, and this further conflation of the sexes, and their secretions, was made express by the claim that '[a]s temperate venery has salutary effects on the male, it must, caeteris paribus [other things being equal], have the same on the female'. Indeed, he described the cessation of a customary evacuation of semen as causing illness for the same reason as did that of *any* 'accustomed evacuation'.⁸⁵

On the one hand, therefore, Anderson was continuing a humoral viewpoint in which the menses and semen were simply interchangeable versions of the blood, taking different manifestations only because sexed differences in temperature influenced the degree to which it was 'concocted'.⁸⁶ On the other, he did, however, give positive properties to the semen, and to the semen but not the menses. While at one level he approached it as an evacuation, in effect interchangeable (in underlying principles *and* in practice) with others, he did not think it only this. It also possessed a 'stimulating active power' and 'nourishing, animating principle', and it was because of these additional properties that the excessive loss of the semen was so 'irretrievably injurious'.⁸⁷ Its loss weakened the nervous system (strong nerves being one of Adair's reasons for the male's characteristic resistance against illness) and reduced 'innate heat' (humoralism's explanation for the male body).⁸⁸ Indeed, Anderson's description of the ideal male body, recounting how 'moderate [seminal] emission... from the *full grown, warm, and athletic* habit preserves health', did hark back to humoralism.⁸⁹

philosophy.

⁸⁵ Anderson, *Remarks*, pp. 86, 92. A similar approach had been taken in such earlier texts as Anon., *Aristotle's book of problems... twenty-sixth edition* ([1715?]), pp. 53-54.

⁸⁶ See Thomas Laqueur, 'Orgasm, Generation, and the Politics of Reproductive Biology', *Representations*, 14 (1986), pp. 1-41, esp. 9.

⁸⁷ Anderson, *Remarks*, pp. 77, 80.

⁸⁸ *Ibid.* p. 86.

⁸⁹ *Ibid.*, pp. 80-81, 85-6, 92 (my emphasis). See above, p. 37.

Part iv: The Anatomical Male Body

New notions of the semen and of human physiology did not, therefore, revolutionize ways of approaching the semen-containing male body. Nor, however, did that ‘nerve physiology’ pioneered in England by Thomas Willis (1621-1675), which introduced a way of categorizing bodies (and explaining disease) through the condition of the nerves.⁹⁰ With female “‘otherness’” ‘attributed to... a fundamental lack of tonic vigour’ in her nerves and fibres, some historians have argued that it was in this understanding of sexed difference that eighteenth-century ‘male scientists... spun their new mythology about *inherent male vigor* and defective *female frailty*’.⁹¹

Yet, texts that did adopt the language and explanatory system of the nerves did not abandon all other sexed and gendered characteristics, or explanations. Allegedly responsible for a ‘major reorientation in medical theory’, that language of (nervous) ‘sensibility’ and (muscular) ‘irritability’ introduced by the Swiss Albrecht von Haller in 1751 (English translation 1755) did run through Adair’s guide of 1772.⁹² Yet, even for Adair, a ‘specialist in “women’s nerves”’, the nerves had not entirely replaced other physiological explanations.⁹³ Indeed, it was in a subsection on the different ‘temperaments’ created by not only the ‘tension and sensibility’ ‘of the nervous system’ but also ‘the state of the simple solids’ (their ‘firmness or debility, laxity or elasticity’) and ‘the circulating humours, secretions, and excretions’ (their quantities and qualities)

⁹⁰ G. J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago and London, 1992), pp. xvii-xii, 3, 15, 29-30.

⁹¹ Rousseau, ‘Semiotics’, p. 222 (my emphasis).

⁹² Albrecht von Haller, *A dissertation on the sensible and irritable parts...* ([1755]); Silvia De Renzi, ‘Old and new models of the body’, in Peter Elmer (ed.), *The Healing Arts: Health, Disease and Society in Europe, 1500-1800* (Manchester, 2004), pp. 166-195, quotation at p. 187.

⁹³ Quotation from Barker-Benfield, *Sensibility*, p. 29.

that Adair gave his chapter on sex.⁹⁴ Adult males, according to this chapter, ‘in general’ had ‘vital powers... stronger, and nervous systems less irritable than... females’.⁹⁵ Nowhere, however, did Adair explain why. Even his preliminary explanation of ‘nervous influence’ stated only that ‘[c]hildren, young people and women are in general more irritable than men : women in child- bed are very irritable’.⁹⁶ Indeed, Adair’s reference to males ‘in general’ was itself problematized by the immediate addition that, whilst ‘in general true[,]... there are many exceptions, as we daily meet with effeminate men, and masculine women’.⁹⁷ The nerves had not made male (or female) attributes any more sex-unique, certain, or natural, than they had been under humoralism.

Nor, however, had the belief that there were sexed parts, or properties, of the skeleton brought any revolution in ways of envisioning the male body. It had certainly not caused any radical rejection of definitive properties that were enacted, gendered, qualitative or descriptive, disregarded in favour of an approach and definition based on the internal fabric. This was not, however, the product of anatomical ignorance. In 1682, Gibson’s derivative anatomy had noted four differences between the male and female skeletons, commented upon as part of a general interest in the variations found in individual parts.⁹⁸ Only one of these (the varying straightness of the clavicles) was left unexplained, with sexed variations in the pelvis bones and the rib and hip cartilage all rooted in the female reproductive role.⁹⁹ Yet, some twenty-five years later, in James Drake’s *Anthropologia nova* (1707), the articulated concept of the sexed skeleton seems

⁹⁴ Adair, *Commentaries*, p. 49.

⁹⁵ *Ibid.*, p. 182.

⁹⁶ *Ibid.*, p. 21.

⁹⁷ *Ibid.*, p. 82.

⁹⁸ Above, p. 35.

⁹⁹ Gibson, *Anatomy*, pp. 271, 254, 483, 472.

to have actually regressed.¹⁰⁰ While Gibson had drawn only ‘the Skeleton of an adult’, Drake did provide separate sketches of the male and female skeletons, but mainly for the opportunity to draw both front and back, with double the annotations.¹⁰¹ Indeed, his written text recognized the question of male-female difference in the bones only twice. Both comments were made in relation to female adaptations, in the hip and in the coccyx attached to it.¹⁰²

By removing the clavicles Drake had reduced sex-specificity solely to *female* adaptation, for pregnancy, and solely to the region around the womb. This was continued when a 1714 compilation gave the Dutch anatomist Frederik Ruysch’s (1638-1731) claims about ‘the Distinction of Sexes in Skeletons’, although these did re-expand the locus of skeletal sex difference to include the ribs. Ruysch (or his translator) did, furthermore, at least term this the ‘Distinction of Sexes’.¹⁰³ When the famed Scottish anatomist Alexander Monro *primus* (1698-1767) produced an account of sex specificity in the skeleton just over a decade later, it was openly labelled ‘the Distinction of the female’, and ‘[o]f the Marks of a Female Skeleton’.¹⁰⁴

Anatomists never set out to discuss a male body existing in the bones, or to discuss the male body through the skeleton. Nowhere in the lengthy account of the human skeleton given prior to this appendix did Monro comment on any distinctively male feature or characteristic, any feature found in particular types of males, or any explanatory factor unique to the male. Similarly, all that the appendix had to say was that the male’s bones

¹⁰⁰ James Drake, *Anthropologia nova: or, a new system of anatomy...*, vol. 2 of 2 (1707), pp. 370-374.

¹⁰¹ *Ibid.*, p. 406; Gibson, *Anatomy*, p. 497; Schiebinger, *Mind*, pp. 194-195.

¹⁰² Drake, *Anthropologia*, pp. 427-428.

¹⁰³ Anon., ‘Adversaria Anatomica... from some scatter'd Pieces of Dr. Frederick Ruysch...’, in Anon., *Bibliotheca Anatomica...*, vol. 3 of 3 (1714), pp. 204-217, esp. 204-5.

¹⁰⁴ Alexander Monro, *The anatomy of the humane bones* (Edinburgh, 1726), pp. 340-344.

essentially ‘agree[d] to the Description already delivered’.¹⁰⁵ By subjoining the two in comparative binaries he had (as he said) discussed both sexes by describing only one, but Monro could have said more about the male. After all, his comments on the female argued that not only nature but also lifestyle – ‘in the sedentary Life which Females enjoy’ – had a role.¹⁰⁶ He had similarly seen the skeletal differences created by nature as extending beyond the presence or absence of a womb, to include the both direct and indirect effects of ‘constitution’ (and the vigorousness of its ‘solids’ and ‘fluids’), the ‘Power of Ossification’, and such ‘general Causes’ as the size, strength and forcefulness of the muscles, in themselves and in their effects on other systems and functions. Furthermore, Monro had said that all of these were properties in which the sexes differed.¹⁰⁷

The male skeleton never developed as radically as implied by historiographical references to the ‘revolution’ of the (skeletal) sexed body.¹⁰⁸ By recognizing (female) adaptation in the limbs, trunk, specific individual bones, and the skeleton as a whole, Monro had at least acknowledged the existence of sex-specificity beyond the presence and absence of the womb. However, while his own account remained in print, in his name, until 1788, neither he nor his posthumous editors ever set out to acknowledge the male skeleton as being an express product of the male’s nature as the stronger, more muscular sex, *or* of the man’s laborious social role, whether a role culturally determined or instituted by nature.¹⁰⁹ Indeed, while his main account of the human skeleton discussed the way in which the muscles produced indentations in the bones, and to varying extents according to activity and muscular power, Monro ignored this

¹⁰⁵ Ibid., p. 340. C.f. p. 71.

¹⁰⁶ Ibid., p. 344.

¹⁰⁷ Ibid., pp. 340, 342.

¹⁰⁸ Schiebinger, *Mind*, p. 160.

opportunity to mention male-female difference in strength and exertion. Yet, these were differences that at least some contemporaneous medical thinkers and teachers presumed to be sexed and gendered. When William Cheselden's osteological anatomy (1733) discussed the grooves carved in the bones by the muscles it was automatically in reference to 'men who have been bred up in hard labour', just as he found certain peculiarities of the cartilage of the true ribs to exist in 'robust men' alone.¹¹⁰ These, however, were implicit assumptions, not express accounts of the male skeleton.

Monro and Cheselden were not alone in failing to develop such properties into an openly discussed particularity of the male skeleton. Instead, and well into the 1780s, many compilers and editors simply continued to republish Monro's account of the *female* bones. Others, even in the 1780s, reduced skeletal sex-specificity back to the pelvic area only, and solely to female adaptation for pregnancy.¹¹¹ Moreover, few, when required to envision a male, did so through the skeleton, many choosing a way of 'seeing' the male unconcerned with what lay beneath the skin. Thus, even in the 1770s, the skeleton, or the nervous system, was not the sole, or even primary, way of summarizing the male. Nor had they universally become even the most obvious differences distinguishing him from the female.

Part v: The Survival of the Humoral Male

There were, therefore, throughout the eighteenth century texts that approached the male not as the possessor of a particular osteology, or a type of nerves and fibres, but as 'the

¹⁰⁹ Alexander Monro, *The anatomy of the human bones...* ('new edition', 1788).

¹¹⁰ William Cheselden, *Osteographia, or The anatomy of the bones...* ([1733]), introduction and chapter three's explanation of tables xvi-xvii (unpaginated).

¹¹¹ G[eorge] Thomson, *The anatomy of the human bones...* (1734), pp. 119-122; Society of Gentlemen, *Anatomical lectures...* (1775), pp. 123-124; Anon, *A system of anatomy and physiology...* vol. 1 of 3 (Edinburgh, 1787).

stronger sex'. Rather than showing a shift to structural anatomy, these works continued a much older set of presumptions merging the innate and acquired, male and masculine, and bodily and social. Jones, for example, had claimed in 1700 that the male semen had the power to 'prevent *Lassitude*, and cause... easier Undergoing of *Labour*', proving this through ungelded horses.¹¹² Monro, an anatomist, similarly taught in the 1720s (and all subsequent editions) that all of the male's crucial internal and external physical properties – and everything that it meant to be a man – could be encapsulated by one label, 'the robust male'.¹¹³

In the same vein, it was also in their robustness that the health-literature recognized, sometimes, the existence of males. In doing this, it merged the male and the man, or male strength and men's exertion, as when George Cheyne (1641-1743), a specialist in nervous disease, stated in the 1720s that '*Strong Men*, those of *large Stature*, and much *Labour*... require *more Food* than *Women*, *Children*, the *Weak*, the *Sedentary* and the *Aged*'.¹¹⁴ Seizing on this prevalent conflation, the only recognition of males and men made in William Forster's 1738 manual of dietary regimen was similarly the ideal-type man, strong, in his prime, and living a physically demanding life. Again, '[s]trong Men, and those that labour hard, require more Food than Women, the Weak, the Unactive, and the Aged'.¹¹⁵ While Jones had linked male strength and robustness to physiological changes at puberty, some authors presumed that they were as natural and inherent to the male as to exist even before the physical effects of the semen, and before gendered 'education'.¹¹⁶ Thus, when in 1753 an apothecary argued against the use of stays on

¹¹² Jones, *Opium*, p. 190 (original italicization).

¹¹³ Monro, *Anatomy* (1726), p. 340.

¹¹⁴ George Cheyne, *An essay of health...* (1724), p. 83 (original italicization).

¹¹⁵ William Forster, *A treatise on the various kinds... of foods...* (Newcastle upon Tyne, 1738), p. 71.

¹¹⁶ Jones, *Opium*, p. 190.

girls it was by the presumption that females were ‘*by Nature* more tender and delicate than Boys’.¹¹⁷

Dichotomies of natural male strength and female weakness, and men’s exertion and women’s inactivity, were also upheld in a manual of domestic physic of 1769 (second edition 1772).¹¹⁸ For Russell and Adair, sedentary inertia had made males sick and ‘delicate’, but neither had described the lives, character, or bodies of inactive men as ‘effeminate’. This was, however, a word that William Buchan (1729-1805), M.D., used profusely. While seeing males’ strength and ruggedness as innate from birth, Buchan simultaneously emphasized that the realization of this potential was far from natural or automatic. Indeed, as ‘[a]n effeminate education will *infallibly* spoil the best natural constitution... if boys are brought up in a more *delicate* manner than even girls ought to be, they *never* will be *men*’.¹¹⁹ ‘*Effeminacy* will ever prove the ruin of any state... and, when its foundations are laid in infancy... can never... be wholly eradicated’.¹²⁰

In Buchan’s text it was ultimately culture that made the man. However, his warning that it was cultural forces that would determine the realization, or non-realization, of that natural potential for strength and courage that males were born with was nothing new to the eighteenth century.¹²¹ The conflation of male domestic inertia with weakness and effeminacy had been a commonplace in the seventeenth century, as had a merging of strength and courage as the definitive male and masculine properties. Thus, Buchan’s warning that ‘[s]edentary employments render men *weak and effeminate*’, ‘whereas... a

¹¹⁷ James Nelson, *An essay on the government of children...* (1753), p. 111 (my emphasis).

¹¹⁸ William Buchan, *Domestic Medicine... by regimen and simple medicines...* (2nd edn., 1772), p. xiii.

¹¹⁹ *Ibid.*, p. 33 (my emphasis).

¹²⁰ *Ibid.*, pp. 43-44, 103n (my emphasis).

¹²¹ For courage see Anthony Fletcher, ‘Manhood, the Male Body, Courtship and the Household in Early Modern England’, *History*, 84, 275 (1999), pp. 419-436, esp. 421-422.

few hours every day without doors would... brace their nerves', and 'increase their *strength and courage*', was far from radical.¹²² If anything was the product of the age in which Buchan was writing it was the scale of anxiety visible in his exclamations against the rise of 'sedentary' 'mechanical employments', men's alleged retreat from 'active and manly diversions', and the failure to train boys in the '*manly* and useful' sports and 'military exercises' that 'increase their *strength*, inspire them with *courage*', and equip them for war.¹²³ The anxiety was not itself new to the eighteenth century, nor confined to medicine.¹²⁴

Buchan's repeated underlining of the need to inculcate (and then proactively maintain) strength and courage was not, however, a denial that these were natural to those born male. Instead, Buchan continued to presume that males were naturally the stronger sex, and that strength was not only a masculine virtue but also an innate component and product of maleness. Thus, he insisted on the division of society by natural, sexed, variations in strength, and by their being enacted, '[n]ature' having 'made an evident distinction between the male and female with regard to bodily strength and vigour'.¹²⁵ Evidently, male strength could still function as a definitive property in itself, not just as a gendered attribute recast inside the skeleton or nerves.¹²⁶

Other traditional notions of definitive male properties survived too. While one mid-eighteenth-century description of a hermaphrodite claimed that 'the Types or Characters of... the Male and Female Sex[es]' pervaded the entire external body, references to the

¹²² Buchan, *Domestic Medicine*, pp. 104, 54, 54n (my emphasis).

¹²³ *Ibid.*, p. xiii, 26, 32-33, 49-50, 54-55, 58, 85, 106 (my emphasis).

¹²⁴ See Giovanni Botero (1540-1617), *Relations of the most famous kingdoms...* (1630), pp. 29-30; Francis Bacon (1561-1626), *The essays... civil and moral, of Sir Francis Bacon...* (1696), p. 82.

¹²⁵ Buchan, *Domestic Medicine*, p. 647.

¹²⁶ Compare to Schiebinger, *Mind*, pp. 201-203.

male more often reduced these to only a handful of what this author called ‘*exterior distinct Marks*’.¹²⁷ Male bodies, and their owners, were still often being condensed to ideal gendered virtues, and, consequently, to gendered characters. Thus, and despite his pathological focus, Russell saw fit to claim that by castration ‘bucks’ lost, amongst other things, their male firmness and vigour (their strength), as well as their courage (for ‘they become cowards’).¹²⁸ Two decades later, Oliver Goldsmith published a natural history that took most of its human content (1774) from the multi-volumed natural history (1749-1808) of an eminent French naturalist, Georges-Louis Leclerc, Comte de Buffon (1707-1788). Maintaining older dichotomies of gendered psychology, this carried the inscription of traditional gendered attributes even further than Jones had done. For Jones, both sexes became more courageous at puberty. Here, however it was the point at which ‘the [male] youth acquires courage, and the [female] virgin modesty’.¹²⁹

While this reference to courage was Goldsmith’s own addition, his chapter on the ‘age of manhood’, translated directly from Buffon, showed a similar interest in cultural behaviours and gendered virtues. It began with claims about the sexed properties of the internal structures, of a similar kind to Russell, but without rooting these in the semen and menses. Puberty was the growth of the ‘fleshy fibres’, ‘swell[ing]’ of the muscles, and rounding of the limbs, a process more prolonged in the male sex because the adult female’s ‘muscles, and all... other parts’ remained ‘weaker, less compact, and solid, than those of man’.¹³⁰ Yet, it was not this that interested Buffon (or Goldsmith, in his additions) when it came to the bodies of adulthood. After this opening paragraph, from

¹²⁷ M. Vacherie, *An account of the... hermaphrodite... upon show in... London* ([1750]), pp. 7-8, 12, 17 (my emphasis).

¹²⁸ Russell, *Oeconomy*, p. 7.

¹²⁹ Oliver Goldsmith, *An history of the earth, and animated nature...*, vol. 2 of 8 (1774), p. 68.

Buffon, discussing puberty as internal solidification, the focus moved immediately to state that '[t]he body of a well-shaped man ought to be square; the muscles... expressed with boldness, and the lines of the face strongly marked', because '[s]trength and majesty belong to the man, grace and softness... the other sex'.¹³¹ Nor was this concern with outer form the product of editing in light of Goldsmith's own interests. Identical content was included in translations of 1775-76 and 1780.¹³²

The focus of some types of medical enquiry might have moved towards the internal 'solids' but this did not create a uniform shift in authors' interests in the male body or the bodies of men (males living the idealized masculine lifestyle). Thus, it was external, gendered, shapes that led Buffon and Goldsmith to envision males and females, and instead of the sexed anatomy of the skeleton it was in more superficial observations, such as that 'the proportions... are obviously different in the two sexes', for '[i]n woman, the shoulders are narrower, and the neck... longer than in men. The hips also are considerably larger, and the thighs much shorter', that this analysis was conducted.¹³³ Only after eleven pages did the discussion of human strength touch on sex difference, and only to say that '[w]omen want much of the strength of men; and, in some countries, the stronger sex have availed themselves of this... in... tyrannically enslaving' them.¹³⁴ Even the Adam's apple merited nothing more technical than the remark that '[i]n men, there is a lump upon the wind-pipe, formed by the thyroid cartilage, which is not to be seen in women; an Arabian fable says, that this is a part of

¹³⁰ Ibid., vol. 2, pp. 79-80.

¹³¹ Ibid., vol. 2, p. 80.

¹³² Georges Louis Leclerc, comte de Buffon, *The natural history of animals, vegetables, and minerals...*, vol. 1 of 6 ([1775]-1776); idem., *Natural history, general and particular...*, vol. 2 of 9 (Edinburgh, [1780])

¹³³ Goldsmith, *History*, vol. 2, pp. 100-101, 107-108.

¹³⁴ Ibid., vol. 2, pp. 120-121.

the original apple, that has stuck in the man's throat... but that the woman swallowed her part'.¹³⁵

While Buffon's chapters on the ages of man differed visibly from the technical anatomical and physiological detail of other sections, it was not because these were intended as a light-hearted, playful, interlude. Nor did translators such as William Smellie (1740-1795), Keeper of the Edinburgh Museum of Natural History, object to them on intellectual grounds, or expect that the purchasers of this lengthy, learned, tome would. Indeed, translations of the text were sufficiently popular to go through at least nine publications, republications and new editions between 1774 and 1798 that openly acknowledged Buffon's authorship.¹³⁶ All but one retained his chapters on the ages of man, and all eight of these kept their gender- and sex-related aesthetic and cultural observations, even when these chapters were heavily condensed. Indeed, far from being embarrassed by this content, one edition moved these chapters to the very start.¹³⁷ A broadly conceived 'natural history' was not ready to reduce humankind solely to a set of physiological and anatomical systems, or to allow its interest in humankind as an 'animal' to displace other facets of being human. The hybrid 'natural history of man' still had room for cultural observation, the anthropological and the sociological.¹³⁸

Nor did medical writing insistently and uniformly trim the male body to the internal and physiological. Many works continued, even in the late-eighteenth century, to envision the male in the features seized on by Haworth. In part, this was because of the continued publication of many late-seventeenth-century texts. The Leiden-educated physician-

¹³⁵ Ibid., vol. 2, p. 102.

¹³⁶ Plus abridgements dedicated to individual species.

¹³⁷ Buffon, *The natural history of animals...*, vol. 1.

¹³⁸ Quotation from, Buffon, *Natural history general*, vol. 1, contents page.

anatomist James Keill (1673-1719), for example, had not only maintained the dichotomy of the male's beard and the female's lack of it, but also elevated this into the primary way of distinguishing between the sexes, specifically in and because of its immediately visible nature.¹³⁹ His 1698 *Anatomy of the Humane Body*, based partly on a French anatomy of 1679, had stated emphatically, and only, that '[w]hatsoever the efficient Cause may be why a Man has a Beard, and a Woman none, it is certain the final Cause is for the distinguishing the Male from the Female... which otherwise could hardly be known, if both were dressed... the same'. It was the feature itself, and its ultimate purpose, that was of significance and concern, not the underlying sexed physiology.¹⁴⁰ This content was still present in the fourteenth (Edinburgh, 1770) and fifteenth (London, 1771) editions. It was also still being reiterated in 1775 in the apothecary-physician-lecturer John Quincy's *Lexicon physico-medicum* (1717), itself based on an older work.¹⁴¹

Eighteenth-century British men (and '[t]he Europeans' as a whole) shaved their faces, and Goldsmith acknowledged that '[t]here is no part of the body which has been subject to such changes of fashion as the hair and the beard'.¹⁴² However, it was not only in republications or plagiarisms of seventeenth-century texts that the beard was elevated as a, or the, paradigmatic feature of the male, or the male reduced to the beard. Thus, the account of a hermaphrodite added in 1740 to Cheselden's (1688-1752) highly successful student-manual of *anatomy* (1713) described its body outside the genitalia

¹³⁹ James Keill, *The anatomy of the humane body...* (1698), pp. 14-15; Oxford Dictionary of National Biography.

¹⁴⁰ By contrast, Galen had explained the beard by both the hot male humoral physiology and men's social role, they 'need[ing]... protection from the cold' (Galen, trans. Margaret Tallmage May, *Galen On the Usefulness of the Parts of the Body*, vol. 2 of 2 (Ithaca, NY, 1968), p. 531).

¹⁴¹ John Quincy, *Lexicon physico-medicum...* (9th edn., 1775), p. 198.

¹⁴² Goldsmith, *History*, p. 95.

simply as of ‘a shape perfectly male’.¹⁴³ That accompanying the illustrations of another hermaphrodite inserted in 1778 similarly stated only that it had a ‘*shape... rather female than male, but too young to have female breasts, or a beard like a male*’.¹⁴⁴ Both ‘description[s]’ were still present, without elaboration, in the thirteenth and final British edition of 1792.¹⁴⁵

It also remained possible even at the very end of the eighteenth century for *new* medical and natural philosophical texts to give only unelaborated references to ‘masculine appearance’ (and to this rather than ‘male’ appearance).¹⁴⁶ In the 1780s there were still authors, from a range of genres, and commenting on a variety of bodily and medical topics, who saw the beard, deep voice, courage, and strength as epitomizing the male. Indeed, across the entire period there were writers for whom it was an interest in the beard, the marks of ‘virility’, the eunuch, or the effects of a loss of semen, that led them to envision the male. It was the features themselves that these made paradigmatic and significant, not any explanatory, internal, structure or substance.¹⁴⁷ Indeed, the way that hermaphrodites were being described gives further confirmation that in the 1770s (and beyond) the male beard and female breasts could still be the ultimate non-genital distinction between the sexes.¹⁴⁸

An unspecified ‘virility’ (or its product, the beard) could likewise still be selected as the shorthand for maleness, and the expected attributes of this correct, virile, man be

¹⁴³ William Cheselden, *The anatomy of the human body... The Vth edition* (1740), p. 314.

¹⁴⁴ Idem., *The anatomy of the human body... the XI edition...* (1778), p. 314 (my emphasis).

¹⁴⁵ Idem., *The anatomy of the human body... The XIII edition...* (1792), p. 312.

¹⁴⁶ Royal Society, *Philosophical transactions of the Royal Society... For the year MDCCXCIX. Part I*, vol. 89 ([1799]), p. 170.

¹⁴⁷ Francis Riollay, *Doctrines... of Hippocrates...* (1783), p. 77; James Parsons, *A mechanical... enquiry into ... hermaphrodites* (1741), p. 29.

¹⁴⁸ Royal Society, *Transactions*, vol. 89, p. 170 (describing a hermaphrodite as having ‘the breasts of a woman, and no beard’).

revealed in the smooth face, high voice, and ‘unmanly softness’ used to signify its opposite, the emasculated man.¹⁴⁹ William Farrer’s text on onanism (masturbation), for example, questioned the existence of the nerves in the 1760s and yet declared confidently that it was the semen that (without explanation) ‘makes men hot, robust, hairy, of a strong and deep voice, bold and courageous, and fit to contrive or execute any enterprise’. Adult males not formed as they naturally should be were ones who, at the explanatory level, lacked this ‘vital Seed’, and at the observed level were devoid of the ‘markes of verility’, being ‘beardless and effeminate’, shrill-voiced, hairless, weak, pale, and wrinkled.¹⁵⁰ Evidently, for some, the interest lay not in men’s difference to women, but in the difference of men who were undeveloped.

Conclusion

It should not be exaggerated how often and comprehensively specifically male bodies that were not just the reproductive organs appeared in medical texts. Yet, the rise of a language of sexed nerves or sex-unique reproductive organs, and the continuation of a notion of osteological sexed peculiarities, did not mean that performative, aesthetic, and non-anatomical gendered characteristics became irrelevant to all models and depictions of the male. Nor did it mean a universal displacement of anatomical characteristics existing beyond the reproductive organs, skeleton, and nerves. This wider body – and the wider man, and his life – did not automatically become sidelined, whether over time or when it was male sexual nature, the nerves or the skeleton that were of interest.

Thomas Laqueur argued that the representation of the sexual organs was gradually transformed over the eighteenth century, as these became the site in which authors

¹⁴⁹ Joseph Nicol Scott, *A new universal etymological dictionary...* (‘new edition’, 1772), ‘emasculat[i]on’.

located male-female difference. His interest lay, therefore, in charting changing notions of the reproductive organs, not in tracing the fate of the wider body.¹⁵¹ According to Laqueur's explanation for this reconfiguration of male-female difference, however, the body beyond the reproductive parts (or perhaps beyond the skeleton and nervous system too) was neither anatomical nor rigidly sex-specific, and, because of this, had become inadequate.¹⁵² With Laqueur claiming that anatomical '[s]ex' then 'replaced... gender as a primary foundational category', and that 'the framework in which the natural and the social could be... distinguished came into being', the reader was left to assume that the non-reproductive elements of the body were increasingly seen by contemporaries as an inferior, and even irrelevant, part and sign of sex.¹⁵³

However, in the late-eighteenth century, as before, there were numerous types of medical discourse. Consequently, there was not just a single male body, and one important only as the standard against which the *female* was to be compared. Whether or not depictions of the sexual organs were transformed in the eighteenth century, reproductive anatomy, or even anatomy more broadly, was not the sole type of medical writing, even for eminent authors. At any one time, different discourses, and different writers, were focusing in on the male for varying facets of his body, his sex, or the man within, without these approaches being mutually exclusive or, furthermore, following simple divisions by authorial education, genre, or intended audience. Instead, the way in which (and reasons why) authors envisioned the mature male varied as much across and within genres as across the period, and perhaps more so. Indeed, when later-eighteenth-century authors did select newer anatomical and physiological frameworks it was often

¹⁵⁰ William Farrer, *A short treatise on onanism...* (2nd edn., 1767), p. 16.

¹⁵¹ Laqueur, *Making Sex*, pp. 149-192, esp. 149-150, 157-158, 167-169.

¹⁵² *Ibid.*, p. 149.

¹⁵³ *Ibid.*, p. 154, although see also pp. 149-150.

to explain attributes very different to a rigidly anatomical notion of sexed difference ‘to be weighed and measured, described and represented exactly’.¹⁵⁴

In some parts of medicine the gender of the mind, the body holder, and the life that he lived remained, therefore, material and embodied, and some medical authors taught men that courage, a certain place in society, exertion, and strength were the way to prove their maleness and assert their masculinity. The role of medicine and its models of sex and gender as an oppressor of women is, consequently, only half the story.¹⁵⁵ Where they commented, medical writers were as insistent, and consistent, in what they expected, and society was to require, of men, and these expectations extended beyond the sexual organs. In many texts, to be secure in his maleness (as judged by his society) a man needed to be manly, and *vice versa*, and manly by having courage, living a life of physical exertion, and being strong. Furthermore, medicine was able to convey these messages precisely because it was *not* a ‘narrow and elite... discourse’ accessed by ‘very few... beside the very rich and professional doctors’.¹⁵⁶ With no single medical discourse, and no single strand that all lay readers read alike, it was this very variety that made it possible for contemporaneous authors to pinpoint such different facets of adult maleness.

A range of strands of medicine taught that men acted, lived, and thought, in particular ways, and that they should naturally do so because they were made this way. They also taught society to judge men by their bodies and the uses that these were put to. It might be that the gendered ideals that such texts were deploying were not those circulating in

¹⁵⁴ Quotation from Schiebinger, *Mind*, p. 201.

¹⁵⁵ See the discussion in Karen Harvey, ‘The Century of Sex? Gender, Bodies, and Sexuality in the Long Eighteenth Century’, *Historical Journal* 45, 5 (2002), pp. 899-916, esp. 902-909.

¹⁵⁶ Tim Hitchcock, *English Sexualities, 1700-1800* (Houndmills, 1997), p. 49.

other types of literature, for the male and man that some types of medicine continued to presume was much closer to the prescriptive ideal discussed by historians of early modern society than to the refined and sensitive masculine figures described as being idealized in the eighteenth century.¹⁵⁷ Either the ideals that medicine often promoted were increasingly out of touch, or several (perhaps contradictory) ideals existed simultaneously. The continued medical elevation, and expectation, of a beard that had fallen out of British cultural fashion, for example, might raise the possibility of a disjuncture between medicine and culture. However, it might simply remind the historian that the beard was imagined as one part of a *nexus* of signs and qualities. Shaving the facial hair would not itself bring a man's full male development (and resultant capacity for procreation) into question, yet these might be questionable in a man naturally lacking both the beard and other signs of maleness (or virility).¹⁵⁸

All of this had implications for the messages that medicine sent to society. In medicine, in both centuries, and at least with such gendered attributes as masculine courage, there was a sense of a character that was innate (as fact or potential) and natural. Across the period, there were authors assuming a continuum of physicality, character, and lifestyle, approaching mind and body as a single unit, and presuming masculinity and maleness to be either present in both or absent in both. Consequently, the materials considered in this chapter do encourage certain observations about medicine's understandings of masculinity and of the relationship between the masculine self and the masculine body. Different ideas might have been surfacing in other genres, but in medicine, and at least

¹⁵⁷ C.f. Alexandra Shepard, 'From anxious patriarchs to refined gentlemen? Manhood in Britain, circa 1500-1700', *Journal of British Studies*, 44 (2005), pp. 281-295, esp. 282-286.

¹⁵⁸ C.f. Edward Behrend-Martinez's discussion of the seventeenth-century Spanish comedy in which '[t]he implication is that, given his soft voice, there was the possibility that he might be a castrate. In this instance, all doubt was removed by the suitor's full beard' (Edward Behrend-Martinez, *Unfit for*

with such gendered attributes as masculine courage, there was a sense of a character that was innate (as fact or potential) and natural.

Certainly, this sample of publications suggests that there existed a resilient core of fundamental ideals of maleness and masculinity, and one that created a degree of unity not only between the different schools of medical thought but also across many of the different ways of envisioning the male. Significantly, this set of core values and assumptions also appears to have shown great consistency over time, and to have absorbed, and received further justification from, changing medical theory. In particular, it was able to survive across what has been seen as a great watershed in Western medicine, the alleged late-seventeenth-century collapse of humoralism. Indeed, that these older, sometimes humoral, ideals of maleness and masculinity continued to be perpetuated within eighteenth-century manuals of medical education makes it possible that they were being inscribed within medical practice itself, and perhaps, therefore, being transmitted or applied to male patients. Certainly, that texts ostensibly for a lay audience and those officially for practitioners could show substantial similarity, in both centuries, in their notions of masculinity of lifestyle, mind, and both inner and outer body does suggest a continuing shared culture of notions about the male, manliness and men. This, furthermore, raises at least the possibility that, in their encounters with the male body, men, their practitioners, and their friends and relatives, were subscribing to similar ideals, and ones revolving around a courageous character, an active social role, and a physicality defined by strength, robustness, and the 'signs' of virility.

Marriage: Impotent Spouses on Trial in the Basque Region of Spain, 1650-1750 (Reno, LV, 2007), p. 127).

However, this itself argues that it might not have been only medical authors who experienced anxiety about the vulnerability of the male body-mind nexus and its masculinity. Certainly, not even medical authors rooting male nature in a sexed anatomy, sex-unique physiology, or uniquely male semen, were automatically confident that male sex would reach its full, and supposedly natural, expression. While the consistency of many of the core features and values used to describe (adult) males might appear to support Laqueur's claim that the male of medical writing has been 'stable' and 'unproblematic', men's real life bodies, and the ability of men to achieve these ideals, could, therefore, be seen as anything but, in 1780 or in 1640.¹⁵⁹

Throughout these 140 years, therefore, there were medical writers creating the potential for society to form ideas of what was and was not natural in men that were not restricted to the reproductive organs. They did so without claiming the need for any specialist skill in judging men in this, and in a vocabulary and set of concepts both long established and part of a pervasive social language. Perhaps, consequently, what had the greatest implications for the individual man's recognition by his society were those related routine assessments to which his body (and body-mind nexus) might have been subject in day-to-day life, not society's understanding of the uniqueness, or otherwise, of his sexual organs. Indeed, later chapters consider the consequences of these gendered medical presumptions for men's socially permissible behaviours.

¹⁵⁹ Laqueur, *Making Sex*, p. 22.

Chapter 3: Problematic male organs

Introduction

Of all of the health issues affecting, or stemming from, the uniquely male body, it is impotence, onanism (masturbation) and venereal disease that have received the most historiographical attention. Yet, the manuscript record gives little evidence of these surfacing in formal practice male sexual and reproductive problems, including impotence, that practitioners saw as something other than a product of venereal disease. Indeed, the formal medical record contains little evidence of a collective male anxiety sparked by the suspicion, expectation, or known possibility, of sexual failure, and only slightly more of men concerned about the harm done by onanism. While there is, by contrast, abundant evidence of men having suffered from venereal disease, it is less clear that victims' suffering was always shaped, let alone exacerbated, by their bodies being male.

There were, however, other ailments that could and did affect the male sexual organs. Although these have generally received little attention from historians, they featured in Lucinda Beier's analysis of 'the ailments middle- and upper-class people suffered on a day-to-day basis'.¹ Significantly, Beier argued that there were problems experienced in the male reproductive organs that were not swathed in the reticence that surrounded '[t]he exclusively female experiences of pregnancy, childbirth and menstruation'.² Consequently, she was able to find in seventeenth-century diaries evidence of Ralph Josselin suffering from a swelling of the groin, Robert Hooke catching cold in his penis, and Samuel Pepys's father having for over twenty years a hernia that occasionally

escaped its truss, causing 'so great pain as I never saw'.³ However, Beier still concluded that urinary problems were more consequential for males than were 'clean' (non-venereal) disorders of the sexual organs, for they were '[p]erhaps more common than' hernias, 'and certainly more deadly'.⁴ Edward Shorter reached a more extreme conclusion, arguing that although '[m]en did [in the past] suffer from several quintessentially male problems', these 'were not frequent', 'occurred very early or very late in life', and, consequently, 'were unlikely to have much affected a man's sexual self-image'. Furthermore, for Shorter these 'male problems' were urinary stoppages, not genital afflictions.⁵

This chapter examines, therefore, the specifically male parts of the male body as a cause of male suffering. While Beier has revealed the severity of those problems exacerbated or encouraged by the anatomy of the male urinary system, it is asked here if the specifically male body was more vulnerable in its *uniquely* male parts than has been uncovered. The chapter also looks at the significance of this vulnerability, exploring whether problems in and of the male genitalia did matter first and foremost for 'sexual self-image'. The first part tests whether suffering from venereal disease was for men a peculiarly male experience, moulded by the maleness of the body. The second searches for evidence in the medical record that men were aware of the potential fragility of their sexual and reproductive capacities, and that this bore heavily on the subjective experience of owning a male body. It also searches for medical evidence that cultural or

¹ Lucinda McCray Beier, *Sufferers and Healers. The experience of illness in Seventeenth-Century England* (London and New York, 1987), p. 139.

² *Ibid.*, p. 147.

³ *Ibid.*

⁴ *Ibid.*, p. 148.

⁵ Edward Shorter, *Women's Bodies. A Social History of Women's Encounter with Health, Ill-Health, and Medicine* (1984, new edn. 2009, New Brunswick, NJ and London), p. 281.

medical teachings were successful in inculcating a fear that the wrong use of the sexual organs would carry physical costs.

The third part then moves away from the sexual nature and use of these organs. Instead, it considers the susceptibility of the male parts to breakdown more generally. It examines the physical vulnerability of the male sexual organs to disease and pain as one element of the male experience, and as an element of this experience that *might* have been specifically and uniquely male. The fourth similarly focuses on the actual experience of having and being treated for inguinal (groin), testicular or scrotal hernias. Exploring just how far adult males could and did suffer in and because of their uniquely male organs, this leads into part five's consideration of the emotional and personal experience of disorder in the male sexual organs.

Part i: Venereal Disease

There were across the period printed texts that represented the body infected with venereal disease as male.⁶ Eighteenth-century lecturers did the same, whether talking of gonorrhoea (*gonorrhoea virulenta*, a purulent urethral running) or *lues venerea*.⁷ However, whilst the infected body was made male the root of the disease was not. Although Thomas Sydenham (1624-1689) had claimed that it was the penile glans that was the seat of gonorrhoea, early-eighteenth-century authors were already dismissing this.⁸ Lecturers similarly spoke of the infected body as male without claiming gonorrhoea a disorder determined by the male body's sexed nature. As was taught at

⁶ E.g. R[obert] James, *A medicinal dictionary*..., vol. 2 of 3 (1743-1745), 'gonorrhoea'.

⁷ WL, MS MSL 86/3, Clinical lectures, John Rutherford, William Cullen and Robert Whytt, pp. 174-259, '[I]nceptis a Dr. Cullen' (1763-1764), p. 253.

⁸ W[illiam] Cockburn, *The symptoms, Nature, Cause, and Cure of a Gonorrhoea* ([1713]), p. 36. Sydenham's various editors corrected him only in 1742 (Thomas Sydenham, *The entire works of Dr Sydenham*... (1742), p. 307).

Edinburgh in the 1760s, '[t]his running is not the Semen as some suppose but... from the Urethra', and '[t]he seat... may be in one or more of the Mucus Glands of the Urethra, and not limited to any particular part, much less to the Prostate Gland as [the French Jean] Astruc imagined'.⁹

In print, furthermore, there were authors for whom most of the seats of gonorrhoea were parts common to both sexes. The glands that in the male 'spewed' 'seminal fluid' for 'defending the Urethra from... Seed and Urine' had been discovered by William Cowper (1666-1709), and, once accepted, there were authors in the mid-eighteenth century who believed them to exist in the female too.¹⁰ Consequently, it was implicit in a 1737 translation of Astruc's thesis that sex had little significance to the seats. Here, the main difference between the sexes lay in the male's greater likelihood of having his gonorrhoea rooted in the urethra, a seat common to male and female alike.¹¹

There was no consensus as to whether other seats were uniquely male. William Cockburn (1669-1739) claimed in 1713 that in males the infection was rooted in the urethral cells secreting that natural 'Liquor' that, when purulent, became the gonorrhoeal running. However, he also recognized homologous female cells, called both by the name of the 'longer known' female version, and did so because they 'equally serve to prod[uce?] and carry on the Symptoms', 'on the same Principles'.¹²

There were authors arguing something similar of the *prostatae* (prostates, or prostate

⁹ RCS, MS 0073, Clinical lectures (c. 1765), William Cullen, Alexander Monro *secundus* and Robert Whytt, pp. 1-113, 'Clinical Lectures Delivered in the Royal Infirmary by Robert Whyte, MD, FRS', pp. 54, 57; *ibid.*, pp. 114-130, 'Clinical Lectures by Dr Cullen', pp. 118, 122. Cockburn, *Symptoms*, pp. 36-40, had said the same.

¹⁰ Quotations from Cockburn, *Symptoms*, p. 13; John [sic] Astruc, *A treatise of the venereal disease...*, vol. 1 of 2 (1737), p. 250. Texts questioning their existence included William Cheselden, *The anatomy of the humane body...* (1713), p. 165.

¹¹ Astruc, *Treatise*, vol. 2, pp. 249-250.

¹² Cockburn, *Symptoms*, pp. 41, 43.

gland) in the mid-eighteenth century, and some who claimed that these existed in both sexes too. Others spoke of the prostates (and Cowper's glands) as male without claiming that they created a specifically male experience of gonorrhoea, instead citing parallel glands that 'are the Seat of Gonorrhoeas in Women as the Prostatae are in Men... and have the same use'.¹³ Indeed, practitioners eroded the significance of anatomical difference between the male and female no matter where they placed the seat. Thus, Robert Whytt, Edinburgh's Professor of Medicine, taught in the 1760s that '[i]n women the chief seat... is in the Vagina, and the Glands situated there, and those at the mouth of the Urethra, and affects them much in the same way as Men'.¹⁴

Throughout the period, authors and lecturers envisioned a male body when explaining the progression of a gonorrhoea, but did not make it a disease of the male reproductive organs. In lectures, gonorrhoea was conceptually located in the urethra, and the urethra kept a purely urinary vessel, despite the additional reproductive purpose that it (and its secretions) served in the male.¹⁵ Instead, it was lists of symptoms that were made male, usually in problems with erection rather than ulcers 'upon the Glans or prepuce'.¹⁶ For Whytt, these ranged from priapism (unprovoked erections) to erections that were painful and downwards inclining (chordee) or sideways-bent, and while some publications noted that pain was similarly felt in 'ten[sio?]ns of the *vagina*', neither Whytt nor his subsequent successor, William Cullen, mentioned this when listing chordee as a defining symptom.¹⁷ The penis featured without vaginal analogy in Whytt's guidelines

¹³ James, *Dictionary*, 'generatio'; G[eorge] Thomson, *Syllabus...* ([1739?]), p. 26.

¹⁴ RCS, MS 0073, Clinical lectures, Cullen, et al, 'Clinical Lectures... by Robert Whyte', quotation at p. 58.

¹⁵ *Ibid.*, p. 118.

¹⁶ But see MS 0073, Clinical lectures, Cullen, et al, 'Doctor Rutherford's Clinical Lectures', p. 133.

¹⁷ *Ibid.*, 'Clinical Lectures... by Robert Whyte', pp. 58-59; *ibid.*, 'Clinical Lectures by Dr Cullen', p. 118; Peter Shaw, *A new practice of physic...*, vol. 2 of 2 (3rd edn., 1730), p. 289 (original italicization).

for diagnosis too, while the testicles similarly provided males with their own diagnostic tools, as well as functioning as secondary seats of infection.¹⁸

It was said by lecturers to matter in other ways too that the body infected with a gonorrhoea was male. Positively, that this vessel was in the penis made it possible to ‘sometimes... determine the precise place where the Urethra is exulcerated’.¹⁹ Negatively, that the urethra was, consequently, enveloped by the corpus cavernosum urethrae created an additional hazard, as ‘Gonorrhoea is very difficult to cure that has been... pushed back into’ this ‘by Injections’.²⁰ This one erectile tissue with no female homologue was also problematic in itself, for in gonorrhoea ‘there is always a considerable degree of Inflammation & swelling’ in it.²¹ As it was this that was blamed for chordee, male anatomy ostensibly created a unique phenomenon that the practitioner needed to be alert to, there allegedly being ‘nothing more dangerous than to give too acrid medicines’ to males.²² Indeed, Whytt’s predecessor claimed to allow this uniquely male danger to determine treatment, ‘on purpose to... prevent an Erection which is of very bad consequence’.²³

In practice, however, such unique dangers, and the unique parts responsible, were not visibly a driving concern of practitioners, or of the instructions issued by lecturers and their treatment of patients. Indeed, the sexual organs were far from always the site or target of the medical procedures prompted by a gonorrhoea, and where applications to

¹⁸ RCS, MS 0073, Clinical lectures, Cullen, et al, ‘Clinical Lectures... by Robert Whyte’, pp. 57-58.

¹⁹ WL, MS MSL 86/1, Clinical lectures, John Rutherford, William Cullen and Robert Whytt, pp. 1-165, ‘Doctor Rutherford’s Clinical Lectures’ (1751), p. 134.

²⁰ Ibid., p. 134.

²¹ Ibid., pp. 133; John Harris, *Lexicon technicum...*, vol. 1 of 2 (5th edn., 1736), ‘cavernosum corpus urethrae’.

²² WL, MS MSL 86/1, Clinical lectures, Rutherford, et al, ‘Doctor Rutherford’s Clinical Lectures’, p. 133.

²³ Ibid.; RCS, MS 0073, Clinical lectures, Cullen, et al, ‘Clinical Lectures... by Robert Whyte’, p. 54.

the penis *were* given they were frequently intended for the urethra.²⁴ The same was true of practitioners treating, and lecturing on, *lues venerea*, a disorder characterized by ‘Crusty Scabs and Ulcerations’ and progressing out of a gonorrhoea by the absorption of ‘the Venereal poison’ into the blood.²⁵ Indeed, when Cullen and the surgeon-physician Alexander Monro *primus* lectured at Edinburgh in 1763-65 on eight men with *lues venerea*, gonorrhoea, and ‘Ven[erea] Compl[ain]ts’, they made no reference at all to any peculiarly male dangers.²⁶ Again, there was no tendency to make *lues venerea* even conceptually a disease in or of the sexual organs, specifically male or otherwise.²⁷

In the absence of any uniform male experience of infection, there were men treated for venereal disease who were totally free of symptoms in the sexual organs and, consequently, whose treatment paid no attention to these parts.²⁸ Yet, there were also many men with *lues venerea* who were suffering in the reproductive organs. Both seen in 1681, the two men in Richard Lockyer’s selected cases who had venereal disease had *lues venerea*, with severe symptoms in the sexual organs. Although these were ulcers, tumours, swellings, and ‘excoriations’ rather than difficult erections, they still resulted in applications to the genitals in their own right.²⁹ Similarly, all but one of the fifteen known or suspected male sufferers of venereal disease recorded in the surgeon Alexander Morgan’s casebook (c.1714-c.1747) had at some point symptoms on the genitals. The sexual organs were certainly of more significance – to their symptoms and to their treatment – for these ten men than they were for the female sufferers under

²⁴ RCS, MS 0073, Clinical lectures, Cullen, et al, ‘Clinical Lectures... by Robert Whyte’, pp. 80, 54-55.

²⁵ Ibid., ‘Clinical Lectures by Dr Cullen’, pp. 122, 124.

²⁶ RCP, MS 468, ‘Cases & Reports from Drs. Monro, Cullen & Whyte’ (1763-1765), Alexander Monro *primus*, William Cullen and Robert Whyte.

²⁷ Ibid., p. 122.

²⁸ WL, MS MSL 86/1, Clinical lectures, Rutherford, et al, ‘Doctor Rutherford’s Clinical Lectures’, pp. 150-153.

²⁹ WL, MS 3319, ‘Admirable observations’ (c.1675-c.1691), Richard Lockyer, ‘Lewis Veneria: E F Aged 30’ and case of John Powell, 13 October 1681.

Morgan, none of who were suffering in their sexual organs (and only one ‘in her groin’).³⁰ Ten men had runnings (one allegedly not urethral), five penile or testicular complaints attributed to these, and eight symptoms on the sexual organs not said to be caused by the running but not by nature unique to these parts. For six the specific, sexed, nature of these sexual organs *was* the source of additional suffering, causing symptoms specific to the particular nature of these male parts, and whether a contraction of the spermatic chord, phimosis (an inability to retract the foreskin, making erections painful), or erectile problems. One was suffering from a uniquely male symptom *and* the effects that it had because of the nature of another part of the penis, his phimosis pushing purulent matter onto the unusually ‘tender’ skin beneath the foreskin.³¹

The hazards that the corpora carnosae urethrae brought did not, however, routinely dominate men’s medical experience of treatment in any type of venereal disease. It was seemingly only in the management of problematic erections that men’s treatment followed something other than generic, non-sexed, principles and procedures, and not all sufferers had such symptoms. Thus, only two of the eight men of 1763-65 (Nisbet and McCraw) presented with problems during erection.³² With nothing said subsequently about Nisbet’s ‘stricture’ except that he ‘has little of the Chordee’, and was ‘free of the Priapism’, it was only for McCraw and Davidson, a three-year-sufferer of ‘Ven[ereal] Compl[ain]ts’, that the complaints noted during these often lengthy hospitalizations included anything erectile.³³ Nor were other symptoms from, or on, the uniquely male organs a universal experience. Only two of the eight had non-erectile

³⁰ WL, MS 3631, Medical case-book (1714-1747), Alexander Morgan.

³¹ *Ibid.*, p. 42. A spermatic chord (the spermatic blood vessels and the semen-carrying vas deferens) ran between each testicle and the abdomen (Malcolm Flemmyng, *An introduction to physiology...* (1759), pp. 363-364).

³² RCP, MS 468, ‘Cases & Reports from Drs. Monro, Cullen & Whyte’, Monro, et al, first set, pp. 213, 53.

symptoms in the genitals – ulcers and ‘tumors’ – and only one, Mckay, had had them earlier.³⁴ However, five, including Mckay, developed non-erectile genital symptoms and side effects during treatment, although these ulcers, tumors and swellings were far from a crucial interest, or concern, of the lectures.³⁵

The male sexual organs were not, therefore, always at the therapeutic centre of the experience of being infected or being treated. (Non-erectile) symptoms of the sexual organs were, furthermore, sometimes amongst the most quickly and easily resolved.³⁶ For both of Lockyer’s patients, it was measures ‘to coole his blood & stop the foment of the humors’, not therapeutics applied to the sexual organs, or alert to these organs’ sex-specific nature, that were the most prolonged.³⁷ In Edinburgh in 1763-65, the genital ‘sores’ that Grant presented with were ‘quite healed up’ within three weeks.³⁸ Of the two men with erectile problems, McCraw’s painful erections were gone before the running and heat of urine left, and before the urethral pain started. A chordee appeared but was subsiding after three days.³⁹ Nisbet’s genitalia were at one point bathed twice a day but his treatment concentrated on purging, moving quickly from injecting mercury into the urethra to ingesting it, and it was the soreness of his gums and the matter in his urine, not anything genital, that both caused him distress and determined his treatment.⁴⁰

There were, however, men whose genital symptoms were more insistent. Thornton’s ‘painful swelling in his groin’ lasted only two days, but was followed by ‘swelling and

³³ Ibid., first set, pp. 53-68.

³⁴ Ibid., first set, p. 30; second set, p. 109.

³⁵ Ibid., second set, pp. 109-117.

³⁶ WL, MS 3319, ‘Admirable observations’, Lockyer, case of John Powell.

³⁷ Ibid., ‘Lewis Veneria: E F Aged 30’.

³⁸ RCP, MS 468, ‘Cases & Reports from Drs. Monro, Cullen & Whyte’, Monro, et al, first set, pp. 213, 30.

³⁹ Ibid., first set, p. 59.

⁴⁰ Ibid., first set, pp. 213-218.

pain in the groin', although this soon declined.⁴¹ After McCraw's chordee lessened he developed a pain and swelling in the testicle that went up the spermatic vessel into the abdomen. It was removed in days but returned, eventually going off (yet leaving the coats of the testicle hard), to be succeeded by tumours in the left groin, a running, and penile pain.⁴² Yet, such pains, swellings and tumours were not products of venereal disease unique to the male sexual organs, or even to the sexual organs of both sexes.

Part ii: Sexual Problems

Erectile repercussions were not, therefore, always an accompaniment of venereal disease. Very rarely, however, did practitioners record encountering them outside of venereal infection. Symptoms stemming *from* erection were noted even less frequently, while note-keeping practitioners referred to excessive seminal loss much less often than might be expected from the contemporary anti-onanism literature.

This was not, however, necessarily a tendency of practitioners alone. Those who kept case histories left no suggestion that the ability of the penis to erect, questions of fertility or sexual appetite, problems attributed to what either party interpreted as excessive intercourse, or (with a single exception) extreme arousal,⁴³ were routinely amongst the complaints or anxieties that men took to surgeons or physicians. Nor did being, or having been, masturbators dominate men's visible anxieties about their bodies, or about themselves as body owners, at least as told to practitioners and then recorded in casebooks. This record might not be indicative of all types of practice, but it contains little to prove that if men were being taught by their medical reading to feel guilt about masturbation this was routinely projected into health anxieties.

⁴¹ Ibid., first set, p. 147.

The bodily costs of masturbation were, therefore, something that far from all men seized on. Written, where dated, between 1681 and 1741, 174 sets of consultation letters in a four-volume sample of letters sent to the physician Sir Hans Sloane discuss in total 154 different males apparently over the age of sixteen.⁴⁴ Yet, while printed texts told males that masturbation would result in nightly seminal emissions, only seven letters complained of seminal or urethral flows or leakages, nocturnal or otherwise, as problems in themselves.⁴⁵ All seven, however, were from patients personally, with four undated and three (from two different men) written in the 1730s. Together, they discussed only 3.9% of the 154 men in the sample but formed 10.9% of the sixty-four letter sets that they themselves sent to Sloane.

Why it was only patients who referred to this complaint, or why these six wrote personally, is unclear. Certainly, it is difficult to link it to a sense of shame. Their frankness discourages any explanation based on an urge for secrecy, while only one (hereafter referred to as the ‘self-disgusted’) replicated the language of ‘heinous sin’, and that angst-loaded self-hatred, displayed in the supposedly authentic letters printed in such texts as *Onania* (1712).⁴⁶ Timothy Carter, in his early thirties, sent two surviving letters that referred to his emissions as ‘[t]he Poll[utions] nocturn[al]’ and ‘Geniturae profusions in somnis by... nocturnal pollution’ but this is not an

⁴² Ibid., first set, pp. 51-68.

⁴³ RCS, MS 0189/1/1, ‘Cases and observations’ (men’s dated cases 1738-post-1803), John Hunter, no. 84.

⁴⁴ In which the language was English and the subject within the British Isles and clearly male, where the authorial type (patient, practitioner, or associate) is known or apparent, and where there is some mention of the symptoms or disorder. BL, Sloane MSS 4034, 4075, 4077-4078, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century). Sloane retired in 1742 (Oxford Dictionary of National Biography). For further details on the use of these letters see the notes in the appendix for chapter 4, tables 4.5-4.7.

⁴⁵ [John Marten?], *Onania...* (4th edn., [1718?]), p. 19.

⁴⁶ Ibid., title page; BL, Sloane MS 4078, Hans Sloane consultations, f. 330, unsigned and undated.

indication of any stigma. His letters showed a sustained erudite concern for exactitude, cross-referencing Latin medical reading and making sustained use of medical terminology.⁴⁷

Onania told males that masturbating even once would cause phimosis, and frequent usage priapism, impotence, penile '[w]eakness', emissions, and urinary, testicular, and penile disorders. If they somehow avoided infertility, their offspring would be "a Jest to others, and a Torment to themselves".⁴⁸ These were warnings repeated across much of the century. Joseph Cam, for example, warned in 1729 that the male would be 'emasculated by this odious Vice', while emphasizing the humiliation of impotence-induced suits for annulment.⁴⁹ Yet, not even the one Sloane letter to claim overpowering guilt and self-hatred declared fears about marriage and fatherhood.⁵⁰ Perhaps even men who did absorb the language of the printed genre did not replicate all of the anxieties that it told them that other men were feeling.

This 'self-disgusted' letter-writer was not, however, alone in blaming masturbation. W. E. (1735) claimed to have 'aggravated' a natural weakness by 'some years' of 'the Scholastick Vice' (onanism).⁵¹ The absence of earlier letters makes it unclear how Carter and Roger Cook explained their leakages, but J. Hopson did at least blame sexual excesses, although recent exploits rather than past habits.⁵² He had urinary problems, penile pain, and a running

⁴⁷ BL, Sloane MS 4034, Hans Sloane consultations, ff. 303-305, from Timothy Carter, 6 February 1732 and 7 November 1734.

⁴⁸ [Marten?], *Onania*, pp. 19-21.

⁴⁹ Joseph Cam, *A practical treatise...* (3rd edn., 1729), pp. 9-11.

⁵⁰ BL, Sloane MS 4078, Hans Sloane consultations, f. 330, unsigned and undated.

⁵¹ BL, Sloane MS 4075, Hans Sloane consultations, f. 85, from W. E., 23 May 1735.

⁵² *Ibid.*, f. 32, from Roger Cook, 9 May; BL, Sloane MS 4034, Hans Sloane consultations, f. 303, from Timothy Carter, 6 February 1733.

most in the night... which makes me beleive [sic] that my Seminal Vessels are in fault... I have seen the Woman... who is perfectly well &... have at present no [venereal] Infection, & therefore think you'll not find it improper to prescribe... Restor[at]ives for the parts...⁵³

The sixth, aged fifty-two, explained his leakage by something entirely non-sexual, a blow to the abdomen, and gave no hint that he feared that masturbatory habits might be read into his affliction.⁵⁴

The six men's concerns also varied. Two (Hopson and the blow-victim) mentioned their leakages as symptoms rather than as a disorder in their own right, or as the cause of affliction or weakness.⁵⁵ For Hopson, they were part of a complaint confined, however, to the penis and urinary system. He was alarmed by what he thought the emissions revealed about his sexual organs – that, 'having made [very?] free with those parts... of late', the seminal vessels were no longer 'capable of containing what they ought'.⁵⁶ By contrast, while Cook's update revealed little about his interpretation of his complaints it did show that he felt the pollutions themselves to do immediate harm, he being 'always... much worse after them'.⁵⁷

Two others – Carter and W. E. – felt that the emissions were *collectively* debilitating. This was a fear that W. E. claimed to be so preoccupied by that it had

⁵³ BL, Sloane MS 4075, Hans Sloane consultations, ff. 264-264v, from J. Hopson, undated.

⁵⁴ BL, Sloane MS 4078, Hans Sloane consultations, ff. 370-370v, unsigned and undated.

⁵⁵ Ibid.

⁵⁶ BL, Sloane MS 4075, Hans Sloane consultations, ff. 264-264v, from J. Hopson, undated.

made him 'dispirited', the great number and amounts of medicaments that he had made use of highlighting the extent of this anxiety.⁵⁸ The 'self-disgusted' feared that he had 'enerv[a]ted my Strength' by *masturbation*, rather than by the resultant nocturnal pollutions, and listed several symptoms, only one described as being worse after such ejaculation. However, that he sought something to stop the pollutions, not to restore his strength, does imply that he somehow blamed them for his weakness and sinking spirits, or at least for their continuation.⁵⁹ Carter too noted that the pollutions were collectively debilitating, but thought their frequency 'more than can be consistent w[i]th my present State of Health' rather than its cause, made no expression of anxiety, and gave them comparatively little attention.⁶⁰

There were similar variations in the way in which these men understood their discharges as causing harm, but it is difficult to see how they made sense of the substance itself. Although referring to his emissions as nocturnal pollutions, suggesting something seminal, the 'self-disgusted' wanted medicines to 'strengthen my Reins and prevent [th]e[ir] frequency', at a time when 'the running of the reins' (kidneys) meant gonorrhoea.⁶¹ Similarly, the blow-victim referred to his leakage as 'a drop or two of Nature' (and something coming from the spermatic vessels) but also 'a sort of gleet'.⁶² What he meant by 'gleet' is uncertain, for it was used in one later-seventeenth-century practitioner's notes for both venereal runnings and any secretion of any 'moysture', anywhere.⁶³ In eighteenth-century printed texts, its use

⁵⁷ Ibid., f. 32, from Roger Cook, 9 May.

⁵⁸ Ibid., f. 85, from W. E., 23 May 1735.

⁵⁹ BL, Sloane MS 4078, Hans Sloane consultations, f. 330, unsigned and undated.

⁶⁰ BL, Sloane MS 4034, Hans Sloane consultations, f. 305, from Timothy Carter, 7 November 1734.

⁶¹ BL, Sloane MS 4078, Hans Sloane consultations, f. 330, unsigned and undated; John Barrow, *Dictionarium medicum...* (1749), 'Renes'; Thomas Sydenham, *Dr. Sydenham's compleat method...* (7th edn., 1737), p. 65.

⁶² BL, Sloane MS 4078, Hans Sloane consultations, ff. 370-370v, unsigned and undated.

⁶³ BL, Sloane MS 153, 'Chirurgical Observations' (c.1633-c.1663), Joseph Binns, e.g. ff. 80v, 49v, 229v.

was confined to gonorrhoeas, but while the majority saw gonorrhoeal runnings as coming from the urethra, not the spermatic vessels, there were some in the early 1700s calling them ‘the Semen’.⁶⁴ The meaning of ‘gonorrhoea’ could itself be unclear, for in *Onania* it was used for venereal discharges *and* those runnings striking the masturbator, even though the latter were characterized here as but a ‘waterish’, rather than purulent, ‘Seed’ (semen).⁶⁵

Cook was equally elusive, *apparently* distancing his unspecified ‘Pollutions’ from anything venereal by referring to a separate ‘gleet’, but thereby raising similar questions of meaning.⁶⁶ What Hopson thought his emission to be is only slightly clearer, for while he insisted that it was not venereal he referred to it as only ‘The Running’. He mentioned a ‘wound’ in the urethra yet referred to the running’s presence as a sign of debilitated seminal vessels (presumably ascribed to excessive ejaculation), rather than as a product of this urethral damage.⁶⁷ W. E. called his ‘Involuntary Nocturnal Pollutions’ ‘the Disease’ and ‘my Disorder’, but gave no indication of what he thought the fluid to be. Indeed, the letter initially made these his sole complaint, and, with the resultant weakness, his disease.⁶⁸

With the exception of Hopson, therefore, these men’s concerns lay in the presumed effect of the emissions, not in any underlying condition of the seminal vessels. It is difficult to know, however, whether it was the removal of the fluid, the manufacturing of its replacement, or the exertion (whether localized or general) of orgasm and ejaculation, that they thought to be harming them. Even if these five did blame the loss

⁶⁴ Richard Boulton, *Physico-chyrurgical treatises...* ([1715]), pp. 260-261.

⁶⁵ [Marten?], *Onania*, pp. 81 (i.e. 18), 19.

⁶⁶ BL, Sloane MS 4075, Hans Sloane consultations, f. 32, from Roger Cook, 9 May.

⁶⁷ *Ibid.*, ff. 264-264v, from J. Hopson, undated.

of the fluid itself it is unclear how they envisioned the relationship of this substance to bodily health. Certainly, in print there was no single way in the early- and mid-eighteenth century (and beyond) of understanding the semen as a fluid inside the male body.⁶⁹ At the least, these letters contain nothing proving that these men had sexed the fluid being emitted, or the effects of its loss. Another letter received by Sloane in the early 1730s did comment on the fluid emitted, although not to complain of the ejaculations themselves. Instead, the author observed, as an indicator of his poor health, that the ‘Seed’ emitted during his nighttime ejaculations was ‘not of a due Consistency’.⁷⁰ Yet, with the exception of one reference to (unstated) ‘Colours’, none of the six authors complaining of the fact of penile runnings or ejaculations, or of the repercussions of masturbation, said anything about the appearance of the substance found.⁷¹ None revealed that they saw the fluid as itself diseased.

Only the ‘self-disgusted’ revealed whether or not he still masturbated, not only dating the start of his symptoms to the time at which he ‘left off’ but also holding the habit responsible.⁷² That masturbation could offer itself as an explanation so long after allegedly abandoned *might* hint at the hold that the textual vilification, or explanatory framework, had gained. However, the other Sloane letter blaming masturbation was very different to the formulaic “‘confessions’” of self-declared victims’ sent to a contemporaneous French practitioner, with their self-abasement, loaded language, and tales of the fatal discovery, effects, and eventual abandonment, of the sinful habit.⁷³ Indeed, none of the letter-writers hinted at that ‘elite’ and ‘bourgeois’ insecurity about

⁶⁸ Ibid., f. 85, from W. E., 23 May 1735.

⁶⁹ Above, pp. 42-57.

⁷⁰ BL, Sloane MS 4078, Hans Sloane consultations, ff. 236-237, from Peter Patrick, 10 January 1731.

⁷¹ BL, Sloane MS 4075, Hans Sloane consultations, ff. 264-264v, from J. Hopson, undated.

⁷² Ibid., f. 330, unsigned and undated.

masculinity, or ‘virility, gender identity, and physical selfhood’, ‘self-control, marriage and population’, by which the printed genre’s success has been explained.⁷⁴ Although anxious about the harm that they thought the emissions to cause or reveal, for not one did this anxiety visibly extend to what these symptoms revealed about, or threatened for, their physical masculinity, their virility, or their fertility.⁷⁵

Part iii: Problematic Organs

Although fertility and potency were not anxieties that led men to consult Sloane, men did seek help for their sexual organs. As external parts, these were vulnerable to knocks. One twenty-one-year-old, having ‘reciv’d a blow’, had a ‘[c]ontused’ (bruised) testicle ‘very hard & much swelled, w[i]th Inflammation.& grate pains’, while Samuëll Curde ‘Hurt his Scrotum’ in 1712 or 1713 ‘getting over a pair of Barrs’.⁷⁶ Indeed, their position made the testicles and scrotum vulnerable even when sitting on a saddle.⁷⁷ Yet, for such exposed parts it is surprising how few men were recorded as being treated even for injuries exacerbating existing genital complaints.⁷⁸ While the seventeenth-century surgical notes compiled by Joseph Binns seem to record the largest number of professional encounters with men suffering in the genitals, even these include only one such disorder explained by injury.⁷⁹

The number of men recorded as receiving paid medical care for genital problems not visibly ascribed to injury is, however, far higher. Although diseases of the prostate were

⁷³ Michael Stolberg, ‘An Unmanly Vice: Self-Pollution, Anxiety, and the Body in the Eighteenth Century,’ *Social History of Medicine*, 13 (2000), pp. 1-22, quotation at p. 1.

⁷⁴ *Ibid.*, pp. 1, 6-7.

⁷⁵ Above, pp. 42-45, 70.

⁷⁶ WL, MS 2933, *Clinical cases (1778-1780)*, Francis Home, p. 178; WL, MS 3631, *Medical case-book*, Morgan, p. 37.

⁷⁷ WL, MS 6919, ‘Nicholas Gaynsford His Book’ (1712-1713), Nicholas Gaynsford, f. 12v.

⁷⁸ For an exception see RCS, MS 0189/1/3, ‘An account of the dissections of morbid bodies’ (men’s dated cases 1755-1782), John Hunter, no. 42.

not diagnosed during life, a variety of surgical disorders were known to affect the male genitals, with the testicular coats and scrotum prone to a range of ‘true’ and ‘false’ hernias.⁸⁰ The ‘true’, as one surgical manual summarized, were ‘tumors’ or ‘swellings in the groin, scrotum, belly, thigh, navel, &c’, ‘produced either by the descent, or protrusion of some of those parts which should... be contained within the cavity of the abdomen’. The ‘false’, by contrast, ‘are original disorders of the parts themselves’, ‘whether... from the induration and enlargement, or other affection of the parts themselves, or from the... accumulation of extravasated fluid’.⁸¹

‘True’ hernias were not unique to the sexual organs, let alone to the male ones, their catalysts – crying, leaping, straining, and constipation – were the same no matter what the part protruded into, and only females had unique causes coming from organs unique to their sex.⁸² However, and according to a French specialist in women’s hernias, they near-never occurred in or from the internal female sexual organs, and were simply non-sex-specific inguinal (groin) hernias when found in women’s external genitalia.⁸³ As complaints of the reproductive organs, ‘true’ hernias were, indeed, implicitly seen as primarily affecting males, although without explanation. The ‘false’, furthermore, were automatically discussed as scrotal and testicular ‘tumors’ and swellings,⁸⁴ recognized by even the practitioner of women’s hernias as almost exclusively male, and described by a specialist as ‘all diseases of the testicles, their coats and vessels’.⁸⁵

⁷⁹ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, f. 17v.

⁸⁰ The prostate did feature in anatomies, morbid anatomies, postmortems and printed discussions of gonorrhoea. See RCS, MS 0189/1/3, ‘An account of the dissections of morbid bodies’, John Hunter, no. 82, 125.

⁸¹ Percivall Pott, *Practical remarks on... hydrocele...* (1762), pp. 1-2.

⁸² Samuel Sharp, *A treatise on... surgery...* (1739), p. 13; Mademoiselle [Marie] Guiton, *Plain and familiar instructions on ruptures...* (1750), p. 4.

⁸³ Guiton, *Instructions*, pp. 2-3.

⁸⁴ Joseph Else, *An essay on the cure of the hydrocele...* (2nd edn., 1772).

Why the testicular and scrotal coats were so susceptible to ‘false’ hernias was not, however, something that eighteenth-century surgeons stated. One seventeenth-century midwifery author explained them by ‘too much repletion of the vessles of seed caused by much grosse or watry blood’, and in the eighteenth century it was only accumulations of fluid that prompted accounts that perhaps reveal why the testicular coats were believed to be so vulnerable.⁸⁶ It was ‘that Water’ ‘continually separating... on the internal Surface of the Tunick, for... lubricating the Testicle’ that was used to explain hydrocele, also called hernia aquosa or hydrops testis (fluid in the tunica vaginalis testis, the innermost testicular coat). A failure in its secretion was similarly given as the cause of hernia humoralis, another ‘false’ hernia.⁸⁷ Authors were not, however, claiming that hydrocele always stemmed from the testicles’ particular nature, or their secretions.⁸⁸ One, for example, argued that ‘true hernia aquosa’, which ‘rarely admits of more than a palliative cure’, ‘is from the abdomen, which either extends the peritonaeum into the scrotum, or breaks it, and then forms a new membrane’.⁸⁹ Another explained both hydrocele and scrotal anasarca by lymph fluid, released not because of any fault in the testicles but because of the condition of the lymphatics. His discussion of their *treatment* alluded to hydroceles caused by the inflammation of the testicle and tunica vaginalis testis, or the bursting of the latter’s vessels, but denied that the resultant swellings differed from those occurring elsewhere in the body.⁹⁰

Only three of the twenty-one or twenty-two ‘clean’ men who were recorded in Binns’s notes as suffering in their groin or sexual organs had disorders in which it was

⁸⁵ Pott, *Practical remarks*, p. 2.

⁸⁶ Jane Sharp, *The midwives book...* (1671), p. 10.

⁸⁷ Samuel Sharp, *Treatise*, p. 34; Percivall Pott, *An account of... a... radical cure of the hydrocele...* (3rd edn., 1775), p. 8.

⁸⁸ Daniel Turner, *The Art of Surgery...*, vol. 1 of 2 (1722), p. 224.

⁸⁹ William Cheselden, *The anatomy of the human body... The VIIIth edition...* (1750), p. 264.

inconsequential that it was these parts affected.⁹¹ The rest had ‘true’ or ‘false’ hernias, a scrotal fistula ascribed to a ‘false’ hernia, a testicular ‘tumor’ with an effect specific to the testicle (stiffness of the spermatic chord), and an eventually fatal complaint that began as a uniquely penile disorder, phimosis.⁹² However, not all men suffering in the sexual organs were suffering because of ailments unique to these parts, adopting a particular character when experienced here, a product of their own disorder, or even original to these organs. Indeed when the hospital surgeon Joseph Warner published *An account of the testicles, their... coats; And the diseases to which they are liable* (1774) it was generic surgical complaints, found anywhere in the body – ‘inflammation, suppuration or abscess, dropsy, mortification, fistulous ulcers, callosities, indurations, and... schirrhous’ – that he thought ‘[t]he[ir] principal diseases’.⁹³

The manuscript record shows surprisingly few men suffering from genital inflammations, mortifications, ulcers and callosities outside of venereal disease. It does, however, reveal men suffering in the scrotum, testicular coverings, and even penis, who actually had oedemas diffused across the loins or lower abdomen, just as publications claimed that *scrotal* anasarca was similarly but the product of a wider oedema.⁹⁴ The sexual organs were, indeed, often just sites where illness in neighbouring parts was manifested, for swellings of the penis or testicles, or testicular ‘retraction’, could be but effects of disorders in the urinary system, themselves sometimes attributed to

⁹⁰ Joseph Warner, *An account of the testicles, their common coverings and coats...* (1774), pp. 26, 35, 39.

⁹¹ Ulcers below the scrotum, a testicular ‘tumor’ and, perhaps seen as venereal, a penile and testicular gangrene (BL, Sloane MS 153, ‘Chirurgical observations’, Binns, ff. 7, 82, 90). ‘Sons’ are excluded unless there is reason to think them sixteen or older.

⁹² *Ibid.*, f. 196v.

⁹³ Warner, *Account*, p. 34.

⁹⁴ *Ibid.*, pp. 28, 42; RCP, MS 468, ‘Clinical Cases and Reports’, Monro, et al, first set, p. 149; WL, MS 5005, ‘Observations on particular Cases’ (1719-1750s), Dr Richard Wilkes, p. 77. As a physician rather than surgeon, the sample of 174 letters sent to Sloane included only five men with genital symptoms. In two these were venereal, and in three (1.9% of the 154 adult males) they had simply *spread* to the genitals.

gonorrhoea.⁹⁵ The particular nature of the male genitalia could, however, add extra elements to generic problems. According to surgical manuals, scrotal anasarca obstructed urination by making the penis swell, and hydrocele could ‘bury’ it, with ‘great inconveniences’ in urination and the sufferer temporarily ‘incapable of procreation’.⁹⁶

It was, however, the more specific testicular and scrotal complaints that received the most attention in print. Sir Percivall Pott (1714–1788), surgeon at St Bartholomew’s Hospital, acquired a specialism, publishing ‘a general treatise on ruptures’ (1756), rupture meaning hernia, an ‘account’ of a ‘true’ hernia touching the testicle (1757), another of ‘the hydrocele... and... other diseases of the testicle, it’s coats, and vessels’ (1762), and a guide to hydrocele’s ‘radical cure’ (1771), as well as claiming to be the first to ‘publicly notice’ scrotal cancer as an occupational disease (1775).⁹⁷ For Pott, there were numerous afflictions experienced in the testicles and scrotum, and these were far more specific disorders than Warner identified. As well as various ‘true’ hernias, the male organs were prone to ‘false’ hernias ranging from ‘wind-rupture’ (allegedly a false notion) to hernia humoralis, hydrocele (with different forms and sites, whether the coats of the testicles or of the spermatic chords), and a similar scrotal disorder. The scrotum, testicular ‘membranes’ and ‘spermatic process’ (presumably the spermatic chord)⁹⁸ were liable to ‘tumor[s]’ from ‘extravasated blood’, and other ‘false’ hernias came from distended blood vessels, scrotal or spermatic. ‘False’ hernias could, furthermore, happen

⁹⁵ WL, MS 6888, Clinical lectures (1749), John Rutherford, ff. 157-157v; RCS, MS 0095, Clinical lectures (1785), John Gregory, pp. 230-236.

⁹⁶ Warner, *Account*, p. 42.

⁹⁷ Percivall Pott, *A treatise on ruptures...* (1756); idem., *Practical remarks*; idem., *An account of a particular kind of rupture...* (1757); idem., *Radical cure*; idem., *Chirurgical observations...* (1775), pp. 63-67.

⁹⁸ Above, p. 84. The term ‘spermatic process’ was used almost solely in later-eighteenth-century manuals and printed cases discussing hernia, hydrocele and testicular cancer, but without definition. It was absent from anatomies and medical dictionaries.

not just in its coats but also inside the testicle itself, it being vulnerable to inflammation, injury, venereal disease, scirrhus, and cancer.⁹⁹

Penile ailments received less textual attention but publications did record generic conditions afflicting this organ, and even necessitating amputation.¹⁰⁰ Authors also said that there were disorders unique to the penis, and the product of its unique nature. One claimed in 1665 that he ‘could instance many’ who, because of paraphimosis (‘where the Prepuce... cannot be brought forwards’), had been incapable of intercourse.¹⁰¹ Indeed, there were supposedly ‘a great many... naturally... [thus] form’d’, and others who succumbed after ‘a sudden Retraction’ (although ‘[m]ost’ were venereal).¹⁰² The absence of non-venereal paraphimosis in the manuscript case notes is, consequently, surprising. Although it was claimed that natural cases usually occurred ‘without any Inconvenience’, sudden forms were said to be severe, their symptoms extending even to penile gangrene (itself recorded only by Binns, and only in venereal disease). Yet, even venereal paraphimosis was rarely recorded by anyone but, once, Binns.¹⁰³ Nor is there frequent manuscript record of surgeons treating non-venereal phimosis, even though publications claimed that it could be severe, and that ‘sometimes... Children are born imperforate’.¹⁰⁴ Authors did say that treatment was often confined to ‘venereal Cases’, but even these were frequently absent from unprinted records.¹⁰⁵

⁹⁹ Pott, *Practical remarks*, pp. 1-10, 23-33, 38-42, 57-63, 70-83, 117-120, 165-172.

¹⁰⁰ Joseph Warner, *Cases in surgery...* (1754), pp. 98-99.

¹⁰¹ Peter Chamberlain [pseud.], *Dr. Chamberlain's Midwives Practice...*(1665), p. 21.

¹⁰² Samuel Sharp, *Treatise*, pp. 54-55.

¹⁰³ *Ibid.*, pp. 54-55; BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, ff. 165, 170v, 208v.

¹⁰⁴ Samuel Sharp, *Treatise*, p. 53.

¹⁰⁵ *Ibid.*, pp. 53-54. For exceptions see WL, MS 3631, Medical case-book, Morgan, pp. 67, 97; BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, ff. 14v, 18, 196v.

The male experience of genital problems recorded in manuscript deviated from that suggested in print in other ways too. Instead of the generic surgical complaints highlighted by Warner, or Pott's range of swellings and hernias, those that men were recorded as suffering from outside of venereal disease were dominated by 'true' hernias and one particular 'false' hernia, hydrocele. Even these featured only inconsistently in the manuscript surgical record, although there were practitioners who hinted at a higher incidence of cases.¹⁰⁶ Thus, men with genital symptoms ascribed to venereal disease consistently outnumbered those suffering in their sexual organs from 'clean' disorders. London's Sir Edmund King noted only one penile and one testicular case between 1664 and 1684, with the latter diagnosed simply as 'paine in the stone [testicle]', yet saw at least seven men with venereal genital symptoms.¹⁰⁷ Penile disorders not labelled as venereal were especially rare, and the diagnosis might still have been implicit. King's patient, for example, had penile 'ulcers', a symptom often present when cases *were* venereal, and at some point underwent the salivation used to treat such infections.¹⁰⁸

Not even hernias appeared in the manuscript records of surgical practice with the frequency implied by publications. The London hospital for which Thomas Wallace left a record in 1710 had fifty male patients outside of the venereal ward with their name *and* illness or symptoms recorded, but none with a hernia in even an unspecified part.¹⁰⁹ Later in the century, Robert Brand, a truss-maker, claimed that hospital students 'seldom had an opportunity of seeing' hernias. Certainly, they were generally absent from clinical lectures, despite the inclusion of other surgical complaints. This might

¹⁰⁶ WL, MS 6919, Case notes and medical receipts, Gaynsford, f. 17.

¹⁰⁷ BL, Sloane MS 1588, Medical receipts and cases (c.1664-c.1684), Sir Edmund King, f. 203v.

¹⁰⁸ *Ibid.*, ff. 133-133v.

¹⁰⁹ RCS, MS 0180, Clinical notebook (1710), Thomas Wallace.

have been because, as Brand publicized, specialists were treating the poor for free.¹¹⁰

It seems possible, therefore, that hernias were a bigger part of the male experience of illness than they were of that sub-section treated by practitioners likely to keep notes or publish cases. It was not genital complaints that took soldiers to civilian clinical wards, yet it has been claimed that hernias were a frequent, dreaded, experience of theirs, and while naval surgeons often left little record of hernias there were enough for the eighteenth-century Greenwich naval hospital to have a 'Truss-Maker' and a 'Surgeon Extraordinary in Cases of Ruptures'.¹¹¹ Similarly, none of these manuscript casebooks recorded referring patients, yet Robert Brand boasted about the patients sent to him, and castigated the named 'eminent' practitioners directing patients to his supposedly charlatan rivals.¹¹² Seeking to explain to his readers why there were not more 'mention[ing] anything of my Truss', Brand claimed that 'many people who are subject to any disorder of that kind are fond of concealing it'.¹¹³ Perhaps, therefore, many men with hernias were consulting directly with the specialists who left no surviving record. Certainly, sufferers could choose in both centuries from a range of 'Instrument'- and truss-makers, or from retailers and practitioners promising 'Medicines and methods' for not only hernias but also 'faults of the Testicles'.¹¹⁴ Indeed, truss-makers alone covered the full spectrum from 'regular-bred surgeons' to such 'Mechanic[s]' as Brand, a

¹¹⁰ Robert Brand, *The rupture curers displayed...* (1771), p. 60.

¹¹¹ Philip Mills, 'Privates on Parade: Soldiers, Medicine and the Treatment of Inguinal Hernias in Georgian England', in Geoffrey Hudson (ed.), *British Military and Naval Medicine, 1660-1830* (Amsterdam and New York, 2007), pp. 149-182; BL, Sloane MS 2779, Diary of practice (1648-1652), John Cony, ff. 105-123 (none); BL, Sloane MS 3943, 'A Memoriall of My Practice...' (1706), Henry Watson, in 'Transactions relating to the Bishop of London 1786', ff. 167-180, esp. 168v (two); RCS, MS 0002, 'Observations and Cases 1781' (1776-1783), Nathaniel Bedford, p. 278 (one hernia humoralis between 1 July 1782 and 1 July 1783).

¹¹² Robert Brand, *Rupture curers*, pp. 10, 15-16, 22-27.

¹¹³ Idem., *The true method of reducing ruptures...* (1771), p. 8.

¹¹⁴ C. Bartlett, *Bartlett, at the Golden Ball...* [[1660?]] (original italicization).

former cutler and surgeon's-instrument-maker, and his 'Bedstead-Maker' rival.¹¹⁵

Part iv: The Experience of Hernias

Not all men experienced hernias, or apparently feared that they would do so. Some recorded their lifelong histories, or left decades' of daily diary entries, without any hint of such complaints, while others made collections of therapeutic information that showed no interest in their management.¹¹⁶ It was, however, hernias that dominated the non-venereal male genital cases recorded in manuscript notes of surgical practice, and they did so despite competition for these patients from specialists and truss-makers. Thus, thirteen of Binns's twenty-two men with clearly or potentially non-venereal complaints in or affecting the genitals or groin had 'false' hernias, two more testicular tumors that could potentially have been interpreted this way, and three 'true' hernias.¹¹⁷ Hernias were the only male genital complaints that Morgan did not approach as potentially venereal, and two of the three male genital patients seen by Firth between 11 November 1727 and 1 January 1730 had 'false' ones.¹¹⁸ They seem, therefore, one of the crucial ways in which possessing male sexual organs influenced men's collective medical experience.

Hernias could, furthermore, impinge heavily on the sufferer's life long before reaching the stage at which surgery became unavoidable. They were, for example, the only disorders of his own – and thus the only ailment not recorded for being a cause of death – that the Reverend Alexander James (d. 1803) entered in his record of the events of 1751-1802. James almost never used religious exhortations but they were made when in

¹¹⁵ Robert Brand, *Method*, pp. 8-9 (original italicization).

¹¹⁶ WL, MS 4021, Astrological diary (1673-1737), Norris Purslow. C.f. below, p. 294.

¹¹⁷ BL, Sloane MS 153, 'Chirurgical Observations', Binns.

¹¹⁸ BL, Sloane MS 45670, Accompt-book (1727-1738), Joshua Firth, f. 175; WL, MS 3631, Medical case-

1766 he entered that

I had suspected for a month... that I had or was going to have an hernia.... Being obliged to go to Camb[ridge?] I consulted Mr Hayles an eminent surgeon... who after mature consideration pronounced to be so; by whose advice I began to wear a truss this day. O my God, I beseech thee to lighten this heavy affliction. or inspire me with a true Xtian [Christian] patience.

He later added

a 2d on Feb.25.1772

a 3.d on March 21. 1774.¹¹⁹

What this meant for his daily life was not commented on. If James was forced to use anything in addition to his truss – whether to encourage the guts to return to their proper place or to manage the pain – it was not recorded. Nor were hernias included in the various curative and palliative instructions saved in his diary. Yet, even ‘the beginning of a rupture’ (testicular or in the groin) was enough to prompt one practitioner to issue a fairly restrictive regimen in 1721, despite claiming that the condition ‘never (but by neglect) obstructs the ordinary functions of life’. Believing that hernias came from ‘the laxity of too tender [peritoneal] fibres’, he barred Sir John Clerk (1650-1722) from sleeping on the affected side, ‘[a]ll violent exercises... such as leaping, running, dancing, hard riding &c’, ‘all flatulent meats’ and ‘[a]ll unctuous things which are relaxing’ (including ‘oyl & butter’). Clerk was to cauterize the skin, maintain

book, Morgan, pp. 8, 18, 97.

‘constant... pressure... on the part by a bandage’, use the cold bath, and keep the ‘belly’ ‘soluble’ with rhubarb.¹²⁰

For some men however, such management eventually failed. Yet, surgery was far from a guaranteed solution, even before in ‘true’ hernias the signs of the ‘strangulation’ of the protruding intestines or omentum (the abdominal peritoneum) revealed that ‘the last extremity’ was approaching.¹²¹ Binns’s hernia cases were not a select sample, yet not one was simple, short-term, or easily resolved. Of the patients with ‘true’ hernias, one died seven days after it began (the hernia *filling* the scrotum, and three practitioners each failing to reduce it), another suffered severely on knocking one already in a truss, and a third’s case was labelled ‘Rupture out[,] not to be red[uced]’. He,

for some yares... troubled w[i]th a Rupture... wore a steele Trusse
w[i]ch kepte it up, [but] haueinge a taken coulde... [it] came
downe..., & hee could not put it up as formerlye he had done sent for
Bostocke whoe made his Trusse & he forceinge & Crowdeinge... it,
& bounde his Trusse... harder, then he used to weare it w[hi]ch put
him to soe muche payne he could not Indure it...

Binns ‘founde it much strutte w[i]th winde in Scrotu[m]’, and impossible to ‘moue nor sturre’, with the spermatic chord ‘much swelled & harde all alonge... into the musckles

¹¹⁹ WL, MS 3012, Diary (1752-1812), Alexander James, entry for 2 July 1766 (unpaginated).

¹²⁰ NAS, GD18/2125/30, Clerk family papers, Medical recipes and prescriptions (1647-1859), Clerks of Penicuik.

¹²¹ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’ (men’s dated cases 1774-1802), John Hunter, no. 54.

of the Abdomen'. He did, however, eventually return it, and 'it kepte up'.¹²²

Binns's 'false' hernias were just as problematic, and these were the ones approached in print as disorders exclusive or near exclusive to the testicles and scrotum.

Accumulations of fluid grew quickly, re-formed after the fluid was released (by 'tapping'), and reached substantial sizes. Thomas Burten's was egg-sized, just a year after 'tapping', and Henry Hooker's head-sized, while Mr Williams's filled the scrotum and buried the penis despite having been 'tapped' thrice in three years.¹²³ All of these, and others, had been present for at least a year, and Will Gwatkin's four.¹²⁴ Many men were repeat patients, the swelling sometimes regrowing so quickly that 'tappings' were only months apart.¹²⁵ Thus, Samuel Davison's was 'tapped' in spring 1653, and again in October, but a range of medicaments failed to prevent it re-filling again. The notes were often inconsistent in the surnames given to individuals and if this was the Mr Davisonne operated on for the same complaint in June 1654, and well by August, he was one of only two of Binns's male hernia patients to be classed even temporarily as cured.¹²⁶ Nor was Davison's the only severe 'false' hernia. The hernia carnososa (testicular growth) was rotten and full of blood and fungus, and the testicle hand-sized. The particular nature and parts of the male genitalia created further problems when, pulled up by the contracting spermatic chord, the testicle fused with the intestines.¹²⁷

Although the frequent failure (particularly by Binns) to record ages conceals any profile, being a hernia sufferer in the testicles and scrotum was not limited to infancy

¹²² BL, Sloane MS 153, 'Chirurgical Observations', Binns, ff. 195, 225v, 87. Binns's treatment of hernias is discussed in Beier, *Sufferers*, pp. 85-86.

¹²³ BL, Sloane MS 153, 'Chirurgical Observations', Binns, ff. 16, 17v.

¹²⁴ *Ibid.*, ff. 26, 17.

¹²⁵ *Ibid.*, ff. 16, 26, 231, 233v.

¹²⁶ *Ibid.*, ff. 124, 229v.

and old age. There were, indeed, many old men being treated for ‘true’ hernias. John Clerk’s practitioner called it ‘a distemper to which *infancy* and *old age* are equally lyable’, and Morgan’s patients were both seventy and had had their hernias for five years or more and ‘for many years’.¹²⁸ Where stated, the men in John Hunter’s mainly later-eighteenth-century ‘morbid anatomies’ who had ‘true’ or ‘false’ hernias had had them since ‘infancy’, for twenty years, and (for two men, one aged sixty-three) for ‘many years’, although a ‘young Lad’ ‘had got the disease’ near instantly, in a fall.¹²⁹ However, while they might usually have needed time to reach the most troublesome stage, not even fatal hernias were the unique preserve of the elderly. A twenty-four-year-old ‘gradually sunk under’ and died from a congenital testicular hernia (shown after death to have been irreducible), and another man was only forty when his testicle grew as big as ever within ‘a few hours’ of ‘tapping’.¹³⁰

Furthermore, that men were compelled to live with hernias for many years might not have always meant a life of constant agony and fear.¹³¹ Many were living full and active lives, and living with hernias so successfully as to allegedly become complacent. Hydroceles were supposedly painless unless handled roughly or allowed, through neglect, to reach obscene sizes, with their palliative treatment allegedly ‘trifling’ (‘merely... letting out the water occasionally’) and their radical cure ostensibly just as easy.¹³² Indeed, not even men requiring surgical reduction for

¹²⁷ Ibid., f. 214.

¹²⁸ NAS, GD18/2125/30, Clerk family papers, Medical recipes and prescriptions, Clerks (my emphasis); WL, MS 3631, Medical case-book, Morgan, p. 8.

¹²⁹ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, John Hunter, no. 51, 52, 55, 68; RCS, MS 0189/1/3, ‘An account of the dissections of morbid bodies’, idem., no. 42.

¹³⁰ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, idem., no. 84, 50.

¹³¹ As also suggested for the fourteenth century (Michael McVaugh, ‘Treatment of Hernia in the Later Middle Ages: Surgical Correction and Social Construction’, in Jon Arrizabalaga, Andrew Cunningham, Roger French and Luis Garcia-Ballester (eds.), *Medicine from the Black Death to the French Disease* (Brookfield, VT and Aldershot, 1998), pp. 131-155, esp. 136).

¹³² Pott, *Radical cure*, pp. 11-12, 15; idem., *Practical remarks*, p. 42.

‘true’ hernias were automatically doomed if unable to afford it. Suffering from a groin hernia, one servant’s inability to afford surgery led to an inability to work, inactivity to weight gain, and this to the growth of the protrusion. The resultant hernia was ‘so large’ that John Hunter concluded that it was incurable, having ‘endeavoured repeatedly to reduce it by every... means’. Yet, the omentum shrunk when the patient lost weight through ‘living low’ and an unrelated sickness, and by ‘lying much in a horizontal position, the contents... went up’ naturally.¹³³

Not even hernias that became so severe as to cause death necessarily prevented men from living normal lives, or dominated their lives. That even those in John Hunter’s collection of cases and morbid anatomies were labelled by their occupation suggests that many hernia sufferers – including those eventually killed by their afflictions – continued to work. Indeed, only one of these Hunterian ‘true’ or ‘false’ hernia sufferers was described as living off charity, after *successful* surgery, by choice rather than necessity, and as a curiosity.¹³⁴ Even protrusions that could not be returned could still be easy to manage and live with, right up to the moment that an unprecedented amount fell down, prompting agonizing pain, gangrene, speedy surgery, or sudden death. Mr Poor had his scrotal hernia ‘for many years’, but was throughout a ‘lusty man’ and ‘otherwise healthy’, even though it was eventually to kill him, in his sixties.¹³⁵ The same was true of inguinal hernias, which neither universally nor automatically had negative effects upon the neighbouring genitalia. Mr Roberts’s was also finally fatal, yet despite having had it ‘for many years’ he was always able to work and it ‘became so well that he often left the truss off’.¹³⁶ Another ‘very seldom proved more than an inconvenience’

¹³³ RCS, MS 0189/1/1, ‘Cases and observations’, John Hunter, no. 121.

¹³⁴ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, *idem.*, no. 54.

¹³⁵ *Ibid.*, no. 68, 55.

¹³⁶ *Ibid.*, no. 68.

throughout the fifteen years that it was left un-reduced, and, indeed, right up to the very moment that, it was presumed, an unprecedented amount fell down, causing death.¹³⁷

Consequently, hernias were not always a constant source of anxiety. A. B. had since ‘infancy’ one that ‘at times... came down, but he was always able to reduce it’, only ‘sometimes wore a truss’ and ‘*often neglected it*’. Poor ‘wore the Truss but seldom could get one to keep the contents of the abdomen up and then became *rather negligent*’. This did not, however, have repercussions, for it was instead a cough that was blamed for the guts eventually, and fatally, coming down ‘more violent’ than ever.¹³⁸ Nor was John Hunter alone in stating that prior to an eventual ‘strain’- or blow-induced falling-down even the aged sometimes had little trouble from hernias. Morgan’s elderly sufferer had his ‘for many years... with very little trouble for he had worn a truss for some time by w[hi]ch means he had a palliative cure’. It was only on ‘straining himself violently’ that ‘it came down’, the patient making it worse precisely because it had always been so easy to manage. ‘[T]hinking to reduce it *as he formerly had done with abundance of ease*... he caused an inflammation by w[hi]ch it could not... be reduced’. Yet, he was made ‘very likely to do well’ with herbal glisters, a cataplasm of lard and sheep dung, and herbal remedies for his vomiting and wind.¹³⁹ Not all sufferers of even severe cases were forced to undergo surgery. Despite the inflammation and massive swelling, Morgan, only an apprentice, cured his other patient with five days of a cataplasm (with no effect), and two of a scrotal pledget (pad or compression), followed by a purge and ointment.¹⁴⁰

¹³⁷ Ibid., no. 52.

¹³⁸ Ibid., no. 51, 55 (my emphasis).

¹³⁹ WL, MS 3631, Medical case-book, Morgan, p. 8 (my emphasis).

¹⁴⁰ Ibid., p. 18.

Not all sufferers were, however, lucky, and surgery and ‘tapping’ were experiences potentially awaiting men of any age. Indeed, surgical reduction for ‘true’ hernias was an experience potentially occurring at any time. Even those that seemed easily and successfully managed, with few symptoms, were vulnerable to any knock (even whilst held up by trusses), or could fall at any minute. A servant was able to manage his inguinal hernia with a truss ‘soe as it was noe trouble’, but when he banged it on a gate it fell out, hardened, and refused to return, with agonizing effects.¹⁴¹ Similarly, when another hernia patient ‘bruise[d] [th]e... part against [th]e pummel of his saddle’ ‘it immediatley became painfull & hard with a large inflamation, his... testicle... as big as my fist’.¹⁴² Surgery could itself fail, for of the five men in John Hunter’s morbid anatomies killed by ‘true’ hernias, one died before surgery could be performed, one after manual reduction, and three within hours or days of a seemingly successful operation.¹⁴³ ‘Tapping’ similarly failed to improve a hydrocele patient’s damaged constitution, or to remove the pain caused by the thickened spermatic chord. He was still suffering half a year later, when another ailment took his life.¹⁴⁴

Part v: Anxious Masculinity?

Perhaps unsurprisingly, it was ‘true’ and ‘false’ hernias that dominated those disorders of the male sexual organs included in eighteenth-century surgical publications. Yet, authors did not openly term these disorders of men. Indeed, seventeenth-century manuals, handbills and adverts had had various ways of categorizing hernias and their sufferers. While some discussed these as afflictions in the scrotum, or gave lists of

¹⁴¹ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, f. 195.

¹⁴² WL, MS 3631, Medical case-book, Morgan, p. 18.

¹⁴³ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, John Hunter.

¹⁴⁴ *Ibid.*, no. 85.

successful cures dominated by men,¹⁴⁵ others advertised their services to ‘Men, Women, or Children’ alike.¹⁴⁶ Others singled out infants, or called hernias one of the ‘attendant Distempers’ of teething, or ‘false’ hernias a childhood disease.¹⁴⁷ Indeed, this concern with childhood hernias was reinvigorated by the mid-eighteenth-century interest in congenital hernias, Pott noting only at the end of one such treatise, when proving something else, that ‘by far the greater number of children... ruptured... are males’.¹⁴⁸

Surgical and medical texts did not, therefore, formulate disorders of the testicles and scrotum (or penis) as ‘men’s diseases’. Nor did writers of any type set out to do this for men’s *sexual* problems. Robert Turner was highly unusual in the interest in, and concept of, ‘particular diseases belonging to men’ given in his mid-seventeenth-century additions to an Italian text on women’s health. Yet, Turner said nothing about sexual or reproductive problems, and included only one non-venereal problem of the genitals (hernias, *apparently* scrotal).¹⁴⁹ The original author had already discussed male sexual problems in his content on women’s health, and some texts for ‘ladies’ continued to make these an expressly female concern.¹⁵⁰

It was instead the German physician Michael Ettmüller’s (1644-1683) collected works, published in Britain in Latin in 1685 (and translated in 1699), that offered a notion of

¹⁴⁵ Sir Richard Carew, *The Warming Stone...* (1640), p. 4; Thomas Moulton, *The Compleat Bone-Setter* (1665); Anon., *Ruptures cur’d by Bartlett...* ([1660?]).

¹⁴⁶ John Peachi, *Some Observations... upon... Molucco Nuts...* (1672); Richard Collings, *Men, Women, or Children...* ([London, 1689]); Anon., *Men, Women, or Children...* ([1680-1700]); John Taylor, *Pulvis Contra Herniam...* ([1700?]).

¹⁴⁷ Lewis Millwater, *The Cure of Ruptures...* (1651); John Choke, *The Famous and Virtuous Necklaces* ([1680?]); Moulton, *Bone-Setter*, pp. 30-31, 40, 36, 27; Thomas Chamberlayne [pseud.], *The Compleat Midwife’s Practice...* (2nd edn., [London, 1659]), p. 167.

¹⁴⁸ Pott, *Particular kind*, p. 31.

¹⁴⁹ Alessandro Massaria (1510-98), trans. Robert Turner, *De morbis foemineis... Whereunto is added, The mans counsellour...* (3rd edn., 1659).

¹⁵⁰ E.g. Physician, *The Ladies Physical Directory...* (3rd edn., 1727). This was also a topic taken up by venereal disease specialists.

‘the Diseases Peculiar to the Male Sex’. Covering both ‘the Defect or Insufficiency’ of the semen and ‘Disorders relating to... Erection’, this chapter on males also summarized the signs of six types of testicular swellings (or ‘false’ hernias), including hydrocele, and gave mainly herbal directions for their treatment. Significantly, their inclusion was predicated on these being ‘Causes of the Deficiency of the Seed relating to the Stones’.¹⁵¹ Yet, this was a way of envisioning the disorders of the male genitalia that seemed to have little influence. Physicians’ texts continued to recognize only the categories of women’s and children’s diseases, while surgeons’ discussion of ‘false’ hernias made no mention of the semen. Instead, they explained their profession’s concern with such disorders as hydrocele by their being ‘so troublesome and inconvenient’ as to be ‘some of the most important diseases and operations of surgery’.¹⁵²

With eighteenth-century surgical authors often uninterested in barriers to male reproductive potential, their instructions for genital and urinary surgery failed to replicate even Jane Sharp’s seventeenth-century warnings against the surgical mistakes that risked impotence or infertility.¹⁵³ Even when discussing the relative merits of surgical and non-surgical procedures for hernias they said nothing about sexual functioning, ‘virility’, or masculinity, made no elevation of the testicles or reference to their functions, and voiced no warning that patients would have prejudices to be managed. Indeed, it was the disorders of the layers *covering* the testes, and only these, that some authors singled out as a unique category, as the diseases of the testicles. If

¹⁵¹ Michael Ettmüller, *Ettmullerus Abridg’d...* (2nd edn., 1703), ‘Book III. Of the Diseases Peculiar to the Male Sex’, pp. 557-577.

¹⁵² Pott, *Radical cure*, p. 1; John Hunter, ‘Observations on the State of the *Testis* in the *Foetus*, and... *Hernia Co[n]genita...*’, in William Hunter, *Medical Commentaries. Part I...* (2nd edn., 1777), pp. 75-89, quotation at p. 83.

¹⁵³ Jane Sharp, *Midwives book*, pp. 18, 26.

disorders affecting the testicle themselves were added they were not problems in their semen-manufacturing functions, or even in their muscles, or their blood, lymphatic or seminal vessels.¹⁵⁴ Authors had even less interest in ‘clean’ penile disorders. Even more so than with the testicles, it was the diseases involving the covering that attracted attention, yet without reference to their obvious repercussions in erection.¹⁵⁵

There is, furthermore, little evidence of either anxiety about the genital completeness of men, or individual alarm about personal incompleteness, and whether in print or manuscript. While this might have been because hernias were often in the coverings or scrotal skin *around* the testis, even that congenital ‘true’ hernia in which the protrusion entered ‘the Testicle itself’, ‘frequently attendant upon new-born children; and sometimes met with in adults’, did not prompt *surgeons* to react any differently, in print at least.¹⁵⁶ Authors also showed little interest in men with undescended testicles, although these apparently did exist. John Hunter, for example, discovered by chance during a postmortem that a twenty-four-year-old operated on by Mr Long at St Bartholomew’s Hospital for a hernia had a testicle still unfallen. Although Hunter was supposedly seeking ‘every opportunity of learning... the state of the *testis* before and after birth’, ‘the original situation of the *testes*’, and the mechanisms of their descent, this patient’s undescended testicle merited only the comment that it was ‘well formed but not so large as the other’.¹⁵⁷ Issues involving the descent of a testicle led another of Long’s St Bart’s hernia patients to surface in Hunter’s curious cases. Again, the interest

¹⁵⁴ Warner *Account*; Pott, *Practical remarks*.

¹⁵⁵ E.g. Edward Dunn, *A compendious... method of performing chyrurgical operations...* (1724), pp. 63-64.

¹⁵⁶ Pott, *Particular kind*, title page; John Hunter, ‘Observations’, p. 89; Albrecht von Haller, *Opuscula Pathologica* (Lausanne, 1755); Samuel Sharp, *A critical enquiry into... surgery* (1750), p. 3; William Hunter, *Medical Commentaries*, ch. IX, ‘Of the Rupture, in which the Testis is in Contact with the Intestine’, pp. 70-90.

¹⁵⁷ John Hunter, ‘Observations’, p. 80; RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, *idem.*, no. 50; William Hunter, *Commentaries*, p. 72 (original italicizations).

was not the testicle but the hernia that, on ‘straining’ and coughing, had followed its (post-pubescent) descent.¹⁵⁸

Thus, unfallen testicles in older males received little attention, and their consequences none. The authors of later-seventeenth-century midwifery manuals had not only noted the existence of men with only one descended but also linked this to being ‘excessive prone to lechery’, calling such men ‘Monsters’.¹⁵⁹ Yet, they failed to descend frequently enough for John Hunter to use the *usual* location of men’s non-fallen testicles to speculate about barriers to their infantile descent.¹⁶⁰ How he had obtained this knowledge is unclear, for there is little in medical consultations, or in surgeons’ interests in writing and dissecting, to show that incomplete testicles were causing concern. Practitioners left no manuscript record of being consulted about undescended testes, and with so many venereal cases it is surprising that none noted coming across this during examinations. It seems that if absent testicles were making parents anxious they were reluctant or unable to pay for consultations, using practitioners who saw such examinations as unworthy of record, or consulting those who did not leave notes. Certainly, there is no evidence of undescended testicles bringing boys’ sex into doubt. John Marten, *Onania*’s suspected author, recalled in 1709 how ‘[s]ome authors’ had told of boys who ‘had pass’d for Girls’ until violent action during puberty had caused the testicles to drop. However, whilst claiming to have himself seen a thirteen-year-old with no testicles, and a penis ‘scarce an Inch out’, he added that he ‘never saw all the genitals ‘so obscur’d as not to discover the Sex’.¹⁶¹

¹⁵⁸ RCS, MS 0189/1/1, ‘Cases and observations’, John Hunter, no. 69.

¹⁵⁹ Chamberlain [pseud.], *Dr. Chamberlain’s*, p. 5; Jane Sharp, *Midwives book*, p. 12.

¹⁶⁰ John Hunter, ‘Observations’, p. 80.

¹⁶¹ Marten, *Gonosologium*, p. 5.

It is even more uncertain how many men might have had *removed* testicles. When the rupture surgeon Thomas Brand railed against truss-sellers in 1785 he argued that the erroneous use of their wares would leave the testes ‘entirely dissolved’, and the man ‘*emasculated* and destroyed’, for by necessitating castration ‘improper trusses’ were ‘liable to be attended with a consequence that every man must naturally be solicitous to avoid... the total deprivation of virility’.¹⁶² Yet, whether or not castration was happening sufficiently frequently to cast fear into the hearts of men in general is unclear. It has been said of Renaissance Italy and seventeenth-century Spain that this was a ‘common practice’ when operating for ‘common health problems’, or when claiming to cure boys of hernias.¹⁶³ Indeed, ‘[u]p until the mid-eighteenth century hernia surgery usually involved the removal of testicles’, at least in Spain.¹⁶⁴ Yet, in all of the manuscript materials studied here only one man was even partially castrated. ‘[H]aving long suffered’ an abscess, ‘& having passed through negligent hands’, this ‘young fellow’ ‘was at last as an object of Charity recommended to’ Morgan. ‘I purposed extirpation it being [th]e only way to save [th]e other to w[hi]ch he *redely consented*’.¹⁶⁵

According to Pott, one fifty-year-old was already decided against castration when first approaching him about a hardened testicle, announcing ‘that he only wanted to know whether he could be cured... without castration, which he was determined not to submit to’.¹⁶⁶ Yet, this was unusual even in print. If men still feared, as in the Middle Ages, that the loss of a testicle would threaten their virility and reproductive prospects, and

¹⁶² T[homas] Brand, *Chirurgical essays on the cure of ruptures...* (2nd edn., 1785), pp. 118, 22, 18 (my emphasis). C.f. above, pp. 42-45, 70.

¹⁶³ Valeria Finucci, *The Manly Masquerade. Masculinity, Paternity and Castration in the Italian Renaissance* (Durham, NC and London, 2003), p. 250.

¹⁶⁴ Edward Behrend-Martinez, *Unfit for Marriage: Impotent Spouses on Trial in the Basque Region of Spain, 1650-1750* (Reno, LV, 2007), p. 129.

¹⁶⁵ WL, MS 3631, Medical case-book, Morgan, p. 30 (my emphasis).

¹⁶⁶ Pott, *Practical remarks*, pp. 215-216.

resisted castration accordingly, this prompted no published comment.¹⁶⁷ Indeed, publications imply that castration was actually happening frequently. Warner, for example, claimed that it was being performed too often, because of misdiagnosis, while also saying that he himself had ‘of later years castrated’ ‘several’, even for hydrocele.¹⁶⁸ Another hospital surgeon had already claimed in 1739 that castration was happening overly-frequently, and blamed practitioner error. However, he argued that patients themselves pushed for it, claiming to ‘have known’ of two men who had demanded castration because ‘so uneasy under... such a load in their *Scrotum*, tho’ *not otherwise in pain*’. He might have known of more such cases, for these two were mentioned only because their requests had been fatal, supporting his warning to be ‘cautious how we expose a Life for... *convenience* only’.¹⁶⁹ This surgeon warned about the risk of death, not of infertility or emasculation through castration.

There is also little to suggest that Thomas Brand’s colleagues shared his belief that ‘[t]he danger of emasculation is... sufficient to deter a surgeon from’ using, in his opinion, ‘an uninformed Truss-maker’.¹⁷⁰ Certainly, surgical manuals failed to make such criticisms despite their interest in extreme, mismanaged, cases – and their rivals’ failings – and Samuel Sharp actually extolled the virtues of trusses.¹⁷¹ Binns’s account of the truss-maker who tried to force a hernia back into a truss was the only time that these practitioners’ private notes referred to trusses negatively.¹⁷² None noted in manuscript treating a man after the erroneous use of a truss, let alone for any resultant testicular damage, or subsequent infertility, impotence or effeminacy. Nor did they

¹⁶⁷ McVaugh, ‘Hernia’, pp. 137-138, 140.

¹⁶⁸ Joseph Warner, *Cases in surgery...* (4th edn., 1784), p. 294.

¹⁶⁹ Samuel Sharp, *Treatise*, pp. 48, 24-25 (first italicization original, others my emphasis).

¹⁷⁰ Thomas Brand, *Chirurgical*, p. 22.

¹⁷¹ Samuel Sharp, *Treatise*, p. 13.

¹⁷² BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, f. 87.

record seeing men who had allowed their hernias to worsen out of a refusal – from patient or surgeon – to use one. Certainly, John Hunter’s anatomies suggest that trusses were not leaving users terrified that their ‘virility’ was being endangered. On the contrary, they actually seem to have made the Hunterian sufferers overly confident, and to have done so because of the reduction of pain that they brought.

If a specifically *testicular* hernia had any additional signification it rarely made its way into case histories, manuscript or print. The men who suffered from hernias generated very few medical records demonstrating that what concerned them was any threat to fertility and potency, the bodily signs of ‘virility’ or their *socially perceived* masculinity, fertility or sexual prowess. Robert Brand, the truss-maker, gave no explanation when claiming that ‘people’ (of unspecified gender) concealed their being afflicted, and it was exceptional for any party to leave evidence of requesting that ‘[i]f... necessary to have a steell Truss you will... pack it up so as not to be known’.¹⁷³ Indeed, when Bishop Petrie needed a ‘Rupture Truss’ in 1778 he simply had a clergyman in Edinburgh obtain one. It was sent with the books and official seal also requested by Petrie, and via the colleague’s brother.¹⁷⁴ Similarly, the anxiety that the Reverend James attached to the complaint apparently came from its painfulness, not from any unique meaning of the organs, and it was habit rather than embarrassment that saw John Clerk relying on a practitioner relative.

Indeed, there were some sufferers whose attitudes, as revealed in their laying-off of trusses, were apparently unaffected by the fact that it was the sexual organs affected, *or* by the fast and agonizing way in which others died. It is even unclear how far ‘true’

hernias were seen as genital problems. Their dangerousness was unrelated to the maleness of the sexual parts, or to their sexual nature, while the unique character of these organs usually came into play only when the spermatic chord became affected, mainly through its effects on the abdominal organs.¹⁷⁵ Thus, Etmüller put ‘true’ hernias not with the (genital) conditions ‘peculiar’ to males but under abdominal disorders, classifying them with anal prolapse as ‘the Vicious Postures of the Guts’.¹⁷⁶

Conclusion

These findings suggest that both the physical and the medical experience of the sexed male body could be problematic. At the very least, they reveal that there was a range of disorders and symptoms to which the penis, testicles, testicular coats, and scrotum were subject. While some of these also attacked non-sexed body parts or the female sexual organs too, occasional other diseases and effects were believed to be unique or near unique to the male genitals, or to at least assume a very particular manifestation (or danger) here. Significantly, even non-sexual disorders of or involving the male sexual organs had the ability to create an apparently distinctive male bodily experience, and one that could potentially involve long-term, unpredictable, or recurrent suffering.

Importantly, however, men were not without recourse in the resolution of such suffering. On the contrary, this research points to several fairly positive observations about men’s ability to seek professional relief for genital, venereal, and perhaps even sexual disorders. In particular, its findings argue that men were able to actively seek – and receive – treatment for a whole host of ‘clean’ genital complaints, as well as for

¹⁷³ Robert Brand, *Method*, p. 8; WL, MS 6868/9, Letters to Robert Whytt (1757-1765), copy-letter (no author named), 15 March 1763.

¹⁷⁴ NAS, CH12/24/288, Bishop Petrie’s correspondence, John Allan to Arthur Petrie, 8 June 1778.

¹⁷⁵ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, John Hunter, no. 85; Guiton, *Instructions*, p. vi.

venereal disease, allegedly non-venereal penile discharges, and unwanted ejaculation. Indeed, not only professional advertisements but also manuscript and printed patient histories reveal that men requiring paid help for ‘true’ and ‘false’ hernias in the testicles and scrotum, for example, had a great choice of practitioners, retailers, and medical services available to them. Certainly, and far from being cowed into submission, their case histories show that men with disorders in the genitals and with venereal disease felt free to dispense with, and replace, practitioners whose successes they deemed inadequate.

On similar lines, these sources also demonstrate that mainstream, professionally respectable, and even professionally famed, practitioners were making such care available to men with genital problems and venereal disease, and, indeed, making it available even to poorer men.¹⁷⁷ Mixed practitioners and general surgeons seem to have accepted, rather than turned away, such patients, and to have done so despite the great difficulty that could evidently attend their treatment. Indeed, these findings also lead to the observation that the experience of *receiving* treatment for ‘clean’ genital problems was not one that such professional participants of the kind likely to produce manuscript case books proceeded to swathe with an air of secrecy and charlatanry, encouraging male sufferers to regard their problems – or themselves – as requiring or deserving this. This study has made little reference to the services also made available by more informal practitioners, truss-makers, and medical retailers. However, its findings from within recorded practice suggest that while informal specialists did make themselves available to men requiring treatment for such disorders as hernias, thereby increasing

¹⁷⁶ Etmüller, *Etmullerus Abridg'd*, pp. 141-144.

¹⁷⁷ Those seventeenth-century men with venereal disease who used Binns’s services, for example, included a gardener, clerk, coachman, linen-draper and tavern cook, servants and artisans, and the ‘men’ of these and similar tradesmen (BL, Sloane MS 153, ‘Chirurgical Observations’, Binns).

their curative options, this does not indicate that ‘clean’ problems of and in the male genitals were surrounded by stigma. On the contrary, this was a time of pervasive surgical specialism, with licensed, and even professionally elite, surgeons allegedly patronizing Robert Brand and his rivals, and absorbing them into institutional medicine.¹⁷⁸ Indeed, these materials show that in both centuries many men sought out *mainstream* practitioners for genital problems both ‘clean’ and venereal, sometimes very quickly. In their subsequent encounters with such practitioners they were, furthermore, able to be honest and open about their disorders, even though some case notes suggest that not all men with venereal actually disease chose to do this.¹⁷⁹

Similarly, these sources also suggest that the patient who approached Pott having already decided to refuse castration was atypical in allowing fears about masculinity or virility to obstruct his treatment, if indeed these were his concern.¹⁸⁰ In this sample, and at least once that males with genital problems or venereal disease had chosen to seek assistance, treatment apparently proceeded uninterrupted, without hindrance from any embarrassment associated with the genitals as body parts, or any association of genital problems with threats to virility or masculinity. Certainly, not one of the seventeenth- or eighteenth-century practitioners’ records considered here noted men refusing to have their sexual organs physically examined, no matter what their claimed or suspected complaint. Indeed, the openness with which the six men wrote to Sloane about ejaculations and penile discharges raises the possibility that men with similar symptoms could also have been equally frank in face-to-face medical care.

¹⁷⁸ Brand, for example advertised himself as truss-maker to the Greenwich Hospital (Robert Brand, *Method*, title page).

¹⁷⁹ Below, pp. 204-205.

This is not, however, the only way in which these findings suggest a less threatening and anxious experience of the male sexual body than other historians have offered. According to Edward Behrend-Martinez's study of Spanish impotence trials (1650-1750), for example, '[p]otency, like masculinity, was always in doubt', encouraging a notion of 'manhood' that 'depended on physical attributes: being a sexually intact male'.¹⁸¹ Yet, the research in this chapter argues that while sexual, sexually-induced and sexually-consequential problems *might* have been a bigger source of cultural anxiety than were other testicular and scrotal problems, medicine's attentions, men's seeking of medical help, and the anxieties that men expressed to practitioners, seem to have been about practical, physical, issues of pain and bodily trauma.¹⁸²

This study has, furthermore, found little evidence of patients concerned for their sexual capacities. Covering c.1640-c.1780, it goes beyond the limits of Behrend-Martinez's analysis and its mainly seventeenth-century examples, and it might be that such anxieties are also difficult to reveal for eighteenth-century Europe, at least in its medical sources.¹⁸³ Yet, these are pressures equally difficult to uncover in the British manuscript medical source base even in the mid-seventeenth century. Although mid- and later-seventeenth-century manuals of midwifery and generation made male sexual and reproductive ability insecure, Binns's contemporaneous 'observations', perhaps the most comprehensive record of British men with genital complaints for the period 1640-1780, make no such concerns visible in his patients.¹⁸⁴ The only possible hint lies in the

¹⁸⁰ Above, p. 113. As Pott gave no elaboration it is equally possible that the patient's fear came from the known dangerousness, and risk to life, of the surgical intervention itself (above, p. 114, fn. 169).

¹⁸¹ Behrend-Martinez, *Unfit*, pp. 15, 22, 114, 127-128, 132, 139.

¹⁸² This also seems true of laymen's manuscript recipe compilations, and might explain why some were silent about impotence and male infertility (below, pp. 248-253).

¹⁸³ The eighteenth century similarly had, for example, little presence in Pierre Darmon's analysis of impotence trials in *ancien régime* France (Pierre Darmon, trans. Paul Keegan, *Trial by Impotence: Virility and Marriage in Pre-Revolutionary France* (1985)).

¹⁸⁴ Jane Sharp, *Midwives book*, pp. 21-22, 27-28, 60, 87-92.

way in which he opened his history of the cancerous penis. With the patient ‘perswaded’ to undergo circumcision because ‘troubled... w[i]th a Phymosis allwayes, & hauinge had manye children’, perhaps fatherhood – whether achieved or aspired to – *could* be a consideration, in penile cases at least.¹⁸⁵

Indeed, this manuscript and printed surgical record offers almost no evidence of any anxiety about male sexual and reproductive potential, even in men with venereal disease, and of an anxiety that either predated or was created by the experience of physical disorder or sexual failure. Discovering whether this apparent absence reveals men’s actual failure to articulate such anxiety (either because it was not felt or because it was too shameful), practitioners’ select interests, or the nature and function of the surgical record, is, furthermore, problematic. Yet, that many surgical records were silent as to even that emotional distress provoked, in these venereal and genital patients, by the experience or anticipation of physical pain does raise the possibility that had patients been voicing alarm about threats to their virility it would not have been added to a manuscript surgical account that served to record symptoms and treatment rather than patients.¹⁸⁶

There is, however, no positive evidence in even the various other types of medical sources included in this thesis to demonstrate that the patients in this chapter *might* have been expressing anxiety about their virility. Problematically, while it is letters to associates and physicians in which men with *non-venereal*, *non-genital*, afflictions can

¹⁸⁵ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, f. 196v (my emphasis).

¹⁸⁶ Certainly, eighteenth-century men were articulating fear and distress at and from their physical symptoms in consultation letters, raising the possibility that this occurred in face-to-face practice too, while in their own letters to colleagues, and occasional other manuscript sources, such practitioners as John Hunter, primary compiler of the above morbid anatomies, do show their profession to have been

be seen claiming fear, anxiety and melancholy as the cause or consequence of their physical symptoms, in surgery's reliance on face-to-face practice, and in the absence of references to venereal and genital problems in chapter 7's sample or familial and social letters, there is no comparable source base in which men with such disorders, or their surgeons, might (or might not) have been making equivalent references to fears about sexual functioning. Yet, there is no clear pattern even in those very few consultation letters that men with venereal disease sent to physicians. While Peter Patrick claimed in 1731 to be distressed that his venereal disease prevented him from marrying, the letters sent by a fellow-sufferer in 1783 reserved their anxiety for social discovery and the prospect of the disease becoming *lues venerea*.¹⁸⁷

Surgeons themselves were almost entirely silent in their manuscript notes as to patients' probable reproductive or even sexual fortunes. Thus, while two of John Hunter's unusual case histories did report on men's erectile abilities during treatment, and, for one patient, four years later, these undated, possibly post-1780, cases were unusually severe. They were also disorders in which it was actual physical damage, and even destruction, held responsible, with their erectile repercussions of interest for what they consequently revealed about penile anatomy.¹⁸⁸ Nor, indeed was it sexual and reproductive outcomes, or patients' related fears, that surgeons used in print to attack the hazardousness of rival methods and practitioners or to celebrate their dealings with reluctant patients. For manuals to give such information even when discussing partial castration, as with a patient 'performing more with one, than he had done before with both his *Witnesses* [testicles], his Wife bearing him a Child, within the Year' (1722),

neither blind nor indifferent to these feelings, especially where they had physical effects. See below, pp. 298, 299.

¹⁸⁷ BL, Sloane MS 4078, Hans Sloane correspondence, f. 236, from Peter Patrick, 10 January 1731; NAS, GD136/436/31-33, Letters sent to William Sinclair, from James Gordon, 2-3 February and 1 April 1783.

was highly unusual.¹⁸⁹ Indeed, and with the exception of anti-onanist writers, and such polemicists as Thomas Brand, it was not self-consciously respectable *British-authored* medical writing that voiced anxieties about ‘virility’, emasculation, or genital incompleteness, or that said that testicular problems ‘frequently... deprive the Man either of his Life or Virility’.¹⁹⁰

If men of these centuries did possess that masculine anxiety about sexual and reproductive prowess described by other historians, it might be that they were wanting to enhance normal abilities rather than seeing themselves as having pathological failures or underlying medical problems, or that they (or their wives) were channeling anxiety into marital suspicion, or nostrums and the services of irregulars.¹⁹¹ Yet, it might be expected that any pervasive concern about male sexual and reproductive potential would have led at least occasional men to pay for the advice of the kinds of practitioners who kept daily notes of their consultations. Certainly, that the male sexual body was apparently totally neglected in the observations, fears, and threats seized on by men writing to practitioners about illnesses outside of genitals does encourage the impression that the general silence of these surgical records indicates more than the absence of only *professional* anxiety about male sexual power.¹⁹² Indeed, even those comparatively few men who wrote medical letters about what they interpreted as the effects of onanism focused their anxieties on that poor physical state of health that they assessed by emphatically physical observations, not on abstract fears about offspring, potency and

¹⁸⁸ RCS, MS 0189/1/1, ‘Cases and observations’, John Hunter, no. 33, 84.

¹⁸⁹ Turner, *Art*, vol. 1, pp. 240-247 (original italicization).

¹⁹⁰ Heister Lorenz, *A General System of Surgery...*, vol. 1 of 2 (1743), p. 191.

¹⁹¹ E.g. Erin Mackie, *Rakes, Highwaymen, and Pirates: The Making of the Modern Gentleman in the Eighteenth Century* (Baltimore, MD and London, 2009), p. 8; Tim Hitchcock and Michèle Cohen, ‘Introduction’, in idem. (eds.), *English Masculinities 1660-1800* (London and New York, 1999), pp. 1-22, esp. 22.

¹⁹² See p. 139.

fertility. They did so, furthermore, even though there exist other manuscript sources suggesting that there were at least some individuals, whether men or their wives, highly alert to the potential reproductive repercussions of (male) venereal disease.¹⁹³

¹⁹³ Sources considered below, pp. 301-302.

Chapter 4: Masculinity in imaginings of male sickness

Introduction

While the male organs were subject to various conditions, some unique to them and others affected by their particular character, a man's body was not only the testicles, scrotum and penis (and even prostate). Being a man with a body, and with a male body, was not just about the possession and experience of parts unique to the sex. The collective experience of being a man with a body extended beyond problems of sexual performance and non-sexual problems in and of the male sexual organs. It extended even beyond those illnesses that struck (or were thought to strike) men or males more often than women.

Modern medicine teaches that being a man and a male is about being prone to characteristic patterns of illness in parts beyond the sexual organs, and whether for reasons of sex, gender, or both.¹ Historians have claimed the same of the men of the past, or quoted contemporaries making claims of this kind.² Yet, not all men suffered from gender-specific or gendered illnesses, and not all men's diseases were 'men's diseases'. However, that their experience of sickness was not solely about 'men's diseases' need not automatically mean that men had no need to make their problems ones of (or from) maleness or masculinity.

¹ Constance E. Ruhl and James E. Everhart, 'Risk Factors for Inguinal Hernia among Adults in the US Population', *American Journal of Epidemiology*, 165, 10 (2007), pp. 1154-1161; Leslie R. Harrold, et al, 'Sex Differences in Gout Epidemiology: Evaluation and Treatment', *Annals of Rheumatic Disease*, 65 (2006), pp. 1368-1372; Rory Jones, et al, *No More Kidney Stones: The Experts Tell You All You Need to Know About Prevention and Treatment* (Hoboken, NJ, 2007), p. 77.

² Lucinda McCray Beier, *Sufferers and Healers. The experience of illness in Seventeenth-Century England* (London and New York, 1987), pp. 60, 147-149; Roy Porter and George Rousseau, *Gout: The Patrician Malady* (London and New Haven, 1998).

This chapter begins with the disorders diagnosed in a sample of surgical and medical records, looking at the men's/male illness profile in its totality, regardless of its uniqueness (or otherwise). Focusing on ailments receiving paid treatment, the first part builds a picture of the collective male (civilian) experience of sickness as made sense of at the time, although aware that perhaps not all contemporaries, or even all of these patients, would have shared such diagnoses. The second part examines a sample of the consultation letters received by the London-based physician Sir Hans Sloane, mainly during the first half of the eighteenth century. It looks at the types of complaints and affected body parts that might have led men to personally seek his help or, alternatively, the parts and processes in which they might have chosen to invest and root their problems. Parts three and four also use Sloane's correspondence, alongside the postal consultations received in the early 1780s by the Scottish M.D. of Thurso and Freswick, William Sinclair (c.1748-1838) and by John Hope (1725-1786), physician, professor, and president of the Royal College of Physicians of Edinburgh.

The usefulness of the Sloane collection lies in its size, and resultant variety of complaints, authors, and patients. However, practitioner replies are missing, many letters give no indication of the patient's identity (or even gender), and there are few surviving sustained dialogues, for men at least. Those received by Sinclair and, in particular, Hope contain several fuller exchanges with long-term patients. Although this means that a sample can expose the self-representation of only a small number of men, preventing statistical analysis on the scale used for Sloane's patients, these repeat letters allow the reader to access a patient-practitioner dialogue concealed by the fragmentary survival of Sloane's collection. Furthermore, Hope kept copies of reports about those

patients who were themselves writing to him, allowing comparison of the way in which patients and their practitioner constructed the same cases.

On the one hand, the chapter asks if these postal consultations suggest that there were certain physical elements of illness that seemed to affect male patients particularly strongly, whether physically or emotionally. On the other, it tests whether society's construction of male sex and masculine gender led men to construct (their) illness and its significance to their lives in a particular way. As sociologists have revealed, multiple levels of social, professional, and personal meaning-making create the experience and concept of being sick, or of having a specific disease. Of especial significance here, 'all illnesses are socially constructed at the experiential level based on how individuals come to understand their illness, forge their identity, and live with and in spite of their illness'. '[I]ndividuals actively shape the parameters of their illness and the meaning of selfhood in relationship to those parameters',³ and, it might be added, they do so not only in response to societal images of the disease and its sufferers but also in reference to their own identities. Recognizing that illness is 'constructed', this chapter builds a provisional picture of the way in which men might have made sense of their sicknesses, and of the succumbing of their bodies.

Part i: The Medical Records and a Male Illness Profile

In the mid-seventeenth century, Robert Turner added to a text on women's health a 'mans counsellour' discussing 'ruptures, and particular diseases belonging to men'. The ruptures (hernias) were apparently scrotal, and these and gonorrhoea, one of the diseases, officially fell under the surgeon's remit. The other two diseases, fever and

³ Peter Conrad and Kristin Barker, 'The Social Construction of Illness: Key Insights and Policy

back pain, were ostensibly in the physician’s realm, but why these, and, indeed, gonorrhoea, were associated with men was left unstated.⁴ Testing Turner’s claims is, furthermore, difficult. There are few extant practice records that appear to depict a substantial portion of the author’s patient base even for a short period of time, particularly after the 1720s. Yet, those that do exist suggest that even in Turner’s generation it was not necessarily gonorrhoea and hernias that dominated surgeons’ diagnoses. Nor was it overwhelmingly fever(s) and back pain that physicians found in men.⁵

As the surgeon Joseph Binns encountered in 230 adult males seen between the 1630s and 1660s, it was the lower body that caused a significant proportion of men’s problems (table 4.1). However, while venereal disease – diagnosed in almost a third of men – played a substantial ascribed role, hernias were less significant.⁶

Table 4.1 Diagnoses given to apparently adult males in London by Joseph Binns, c.1633-c.1663

Diagnosis type	Times diagnosed	Diagnoses as a percentage of all those given to adult males (%)
Venereal disease ⁷	76	30.5
Injury ⁸	63	25.3
Internal or external ulcer, abscess	26	10.4
Fistula (abnormal opening)	16	6.4

Implications’, *Journal of Health and Social Behavior*, 51, 1 (2010), supplement, pp. 567-579, quotation at p. 576.

⁴ Robert Turner, *De morbis foemineis... Whereunto is added, The mans counsellour...* (3rd edn., 1659), pp. 187-218. For the official distinction between surgeons and physicians see above, p. 18.

⁵ The following records and their statistical analysis are discussed in the appendix.

⁶ BL, Sloane MS 153, ‘Chirurgical Observations’ (c.1633-c.1663), Joseph Binns. With ages given only occasionally, the figures in part one include all male cases unless the patient is described as under sixteen or there is reason to suspect this.

⁷ All figures in part one classify venereal patients under the single label of ‘venereal disease’.

⁸ Analyzed below, pp. 198-202.

or connection)		
Tumour, cancer	13	5.2
Fluid-filled swellings ⁹	11	4.4
Pain, soreness etc.	7	2.8
General illness	6	2.4
Piles	5	2.0
Disorders of the urinary system	4	1.6
Hernia	3	1.2
Swelling, oedema	3	1.2
Skin conditions	3	1.2
Amputation	2	0.8
Aneurism	2	0.8
Inflammation	2	0.8
Named illnesses	2	0.8
Lungs, coughs, breathing	2	0.8
Bowel disorders ¹⁰	1	0.4
Other surgical problems diagnosed once	2	0.8
Total	249	100

Source: BL, Sloane MS 153, 'Chirurgical Observations' (c.1633-c.1663), Joseph Binns

In both body part and disorder type, a small core dominated Binns's diagnoses.

Together, injury and venereal disease accounted for well over half of the diagnoses, and surgical complaints that could strike any part – primarily ulcers, abscesses, fistulas and tumours – another quarter. Similarly, a third (eighty) involved the genitalia or groin, mainly in the fifty-eight diagnoses of venereal disease (23.9% of diagnoses) involving genital symptoms or urethral runnings. Another seventeen (6.8%) involved the anus or (once) buttocks, in apostems, fistulas and piles.

This was not, however, a uniform pattern in practices treating men with surgical problems. Despite officially being a physician, a third of the labels that Sir Edmund

⁹ See pp. 94-95.

¹⁰ All figures in part one follow Sir Edmund King's index (below) in interpreting 'worms' as a bowel disorder, but not its classification of diarrhoea as a fever.

King issued to men in the immediately subsequent years involved surgical complaints.¹¹ However, the 145 diagnoses that his apparently adult male patients received between c.1664 and c.1684 still reveal a side of men's collective experience of bodily suffering very different to that recorded by Binns (table 4.2).¹²

Table 4.2 Diagnoses given to apparently adult males in London by Sir Edmund King, c.1664-c.1684

Diagnosis type	Times diagnosed	Diagnoses as a percentage of all those given to adult males (%)
Unconsciousness, paralysis, madness, psychological state	20	13.8
Pains, soreness etc.	17	11.7
Disorders of the urinary system	16	11.0
Lungs, coughs, breathing	14	9.7
Fevers	11	7.6
Problems affecting individual organs	9	6.2
Bowel disorders	9	6.2
Named illnesses	12	8.3
Venereal disease	8	5.5
Piles or anal itching	8	5.5
Skin conditions	8	5.5
Surgical complaints (tumour, ulcer, gangrene, etc.)	6	4.1
Vomiting	5	3.4
Injuries	1	0.7
Unidentifiable	1	0.7
Total	145	100

Source: BL, Sloane MS 1588, Medical receipts and cases (c. 1664-c.1684), Sir Edmund King

¹¹ Disorders of the eye, urinary system, rectum, anus and skin, venereal disease, other surgical problems, and one injury.

¹² BL, Sloane MS 1588, Medical receipts and cases (c.1664-c.1684), Sir Edmund King.

King's diagnoses also suggest that the male experience of bodily disorder could be more mixed, and more diffuse, than is implied by Binns's records. Thus, although twenty (13.8%) of King's diagnostic labels were for 'pain(s)' or (three times) arthritis, these were far from dominated by any single body part. At most, six were or *could* have been in the 'limbs'. Three (2.1% of all labels) were in the 'side', three in the ear, three in the throat, and two (1.4%) in the head, with three other parts each the site of a single man's pain. Yet, not all of the complaints diagnosed were so diffuse, for 13.1% of King's labels involved diseases of the nerves or brain. Twenty men were diagnosed as having convulsions (seven, in one case with madness), vertigo (dizziness, five), scorbutic paralysis (three), apoplexy (a comatose state, one), melancholy (one), hypochondria (one), or syncope (the temporary loss of consciousness, one), and all but the latter were listed as diseases of the nerves or head. The urinary problems (11.0% of labels) were dominated by suppressions and bloody urine, while over half of the men with lung conditions were diagnosed with asthma, 'asthmatical' complaints, or a shortness of breath. Indeed, combined, pain, disorders of the nerves and brain, fevers, and problems with urination or breathing, made up over 60% of these 140 men's diagnoses.

This was a pattern partially replicated in a practice of a different type. Fevers, lung conditions and problems with the senses and consciousness were again amongst the five main diagnoses given to a set of seventy males (of unascertainable age) treated at London's Westminster Infirmary (later the Westminster Hospital) in 1723-24. Here, however, it was fevers and lung conditions that were the most common, each being

responsible for almost a sixth of the total 128 diagnostic labels, and present in over a quarter of the cases (table 4.3).¹³

Table 4.3 Diagnoses given to males at London’s Westminster Infirmary, 1723-1724

Diagnosis type	Times diagnosed	Diagnoses as a percentage of all those given to males (%) ¹⁴
Fevers	20	15.6
Lungs, coughs, breathing	20	15.6
General illness	15	11.7
Surgical complaints	13	10.2
Unconsciousness, paralysis, madness, psychological state	10	7.8
Bowel disorders	10	7.8
Ascites, dropsy	6	4.7
Rheumatism	5	3.9
Scrophula	5	3.9
Other named illnesses	5	3.9
Scurvy	4	3.1
Skin conditions	3	2.3
Problems specific to other organs	3	2.3
Pain, soreness, etc.	3	2.3
Disorders of the urinary system	3	2.3
Tumours	3	2.3
Total	128	100

Source: RCP, MS 625, ‘Medicinal Observations at the Infirmary in Petty France. Westminster’ (1723-1724, and June 1724), Alexander Stuart and William Wasey

Surgical complaints made up a third of these diagnoses, but without that high presence of the genitalia recorded in Binns’s practice. There was no venereal disease, perhaps because such cases were barred, or confined to ‘foul’ wards, but also a total absence of

¹³ RCP, MS 625, ‘Medicinal Observations at the Infirmary in Petty France. Westminster’ (1723-1724, and June 1724), Alexander Stuart and William Wasey.

¹⁴ The index used for these calculations lacks ages, making it possible that the figures include children.

hernias and genital swellings. It was fever(s), lung complaints, general debility and general surgical problems that were instead responsible for half of the diagnostic labels.

Slightly later in the decade, fever(s) and lung conditions were again amongst the most common diagnostic labels (often derived from urine readings) given in the West Riding of Yorkshire by the mixed practitioner Joshua Firth. The 125 apparently adult males seen between 11 November 1727 and 31 July 1728 received 288 diagnostic labels, as well as the terms ‘sick’ and ‘lingring’, with a smaller range of disorders than at Westminster, fewer surgical problems, and more reference to general complaints (table 4.4).¹⁵

Table 4.4 Diagnoses given to apparently adult males in the West Riding of Yorkshire by Joshua Firth, November 1727-July 1728

Diagnosis type	Times diagnosed	Diagnoses as a percentage of all those given to adult males (%)
Pain, soreness etc.	53	18.4
Agues, aguish, aguish fever (intermittent fever)	48	16.7
‘Surfet’	47	16.3
Lungs, coughs, breathing	44	15.3
General illness	35	12.2
Bowel disorders	17	5.9
Stomach problems	15	5.2
Named illnesses	13	4.5
Surgical complaints	6	2.1
Skin conditions	4	1.4
Disorders of the urinary system	4	1.4
Fever	1	0.3
Unknown	1	0.3
Total	288	100

¹⁵ BL, Additional MS 45670, Accompt-book (1727-1738), Joshua Firth.

Here, the label given most commonly was 'pain'. Indeed, if more specific types are included 23.3% of the diagnostic labels involved pain(s). This was followed by intermittent fever ('ague') (16.7% of labels), and 'surfet(s)' (16.3%).¹⁶ What Firth meant by 'surfet', usually diagnosed here by urine readings, was unclear, but it might have meant heaviness in the stomach.¹⁷ However, its use, alongside 'pain', as a descriptor did mean that more specific symptoms formed only a small percentage of Firth's labels. In terms of sufferers, however, 38.4% were described as having agues, 35.2% coughs and lung conditions, 13.6% defecatory and bowel disorders, and 12.0% stomach problems. More generally, 42.4% also had 'pain' – and over half either 'pain' or conditions characterized by painfulness – and 37.6% 'surfet'.

As the differences between these practices suggest, there was no single male illness profile. What is perhaps surprising is what practitioners diagnosed only inconsistently. There were, after all, thought to be diseases that sexed anatomy made males especially prone to. It was claimed in print that boys and men were more liable than the other sex to stones in the urinary system, and to the resultant obstruction becoming so serious as to require surgery.¹⁸ Indeed, in King's practice 6.3% of men's labels, and 6.5% of their cases, had involved either stones or blocked or bloody urine not ascribed to other named urinary problems. Richard Paxton was at Newcastle's infirmary for only nineteen months in the 1750s but allegedly saw Robert Lambert operate numerous times for stone. Indeed, Lambert, 'a famous Lithotomist', claimed in 1791 to have 'cut' 120

¹⁶ B. N. Defoe, *A compleat English dictionary*... (1735), 'ague'.

¹⁷ *Ibid.*, f. 183v. Firth's use of 'surfet' is discussed below (pp. 194-195).

hospital patients, as well as a ‘very considerable’ number in ‘private Practice’.¹⁹ Yet, at Westminster only two of seventy males of any age were classed as suffering from stone, and none of the six males treated for kidney and urinary problems at an unknown London hospital in 1710 had been labelled as having it.²⁰ Firth’s mixed practice similarly found 2.4% of adult male cases to involve painful or bad urination, or bloody urine, but only once with reference to stone or smaller fragments (gravel). Indeed, Binns, a surgeon, had recorded only four adult males with urinary problems of any kind that, as he made sense of them, were not just from venereal disease.²¹

More consistently absent were ailments allegedly gendered as male and masculine, and diagnosed accordingly. Illnesses held responsible for certain psychological states were already gendered at the start of the period, with spleen and melancholy both men’s diseases. This was maintained when Thomas Willis (1621-1675) made the nerves the cause of their successor, hypochondria.²² This did not, however, mean that practitioners diagnosed male hypochondria willy-nilly, or that men took to presenting themselves *en masse* with such self-diagnoses. In the late-seventeenth century, spleen, melancholy and hypochondria remained inconsistently, and often rarely, diagnosed. No man received such labels from Binns, and King labelled seven women with the female equivalent,

¹⁸ J. S., *Paidon Nosemata...* (1664), pp. 146-147; William Nisbet, *The clinical guide... on... diseases...* (Edinburgh, 1793), pp. 152-153; idem., *The clinical guide... on... diseases of infancy...* (1800), p. 145; Joseph Warner, *Cases in Surgery...* (2nd edn., 1760), p. 205.

¹⁹ WL, MS 3820, Case book (c.1753-c.1798), Richard Paxton, pp. 3-4.

²⁰ RCP, MS 625, ‘Medicinal Observations at the Infirmary in Petty France. Westminster’, Stuart and Wasey, index entries for John Wells and Thomas Stevens; RCS, MS 0180, Clinical Notebook (1710), Thomas Wallace, entries for Thomas Addams, John Woodnull, Michael Turner, Thomas Mayn, and Johannes Farry (unpaginated).

²¹ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, ff. 93, 149, 151.

²² Thomas Willis, *Dr. Willis’s Practice...* (1684), pp. 129, 33, 78, 81.

hysteria, but only one man with ‘melancholia’.²³ He diagnosed one man (and two patients of unstated gender) as having hypochondria, but also a woman.²⁴

There was no radical change in the eighteenth century. Claims of hypochondria do not surface in collections of notable cases, or in the medical histories given in the later-eighteenth-century morbid anatomies compiled by John Hunter.²⁵ Firth recorded no hypochondria, made no reference to the spleen, and described no male as melancholic.²⁶ John Murray (1720-1792), M.D. of Norwich, was equally silent between January 1751 and March 1752, with the exception of an outbreak of ‘hysterick & Hypochondriac Cholicks’. Even here, Murray left no hint as to whether he diagnosed the hysteric in females and the hypochondriac in males.²⁷ And while hospitals did treat men diagnosed as having hypochondriac complaints, with two at Westminster in 1723-4, not even the alleged diffusion of this once socially-exclusive diagnosis gave it a dominant role in the way that practitioners made sense of men’s sicknesses in late-eighteenth-century clinical lectures.²⁸ Even if practitioners *were* more likely to diagnose men than women as hypochondriac, it is, therefore, possible that they did so to comparatively few.

Gout too was allegedly gendered conceptually as male and masculine, and made the accompaniment of wealth, genius, and good blood by claimed sufferers and their self-serving practitioners.²⁹ Yet, there were few diagnoses even in those patient bases that,

²³ BL, Sloane MS 1588, Medical cases and receipts, King, index (‘nervi’, ‘splene’) and f. 74v.

²⁴ *Ibid.*, index (‘hypochondri’).

²⁵ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’ (men’s dated cases 1774-1784), John Hunter; RCS, MS 0189/1/3, ‘An Account of the Dissections of Morbid Bodys’ (men’s dated cases 1755-1782), *idem.*; WL, MS 5005, ‘Observations on particular Cases of Patients’ (1719-1750s), Dr Richard Wilkes.

²⁶ BL, MS Additional 45670, Accompt-book, Firth.

²⁷ WL, MS 7840, Journal (1752-1759), John Murray, f. 13.

²⁸ RCP, MS 625, ‘Medicinal Observations’, Stuart and Wasey, index entries for John Goldylock and John Woodcock; Guenter B. Risse, *New Medical Challenges During the Scottish Enlightenment* (Amsterdam, NY, 2005), pp. 311-12, 317, 319-21.

²⁹ Porter and Rousseau, *Gout*, pp. 5-6.

like Binns's and, especially, King's, included the titled. Binns described no men as having gout, while King diagnosed it only in *females*, describing one male as having '[g]outie-pain's'.³⁰ Murray identified no gout or gout-related pains in either sex, and whilst Firth, Wallace, and Wasey and Stuart all diagnosed men with a related disorder, rheumatism or rheumatic pains, none decided that men had gout.

Sexed and gendered diagnoses did not, therefore, dominate the way in which the complaints of the male patients encountered in these four practices (and others) were made sense of. Nor did Turner's four male diseases – gonorrhoea and hernias (surgical problems) and back pain and fevers (the physician's realm). Venereal problems of all types – far from all of which included gonorrhoea – were found in only 14.9% (84) of these four practices' 565 cases, although this might have been higher had the Westminster records included such patients. Similarly, although 40.7% of the patients came from a surgeon, and all of the practices took on some surgical problems, only 0.7% of their cases involved hernias.³¹ Fevers were identified in 14.2% of cases, but back pain in only six, and in only three (0.5% of cases) was it unique to this part. Instead, it was general, non-site-specific, surgical problems (99, 17.9% of cases), especially ulcers, abscesses, fistulas and tumours, that were found most often, followed by venereal disease, lung complaints and fevers (both 80, or 14.2%), pain(s), cramp and soreness (78, 13.8%, plus disorders characterized by pain), and injury (64, 11.3%).

However, almost two thirds of the general surgical complaints, 90% of the venereal cases, and all but one injury came from Binns. By excluding his practice surgical problems become much less significant, with only thirty-five (10.4%) of the remaining

³⁰ '[S]tone-gout' was, however, used to explain *another* affliction (BL, Sloane MS 1588, Medical receipts

335 men having non-site-specific surgical complaints, eight (2.4%) venereal disease of any kind, and one (0.3%) an injury. Instead, the most common diagnoses become fevers (80, in 23.9% of cases), lung conditions (78, 23.3%), and pain (71, 21.2%, many from Firth), followed by general signs of sickness (50, 14.9%), surfet (47, 14.0%, all Firth's), and various named illnesses (44, 13.1%). It is not clear how typical Binns's male cases were of men's surgical needs, particularly as he recorded so few urinary and skin complaints. However, his diagnoses do suggest that surgeons and physicians (or general practitioners) might have seen very different types of male bodies, with their practices revealing, therefore, very different elements of male suffering.

Part ii: Men's Complaints

Comparatively few surgeons sent cases to the physician Sir Hans Sloane (1660-1753). Consequently, the letters that he amassed do seem to support the suggestion of a potential absence of certain surgical problems from the practices of physicians and mixed practitioners. Just as men of all statuses consulted King and Binns, those in Sloane's letters ranged from nobles to servants and charity patients, although most seem to have been solvent. Furthermore, men representing the whole of this spectrum produced self-penned letters. This section uses three of the volumes of Sloane's correspondence most heavily composed of consultation letters, which together contain 148 English-language letters or chains of letters that are clearly about males, discuss a sufferer visibly or apparently aged sixteen or over and in the British Isles, make reference to the complaint, and were written by an author of known or probable type (patient, practitioner, or associate).³² In total, these discuss 132 different men, fourteen

and cases, King, ff. 191, 219, index, 'Gout').

³¹ Possible reasons for the absence of hernias from records of practice are considered in pp. 99-101.

³² BL, Sloane MSS 4075, 4077-4078, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century). See the appendix for discussion of this source base.

of whom feature in two or more different sets of letters. Although the earliest date from the 1680s, most of the cases were sent between 1700 and 1741, on either side of the years in which Firth's and the Westminster notes were compiled. Fifty-one were written by patients, and comparing these with the sixty-two from known or apparent practitioners (including one charitable practitioner), and the thirty-five from clear or probable friends, employees and relatives, this part asks if sick men collectively imagined or represented their plights differently to the other parties involved in their care.

In their concern to depict the patient's true state, and the severity of his suffering, many letter-writers named multiple afflictions. The patient Henry Downing was unusual in giving *eighteen* multi-faceted sets of current problems, as well as more general complaints, but many letters referred to multiple signs and symptoms.³³ Such descriptive, holistic, accounts were not universal. Nor, however, were they unique to the patient's self-construction, or to the sufferer's process of meaning-making. Letter-writers of all types could give as much weight to paleness, low 'spirits', or poor appetite as to an ailment's defining symptoms.³⁴ Consequently, table 4.5 includes all such observations.

³³ BL, Sloane MS 4075, Hans Sloane consultations, f. 73, from Henry Downing, 19 July 1726.

Table 4.5 Signs and symptoms named in letters about sick men sent to Sir Hans Sloane, 1681-1741

		References by each authorial group, as a percentage of all its references to complaints (with number of times named)		
		Practitioners	Patients	'Friends'
General	General signs	28.1 (104)	22.5 (71)	26.0 (32)
	Pain(s), aches	10.3 (38)	14.6 (46)	13.0 (16)
	Poor sleep	1.9 (7)	1.0 (3)	1.6 (2)
	General problems in named part	16.8 (62)	19.0 (60)	17.0 (21)
	'Spirits'		2.5 (8)	2.4 (3)
	Thoughts, melancholy	1.9 (7)	1.3 (4)	0.8 (1)
	Dreams	0.3 (1)	0.3 (1)	
Processes, products	Urine, urination	9.5 (35)	6.7 (21)	6.5 (8)
	Defecation, faeces	3.0 (11)	1.9 (6)	4.1 (5)
	Ejaculation, ejaculate		0.6 (2)	
Other evacuations		3.5 (13)	4.8 (15)	2.4 (3)
Mobility, movement		1.6 (6)	2.2 (7)	1.6 (2)
Other functions		2.2 (8)	4.1 (13)	3.3 (4)
Nausea, vomiting, indigestion		4.6 (17)	5.1 (16)	5.7 (7)
Eyes, vision		1.9 (7)	2.2 (7)	4.9 (6)
Wind, rumbling		0.3 (1)	1.6 (5)	
Complaints with unique seat		6.0 (22)	3.8 (12)	3.3 (4)
Sexual functions	Erections		0.3 (1)	
Gout		1.1 (4)	1.0 (3)	
Nervous disease	'Hypochondriacal or nervous disorder'	0.3 (1)		
	Spleen	0.3 (1)	0.3 (1)	0.8 (1)
	Hypochondriacal vapours		0.3 (1)	
	Hypochondriac and intermittent fever			0.8 (1)
Nervous system		4.1 (15)	1.0 (3)	4.1 (5)
Other named complaints		2.4 (9)	2.5 (8)	1.6 (2)
Other (incl. unclear meaning)		0.3 (1)	0.3 (1)	
Total references		370	315	123

Source: BL, Sloane MSS 4075, 4077-4078, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century)

³⁴ BL, Sloane MS 4078, Hans Sloane consultations, f. 149, from James Keil, undated, about Robert

The sample contains no illness (or patient) described by both the sick man and his practitioner, for direct comparison. Collectively, however, there is little in the complaints that these sick men wrote about to distinguish their letters from those that other groups sent about male patients. Few symptoms featured in men's letters disproportionately frequently, or rarely. Indeed, so great a range of complaints was mentioned that many had only a very small presence, easily swollen by the existence of a single letter naming several complaints falling within a single category. The clergyman Robert Thomlinson, for example, sent a minutely detailed case history discussing a whole host of respiratory problems that someone else might have summarized under a single label.³⁵ It was not, however, men's superior self-knowledge, or lack of formal medical training, that determined the detail, descriptiveness, or number of symptoms and signs picked up on, but personality, the letter's function and the recipient's prior knowledge. Thus, a practitioner similarly listed every element of Mr Howard's aguish fits right down to yawning and thirst.³⁶

The sheer number of observations consequently mentioned makes it significant that there is such consistency between the authorial groups in the types and variety referred to. Together, the letters named sixty-two categories of symptom, signs and, less commonly, illnesses. Practitioners referred to fifty-two, and patients forty-seven, despite writing eleven fewer letters or chains of letters. Friends and relatives sent only 56% of the number of letters that practitioners did, yet still included two-thirds of their number of different symptom types.

Spencer, 2nd Earl of Sunderland.

³⁵ BL, Sloane MS 4077, Hans Sloane consultations, f. 271, Robert Thomlinson to Richard Thomlinson, undated.

³⁶ BL, Sloane MS 4078, Hans Sloane consultations, f. 89, unsigned and undated.

Sick men were one of the groups making reference to symptoms not seized on by members of other groups, but not because of preferred methods of self-representation, or because embarrassment led them to seize on alternative, euphemistic, descriptions. Ultimately, patients and practitioners wrote more letters than did friends and relatives, making a larger total number of references. Thus, sick men were the only group to refer to erections, for example, but as only one of their collective 315 observations.³⁷ The same was true of ejaculation and the material ejaculated, discussed by no practitioners or 'friends' but only one patient. Indeed, it was the same man, Peter Patrick, who mentioned erections, ejaculations, and the material ejaculated, having 'forgot[ten] to tell you that for severall years my nightly Erections have not only been infrequent, but also very weak', the 'sencation' on ejaculating 'feeble', '& the Seed... not of a due Consistency.'³⁸

As Patrick begged Sloane to consider 'my Follys', referred to a prospective marriage, and mentioned a 'Pimple', his unstated condition might have been venereal. The inclusion of such content was the product of one individual's personality, not of men's gender, or an archetypal tendency of patients. Nor was it automatically the product of the perceived nature of this particular complaint, the patient mentioning it only as an aside, in an update.³⁹ The sexed body was not, therefore, a great source of difference between men's letters and those written by others. Nor were allegedly fashionable illnesses. Indeed, there is no significant evidence here of men claiming those sensitive

³⁷ Ibid., f. 236, from Peter Patrick, 10 January 1731.

³⁸ Ibid.

³⁹ Although other men mentioned genital runnings (above, pp. 86-93).

nerves celebrated culturally as a concomitant of ‘social and moral status’, and which some male ‘nerve doctors’ were publicly identifying *themselves* with.⁴⁰

Indeed, ‘fashionable’ disorders and conditions were claimed by these men only slightly more frequently than they were diagnosed in Firth’s provincial and often rural practice. Although Firth made no such diagnoses, only 0.6% of the signs and complaints (two of 315) picked up on in these fifty-one self-authored letters concerned hypochondria, spleen or melancholy, compared to 1.6% (two of 128) of the diagnostic labels given to hospital patients at Westminster. Both of these epistolary references were made in the same letter – Lord Stanhope’s (1673-1726) report on the effects of Sloane’s prescriptions. Stating that the ‘Spleen and the Hypochondriacall vapors, which threw up absurd notions... is now fell upon my ears for I cant hear now near so well’, Stanhope, like most sick men (and ‘friends’), gave no hint as to the provenance of these labels, whether self-diagnosed or otherwise.⁴¹ Yet, practitioners and ‘friends’ had themselves mentioned (the) spleen only in relation to Stanhope. It formed, therefore, only 0.3% of patients’ and practitioners’ references to complaints, and 0.8% of relatives’.⁴² Otherwise, the sixty-two letter sets sent by practitioners only once described any man as having a disorder that ‘seems to be hypochondriacal or nervous’.⁴³

Gout was seized on slightly more often. However, while male letter-writers referred to it as a potential complaint more frequently than it was diagnosed by Firth or at

⁴⁰ Lisa Smith explained this by it being ‘not surprising that men would not want to claim that an upset of the emotions had resulted in sickness’ (Lisa Smith, ‘Women’s Health Care in England and France, 1650-1775’ (unpublished Ph.D. thesis, University of Essex, 2001), p. 103). For print, see G. J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago and London, 1992), pp. 9, 24-25.

⁴¹ BL, Sloane MS 4077, Hans Sloane consultations, f. 10, from Philip, Lord Stanhope, 29 July.

⁴² Although authors of *unknown* types also occasionally explained ‘atacks’ as ‘Hypochondriacall’ (ibid., f. 228, from John Watts, 21 September 1708).

⁴³ BL, Sloane MS 4078, Hans Sloane consultations, f. 158, undated prescription.

Westminster, and two claimed to have suffered it in the recent past, only three men described their current disorders in this way. Indeed, sick men seized on current gout less often, proportionally, than did practitioner letter-writers, who themselves made only four references to it (of 370), although also referring to earlier attacks, or to 'goutish' pains. Certainly, there is no evidence in these letters of men *courting* the diagnosis. The only man to come anywhere close stated in 1734 that he would continue his current method 'if you apprehend... an aguish or feverish disposition, [but] I beseech you not to be unmindful of the gout, you best know whether the overheat in the feet and legs has nothing of the gout in it'.⁴⁴ It was not the attractiveness of the gout that led him to do so, but the fear that it provoked, combined with a nervous character. Indeed, while neither elite nor middling men left evidence here of being attracted by the social connotations of gout, not even the desperation for an explanation (and cure) for pain led many others to propose a potential connection. Scholars have claimed that diagnoses were driven by the whims and self-image(s) of the rich, yet the ailments, and men, that these practitioners wrote about were not significantly more likely to be decided to be goutish, hypochondriac or nervous than were those that Firth, or even Wasey and Stuart, treated.⁴⁵

Collectively, therefore, the men writing about their own sicknesses showed great similarity to others writing about sick adult males. Usually, any differences between the three authorial groups in the relative attention given to individual symptoms were under two percentage points (and frequently much less), with only five of the seven exceptions even partially due to patients' tendencies. In two of these, hardness or oppression and pain(s), men's attention was slightly higher than friends', although, proportionally,

⁴⁴ BL, Sloane MS 4077, Hans Sloane consultations, f. 305, from Arthur Price, 13 February 1734.

practitioners gave lower reference than *both* groups, particularly for pain. By contrast, patients made relatively little mention of sweating and temperature. They said especially little about general sickness and tumours and swellings, categories in which practitioners and 'friends' made rates of reference very similar to each other. Yet, for patients at least, such variations, and others, seem the product of practicalities. It was, for example, presumably because the severity of the situation ensured that practitioners were involved that the majority of references to fits, losses of senses or consciousness, or brain disorders came from others (fifteen from practitioners, five from 'friends', and only three from patients). The same seems true of cases in which liver problems had progressed so far that the patient was yellow, allowing diagnoses of jaundice.

There were therefore, no symptoms so consistently but surprisingly absent from self-penned letters as to suggest that there were certain health problems that men were reluctant to see themselves as having. Indeed, there is no indication of symptoms too embarrassing for men to want to mention. It was the surgical nature of such disorders, not stigma, that ensured that men rarely wrote to Sloane about problems in or concerning the sexual organs. Indeed, there was only one letter about venereal disease that was even potentially written by a male sufferer pretending to be a concerned friend.⁴⁶ The one patient in this sample who did write about his own infection had already sought face-to-face treatment from three surgeons and, if only in his desperation, wrote frankly about his situation (both medical and personal) and his fears.⁴⁷

⁴⁵ N. D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology*, 8 (1974), pp. 369-385.

⁴⁶ BL, Sloane MS 4077, Hans Sloane consultations, f. 38, from Joseph Smith, undated.

On the other hand, there were no problems seized on so disproportionately *frequently* by sick men as to suggest that these were considered so serious, or embarrassing, that men were not prepared to entrust them to a lesser practitioner, or to trust another party to write. Or, similarly, to suggest that there were parts in which problems caused men anxiety disproportionate to what observers might have seen as their physical effects. As chapter 2 argued, male vigour, outside of the house, remained an ostensible presumption in medical publishing. However, while men made slightly more reference to problems of mobility and movement than did their practitioners or relatives, the difference was a small one (2.2% of references, as opposed to 1.6% and 1.6%). Nor did men need to identify with, or reassert, their sexual and reproductive sides. While a disproportionate number of men, relative to other writers, mentioned complaints rooted authorially in the genital organs, it was in the discussion of runnings and emissions. Indeed, it was this that produced men's disproportionately high reference to discharges.⁴⁸

Certainly, other disproportionately frequent or absent references seem to have come from something other than shame (gendered or otherwise) or societal constructions of masculinity. Where men made disproportionately *high* mention of specific effects it was because of their special access to sensations and feelings, or their constant exposure to expressed fluids. Thus, they made slightly higher reference than did observers to stiffness and pains, numbness and twitching, wind or rumbling, evacuations (discharges, spitting and phlegm, and haemorrhages), and parts that felt hard, oppressed, 'loaded', heavy, and weak. Difficulty in breathing also received far more comment from men than from practitioners, although the contrast with relatives is less extreme. Either it was more alarming to sufferers (and observers) than to a practitioner, or something that

⁴⁷ BL, Sloane MS 4078, Hans Sloane consultations, f. 242, Neill McArthur to the Royal College of

patients saw as having great potential significance in diagnosis, or it was a problem that few bothered local practitioners with. However, it was as the corollary of this unrivalled personal experiencing of the body that men made slightly low use of some of the signs that others used to identify the presence of sickness or to describe the sick body. In particular, the generic signs of illness made up 22.5% of men's observations but 28.1% of those of practitioners.

In this discourse at least, men were not constructing their suffering in a way radically different to the manner in which other parties made sense of it, or choosing to write about illnesses amenable to flattering meaning-making. There is nothing in these Sloane letters that suggests particular patterns in the illnesses that men felt compelled to write about, and to write about personally, the problems that they selected to be included in their own letters, or the way that they collectively chose to interpret and describe ailments. Similarly, there is no sign that threats to masculinity, or insults to male pride, lay in having illnesses in, from, or affecting, certain parts or processes, or having particular manifestations. Men apparently faced few constraints in deciding, or expressing, the truth of their disorders. Indeed, there is little to suggest that there were impediments or symptoms that men as a group found far more alarming than observers did, *or* about which they were collectively in denial, or claiming to be *blasé*.

Part iii: Men Making Sense of Sickness

Sick men's bodies were here made male only by the discussion of problems in the genitals, and this was true of both Sloane's incoming correspondence and the accounts sent to John Hope and William Sinclair in the early 1780s. Mentioning such genital

Physicians, 30 July 1727.

complaints was, however, itself rare, presumably because of the surgical nature of such disorders. Very few authors showed *any* notion of human 'oeconomy' that was not confined to localized processes or their products, seizing instead on properties of the blood, an unspecified 'humour', or, without explication, their 'constitution'.⁴⁹ Others referred to underlying bodily states *and* explained each individual symptom separately, by localized causes. Thus, Timothy Lovett blamed his breathlessness on phlegm and smoking, the phlegm on his digestion, his 'knots' and 'Itching pimples' on '[th]e Scurvy', and his emaciation on his 'whole mass of blood' being 'corrupted'.⁵⁰ With practitioners' explanations very similar, none of this was the product of a lack of formal medical education.⁵¹

Whether or not it was because of this explanatory style, where men had bodily explanations these were unrelated to their bodies being male. There seemed to be no sense of any distinctively male function responsible for the wellbeing of the specifically male body as the analogue of menstruation, or any reference point for men's health, related to their maleness or not.⁵² Their letters give no hint that any man envisioned a body made by, or a health reliant upon, the distinctively male semen.⁵³ Indeed, sick men only summoned the seminal fluid in references to health-damaging ejaculations or leakages, if they did mean semen. Even this was done in such a manner that they might

⁴⁸ Discussed above, pp. 86-93.

⁴⁹ BL, Sloane MS 4034, Hans Sloane consultations, f. 302, Timothy Carter to Dr North, 27 August 1732; BL, Sloane MS 4078, Hans Sloane consultations, f. 63, unsigned, about Charles Seymour, 5 January 1730; NAS, GD253/143/6/6/3, Letters sent to John Hope (1769-1786), from Edward Hamilton, undated.

⁵⁰ BL, Sloane MS 4076, Hans Sloane consultations (late-seventeenth to mid-eighteenth-century), ff. 44, 46, from Timothy Lovett, 21 and 12 February 1723.

⁵¹ BL, Sloane MS 4034, Hans Sloane consultations, f. 239, Samuel Bowden, M.D., about Mr Priddle, 5 May 1732.

⁵² For menstruation as a dominant theme in letters about women, including those from male relatives, see WL, MS 6868/4, 10, Letters to Robert Whytt (1757-1765).

⁵³ As some medical texts did (discussed above, pp. 44-57).

have been envisioning it in the de-sexed way highlighted by Thomas Laqueur.⁵⁴ It was not, however, only in the tales that sick men told that the distinctively male body was absent. Practitioner letter-writers made no reference to a male physiology either.

It was only slightly more often that the sick body was made male by reference to the male line. While John Wallis thought his respiratory disorder ‘in some measure.... in my Disposition, as my Father & two Uncles strong Hail Men died in the prime of Life, in a Consumption’, father-son heredity was actually rarely proposed.⁵⁵ Heredity of any kind was only occasionally mentioned (even to dismiss it), as with the sufferer of a skin disorder, ‘afraid it is somewhat naturally inherent in me, although my father & *mother* & *sister* are free’.⁵⁶ While men were able to recognize inherent constitutional tendencies, none in these samples tried to link these to anything inherited. Notions of a ‘family distemper’ were rarely expressed, and it was not a male sufferer who referred to gout as ‘[th]e disease of my famely’.⁵⁷ Even those who did raise the possibility of an inherited disposition or illness refused to prioritize this, Wallis mentioning heredity only after finding the origins of his disorder in catching cold, and the cause of its continuance in a ‘Disquiect Mind’.⁵⁸

Nor was specifically male-male heredity privileged. No group tended to mention fathers’ sicknesses, constitutions, general states of health, or longevity more than they did mothers’, and where fathers were mentioned there was nothing to show that their

⁵⁴ Thomas Laqueur, ‘The Social Evil, the Solitary Vice, and Pouring Tea’, in Paula Bennett and Vernon A. Rosario II (eds.), *Solitary Pleasures. The Historical, Literary, and Artistic Discourses of Autoeroticism* (London and New York, 1995), pp. 155-162.

⁵⁵ BL, Sloane MS 4077, Hans Sloane consultations, f. 208, from John Wallis, 13 July 1734.

⁵⁶ BL, Sloane MS 4078, Hans Sloane consultations, f. 230, from James Mason, 18 November 1701 (my emphasis).

⁵⁷ BL, Sloane MS 4076, Hans Sloane consultations, f. 368, from Honour St Barb[e], 10 March 1707.

⁵⁸ BL, Sloane MS 4077, Hans Sloane consultations, f. 208, from John Wallis, 13 July 1734.

maleness was being made relevant. In a different type of letter, from 1710, Thomas Wharton proved his adult son's constitutional fragility by a delicacy transmitted via the male line, as a literal blood tie. Thomas's father

had 11 Children all dyed but me, & most tenderly was I brought up, and as y[ou]r mother was a most vertuous woman, I believe you are my son, & you may conclude, that you have been born of tender family, & you may as well wash a Blacke moor white... as to bring y[ou]r body to endure hardship.⁵⁹

Fathers writing to practitioners were, by contrast, slow to identify any parental input, male or otherwise, into their children's constitutions. Furthermore, where *offspring* were used as a barometer of *paternal* health it was not for children and parents of a single sex. It was as a proof of the infection, or otherwise, of both parents alike, but in venereal disease only.⁶⁰

Medicine did claim that by sexed anatomy and gendered lifestyles men would (or should) be of more resistant 'constitution of Brain, and nervous stock'.⁶¹ However, that only two of ninety-five causes proposed by the men in the original Sloane sample were 'nervous' (table 4.5) is far from proof that this expectation had been absorbed. Nor does it prove the shamefulness for men of emotionally induced sickness. To offer an explanation based in the nerves was not necessarily to imply vulnerability to the emotions. On the contrary, authors of all types could discuss nervous disease as the

⁵⁹ DUL, WHA/23, Wharton Papers, Thomas Wharton to George Wharton, 26 December 1710.

⁶⁰ NAS, GD253/143/6/75, Letters sent to John Hope, unsigned report on Captain B., 30 July 1785.

⁶¹ Willis, *Practice*, p. 129; James Makittrick Adair, *Commentaries on... Physic...* (1772), p. 82. See also above, pp. 33, 58-59.

product of material damage to the nerves, and this alone, and explain this physical harm by equally physical, often very masculine, causes. It was, for example, such masculine behaviours as '[I]rregular living' and 'greivous Colds which his Employment much exposes him to', with a resultant decidedly physical harming of the nerves, by which one practitioner explained his male patient being 'Hypochondriacall'.⁶² If any stigmatizing association with emotional fragility did exist it was not one that caused male letter-writers to make pre-emptive denials of the possibility of nervous explanations. Instead, it seems that this was simply a vocabulary slow to permeate men's understandings of their bodies, or their resultant anxieties, bodily or social, there being no medical or cultural imperative to consider such causation. Certainly, nerves were not routinely included in men's even contextual self-descriptions.

Scottish men might have been making more use of this language by the 1780s, yet it was still not automatically the explanation of choice. Edward Hamilton claimed to have left 'the Tropics' with 'My Nerves shatter'd to Peices', and to have obtained an additional 'very uncommon *irritability*' from a wound that 'bled for near 16 Hours'. However, he also knew himself 'naturally very apt to perspire', and claimed, as its consequence, a 'great sensibility of Heat & Cold'.⁶³ Mr Haig claimed to have been treated for 'Acid in his stomach, which produced... a general debility of the nervous system' but blamed a complaint involving weakness and lassitude on a sprain.⁶⁴ None of these men showed any anxiety, furthermore, that through their nerves doubt might be cast on their masculinity. Medical and cultural fashions, languages and ideals – in this case those of 'sensibility' – did *not* automatically dictate the 'illness identities' that men

⁶² BL, Sloane MS 4075, Hans Sloane consultations, f. 265, John How (apothecary) on Mr Harsnett, 8 October 1720. Compare to above, p. 142, n. 40.

⁶³ NAS, GD253/143/6/61/1, 3, Letters sent to John Hope, from Edward Hamilton, undated and Monday (my emphasis). For nervous 'irritability' see pp. 58-59.

‘embrace[d]’, or the way in which they ‘struggled to make sense of their illness and reclaim a sense of self’.⁶⁵

Furthermore, authors who were not making sicknesses and sick bodies *male* were not necessarily making them *masculine* or a product of masculinity instead. As the original Sloane sample demonstrates, men showed no great tendency to associate their being ill with their being men, let alone with being *especially* manly (table 4.6).

Table 4.6 Ascribed or proposed causes of male sickness in letters sent to Sir Hans Sloane, 1681-1741⁶⁶

		References by each authorial group, as a percentage of all its references to causes (with number of times named)		
		Practitioners	Patients	‘Friends’
Natural or heredity predisposition, illness, constitution or habit		3.9 (3)	8.8 (9)	
Body, illness, or cause ‘nervous’, or state of nerves		5.2 (4)	2.0 (2)	5.3 (1)
Spirits		1.3 (1)		
Mental state			1.0 (1)	
Colds		6.5 (5)	2.9 (3)	10.5 (2)
Internal causes		11.7 (9)	20.6 (21)	10.5 (2)
Blood loss			1.0 (1)	
Named illness		26.0 (20)	19.6 (20)	31.6 (6)
Epidemic illness			1.0 (1)	
Named surgical problem		1.3 (1)		
Cessation of other pathological processes			1.0 (1)	
External	Environment (air, weather, season, contagion)	5.2 (4)	7.8 (8)	
	Medical treatment, incl. self-prescribed	6.3 (5)	5.9 (6)	5.3 (1)

⁶⁴ NAS, GD253/143/6/70, Letters sent to John Hope, ‘The Case of Mr Haig’, 24 January 1785.

⁶⁵ Conrad and Barker, ‘Social Construction’, p. 572.

⁶⁶ Cause of an illness, relapse, exacerbation, individual attack, or specific symptom. Where authors referred to another person’s claims these are recorded for the category in which this third party falls.

	Damp bed	1.3 (1)		
	Behavioural	31.2 (24)	28.4 (29)	36.8 (7)
Total (and total references)		100 (77)	100 (102)	100 (19)

Source: BL, Sloane MSS 4075, 4077-4078, Hans Sloane consultations (late-seventeenth to mid-eighteenth-century)

Sick men had no uniform tendency to offer causes, whether to explain individual symptoms, whole illnesses, new attacks, or severity. Many named none at all, others multiple levels of causation, and some the same factors again and again. Robert Thomlinson (above), for example, seized repeatedly on preaching (in itself, in cold churches, or with a cold) and Newcastle's smoky air, to explain numerous different internal phenomenon, and alongside wind (from phlegm and cholera), windy food, late suppers, the seasons, seasonal disorders, matter in the stomach, 'adhesion' of the lungs, an old scorbutic complaint, hot medicines, named respiratory disorders (past and present), a disposition to the relaxation of the nerves, and changes in temperature, wind and moon.⁶⁷

Thomlinson's letter swells the total number of causes given by men, but, by noting such a range of factors, does not distort their composition. Overall, 42.4% (forty-three of 102) of the causes that these men seized on were explaining suffering by external forces, whether behavioural, medicinal, or environmental. Significantly, the same was true of near-identical proportions of the causes proposed by men's practitioners (44.2%) and 'friends' (42.1%) (table 4.6). Furthermore, when authors found external causes on which to blame men's sickness it was for all parties overwhelmingly in men's behaviours (table 4.7).

Table 4.7 Ascribed or proposed behavioural causes of male sickness in letters sent to Sir Hans Sloane, 1641-1781⁶⁸

		References by each authorial group, as a percentage of all its references to behavioural causes (with number of times named)		
		Practitioners	Patients	'Friends'
Occupational	Preaching	4.2 (1)	10.3 (3)	
	Overexertion	4.2 (1)		
	Catch cold when leave house to work		3.4 (1)	
	Sitting in wind		3.4 (1)	
	Delay treatment		3.4 (1)	
	Hardships and climates on ships	4.2 (1)		
	Working with a cold		3.4 (1)	
Occupation causes colds	4.2 (1)			
Consumption	Drink	20.8 (5)	17.2 (5)	14.3 (1)
	Drink fall on parts			14.3 (1)
	Food	8.3 (2)	6.9 (2)	
	Irregular, free living	4.2 (1)		14.3 (1)
Recreational	Late nights	4.2 (1)		
	Lack exercise	4.2 (1)		
	Sitting near open window		3.4 (1)	
	Excessive sex, women, masturbation	4.2 (1)	6.9 (2)	14.3 (1)
Lifestyle	'Sedentary' living	4.2 (1)	3.4 (1)	
	Over-fatigue	4.2 (1)		
Travel	Long journey	4.2 (1)	3.4 (1)	
	Heavy walking, then boat			14.3 (1)
Other one-off events/actions		16.7 (4)	10.3 (3)	14.3 (1)
Outdoors (riding or leisure exposes to bad weather, riding, horse falls)		8.3 (2)	24.1 (7)	14.3 (1)
Total		100 (24)	100 (29)	100 (7)

⁶⁷ BL, Sloane MS 4077, Hans Sloane consultations, f. 271, Robert Thomlinson to Richard Thomlinson, undated.

⁶⁸ See above, p. 151, n. 66.

Source: BL, Sloane MSS 4075, 4077-4078, Hans Sloane consultations (late-seventeenth to mid-eighteenth-century)

Over a quarter of the behavioural explanations that this sample of men gave involved being outdoors or travelling, another quarter food and, especially, drink (not always with the suggestion of excess), and another work and working (both directly and indirectly). Nor were these beliefs, or claims, unique to sick men and their self-constructions. The explanations offered by men were not, it seems, an artificial fabrication produced in response to society's modeling of the ideal man. That their friends and relatives incriminated a similar range of both long-term tendencies and individual actions does suggest that the behavioural factors that dominated men's own self-assessments and self-representations might, to some extent, have reflected their actual lived reality.

Although the figures are small, conviviality, outdoors sports and recreations, occupational obligations, and masculine activity and mobility outside the home do appear to have played, or to have been thought to play, a role in the decay of some men's health. However, that there were not more relatives seizing on these is significant. The relative absence of problems associated by letter-writers with promiscuity, and total absence of those explained by violent sports, riding accidents and aggression, can be linked to Sloane not being a surgeon. However, that there were not more local practitioners and, especially, relatives explaining men's illnesses by heavy drinking, late nights, overwork, long journeys, or riding in the rain makes it possible that men were not *en masse* participating in destructive behaviours yet concealing it when they themselves wrote.

It was only in the two explanatory references to what authors called ‘sedentary’ living that these behaviours involved something neglected, and in print this was a language with gendered connotations. However, what *these* authors meant was far from clear. A practitioner noted that Mr Kynnesman had ‘formerly used a good deal of exercise & feild sports’, yet Henry Downing was less specific when claiming to have exacerbated the delicacy of his ‘constitution’ by a lifelong ‘Aversion to Exercise’, or that ‘[m]y life has been... very sedentary’.⁶⁹ It seems, however, that the ‘sedentary’ way of living in part blamed for these two men’s suffering was not only about sports. Although medical texts gave no definition, they grouped the ‘sedentary’ with women, the elderly and the scholarly, and in discussing scholars’ ‘want’ of ‘Exercise’ suggested a broad definition that encompassed physical industriousness, physically active employments, and perhaps activity more generally.⁷⁰ Indeed, in a long medical history sent to accompany the case of an Irishman it was noted – although not to explain his ailment – that ‘[f]or... 20 yeares... he has us’d little exercise, the nature of his business requiring a Sedentary Life’.⁷¹

The role of personality in both behaviour and reporting habits should not be discounted, yet some of the men in this sample explained their encounter with sickness by typically masculine behaviours and social roles, and occasional others by deviation from these. Their letters do not, however, prove that social constructions of men and masculinity, and the male social role, dictated how these men saw their sick bodies, or how they felt compelled – or wanted, opportunistically – to represent them. In particular, the ability to recognize enacted factors does not prove that men were ashamed about sickness,

⁶⁹ BL, Sloane MS 4075, Hans Sloane consultations, f. 116, from Thomas Farrer, 29 April 1727; *ibid.*, f. 73, from Henry Downing, 19 July 1726.

⁷⁰ George Cheyne, *An essay of health and long life* (1724), p. 34.

needing to recast bodily failure as something forced upon the body. Indeed, a third of the causes offered by this sample of men were about the internal body. Relatively *and* absolutely, it was men themselves who most often singled out causes inside the body, with 20.6% of their explanations rooted in ‘humours’, ‘matter’, named organs, and disrupted processes, but only 11.7% of practitioners’ (and even fewer of relatives’).

Even more significantly, men were not afraid to admit to natural vulnerability. Thus 8.8% of causes, or 15.3% of the non-external causes, offered by these men concerned properties natural to a certain part, weak constitutions, predispositions, illnesses, or sensitivities that they claimed inherent to them, or inherited. Indeed, in this sample, sick men found the explanations for their being sick to lie in permanent weaknesses and vulnerabilities natural to their bodies far more often than did practitioners (and, certainly, ‘friends’). Furthermore, far from this being a way of denying bodily weakness, the men who found external, behavioural, explanations were often also the ones describing themselves as having inherent, constitutional, delicacies. Downing, for example, blamed ‘sedentary’ living, ‘poor’ blood, a ‘long Journey’ in bad weather (when already ‘brought pretty low by Physick’), the resultant rheumatism, and the phlebotomy that it necessitated, but also a natural tenderness of constitution.⁷² The man who claimed to have weakened himself by masturbation similarly declared himself to be ‘naturally of a weak constitution’.⁷³

Part iv: Sick Men and the Experience of Sickness

⁷¹ BL, Sloane MS 4075, Hans Sloane consultations, f. 203, T. Molyneux, et al, about Mr Campbell, 6 October 1724.

⁷² *Ibid.*, f. 73, from Henry Downing, 19 July 1726.

⁷³ *Ibid.*, f. 85, from W. E., 23 May 1735.

It was not, however, *causes* that preoccupied sick men. Indeed, not all men were even preoccupied by their illness itself, for there were symptoms that they could live with. As one sufferer told Sinclair, he would not even have taken note of his ‘dull stounding’ penile ‘pains’, even after they spread to the ‘loins down the inside of my thighs’ and ‘at times on my shin bones, about my armpits & down my arms’, had it not been for the circumstances. ‘[I]f I had not reckon’d them symptoms of a Ven[era]l infection I should not have regarded them’.⁷⁴

There were, however, numerous men who *were* worn down physically and mentally by illness. Again and again, sick men were described, and described themselves, as being ‘dispirited’, suffering a ‘loss of spirits’, or being in ‘distress’, and it was most often pain, a lack of sleep, or the prospect of their continuation, that they found the most distressing.⁷⁵ Particularly disheartening were ailments that the long use of multiple medicines, strict regimens and great self-sacrifice had had no effect upon, or long-standing complaints, for *being* long-term.⁷⁶ ‘Being many years subject to those disorders’, Paul Orchard had ‘less hopes of ever being... free from them which I fear grow on me’, while James Innes professed that it ‘allarms me’ that the scurf ‘is now spread all over the back of my hand, & it used to be only in sports [sic]’, and that it had grown despite being ‘very careful about what I eat & drink’.⁷⁷ Nor was this concealed. At least one wife knew that ‘when he reflects of all his regularity, exercises & goeing into company & nothing doe, his being so much dishartned, makes him wors’.⁷⁸

⁷⁴ NAS, GD253/143/6/64/1, Letters sent to John Hope, from William Bruce, undated.

⁷⁵ NAS, GD253/143/6/63/3, Letters sent to John Hope, from Michael Bruce, 12 May 1784; NAS, GD136/436/40, Letters sent to William Sinclair, from Ben Henderson, 9 May 1784; BL, Sloane MS 4077, Hans Sloane consultations, f. 192, from Thomas Fane, 12 May 1723.

⁷⁶ BL, Sloane MS 4078, Hans Sloane consultations, f. 33, from John Sisley, 31 October 1734.

⁷⁷ BL, Sloane MS 4076, Hans Sloane consultations, f. 183, from Peter Orchard, undated; NAS, GD136/436/44, Letters sent to William Sinclair, from James Innes, 8 June 1785.

⁷⁸ BL, Sloane MS 4078, Hans Sloane consultations, f. 184, from Lady Elizabeth Egerton, about the 4th Earl of Leicester, [1702].

An inability to keep down food was another source of great distress, with desperate men announcing that ‘I can’t think of subsisting, being Extremely Reduced for w[a]nt of Victu[a]ls & Rest at night’.⁷⁹ Yet, even when men had multiple complaints it was often still their lack of sleep (or the symptom responsible for it) that they singled out as ‘particularly Distressing’, or ‘the uncomfortable article of my life’.⁸⁰ Practitioners were aware of the way in which physical suffering prevented rest, but a case for which both parties’ representations survive raises the possibility that they might not have replicated the emphases that sick men would themselves have made. While the practitioner told Sinclair that he ‘complains much of an inflammatory corruption in his skin which troubles him... on Acco[un]t of a continual Itching’, the patient claimed that his suffering actually lay in the consequences, he being ‘in the greatest distress... for want of the pills’ ‘procuring me rest and sleep’.⁸¹ He had made similar complaints before, stating in January that it was the fact ‘that I have got no sleep since 7... last night until about 1’, ‘I get no rest either in... or out of bed’, and the medicine ‘procures me no sleep; so that effect of the pills... is intierly done’ that had in part prompted a letter.⁸² Two years previously it had similarly been that ‘I get no sleep’ that was ‘my greatest distres’.⁸³

Otherwise, it was individual symptoms that were singled out, although many letters failed to set out why these in particular caused such distress. However, when men did

⁷⁹ BL, Sloane MS 4076, Hans Sloane consultations, f. 138, from John Nappere, 3 October 1724; NAS, GD136/436/38, Letters sent to William Sinclair, from Ben Henderson, 25 April 1783.

⁸⁰ BL, Sloane MS 4077, Hans Sloane consultations, f. 305, from Arthur Price, 13 February 1734; NAS, GD253/143/6/76, Letters sent to John Hope, from William Brown, 18 July 1785.

⁸¹ NAS, GD136/436/85, 115, Letters sent to William Sinclair, from James Robertson, 30 May 1782, and Alexander Sinclair, 4 May 1782.

⁸² NAS, GD136/436/111-112, Letters sent to William Sinclair, from Alexander Sinclair, 3 and [?] January 1782.

⁸³ NAS, GD136/436/104, Letters sent to William Sinclair, from Alexander Sinclair, 9 July 1780.

give reasons, or others recounted these, they were not to do with symptoms' consequences for men's wider lives, whether feared or already suffered. Men's letters, and their frequently impassioned language, were a reaction to immediate physical experiences, and to the discomfort and, especially, pain that these entailed. Their concern did not lie in their self-image as presented to the recipient, whether as an audience in his own right or because of his power to dispense the diagnoses that would convey the sufferer's situation to 'the world' at large. Nor was it about a need to respond to society's construction of masculinity and men's place in society, whether defensively, habitually and regardless of context, or opportunistically. Even those who expressed a concern for diagnosis were driven by the desire for medical action, not an underlying interest in receiving particular labels.

In these letters, therefore, men were trying to convey the immediacy of their physical suffering, not its significance. They were not grappling with its practical repercussions for their familial, social, and professional roles, or its psychological and social effects through their self-identities and familial and social images. Although evidently able to express in these letters, or to make visible to local practitioners, the *possession* of fear or anxiety, authors only occasionally expanded on their causes. A small minority did vocalize a distress lying expressly in fears for the future, but these were not expressed by reference to specific outcomes, even bodily ones. If they were stated, such fears were very general – the prospect of a continuation of pain, debility and decline, or (less commonly) the progression of the illness into an unstated something even worse.⁸⁴ Often, however, no more was said than that he had been 'reduced to so forlorn a state of health, [tha]t he despairs of ever seeing it restored', or was 'dispirited dreading the bad

⁸⁴ BL, Sloane MS 4077, Hans Sloane consultations, f. 326, from Thomas Powelle, 1 June 1738.

consequences if not a... Remedy... be had'.⁸⁵ Near never did discussions of these fears refer to the wider social and personal fate of the man within the body. Even when sick men were consulting practitioner relatives, and despite frequent claims of friendship, such accounts almost never went beyond the patient's physical symptoms or, at most, his emotional response to the *bodily* aspects of these complaints.

There were only very specific circumstances in which it was the repercussions that these men's letters focused on. These were, furthermore, *medical* circumstances, and usually bodily consequences. Men were, for example, able to express aesthetic considerations. Thus, an 'eruption' on the back of one hand (and a palpitation) were sufficient for one patient to declare that 'I cant stir any where until... quite [sic] of this confounded disorder'.⁸⁶ Even a former soldier-sailor announced that '[a]s I never had in my life the least blotch upon my Skin. I shou'd be glad to get rid of this'.⁸⁷ Practitioners showed the same concerns *for* men. A physician treating his adult son in 1716 for 'Tumors' on the brow, and a decay in the bone above, announced in his very first letter that incision had to be avoided, 'to prevent an unavoidable scar in the forehead'. A week later he re-stated that any scars 'will be all in view; therefore... to cure without Opening the Skin... all Expedients are to consider'd'. Significantly, the affliction had been caused by his son's efforts 'to take away large Pustules of his Face... contracted by the Smal-pox... 25 yeres since'.⁸⁸

Usually, however, where men gave reasons for being especially distressed by specific

⁸⁵ Ibid., f. 170, signature damaged, 22 March 1703; BL, Sloane MS 4075, Hans Sloane consultations, f. 85, from E. W., 23 May 1753.

⁸⁶ NAS, GD136/436/44, Letters sent to William Sinclair, from James Innes, 8 June 1785.

⁸⁷ NAS, GD253/143/6/61/1, Letters sent to John Hope, from Edward Hamilton, undated.

⁸⁸ BL, Sloane MS 4077, Hans Sloane consultations, ff. 25, 14, from William Smith, M.D., 4 and 11 November 1716.

symptoms these lay in their painfulness, longevity and anticipated continuation. Patients with sight problems were subject to similar fears, 'his sight growing worse & worse notwithstanding [th]e many Evacuations & Revulsions that have been made' 'set[ting] such a weight upon' Sergeant Reynolds's 'spirits, that he is hardly able to bare up under it'.⁸⁹ Very rarely were fears said to come even from the deeper troubles that such symptoms were suspected to reveal.⁹⁰ Instead, it was usually current (physical) effects that men claimed had caused them to single out particular symptoms, and these that ensured that it was not only the unexplained nature of complaints that exacerbated emotional distress.⁹¹

There were, however, cases in which the problems singled out involved mobility, and men did not need to be literally lame to do this. While the elderly Sir Ambrose Phillips's 'Greatest Greif' was 'soreness, and... paine in... his Hipp Bones and Back, and [that he] Cannot stir to goe without being supported under the Armes by two people', a gravel-sufferer finished his account with the claim that '[t]he pain in [th]e region of my Kidneys is as great as ever, so that I'm disabled from walking much abroad, or riding' (as well as that 'I can't sit long').⁹² Reynolds Calthorpe had numerous 'very greivous', 'very troublesome' and 'violent' complaints but it was the breathlessness that he singled out as the 'most vastly irksome', because 'I am [th]e most *incomoded to mount my horse*... I am soe much put out of breath by it'. He added that 'my leggs are so swelled... that I can hardly put on boote'.⁹³ Alexander Sinclair stated that the swelling and itching of his legs 'drives away all sleep' but still focused on 'begg[ing]' for the

⁸⁹ BL, Sloane MS 4034, Hans Sloane consultations, f. 280, unsigned and undated.

⁹⁰ BL, Sloane MS 4078, Hans Sloane consultations, f. 323, unsigned and undated.

⁹¹ Ibid., f. 200, from Thomas Osborne, 15 January 1705.

⁹² Ibid., f. 86, unsigned, on Sir Ambrose Phillipps, 6 April 1706; *ibid.*, f. 296, unsigned and undated.

⁹³ BL, Sloane MS 4034, Hans Sloane consultations, f. 289, from Reynolds Calthorpe, 1 August 1719 (my emphasis).

‘taking off this swelling that I may be able to put on shoes. If I were able to do this and red out; I flatter myself I might recover’. Five weeks later, it was ‘my confinement here’ that was seized on as ‘very hard on me’, the swelling ensuring that ‘I have never been able to put on a shoe’.⁹⁴

Yet, Alexander was highly unusual in complaining so vocally of his *confinement*. One man, suffering only from burning stools, demanded ‘nothing [tha]t need confine me to the House’, and another wondered if there would ‘be any harm in suspending the medicines... as I need to be sometimes from home’.⁹⁵ However, men suffering from lengthy confinement and disability did *not* make vehement declarations of antipathy to the house or inactivity. Not even their pain and frustration led to these men being carried away by morbid, angst-filled imaginations, let alone ones rooted on the implications of sickness for their lives outside the sick room. Their expressed concerns were still about things current and physical, and even Alexander’s discomfort seemingly came from the desperate belief that riding would cure him. Other men described their immobility only to convey the severity of their symptoms, without bemoaning its personal or social consequences, and without those declarations of weighted spirits and fears for the future that other men made in the face of pain and sleeplessness.

This was true of sick men generally. Where they had specific requirements, or were concerned to raise particular issues, these were not about the relationship between (the) illness and their lives. The Duke of Newcastle was unique in even appearing to countenance allowing socializing to disrupt treatment, asking if blistering after drinking

⁹⁴ NAS, GD136/436/106, 108, Letters sent to William Sinclair, from Alexander Sinclair, 12 August and 18 September 1780.

⁹⁵ BL, Sloane MS 4076, Hans Sloane consultations, f. 155, from Thomas Pelham-Holles, Sunday; NAS, GD253/143/6/39/5, Letters sent to John Hope, from Henry Burt, 2 December 1783.

would be dangerous because ‘I am to have... many Foreigners on Monday with [who?]m I may drink plentifully’.⁹⁶ Certainly, men who proposed drinking framed it in a therapeutic way, and being sociable, keeping up appearances, concealing sickness, or fulfilling specific social or ceremonial obligations, made no appearance.⁹⁷ The threat that illness posed to official and professional positions was also absent, as were risks to relationships, except for Peter Patrick (above), fearing that ‘the Person, on whom is my chef dependence, will... proceed to Extremitys... if I can not soon come into hir Proposals of mariages [sic]’.⁹⁸ Socially prevalent notions of masculine character did not lead men to construct their illness, tales of its rise, or statements of its severity (and calls for its urgent cure) through their disrupted social or occupational roles. Nor did they need to do this in order to distract observers from their suffering, and from the emotional or physical vulnerability that this revealed.

As chapter 7 argues, these consultations reveal a strong sense of claimed intimacy between patient and practitioner, creating dialogues with room for the social and personal. This intimacy did not, however, stretch to the sufferer’s personal life as impinged upon by his sickness. The often very personal nature of the medical relationship extended only so far. In epistolary form at least, a line was drawn at the expression of the social, personal, occupational, and even financial, experience of sickness, and this was a line that almost all of the men writing to Sloane, Hope and Sinclair observed, unless needing charitable help. The patient’s family was rarely mentioned, and it was only in letters recommending charity cases, usually for blindness,

⁹⁶ BL, Sloane MS 4076, Hans Sloane consultations, f. 153, from Thomas Pelham-Holles, undated.

⁹⁷ *Ibid.*, f. 44, from Timothy Lovett, 12 February 1722.

⁹⁸ BL, Sloane MS 4078, Hans Sloane consultations, f. 236, from Peter Patrick, 10 January 1731.

that men's need to work, role as provider, or having dependants, surfaced.⁹⁹ Indeed, and whether it was patients, friends, wives, offspring, siblings, or practitioners writing, consultation letters near never mentioned even men's *capacity* to work, even to depict the complaint's severity or to assess improvement.¹⁰⁰ Yet, anxieties did exist. They surfaced, for example, in discourses with current or coveted patrons, where men of a range of statuses expanded on the consequences of their health for their working lives, and *vice versa*.¹⁰¹ Their non-medical correspondence shows numerous men of high birth, the professions and the cloth – and, indeed, their inferiors – either being forced to allow bad health to disrupt their professional and social lives or complaining that their occupations had caused them harm.¹⁰²

Conclusion

This chapter began with social constructionists' interest in the 'subjective experience of illness', sickness being something 'managed in the social contexts that sufferers inhabit'.¹⁰³ Yet, as visible in these letters, men's experiencing, imagining, and retelling, of the sick body was not socially conditioned to be masculine. Nor, furthermore, did sickness lead these male letter-writers into the reactionary self-identification with such

⁹⁹ BL, Sloane MS 4077, Hans Sloane consultations, f. 286, petition of John Thompson, undated; *ibid.*, f. 240, Ann Townsend on unnamed, 1 January 1739, and f. 241, his self-account, undated. These were also amongst the tactics utilized in petitions by applicants (of both genders) for non-resident poor relief during sickness (Thomas Sokoll (ed.), *Essex Pauper Letters 1731-1787* (Oxford, 2001), pp. 715, 289).

¹⁰⁰ For an exception, using a man's inability to 'apply himself to any business [that] requires much thought or attention' (or to stoop or look closely) to prove the severity of his symptoms, see BL, Sloane MS 4078, Hans Sloane consultations, f. 329, unsigned and undated. Despite mentioning being 'thrown out of bread' in the first of six, frequently dramatic, surviving letters, James Hay's following accounts made no mention of his subsequent fortunes (NAS, GD253/143/5/1-10, Letters from James Hay to Hope, with Hope's reports (1781-1784)).

¹⁰¹ NAS, GD248/226/4/75-6, GD248/353/1/4, Grant correspondence, Richard Falconer to Hugh McVeagh, 30 May and 11 July 1774 and 9 November 1772; NAS, GD44/43/246/26, Gordon family correspondence, James Beattie to James Ross, 9 December 1780; NAS, GD248/50/5/34, Grant of Grant correspondence, John Grant to [?Sir James Grant], 2 September 1773; NAS, CH12/12/298, Episcopal chest, Honourable Archibald Campbell's resignation as Bishop of Aberdeen, 5 April 1725.

¹⁰² NAS, GD157/2941/1, Papers of the Scott family, Alexander Boswell to Hugh Scott, 10 September 1780; NAS, CH12/24/324, Bishop Petrie's correspondence, William Mitchel to Arthur Petrie, 5 December 1778; NAS, GD44/43/89/3, Gordon family correspondence, Charles Gordon to James Ross, 3 April 1773.

cultural constructs that would suggest the fragility of gendered identities. On the contrary, the male authors of consultation letters – and, indeed, those writing on their behalf – seem to have been readily able to detach their illness, and the fact of being ill, from their maleness and masculinity.

It is not, however, only maleness and masculinity that are missing. Body and sufferer are themselves difficult to uncover, for sick men usually did little to contextualize or populate the account of their illness. Even when occasional men produced lengthy case histories, some heavily concerned with explanation, they did not necessarily include individualized detail, physical *or* personal. Even sick physicians sometimes recognized only symptoms, and it was unusual even to say ‘[a]ge 54; strong, well proportiond, of a robust Constitution, and much too corpulent; His bulk rather owing to plentiful drinking then eating’.¹⁰⁴ If practitioners gave ages it was normally for the elderly, and if any natural bodily state or type *was* mentioned it was generally in being ‘robust’ or ‘strong’, usually in a single word and at most a handful (‘of a robust strong constitution’).¹⁰⁵ The fact of sobriety or indulgence, or ‘sedentary’ living, featured more often, but still merited only a few words. Instead, it was elsewhere that practitioners contextualized heavy drinking and late nights within the homosocial conviviality of the male professions.¹⁰⁶ Indeed, practitioners who thought even personal *physical* information relevant still considered dietary intake more important, and the complaint’s development even more so.¹⁰⁷

¹⁰³ Conrad and Baker, ‘Social Construction’, pp. 571-572.

¹⁰⁴ BL, Sloane MS 4077, Hans Sloane consultations, f. 290, from John Tabor, on the Duke of Newcastle’s steward, 29 November 1725.

¹⁰⁵ BL, Sloane MS 4076, Hans Sloane consultations, f. 317, from John Manners, undated.

¹⁰⁶ BL, Sloane MS 3984, Letters and papers (seventeenth- to eighteenth-century), Sir Hans Sloane, ff. 282-285, Sir Hans Sloane’s account of the last illness of Christopher Monck, 2nd Duke of Albemarle (1687).

¹⁰⁷ BL, Sloane MS 4075, Hans Sloane consultations, f. 203, T. Molyneux, et al, on Mr Campbell, 6 October 1724 (from Dublin).

The person himself was, furthermore, almost uniformly absent. Even challenging a physician's accusations of heavy drinking, and doing so when such criticisms had not been apportioning direct blame, was exceptional.¹⁰⁸ With the contexts for even individual behaviours usually absent, lives as a whole were near-never implicated. Friends rarely waxed eloquent on the virtues, or connections, of men even to encourage Sloane to accept the patient, and never did this by revealing that sick men were fathers or husbands, let alone good ones.¹⁰⁹ Nor, on the other hand, was the way that illness had impinged upon men's lives seized on when remembering sickness, and even as a gauge of severity. Certainly, it was not acute or potentially fatal illnesses that filled James Burgess's medical history as he made sense of it in 1784, but the day-to-day grind of nausea, costiveness, and aching teeth.¹¹⁰

Indeed, in the narratives chosen by letter-writers, the tale of the suffering body became one confined to the decisions and experiences of the sick room the very moment that the illness or relapse was caused. Consequently, the symptoms and ill body were usually divorced from even the sufferer himself in anything other than the *fact* of his pain and dispiritedness and anxiety, it being rare for patients to make even such comments as 'I can be chearfull in Company, or follow my business till it returns', here to emphasize the ailment's intermittent nature.¹¹¹

¹⁰⁸ BL, Sloane MS 4076, Hans Sloane consultations, ff. 375v-376, Simon Adams on Mr Ives, 5 April 1719.

¹⁰⁹ But see *ibid.*, f. 274, Stephen Poyntz about Dr Cannon, 26 February; *ibid.*, f. 254, Margaret Cavendish Bentinck on a royal footman, 8 December; *ibid.*, f. 154, Thomas Pelham Holles about the Bishop of Chichester, 26 July 1729.

¹¹⁰ NAS, GD253/143/6/37, Letters sent to John Hope, from James Burgess, 6 January 1783.

¹¹¹ BL, Sloane MS 4076, Hans Sloane consultations, f. 236, from Thomas Peirce, 1 January 1725.

Significantly, the research undertaken in this chapter suggests several observations about men's experience of sickness and of being under a practitioner that might explain this textual depersonalization of the sick body. In particular, it encourages the conclusion that men generally experienced sickness in a way free of embarrassment about their self-identities, at least within the patient-practitioner relationship. Indeed, male sufferers' epistolary detachment of sickness from themselves as men indicates that succumbing to illness, and the subsequent experience of being ill or under a practitioner, was not deemed a threat to their self-images. It seems that masculine identities were sufficiently resilient for sick men to automatically presume that their images and reputations would be unaffected by the revelation of bodily failure and vulnerability, practitioners' potential critiques of patient or body, the possible self-inflicted nature of some sicknesses (or the possibility of others presuming this), or men's subsequent behaviour (or limited capacities beyond the sick room) as sufferers.

Indeed, their self-authored consultation letters show that even in times of prolonged physical failure the men who did seek professional help were free of an embarrassment about the body that could otherwise have caused them to hesitate in doing so. At the very least, these male letter-writers seem to have allowed themselves great liberty in the articulation of what they felt to be potentially pertinent to the sickness and, therefore, to be possible hints to its removal, even when this involved sustained failure or innate delicacy of the inner body. As their letters reveal, men had full freedom to announce – at least to practitioners – what they felt to be the true condition of their bodies, and the reasons for this, in the functional pursuit of a successful cure.

This research encourages, therefore, the observation that men at least imagined their experience of the sick body itself as being primarily about physical sensations. Certainly, these patients wrote of their physicalities in purely physical terms, deviating only to emphasize the severity of such physical effects by reference to their being distressing psychologically. Yet, rather than this reflecting an anxious and self-conscious, reactive, severing of the individual (and his identity) from his failing body, the candour of these letters suggests that it was the pre-existing allowance of a comfortable distance between the two that allowed men seeking medical help full liberty in exposing what they interpreted as the true natures of their bodies. That so few sick men identified with fashionable weaknesses and physical liabilities reinforces this impression of a medical experience characterized by close and honest self-scrutiny in the careful concern for factual exactitude. Yet, while the problematic body was in some ways depersonalized, as represented in these letters the male experience of sickness was not one dominated by resentment, railing against this body as something cast upon the patient, some extraneous object that the individual had to endure. Instead, these sick men had a relationship with the suffering body that was very much matter of fact, they being concerned with, and responding to, it in these letters purely as a physical object having material effects to be coped with. That it was only intermittently that anything constitutional was blamed does not, therefore, prove that a stigma surrounded natural weakness, even for a sex modeled medically and culturally as 'robust' and 'strong'. When men (or their wives) *did* blame constitutions, including those naturally 'tender', it was matter-of-factly. Indeed, seizing on external, accidental, causes was not necessarily any less a recognition of vulnerability. Nor was it the product of a need to find ways, let alone *masculine* ways, of explaining away their plight.¹¹²

¹¹² BL, Sloane MS 4075, Hans Sloane consultations, f. 193, S. Gyllenborg on Carl, Count Gyllenborg, 11

Consequently, these letters cannot reveal the types of illnesses, and issues within these, that had the most effect on men's lives, and *vice versa*. Indeed, it seems that culture did not always shape the construction of illness, or the construction and resultant experience of the immediacy of physical suffering. Certainly, these men did not, for example, assess the suffering body through its capacity for gendered tasks, while those few who proposed drinking left no evidence that their concern was to prevent the (failings of) the body becoming public knowledge. Those who did, on the contrary, and highly unusually, focus their concerns on an ailment's implications for their lives were those whose illnesses touched upon these most marginally. They did so, furthermore, as a product of personality, not in the concern that the recipient receive the 'correct' picture of their character, defined by professional success.¹¹³

In these letters, therefore, men showed no sign of being programmed culturally to (re)align themselves with masculine and patriarchal duties, fatherly responsibilities, their professional worth, or a robust, outdoors, life, even when ill or inactive for lengthy periods of time. Nor did they reveal any anxiety about the male sexual role, and that procreative ability on which depended the attainment of a patriarchal position, or indeed about masculinity itself. The next chapter, however, tests whether *healthy* men's self- and social-identities were reliant on the performance of masculine behaviours, and ones

August 1729 (from Stockholm).

¹¹³ BL, Sloane MS 4034, Hans Sloane consultations, f. 238, from Peter Calmell (a teenage 'Student of the Law' who 'find[s]' his poor sight 'agreat [sic] Inconveniency and... am Ashamed to wear Spectacles in an Open Court'), 26 January 1738.

that made them sick. It asks whether masculinity was more damaging than these letter-writers saw fit to mention, or felt culturally obliged to claim.

Chapter 5: The bodily costs of living as men

Introduction

Writing in 1775, the ‘nerve doctor’ James Makittrick Adair dedicated hundreds of pages to the implications for health of the different states of the nerves and ‘solids’.¹ However, when it came to the health effects of sex and gender some of his concerns, and explanations, were very different. While women’s pathology was ultimately explained by another element of their sexed nature – the reproductive organs – there was no conflation of men with *their* sex. Instead, females were reduced to reproduction (and a concomitant domesticity) and men to the dangers of the world at large. Thus, men’s bodies and health were made to be about their gender, and about the physical costs of living in this gendered way.² The text had claimed previously that men who lived an inactive, domestic, life brought upon themselves chronic illness. However, Adair argued here that an active lifestyle, lived outside of the home, was harming men at large, not by creating long-term sicknesses, as inertia did, but by killing them. For Adair, it was ‘[i]ntemperance and the hazardous employments of men, not only in various occupations in civil life, but also during war, [that] destroy many men’.³ It was because of lifestyle factors that ‘it has been found that of unmarried men the proportion of those who die, to... unmarried women, is 12 to 11’ and the ratio ‘of married men to married women.... 15 ½ to 10 ½’ (31:21).⁴ A masculine culture, occupational and recreational, was allegedly killing men.

¹ For Adair see G. S. Rousseau, ‘Towards a Semiotics of the Nerve: The Social History of Language in a New Key’, in R. Porter and P. Burke (eds.), *Language, Self, and Society: A Social History of Language II* (Cambridge, 1991), pp. 213-275, esp. 228, 231, 235-238. See also above, pp. 53-59.

² James Makittrick Adair, *Commentaries on the Principles and Practice of Physick...* (1772).

³ *Ibid.*, pp. 80-81.

⁴ *Ibid.*, pp. 83-84.

Two and a half centuries later, masculine behavioural tendencies are still given centre stage when identifying and explaining a characteristically ‘male’ health pattern. It is still said that ‘[m]ost of the leading causes of death among men are the result of... gendered behaviors’.⁵ The range of behavioural factors has been expanded to include sexual behaviour and indulgence in recreational ‘risk-taking’, yet heavy drinking and gendered occupations continue to be seen as some of the crucial forces behind unfavourable male morbidity and mortality rates.⁶ Indeed, social historians again and again identify remarkably similar ‘male’ behaviours as existing in the seventeenth or eighteenth centuries. While Alexandra Shepard found these in a youthful counter-‘manhood’, others have written of promiscuity, violence and drunkenness as tendencies of men in general.⁷ Indeed, what Shepard highlighted as the ‘excess’ of youth does appear but an exaggeration of some of the universal values that Elizabeth Foyster put at the heart of elements of seventeenth-century ‘manhood’.⁸ Such historiographical claims are, furthermore, endorsed by a recent historical study of gendered medical needs. In a section on ‘gendered’ ‘suffering’ given in a thesis on women’s healthcare, Lisa Smith reached similar conclusions to Adair.⁹ For Smith, later-seventeenth- and eighteenth-century England and France did make both occupations and involvement in public pleasures gender-specific, and this made men ill. ‘Several male health problems occurred because of men’s... public social roles and opportunities beyond the

⁵ Series editor’s introduction, in Donald Sabo and David Frederick Gordon (eds.), *Men's Health and Illness: Gender, Power, and the Body* (1995), pp. vii-viii.

⁶ Nikki Bradford, *Men's Health Matters. The Complete A-Z of Male Health* (1995), pp. 165-199, 255-268, 296-420, 463-472.

⁷ Alexandra Shepard, *Meanings of Manhood in Early Modern England* (Oxford, 2003), p. 105.

⁸ Elizabeth Foyster, *Manhood in Early Modern England. Honour, Sex and Marriage* (Harlow, 1999), pp. 40-41.

⁹ Lisa Smith, ‘Women’s Health Care in England and France, 1650-1775’ (unpublished Ph.D. thesis, University of Essex, 2001), pp. 90-131.

household’, and ‘men contracted many of their illnesses from activities outside of the home: debauchery, stresses of business, or work-related activities’.¹⁰

While Smith’s interest lay in the possibility of difference between the two genders, this chapter concentrates on men. Where possible, it also focuses on Adair’s concern, the causes of their deaths. Searching for the bodily repercussions of allegedly pervasive ‘masculine’ behaviours, it tests whether the medical records allow the historian to follow Adair in concluding that there was a distinctive men’s experience of the body, and one that came from culture and the public world. That is, on the one hand, from the ‘work’ (already differentiated from unwaged domestic duties) required of men in the gendered division of labour.¹¹ And, on the other, from the social behaviours said to have been demanded by society’s ideals of ‘manhood’ and ‘masculinity’, and allegedly entrenched in a routine gendering of public ‘leisure’.¹² In testing this, it ultimately asks whether the formal medical record can support the claims made by cultural, social, and gender historians, and their suggestion of a shared male and masculine culture predicated on drink, sex and violence. Consequently, it begins with Adair’s interest, the gendered cultural causes of male deaths. It then assesses the claim that men’s jobs (and ‘men’s work’) were so bad for the health as to be fatal, before moving to the bodily repercussions that male drink-based conviviality, aggression, and sexuality surely should have had if as prevalent as claimed.

Part i: Explaining Death

¹⁰ Ibid., pp. 93, 100.

¹¹ Robert Shoemaker, *Gender in English Society 1650-1850: The Emergence of Separate Spheres?* (Harlow, 1998), p. 125.

¹² G. J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago and London, 1992), p. 53.

The collection of morbid anatomies and occasional cases started by the London-based Scottish surgeon John Hunter (1728-1793) made an unusual degree of reference to the case, the man, and his medical history.¹³ Ranging from the 1750s to 1802, 153 of the reports visibly discussing males aged sixteen or over named an illness or injury, although not always as the cause of death. Hazardous living was, however, surprisingly absent. Despite the inclusion of men ranging from soldiers and labourers to a prime minister and the titled, not one's corpse, or medical history, was described as showing the signs of excessive alcohol, or of the coffee and tobacco consumed in the allegedly male enclave of the urban coffee shop.¹⁴ A cold and a spate of hunting 'very severely' were together blamed for that exacerbation of a lifelong heart condition concluded to have killed Mr Bulstrode in the winter of 1780-81, this disorder having caused 'almost... total suffocation' upon any 'violent exercise such as hunting' (but also, eventually, on any 'anxiety').¹⁵ Sir William Stonehouse was similarly said to have destroyed his 'Constitution... by living rather free, exposing himself to colds by getting up early' and 'hunting in all weathers'.¹⁶ These were, however, the only medical histories, case histories or corpses to be described as showing the effects of athleticism, sports injuries, heavy labour, or exposure to the elements.

Even alcohol featured only descriptively. There was an illness initially taken for 'a cold, as he had been intoxicated, & slept out of his lodgings', and an account that began by

¹³ RCS, MS 0189/1/2, 'Records in Morbid Anatomy' (men's dated cases 1774-1802), John Hunter; RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', (men's dated cases 1755-1782), *idem.* Accompanying case histories revealing far less about the individual's life include RCP, MS 109/3, Postmortem examination of the Right Hon. George Grenville (1770), unsigned (but 'examined by Mr Harkins in the presence of Dr. Lawrence, S[ir] W[illiam] Duncan and Dr Hunter'). The appendix gives further information on the analysis of the Hunterian anatomies.

¹⁴ See Helen Berry, *Gender, Society, and Print Culture in Late Stuart England: the Cultural World of the Athenian Mercury* (Burlington, VT, 2003), pp. 56-58.

¹⁵ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', Hunter, no. 39; RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', *idem.*, no. 184 (for the dissection).

¹⁶ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 4.

stating that the cadaver belonged to a gardener ‘a good deal addicted to drinking’. If this was seen as having any medical significance it was not, however, stated.¹⁷ A servant was recorded as being a hard drinker but there was no effort to establish any causal relationship between alcohol and the apoplexy that killed him. Nor was there any claim to have found in any organ the effects of his behaviour.¹⁸ Two other men were said to have suffered at some point what had been known or suspected at the time to be gouty humours, and an earl was both described as ‘long affected with the Gout’ and concluded to have died from it.¹⁹ The causes of these afflictions were not, however, stated. Printed literature claimed that it was those gorging ‘on... *high Seasonings, and Spicy Sauces*’, ‘using *too little Exercise*’, and, significantly, ‘drinking liberally of *generous Wines, and other strong Liquors*’ who were most prone to gout, yet in none of these Hunterian cases and postmortems was any indication given of the believed cause of men’s gout, whether or not in a way that would have supported Adair’s claim of fatal ‘intemperance’.²⁰

It is only slightly easier to find the authors of these reports even *possibly* linking men’s deaths to their sexual behaviour. Indeed, not one medical history or organ-by-organ description of the corpse mentioned men having *previously* had (non-fatal) venereal disease. There was only one man whose symptoms made a recorder consider venereal infection as a *current* diagnosis, and it was simply noted, without comment, that he ‘declared he never to his knowledge had the Disease’.²¹ As a cause of death, moreover, it was only once felt that there was ‘reason to suspect it’, and in this case the dissector

¹⁷ Ibid., no. 67, 69.

¹⁸ Ibid., no. 3.

¹⁹ Ibid., no. 4, 6; RCS, MS 0189/1/3, ‘An Account of the Dissection of Morbid Bodys’, *idem.*, no. 174.

²⁰ R[obert] Drake, *An essay on the nature and manner of treating the gout...* (1758), p. 11 (original italicization).

²¹ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, Hunter, no. 22.

was still 'not sure whether' the fatal urinary stoppage 'was Venereal'.²² Only one other report featured sexual behaviour even tangentially or contextually, yet expressly dismissed it as a cause of death. Its introduction recorded that this sixty-year-old, 'ailing with a wore out Constitution', married a younger 'maid', went to bed 'to her', and soon fell ill, adding that '[i]t is not known whether or not he was taken Ill in [th]e act of Consumnation'. Yet, the conclusion reached from the postmortem was that, even combined, the 'Appearance' of his organs and the alleged 'situation' 'were not sufficient to account for his Death'.²³

There are even fewer hints of violence, and where human-inflicted injuries were recorded it is not always clear that they killed. Only once was an expressly fatal wound expressly linked to violence, and the victim of this injury was shot in unspecified circumstances, from forty feet away.²⁴ Another account, of 'a Young Gentleman... Stab[b]ed with a Sword', contains nothing stating that it killed him, while it is only the fame of the event that enables the historian to state that 'Mr Chaworth who was stabd by Lord Biron' in 1765 died the next day.²⁵ Beyond these, not one of the numerous other accounts of wounds and injuries, fatal and non-fatal, includes even those references to stab-wounds, attackers, or swords and fists that might suggest the *possible* involvement of violence.

These accounts were even more silent about the consequences of what, according to the ideals highlighted by gender historians, should have been seen as unmanly behaviours.

²² RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', *idem.*, no. 14.

²³ *Ibid.*, no. 142.

²⁴ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 29.

²⁵ RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', *idem.*, no. 105; RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 104. Chaworth, Byron's cousin, was killed in a

Indeed, these were behaviours that, in printed medicine, were criticized when adopted by males. Adair was not alone in arguing that ‘sedentary’ living made, or was making, men ill, and others of the eighteenth century used this inertia to explain the vulnerability of certain types of men to nervous disease and gout, or to periodic evacuations.²⁶ Yet, these were not concerns, or explanations, shared by these dissectors. They never claimed that confinement, scholarliness or urban inertia were being revealed in the corpses and medical histories of even the titled and professional, let alone fatally.

Men’s occupations are only slightly more visible as the (ascribed) cause of death than is masculine leisure. Whether before or after death, very few parties were recorded in these notes as ascribing even non-fatal health problems to men’s work. Thus, even military employments featured only twice. The ulcerated stomach of an artilleryman stationed abroad was blamed on ‘the intermittent fever of the island’, but this was the sole case in which non-fatal sicknesses were attributed to men’s occupations of any kind.²⁷ The other soldier had been shot in 1759, but continued serving and ‘always appeared strong and healthy’. Yet, when he died years later, from a ‘fit at the door of his ‘hut’, the postmortem placed the blame on the bullet, in a splinter of bone presumed to have caused a cerebral running.²⁸ Civilian occupations were, however, blamed even less frequently for such fatal illnesses, by the dissectors at least. Thus, while one man died from a complaint emerging ‘soon after’ making a preparation of lead, the postmortem

tavern dual, in a quarrel about drink (Robert Shoemaker, *The London Mob. Violence and Disorder in Eighteenth-Century England* (London and New York, 2004), p. 192).

²⁶ William Forster, *A treatise on the causes of most diseases...* (2nd edn., 1746), p. 343. See also above, pp. 53-54, 61, 63-65, 154.

²⁷ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, Hunter, no. 49.

²⁸ *Ibid.*, no. 24.

operators rejected the prior claim that a bricklayer's labourer's fits (the cause of a fatal knock to the head) had come from 'carrying weights upon his head'.²⁹

Similarly, although falls and blows, or their eventual repercussions, were said to have killed numerous men, few were given the contextual details that reveal an occupational setting. Thus, while thirteen men were described as being killed by falls or blows to the head, only two of these incidents had clearly occurred at work. Both were falls, one from scaffolding and one onboard (as a sailor), with the latter, it was presumed, acting in conjunction with the consequences of a prior hernia.³⁰ Another fatal fall did apparently happen while doing labour of some kind, occupational or otherwise, when a man fell while carrying 'a load', and a fatal blow from falling timber might *potentially* have occurred at work, as *might* have the fall from a coach box.³¹ Otherwise, the context of these fatal accidents is inaccessible, two men receiving unspecified 'blows', two falling down stairs, three more falling during unrecorded activities (in a stable yard, from the third floor, and 'from a considerable height'), and one injuring his ribs and brain in an unstated incident.³²

Hunter's collection does not necessarily reflect the medical histories, and deaths, of all men. This was a compilation mixing post-mortems on hospital patients, autopsies on the rich, curious specimens discovered whilst preparing teaching cadavers, and bodies coveted because of prior conditions. Whilst this might bring into question the representativeness of the causes of deaths included it does not undermine the

²⁹ RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', *idem.*, no. 98; RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 14.

³⁰ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 8; RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', *idem.*, no. 42.

³¹ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', *idem.*, no. 33, 17, 19.

significance of the absence of behavioural factors in these men's medical *histories*, or when reporting on the condition of the body and organs. Indeed, such silences were often replicated in histories compiled while patients were still alive, raising the possibility that in the eyes of many practitioners men were not, as a group, slowly being killed by their lifestyles.

Problematically, there are also sources that suggest that men's behaviours were not claimed to be killing them suddenly either. Few collections of coroners' records have pre-1800 content, and where such entries do exist they are dwarfed by those of later decades.³³ However, those inquests into sudden deaths that are available do not show that a large proportion even of men who died suddenly and unexpectedly were believed to have died from violence or drink.

In the staging post of Marlborough (Wiltshire), the records offer little in support of Adair's claims. Nineteen coroners' verdicts survive from 1773-1800, prompted by the deaths of nine males and five females aged sixteen or over, and five children.³⁴ In absolute terms it was men more often than women who were concluded to have been killed by accidents, yet these far from dominated the deaths even of men who died suddenly. Drink, furthermore, was totally absent. Indeed, a third of even the (few) men who died suddenly and unexpectedly were concluded to have been killed by natural causes, and two more to have killed themselves (one whilst insane). Only one was the victim of manslaughter, although three of the men, a third, died in accidents, two from falls whilst travelling.

³² Ibid., no. 15-16, 20, 32, 37; RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', idem, no. 141, 146, 151.

³³ Suggesting poor survival rates.

There is, therefore, little evidence of any masculine culture killing men, even in a small town where the male ratepayers of the coroner's jury might have been familiar with victims' ways of living. The only male to die at another's hand was killed accidentally, in a game, teenagers 'throwing stones at each other in the way of... play' (1775). There might be suggestions of a gendered way of raising *boys*, but in Marlborough men were not killed by their leisure activities, at least not suddenly. The same was true of accidents while working, which killed only one male over the age of sixteen, a seventeen-year-old helping his father to grease the wheels of another man's wagon.³⁵ The Marlborough records seem to suggest that if membership of a male and masculine world did impinge on the body it was in long-term repercussions, not in those accidental or sudden fatalities that surfaced in inquests.

Yet, in Suffolk the picture is very different, in certain elements at least. In total, 206 males received (surviving) coroners' verdicts between 1767 and 1800. Although the twenty-four given ages were all children, primarily infants, a contextual reference suggests that the remaining 182 were not exclusively adults.³⁶ There was again, however, a marked absence of not only violence explained by drink but also spontaneous attacks, planned bouts, and aggressive sports (table 5.1).

³⁴ As there are no entries for 1792-1798, the editor concluded that the collection is incomplete (Jean A. Coled (ed.), *Marlborough Coroner's Inquisitions 1773-1835* (Devizes, 1993), p. 6).

³⁵ *Ibid.*, pp. 7-51.

³⁶ This was a reference to 'playing'.

Table 5.1 Male causes of death in Suffolk coroner verdicts, 1767-1800³⁷

Category	Cause	Deaths (as a percentage of 182 male deaths)	Details
Potentially killed by 'masculine' culture	Drink	3.3%	Excess drink (2); in liquor (1); liquor fumes (1); a fit due to drink (1); cart accident when drunk (1)
	Exposure	1.1%	Incl. got lost (1)
	Killed by man	0.5%	Method unspecified
	Hunting accident	0.5%	Wildfowling
	Collapsed ploughing	0.5%	
	Sea	23.6%	Shipwrecked; washed ashore; fell off
	Swimming	4.4%	
Killed by women	By woman	0.5%	Shot
Transport	Horses, cart/wagon	12.6%	
	Cart/wagon that clearly driving	2.7%	
Accidents	Struck by objects	3.3%	
	Falls	2.7%	
	Drown (non-sea)	2.2%	
	Fall into boiling substance	1.1%	
	Fall from tree	1.1%	
	Sand pit caved in	0.5%	
	Stoppage of breath	0.5%	
Killed self	Suicide or lunacy	10.4%	
Natural	Illness, fits	18.7%	
Exhaustion		0.5%	Ran away
Unspecific	Name only place	2.7%	
No details		3.8%	
Total		182 (100%)	

Source: Leslie Smith and Doreen Smith, *Sudden Deaths in Suffolk 1767-1858. A Survey of Coroner's Records* (Ipswich, 1995)

³⁷ Data from Leslie Smith and Doreen Smith, *Sudden Deaths in Suffolk 1767-1858. A Survey of Coroner's Records* (Ipswich, 1995), pp. 23-60.

Men's sudden deaths in Suffolk did, by contrast, show the effects of the area's coastal location. Thus, the sea was responsible for a quarter (forty-three) of these 182 male deaths but for less than one-fifth (two) of the thirty-five unexpected deaths of females not labelled as children.³⁸ However, thirty-six of these forty-three drowned males were 'unknown'. While this makes it possible that only eight men from Suffolk had prompted coroners' inquests in their own community by drowning at sea it also raises the possibility that *Suffolk* men were similarly being washed up, and recorded, elsewhere. Indeed, of those not labelled children, all of the eight males killed at sea whose identities were known had been on boats or ships, yet only one of the two drowned females.

Even without these 'unknown' males, more males died suddenly or unexpectedly than did females, for only forty-seven females of any age prompted coroner inquests. Furthermore, 37% of those thirty-five females not labelled as children had, it was concluded, died naturally, but only 19% of that much larger number of potentially adult males. Another 34% of these thirty-five females had died at their own hands (some while insane), compared to only 10% of the five times as many possibly adult males. Accidental deaths were, therefore, male both relatively and absolutely.

With all but 29% of the possibly adult females dying naturally or at their own hands, there were accidental causes that played a far bigger role in men's sudden or unexpected deaths than in those of women. In particular, of the 182 males and thirty-five females not labelled as children, twenty-eight (12%) of the former had died after incidents with horses and wagons, but only one female (3%), as a passer-by. This discrepancy might

³⁸ Excluding suicide by drowning.

reflect boys' recreations but it might also have been a product of men's gendered occupations. Although the recreations of childhood might have influenced these figures too, another 12% of the 182 males died from other accidents yet only 6% (or two) of the thirty-five females. By contrast, the same number of females as males (two) died of exposure, and another two of each gender at the hands of others. With the total number of male fatalities swollen by their drownings and accidents, these deaths from violence and exposure make up only 2% of males' sudden deaths but 12% of females', while only 3% of the 182 males but 6% of the thirty-five females were recorded as being killed by excessive drink.³⁹ In absolute terms, however, three times as many males as females died suddenly through alcohol. In Suffolk, therefore, drink, transport and a dangerous local industry allegedly killed far more males than they did females.

Part ii: Men at Work

The maritime trades were not, however, the only "male" occupations' from which were absent 'the great majority' of women.⁴⁰ Manufacturing, '[h]ard labour, and heavy industries were [all] "male" trades' in eighteenth-century London, and men allegedly dominated England's construction industries too.⁴¹ '[P]robably' employing up to 20% of the adult male labour force, the latter were 'tedious and back-breaking' occupations, with perhaps half of Chester's joiners dying in or before their mid-forties.⁴² As 'most' lead miners were killed by 'respiratory disease', 'at an abnormally early age', regional industries left their mark as well.⁴³ Agriculture presumably did the same, for in 1750

³⁹ Of those not labelled children.

⁴⁰ Peter Earle, 'The female labour market in London in the late seventeenth and early eighteenth centuries', *Economic History Review*, 2nd ser., 42, 3 (1989), pp. 328-353, quotation at p. 339.

⁴¹ *Ibid.*, pp. 339, 341.

⁴² Donald Woodward, *Men at Work. Labourers and Building Craftsmen in the Towns of Northern England, 1450-1750* (Cambridge, 1995), pp. 15, 23, 25, 110, 211.

⁴³ J. Hunt, *The Lead Miners of the Northern Pennines in the Eighteenth and Nineteenth Centuries* (Manchester, 1970), pp. 23-5, 28-9, 208, 212.

only 9.2% of Scots lived in towns of 10,000 or more, and only 10% of England's population in London.⁴⁴ Indeed, although the men of the upper Pennines had 'virtually no alternative' to lead mining, and while the analysis of the sexual division of agricultural labour focuses on women and children, what is apparently not disputed is that men were employed year-round, in the most onerous roles.⁴⁵

Manuals of health did not acknowledge the 'male' nature of such trades. They did, however, recognize them as hazardous, mainly by plagiarizing an Italian text translated in 1705.⁴⁶ Men's actual experiences did not, however, always correlate with such claims, let alone with Adair's. On 'HMS Tyger', the only evidence of occupational hazards visible in ten months' of cases lies with a fatal fall 'from the fore top upon the Deck' and three sailors seized on the same summer's day with 'gr[e]at dimness' of sight 'occasioned... by the... Sun'. The latter three all recovered.⁴⁷ While it was illness that attacked men on this ship it was not overwhelmingly the costiveness and scurvy identified textually as the diseases of seafarers.⁴⁸ With only seven apparent sufferers of scurvy, it was instead a fever epidemic that dominated these sailors' experiences of ill health. Even dysentery, linked by contemporaries to a lack of cleanliness (of food and water included), killed only two men, both from the sick of another ship.⁴⁹ Venereal disease was also apparently a less consequential *de facto* occupational hazard than might be expected, for only two men had even the *suspected* 'foul' bones that might hint

⁴⁴ Elizabeth Foyster and Christopher A. Whatley, 'Introduction, Recovering the Everyday in Early Modern Scotland', in idem. (eds.), *A History of Everyday Life in Scotland 1600 to 1800* (Edinburgh, 2010), pp. 1-26, esp. 5; Roy Porter, *London: A Social History* (1994), pp. 122, 158.

⁴⁵ See the discussion in Pamela Sharpe, 'The Female Labour Market in English Agriculture During the Industrial Revolution: Expansion or Contraction?', *Agricultural Historical Review*, 47, 2 (1999), pp. 161-181. Quotation from Hunt, *Lead Miners*, p. 4.

⁴⁶ Bernardino Ramazzini, *A Treatise of the Diseases of Tradesmen...* (1705).

⁴⁷ BL, Sloane MS 3943, 'A Memoriall of My Practice in Pysick and Surgery on board Her Maj[es]ties Ship Tyger... 1705/6', Henry Watson, in 'Transactions relating to the Bishop of London 1786', ff. 167-180, quotations at ff. 168v, 177.

⁴⁸ Anon., *The best and easiest method of... health...* (1748), pp. 190-196, esp. 195.

at such a diagnosis.⁵⁰ Injuries also struck surprisingly rarely, with one fall, a laceration, and five burns, but not a single battle casualty in ten months. Indeed, and in Adair's own generation, the surgeon Nathaniel Bedford recorded only one engagement during eleven months of onboard service in the final year of the American War of Independence. Although destroying 'the designs of the French & Spaniards against Jamaica', this resulted in only thirty-eight British men being wounded, and only thirteen dying.⁵¹

The visible health effects of civilian jobs also diverged from the claims made in print. Bedford claimed to have 'often been affected with a diarrhoea when Dissecting', while 'Dr Stark' thought himself to have succumbed to 'Poisons from opening Dead Bodies', but when occupations were blamed in medical practice it was not for those 'pernicious' particles that the health literature seized on.⁵² When a miner was suffering because of his occupation in 1695 it was from a rock-fall, not 'Difficulty of Breathing', and when a mid-eighteenth-century patient blamed working in a quarry it was in having 'got cold', not bad air.⁵³ Similarly, the scrotal cancer that Percivall Pott identified in 1775 as the occupational disease of chimney sweeps was very rarely diagnosed, and never in males recorded as belonging, or having belonged, to this trade.⁵⁴ Indeed, Sir Edmund King, practising in later-seventeenth-century London, and John Rutherford, lecturing in Edinburgh in 1751, were highly unusual in diagnosing men as suffering from the substances on which they worked. Both, furthermore, were treating lime-workers, an

⁴⁹ Gerard Freiherr van Swieten, *The diseases incident to armies...* (Dublin, [1776]), p. 64.

⁵⁰ BL, Sloane MS 3943, 'A Memoriall of My Practice...', Watson, ff. 179-179v.

⁵¹ RCS, MS 0002, 'Observations and Cases 1781' (1776-1783), Nathaniel Bedford, p. 157.

⁵² *Ibid.*, p. 166; RCS, MS 0189/1/1, 'Cases and observations' (men's dated cases 1783-post-1803), John Hunter, no. 57; Forster, *Treatise*, p. 359.

⁵³ WL, MS 3319, 'Admirable observations' (c.1675-c.1691), Richard Lockyer, case of Thomas Carpenter; MS 6888, *Clinical Lectures* (1749), John Rutherford, f. 105; Forster, *Treatise*, p. 355.

⁵⁴ Percivall Pott, *Chirurgical observations...* (1775), pp. 63-68.

occupation absent from these health manuals. They were also treating them for convulsive fits and an ocular condition, disorders very different to those asthmas and coughs that the texts said afflicted other metalworkers.⁵⁵ It seems that neither patients nor practitioners were overwhelmed with anxiety about the nature of manufacturing work, the materials with which they worked, or the ‘serious pulmonary infection’ that historians claim attacked manufacturers.⁵⁶

Focusing on diet and environment, the manuals that discussed workers’ health were silent about occupational injuries. Men’s work did, however, sometimes cause their bodies to suffer in such a way, and the consequences could be serious. Thus, the ‘cureing & attending’ a ‘Day labourer’ ‘bruised by a fall’ cost one estate manager over £15 Scots in 1750-51, when the treatment of the wright ‘seised with... Inflammation in his throat after takeing up the Duks Timber’ came to less than £2.⁵⁷ Similarly, and as Smith noted, the mid-seventeenth-century London surgeon Joseph Binns recorded at least four male patients clearly or presumably being injured at work, three in falls.⁵⁸ Occasional other collections of extreme or curious surgical cases similarly refer to falls, sometimes fatal, suffered by such men as coal-porters and lamplighters.⁵⁹ More frequently, however, where there is evidence of men themselves linking afflictions to their occupations, or to working, it is not in accidents.

⁵⁵ BL, Sloane MS 1588, ‘Medical Receipts and Cases’ (c.1664-c.1684), Sir Edmund King, ff. 42v, 62v; WL, MS MSL 86/1, Clinical lectures, John Rutherford, William Cullen and Robert Whytt, pp. 1-165, ‘Doctor Rutherford’s Clinical Lectures’ (1751), p. 150; Forster, *Treatise*, p. 355.

⁵⁶ George Rudé, *Hanoverian London, 1714-1808* (1971), p. 84.

⁵⁷ NAS, GD220/6/1091/27, 38, Montrose papers, Factory accounts of Mungo Graeme (1750).

⁵⁸ BL, Sloane MS 153, ‘Chirurgical Observations’ (c.1633-c.1663), Joseph Binns, ff. 12, 56, 104v, 113, 212; Smith, ‘Health Care’, p. 102 (concluding that, ‘[n]ot surprisingly, the most hazardous of trades were those in construction... – all male trades’), citing Lucinda McCray Beier, *Sufferers and Healers. The experience of illness in Seventeenth-Century England* (London and New York, 1987), p. 67 (arguing that in Binns’s clientele the construction industries were the most dangerous occupations).

Instead, where men and practitioners blamed working for their being sick they most frequently did so by reference to exertion and cold. Health writers claimed that ‘husbandmen’ suffered because of ‘the Inclemencies of the Air, which obstruct the Pores’, and even William Buchan, that great proponent of male agricultural employment, noted that ‘[h]usbandmen... are exposed to’ ‘great and sudden’ ‘vicissitudes of the weather’ and ‘forced to work hard, and... carry burdens above their strength.’⁶⁰ It was not only in texts, however, or only in relation to agricultural workers, that the dangerous nature of occupations was articulated through their highly physical nature and their outdoors setting.

Seventy-eight males aged sixteen or over featured in a series of clinical lectures delivered by three different practitioners at the Edinburgh Royal Infirmary in 1763-65, and six (7.7%) had tales that, whether independently or on prompting, gave strains and heavy weights a role. They, or their practitioners, attributed a range of bodily problems to these actions. They also had long memories, tracing their problems to lifting weights anything up to four years earlier. Yet, only one narrative, as recorded, stated that a strain had been incurred at work, and even this had then been exacerbated ‘from being exposed to the Cold Air when very warm’.⁶¹ Similarly, and although five of these men were twenty-two or under, there is nothing by which to test Buchan’s claim that ‘[c]arrying heavy burdens... proceeds... from bravado, or an emulation to outdo

⁵⁹ RCS, MS 0189/1/1, ‘Cases and observations’, Hunter, no. 44; RCS, MS 0002, ‘Observations and Cases 1781’, Bedford, pp. 4-6.

⁶⁰ Forster, *Treatise*, p. 359; William Buchan, *Domestic Medicine... by regimen and simple medicines...* (2nd edn., 1772), p. 48.

⁶¹ RCP, MS 468, ‘Cases & Reports from Drs. Monro, Cullen & Whyte’ (1763-1765), Alexander Monro *primus*, William Cullen and Robert Whytt, first set, p. 34.

others', with 'daily instances.... of the *fatal* effects of carrying great weights, running, wrestling, &c'.⁶²

Another eight (10.3%) had similar stories involving the performance of either hard labour or unspecified 'fatigue' or 'Exercise' during or immediately prior to exposure to the elements. Indeed, men of all ages from sixty down to eighteen were able to 'impute' their disorders to such a cause, or to remember their development in such a way that practitioners could construct these tales. They also ranged from a mustard-maker to a chairman and soldiers (three, aged from twenty-three to sixty), with their narratives, as repeated by lecturers, taking two forms. The first placed the emphasis on being outside in cold and wet weather, in this case as 'a labouring man... employed in the fields'. Adopted by one thirty-year-old, this made work of significance for prompting exposure, without emphasizing the physically demanding nature of his occupation.⁶³ The second, utilized in the seven other cases, claimed that 'after working very hard, and being hot he exposed himself to Cold Air', referred to long marches in poor weather and wet clothes, or blamed exposure after 'Exercise'.⁶⁴ All of these seven men remembered specific episodes of combined exertion and exposure, and whether they had happened days or years before they told their stories.

As Smith demonstrated, the sick needed to make sense of their plight.⁶⁵ Perhaps these men did so by seizing on the identity that society gave them as robust men performing what (writers such as Buchan told them) was a manly job. If, however, men *were* demonstrating a need to align themselves with their ruggedness and masculinity in the

⁶² Buchan, *Domestic Medicine*, p. 49 (my emphasis).

⁶³ RCP, MS 468, 'Cases & Reports from Drs. Monro, Cullen & Whyte', Monro, et al, first set, p. 28.

⁶⁴ *Ibid.*, first set, pp. 156, 87, 200.

face of debility and vulnerability they did not do this only by emphasizing occupations. Others blamed 'Cold' more generally, but another eight men at Edinburgh traced their symptoms, or had them traced, to 'exposing himself to Cold' *without* mentioning work, although twice with a similar prior heating of the body. These eight did so, furthermore, for illnesses overlapping substantially with those diagnosed in the men who blamed exposure with exertion (whether at work or recreational), which themselves echoed those diagnosed in men alluding to strains and weights.⁶⁶ Indeed, those who blamed exertion in cold weather were not unique in being able to pinpoint specific but distant episodes. Those referring to cold only, or to the exposure of a body heated by artificial means, remembered incidents up to nine years prior to the consultation. Nor were these claims – or overlaps – limited to these three lecturers, or to Scotsmen. Similar trends were shown by William Currie and his clinical ward patients in Cheshire in 1769.⁶⁷ The outside world that some men saw their bodies through was not just beyond the domestic sphere. It was literally outside. Yet, none of these men of 1763-65 appear to have been killed by the resultant cold or exertion. Of those four blaming cold (with or without exertion) with outcomes recorded, three were dismissed 'cured' and one sent to the ordinary ward as 'cured'.⁶⁸

In an apparent continuation from humoralism, the air mattered in these narratives not for its contents but its temperature. There were eighteenth-century authors, including the internationally renowned, who similarly argued that cold, windy and wet air, prolonged

⁶⁵ Lisa Wynne Smith, "'An Account of An Unaccountable Distemper': The Experience of Pain in Early Eighteenth-Century England and France", *Eighteenth-Century Studies*, 41, 4 (2008), pp. 459-80.

⁶⁶ RCP, MS 468, 'Cases & Reports from Drs. Monro, Cullen & Whyte', Monro, et al, first set, pp. 1, 15, 22, 113, 119, 163, 167; second set, pp. 1, 173, 190.

⁶⁷ RCP, MS 242, Clinical Cases, vol. 1 (1769), William Currie, pp. 1 ('he imputes it to alternate heats & colds being by trade a smith'), 18 ('[h]e imputes... to hard work &... being exposed to cold'), 218 ('what he calls a hard Stress of work'), 318 ('being obliged to march a long way, was much heated & fatigued when stopping he impudently exposed himself to cold'), 359 ('he imputes... to being on hard Duty').

‘violent motion’, and ‘too great *Heat*’, whether from exertion or from ovens and furnaces, caused illness. They added, furthermore, that these did this by disrupting a body-wide ‘perspiration’.⁶⁹ Significantly, some such authors made the bodies exposed to extreme or changing temperatures male, proving their claims about the effects of cold and windy air with the apparently self-obvious observation that ‘such as keep within doors, as for example Women, are not troubled with Coughs, Catarrhes, or inflammations of the lungs’.⁷⁰ Yet, these texts were not claiming that it was only ‘man’s work’ that exposed male bodies to the elements. ‘A person just come out of his warm bed, or a close warm room, or crowded assembly, or from a ball, into the open air with his... body heated’ was allegedly equally susceptible.⁷¹ ‘[L]uxurious’ diet, ‘confined and heated [urban] air’, ‘going warm on the river’, ‘wet rooms’, being ‘late in the night, at study, without fire’ or, indeed, ‘a *want* of... exercise’, exposed the body to the same effects, and to the same resultant illnesses.⁷²

There was, therefore, no conceptual singling out of the outdoors, the ‘man’s work’ that took place in it, or the men performing it. Manuscript case histories and lectures discussed men heated by hard labour and exposed to cold in exactly the same way as those heated by working in proximity to ovens and furnaces and, furthermore, those warmed by unspecified ‘exercise’, or even by sitting too close to the household hearth.⁷³ Nor was it only in the occupations performed by men that work was seen as carrying such threats. The physician Thomas Willis (1621-1675) recorded not only a twenty year

⁶⁸ RCP, MS 468, ‘Cases & Reports from Drs. Monro, Cullen & Whyte’, Monro, et al, first set, pp. 232, 208, 168, 196.

⁶⁹ Herman Boerhaave, *Dr. Boerhaave's academical lectures...*, vol. 3 of 6 ([1742-46]), pp. 327-329 (original italicization); John Chandler, *A treatise of the disease called a cold...* (2nd edn., 1761), pp. 24-25, 107-108.

⁷⁰ Sanctorius, *Medicina Statica... English'd by J. D.* (1676), p. 71.

⁷¹ Chandler, *Treatise*, pp. 38-9.

⁷² *Ibid.*, pp. 71, 100-101 (my emphasis).

old 'countryman, of swarthy colour and robust build' being taken fatally ill after a 'whole day ploughing in a biting north wind', but also '[a] widow, aged 60, [who] having spent the... day washing clothes, caught cold and fell into an acute fever'.⁷⁴

There were other circumstances in which characteristically male occupations exposed the body to threats also posed by 'women's work', and with the same effects. Amongst the '[f]our or five' victims of skin eruptions seen at a London hospital in 1776 were two men working with extreme heat, but also '[a] woman... much exposed to the sun' (in unspecified circumstances), a 'washerwoman', and a housemaid. While it was the housemaid's complaint that was the most difficult to cure, the woman 'exposed to the sun' 'had the same appearance as the Blacksmith', and the 'washerwoman' 'the same... as the Baker'. That this 'appearance' was one 'pretty common to all' laundresses and 'all who work much with soap' suggests, furthermore, that the baker's eruptions might have come from the scrubbing of his hands, not from the heat of his oven.⁷⁵

Part iii: Drink, Bravado and Violence

The world of work was not, however, the only sphere that men, as men, allegedly occupied. Again and again, historians refer to a male nexus of drink, promiscuity, and violence, played out in the public world, and often revolving around the 'man's world' of the drinking establishment.⁷⁶ The expression of aggression might have been reined in,

⁷³ RCS, MS 0189/1/1, 'Cases and observations', Hunter, no. 53; WL, MS 6888, Clinical lectures, Rutherford, f. 75v; RCS, MS 0095, 'Clinical Lectures' (1782), John Gregory, f. 221.

⁷⁴ Kenneth Dewhurst (ed.), *Willis's Oxford Casebook (1650-52)* (Oxford, 1981), pp. 99, 102.

⁷⁵ RCS, MS 0002, 'Observations and Cases 1781', Bedford, p. 12.

⁷⁶ Porter, *London*, p. 207; Foyster, *Manhood*, pp. 40-41, 178; Barker-Benfield, *Sensibility*, pp. 50-52, 56.

in London at least, yet public violence was allegedly ‘part of an accepted code of masculine behaviour’ and ‘an integral aspect of masculinity’.⁷⁷

As Smith argued, there is medical evidence linking male patients to drink. The references that practitioners made to men’s drinking habits do not, however, give a clear-cut picture of the harm that they did, or did not, think that men were doing to their bodies through these. A collection of select cases from the early- and mid-eighteenth-century West Midlands practice of Richard Wilkes, for example, passed no comment on the intake of the ten female patients but labelled four men, aged from thirty to fifty-five, ‘free Liver[s]’ or ‘free’ or ‘pretty free’ drinkers (although one of these ‘could never bear a large Quantity’). Yet, these were not Wilkes’s only assessments of male consumption.⁷⁸ He also recorded that a man ‘lived regularly’, that a clergyman, while fond of ‘rich Sauces, sitting up late, & strong, fenerous Wine’, ‘seldom or never drunk it to Excess’, and that although a forty-nine-year-old ‘always eat heartily & drunk a cheerful Glass’, the latter was ‘never to Excess’.⁷⁹

Thus, Wilkes commented almost as often on men’s *lack* of excess in drink as he did on their excess. Nor did he make alcohol the male health hazard, or even a hazard to these alleged heavy drinkers, even in this sample of select cases. Thus, whilst all four of the heavy drinkers eventually died – one from something else (long journeys and heavy business) – the same was true of both of those who had ‘never drunk’ to ‘excess’.⁸⁰ Indeed, all but one of Wilkes’s references to male drinking were made contextually,

⁷⁷ Shoemaker, *Mob*, pp. 153-154, 168, 170-171, 175-176; Elizabeth Foyster, ‘Boys will be boys? Manhood and aggression, 1660-1800’, in Tim Hitchcock and Michèle Cohen (eds.), *English Masculinities 1660-1800* (London and New York, 1999), pp. 151-166.

⁷⁸ WL, MS 5005, ‘Observations on particular Cases of Patients’, Wilkes, pp. 16, 28, 80.

⁷⁹ *Ibid.*, pp. 46, 21, 33.

⁸⁰ *Ibid.*, pp. 21, 33, 28.

without establishing any link between the illness, its outbreak, or barriers to recovery. In the one case where he did directly implicate drinking (operating in conjunction with other behavioural factors) the patient ‘soon recovered’.⁸¹

The twenty-four male cases compiled in the final quarter of the seventeenth century by Richard Lockyer, a general practitioner, similarly show the men of this unknown area suffering from the negative consequences of drink and of drunken behaviour. They also reveal that such indulgence could extend to the poorest, and to medical experts, with Lockyer on one occasion suffering a severe pain attributed to ‘strong hott lickuors & smoakeing to backo’.⁸² Similarly, when a tailor suffered a severe rheumatism, and a near-fatal relapse, Lockyer blamed these on drink, although without stating whether the patient had made this link, or even admitted to heavy drinking.⁸³ A third man suffered from the consequences of drunken behaviour – a night spent outside – and had indulged in heavy festive drinking despite being an impoverished father of seven. Yet, while his resultant stitch and breathlessness were treated with great difficulty, the repercussions of drink were in all three cases ultimately curable ailments of varying longevity, not fatalities or lifelong debilities.⁸⁴

Even in the atypically severe or unusual cases chosen for select samples of cases it was not, therefore, routinely claimed that drink was threatening even individual men’s lives. Male drinking was, furthermore, rarely seized on as frequently in more complete

⁸¹ *Ibid.*, p. 27.

⁸² WL, MS 3319, ‘Admirable observations’, Lockyer, 2 January 1685.

⁸³ *Ibid.*, case of John Tylly, October 1685.

⁸⁴ *Ibid.*, case of Richard Wood, 1687.

collections of cases, or always identified as having such severe effects.⁸⁵ It was mentioned only seven times in Binns's 230 apparently adult male cases, and only twice with reference to excess. Indeed, it was twice the peculiar character of the drinks, rather than their alcoholic content, that was blamed, and neither of these drinkers was harmed permanently.⁸⁶ Not even the two disorders that Binns did link to specifically heavy drinking were fatal. The urinary retentions that struck 'after' 'much drinckinge' were curable, as was the genital gangrene developing after having sex '& continewinge drinckinge verie much'. The cure of this latter disorder took three months but it might well have been linked to venereal disease.⁸⁷ Nor was continued drinking necessarily a barrier to recovery. The man who had repeated returns of his gonorrhoea continued drinking, refused the injections and carried on 'wenching', yet even he was cured eventually.⁸⁸ '[A] young Sparcke' recovered from a urinary 'smarteing' despite being 'many times ouer take[n] w[i]th wine & a wench', just as the victim of a 'flunge' 'pinte pott' was made well despite making himself 'much distempered' by leaving his bed and drinking 'stronge beere'.⁸⁹

The evidence is equally mixed for the eighteenth century. While the general practitioner Joshua Firth diagnosed over seventy men between November 1727 and the end of July 1729 as having, or having urine indicating, 'surfet', it is unclear whether he was referring to heavy drinking. In print, surfeits were defined as sickness and a sense of fullness, with multiple causes. One was 'excess, or some ill quality... of the [ingested] solids or liquids', and another 'small liquors' in hot weather or when heated by exercise,

⁸⁵ Compare to the claim that '[w]hen doctors reported about a patient's habit of life, they generally noted in the case of men (less often for women) the amount a man tended to drink. Some... could be quite condemning' (Smith, 'Health Care', p. 101).

⁸⁶ BL, Sloane MS 153, 'Chirurgical Observations', Binns, ff. 196v, 60.

⁸⁷ Ibid., ff. 177, 170v.

⁸⁸ Ibid., f. 204.

‘which... chills the fluids, and gives a check to perspiration’ (as did cool, moist, ‘summer fruits’).⁹⁰ If Firth was following this quasi-humoral framework he might not have been blaming drink for its alcoholic content. That he *was* blaming drink is itself uncertain, for only once were these specifically ‘surfets of Liquors’.⁹¹

Even when it was made clear that practitioners meant alcohol they only occasionally claimed expressly that it had had even temporary repercussions. In a journal of nosological observations kept in the 1750s, six of the seven times that John Murray, M.D. of Norwich, highlighted excessive drinking habits were in relation to men. Four, however, were contextual, describing the man rather than, as far as can be seen, explaining the illness’s cause, severity, or recurrence. One of the exceptions concerned a thirty-year-old ‘addicted to hard drinking, [who] after great Irregularity... had an Erisypelatous eruption’ and fever, which were cured, but not without ‘great Danger’, and the second a patient who, ‘as he was a hard drinker’, ‘no sooner felt Relief than he return’d to his old manner of living & catching cold had a return of his Disease with much... Violence’. He too, however, recovered (by ‘a plentiful bleeding’), ‘& continued free of fever ever after’.⁹² Indeed, Murray’s one patient to be killed by an illness originating from being ‘much addicted to hard drinking’, and one which ‘from’ the sufferer’s ‘way of Life was with great Difficulty cured’, was ‘[a] Middle aged’ spinster.⁹³

On board H.M.S. Conqueror in May 1758-March 1759, Murray’s monthly observations were totally silent about the effects of drink. For Murray, his sailors suffered ‘mostly...

⁸⁹ Ibid., ff. 204, 6v.

⁹⁰ Peter Shaw, *A new practice of physic...*, vol. 1 of 2 ([1726]), pp. 160-3.

⁹¹ BL, Additional MS 45670, Accompt-book (1728-1738), Joshua Firth, ff. 188v-169v.

⁹² WL, MS 7840, Journal (1752-1759), John Murray, pp. 1, 11.

Disorders from obstructed Perspiration'.⁹⁴ Yet, *Bedford's* onboard diary of the early 1780s several times attacked a 'very frequent' 'intemperance'.⁹⁵ In Antigua, he blamed a 'very great encrease of' 'alarming' 'Fevers' on 'continual drunkenness... after the payment of prize money', fiery 'New-Rum', and wet clothes (the men swimming to shore to buy it). Yet, 'such a small proportion' of those acting so 'imprudently was taken ill, that my faith would be staged had my eyes not been witnesses'.⁹⁶ He had reached a similar conclusion on a different ship and while still docked in Britain, noting that the frequent drunkenness facilitated by prize money created no particular unhealthiness despite the ship being fungus-covered, damp, 'dirty, & crouded'.⁹⁷ Even practitioners attacking patients' drinking habits were, it seems, sometimes forced to admit that these had not caused men harm.

Furthermore, while Bedford supported another observation by the fact 'that many patients, especially hard drinkers, are often affected by Jaundice', he made no such diagnosis in a single sailor.⁹⁸ Other practitioners, in both centuries, diagnosed occasional men with jaundice, and even jaundices potentially or actually fatal. Rarely, however, did they link it to drink, or to men who drank. Unusually, Mr Feilde was treated in the later-seventeenth century for 'a surfeit' developing 'after a fit of drinking', and subsequently fell into a jaundice, while Murray described a civilian male as 'of a choleric Constitution, a pretty free Liver and formerly often subject to the Jaundice'.⁹⁹ Murray, however, recorded more 'hysteric' jaundices, and far more *women* suffering

⁹³ *Ibid.*, p. 14.

⁹⁴ *Ibid.*, p. 32.

⁹⁵ *Ibid.*, p. 142.

⁹⁶ *Ibid.*, pp. 242, 261-3, 318.

⁹⁷ RCS, MS 0002, 'Observations and Cases 1781', Bedford, p. 142.

⁹⁸ *Ibid.*

⁹⁹ BL, Sloane MS 1588, 'Medical Receipts and Cases', King, f. 131v; WL, MS 7840, Journal, Murray, p. 21.

from or prone to it. Some left men's jaundices unexplained,¹⁰⁰ but those practitioners who gave reasons seized instead on 'bilious colic', 'matter forming in the liver', or an 'adhesion' of liver and abdomen, and the two sufferers in the lectures of 1763-65 cold air with a strain and 'exercise'.¹⁰¹

The medical evidence also offers little proof even in the seventeenth century of heavy public male violence, or at least of violence that caused bodily harm. Yet, in the cases prosecuted in County Middlesex's mid-seventeenth-century secular courts (including those of London) it was almost entirely men who were the victims of public violence, often committed in the street.¹⁰² Seventy-four alleged acts of violence to the body resulted in coroners' inquests, true bills, indictments, recognizances and gaol deliveries between 14 March 1660 and 30 April 1674, and in sixty-five the bodies harmed belonged to adult males (sometimes with multiple victims). The same patterns were shown in the preceding and subsequent reigns, although fewer incidents were pursued.¹⁰³ Robert Shoemaker found something similar in eighteenth-century London, arguing that it was men who were murdered outside the home, or targeted by violence committed 'in the explicit assertion or defence of male honor' and 'to prove manliness'.¹⁰⁴

Public violence against the body does, therefore, initially seem one of the ways in which codes of manhood and masculinity might have created a distinctive male bodily

¹⁰⁰ BL, Additional MS 45670, *Accompt-book*, Firth, ff. 188v, 184v, 176v.

¹⁰¹ WL, MS 1856, *Diary* (1786), - Cooper, p. 14; RCS, MS 0189/1/3, 'An Account of the Dissection of Morbid Bodys', Hunter, no. 8; RCP, MS 468, 'Cases & Reports from Drs. Monro, Cullen & Whyte', Monro, et al, first set, p. 203; second set, p. 182.

¹⁰² Although women were victims of violence committed within the home and surfacing in church courts. See Elizabeth Foyster, 'Creating a veil of silence? Politeness and marital violence in the English household', *Transactions of the Royal Historical Society*, 12 (2002), pp. 395-415.

¹⁰³ John Cordy Jeaffreson (ed.), *Middlesex County Records*, vols. 3-4 (1892).

¹⁰⁴ Shoemaker, *Mob*, pp. 155, 157-158, 164-168, 172.

experience. Yet, even in London, with its high concentration of youths, the effects of violence took comparatively few men to Binns.¹⁰⁵ Although he recorded treating sixty-four apparently adult males suffering from injuries or their repercussions (28% of his patient base of probable adult males), the details and narratives that Binns chose to include reveal only thirteen whose cases clearly point to human-inflicted suffering (table 5.2).¹⁰⁶

Table 5.2 Causes of adult male injuries in Joseph Binns's 'Chirurgical Observations', c.1633-c.1663

Cause		Apparently adult males injured
Clearly not violence (24)	Fall	10
	Riding accident	6
	Burn	2
	Walking accident	2
	Animal	2
	Suicide	1
	Accident	1
No context recorded, with nothing suggesting violence (15)	Break	9
	Bruise	3
	Cut, incl. by glass	2
	Wound	1
No context recorded but could potentially have been violence (7)	'[W]ounded', 'hurte', 'received a wound'	5
	A blow	1
	'Baylye' wounded	1
Likely to have been violence (5)	Wounded by knife in armpit/head	2
	Wounded by sword	1
	Wounded by spur	1
	Wounded by javelin	1
Clearly violence (13)	Shot	3
	Thrust	3
	By named party	3
	'[F]lunge' pint pot	2

¹⁰⁵ A youthful population was allegedly a cause of particularly high violence (Porter, *London*, p. 159).

¹⁰⁶ BL, Sloane MS 153, 'Chirurgical Observations', Binns. 'Sons' are excluded unless there is reason to think them adults. See the appendix for notes on the formation of the figures in tables 5.2-5.3.

	Trodden on	1
	Bitten	1
Total		64

Source: BL, Sloane MS 153, 'Chirurgical Observations' (c.1633-c.1663), Joseph Binns

With the thirteen most certain victims of attacks making up 6% of Binns's 220 separate apparently adult male patients, violence had serious consequences sufficiently often to create more visible male patients than did falls, and more than twice as many as did riding accidents. Indeed, with only twenty-four of the other fifty-one men with injuries clearly harmed in *non-violent* contexts, twenty-seven (a further 12% of the men seen by Binns) could potentially have been the victims of violence. Certainly, five seem very likely to have been injured in this way, as suggested by the involvement of weapons or unexpected sharp objects, or the curious situation of knife wounds.

Even in the thirteen cases where it seems most likely that men were suffering the effects of violence it is not, however, definite that the injury was intentional. In only four cases was the existence of an attacker or opponent expressly stated, and in only four more was this implicit. While the use for the other five of the thirteen of such phrasing as 'receued ablowe' (or 'a Shott' or 'wounde) or 'was wounded' *suggests* the actions of another party, it does not allow accidental injury to be ruled out.¹⁰⁷ It is, furthermore, far from clear that even those apparently injured in violent incidents were always the victims of a competitive display of strength and courage, a shared notion of masculine 'honour', or even *male* violence. While attackers or opponents were named in three cases, showing them to be male, the gender of those responsible for harming all other men was left

¹⁰⁷ Ibid., ff. 16v, 126 72v 157, 21, 99, 17v, 83v, 141, 21.

unstated.¹⁰⁸ Similarly, honour had not prevented ‘sergeant maior Jenkins’ from thrusting ‘an old gar[de]ner nere 80’ and giving him ‘an other puncture behinde the lefte Showder [and] seuerall brus aboute the heade’, while Binns’s uncle might not have been the only man hurt by thieves.¹⁰⁹ As the Middlesex papers show for the years immediately afterwards, male-male violence and its bodily repercussions were not solely or always a consequence of performative honour. Mob fury (and self-defence against it) played its role in Middlesex in 1667-1674, alongside more prosaic interests. Ten male victims, in half of the non-fatal attacks, were robbed, and other incidents happened when men intervened in a spousal fight, kidnapped a victim to sell for transportation, or resisted questioning.¹¹⁰

On similar lines, not all of the men whose bodies were affected by violence (or at least weapons) suffered heavily – or at least lengthily – because of it. Even incidents serious enough for indictments did not always kill, for almost a quarter of those pursued in Middlesex, some with multiple victims, were non-fatal. Of those forty-four men who were killed, however, 80% died within a week (43% instantly, 7% that day, and 30% within a week), and only three after a month or more (once almost six months later).¹¹¹ As recorded in the sessional papers, therefore, most of the male victims of violence who died in Middlesex, predominantly in London, died quickly. Yet Binns, also in London, not once recorded seeing any man who had died during or immediately after an attack, with remarkably few fatalities in those victims of visible violence he did treat. It seems possible that where violence did not have immediately fatal consequences – and Binns

¹⁰⁸ Ibid., ff. 83, 99.

¹⁰⁹ Ibid., f. 21 (1643).

¹¹⁰ Jeaffreson, *Middlesex*, vol. 4. C.f. Shoemaker, *Mob*, pp. 157-159 (finding a ‘relatively rare’ use of violence in eighteenth-century robberies).

¹¹¹ One entry gives no date of death.

recorded no cases where it did – the aggression that men committed against each other was often (comparatively) mild, unsuccessful or interrupted.

Even when violence or weapons created wounds severe enough to require a surgeon their effects were surprisingly transient, at least as encountered (and dismissed) by Binns. Indeed, only three of the thirteen died, two from gunshot wounds where the bullet broke the bone and one from a heavily bleeding knife-wound to the head, allegedly with severe medical negligence.¹¹² All of the others were very quickly classed as ‘well’, usually within a month and sometimes much less. Even the eighty-year-old was ‘in pretty temper’ by the fourth day, when he ‘bayled’, and while Mr Ffitsjames had spat a porringer of blood and bled heavily after being stabbed in the thorax he was ‘well’ after three weeks.¹¹³ Nor was damage to the bone always fatal. An embroiderer’s sword-wound was five inches long and ‘verie deepe’, with the bone ‘incised’ and shards in the flesh, yet the patient had not ‘mutch payne’, and wound and bone healed within three weeks.¹¹⁴ Both pint pot victims had the skull exposed, but one’s treatment was over within a week, despite his making himself ‘much distempered’ with drink, and the skin had regrown over the other’s incomplete and ‘depressed’ bone within a fortnight.¹¹⁵ Indeed, there were not even automatically *life-limiting* consequences. An oilman was walking on his leg within two months of a bullet passing through his thigh, and even the servant ‘thruste in his [e]ye’ retained ‘resonable good sighte of it’, being ‘well of all’ in only eight days despite a ‘tumor’, inflammation of the conjunctiva, and an ague.¹¹⁶ The one exception was the man who attributed his hernia to being trodden on a year and a

¹¹² Ibid., ff. 72v, 64v, 7v.

¹¹³ Ibid., ff. 24v, 66v.

¹¹⁴ Ibid., f. 157.

¹¹⁵ Ibid., ff. 16v, 211.

¹¹⁶ Ibid., ff. 66v, 126.

half beforehand, although Binns passed no comment on this claim.¹¹⁷ Indeed, he was the only one of 220 men to have suffered violent incidents that Binns saw as worthy of inclusion in even descriptive medical histories.

In Binns's practice, accidents and injuries featured far more frequently than did men recorded as suffering from the repercussions of intemperance or drunkenness. The same was true of various *eighteenth*-century (select) surgical collections.¹¹⁸ Never, however, did such surgeons record being told or suspecting that these injuries had been incurred in displays of bravado, from homosocial euphoric misadventure, or through drink. Sports were absent and it was incredibly unusual for even clinical lecturers to record retrospective patient references to 'a Bruise at a Boxing match'.¹¹⁹ Occasional cases referred to men being the victim of other men's strength, yet without alluding to drunken behaviour, and not necessarily in violent or intentional harm. Thus, it was 'a most violent squeeze of a strong mans hand... in horse-play', not anything belligerent or competitive, by which Charles Abercrombie explained his glandular swellings.¹²⁰ Even drinking establishments had featured in Binns's notes only for the two men harmed with drinking vessels, and in both cases the consequences were soon removed. Others were less lucky, with all three male victims of the similar incidents recorded in the sessional papers in 1660-74 receiving fatal injuries. Yet, it was not only males who were killed in Restoration Middlesex by men wielding bottles and pewter pots.¹²¹

¹¹⁷ *Ibid.*, f. 17v.

¹¹⁸ E.g. WL, MS 3820, 'Case book of Mr Richard Paxton' (c.1753-c.1798), Richard Paxton, pp. 90, 93, 117, 122, 131.

¹¹⁹ RCS, MS 0095, 'Clinical Lectures', Gregory, p. 269.

¹²⁰ RCP, MS 664/2, 'C. A.'s own Observations on his health Transmitted to Mr. P.', Letter from Charles Abercrombie to Dr Pulteney, undated. A practitioner rejected this (RCP, MS 664/1, 'The Case of C. A.', unsigned and undated).

¹²¹ Jeaffreson, *Middlesex*, vol. 3, p. 383, and vol. 4, pp. 5-7, 16.

Part iv: The Wages of Sin

Various historians have claimed that this was a society elevating male sexual performance within, before, and outside of, marriage.¹²² The consequences of this ‘relaxed and exuberant attitude to [male] sexuality’ are said to have been venereal disease, and to have been expected.¹²³ Indeed, and in the seventeenth century at least, infection was allegedly ‘seen as a direct consequence of illicit sex, acting as a *sign* of engagement in extra-marital sex for married men... as *physically visible to the world* as pregnancy’.¹²⁴

While it has also been argued that such was the stigma of venereal disease that sufferers sought out the specialists who promised secrecy, by far the biggest single group of Alexander Morgan’s male patients in Bristol had venereal disease.¹²⁵ Although there were sailors under Morgan for other problems, none of the fifteen known or suspected male sufferers of venereal disease (a quarter of his adult male patients) were recorded as belonging to Bristol’s maritime economy. Nor was venereal disease necessarily primarily a plight of the young. Although six of the eight for whom Morgan gave ages were youngsters (seventeen, nineteen, twenty, twenty-five and, twice, ‘young’), this was in line with the youthfulness of his male patient base as a whole. The remaining two were, furthermore, both forty.

¹²² Foyster, *Manhood*, p. 41; Tim Hitchcock and Michèle Cohen, ‘Introduction’, in idem. (eds.), *English Masculinities*, pp. 1-12, esp. 8.

¹²³ Fletcher, *Gender*, p. 342; Raymond Anselment, *The Realms of Apollo: Literature and Healing in Seventeenth-Century England* (Newark, NJ and London, 1995), p. 12; Betty Rizza, ‘Decorums’, in Linda E. Merians (ed.), *The Secret Malady. Venereal Disease in Eighteenth-Century Britain and France* (Kentucky, 1996), pp. 149-167, esp. 149, 163-164.

¹²⁴ Foyster, *Manhood*, pp. 80-81 (my emphasis).

¹²⁵ Kevin Siena, ‘The “Foul Disease” and Privacy: The Effects of Venereal Disease and Patient Demand on the Medical Marketplace in Early Modern London’, *Bulletin of the History of Medicine*, 75, 2 (2001), pp. 199-224; WL, MS 3631, Medical case-book, Morgan.

Nor was this a solely male complaint for Morgan, despite the gendered codes of sexual honour that supposedly made women reluctant 'to confide in a male doctor'.¹²⁶ Over half (six) of the – fewer – female patients had venereal disease, and those whose ages were given were similarly young.¹²⁷ It was, however, only for males that Morgan gave evidence of repeat sufferers. One, after being cured of a gonorrhoea, returned 'within a week' with another 'contracted 3 or 4 days before'. Another, with a chancre, had already been treated by Morgan six or seven times for a gonorrhoea, although it was never said whether these, chancre included, were new infections.¹²⁸ Perhaps not all repeat cases were evidence of lessons not learnt, for Morgan recorded without comment another patient's claim that his gonorrhoea was simply an old one, re-stimulated by a long journey.¹²⁹

Furthermore, it was far from a uniquely female behaviour to deny being infected. Some men refused to admit possession of the disease even in a confidential, male-male, one-on-one discourse with Morgan, and even when, as an apprentice, he was presumably young too.¹³⁰ Perhaps the ability of young men to delight in infection as a proof of sexual prowess was limited to the elite, or to certain audiences and conversations.¹³¹ Nor was it simply the case that it was only as they got older that men became more reluctant to admit to infection. A forty-year-old with a hard, swollen, testicle that Morgan 'supposed... venereal & rising from a suppression of a Gonorrhoea' 'denied it', yet a twenty-five-year-old with venereal warts was similarly reluctant to admit it despite the anonymity offered by 'being not one of this town'. He only 'confessed', 'at length',

¹²⁶ Siena, 'Privacy', p. 200.

¹²⁷ WL, MS 3631, Medical case-book, Morgan, pp. 17, 21, 28, 43, 48.

¹²⁸ Ibid., pp. 5, 20.

¹²⁹ Ibid., p. 54.

¹³⁰ Ibid., p. 4; Keith Moore, 'Illustrations from the Wellcome Institute Library. Nicholas Gainsford: His Book', *Medical History*, 37 (1993), pp. 442-447, esp. 447.

after Morgan had ‘tould him it was Veneriall’.¹³² Another patient had already been seen by other practitioners, had been in receipt of surgical treatment for at least a year, and was in a sufficiently desperate situation as to be recommended ‘as an object of Charity’, but still ‘strongly denied’ it when Morgan ‘charged him’ with being infected. He too was a ‘young fellow’.¹³³

Practising in London between the 1630s and 1660s, Binns had labelled at least sixty-six separate men, or 30% of his apparent adult male patients, as having either venereal disease (or its repercussions) or the symptoms that suggest that such a diagnosis was being made. Although their ages were unlisted, they ranged from servants to Sir Charles Cotton, with several detailing a history of recurrent infection or relapse. Yet for only three men did Binns see fit to record the means by which it had been transmitted, whether ‘by dealing w[i]th a pockye woman’, heavy drinking after ‘haueing layn wth a wench’, or it being ‘gott by a wench’.¹³⁴

Similarly, only once did Binns mention the marital *implications* of infection, stating of John Lowe of Derbyshire, suffering from a gonorrhoea, that ‘he was well prayesd be god, . . . afore he married’.¹³⁵ The significance of the religious exclamation should not be exaggerated, for Binns repeatedly concluded cases with ‘Well Laus Deo [thank God]’ or ‘almoste wel prayesd be god’.¹³⁶ Nor, on the other hand, were Binns’s silences necessarily reflective of uniquely metropolitan attitudes, a Restoration relaxation of sexual morals, or any city-based liberalness. In Oxfordshire in 1650, Willis was happy

¹³¹ C.f. Rizza, ‘Decorums’, p. 153.

¹³² WL, MS 3631, Medical case-book, Morgan, pp. 19, 87.

¹³³ Similarly, Morgan ‘by no means could’ make the sufferer (of unstated age) of a venereal penile ulcer ‘own itt’ (ibid., pp. 16, 30).

¹³⁴ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, ff. 27, 170v, 177.

¹³⁵ Ibid., f. 177.

to label as '[a] man of good family, and a close acquaintance of mine' a gonorrhoea sufferer who 'says he has had these symptoms for... seven years'.¹³⁷ What being infected might have meant for these seven years of his life is, however, uncertain. The records left at the same time by Binns make it doubtful as to whether the friend was *constantly* carrying the scars (or proofs) of his sexuality on his flesh, let alone in a way causing uninterrupted physical suffering, or in a seven-year-long continuous broadcast of his sexual proclivities.

As seven of these male venereal sufferers returned to Binns, three times, he treated a total of seventy-six such cases. Many were cured relatively quickly, for in twenty-nine cases (38%) all of the symptoms were removed in two months or less, and in half of these twenty-nine in less than one month, sometimes within days, and often using only a small range of therapies. Indeed, in over half of the venereal cases (forty, or 53%), men were deemed to have escaped all of the signs and symptoms of their disorder within six months or less. Seventeen (22%) had no recorded outcome, and two were cut short when patients left or were hospitalized, but there were a further seven cases (9%) in which men had all or almost all of their symptoms removed, albeit in an unspecified time. Although also twice described as slow or prolonged, in only seven cases (9%) did recovery visibly take six months or longer (twice around six months or more, thrice over a year, and twice more than three years), and one of these cures was prolonged only because the patient went through a repeated cycle of *self-induced* relapses.

Equally significantly, it was not just a small number of individual symptoms that could (allegedly) potentially be removed so quickly, but the whole spectrum of venereal

¹³⁶ Ibid., ff. 209v, 141v.

complaints that men took to Binns, and at all levels of severity. Even in a case where the glans was putrefying and turning black, the penis mortifying and approaching gangrene, and the patient delirious, the mortified parts were removed in just over two weeks, with the skin cicatrized and the patient well ten days later.¹³⁸ These were, furthermore, symptoms that could potentially be removed quickly even when entrenched or problematic, or on the bodies of men who were self-destructive. Stockedell, for example, had had his gonorrhoea and burning urine for two years, and the medicines that Binns used for the first six weeks had no effect. Their replacements, however, did immediate good, and within two weeks ‘he began to be well. & was well’.¹³⁹ Similarly, Hendricke’s ulcerations and tumours of the glans were impossible to access because of the resultant phimosis, yet in just twelve days the discharge had been reduced significantly, and after another six the skin had grown back and the ulcers healed. Even the ganglions were gone little over a month after treatment started.¹⁴⁰

This is not, however, the only way in which having venereal disease might have been less of a source of suffering, and less of a cost of sexual behaviour, than the historian could expect.¹⁴¹ The social suffering, and public exposure, that it brought might also have varied.¹⁴² Others of Binns’s patients had pain or soreness, especially in the head or limbs, but less than a third (twenty-one) of the sixty-six men with venereal disease were recorded as ever having symptoms (distinct from medicinal side-effects) outside of the

¹³⁷ Dewhurst, *Casebook*, p. 88.

¹³⁸ BL, Sloane MS 153, ‘Chirurgical Observations’, Binns, f. 170v.

¹³⁹ *Ibid.*, f. 168.

¹⁴⁰ *Ibid.*, f. 18. Above, p. 84, discusses phimosis.

¹⁴¹ See Foyster’s discussion of the mockery of former sufferers (showing that ‘a single act of illicit sex could haunt or shame a man for years to come’), and the use against those in high office of ‘libellious accusations of venereal disease’ (Foyster, *Manhood*, pp. 82, 117-118).

¹⁴² Compare to references to ‘a loathsome disease’ that ‘marked its victims both physically and morally’, ‘disfigured... and lasted a dreadfully long time’ (Beier, *Sufferers*, pp. 87, 93).

genitalia that were visible to the eye, whether prior to consulting Binns, when first approaching him, or at any point during his employment.

Over half of these twenty-one (thirteen, or 20% of all sixty-six men) did at some point have symptoms that, being on the nose, face, or head, would have been especially noticeable.¹⁴³ Yet, and significantly, the visible signs of venereal disease were also often quickly removed. Two men treated twice by Binns had on both occasions symptoms visible on the wider body, as did another on two of three encounters. It was not, however, inevitable that repeat patients would have such symptoms in every outbreak or relapse, for when Kinge came back after having a mixture of facial and genital complaints removed it was because of symptoms in the latter only. Moreover, of the other seventeen of the twenty-one, five (23%) were cured of their entire complaints in under two months, one in less than three, and another in under a year. Three more were relieved of all their symptoms after unspecified times, and only one after a year or more. Two other cases involving symptoms visible on the wider body were interrupted by hospitalization or relocation, and three had no stated outcome, but only one was recorded as failing, here by terminating in death. The disease was often purged out of the body using mercury, and this therapeutic 'Fluxe' did cause heavy spitting.¹⁴⁴ Yet, even fluxing might have meant, at least sometimes, less social exposure than is claimed in the secondary literature.¹⁴⁵ Mr Egas, for example, was '[s]pitt[ing] verye much' for

¹⁴³ In the nose ulceration, the destruction of the bones and septum, stanches, sloughs, and discharge, and on the head ulcers, sores and swellings, but predominantly scabs.

¹⁴⁴ BL, Sloane MS 153, 'Chirurgical Observations', Binns, f. 16.

¹⁴⁵ See claims that it 'made... syphilis... virtually impossible to conceal' (W. F. Bynum, 'Treating the Wages of Sin: Venereal Disease and Specialism in Eighteenth-Century Britain', in idem. and R. Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850* (Breckenham, 1987), pp. 5-28, quotation at p. 16).

only thirteen days, two days later 'it was done', and he was able, and willing, to go 'abroade all t[h]e time he toke the pilles & dureinge his fluxing'.¹⁴⁶

Table 5.3 Male patients with severe venereal cases in Joseph Binns's 'Chirurgical Observations', c.1633-c.1663

	Repeat patient of Binns	Visible symptoms on wider body	Potentially/ clearly under Binns for three or more months at a time	Ill for at least a month before using Binns	Treated before Binns	Dies
Total	7	21	12	15 [and 4 who had had infections previously]	15	4
As % of 66 patients	11	32	18	23 [or 29]	23	6

Source: BL, Sloane MS 153, 'Chirurgical Observations' (c.1633-c.1663), Joseph Binns

The existence of at least five sufferers whom it took Binns more than a year to cure, fifteen men recorded as having had symptoms for a month or more (prior treatment having failed for at least eight of these), and seven return patients, makes it even more significant that (as far as Binns knew) only four died (table 5.3). It is not clear, therefore, that even men in whom the disease had had time to take root were destined either to succumb to the disease or to spend their whole lives struggling against it. Only two of those fifteen who had had the complaint for at least a month (constantly or on-and-off) before seeking Binns's help needed to become repeat patients of his, and only

¹⁴⁶ BL, Sloane MS 153, 'Chirurgical Observations', Binns, f. 159v.

three of the fifteen (including one of the fatalities) visibly needed longer than three months to be cured or re-cured on any one occasion. Similarly, only two of these fifteen died, both after they had left Binns's care. Carothorne's gonorrhoea had set off a chain of other illnesses, and led to his being fluxed for six weeks, purged, dieted and sweated even before seeing Binns in June 1658. It was so severe that he underwent seemingly constant treatment, with a slight improvement in early May 1660, after which he put himself 'in seuerall handes... but noe better by anye', wasting away in 1661.¹⁴⁷ The other death occurred not only after leaving Binns but also after being cured. This hospital patient was 'well of all' within a month of putting himself in Binns's care, and under another in-house practitioner when he contracted a fatal '[h?]ypothermia'.¹⁴⁸

Conclusion: Culture and the lived body

Echoing Smith, this chapter found that '[h]ealth problems *could* be gendered, since men's and women's... social roles and occupations often affected health'.¹⁴⁹ Yet, it also suggests that the potential for gendered difference in the experienced body might for many men have remained just that.¹⁵⁰ It seems that very different arguments can be reached from different records and even from different interpretations of a single account. Indeed, Smith's conclusions were made by reference to some of the sources used here, implying that arguments based on what is not present (or how often something is absent) can be very different to those based on what is.¹⁵¹ This chapter, however, argues that male cases implicating sex and violence, and even drink, have more significance if compared to the female record than to the medically documented male experience as a whole. Its findings encourage the observation that masculine life

¹⁴⁷ Ibid., ff. 28v-30v.

¹⁴⁸ Ibid., f. 202.

¹⁴⁹ Smith, 'Health Care', p. 93 (my emphasis).

¹⁵⁰ Compare to *ibid.*, p. 102.

was less precarious – and precarious because of the pleasures and obligations allocated to men by patriarchy – than might be expected from the secondary literature. Certainly, the record left by practitioners offers little to support Adair’s belief that the pressure (or encouragement) to live as a ‘man’ was killing men *en masse*.

On the contrary, this chapter’s research has generated a fairly positive picture of the male physical experience of patriarchy and of masculinity. In particular, these findings suggest that, as a gender, men received patriarchal dividends without paying a heavy physical price in return. The occupations that men adopted in the fulfillment of their patriarchal obligations did not necessarily exert costs – or repercussions – upon their bodies any greater than those being suffered by the women denied such gendered privilege. Thus, there is no evidence in this source base suggesting that, for example, men of middling and high status were the victims of the manner in which they satisfied gendered obligations of provisioning. ‘Sedentary’ occupations, stress, and over-application were totally absent from Hunter’s socially-mixed post-mortems and morbid anatomies and, indeed, only slightly more present in the consultations by and about middling, professional, and elite men received by physicians.¹⁵²

The employments that men of lesser-status were required to adopt do appear to have exacted greater physical costs than did those performed by their male superiors. Yet, and significantly, it seems possible that lower-sort men made ill by their occupations were often suffering because of their social group rather than their gender. Even war wounds, a threat unique to this gender, seem to have played quantitatively little role in the average sailor’s experience, with injuries even more absent from those tales

¹⁵¹ The records kept by Wilkes, Morgan and (through Beier, *Sufferers*) Binns.

constructed at Edinburgh's civilian hospital to explain health problems ascribed to serving as soldiers. Instead, these latter narratives drew on behavioural and environmental dangers that medical publications claimed to extend well beyond peculiarly male occupations and, significantly, beyond employment. Indeed, when combined, practitioners' records and medical publications suggest that even the risks associated with those civilian 'male' occupations involving the outdoors, dangerous substances, or heavily physical exertion, were ones that women of similar status were also imagined as suffering, did suffer, and suffered because of daily living, one-off dangers, and wider environmental hazards.¹⁵³ Certainly, few males were recorded in this source base as having ever yielded to the very particular substances that some men were exposed to by their employments, and none at all as having subsequently suffered especially heavily because of the sex of their bodies.¹⁵⁴

Consequently, the practitioner explanations, and occasional patient narratives, recorded in manuscript do encourage the observation that men's experience of sickness was not simply or even primarily about dealing with the repercussions of patriarchy, masculinity, or lifestyle. However, they also suggest that contemporary knowledge of the gendered inequality in access to public pleasures that patriarchal privilege allowed to men, as expressed in part by Adair, was not creating a peculiarly masculine *medical* experience or relationship. Male patients' gender, their age and social status, and even the way that medical theory linked certain disorders to particular lifestyles, did not

¹⁵² Above, pp. 151-154. Occasional male individuals did, however, complain to associates of having been made ill by other aspects of their occupations (p. 164).

¹⁵³ London's population at large was, for example, seized with 'a disease to which' 'painters, plumbers, glaziers, and... workers in white lead are liable' when a warm summer created 'a great deal of business for' its painters (RCS, MS 0002, 'Observations and Cases 1781', Bedford, p. 12).

¹⁵⁴ That scrotal (and subsequently testicular) cancer allegedly attacked chimney sweeps, for example, might show male anatomy and masculine occupational culture coinciding to create distinctively male suffering, yet scrotal cancer was never diagnosed in any of the records analyzed in this chapter, even

visibly lead practitioners to blindly follow rigid stereotypes of behavioural causality, at the cost of men's recovery or to the detriment of the patient-practitioner relationship.

On the contrary, these findings indicate that the sick man's experience of medical care was not, even in particular eras, or for men of certain ages and statuses, about fending off the suspicion of dangerous behaviours. If the manuscript case notes can be approached as an accurate representation of the medical dialogue, the patient-practitioner relationship was not censorious, chastising, or concerned with the inscription of blame, even when practitioners did believe individual men's afflictions to be the product of sex, drink or violence. Consequently, this research suggests that practitioner criticism was not the cost, let alone the expected cost, of indulgence in masculine (mis)behaviour, and that even men who knew or suspected their own afflictions to be linked to sex, drink or violence – or, on the other hand, inertia – were free to seek medical assistance without the anticipation of moralistic judgement. Certainly, Morgan's apparent belief that men's denial of venereal infection was often duplicitous is the only suggestion that any of this sample of practitioners expected male subterfuge and deceit over the nature or causes of diseases or injuries. Indeed, while some of the eighteenth-century men whom Morgan thus diagnosed refused to admit their disorder, Binns's seventeenth-century records show that there were others apparently willing to tell practitioners the whole story of their infection and subsequent treatment.¹⁵⁵ Whether this reflects chronological changes, differences between metropolitan and provincial men, or simply variations in the patient-practitioner relationship, it shows that the collective male experience of seeking a cure even for

without reference to the sufferer's occupational history. See Percivall Pott, *Chirurgical observations...* (1775), pp. 63-67; above, p. 97.

¹⁵⁵ Above, pp. 204-205, 209.

venereal disease – or for what sufferers feared *might* be venereal disease – could be far from one of deceit and the fear of discovery.

Collectively, therefore, these findings suggest a patient-practitioner relationship unaffected by stereotypes of certain male and masculine behaviours. They also indicate that (believed) actual indulgence in allegedly masculine recreations did not necessarily create a relationship between the public world and the individual and the body that was uniquely dangerous in physical ways, nor automatically carry physical dangers that damaged men's relationships in this world at large. This is not to deny the significance of venereal disease to men's collective experience of health problems in the sexual organs. Indeed, it seems possible that what was believed to be venereal disease caused far more men to suffer physical problems within the genitals than did these parts' vulnerability to (non-sexual) 'clean' disorders, and, furthermore, than did gendered occupations or any other element of a vaunted active masculine lifestyle.¹⁵⁶ Yet, and significantly, there was no single male experience – physical or medical – of venereal disease. While historians have approached infection as the consequence of public constructions of male sexuality, the disease did not necessarily bring this relationship between the body and the public world full circle, endangering men's public status and reputations. As Binns's notes reveal, it was not inevitable that the infected male body would function as a visible or enduring signpost publicizing such (allegedly) illicit sexual behaviour.

Similarly, this medical material also challenges the idea of a post-1660 transformation in actual behaviour as 'masculinity' allegedly displaced 'manhood', a 'reformation of

male manners' ostensibly occurred, and textual ideals came, it is claimed, to promote masculine refinement and self-control.¹⁵⁷ It does so, furthermore, by bringing into particular question the extent or frequency to which some of the values allegedly at the core of early modern 'manhood' (or its transgressive youthful version) were actually enacted. A conferred masculinity allegedly came from obedience to public codes of male recreation, but that such behavioural factors were not more frequently blamed for men's bodily problems, and for those that were fatal or incurable, suggests that in both centuries it might have been possible for men to achieve such recognition without their needing to succumb to those depraved extremes of behaviour that so antagonized didactic writers.¹⁵⁸

Ultimately, it is a life lived literally outside rather than in those centres of conviviality that 'were predominantly male space[s]' that men's medical care reveals.¹⁵⁹ Yet, the recorded consequences of travelling and falls (primarily encountered by surgeons) and of being outside, particularly during exertion, (perhaps diagnosed mainly by physicians) were still outnumbered by apparently ungendered problems. Indeed, and in the frequent absence of a supposedly near-ubiquitous recreational masculine culture, and of gendered, occupation-specific, health costs, it is difficult to see the health-related variations that might have revealed how social and chronological differences influenced men's engagement with masculine culture or cultures.¹⁶⁰ Chapter six, therefore, tests

¹⁵⁶ Only one of the adult males' hernias in Hunter's morbid anatomies, for example, was ascribed to a strain or injury (above, p. 105). For the difficulty of assessing the frequency of 'clean' genital health problems see pp. 99-101.

¹⁵⁷ Barker-Benfield, *Sensibility*, pp. 37-103.

¹⁵⁸ Below (p. 226).

¹⁵⁹ With a frequent absence of fractured limbs, presumably because of the existence of bonesetters. Quotation from A. Lynn Martin, *Alcohol, Sex, and Gender in Late Medieval and Early Modern Europe* (Basingstoke, 2001), p. 61.

¹⁶⁰ In the shortage of surgical records for the rich it might be argued that the effects of hunting and elite sports are under-represented, yet such activities were almost never mentioned in the histories sent to wealthy men's physicians. See p. 154.

such silences by exploring how men themselves might have envisioned, and represented to each other, the relationship of their bodies with and to the outer world.

Chapter 6: Masculinity and taking care of the body

Introduction

Approaching the interaction between masculinity, (the) man, and the body from a different angle, this chapter asks whether men's gender mattered when it came to the protection of the body. It asks how men negotiated the demands that *might* have been placed upon them by a society seemingly expecting masculine bodies, and, according to historians of early modern manhood, having high expectations of these. On an immediate level, therefore, it considers the significance to men's health care of gendered corporeal ideals. By doing so, it casts some light on the significance of the social construction of masculinity to men's ideals about, and responses towards, their bodies more broadly.

There are reasons to expect that society should have been putting pressure on men to take particular stances towards their bodies. Scholars have already shown the importance given to physical strength (and courage) in ideals of early modern 'manhood', or revealed the continuation of such values in the eighteenth century, in certain genres at least.¹ As chapter 2 argued, medical publishing sometimes assessed maleness and masculinity by strength and robustness, concepts carrying denotations of fitness, activity, and industriousness. Certainly, Philip Carter argued that eighteenth-century critics of a perceived effeminization depicted 'physical health and hardiness' as 'traditional' (although threatened) 'male qualities'.² Indeed, chapter 4 raised the possibility that fewer earlier-eighteenth-century men might have wanted to associate themselves with the physical and emotional sensitivity elevated by 'sensibility' than

can be suggested by the analysis of its associated medical publications.³ Whether or not this was the case, other historians have still suggested that there was by the mid-eighteenth century a heightened sensitivity to physical masculinity, or rather to its absence, and one that emerged partly in response to this ‘sensible’, delicate-bodied, man.⁴

Consequently, if this was a period of ‘intense concern about “manliness”’, when ‘the “other” to manliness... was not simply the feminine, but also the effeminate’, perhaps men identifying with either masculine body type – the robust or the sensitive – felt a resultant pressure.⁵ Both might have had a stake in the possession of medical knowledge, whether in its use, to protect and recover threatened strength and healthiness, or in its known ownership, parading the body’s *lack* of robustness. Accordingly, this chapter asks if changing masculine stock-characters prompted similar changes in the medical information that British men selected for exchange and preservation, and if the content of their collections can itself give evidence of gendered bodily anxieties.

To answer this, it uses homemade manuscript compilations of several types, from a range of dates, and by men of varied social status, occupations, and locations. These include the medical commonplace books kept by Lancashire’s Reverend John Heywood (compiled in the mid-seventeenth century), and Dr Thomas Wilson (1664-1755), Bishop

¹ Joanne Bailey, ‘“A very sensible man”: imagining fatherhood in England c. 1750-1830’, from a forthcoming work. I am grateful for the opportunity to see this.

² Philip Carter, *Men and the Emergence of Polite Society, Britain 1660-1800* (Harlow, 2001), p. 131.

³ See, for example, the conclusions reached in G. S. Rousseau, ‘Towards a Semiotics of the Nerve: The Social History of Language in a New Key’, in R. Porter and P. Burke (eds.), *Language, Self, and Society: A Social History of Language II* (Cambridge, 1991), pp. 213-275, esp. 221-224.

⁴ Carter, *Men*, pp. 2, 10, 130-131.

⁵ Tim Hitchcock and Michèle Cohen, ‘Introduction’, in idem. (eds.), *English Masculinities* (London and New York, 1999), pp. 1-22, quotations at pp. 22, 5-6.

of Sodor (undated but referring throughout to texts from the first half of the eighteenth century).⁶ Where illuminating, reference is also made to items from the collection of medical, culinary and household recipes started by the politician Sir Peter Temple, apparently begun well before 1640, and using creations from the turn of the century or earlier.⁷ As a navy commissioner and director of Greenwich (naval) hospital, the mixed scrapbooks compiled at the opposite end of the period by George Marsh (b.1723) are likewise touched on, here for the possible effects on men's collecting habits of a professional involvement on the edges of the medical world.⁸ Occasional comparisons are also drawn with manuscript recipe and medical commonplace books of female or unknown authorship, or kept by practitioners, and diaries produced by medical students and trainees analyzed for insight into another area of men's recording habits.

Underlying the chapter is, however, a statistical analysis of three clearly or apparently male-compiled manuscript recipe collections selected for their size. The first comes from the Clerk family of Penicuik (county Edinburghshire), who here gathered together items obtained, where dated, between 1647 and 1781. Included in this collection are prescriptions, practitioner letters, and apothecaries' slips naming Sir John Clerk of Penicuik (1650-1722), 1st baronet, Sir John (1676-1755), 2nd baronet, James and Alexander Clerk, George Clerk-Maxwell (1715-1784), 4th baronet, and, perhaps in the extended family, Mr Adam and Mr J. Adam. These might have been the main

⁶ CL, MS A. 2119 Heywood, Commonplace book (seventeenth-century), Reverend John Heywood; BL, Additional MS 19688, Medical receipts (eighteenth-century), Dr Thomas Wilson.

⁷ Although the first volume has a title dated 1656. BL, Stowe MSS 1077-1078, Medical, cookery and other recipes (seventeenth-century), Sir Peter Temple.

⁸ WL, MSS 7628-7629, Scrapbook (late-eighteenth-century), George Marsh.

compilers, or those whose ailments created the materials that somebody else preserved.⁹

However, for reasons discussed below, the compilers appear to have been men.

The second collection was created by a member of the Wharton family of Old Park, County Durham. It follows on from, and is in the hand of, a set of familial accounts, estate records, and instructions on estate management and ‘bidding for an estate in Chancery’. Included within these is the note that that in ‘1743 I paid... for This house Gardens & crofter 360 00 00’, giving a possible indication of both date and authorship. Scattered amongst the medicinal and culinary recipes are directions for crop rotations and lists of seed prices, animal recipes, and ‘advice on watering and feeding horses while travelling’, all of these additional contents suggesting strongly a male authorship, if this can be judged by the way that they were presented as gendered responsibilities in the printed literature.¹⁰ The third collection, created by the otherwise unknown Thomas Freeman in 1779-80, was completed in Dublin but is useful in its size, certain male authorship, and known, and late, date.¹¹

Men’s medical compilations are a source-base that has received little analysis from medical history or from historians of manhood and masculinity. While Lisa Smith has shown that the ideological construction of the patriarch’s obligations required that he participate in the provision of domestic medicine, the male ownership of medical knowledge has received little examination as something in its own right.¹²

⁹ One, dated 1673, was ‘[a]nent My fathers sicknes’ (NAS, GD18/2125/1-167, esp. 155, 87, 126, Clerk family papers, Medical recipes and prescriptions (1647-1859), Clerks of Penicuik).

¹⁰ DUL, WHA/88, Wharton papers, Unlabelled notebook (mid-eighteenth-century), pp. 1-25, 40-115; Lynette Hunter, ‘Women and Domestic Medicine: Lady Experimenters, 1570-1620’, in idem. and Sarah Hutton (eds.), *Women, Science and Medicine 1500-1700, Mothers and Sisters of the Royal Society* (Stroud, 1997), pp. 89-107, esp. 96.

¹¹ RCS, MS 0088, ‘A Collection of choice Receipts’ (1779-80), Thomas Freeman.

¹² Lisa Smith, ‘The relative duties of a man: domestic medicine in England and France, ca. 1685-1740’, *Journal of Family History*, 31, 3 (2006), pp. 237-256. Some historians have spoken of domestic medicine,

Consequently, this chapter broadens the question of the gendering of health protection. It goes beyond the role of gender in the provision of *familial* medical care, analyzing men's collections as a specifically male project and searching for insights into men's gender as it related to their own health, and *vice versa*. The first part, however, makes a preliminary analysis of the printed conduct literature, looking for gender-specific, socially inculcated, reasons for taking care of their bodies that men might have been subject to. The second turns to the manuscript sources, asking what such compilations reveal about men's ability to access health-related information of practical use. The third part searches their compilations for men's actual reasons for doing so, testing whether it was gendered expectations, or ideal-types of the kind expressed in the conduct literature, that these collectors were pursuing.

Part i: Masculinity as an Imperative to Healthy Living

If society's constructions of masculinity or maleness gave men cultural reasons to want to gather health-related information it is difficult to see this in printed texts. Medical guides to health gave sexed needs only to females and rarely made exhortations that were gendered. Their comments targeted at men were no more specific or explicit than the presumption of male vigour and exertion, itself mentioned mainly for consequently higher dietary needs, or in the linking of 'sedentary' men with reduced nutritional requirements, or with delicate health.¹³

and the collection of domestic medical knowledge, as a female activity (e.g. Montserrat Cabré, 'Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia', *Bulletin of the History of Medicine*, 82, 1 (2008), pp. 18-51, esp. 23). Others have used examples from both genders interchangeably, without commenting on the implications, or otherwise, of (men's) gender. See, for example, Elaine Leong, 'Making Medicines in the Early Modern Household', *Bulletin of the History of Medicine*, 82, 1 (2008), pp. 145-168; idem. and Sarah Pennell, 'Recipe Collections and the Currency of Medical Knowledge in the Early Modern "Medical Marketplace"', in Mark Jenner and Patrick Wallis (eds.), *Medicine and the Market in England and its Colonies, c.1450-c.1850* (New York, 2007), pp. 133-151.

Non-medical prescriptive literature similarly reveals few ways in which social expectations might have made men think that having a healthy body, or taking a particular stance towards the body, was a prerequisite or stepping-stone to being acknowledged as masculine. Instead, it was a 1695 translation of a French educational manual that expressly linked health, strength and robustness to masculinity.

Automatically speaking of males only, this elevated strength and conflated it with health, rooted these in temperance and exercise, advised that boys be raised in ‘Contempt of the Soft and *Effeminate* Life’, and bemoaned a decline in the training of males in ‘that which is most essential; that is, to make them *Healthy*, and render their Bodies *Robust*’, and doing so by accustoming them ‘to inure themselves to all sorts of Fatigues’.¹⁴

So insistent was Claude Fleury (1640-1723) (or his translator) that male health lay in robustness, exertion, hardiness and asceticism that he condemned men who recognized their bodies as vulnerable and fallible, using language that left no doubt of his opinion about their lack of masculinity. Men were to force their bodies into lives of exertion, hardship, and physical denial, not to pander to them. ‘When I speak of having a care of Health, I do not mean those... Women, *Sedentary and Lazy Men*, who are feeling their Pulses every Moment’, ‘their softness’ displayed in the fact ‘that they never use the means... of Labour and Abstinence’. Indeed, Fleury attacked those men who sought not to push the body to its limits but to protect it, slurring them as *inactive*, ‘*sedentary*’, and physically *soft* – the total opposite of his active, robust, austere, ideal.¹⁵

¹³ Above, pp. 53-55, 62-64.

¹⁴ Claude Fleury, *The history, choice, and method of studies...* (1695), pp. 103-104 (my emphasis).

¹⁵ *Ibid.*, pp. 105-106 (my emphasis). For the use of ‘sedentary’, ‘effeminacy’ and ‘softness’ see this thesis, pp. 43, 52-54, 61, 63-65, 71.

Published in Britain only once, Fleury's text was highly unusual in the vehemence of its demands, and in its denunciations. Prescriptive literature did, however, occasionally criticize what by the early-eighteenth century was called the 'valetudinarian', 'a sickly Person, or one *always anxious about his Health*'.¹⁶ Yet, even prescriptive literature written especially for youths and men did not make the male valetudinarian effeminate, unmanly, or 'soft', in body or in lifestyle or character. Thus, James Todd's *School-boy and young gentleman's assistant* (1748) associated the valetudinarian with '*lazy and sedentary* People', but not with effeminacy.¹⁷ Indeed, the normative male body-owners of the texts in which the valetudinarian featured were frequently schoolboys and 'young gentlemen', not martial ascetics or even great sportsmen.¹⁸ Nor did Todd return to even this language of sedentary indolence, with its *potential* denotations of a lack of robust masculinity, when denouncing those 'who by fearing Diseases are almost ever sick', and by 'tampering with Preventive Physick to disappoint an imaginary Disease, create a real one'.¹⁹ It was not a concern or even 'Tenderness' for health that offended Todd, but one taken to obsessive extremes.²⁰ Thus, even his condemnation of the all-consuming 'Dread of Death' was followed by a reminder of a 'rule' to be followed by all – the need to 'be careful to observe what has been formerly hurtful or agreeable to... Health'.²¹

The conduct literature did not teach that it was a proof and product of weakness for men to care for the body, or to make the implicit recognition of its vulnerability that this might have entailed. Yet, that written for men, as opposed to boys, rarely expressly instructed readers to preserve their health. Many such works mentioned health only in

¹⁶ John Quincy, *Lexicon physico-medicum...* (1730), p. 453 (my emphasis).

¹⁷ James Todd, *The school-boy and young gentleman's assistant...* (Edinburgh, 1748), p. 23 (my emphasis).

¹⁸ Anon., *The young gentleman and lady instructed...*, vol. 2 of 2 (1747), pp. 193-194.

¹⁹ Todd, *School-boy*, p. 23.

²⁰ *Ibid.*, p. 12.

the context of consumption, especially of drink, reducing physical wellbeing and its attainment to the restraint of bodily appetites.²² Thus, William Burkitt's (1650-1703) religious *Poor man's help* (2nd edn. 1694), still in print in 1790, was unusual in calling for 'every one' to 'understand his particular Constitution', and 'what is most conducive to his own Health, and let that... measure... his diet'. Even this was stated as only one of multiple religious reasons for the restraint of the appetites, with health made of significance only because the body had to be able 'to serve the soul'.²³ Indeed, there were many texts, religious and secular, that made no mention of physical wellbeing even when talking of temperance, or of drunkenness and the drunkard.²⁴

It was not only print that reduced good health to consumption. The Reverend Heywood's mid-seventeenth-century commonplace book was dominated by the humoral discussion of foodstuffs and their properties, and at the end of the eighteenth century George Marsh's commonplace and scrap books reduced the maintenance of health to temperance alone. His only medicinal content for the protection of health, distinct from the cure of ailments, lay in preventatives against named illnesses. Indeed, Marsh's '[r]ules for pr[e]serving Health in Eating and Drinking' were traditional, simple, humoral, cautions against gluttony, luxury and excessive variety, with a simple modification for the dryness of the 'aged and decrepid' (another humoral notion).²⁵ Where it did make temperance about health rather than efficiency, character and self-control, the seventeenth- and eighteenth-century conduct literature followed the same rules. In both centuries, the understanding of food and its bodily effects seemed

²¹ Ibid., pp. 22, 24.

²² Sir John Barnard, *A present for an apprentice...* (2nd edn., 1740), p. 8.

²³ William Burkitt, *The poor man's help...* (10th edn., 1712), pp. 12-17.

²⁴ Anon., *The parents pious gift... between a religious father and an extravagant son* ([London?] and [Newcastle?], 1750).

²⁵ WL, MS 7628, Scrapbook, Marsh, pp. 156, 61-79, 85.

humoral, and the (consuming) body unsexed and almost entirely ungendered.²⁶

More often, however, when this printed non-medical literature called for self-control in consumption it was not the condition of the body that was its driving concern. Nor, however, was a masculinity specifically of body and body-owner, in the elevation and praise of a body type that was masculine in its appearance, slenderness or healthiness (internal and external), or in its firm self-control and its power over base appetites.

Religious guides called for temperance as one of numerous pre-requisites for ‘the *Soul’s* eternal Health’, and usually this alone, while in many secular texts the crucial worry bringing temperance into play was actually the youth’s ‘entry “into the world”’ and his negotiation of the threats that this adult society posed to his name, money, prospects, and soul.²⁷ This concern with dietary restraint was not, therefore, the expression of an anxious, body-based, masculinity, or of an anxiety about a sickness thought to be masculinity’s creation. Elite sons were allegedly being taught parentally that ‘masculinity rested upon the... self-command’, ‘self-possession and moral authority’ that came from a ‘male virtue’ lying in the ability to resist ‘temptations’.²⁸ It seems that this was also true of messages conveyed both textually and to lower social levels. Prescriptive writers were similarly promoting ‘values of masculine autonomy, virtue and authority’ that both required and proved a man’s ability to resist temptation.²⁹

Consequently, it was a loss of self-control when released into the temptations of ‘the

²⁶ Todd, *School-boy*, pp. 13-22.

²⁷ Anon., *Pious gift* (unpaginated, my emphasis); Anon, *The advice of a father...* (1665), p. 96 (i.e. 106), 10-13, 52; G. B., *The last advice of an old father...* ([Edinburgh], [1793]), p. 3. Quotation from Henry French and Mark Rothery, ‘“Upon your entry into the world”: masculine values and the threshold of adulthood among landed elites in England 1680-1800’, *Social History*, 33, 4 (2008), pp. 402-422, quotation at p. 420.

²⁸ French and Rothery, ‘Masculine values’, pp. 420-422.

²⁹ *Ibid.*, p. 420.

world' that served as the ultimate fear bringing temperance into literature written for young men. Throughout the period, gluttony, drunkenness, corrupting '*Bottle Companions*', gambling and sometimes female temptations ran through texts written for youths of all statuses, and even for public schoolboys.³⁰ No matter how much attention they gave to its health consequences, secular authors tended to reduce temperance to an issue of self-control, and, indeed, to just one of many interlinked types of restraint, efficiency and respectability.³¹

With conduct literature for males only very occasionally having sections dedicated to health (usually in texts for boys),³² temperance was, therefore, usually approached as but one part of a whole nexus of self-control. Where more general imperatives were given for living a life of temperance they were for the saving of the soul, not for the prolongation and improvement of life in this world by bodily wellbeing. Similarly, where temperance was promoted as a requirement for material, financial and personal success this was not because gluttony brought fits of sickness that took men away from business, or for the more general sluggishness that could have been said to accompany a life of excess. Instead, it was in the drowsiness that lay in being sated, or the distractions posed by food- and drink-based sociability.

Thus, when secular texts made temperance one of several overlapping mechanisms for advancement it was as a way of life, 'none but the Industrious either deserving, or having a Possibility to thrive'.³³ In guides for apprentices, servants and tradesmen, a set of interlinked imperatives made *intemperance* of significance because over-indulgence

³⁰ Quotation from George Cheyne, *Dr. Cheyne's account of himself...* (2nd edn., 1743), p. 1 (original italicization).

³¹ E.g. Caleb Trenchfield, *A cap of gray hairs... the fathers counsel...* (1671), pp. 17, 50.

³² Todd, *School-boy*, pp. 15-22.

in sleep, drink and food ‘not only impairs the Body, but stupifies the Mind, and makes us Bankrupts of our Lives... *Credits, and Estates*’. This excess did so, however, in exactly the same way as did over-indulgence in luxury, leisure and company.³⁴ Likewise, while ‘scarce any business is... done without [temperance]... for he who wants this moderator ... is... unfit for any employment’, this was a question of suitability of character, not of physical capacities.³⁵ The self-control promoted to apprentices and servants was ultimately about the way of living required in order to avoid a loss of name and prospects, not a loss of health. It was certainly not about a peculiarly masculine type of body, whether robust and strong or refined and delicate. Yet, it was not just because of forms of credit particular to the lower orders that temperance, or temperate and intemperate men, were approached in this way. Over-indulgence (particularly drunkenness) was also railed against as one of the means by which titled men endangered patrimonies and estates.³⁶

This was, furthermore, a mentality shared by at least one real-life father. The concerns of the paternal ‘memorandum’ issued to Gilbert Innes (1751-1832) on ‘the first payment’ of his annual allowance were personal, professional, familial and financial self-improvement, the productive use of time and money, and the dangers posed to these by irreverent sociability. Health featured as but a by-product of the lifestyle most likely to bring these gains, and not even as a pre-requisite for the sustained application of the kind of man who maintained meticulous accounts, avoided ‘all Vice & vitious Company’, and dedicated his time and thoughts to the ‘studys & Labour... most likely to procure... Property & Reputation’. Instead, Gilbert was warned against a single,

³³ Barnard, *Present*, p. 5.

³⁴ *Ibid.*, p. 7 (my emphasis).

³⁵ Trenchfield, *Cap*, p. 17.

³⁶ Anon., *A father's advice to his son...* (1736), pp. 32, 48.

multifaceted, web of excess similar to that envisioned in the conduct literature. 'Immoderate Desires, Idleness, & Sloth' were the 'Parents of all Vice', and so 'enticing' that he was to 'Call up... all your Powers to conquer them', and to do so by prayer, regular and early hours, spurning night-time gatherings, and dedicating his time to 'Business or Education'. His father, it was claimed, 'knows' the 'utility' of such 'Particulars', 'both inpoint of health & carrying on of Business & Oeconomy', and in the hope of 'the Death of the Righteous'.³⁷ Business, salvation, efficiency, money, and health, pointed in the same direction.

That one father could adopt a discourse so similar to that of the printed instructions raises the possibility that others did so too. This value system was *not*, however, claimed to be uniquely male and masculine. In print, dietary restraint was demanded of young women too, and for the same reasons.³⁸ Privately, John Hervey (1665-1751), First Earl of Bristol, in 1704 'made a vow to play [gamble] no more, for [th]e following reasons, which I would have all my children' – of both sexes – 'consider seriously'. The concerns were again loss of time and money, corrupting company, and – as only the fifth of seven reasons – that 'Play necessarily makes one keep very ill hours, & setting up all night disorders [th]e health, and weakens [th]e memory, & renders one altogether unfit for any sort of business either publick or private'.³⁹

In neither century did behavioural literature routinely convey any notion of a physically masculine body, or of an ideal corporeal body-type that was peculiarly masculine. It did not even tell men that they would be judged as men, or as prospective householders, on

³⁷ NAS, GD113/5/212/61, Papers of the Innes family, 'Memorandum for Gilbert Innes from his Father 29 May 1769'.

³⁸ Anon., *The Whole Duty of a Woman* ([London?], [1701?]), pp. 26-28.

³⁹ John Hervey, ed. E. Jackson, *The Diary of John Hervey... 1688 to 1742* (Wells, 1894), p. 39.

their mental capacity for self-control. Even lengthy character satires and scandalized denunciations describing the drunk as ‘unman[ned]’ saw him as dehumanized, not physically or figuratively emasculated.⁴⁰ Nor did ‘politeness’ introduce drunk men as the possessors of corporealities. Instead, the focus of its discussion of drink remained the offensiveness of the drunkard, not that of his body, while drunk *or* in its eventual decay. Thus, the text instructing ‘[t]he young gentleman and lady... in such principles of politeness, prudence, and virtue, as will lay a sure foundation for... respect, esteem, and satisfaction in this life, and eternal happiness’ afterwards (1747) claimed to write of the effects of drinking on mind, body and fortune but considered its consequences for the body only in ‘hot’ and contaminated liquors and late nights. What is significant is that it could automatically envision drunks as (professional) men, who should have been ‘well-disposed citizen[s]’ but were drunk ‘before the hours of business. And in that condition buy and sell stocks’.⁴¹

Paradoxically, while Marsh demonstrated that this nexus of self-control could be seen to prove the type of *person*, nobody claimed expressly that it proved the man. Marsh showed that temperance could be tied to positive ideal-types and values, but ungendered ones, and his masculine model was his only ideal-type to actually lack temperance. It had instead eighteenth-century ‘politeness’, and an older notion of ‘honour’.⁴² ‘Politeness’ said little about the flesh as a physical, living, entity, but did bring the body into didactic literature through deportment and a deliberate non-offensiveness of dress, manners, and person. Yet, not even the editor claiming to adapt for youths of lesser status the letters (1738-1768) written for an elite (illegitimate) son by the Earl of

⁴⁰ Anon., *The new letter writer; or, the art of correspondence...* (Whitehaven, [1775?]), p. 160; Anon., *Advice of a father*, p. 10.

⁴¹ Anon., *Young gentleman*, vol. 2, p. 177.

⁴² WL, MS 7628, Scrapbook, Marsh, ff. 144-145.

Chesterfield seemed to think that ‘young men, on their first outset in life’, needed to be told about or bodily self-management. This edition’s one reference to even health preservation stated only that ‘[b]esides, a clean shirt and... person are as necessary to health, as not to offend’.⁴³ Elevating Chesterfield’s letters as the most ‘fine... portrait... Of the Man of honor and the Gentleman’, Marsh’s notes lacked even this.⁴⁴

There were occasional publications in which ‘politeness’ elevated an ideal body existing beyond cleanliness or kinesics. However, it was a body ungendered in its physical properties, and one not requiring strength, robustness, or health, of men. Thus, Francis Brokesby’s 1701 manual of male education was unusual in trying to make even the deportment elevated by ‘politeness’ relevant to those issues by which other strands of male prescriptive literature made temperance (in all indulgences) male and masculine – the professional role, and personal and social credit. When he recognized that acting and dancing should never be allowed to ‘effeminate’ boys’ ‘minds’ it was without reference to bodily effeminization, or, alternatively, to those changes in fitness or physical shape, positive or otherwise, that could have come from the sustained use of the dancing master. Instead, Brokesby simply stated that such activities ‘regulate the carriage of their Bodies’, and inculcate ‘genteel behaviour in... converse’, the latter being ‘of great concernment to Men in the time of business and Action’.⁴⁵

Brokesby had considered sports as just one of many ‘recreations’, ideally improving, and of concern because of their power to ‘refresh the mind after Studies and Labour,

⁴³ Philip Stanhope, fourth Earl of Chesterfield (1694-1773), *Principles of Politeness...* (1775), pp. 19, 21-25.

⁴⁴ WL, MS 7628, Scrapbook, Marsh, f. 145.

⁴⁵ F. B. [Francis Brokesby], *Of education...* (1701), p. 110, 112.

and preserve the health of the Body'.⁴⁶ Over four decades later, *The young gentleman and lady instructed* did move to discuss exercise as a bodily need, although initially treating it as a recreation.⁴⁷ It did this, however, with no reference at all to those 'principles of politeness' that the text claimed to instruct in, sexed variations in capacity or needs, gendered cultural propriety, or any requirement for youths to participate in the 'manly' sports that would instill a courageous mentality or physical 'lustiness'. Instead, the only time that this unusually lengthy discussion singled out either gender was to discuss the gaiety and beauty that riding brought women.⁴⁸

This was not, however, reflective of an eighteenth-century de-gendering of the male('s) body. Prescriptive authors had not routinely drawn on the slur or threat of physical effeminacy even in Fleury's generation.⁴⁹ The 1665 text that demanded that youths be not 'effeminate in thy sports, [for]... the most *manly*, will best become thee', was already unusual in even mentioning the existence of masculine sports, let alone in recognizing a potential conflict between manliness and bodily wellbeing when adding that such sports were not to 'be too violent, lest they prejudice thy health, and do thy body harm'.⁵⁰ Even the manual of 1671 that warned that learning fencing would create a fatal 'resolute fool-hardiness' was fairly atypical in alluding to recreations beyond improving conversation and reading.⁵¹

Similarly, while it was in manuals on schoolboy education that physical recreations were most often, or most explicitly, mentioned, these texts did little to make exercise

⁴⁶ Ibid., p. 102 (my emphasis).

⁴⁷ Anon., *Young gentleman*, vol. 2, pp. 108-111, 117.

⁴⁸ Ibid., vol. 2, pp. 110-111.

⁴⁹ Barnard, *Present*, p. 5.

⁵⁰ Anon., *Advice of a father*, p. 5 (my emphasis).

⁵¹ Trenchfield, *Cap*, p. 69.

expressly about a corporeality. While Brokesby mentioned by way of introduction that some ‘recreations’ ‘strongly move the Body, and... preserve natural strength, and infuse vigour, and activity’, while others ‘recreate’ ‘the Mind’, discussions of exercise more commonly recognized the physicality of the body only in reminders to leave a gap after eating.⁵² Others ignored even this, treating exercise as but one of several past-times, all to be ‘innocent, philosophical and improving’.⁵³ A manual for medical students (1776) did remind them that ‘[t]he sedentary life, with close application to study’ is ‘very dangerous... in respect to health’, with ‘exercise’ necessary in order to ‘avoid the bad effects’. However, after simply naming walking, riding, hunting and shooting as types of exercise it instantly turned the discussion of recreations to disreputable pleasures. Thus, it was not in the indolent and lazy, the self-consciously ‘tender’, or that satirized fop whose physical and mental delicacy was self-inflicted, that effeminacy was here satirized.⁵⁴ Instead, it was in the coxcomb and his public indulgences.

Brokesby was, therefore, alone in this sample in referring to masculinization through militarization. Although quoting the recommendation that boys be trained martially *as ‘the likeliest means to make them grow large and tall’, ‘keep them healthy, nimble, strong’,* and instill ‘*a gallant and fearless courage*’, even he was ambivalent.⁵⁵ Nor was the usual near reduction of physical exercise to a recreation, and one as important for the mental as for the physical, entirely a product of the academic focus of schoolboy manuals. Burkitt had done the same in an emphatically Christian didactic text, and even practitioners failed to single out (and prioritize) the body as something separate,

⁵² F. B., *Education*, p. 103; Todd, *School-boy*, p. 18; Trenchfield, *Cap*, pp. 102, 163-167.

⁵³ James Rymer, *An essay, on medical education...* ([1776]), p. 48.

⁵⁴ *Ibid.*, pp. 47-48.

⁵⁵ F. B., *Education*, p. 104 (original italicization).

with its own needs.⁵⁶ Thus, in 1738, in his diary, an apprentice practitioner wrote of ‘husbandry’ as ‘a useful & healthy, manual Exercise... wherein I may both divert my Mind & employ my Body’, and ‘a means both to refresh my mind & confirm my Health & Strength’.⁵⁷ Bishop Wilson did the same in his mid-eighteenth-century reference guide to illnesses, noting to ‘let the Exercise of [th]e body be attended with [th]e Amusm[en]t of [th]e mind. Thoughtfulness (too Intence) very Hurtful[,] Reading Diverting– Conversation Easy – Diversion inexpensive’.⁵⁸ Indeed, it was precisely because ‘not only the Body, but also the Mind must be properly Employed’ that a later-eighteenth-century layman was advised by his brother that a broadly conceived ‘Exercise’ would ‘Reestablish’ ‘Health’.⁵⁹

Part ii: The Possession of Medical Knowledge

The active preservation of health by something other than diet and (sometimes) exercise was not, therefore, an area of life on which the adult male readers of conduct literature were routinely instructed. Only very rarely did authors tell men that they should be equipping themselves with resources for the protection and defence of their bodies. Even when *The advice of a father* (1665) advised men to learn physic, that ‘thou may’st both enrich and cure thy self’, it was without giving them expressly masculine identities to attain, or masculine bodies to protect. Instead, the concern was a career and financial gain, and it was recommended in the same vein as was legal education, there being ‘no Professions... so surely profitable’.⁶⁰ Yet, there were in both centuries men who developed and owned medical knowledge in a more informal way. Whether or not they

⁵⁶ Burkitt, *Poor man’s*, pp. 18-20.

⁵⁷ CL, MS A. 7. 76, Manuscript diary (1737-51), Richard Kay, p. 18.

⁵⁸ BL, Additional MS 19688, Medical receipts, Wilson, f. 2.

⁵⁹ NAS, GD237/10/25/1, Correspondence from and relevant to Gilbert Laing, Gilbert Laing to William Laing, 27 April 1772.

⁶⁰ Anon, *Advice of a father*, pp. 16-17.

were also making a precautionary preservation of good health, there were at least men making a pre-emptive gathering of resources in preparation for the repair of the damaged body.

There were collections ascribed to women or with no known compiler in which men who might not have been practitioners played a comparatively small credited role as the possessors or transmitters of medical knowledge.⁶¹ Thus, one later-seventeenth and eighteenth-century compilation named Sir Kenelm Digby (1603-1665) as a source, presumably via his *A Choice Collection of Rare Secrets* (1682), alongside seven men called ‘Doctor’, one clergyman (in 1786), and only three Misters (a title, however, that was also used for surgeons and apothecaries).⁶² Yet, textually at least, its compilers still gave such men equal status as a source to Digby.⁶³ Indeed, what is consequential here is that men wanted to be part of the process of uncovering and transmitting usable medical knowledge. There was not something about masculine gender (or their non-possession of feminine gender) that meant that men needed Digby’s medical fame or natural philosophical background – or the kudos of the charitably practising clergyman – to have the self-confidence to regard (and expose) themselves as sources, judges, or creators of medical knowledge.

Indeed, there were men promoting their own creations even before 1640. Sir Peter Temple (c.1592-1653), for example, owned, amongst other male-creations, both ‘S[i]r George Hastings Balsome us’d by S[i]r Edward Tyrrill and often approved’ and another

⁶¹ RCP, MS 507, Medical and culinary recipes (seventeenth- to eighteenth-century), unknown author, ff. 27, 9, 18, 7, 10v.

⁶² WL, MS 7721, Late-seventeenth- to eighteenth-century English recipe book, unknown author. Other recipes gave only initial and surname.

⁶³ *Ibid.*, pp. 161, 162, 258, 306, 728 [sic].

‘Excellent Balsome by Sir Al[exander] Hamilton not unlike [tha]t’.⁶⁴ At elite levels at least, contemporary constructions of gender were not excluding early-seventeenth-century men from the useful medical knowledge that their bodies might one day need, whether this was self-created or the fruits of others’ experience. Men of Temple’s status were already capable of participating in the discourses that would allow them to obtain useful medical information, and in dialogues apparently conducted with, or stemming from, both genders alike.

This was, furthermore, a practical medicine that did not need to have pretensions to sophistication for men to be able to obtain it from each other. Indeed, the Wharton collection contained nothing but kitchen physic. Its longer medical recipes ‘from’, ‘by’ or ‘used by’ men who could have been laymen called simply for ‘the greenest shoots or leaves of Eldar’, ‘pound[ed]... in a... mortar’, mixed with ‘white wine or ale’, and ‘strain[ed]... through a clean lin bag’, or for ‘Ginger, cinnamon, & Galling..., annise seed, caraway seeds, & fennel seeds... long pepper graynes mace & nutmegs’, valerian root and ‘white sugar candy’. The simpler advice obtained from or created by such men required the recipient to do nothing more than dip toast in brandy, put a fish on the stomach, or ‘wash’ piles ‘with cold water’.⁶⁵ Evidently, men did not need to be engaging in discourse with women for their discussion of an emphatically practical medicine to be acceptable.⁶⁶

⁶⁴ Seemingly Sir George Hastings, 4th Earl of Huntingdon (1540–1604) and the MP Sir Edward Tyrrell (1651–1606) or his son, also Edward (1673–1656). BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, f. 96; BL, Stowe MS 1078, Medical, cookery and other recipes, idem., f. 14. ‘Balsames’ were thick ‘Persume[s] [sic]’, resinous or thick anointments, or ‘Gums of Trees’ (Stephen Blancard, *A physical dictionary...* (1684), pp. 38–39).

⁶⁵ DUL, WHA/88, Wharton papers, Unlabelled notebook, pp. 105–107, 47, 51, 94.

⁶⁶ Although women did give men similar recipes (e.g. NAS, GD158/925, Papers of the Hulme family, Recipe for the restorative water, given to Patrick, Earl of Marchmont by Christian Leslie, Marchioness of Montrose, 1708).

The same kind of content also dominated the Clerks' lay male-male transfer of medical information, both before and after 1700. Thus, the 'Easy Remedy against the Bite of a mad dog communicated to me by Mr Gale... 1739' involved only salt and water, with the '[a]pproven Remedy for Rheumatick pains communicated To me by Mr Lastels 1740' reliant on rhubarb, Virginia snakeroot plant and powdered cochineal, in brandy.⁶⁷ Laymen were together producing, and exchanging amongst themselves, a corpus of medical knowledge revolving around herbal and culinary ingredients, based on the simple methods and household equipment reminiscent of brewing, preserving and culinary preparation, described in a matter-of-fact vernacular, and thereby possessing the very features that for some historians gave 'domestic medicine' its contemporaneous 'association with female "household" skills'.⁶⁸

Certainly, men's gender imposed no restrictions on the sources from which they could access, or be known to access, medical information. As table 6.1 shows, whether they were laymen or university-educated practitioners, men's gender never barred them from making use of women as sources. Thus, the memorandum book compiled in 1679 by John Locke (1632-1704), medical author, bachelor of medicine, and philosopher, left no evidence of favouring the knowledge of men – let alone of his colleagues – above that of women.⁶⁹ The same was true of the commonplace book (c.1694-c.1708) produced by Archibald Pitcairn (1652-1713), M.D., Newtonian, follower of a decisively mechanical, mathematically based, model of the body, and former chair of the practice of medicine at Leiden.⁷⁰ Another collection compiled by a practitioner, in the eighteenth century,

⁶⁷ NAS, GD18/2125/114-115, Clerk family papers, Medical recipes and prescriptions, Clerks.

⁶⁸ Leong and Pennell, 'Recipe Collections', p. 136.

⁶⁹ BL, Additional MS 15642, Memorandum book (1679), John Locke; Oxford Dictionary of National Biography.

⁷⁰ BL, Additional MS 29243, Medical prescriptions etc. (1694-1708), Archibald Pitcairn; Oxford Dictionary of National Biography.

similarly mixed its recipes from ‘an old woman’ indiscriminately with those of males, and whether the latter were sufferers, practitioners, healers, or pill manufacturers.⁷¹

The *types* of knowledge that men wanted to, and could, pursue were also free of visible restrictions. Men not only utilized sometimes multi-faceted networks of knowledge transfer but also frequently utilized these in a desire for knowledge that was primarily, and sometimes solely, medical. Furthermore, this medical knowledge was itself usually primarily human, and sometimes solely so, despite the existence of sources suggesting that a large part of *some* men’s medical concerns lay with the non-human. Despite having a family and a household of employees, William Cunningham’s financial accounts of 1674-1680 show him to have been directly responsible only for the paid medical care and products used by himself and his horses. It was, furthermore, equine treatment to which his records gave the greatest detail, just as there were male-compiled collections of recipes giving it equal status to human needs.⁷² Thus, a copy of those exchanged between the third Earl of Burlington (1694-1753) and the Duke of Albemarle (1666-1735) began with five for horses, only one of which expressly stated this in its title, and made no distinction between these and the human recipes that followed.⁷³ This was not, however, a routine male tendency. Even the Wharton collection, including instructions about horses and farming, and part of a book initially about estate management, had only four recipes clearly for animals, few others even potentially so,⁷⁴ and only two for both livestock and humans. Indeed, this animal medicine was vastly

⁷¹ RCS, MS 0108, Recipes and accounts notebook, (c.1690-1763), unknown author.

⁷² William Cunningham, ed. James Dodds, *The diary and general expenditure book of William Cunningham...* (Edinburgh, 1887), pp. 57, 70-2, 84, 88, 95, 96, 102, 116.

⁷³ BL, Sloane MS 4034, Hans Sloane consultations (late-seventeenth-century to mid-eighteenth-century), ff. 132-137, ‘Receites of ye Earle of Burlington for his Grace ye Duc of Albemarle’.

⁷⁴ DUL, WHA/88, Wharton papers, Unlabelled notebook, pp. 81, 108-112.

outnumbered by the more than seventy medical receipts clearly for exclusively human use, and, indeed, by the thirty-four culinary recipes.

Livestock and equine needs did not, therefore, routinely dominate the medical information that men chose to collect, or their reasons for collecting it. Spanning at least 130 years, the Clerk collection must have had several compilers. It contained 176 prescriptions, consultation letters, apothecary slips, and printed and handwritten recipes,⁷⁵ with all but six of these for medical or bodily use.⁷⁶ Sick animals featured only five times (one of these a duplicate), always in relation to mad-dog bites and always, where dated, in items from the 1730s. All of these recipes were expressly for human use too, while two others for mad-dog bites excluded animals altogether.⁷⁷ It seems that men were far from collecting medical information only for their (gendered) hobbies and non-medical pet interests.

It was similarly personality rather than gender that determined the *way* in which individuals gathered and recorded this information. Men could, if they wanted, be committed, careful, and informed possessors of medical knowledge, with sustained concern for the origins and reliability of the recipes that they accepted. Temple, for example, started two volumes (both with indexes), organized by illness type, and with some ingredients and contributors in cipher. With items labelled as ‘Booked in [th]e folio bok of Recept’,⁷⁸ this Clerk collection was but the source base for a neat

⁷⁵ Plus three slips giving the names and addresses of individuals who might have been medical retailers or practitioners. At least ten items were extracts, copies or translations of others.

⁷⁶ And one with five medical uses and the ability to strengthen steel tools.

⁷⁷ NAS, GD18/2125/33, 75, 103, 111, 112, Clerk family papers, Medical recipes and prescriptions, Clerks.

⁷⁸ NAS, GD18/2125/1-2, 7, 16, 47-48, Clerk family papers, Medical recipes and prescriptions, Clerks.

compilation,⁷⁹ perhaps similar to Freeman's meticulous presentation copy of over 150 pages of recipes alone, each titled (with the donor's name), seven marked with an 'x' (for proven efficacy), and an index almost twenty pages long (complete with 'x's). Even the Clerks' rough copies were labelled with source and date obtained, sometimes with notes on familial use or subsequent transmission, and on both the front and back, with the latter often in a different hand.

Similarly, men were not restricted by their gender to an ownership of medical knowledge that was superficial and amateurish. Compilers varied, but such collections as the Clerks' show that men could have a careful concern for the minutiae of preparation, or with the need for different courses in different patients and circumstances. Thus, their receipts ranged from the simple instruction to 'drink your own urine every morning fasting' to a 'very effectual' recipe from 'the master of Lockmebar' calling for variations in dosage between men and 'Young and Weak Persons', naming a suitable preparative, and offering further methods for when it 'works too violently' or had side effects.⁸⁰ Similarly, a 'singullar receipt... my Lord Lothian gave... me the 12 off february 1655' insisted that its base be prepared only 'in the spring... when the herbs are at the Best', gave step-by-step directions, emphasizing that the 'brayed ginger' measured as the amount that 'will couer ouer A Six pence' was to be 'A little thick [yet]... not heaped on the Six pence', and finished with detailed directions for its administration.⁸¹

⁷⁹ Perhaps NAS GD18/2130, GD18/2142, Clerk family papers, Medical recipe books (1693-1734 and 1740-1751), Clerks of Penicuik (privately held and unavailable for consultation).

⁸⁰ NAS, GD18/2125/14, 16, Clerk family papers, Medical recipes and prescriptions, Clerks.

⁸¹ NAS, GD18/2125/2, Clerk family papers, Medical recipes and prescriptions, Clerks.

Yet, that men could have a careful, detailed, interest did not mean that they were confined to a knowledge of medicine concerned only with the highbrow, academic or theoretical. Oxford-educated Heywood was, according to a later owner of his book, ‘very learned’, but the only text that he named was a printed collection of kitchen physic.⁸² Indeed, gendered differences in educational access did not lead men to reject on principle the information circulating orally that might one day have been able to help them. These items were far from all of the recipes and letters of instruction that male Clerks saved in this period.⁸³ In this collection, however, these men and their human sources expressly took therapeutic information from medical books and handbills only eight times, and made supporting reference on only two occasions. They used newspapers almost as often, citing or keeping articles six times, as well as making additional, unattributed, copies. Yet, newspapers were themselves overshadowed by the Clerks’ use of lay connections, and these were deployed despite the compilers having, and making use of, practitioners inside the family.⁸⁴

Some men did, however, display a large level of medical reading, and of knowledge extracted from this. In the eighteenth century, the only published source named in the Wharton collection had itself taken the recipe from a newspaper, while Freeman not once referred to information coming via print.⁸⁵ Bishop Wilson, however, was able to refer constantly to named medical books, with page numbers, and these were the

⁸² CL, MS A. 2119 Heywood, Commonplace book, Heywood; Elizabeth Grey, Countess of Kent, *A choice manuall, or rare and select secrets...* (1653).

⁸³ E.g. NAS, GD18/5426, Clerk family papers, Letter from Lord Ilay to John Clerk, 1 September 1739, discussing a recipe book of 1655; NAS, GD18/4960, Clerk family papers, Medical prescriptions for Robert Adam (1744-1745); NAS, GD18/2143, Clerk family papers, Doctor John Clerk’s advice for Sir John Clerk, 7 January 1744. See also above, p. 239.

⁸⁴ NAS, GD18/2125/ 29, 30, 126-127, 149 (the only time that a recipe was corrected by a practitioner relative) and (apparently from a practitioner brother) 83, 86-87, Clerk family papers, Medical recipes and prescriptions, Clerks.

⁸⁵ Although a French one was ‘published by order of Government’ (RCS, MS 0088, ‘A Collection of choice Receipts’, Freeman, no. 108). DUL, WHA/88, Wharton papers, Unlabelled notebook, p. 53.

express source of much of his detailed knowledge. Despite having studied medicine at university these were, however, accessible texts, and they were combined without distinction with recipes from lay acquaintances, practitioners (in both personal and professional capacities), prescriptions (whether for himself, friends, or relatives), 'the Dublin papers' and the 'Edinburgh Transactions'.⁸⁶ Marsh, responsible for a naval hospital, took his ascribed medical information from the adverts and recipes (reader submissions included) printed in newspapers, just as he did his non-medical news and knowledge. With men's medical reading apparently no different to women's, their collections were certainly not more concerned with abstract theory or theoretical niceties, deliberately more textual, or carefully and ostentatiously learned. They too were concerned with utilitarian information.

Men did, however, differ amongst themselves in the types of *human* sources used as a repository of medical knowledge. Temple's second volume had mentioned the same number of sirs, colonels or misters in direct association with recipes as it had women (eleven), and two of these men were passing on women's recipes.⁸⁷ In the bigger Freeman collection, however, only 39.1% of ascribed recipes were obtained via women, and in the Wharton compilation only 11.1%. In the Clerk materials this fell to 6.7% of the 90 pieces of domestically useful medical information that (of 147) give some insight into origin or transmission. The contribution of men who were potentially laymen (being referred to by their full names, surnames, or as 'Mr'), increased accordingly. Alone or with other parties, such men provided a quarter of Freeman's ascribed items,

⁸⁶ BL, Additional MS 19688, Medical receipts, Wilson, f. 1. These were not the *Transactions of the Royal Society of Edinburgh*, first published in 1788.

⁸⁷ Entries apparently in his own hand. Two more came from people of unclear gender, and one from a practitioner (BL, Stowe MS 1078, Medical, cookery and other recipes, Temple).

over 40% of these 90 Clerk recipes, and an even greater proportion of the Wharton pieces (table 6.1).

Table 6.1 Origins of the contents of male-compiled manuscript recipe collections, as a percentage of attributed medical information of domestic use ⁸⁸

Source		Wharton (mid 18 th century)	Freeman (1779-80)	Clerks (c.1647- c.1781) ⁸⁹
Practitioners ⁹⁰		29.6	26.1	28.9
Print		3.7		20.0
People of unclear gender		7.4		
Women (as creators/transmitters, incl. of practitioners' recipes)		11.1	39.1	6.7
Laymen	Clearly not practitioners	22.2	8.7	11.1
	Potentially not practitioners ⁹¹	18.5	17.4	25.6
	Chain mixing men potentially not practitioners and those clearly not			1.1
	Chain mixing men clearly/potentially not practitioners with practitioners	3.7		5.6
	Men clearly/potentially not practitioners passing on recipes associated with famous men	3.7		
	Total involving laymen	48.1	26.1	43.4
Other	(Irregular practitioner, printed on order, multiple sources)		8.7	1.1
Total naming source/origins (and as a percentage of all domestically useful medical information)		27 of 81 (33.3%)	23 of 121 (19.0%)	90 of 147 (61.2%)

Sources: DUL, WHA/88, Wharton papers, Unlabelled notebook, pp. 40-115 (mid-eighteenth-century);

RCS, MS 0088, 'A Collection of choice Receipts' (1779-80), Thomas Freeman; NAS, GD18/2125/1-167,

⁸⁸ Human and animal.

⁸⁹ Some items included twice give the origin in one copy only, while items with the same source provide varying amounts of information. For parity with collections without duplicates, these entries are read in isolation of each other.

⁹⁰ Includes surnames pointing to famous practitioners, and items 'prescribed by' 'Mr'.

⁹¹ Called 'Mr' or given a full name or surname, although these could be used for practitioners too.

The Clerk collection was not, therefore, unusual in the male nature of its content. Indeed, it might have been that men's medical knowledge more generally, through which they made sense of recipes, was sometimes similarly shaped by male discourses. Wilson, for example, showed a sustained interest in diet, exercise and diagnostic signs, and while his recorded knowledge on diet and healthy living came from textual sources the curative ideas that slotted into this came from uniquely male sources.⁹² Nor, therefore, was the Clerk collection unusual in the role played by men who were either clearly or potentially not practitioners.⁹³ Even if those passing on professionals' knowledge are excluded, such men provided Freeman with exactly the same number of recipes as did men who 'prescribed' or were called 'Dr'. In the Wharton compilation their contribution was 1.6 times greater than that of visible practitioners.

It is, however, the Clerk collection that is especially illuminating. Only eight women, two apparently from the extended family, were named as being involved in the underlying process of exchange prior to the Clerks, and it took at least fifty-six years for all of these to play a role. Only one woman's testimony or usage was noted, and only one recipe associated with or transmitted by a woman was labelled as being 'good against' certain disorders.⁹⁴ By contrast, ten males outside of the compiling family were associated with recipes described as having cured many, 'approved', 'probatum', 'effectual' or 'excellent', and three more described as having expertise in their use. The Clerk collection certainly suggests that the men of this family did not see the testimony

⁹² BL, Additional MS 19688, Medical receipts, Wilson.

⁹³ Although problematized by the use of surnames for practitioners' creations, and the possible use of 'Mr' for apothecaries and surgeons.

⁹⁴ NAS, GD18/2125/6, Clerk family papers, Medical recipes and prescriptions, Clerks, 'Fra Anna Irwing which shoe said Curd hir off the axes' (1670).

of their own gender as inferior, despite historiographical claims that it was female roles, and feminine virtues, by which domestic medical knowledge was accrued.⁹⁵

The male nature of the information that the Clerks amassed in this collection was not the enforced product of circumstance. They were not lacking in access to female circles, the first baronet having two wives and sixteen children, and the second two wives, seven daughters and ten sons.⁹⁶ Nor was it limited to the recipes. Only one consultation letter, prescription, or apothecary's invoice had been sent to a woman, and only three others (sent to men) mentioned females in any way. These latter three were apparently included because one, discussing a wife's use of a powder, also mentioned its other uses, another (about a girl's worms) pursued an illness of visible interest in the recipes, and the third focused on measures for the male recipient, although also answering a question about their use on 'Miss Geannie'.⁹⁷ It seems that in this household the male share of responsibility for family health was neither limited to that *purchase* of services revealed in William Cunningham's accounts nor as self-centred.

It certainly seems that the imperative for the Clerk collection came from men, and this might have happened elsewhere too. Only once was a woman named in the chains by which the Clerks' sources had received this knowledge, and she had supplied another woman.⁹⁸ The networks (and knowledge) were male before they reached the Clerks'

⁹⁵ E.g. Hunter, 'Lady Experimenters', pp. 96-100, 103.

⁹⁶ R. A. Houston, 'Clerk, Sir John, of Penicuik, first baronet (1649/50-1722)', *Oxford Dictionary of National Biography*, Oxford University Press, 2004 [<http://www.oxforddnb.com/view/article/47927>, accessed 10 August 2010]; Rosalind Mitchison, 'Clerk, Sir John, of Penicuik, second baronet (1676-1755)', *ibid.* [<http://www.oxforddnb.com/view/article/5617>, accessed 10 August 2010].

⁹⁷ Perhaps Jeanne, daughter of the first baronet. NAS, GD18/2125/155, 87, 126, Clerk family papers, Medical recipes and prescriptions, Clerks. Male Clerks also received, and kept, other consultation letters about both their own health and that of male and female dependants (e.g. NAS, GD18/5298, Clerk family papers, Doctor John Clerk's letters to Sir John Clerk, 1st baronet, and Sir John Clerk, 2nd baronet (1716-1721 and 1723-1743)).

⁹⁸ NAS, GD18/2125/62, Clerk family papers, Medical recipes and prescriptions, Clerks.

circle. Indeed, that almost forty apparently or visibly lay men not belonging to this family were involved in the creation, transmission and recording of these recipes, often in uniquely male chains of exchange, suggests that far more men might have been creating and amassing recipes than that small number revealed by the survival of their own collections.⁹⁹ Literate men were not disempowered by their gender, or unable to equip themselves to take care of their bodies. Nor was it the case that they could equip themselves only by relying on females, and on the knowledge that this other gender was allegedly expected to develop as a consequence of its social role.¹⁰⁰

Part iii: Men's Medical Knowledge

Men could, therefore, take precautions in response to the possibility of illness. They also took proactive steps to stave off certain diseases, with some men sufficiently concerned about their vulnerability to smallpox as to be inoculated, if only in the epidemics of the 1720s.¹⁰¹ Accessing healthy men's participation in a day-to-day tending to the healthy body is, however, more difficult. Even medically educated and trained men often left little visible evidence of trying to live in a way designed to preserve strength and health when not ill.

Daily diaries were, for example, kept by Thomas Kincaid (1661-1726), a medical student at Edinburgh University (covering January 1687-December 1688), Richard Kay (1716-1751), a Lancashire apprentice and subsequent general practitioner-surgeon

⁹⁹ E.g. RCS, MS 0030, Volume of recipes (c.1659), Elizabeth Isham (?1658) and Thomas Sendall (1659), with other hands.

¹⁰⁰ See, for example, Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680* (Cambridge, 2000), p. 52 (claiming that '[t]he link between cooking food and making medicines placed medicine squarely in the realm of the kitchen and women's work').

¹⁰¹ BL, Sloane MS 4034, Hans Sloane consultations, ff. 23-26v, surgeons' reports on inoculation (c.1723-c.1726); BL, Sloane MS 4075, Hans Sloane consultations (late-seventeenth-century to mid-eighteenth-century), f. 215, from J. Hetherington, 26 August 1725; WL, MS 6139/12, Correspondence of James Jurin

(1737-51), and Cooper, an unknown student or trainee in a London hospital (12 June-27 August 1786).¹⁰² All were practitioners' sons, interested in medical theory or practice, and not averse to using their diaries to record their illnesses and self-treatment, medical reading and discussions (Kincaid), or patients (Cooper and, occasionally, Kay). All noted their daily activities, and were careful to record the detailed information or contemplations that did interest them.

None of the three, however, mentioned their own bodies beyond the occasional fact of illness. Theirs were occupations and medical educations available to their gender only, yet their diaries give no sign that these three diarists *were* protective of their health. They certainly do not reveal a particularly pronounced anxiety about health, stemming from their specialist knowledge, or any special imperative to fortify it, coming from the hazards that they faced as practitioners. None of the three even hinted at an awareness of that threat of contagion that worried others of this and related professions.¹⁰³ Nor did they make even incidental reference to any course of health-preservation. The one exception was Kay's vow (in 1738), on 'find[ing] that a sedentary studious Life has of late been prejudicial to my Health', to 'often to be exercising my self' in 'husbandry'.¹⁰⁴ Kay never mentioned other types of exercise, or sports, even as a recreation, although he did hunt and shoot. Cooper, in seventy-six days, recorded only one game of bowls and another of cricket (on the same day), but multiple sessions of billiards.¹⁰⁵ And while Kincaid's successive fads did include shooting and golf, it was as amusements, the lengthy reflections that they prompted never considering their

(1724-1746), from Edward Vernon on behalf of 'a Noble Lord', 16 August 1724; Thomas Turner, ed. David Vaisey, *The Diary of Thomas Turner* (East Hoathly, 1994), p. 397.

¹⁰² CL, MS A. 7. 76, Diary, Kay; NLS, Advocates MS 32.7.7, Diary (1687-88), Thomas Kincaid; WL, MS 1856, Diary (1786), - Cooper.

¹⁰³ WL, MS 7628, Scrapbook, Marsh, f. 16.

¹⁰⁴ CL, MS A. 7. 76, Diary, Kay, p. 18.

bodily effects.

Similarly, not one of these diarists displayed an interest in temperance, whether for health, financial or moral reasons, religion (despite Kay's dutifulness as a Baptist), their personal or professional reputations, or character improvement. Nor did dietary advice – as a treatment *or* for lifelong health – dominate the various forms of medical knowledge that men recorded in recipe books. It was present in the especially varied content of commonplace books, but as cures rather than lifelong habits. Indeed, this medical knowledge rarely showed any concern with the long-term defence of an existing health, let alone of strength and robustness.

The medical knowledge that men recorded even in commonplace books was not, therefore, about the *proactive* diets, instructions, tonics and regimens that would allow compilers to live active, efficient, industrious lives, and to perform their duties as provisioning fathers. Temple's two volumes (added to by others) contained an entry for 'Health. youth & vigour', and instructions for a biannual purging ale, but this was the exception here.¹⁰⁶ In the entire Clerk collection there was only one recipe for 'Ceiping [th]e Bodie on health', in an old hand, 'to be taken euerie spring and fall', not as a preventative but because 'used in tyme [it] will cure' a whole host of disorders.¹⁰⁷ Freeman similarly had '[c]harm[s]' and '[p]reventative[s]' against named illnesses, and the Wharton collection 'a Powder' 'To preserve or cleanse [th]e Teeth', 'A strengthening Drink to prevent inward bleeding' and 'Dr Mead[']s' advice 'for preventing the gout' (actually attacks of an existing gout), yet neither possessed anything for the

¹⁰⁵ WL, MS 1856, Diary, Cooper, pp. 9, 16-17, 22.

¹⁰⁶ BL, Stowe MS 1078, Medical, cookery and other recipes, Temple, ff. 53, 6.

¹⁰⁷ NAS, GD18/2125/78, Clerk family papers, Medical recipes and prescriptions, Clerks.

maintenance of general wellbeing.¹⁰⁸

The medical knowledge that men were gathering in the form of recipes might not have been all of the medical knowledge that they were amassing, or even all that they were recording. Yet, in these particular recipes it was concerned with very specific bodily needs, not with general health. These were not, however, needs visibly influenced by society's expectations of masculine gender. There is certainly no consistent trend visible on comparing their content to what Lisa Smith found to be the most common illnesses in a sample of female-compiled English and French collections (table 6.2).¹⁰⁹

Table 6.2 Content of male-authored recipe collections, as a percentage of medical entries¹¹⁰

		Wharton (mid 18th century)	Freeman (1779-80)	Clerks (c.1647-c.1781)¹¹¹
Smith's most common categories	'Women's' health	2.5 (no breasts, 3.7 incl. udders)	0.8 (4.8 incl. breasts)	2.4 (2.9 incl. breasts)
	Injury, bleeding	3.7	9.9	2.9
	Chest, lungs	2.5	6.6	1.2
	Mixed use ¹¹²	4.9	5.0	12.9
	Stomach ¹¹³	8.6	2.5	5.9
Actual four main body parts	First	No single core/site 24.7	No single core/site 24.0	No single core/site 21.8
	Second	Urinary system 14.8	Surface, incl. blood vessels 14.9	No information 20.0
	Third	=Surface, incl. blood vessels =No information 9.9	Chest 6.6	Multiple use 11.8

¹⁰⁸ RCS, MS 0088, 'A Collection of choice Receipts', Freeman, no. 44, 82, 88, 32-33; DUL, WHA/88, Wharton papers, Unlabelled notebook, pp. 65, 60, 46.

¹⁰⁹ Lisa Smith, 'Women's Health Care in England and France, 1650-1775' (unpublished Ph.D. thesis, University of Essex, 2001), p. 68.

¹¹⁰ Includes recipes for animals.

¹¹¹ All 170 medical/bodily items.

¹¹² In my definition at least two non-overlapping and non-related ailments.

¹¹³ Figures presume that compilers followed some printed texts in thinking worms a problem of the belly.

	Fourth		=Bowels =Urinary 5.8	Stomach 5.9
Actual four main illness types	First	Stone, gravel 14.8	=Injury, bleeding =Pain, soreness 9.9	None named 19.4
	Second	Gout 11.1		Mixed 12.9
	Third	None named 9.9	Growths, eruptions 6.6	Stone, gravel 4.7
	Fourth	Jaundice 6.2	Stone, gravel 5.8	=Ague =Mad-dog bite 4.1

Sources: DUL, WHA/88, Wharton papers, Unlabelled notebook, pp. 40-115 (mid-eighteenth-century);
RCS, MS 0088, 'A Collection of choice Receipts' (1779-80), Thomas Freeman; NAS, GD18/2125/1-167,
Clerk family papers, Medical recipes and prescriptions (1647-1859), Clerks of Penicuik

As Sir John Clerk, first baronet, demonstrated with the gravel, some men were collecting solutions for the bodily problems that they themselves were struggling with.¹¹⁴ They were not, however, interested solely in their own health care, let alone in those needs unique or particular to them as males and men. As table 6.2 reveals, men recorded recipes that covered great, and varying, ranges of problems. Indeed, they were collecting medical information for the same purpose as were women – as a reference guide for collective use – and, consequently, possessed medical knowledge especially apt for, and even unique to, other family members.¹¹⁵ This makes it even more significant that Freeman, the Clerks, and the Wharton compiler saw no place for the male body in these deliberately wide-ranged texts, even in non-sexual and non-procreative, non-sexed, or emphatically non-venereal, problems. They made no recognition of the existence of male-specific sexual organs, let alone their sexual and

¹¹⁴ NAS, GD18/2125A, Clerk family papers, Memoranda and recipes for the gravel, John Clerk, with notes by Sir John Clerk (1663-1671 and 1772).

reproductive functions, or of a male physiology in which, as some texts taught, male health was shaped by the semen and its loss.¹¹⁶

At the most, the Freeman and Clerk collections might have been alluding implicitly to the male organs in their inclusion of one recipe each for or including hernias.¹¹⁷ Yet, Freeman's recipe for 'all hernia and rupture', and the Clerks' inclusion of hernias as one of six 'Vertues' of a 'herbe', made no reference to the affected parts, or to the sex of sufferers.¹¹⁸ Although Sir John Clerk, first baronet, had a hernia (in the groin or genitals), the 170 items that he and his descendants amassed in this collection mentioned such disorders only twice, once in that practitioner's letter of 1721 that reveals his plight to the historian and once in the above recipe.¹¹⁹ Although thought at the time to be a prevalent disease of infants and the elderly, Marsh, sensitive to the aged state of his body, had no recipes for even hernias in unspecified parts, and Wilson, equipping himself for charitable medical care, only one.¹²⁰

The surgical nature of penile, testicular and scrotal conditions might help to explain the absence of the genitalia, but it does not seem the full answer.¹²¹ Men's recipe collections certainly included other surgical disorders, with stone and gravel some of the most common problems in the Wharton and Clerk collections, as were skin problems and injuries in Freeman's. Freeman, furthermore, had six recipes for venereal disease, and

¹¹⁵ WL, MS 2367, Collection of cookery receipts (1703-1707), Lady Catherine Fitzgerald, f. 79 (children's worms); RCP, MS 507, Medical and culinary recipes, unknown author, f. 10v (delivery); Smith, 'Women's Health Care', p. 69.

¹¹⁶ Above, pp. 50-53, 56-57.

¹¹⁷ For hernias as afflictions of the testicles and scrotum see pp. 94-95.

¹¹⁸ RCS, MS 0088, 'A Collection of choice Receipts', Freeman, no. 80; NAS, GD18/2125/15, Clerk family papers, Medical recipes and prescriptions, Clerks. Locke similarly gave no indication of the part or sex for which his hernia recipes were intended (BL, Additional MS 15642, Memorandum book, Locke).

¹¹⁹ NAS, GD18/2125/30, Clerk family papers, Medical recipes and prescriptions, Clerks, 'Advice for [sic] my nephew Dr Clerk... 21 march 1721'.

¹²⁰ Ibid.; BL, Additional MS 19688, Medical receipts, Wilson, ff. 1, 32v.

two mixed remedies including it. Similarly, there was room for *other* disorders characterized by pain, including gout (11.1% of the Wharton recipes), and for aches and pains more broadly (9.9 % of Freeman's), yet not for the bandaging required by hernias, the palliative measures in the Clerk letter, or those herbal applications and medicines, for use alongside trusses, given in some other collections.¹²² Belonging to this sex and gender did not exclude collectors from the ownership of knowledge about the female reproductive organs. However, it did not follow that they would automatically own information about the *male* body, or at least information recorded in recipe books.

That many men in this sample did not acknowledge the specifically male organs suggests that it was not a *gendered* propriety, or only this, preventing women from recording such information. Indeed, it was a seventeenth-century woman who authored 'a most Material paper upon the Cure of Ruptures' within which express reference was made to the scrotum (although in only one of four recipes), and from 'whom Renton [a hernia specialist] had what he knew'.¹²³ There were also other male-authored compilations that did include the 'male' organs, although their authors made no effort to distinguish these parts' diseases. Nor, however, did they include them as the exact corollary to their straightforward treatment of the female. Temple gave recipes for 'Conception' and 'Lust', a number for so-called women's medicine, and many for venereal disease, but automatically discussed 'Barrenness' as a female affliction, and only recognized the genitalia in unsexed complaints of the 'Privy part' (genitals), once expressly those 'of man *or* woman'.¹²⁴ A later anonymous collection similarly

¹²¹ Above, p. 18.

¹²² WL, MS 7721, Late-seventeenth- to eighteenth-century English recipe book, unknown author, f. 231.

¹²³ BL, Sloane MS 3984, Letters and papers of Sir Hans Sloane (seventeenth- to eighteenth-century), ff. 16-17, rupture receipts 'in the handwriting of Mrs Bowles' (seventeenth-century). For Renton see BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, insert.

¹²⁴ BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, ff. 15-16, 149 (my emphasis).

mentioned the genitals as a general, non-sex-specific, region of the body, in ‘a water for the privie parts’, but the Wharton, Freeman, and Clerk collections lacked even this.¹²⁵

There were, however, some men who did visibly receive and retain information about specifically male genital health. The recipe book owned by the physician Sir Edmund King (1630-1709) (using the heads entered by a previous owner) went straight from the womb to ‘[th]e pryvie members’, but only male ones. Like Temple, it made problems in reproductive capacity uniquely female. Unlike Temple, however, it had room for one non-sexual, non-venereal problem of the male reproductive organs (hernias, *presumably* scrotal or testicular), included here in a section labelled ‘yard’ (penis) yet also discussing gonorrhoea.¹²⁶ Heywood too treated the penis and testicles as specific parts without recognizing the existence of female or unsexed genitalia. He did so in English, despite keeping some recipes for the female in Latin.¹²⁷

Heywood and King (and an unknown seventeenth- or eighteenth-century compiler) recognized, therefore, the existence of uniquely male organs.¹²⁸ They also recognized these as having medical needs, and even some needs unique to them. Thus, while they approached venereal disease as a purely male phenomenon – perhaps because decency prevented their discussing infected female organs – these three compilers also acknowledged that the penis or testicles suffered non-venereal ailments. Yet, they moved back and forth between non-venereal complaints of the expressly (and solely) male genitalia, implicitly male venereal disease, and urinary problems in bodies of unspecified sex, thereby undermining the distinctiveness of both the male organs and

¹²⁵ WL, MS 7721, Late-seventeenth- to eighteenth-century English recipe book, unknown author, f. 212.

¹²⁶ BL, Sloane MS 1588, Medical receipts and cases (c.1664-c.1684), Sir Edmund King.

¹²⁷ CL, MS A. 2119 Heywood, Commonplace book, Heywood, ‘Physicall notes... from Severall Authors’.

¹²⁸ BL, Sloane MS 4034, Hans Sloane consultations, ff. 183-189v, untitled recipes.

those diseases peculiar to their anatomy. Nor should the attention that King and Heywood gave to this nexus be overstated. Indeed, not even venereal disease received consistent consideration in men's recipe collections. Wilson – although equipping himself for charitable care – and the Wharton compiler were silent in the mid-eighteenth century, as was Marsh at the century's end. There was, however, no chronological pattern. While the Clerk collection was silent in both centuries, Temple provided numerous venereal cures on the eve of this period, Heywood some in subsequent decades, and Freeman several in 1779-80.¹²⁹

Even more absent from these broad family pharmacopoeias was the *gendered*, man's, body. The Clerk collection was an almost uniquely male enterprise but not visibly masculine. The knowledge that these men possessed, and were willing to be known to possess, was not about, let alone limited to, the gluttony, drink and prolonged mental application of the conduct literature, those bodily threats that behavioural (and medical) literature told men that they, as men, created. Nor was there any such limitation to the illnesses that men were happy for others to know that they had suffered, in the circulation of their prescriptions and testimonials.

There were, therefore, no hangover cures, and no tonics or restoratives to alleviate the consequences of past or lifelong drinking. The book owned by King had a recipe for 'Headache of drunkenness' (as one of twelve types of headaches), while another, eighteenth-century and Scottish, probable practitioner mentioned drink-induced head pains for the same reason, warned those careful of their brains to 'be war of surfeiting and drunkenness' (and of certain vegetables), gave cures for and preventatives against

¹²⁹ BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, ff. 2-3, 63v, 113-114, 223, 225-227,

inebriation, and listed the dangers of excessive tobacco.¹³⁰ Yet, of the collections compiled by laymen, Temple's was the only one to make any reference to inebriation ('Drunkenesse settled').¹³¹

This could even suggest that some men (if only those sufficiently interested in health to make such collections) were not routinely succumbing to the drinking company that so antagonized the authors of prescriptive writing. Unless these were topics insufficiently respectable for inclusion in a recipe collection perhaps shared with others, and not of interest to Heywood, Wilson, and Marsh when compiling possibly more private *commonplace* books, their absence does imply that the alleviation of drunkenness and hangovers were not something that men routinely discussed amongst themselves. Certainly, it suggests that even men with a sustained concern about health and sickness did not feel any particular anxiety about their drinking habits, at least for (or projected into) their bodily and health consequences. Nor did they show any anxiety about the physical costs of the life that patriarchy demanded, never referring to ailments as occupational diseases or implying as much in 'virtues'. None of the compilers of recipe and commonplace books in this sample included anything specific to the exposure that medical authors in both centuries told them that they faced as men working outside, doing 'man's work'.¹³²

Similarly absent were the values allegedly invested in the male and man-owned body itself. Certainly, masculinity of character, had no presence in these laymen's

331-332; RCS, MS 0088, 'A Collection of choice Receipts', Freeman, no. 36, 56-8, 108, 117-18.

¹³⁰ BL, Sloane MS 1588, Medical receipts and cases, King, index; RCPSG, MS 1/20/3/1, Book of herbal remedies (eighteenth-century), unknown author (who, however, referred to remedies 'that I despended when I was in the despencary office'), pp. 138, 149, 252, 256.

¹³¹ BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, contents.

¹³² See p. 187.

compilations, it being instead an apparent practitioner who created a recipe collection that discussed the talisman that ‘born[e] about one adds valour and makes one strong in the sports of venus and beloved by all’.¹³³ (Especially) masculine lifestyles and masculine bodies made no appearance, suggesting that the men who collected recipes were not driven to do so even partially by pressure to meet male and masculine bodily standards. There were no treatments expressly for fencing wounds or sports injuries, and never advice (medicinal or behavioural) for the *attainment* of that robust, strong, male body (sometimes) assumed in health writing.¹³⁴ Whether it shows that bodily aesthetics were a concern of the other gender only, or simply reflects the broader absence of cultural and gender-specific pressures, none of these male compilations other than the earlier Temple collection contained advice for hair, beards and scent, and only one might have had a recipe for complexions.¹³⁵

These absences were not, however, unique to compilers. Printed medical instructions for healthy living were also silent about the creation of this ideal body type, beyond exertion. The robust constitution promised by medical entrepreneurs advertising in *The Proceedings of the Old Bailey* was unsexed, and the bodily aesthetics to which they appealed were ungendered. Thus, tonics were not promoted as producing a specifically masculine strength and robustness, or promises of strength and robustness openly directed at men.¹³⁶ The *Newcastle Courant* advertised no medicines or cosmetics in any edition between numbers forty-five and 223 (November 1711-December 1712). The remedies that it was occasionally advertising by the 1720s, from a single local

¹³³ RCPSG, MS 1/20/3/1, Book of herbal remedies (eighteenth-century), unknown author, p. 214.

¹³⁴ For the latter see pp. 63-64.

¹³⁵ This recipe ‘for C.-d C-m [sic]’ *seems* to have been for cold cream, yet it had ingredients very different to printed recipes (DUL, WHA/88, Wharton papers, Unlabelled notebook, f. 75).

¹³⁶ Old Bailey Proceedings Online (www.oldbaileyonline.org, version 6.0).

practitioner, were only unsexed, ungendered, cure-alls.¹³⁷ The question-and-answer periodical *The Athenian Mercury* did contain adverts for medical goods, services, and books, but not once in volumes one to twenty, from March 1691 to June 1697, was the audience for a medical or cosmetic advert gendered as male or masculine. Yet, there were other adverts for a gendered audience, and (alleged) reader questions written from a male perspective. Indeed, some of the latter, claiming to be written by male readers, discussed drink and its health effects.¹³⁸

On the other hand, there is no evidence in their collections that the men who chose to gather useful medical information did so because they had absorbed medicine's teachings about lives *unhealthy* for males, or about the unhealthy way that modern men were living. Although compilers were collecting information for a whole range of more and less likely situations, there were no restoratives or preservatives for people living sedentary lives, overwhelmed by business or stress, suffering from confinement and over-application, or with delicate bodies (naturally or from a 'polite' lifestyle). Indeed, the content collected gives no hint of anxiety about a potential failure (whether personal or collective) to attain an idealized masculinity of any kind, no anxious desire to do so, and no alarm about the *effects* of such ideals. These men's visible concerns were equally silent about what the conduct literature said was the hazardous social life that so many men succumbed to, the lifestyle (and resultant body) that some medical authors taught was effeminate, and the body that some medics classed as manly and healthy, and as created by (and living) an active lifestyle.

¹³⁷ Eighteenth Century Provincial Newspapers, series 4, Newcastle Papers, part 1 (The Newcastle gazette or Northern courrant, 1710-1712; The Newcastle courrant 1711-1800; The Newcastle weekly mercury, 1722-1723; The north country journal or the Impartial intelligencer, 1734-1738), microfilm, Research Publications, Woodridge, CT, 42 reels, 1990.

¹³⁸ John Dunton, ed., *The Athenian gazette: or casuistical mercury...*, vols. 1-20, 1691-1697, microfilm, British Library, London, 2 reels, 1994.

The fashionable (man's) body, sick or otherwise, was similarly absent. The only advice that made any reference to 'men' in its title or contents, and for something other than dosages, was the Clerks' 'Receipt for making the Limbs thick & strong. 1727'. Out of place, having no medical content, this advised simply that 'young men wear nothing on their feet higher than pumps that is, let the heels of their shoes not exceed a quarter of an inch'. This would 'have the admirable effect of thickning the calves' by exercising the muscles, which 'by consequence turn bigger & stronger'. Although it was not stated why, 'this receipt is only for young men', for males only, but not for all men. Furthermore, while the instructions might have been a product of cultural trends, their inclusion was not. It seems instead the result of that anxiety about the *poor* state of one individual's legs revealed by the possession of (medical) recipes for leg wounds, another 'for Mr Adam's Leg', and a note (included twice) about 'M.r Hornege... famous for curing sore Legs'.¹³⁹ This 'recipe' might suggest that gendered cultural pressures *could*, potentially, influence authors' compiling interests. There is, however, a near-total absence from some men's compilations – although not the earlier Temple collection – of 'fashionable' diseases allegedly gendered as male and masculine.¹⁴⁰ Hypochondria, a disease gendered as male, and its predecessors (spleen and melancholy) were totally absent from the compilations in table 6.2. Ostensibly the idealized illness of men of wealth, gout was one of the four most mentioned disorders in the Wharton collection only.

Conclusion

¹³⁹ NAS, GD18/2125/13/1/147, 1, 53, 59, 138, Clerk family papers, Medical recipes and prescriptions, Clerks.

¹⁴⁰ See pp. 134-136 for these illnesses. BL, Stowe MS 1077, Medical, cookery and other recipes, Temple, contents; BL, Stowe MS 1078, Medical, cookery and other recipes, Temple, ff. 19, 43.

The prescriptive authors considered here were not trying to establish a normative male or masculine body that was normative in characteristically masculine attributes, or to inculcate any normative, particularly masculine, relationship with the body. It was certainly far from routine to demand a masculine denial of the body's fragility and to juxtapose this with a tenderness (and tendering) depicted as effeminate or 'soft'. Consequently, the conduct literature did not make men's health about masculinity, the strong, robust, active body, or a masculine status and identity coming from such a body or its possession. Instead, where it gendered men as the possessors of bodies it was in the dangers that they exposed themselves to, and it was the hazards that were depicted as tied to masculinity, not any correct response to the body that they threatened. Yet, these threats were not those encountered honorably while performing the gender-specific roles and responsibilities of patriarchy, the excesses (or feared effeminacy) of the 'politeness' and 'sensibility' that allegedly defined 'polite society['s]' 'ideal gentleman', or, indeed, attendants of an alternative masculinity 'based on sport', 'hunting, riding, drinking and "wenching"'.¹⁴¹

While the existence of a complementary medical genre might explain why behavioural texts did not feel it necessary to tell men *how* to live healthily, it is significant that they offered men no additional reasons to *want to* do so. With bodily preservation only sometimes singled out as an area of life in its own right, not even self-control over the appetites was expressly claimed to be crucial to men's patriarchal social roles, a microcosmic proof of the ability to manage a household. Such literature is not necessarily an accurate representation of the identities and pressures encountered by

¹⁴¹ Carter, *Men*, p. 8; Lee Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850* (1987), p. 110, cited in Michèle Cohen, "'Manners' Make the Man: Politeness, Chivalry, and the Construction of Masculinity, 1750-1830", *Journal of British Studies*, 44 (2005), pp. 312-329, citation at p. 312.

men in real life. Yet, in its overlaps with men's recorded thoughts and reading, and in itself, it reveals the existence of few strands of thought linking masculinity and the body.

In terms of real men, however, some at least were able to take an interest in their health, and to do so without any visible resultant sensitivity about their gender identity. Men *might* have been disadvantaged when illness struck by their seeming failure to possess (at least publicly) advice for illnesses of the uniquely male organs. Evidently, if the sexual and reproductive male body provoked anxiety, not all men chose, or felt able, to make collections reflecting this. However, men (and their health) did not have to be disadvantaged in all ways by their non-membership of the other gender. As Marsh demonstrated, there were *ungendered* cultural imperatives that justified taking a concern for one's own body and, according to Lisa Smith, men's gendered domestic responsibilities pushed them in the same direction.¹⁴² The recipes that men were willing to be known to possess give no suggestion that this latter imperative created problems for other aspects of men's gender identities, beyond the domestic sphere and their patriarchal identities. Certainly, men left no evidence of needing to distinguish their collections from hands-on nurturing, even when the ideal of the 'tender' father was still to emerge.¹⁴³

Their recipe and commonplace books were repositories of information that men wanted and needed, for themselves and for others. They were also potentially a performance and self-representation, whether to posterity, to the recipients of individual contents, or

¹⁴² Smith, 'Relative Duties'.

¹⁴³ Bailey, 'Very sensible'.

to those receiving entire volumes in symbolic ‘gift exchanges’.¹⁴⁴ They allowed men to parade their medical knowledge (and their authority in judging it), and to construct self-images as medical experts. Being able to name famed practitioners or eminent acquaintances might have been a source of social kudos too. Yet, in this sample none of these potential motivations resulted in collections showing men wanting (or being under pressure) to have particular types of bodies, or to be seen to respond to their bodies in particular ways. Men’s collection of medical information was not visibly about the compilers as men even where it surfaced in the more mixed contents of medical commonplace books.¹⁴⁵ Indeed, Marsh’s mixed scrap books had a whole range of social, moral and religious teachings, news, and cutouts, reflected cultural values and even gender-specific ideals, and made use of lengthy prose. Yet, Marsh never suggested that men would be judged (and judged on their masculinity) by their bodies, whether in their robust healthiness and masculine strength, ‘politeness’s’ ungendered non-offensiveness, a fashionable delicacy, their response to the weaknesses – or appetites – of the flesh, or, indeed, anything that the condition of the body might reveal about their character, morals, or capacity for self-control. On the contrary, Marsh’s depiction of the masculine ideal said nothing about the behaviours that impinged upon or grew out of the body. Nor did ideals of masculinity, or their changes, have any effect on the way that the three diarists recorded possessing and responding to a corporeality. Evidently, not even medical students and practitioners necessarily chose to construct a self-identity, gendered or otherwise, through their thoughts and activities as body-owners.

It seems, therefore, that men were not interested in their bodies – and health – only in the pursuit of social and cultural ends. In particular, their involvement in the enterprise

¹⁴⁴ Pennell and Leong, ‘Recipe Collections’, p. 141. Temple bequeathed a volume to his daughter (BL,

of amassing useful medical knowledge was not noticeably an anxious one. It was not about compensating for the physical effects of something else, seemingly neither came out of nor created anxiety about their gender status or the physical repercussions of gendered behaviours, and gives no evidence that men feared that their masculinity would be brought into question by illness. In particular, these sources give no indication that their gender made even individual men more anxious about their health than were women, whether because it exposed them to additional dangers, because of their numerous responsibilities, or because health was important to both constructions of male sex and being (seen to be) a man. Perhaps there was, however, no fear of the slur of valetudinarianism, or of that of physical inferiority, for the first baronet Clerk packed his spiritual journals with references to sicknesses, many of them mundane.¹⁴⁶

Indeed, further observations generated by the research for this chapter do suggest that laymen's involvement in the development and transmission of useful bodily-related knowledge was as much about the treatment of illness and injury as was that information available to and preserved by women. Men's interest in 'bodywork', or in 'attending to the human body' was, these findings suggest, focused overwhelmingly on illness, for the aesthetic body received almost no attention in any of these laymen's manuscript recipe compilations other than the earlier Temple collection, and even in those of sufficiently broad purpose to include non-bodily contents.¹⁴⁷ This masculine interest in sickness was, furthermore, itself apparently concerned specifically with physical suffering and its alleviation. Indeed, the aesthetic elements and repercussions of illness and injury were totally absent from all of these post-1640 laymen's

Stowe MS 1077, Medical, cookery and other recipes, Temple, cover).

¹⁴⁵ In this sample at least.

¹⁴⁶ NAS, GD18/2092, Clerk family papers, Spiritual journals (1692-1722), Sir John Clerk.

¹⁴⁷ Quotation from Mary E. Fissell, 'Introduction: Women, Health, and Healing in Early Modern Europe',

collections, revealing a pre-emptive interest in the illness-related experience of the body that was more single-mindedly concerned with matters of health and its recovery, and freer of aesthetic and cultural considerations, than were the recipe books produced by some women (and, furthermore, some practitioners).¹⁴⁸

Similarly, this sample of manuscript collections also encourages several observations about men's participation in the exchange of useful medical knowledge. The chapter's research suggest that men were fully able to access bodily-related advice, and, indeed, utilitarian, medically-oriented, information extending beyond that which could be claimed to have direct aesthetic import. Evidently, as individuals and as a gender men were able to take responsibility for their own health. Both at the individual level and as a gender, men apparently had the ability to access and store useful medical knowledge, and, significantly, to do so without the assembling process, the information and experience thereby accumulated, or the creation of this knowledge, being dependent upon women. The useful medical knowledge that these laymen collectors accumulated was, to varying extents, the product of male experience, male creations, and the shared medical interests of individual masculine social circles, not a male-owned condensation of the information possessed by female compilers, or of a knowledge pool amassed by women in feminine social roles.

Consequently, men's health, and men's ability to prepare for recovering health, did not have to be reliant on women or on a gendered 'women's knowledge' generated through women's roles as mothers and informal healers. Equally significantly, these manuscript

Bulletin of the History of Medicine, 81, 1 (2008), pp. 1-17, quotation at p. 11.

¹⁴⁸ Perhaps, therefore, those occasional men who complained in consultation letters of the cosmetic effects of current skin conditions were, for their gender, unusually sensitive to threats to their material appearance (above, p. 160).

materials indicate that this gender group chose to have independence from women in the preparation for ill health. That two of the compilations in the statistical analysis did name occasional females as immediate sources shows that men had the ability to use women as a source of information for their own potential health needs, and for these rather than disorders specific to wives and children.¹⁴⁹

However, these manuscript materials also imply that, for men, women were not the preferred or most important even of lay medical sources. Certainly, this sample gives no indication that had it not been for their ability to converse with women on medical matters men would have been incapable of preparing for sickness, and automatically and absolutely reliant upon nearby females – and on females’ access to a curative knowledge shared between women – or the purchase of treatment when struck by illness. On the contrary, educated and literate laymen were seemingly able to obtain abundant medical information from each other, much of it verified or of known prior usage, and some of it ostensibly newly created.

Consequently, this research suggests that it was not only in the act of purchasing paid medical services that seventeenth- and eighteenth-century men were able to take responsibility for their health, or to have independence from women in their health care. On the one hand, men as a group apparently had great independence in the creation, attainment and possession of useful medical information. On the other, men did not need to be reliant upon wives and female relatives to take pre-emptive health-related precautions on their behalf. Certainly, this sample argues that male individuals who so

¹⁴⁹ The items that the Clerks associated with female transmitters involved ague, stone, rheumatism, trembling fever, dropsy, gout, and the pectoral ointment. Where stated, their gynaecological items were linked to a practitioner and medical publications (NAS, GD18/2125/79, 96, Clerk family papers, Medical recipes and prescriptions, Clerks).

desired could take responsibility for, and have self-reliance in, their own domestic healthcare, both before and – at the decision-making level at the very least – during sickness.¹⁵⁰ By engaging in the pre-emptive collection of medical knowledge men too were providing themselves with ‘health agency’, and with authority over sicknesses of their own.¹⁵¹ To what extent men also retained, and wanted, agency and autonomy when sufficiently ill to need paid medical care is considered in chapter 7.

¹⁵⁰ The language in which they recorded recipes, or referred to cures performed by or upon laymen, gives no indication as to whether or not men prepared medicines themselves, either in advance or when struck by illness.

¹⁵¹ Quotations from Cabré, ‘Women’, pp. 23, 50.

Chapter 7: The sick man

Introduction

This chapter turns to men dealing both with sick bodies and with their status as the owners of these. On the one hand it asks if men can be seen fearing that falling ill would have consequences for their social identity, or if being sick threatened men's self-images. On the other, it examines whether the sick man had identities, relationships and behaviours that had consequences for his medical care. In particular, it focuses on those that might have influenced the bodily, medical, personal, or social experiences of being sick or under a practitioner, and through this physically shaped the body coming out of illness. The way in which illness itself impinged upon such identities, relationships and behaviours is similarly of interest, particularly where sickness might have brought out tensions pre-existing or even inherent in certain male statuses and relationships.

The chapter begins with letters exchanged within a sample of primarily Scottish families, from across the period, and whether discussing sicknesses themselves or responding to their repercussions. Mainly sent from one male to another, these are used to explore the ramifications of sickness for filial and paternal male-male relationships, particularly when sons were still financially dependent. The second part widens this to other relationships pertinent to and drawn into men's sicknesses and men's experiences of being ill, in a society in which to be a (normative) man was allegedly to be self-reliant. Consequently, the sources used in part two change to consultation letters, particularly those written and forwarded in the first half of the eighteenth century, and occasionally earlier, to the London-based Irish-born physician Sir Hans Sloane. Letters sent to the Scottish physicians John Hope (1725-1786) and William Sinclair (c.1748-

1838) are similarly examined, mainly where dating from 1780-1785 (these collections containing few earlier items) but with occasional illuminating later examples.

Comparisons are also drawn with casebooks, where revealing. Such sources are also used in part three's exploration of the sick man's interaction with his practitioner as a multi-faceted relationship, and one linking the intimacies of the medical consultation with the interactions and exchanges of the wider world. As the sick-time experience was, it is suggested, played out in the public sphere, part four asks whether the relationships and behaviours stemming from the sick body always had to be arenas for the performance or (re)assertion of masculinity. It does so by considering men's sick role(s), looking for the effects of hegemonic ideals of manhood and masculinity, and of changes within these.

Part i: Illness and the Father-Son Relationship

It was not until the later-eighteenth century that the conduct literature elevated paternal 'tenderness', and only in relation to young offspring.¹ Yet, fathers were expressing an interest in the health and illnesses of boys, youths, and adult sons throughout the period, and sons similarly voicing a concern for the physical wellbeing of fathers and grandfathers.² Sometimes, however, paternal affection went only so far. Actual and *de facto* fathers did not always respond to sick sons with unmitigated affection.

On the grand tour in the mid-1720s, Humphrey Grant had already sacrificed the favour

¹ Joanne Bailey, "'A very sensible man": imagining fatherhood in England c. 1750-1830'. I am grateful for the opportunity to see this and other chapters from a forthcoming work.

² NAS, GD112/54/2/2-3, GD112/39/319/3, Papers of the Campbell family, Duncan, Lord Sinclair, to his father, John Earl of Caithness (later Breadalbane), 22 April and 10 September 1679, and John Campbell of Carwhin to Mrs Campbell, 5 May 1779.

of his father, the MP James Grant.³ Consequently, his second use of illness, in July 1726, as the latest excuse for extravagant spending and the refusal to leave Paris prompted not a flicker of paternal anxiety. If news of his sickness could have potentially won a temporary reprieve from the hostilities generated by his prior misdemeanours, Humphrey destroyed any such hope. He blamed his spending and failure to depart on his father's refusal to settle the debts, continued to find excuses, bad health included, for staying, and even confirmed paternal suspicions that the sickness 'was mostly o[w]ing to my mismanagement of my self'.⁴ Consequently, his father's only reply was that, having reached 'the years of discretion', Humphrey's debts were his own responsibility. Indeed, it was this final illness that prompted James to threaten disinheritance, despite knowing that it really had left Humphrey unfit to travel.⁵ Here, illness (and its repercussions) won only a father's promise to 'make you sensible of your... undutifulness to me'.⁶

There were circumstances, therefore, in which absent young men's sicknesses could be interpreted as but the just desserts of an already resented bad character. It was not, however, only with the grand tour that such behaviours, paternal suspicions, and the resultant tensions, existed. When Thomas Luttrell, aged seventeen to eighteen, allegedly fell ill with headaches and then fits in 1764-1765, it was in similar circumstances. He was, however, at college in Aberdeen, with the immediate paternal responsibilities delegated to Sir Archibald Grant (1696-1779), at the behest of Sir Alexander Grant

³ NAS, GD248/47/2/1-3, 8-9, 14-15, 17-19, 21-24, Grant of Grant correspondence, James Grant's correspondence with and about his son, Humphrey Grant, 8 January-10 October 1726.

⁴ NAS, GD248/47/2/2, 1, Grant of Grant correspondence, Humphrey Grant to James Grant, 10 July 1726, and A. Alexander to James Grant, 3 July 1726.

⁵ NAS, GD248/47/2/3, 8, 1, Grant of Grant correspondence, James Grant to Humphrey Grant, undated, James Ogilvie to James Grant, 10 August 1726, and Mr Alexander to James Grant, 3 July 1726.

⁶ NAS, GD248/47/2/3, Grant of Grant correspondence, James Grant to Humphrey Grant, undated.

(1705-1772).⁷ In place of Humphrey's governor, it was Thomas's landlord (Professor Skene) who struggled against the youth's misdemeanours, and it was the relationships of ward and patron and ward and guardian that were endangered. However, just as the governor complained to Humphrey's father of his having 'fallen into very bad Comppa[ny]', Sir Archibald was receiving both before and during the alleged sickness Skene's reports of 'threatnings of vengeance & low cunning', a suspicious 'attachment', Humphrey's blatant refusal to honour his debts, and, overwhelmingly, that profligate spending that was very reason for his being removed to Scotland.⁸

Yet, when Thomas (apparently) fell ill his plight did initially prompt compassion. That of Skene, Grant's family, Sir Alexander, Thomas's parents, and his physicians soon wavered, but even in these circumstances Sir Archibald was able to respond with sustained compassion. Evidently, claimed illness did not always cause problems for youths financially dependent on others, already the target of suspicion, and already resented as a financial burden. On the contrary, Sir Archibald's sympathy led him to take Thomas into his own home and to continue what was in effect that other fatherly duty, provisioning, he and Sir Alexander knowing the emptiness of the 'very straitned' Luttrell senior's promises of compensation.⁹ Indeed, and in great contrast to Humphrey's experiences, this youth's illness actually brought the bolstering of a foundering quasi-fatherly relationship. The illness distracted Sir Archibald and, temporarily, other men from their prior grievances and, they were told, made their

⁷ NAS, GD345/850/1-75, Papers concerning the debts and ill health of T. W. Luttrell (1763-1766, unnumbered, with many copy letters lacking author names, and separated inserts). Although he is absent from lists of their offspring, the letters show that Thomas's parents were the MP Simon Luttrell (1713-1787), first Earl of Carhampton and member of the Hell-Fire Club (known contemporaneously as the 'King of Hell') and his wife Judith Maria, both of Warwickshire.

⁸ NAS, GD345/850/1-75, Papers concerning the debts and ill health of T. W. Luttrell, [Francis Skene] to [?Sir Archibald Grant, hereafter Grant], 23 April, 20 March and 10 June 1765.

⁹ NAS, GD345/850/1-75, Papers concerning the debts and ill health of T. W. Luttrell, 'A. Grant' to [?Grant], 25 May 1765.

pursuit physically dangerous.

The bolstering of this particular relationship was, furthermore, one that survived the tensions that sickness itself brought. Wrangling over the cost and payment of medical care, disputes over the authenticity of the sickness, and the barriers to his removal posed by Thomas's continued delicacy (and public knowledge of it), caused a further breakdown in relationships.¹⁰ However, and despite earlier complaints of having a ward '[r]epeatedly urged upon me', not 'in health, or even without uncomon Ailements', nor 'tollerably governable, or [with] health to fear harsh Reproofs & Restraints – which is still more Difficult with one long accustomed to high life', when the break came it was not between Sir Archibald and his ward. Instead, it divided Sir Archibald, Thomas's parents, and that unwitting patron, Sir Alexander, on whom the bills threatened to fall.¹¹

Being able to express concern for sick youths was not, however, the product of the later-eighteenth-century 'shift in ideals from an authoritarian father to one who incorporated more "feminine" characteristics of nurturing and caring'.¹² In the 1710s, the physician Thomas Wharton (1652-1714) had similarly been worried by accounts of the health of his son. George (1688-1739) was in his mid-twenties, had graduated as a bachelor of medicine, and was practising under a master. Yet, when Thomas heard of his rheumatic fits it was the anxieties and affections of a father that he expressed. Thus, his warning that this rheumatism 'comes upon takeing of cold' was proven not by medical theory

¹⁰ NAS, GD345/850/1-75, Papers concerning the debts and ill health of T. W. Luttrell, Middleton to Grant, received 2 September 1765, and [?Skene] to [?Grant], 14 December 1764; Grant to [?Sir Alexander Grant], 2 June 1765.

¹¹ NAS, GD345/850/1-75, Papers concerning the debts and ill health of T. W. Luttrell, [?Grant] to [?Simon Luttrell], 2 June 1765.

¹² Joanne Bailey, 'Reassessing parenting in eighteenth-century England', in Helen Berry and Elizabeth Foyster (eds.), *The Family in Early Modern England* (Cambridge, 2007), pp. 209-232, quotation at p. 221.

but by George's own father and tragic, dead, mother. Indeed, it was Thomas's affection for George (and George's mother) that dominated the first half of the letter, referring to an enclosed 'little papr book with clasps in it' containing 'the care of a Rematisme, [th]e things y[ou]r mother used'. Evidently, fathers were able to express affectionate concern even when ill sons were men, for after proffering his own medical instruction, as a physician, the father in Thomas resurfaced to ask to hear 'every post till you are well'.¹³

The correspondence exchanged between George and Thomas also reveals that it was not inevitable that absent sons' use of medical care (and its claimed costs) would be a source of father-son conflict. At Cambridge, George had been required to send itemized accounts, and medical spending featured fairly frequently. That he mentioned even his most major medical needs at the end of the quarter as something new to Thomas implies that George did not seek prior approval. Yet, cost was never a driving force in this father's interest in his son's use of medical services. George's spending was repeatedly questioned but only once did he feel compelled to emphasize his suffering or its dangerousness in order to justify bills related to health.¹⁴

This does suggest that it might have been its relative cheapness that prevented medical care from becoming a source of tension in the way that George's fondness of periwigs and clothes did. Yet, his one atypically high sickness-related spending, one that he felt compelled to pre-emptively explain, and which came at the same time as a criticized purchase of a periwig, did not prompt censure. His father's sole 'Objections' actually came from *the cook's* claims after a 'Violent' cold.¹⁵ Although receiving at least one

¹³ DUL, WHA/23, Wharton papers, Thomas Wharton to George Wharton, 26 December 1710.

¹⁴ DUL, WHA/17, Wharton papers, George Wharton to Thomas Wharton, May 1712.

¹⁵ DUL, WHA/20, Wharton papers, George Wharton to Thomas Wharton, 4 January 1709.

negative report about George, Thomas not once questioned his son's statements of illness or injury, or his explanations of their cause, even with a stab wound.¹⁶

Even after starting work, George remained financially dependent, sent off his 'vouchers', and was forced to defend his purchases. Still, spending on medical needs, now with clear evidence for the historian that they were self-prescribed, failed to provoke conflict. Even when George, long criticized for his extravagant spending on clothes, bought 'flannell wascoates', ostensibly 'upon [th]e account of sweating so much, without [which] I generally used to... be chill', and at the same time as spending almost £8 on other clothes, his father made no visible comment.¹⁷ Evidently, for sons distant from their father's control yet still reliant on their money, and even when their spending had already aroused criticism, the claimed use of a father's money for medical purchases did not have to strain relationships.¹⁸

George's later accounts also show, however, that not even adult sons always had, or wanted, full independence in their healthcare. The paternal role could, moreover, be far more interventionist, as when Colin Campbell of Ardmaddie (1679-1708), also in his twenties, was dying in London. Although this younger son had a mistress, son and, significantly, estates and income, his father, the first Earl of Breadalbane (1634-1717), was an insistent participant in his healthcare, frequently against Ardmaddie's will. His intervention was, furthermore, at the very least accompanied by a 'family motive' that

¹⁶ DUL, WHA/16, Wharton papers, George Wharton to Thomas Wharton, 7-8 January 1708.

¹⁷ DUL, WHA/31, Wharton papers, George Wharton to Thomas Wharton, 11 November 1712.

¹⁸ A similar situation is revealed in George Baker's bills from Eton and Cambridge, sent, as his father was dead, to a 'Cosin' and Richard Burton. Again, there were large bills that authors felt necessary to justify, and heavy spending on clothes and wigs, although, and as with Thomas Wharton, medical outlay was small and not always present. Nor did large bills cause a refusal of permission for a month at Scarborough after claims of being 'Six weeks... out of order'. A few months later, George was explaining a quarterly bill of £91 by 'The Expences of my illness', with his guardians sufficiently satisfied by this to have paid it

led Breadalbane to attempt to manage not just Colin's medical care but Colin himself, arranging a marriage match (while reminding him of his familial duty to procreate) and seeking even to control access to his person.¹⁹ It was also an intervention made possible by a network of men at this patriarch's bidding, using pre-existing ties but heavily driven by one individual.²⁰ Indeed, Breadalbane assumed this role despite the problems that he faced as a 'suspect person' in the aftermath of the Jacobite invasion plan of 1708, although himself suffering from severe gout, gravel and the debilities of old age (being seventy-three), and even though, as he emphasized when ordered 'to make ready to sent prisoner to London', consequently so incapacitated as to be confined to his estate.²¹

Family involvement in men's poor health was not, however, unusual. Nor was it only fathers who could have less than purely altruistic reasons for intervening. James (1658-1712), Earl of Arran's, grand tour had been seen by his father as simply furnishing further proof of his profligacy and fondness for low company.²² The failure of this eldest son of William (1634-94), third Duke Hamilton to embrace his dynastic obligations after returning enraged his parents further, as did his subsequent actions. Consequently, it is significant that, in the midst of these misdemeanours, Arran's

within days (DUL, BAK, Baker Baker papers, 1, 3-8cxix, 12, 17, 22-23, 25b, 36-40, 44, 47b, Bills and letters about or from George Baker (January 1739-March 1748)).

¹⁹ NAS, GD112/39/211/8, 31 and GD112/39/212/26, Papers of the Campbell family, 1st Earl of Breadalbane to Colin Campbell of Carwhin, 11 and 29 January 1708, and 24 February 1708; NAS, GD112/39/211/23, Papers of the Campbell family, 1st Earl of Breadalbane to Colin Campbell of Ardmaddie, 24 January 1708.

²⁰ NAS, GD112/39/211/2, 8, 15, 18, 20, 23, 25, 31, 34, GD112/39/212, 1-2, 10, 12, 16, 26, 33, GD112/39/213/1-15 and GD112/39/214, 2, 6-7, Papers of the Campbell family, Correspondence of and about Colin Campbell of Ardmaddie, January-February 1708.

²¹ NAS, GD112/39/214/19, 27, Papers of the Campbell family, Letters to the 1st Earl of Breadalbane, from Sir James Steuart, HM Advocate, 27 March 1708 and Colin Kirk, 30 March 1708; NAS, GD112/39/216/18, 23/1-5, Papers of the Campbell family, David, 3rd Earl of Leven, to Breadalbane, 23 May 1708, and Breadalbane's draft letters to Leven and unnamed, undated. He made this claim again, for the same reasons, in 1715 (NAS, GD112/2/141/29, Papers of the Campbell family, Affidavit of the signatories of a certificate of 1715 testifying to the 1st Earl of Breadalbane's infirmity, 4 February 1719).

²² Oxford Dictionary of National Biography.

behaviour during his father's illness still formed a significant part of a parental letter of correction of 1685. Arran's insistence that he *had* taken care to keep up with Hamilton's health, although obstructed by 'most of My Freinds & all of your servant[s] that did neaver give me the leest account', confirms that sick fathers sometimes were neglected by absent sons. However, his letters also show that decision-making in and about fathers' illnesses could be diffused, with not even patriarchs always having full control over the care that they received, or even the number of practitioners employed to cure them. Thus, Arran claimed to have already 'talkt a great whill' of his father's case with Hamilton's prior consultant, requesting that his father 'gett his phisitian to sett down his condition at more lenth then his Gr[ace] did in his Last to him'. However, it was the current physician, rather than Hamilton, whom Arran decided would write an additional report, Arran's mother who was to order this, and Arran himself who was to send it to France, he supposedly being 'most particularlie aquainted with one of the Famousest men in the whole worlde'.²³

Ten years later, when his elderly father was again taken ill, Arran took total control. Hamilton had suffered what one scholar calls a stroke, but was sufficiently well, and able to communicate, to insist on continuing his journey.²⁴ Yet, 'immedieatly' after hearing, Arran 'sent for the phisitian that attended him heer & gave him the Letters', obtained and forwarded a report, sent for other physicians, wrote to express his concern to his mother, found out the medicine that 'all are of opinion' was the most suitable, obtained it, and sent it to her by the first and 'best' post. He also wrote to tell his father that he had done all of this 'tho I had noe order for it', and had done it because 'it was

²³ NAS, GD406/1/8451, Correspondence of the Dukes of Hamilton, Earl of Arran to Anne, Duchess of Hamilton, 17 January 1685.

²⁴ Oxford Dictionary of National Biography.

my diuty to Loos noe tyme'.²⁵

Adult sons could, therefore, take it upon themselves to offer as much practical help, intervention and managerial expertise as patriarchs did for dependants. Indeed, Arran took a very different course to that urged in some conduct literature, which called for the aged man to submit to the decrepitude of old age as a welcome proof of death's approach.²⁶ Arran, by contrast, took it upon himself to be the one to reassure his father with a careful re-interpretation of the physicians' report, despite his own private fears. Indeed, neither codes of male fortitude nor the association of emotion with femininity prevented Arran from being put 'in noe small disorder' by his father's plight. He did, however, choose to articulate this fear through the family's reliance on his father. He had done the same five days before, when his father's complaint had been gravel, justifying his request that his father 'mind your oun health beyond all other thinges' by the fact that 'I am convic't if any thing should ail you The Family would bee in great danger of ruin'.²⁷ Now, he tempered this with the claim that 'every moment... shoes me more: what I ow to him and all that are concerned in the family can't be enough sensible of what he has done for itt'.²⁸

Part ii: Sick Men, Autonomy and Friends and Family

Sickness was, therefore, often a family affair. 'The Case of Mr Haig' (1785) was delivered to his earlier practitioners 'by Mr H's son, now a medical student', but it was

²⁵ NAS, GD406/1/7769, 7768, Correspondence of the Dukes of Hamilton, Earl of Arran to Anne, Duchess of Hamilton, and to the Duke of Hamilton, both 17 April 1694.

²⁶ Robert Saint Southwell (?1561-95), *The dutifull advice of a loving sonne to his aged father* (1632 and 1650).

²⁷ NAS, GD406/1/7767, Correspondence of the Dukes of Hamilton, Earl of Arran to the Duke of Hamilton, 12 April 1694.

²⁸ NAS, GD406/1/7769, Correspondence of the Dukes of Hamilton, Earl of Arran to Anne, Duchess of Hamilton, 17 April 1694.

not only the medically educated who were given, or took, a role in the administration and negotiation of paid medical care.²⁹ Even when patients were financially autonomous adult men there were limitations to the extent, and expectation, of male autonomy.

To be a male in the age of manhood was ostensibly to have come through that preparation for independence and self-reliance central to the parental management of the male youth's 'entering the world'.³⁰ However, even patriarchs and heads of family lines needed, were seen to need, and chose to use, the help of those around them when ill. As one manual of male education stated in a chapter on health,

when we are even arriv'd to... Manhood, Providence... has laid in
our very Nature and Circumstances, a Necessity for our
Dependence upon one another. Hence the many Relations,
Friendships and Alliances among Mankind... established for...
making them mutual Assistants and Comforts.³¹

At the most basic level this involved spouses and relatives providing bedside care, or functioning as amanuenses. Similarly, when men were (deemed) incapable of taking responsibility for their own healthcare others stepped in to arrange practitioner visits or new prescriptions. These were usually those physically closest to men – their wives or sisters, and, especially frequently, sons, brothers, or brothers-in-law.³²

²⁹ NAS, GD243/143/6/70, Letters sent to John Hope, 'The Case of Mr Haig', 24 January 1785.

³⁰ Henry French and Mark Rothery, "'Upon your entry into the world": masculine values and the threshold of adulthood among landed elites in England 1680-1800', *Social History*, 33, 4 (2008), pp. 402-422.

³¹ James Todd, *The school-boy and young gentleman's assistant...* (Edinburgh, 1748), pp. 11-12.

In some cases, however, male relatives went further. It was, for example, a brother-in-law who ‘perswaded’ his ‘Br[other] Butler’, ‘with much adoe[,] (as you had directed...) to take a Glyster’, and subsequently laudanum. That this patient ‘would by no means consent’ did not prevent this kinsman from requesting that Sloane ‘come hither to me’, at ‘my house’, ‘& give me your directions’.³³ Yet, it was not only with raving patients such as Butler, or the intervention of male ‘friends’, that at least some of the management of men’s medical care was devolved, the patient’s authority delegated, and his autonomy reduced. Even a practitioner was so subject to his female circle in the late-seventeenth century that when he rejected his physician’s diagnosis it was ‘his Lady with other weomen’ who formulated an alternative diagnosis and had it carried to an alternative practitioner, expecting a prescription.³⁴

Certainly, practitioners knew that others were likely to be involved in the medical process, whether or not their opinions were sought, whether or not the patient knew, and even when patient and practitioner consulted without intermediaries. Indeed, some set out to exploit this involvement of ‘friends’ for the patient’s good, deliberately drawing third parties into practitioner quarrels.³⁵ Similarly, patients felt no need to conceal that they remained open to the opinions of non-practitioner associates, or were wavering under their instruction. Indeed, this was a susceptibility to being ‘pressed’ that, as Shallett Turner (c.1692-1762) showed, extended to professors and Fellows of the Royal Society, those responsible for the management of others’ health care, and men who

³² E.g. BL, Sloane MS 4075, Hans Sloane consultations (late-seventeenth- to eighteenth-century), f. 154, from Ralph Freeman, undated (about his father).

³³ *Ibid.*, f. 46, from W. D., 1 February 1707.

³⁴ WL, MS 3319, ‘Admirable observations of strange cures’ (c.1675-c.1691), Richard Lockyer, case of Dr John Fust (1685).

³⁵ NAS, GD44/43/3/92, Gordon family correspondence, A. Kennedy to Alexander, Marquess of Huntly, 6 August 1711, about Alexander’s father, the Duke of Gordon.

were close friends with their practitioner.³⁶ He openly told a physician that his help was wanted only because of the prognoses given by '[t]he Folks I talk to hear', who 'all advise me to consult a Physician in time for fear of an ill consequence'.³⁷

Consequently, practitioners recognized that the involvement of relatives and friends had real repercussions for men's treatment.³⁸ Seized in 1790 with severe bowel and rectal troubles, Thomas Thurlow (1737-1791), Bishop of Durham, had five practitioners, including an eminent surgeon, yet 'the Family were importuned to have Taylor the Cattle D[octo]r to attend him'. Although Thurlow had already received ease on 'leaving off' a disagreeable treatment, 'the Patient as well as... his Friends fargot the former [improvement]... and dated the time of ease from the application of Taylor's Medicine'. Thurlow was actually dying but the family issued repeated reports of his doing well, and when 'he did not get flesh, altho' he and they were in hopes he did', 'his Barber was apply'd to' 'for the confirmation'.³⁹

Sometimes, furthermore, men and women were able to shape men's healthcare without the full invitation, or knowledge, of the patient. Mary Cheale wrote to inform Sloane of the effects of his prescription and of her husband's current state, and to pass on Cheale's request for 'abill of Derictions'. However, while claiming to have written only because it was 'my Hosbon not my self [who] cant be easeir with out your good atvis', she also added her own request for 'a lien or to of at vice to... go to bed early and rise early and youse exercise and not Drink which has brut him in [thi]s ill steat of helt[h] tho never

³⁶ Quotation from BL, Sloane MS 4078, Hans Sloane consultations (late-seventeenth- to eighteenth-century), f. 254, from William Bouchier, 24 July.

³⁷ WL, MS 6139/8, Correspondence of James Jurin (1724-1746), from Shallett Turner, 20 February 1726.

³⁸ BL, Sloane MS 4077, Hans Sloane consultations (late-seventeenth- to eighteenth-century), f. 28, from William Smith (in Dublin), 29 August 1698.

Drank hard but to constant', begging that Cheale not be told of this.⁴⁰ Other family members went so far as to intervene either without invitation or well beyond the role offered to them, even when men were evidently capable of managing themselves.⁴¹

Women had a voice in men's medical care in other ways too. They too could occupy a logistic role, without sacrificing their authority to a male practitioner.⁴² Sometimes, furthermore, there was a whole network of participants involved who were purely female. Thus, it was a wife and, especially, sister, who managed Sloane's care of the MP Viscount Soudes (1686-1722), at least once initiating further action while asking that Sloane not let on that he 'had heard of his being sick'. Soudes's father, the only other man named in the two letters, featured solely for his absence. If only because of this father's absence – and he cannot have been the only parent forced to leave sick adult offspring – it was a sister who was visiting, compiling reports, and passing on information. Yet, there is nothing to suggest that the patient could not have written.⁴³

This might be an atypical example but women were frequently involved in orchestrating both sick men's medical care and their lives. These were, furthermore, women who themselves sometimes had multiple relationships with the practitioners responsible for their husbands, fathers and brothers.⁴⁴ One daughter, for example, received reports 'about my Father' from both Mr Robert and, separately, Sinclair. Apparently familiar

³⁹ RCS, MS 0189/1/2, 'Records in Morbid Anatomy' (men's dated cases 1774-1802), John Hunter, no. 58.

⁴⁰ BL, Sloane MS 4034, Hans Sloane consultations (late-seventeenth- to eighteenth-century), f. 351, from Mary Cheale, 13 January.

⁴¹ BL, Sloane MS 4076, Hans Sloane consultations (late-seventeenth- to eighteenth-century), ff. 154, 165, from Thomas Pelham-Holles, about the Bishop of Chichester, 26 July 1729, and about Lord Townshend, undated.

⁴² BL, Sloane MS 4078, Hans Sloane consultations, f. 181, from James Keill, 1[?] September.

⁴³ BL, Sloane MS 4077, Hans Sloane consultations, ff. 222-224, from Margaret Watson, undated and 13 March.

with the physician responsible for her father by having herself been his patient, *she* decided that ‘the Election... will be apt to hurt him as he will there be obliged [to] exert in the Dringing [sic]’, and that, should it be agreed between the physician and herself, the patient would be removed from harm’s way.⁴⁵ When patient and practitioner were male the resultant discourses were not necessarily male only.

Men's illnesses, and healthcare, did not, however, happen in a vacuum, isolated within the immediate family. Sometimes it was members of the wider family who chose to approach the practitioner by letter, and even they took on a bigger interpretative role than did intermediaries involved in writing French consultation letters.⁴⁶ Acquaintances and friends could also be important to ill men, and could take it upon themselves to intervene, whether as a one-off update or in engineering the entire curative process. Thus, William Thomson wrote that ‘[a] freind of mine one Mr Ryves is very ill of a sore throate... he lodges at [th]e next doore on this side Barnard's Inn in Holbourn – I wante... you to visitt him forthwith, & to take proper care of him’. He also appeared to ‘desire you [w]ould not lett him or any’ one know of this request, with Sloane ‘to stepp in to my house’ beforehand.⁴⁷ A woman requested that Sloane’s visit to *Lady Sondes* ‘may seem accidental’, and similar schemes from Breadalbane raised Ardmaddie’s hackles.⁴⁸ There were, however, some men whose entire medical care, rather than individual consultations, was being arranged without their participation or knowledge.

⁴⁴ BL, Sloane MS 4078, Hans Sloane consultations, f. 385, from Mary Somerset, wife of Henry, Duke of Beaufort, May.

⁴⁵ NAS, GD136/435/107, Letters sent to William Sinclair, from Miss Honeyman, undated.

⁴⁶ Laurence Brockliss, ‘Consultation by Letter in Early Eighteenth-Century Paris: The Medical Practice of Étienne-François Geoffroy’, in Ann La Berge and Mordechai Feingold (eds.), *French Medical Culture in the Nineteenth Century* (Atlanta, GA and Amsterdam, 1994), pp. 79-117.

⁴⁷ BL, Sloane MS 4077, Hans Sloane consultations, f. 270, from William Thomson, date missing.

The ability of ‘friends’ to shape the patient-practitioner relationship, and the conclusions reached within it, was not, however, the product of otherwise powerless relatives playing on temporary weakness. Robert Thomlinson, a clergyman, was capable of writing minutely detailed and very lengthy accounts of his multiple ailments, but sent these to his brother, a London merchant, to present to Sloane.⁴⁹ Not all brothers were just couriers. When Captain Delafaye, brother of Charles, the under-secretary of state, fell ill in 1734, Charles already had a knowledge of his lifelong health and most recent problems and treatments. The Captain sent a self-authored personal account to forward, but Charles added – even before any additional *verbal* commentary – his own summary of the Captain’s medical history, description of his condition at their last meeting, paraphrasing of his state as described in an earlier (personal) letter, and confirmation of the claims given in the Captain’s self-account. He was entrusted with this role because of his access to Sloane, as his patient, but added that ‘a Brother’s sufferings is a Case of Compassion, & I was willing to give you all [th]e Light into it... in my Power’. Indeed, he had in the role expressly given to him the power to shape Sloane’s first impressions of case and patient and used this to correct the patient’s own account, adding that ‘[h]e has besides, I doubt... been a free Liver; & possibly may have suffered from [th]e Sexe’.⁵⁰ He was far from alone in proffering his own opinions about contributory behaviours.⁵¹

⁴⁸ BL, Sloane MS 4078, Hans Sloane consultations, f. 232, from Anne Finch, undated; NAS, GD112/39/213/8, Letters from Colin Campbell of Ardmaddie to Colin Campbell of Carwhin, [January-February 1708].

⁴⁹ BL, Sloane MS 4077, Hans Sloane consultations, ff. 271-273, Robert Thomlinson to Richard Thomlinson, undated and 14 March 1720.

⁵⁰ BL, Sloane MS 4075, Hans Sloane consultations, f. 59, from Charles Delafaye, 20 January 1734; *ibid.*, f. 58, from L. Delafaye, 4 February 1735.

⁵¹ BL, Sloane MS 4077, Hans Sloane consultations, f. 320, David Stone to Richard Tilden, undated.

Thus, friends and relatives were often *invited* into the formal arrangement of the health care of competent men, and into the patient-practitioner relationship itself, and invited because men had consciously chosen to utilize them. Other people, their mobility, proximity to the desired practitioner, or servants, were all employed as a way of making speedier communication with the physician, or of increasing the likelihood of his taking up the case.⁵² Indeed, they were made use of as with the purchase of any commodity, Alexander Duff using his Edinburgh-dwelling sister in 1753 to obtain flour, various other ‘things’ that he ‘desired to buy’, and a prescription.⁵³ This was, furthermore, a service that men valued. Although convinced that his disorder was deep-rooted, Henry Burt still decided that he had found ‘much relief’ from the medicines ‘recommended’ by the surgeon ‘to whom my friends had been describing my situation’.⁵⁴

Both before 1750 and after 1780, men could choose to rely on acquaintances to communicate with their practitioner, whether in place of, prior to, or in addition to their own letters, and even when able to claim to have ‘on many occasions experienced’ his ‘friendship’.⁵⁵ Although fewer letters survive, seventeenth-century practitioners likewise received, and acted on, news of patients from, for example, ‘[th]e Ladyes yof[u]r Sisters’.⁵⁶ Furthermore, while it was an inner circle of friends, colleagues and relatives who were employed as direct agents and intermediaries, they had contacts of their own to be utilized.⁵⁷ Men’s illnesses and medical care were far from private knowledge, and this knowledge prompted and grew out of wide lines of communication.

⁵² BL, Sloane MS 4075, Hans Sloane consultations, f. 32, from Roger Cook, 9 May.

⁵³ NAS, GD248/504/9/1, Duff of Hatton business correspondence, Helen Abercrombie to Alexander Duff, 24 February 1753.

⁵⁴ NAS, GD253/143/6/39/2, Letters sent to John Hope, from Henry Burt, 18 October 1783.

⁵⁵ NAS, GD136/435/175, Letters sent to William Sinclair, from William McLeay, 18 September 1792.

⁵⁶ BL, Sloane MS 4062, Seventeenth-century medical correspondence, f. 209, Leonard Plu[n]kenet[t] to unnamed male, 15 October 1689.

⁵⁷ BL, Sloane MS 4076, Hans Sloane consultations, f. 76v, George Bradshaw to his son, undated.

Consequently, it was not only a man's own interpretations of his body, or his own healthcare expectations and decisions, that were inscribed in his flesh. Even as co-opted, utilized, third parties, and even when acting solely within the role given to them, spouses, relatives, and friends were far from passive. They decided the oral or written description that accompanied the presentation of a patient's own report, or were asked to provide this account themselves. Even employees introduced case and patient to the practitioner for the first time, thereby having the power to influence the options that, from the very start, sick men would be presented with. An earl sent in 1707 only '[th]e short of my Case' that began with the statement that '[m]y servant that brings you this will give a larger acc[oun]t of my Condition', listed his symptoms only briefly, and added that '[m]y servant will Acquaint you' with the methods used and 'a powder which I am advised... concerning which I desire your opinion'. He gave a servant this role despite being only in Wimbledon, with Sloane in London, and being able to 'come to Town... to apply any thing which cannot be done.... Here'.⁵⁸

Part iii: The Patient-Practitioner Relationship

Whether or not they had full personal control over its negotiation, men did not see themselves as just the purchasers of a commodity, or the men curing them as simply the hired providers of a commercial service. For many, the professional tie was not their only relationship with the man who was acting as their physician, apothecary or surgeon. However, sick men often saw the patient-practitioner relationship as something more than a financial transaction even when such additional, non-medical, intimacies were absent.

This intimacy did not, however, always prevent face-to-face patient-practitioner relationships from breaking down. Nor did male (homo)sociability, codes of gentlemanly ‘honour’, or eighteenth-century ‘politeness’. An apothecary was, for example, required in 1711 to defend himself against ‘a refelection [sic] at mr Pringles for my proceedings in his Case’, and for treatments ‘forced’ upon him by a patient who ‘passionately protested that he woud fling him selfe out of the Window as soone as he found a phisition with him’.⁵⁹ Another, ‘eminent’, patient fell out with his practitioner despite the latter having been ‘on all occasions... more then ordinary sollicitous in doing my Duty’, in both ‘[th]e Regard, I have always had for you as a Patient’ and ‘my real esteem for you as a friend’. In this case, the patient had delayed seeking treatment (and self-treated with a knife), disobeyed his practitioner, and (as the latter chose to phrase it) fallen prey to a scaremongering charlatan who ‘has taken... advantage of your fears, and of my absence’.⁶⁰

Even kinship was far from a guarantee of good relationships. The intrusion of other relatives, or the favours expected, could themselves be a source of fraction. In particular, they were the cause of an undated (pre-1753) dispute erupting between the apothecary John Conyers and his married male cousin. Here, it was the privileges demanded from kinship, the self-sacrifice felt necessary for a kinsman, hostility to the consequently large bill, and subsequent claims of ingratitude, that caused the conflict, and one that quickly moved from the apothecary and his lodger-patient to the latter’s father. In this instance, the closeness of male family members backfired and fed into

⁵⁸ BL, Sloane MS 4078, Hans Sloane consultations, f. 198, from Thomas Osborne, Earl of Danby, 10 January 1707.

⁵⁹ BL, Sloane MS 4076, Hans Sloane consultations, f. 260, from John Povey, 12 October 1711.

⁶⁰ BL, Sloane MS 4078, Hans Sloane consultations, ff. 319-320, unsigned and undated copy.

pre-existing familial disputes, with the resultant attack allegedly deliberately made public (via Conyer's servants), to besmear his public reputation.⁶¹

Consultations by post are, however, remarkably free of signs of breakdown. There are expressions of frustration, but only occasionally, and not just from men.⁶² Even if but a rhetorical courtesy, patients repeatedly expressed an effusive sense of gratitude, claiming to believe that practitioners had sent 'friendly' letters, displayed 'Friendship' and 'Humanity', or given 'equall testimonys of your kindnesse & concerne'.⁶³ John Slinger, for example, wrote to a 'Right worshipfull', Sloane, in 1671 declaring that he 'should exceedingly transgress the Rules of com[m]on Gratitude: if I should not keep up an hearty and thankfull Resentment of your tender care... and bountifull Kindness'. He was medically confident enough to 'suppose it will now be high tyme to take som phisick to remoove the Dregg... and likewise to Bleed' but still added, despite having left London, where Sloane was based, that 'I dare not adventure on either without your grave Advice: which I now humble Crave'.⁶⁴

Many sick and recovering men were, indeed, careful to avoid causing offence. Thus, Patrick Campbell, eager to explain his reasons for not using *all* of Hope's prescriptions, stressed that otherwise 'I applied most strictly to your advice in every thing', added that he had tried to visit, and was eager to do so, to 'gratefully thank you for the most polite and freindly behaviour I have yet met with', and signed off 'with the greatest sensibility

⁶¹ BL, Sloane MS 2251, Seventeenth-century medical papers, ff. 86-87, Letter from J. Conyers to [-] Tayler, undated.

⁶² NAS, GD136/434/75, Letters sent to William Sinclair, from Henrietta Grant, 29 December 1793.

⁶³ BL, Sloane MS 4078, Hans Sloane consultations, f. 236, from Peter Patrick, 10 January 1731; BL, Sloane MS 4076, Hans Sloane consultations, f. 1, from John Hough, Bishop of Lichfield and Coventry, 7 July 1716; BL, Sloane MS 4062, Seventeenth-century medical correspondence, f. 273, Henry Crow to Dr W. Gibbens, 1 December 1697.

⁶⁴ BL, Sloane MS 2251, Seventeenth-century medical papers, f. 94, Letter from John Slinger to Sir Hans Sloane, 3 April 1671.

of your goodness'.⁶⁵ It mattered to men what their practitioners thought of them, not only in terms of their behaviour within the sick room but also outside of it, and as men and not just patients.

Many men openly declared the believed strength of their relationship with the man treating them, often signing off as an old or 'most affectionet friend'.⁶⁶ They did so, furthermore, with practitioners of varying levels of fame and social status, one begging the estate-owner Sinclair, 'as a friend', for the medicines that he knew 'that it is quite contrary to your inclination to give... in [t]his Country'.⁶⁷ Another 'rejoice[d]' to 'have the liberty of making known my case to such an amible friend' as the professionally and socially elite Hope, grandson of a Lord of Session.⁶⁸ It was certainly acceptable for men to show a dependency that extended to the emotional. Thomas Bury, Chief Baron of the Exchequer, was, as Sloane knew, able in 1721 to use a 'Dr Bever' and 'Dr Bosworth' ('a cautious man') yet still announced that 'it is a great affliction to me that I am so farr from you'.⁶⁹ Sixty years later, John Grant was similarly telling Sinclair that 'without *your* help I belive [sic] I never will be better', and local practitioners warning distant consultants that '[t]he poor man will be quite Uneasy Untill you write'.⁷⁰

Sometimes, furthermore, practitioners showed themselves in agreement with these claims of friendship. One referred his 'Good Friend and neighbor not unworthy of yor acquaintance' to a physician, consultation letters sent to patients addressed them as 'my worthy friend', and colleagues were informed of the death of 'one of the best natured

⁶⁵ NAS, GD253/143/6/13, Letters sent to John Hope, from Patrick Campbell, 30 March 1779.

⁶⁶ BL, MS 4075, Hans Sloane consultations, f. 63, from James Stanley, 19 February 1714.

⁶⁷ NAS, GD136/436/44, Letters sent to William Sinclair, from James Innes, 8 June 1785.

⁶⁸ NAS, GD253/143/6/77/2, Letters sent to John Hope, from William Buchanan, 10 May 1785.

⁶⁹ BL, Sloane MS 4034, Hans Sloane consultations, f. 252, from Thomas Bury, 29 July 1721.

Men of our Acquaintance'.⁷¹ Indeed, it was sometimes practitioners pushing the professional alliance onto another, more intimate, footing. Alexander Hume Campbell (1675-1740), second Earl of Marchmont, for example, apparently had numerous areas of affinity with his physician of 1717, David Dickson. One of these was a sense of shared affliction, Marchmont labelling one (non-medical) letter as from 'my special friend, fellow sufferer, & physitian'. Another was political affinity, when the Jacobite failures still rankled. In his eulogies to Marchmont, and pro-Jacobite poetry, Dickson was courting his own patient, using an inversion of authority to offer self-depreciating flattery and lavish groveling.⁷²

Frequently, however, the additional ties linking patient and practitioner were more egalitarian. John Cock felt compelled to remind Sloane that he, Cock, had 'a graitfull soule', but thought himself on a cultural par with Sloane. He added that 'I am Repairing some admirable pictuers att Esq[ui]r[e] Jeffries. Roehampton. hear is a Right Pictuer of Rafale & a Moddell of one of [th]e Cartoons, that is lost a most surprising piece...'.⁷³ Others too claimed to share Sloane's well-known interests, or took advantage of them. A sick physician was happy to combine an account of his medical woes, a description of his fossil-finding activities (as fellow collectors), and an enquiry into a book.⁷⁴ Joseph Webster similarly promised '[th]e greatest Rarity I have seen' when, on the basis of '[t]

⁷⁰ NAS, GD136/436/34, 99, Letters sent to William Sinclair, from John Grant, 9 October 1782 (my emphasis), and William Young, 8 October 1782.

⁷¹ WL, MS 6139/5, Correspondence of James Jurin, from Dr Slare, 13 July 1724; BL, Sloane MS 4076, Hans Sloane consultations, f. 175, from William Oliver, 27 October 1739; *ibid.*, f. 258, from John Powell, 24 July 1720.

⁷² NAS, GD158/1203, Papers of the Hume family, David Dickson to the Earl of Marchmont, 1 June 1717.

⁷³ BL, Sloane MS 4034, Hans Sloane consultations, f. 363, from John Cock, 20 October 1712.

⁷⁴ BL, Sloane MS 4078, Hans Sloane consultations, f. 13, from Richard Massey, 14 November 1741.

he goodniss of your nature and former kind Expressions', he wrote to beg help in obtaining a 'Hospitall' place.⁷⁵

Nor were men who shared recreations with their practitioner the only ones for whom medical experts, and their opinions of their patients, mattered outside of the time of sickness. There were other men too who might have felt that the impression that they gave men during treatment would remain important after their professional services were dispensed with. Most obviously, there were men whose practitioners were also their kinsmen, and who, after the physical intimacies of the sick room, remained in their lives as in-laws and relatives. Indeed, kinship could give men access to eminent practitioners, whose advice was relied on despite geographical distance, the availability of local practitioners, and the known 'miscarriage' of their replies.⁷⁶ Furthermore, while it is the survival of such letters that reveals that, for example, Hope and Sinclair were also treating male relatives, it was not only by correspondence that kinsmen were involved.⁷⁷ They could also be active participants in the emotions, suffering, and visceral exposure of the sick room. Physician fathers treated adult sons in person, and in the seventeenth century Mr Kinge, suffering from venereal disease, began his treatment with 'Dyett & Physicke of his Sonne Mr. Cobbe'.⁷⁸

Sir John Clerk, first earl of Pennicuik (1650-1722), and his descendants also had practitioners within the immediate family, successive male generations making use of

⁷⁵ BL, Sloane MS 4062, Seventeenth-century medical correspondence, f. 2, from Joseph Webster, undated.

⁷⁶ *Ibid.*, f. 275, Mary Willes to Nehemiah Grew, M.D., 18 December 1697.

⁷⁷ NAS, GD136/436/104-115, Letters sent to William Sinclair, from Alexander Sinclair, 9 July 1780-4 May 1782; NAS, GD243/143/6/105-108, Letters sent to John Hope, reports on Sir Archibald Hope, 5 November 1785-25 June 1786.

⁷⁸ BL, Sloane MS 4077, Hans Sloane consultations, f. 25, from W. Smith, 4 November 1716; BL, Sloane MS 153, 'Chirurgical Observations', Joseph Binns, f. 184v.

these men for advice on their own and their dependants' sicknesses. Thus, in just one collection, the letters received in Sir John's lifetime alone included two, of the 1690s, from 'Your Loving Brother' Robert, another from his brother William, one 'from Drs Clerk & Mitchell' (1717), and one from 'my nephew Dr Clerk' (1721). Together, these provided recipes for 'the childring or any [Mungo?] that askes a purging potione' ('[a]ccor[d]ing to your order'), Sir John's wife, Robert's son, an 'oyntment', and the baronet himself.⁷⁹

Still, having practitioner-relatives did not make the Clerks feel obliged to spurn other sources of medical advice. These familial letters were only one of many resources amassed (both directly and indirectly) from other practitioners and apothecaries, non-practitioner associates, and print. Indeed, Clerk senior also maintained for over thirty years an intimate correspondence, medical and non-medical, with Herman Boerhaave (1668-1738), Leiden's internationally renowned professor and physician.⁸⁰ This was a respect for Boerhaave that was apparently passed on. They came from print and associates, not personal contact, but the Clerk collection of recipes did include recipes ascribed to Boerhaave and which dated, where stated, from after the first baronet's death.⁸¹

⁷⁹ NAS, GD18/2125/29-30, 83, 86-7, Clerk family papers, Medical recipes and prescriptions (1647-1859), Clerks of Pennicuik. This collection is analyzed in chapter six.

⁸⁰ NAS, GD18/5079, GD18/5082, Letters from Herman Boerhaave to Sir John Clerk (1698-1731) and Draft and copy letters from Sir John Clerk to Herman Boerhaave ('with whom since our first acquaintance in 1698 I always kept a correspondence') (early-eighteenth-century).

⁸¹ NAS, GD18/2125/35x, 103, 75, 154, 131, 144, 163, Clerk family papers, Medical recipes and prescriptions, Clerks.

Nor was Clerk alone in maintaining friendships with practitioners.⁸² These could, however, be more face-to-face relationships. Joshua Firth, a mixed practitioner in Yorkshire, was interacting with his medical catchment area as an employer, agricultural retailer, church money- and rent-collector (perhaps as a landowner), and moneylender, with a strong overlap between his medical and non-medical customers.⁸³ Indeed, men of all statuses lived alongside practitioners in the latter's alternative capacities as relatives, employers and owners of leased land (William Sinclair), and members of a tight-knit religious community (the Baptist Richard Kay and perhaps the dissenter Firth), or socialized or corresponded with men who happened to be practitioners.⁸⁴ Even men who, as far as visible, were less interested in medical matters maintained such friendships, and had men to refer to as their 'old friend[s]' who were practitioners.⁸⁵

Whether these friendships came out of a medical relationship, or *vice versa*, is less clear. Thomas Herne reported on the treatment given '(much to my disadvantage as I think appears...)' by '[a] neighbouring Dr of Physick whom I had been well acquainted with at Oxford', but without making it obvious whether it was affection, politeness, chance, or a lack of alternatives, that had led him to consult this physician in particular.⁸⁶ Yet, there is at least evidence that some men felt compelled on the basis of friendship to continue to make use of associates' medical services. Thus, Sir William Clerk was put in a difficult position in the first half of the eighteenth century, 'being very desirous to entertaine a good correspondency with Docter Harvey, who is *his*

⁸² Despite claims that practitioners were as a profession loaded with disrepute, e.g. Roy Porter, 'A touch of danger: The man-midwife as sexual predator', in Roy Porter and G. S. Rousseau (eds.), *Sexual Underworlds of the Enlightenment* (Manchester, 1997), pp. 206-233, esp. 206.

⁸³ BL, Sloane MS 45670, Accompt-book (1727-1738), Joshua Firth, ff. 1-75.

⁸⁴ NAS, GD136/429/1-28, Letters sent to William Sinclair, from tacksman John Bain (1775-1784); CL, MS A. 7. 76, Manuscript diary (1737-1751), Richard Kay; Thomas Turner, ed. David Vaisey, *The Diary of Thomas Turner* (East Hoathly, 1994), p. 41.

⁸⁵ WL, MS 3012, Diary of Alexander James (1752-1812), entry for 25 September 1777.

⁸⁶ BL, Sloane MS 4075, Hans Sloane consultations, ff. 222-223, from Thomas Herne, 8 December 1720.

neighbour, and hath binn his phisician formerly'. Harvey's medicines failing, Clerk sought Sloane's opinion of his prescriptions, 'with all the privacy imaginable'.⁸⁷

At the least, there were many men who sent letters to practitioners from within the medical relationship that show the two to have been associates in the wider world. That is, to have belonged to the same social circle, had common acquaintances, and even socialized together. Some men, for example, used medical letters to send messages to relatives or common associates, addressed their practitioners as 'my very lo[ving] friend', sent 'loving respects to y[ou]r selfe & good wife', or signed off as 'y[ou]r ve[r]y lo[ving] friend'.⁸⁸ Indeed, patients sought to uphold the intimacy based on other associations even when suffering stigmatized diseases. William Gordon maintained a personal, jocular, relationship with his physician in 1783 despite his affliction being venereal disease. Indeed, Gordon had chosen Sinclair despite being so aware of their shared social circle's opinion of such afflictions that he emphasized even to a practitioner the need for discretion.⁸⁹

Part iv: Men's Sick Role

If only at solvent and literate levels, the medical relationship could, it is argued, spill out into the public world. There were at least some men, sharing additional relationships with the experts treating them, who might have felt that it was not only these men's opinions of them, or these men's opinions of them as patients, that were at play. Indeed, the playing out in the social sphere of these additional relationships perhaps increased

⁸⁷ BL, Sloane MS 4034, Hans Sloane consultations, f. 355, unsigned and undated (my emphasis).

⁸⁸ BL, Sloane MS 4076, Hans Sloane consultations, f. 139v, from John Nappere, 3 October 1724; BL, Sloane MS 1393, Medical papers and correspondence (later-seventeenth-century), f. 4, Henry Wilkinson to Dr Henry Power, 26 November 1663.

⁸⁹ NAS, GD136/436/31-33, Letters sent to William Sinclair, from James Gordon, 2-3 February and 1 April 1783.

the likelihood of men's medical relationships, behaviours, decisions and experiences as sufferers being known about in their social worlds, and even in the world at large. The same seems true of the communal ways in which men sought a cure. There is, however, little evidence that, consequently, men's sick time behaviours were stage-managed, or, indeed, a deliberate performance.⁹⁰

The men who wrote to practitioners were not reluctant to admit to succumbing, physically and mentally, to pain. Thus, some freely admitted in the early 1780s to feeling that 'my case is so melancholy that I cannot express' and that 'for all that a man has would not give it in exc[h]ange for his life'. Only a few days after a pain started, another began a letter with '[i]n the utmost distress and Torment' and ended it with 'if you knew with what distress i write ...'.⁹¹ Nor did practitioners expect otherwise. The late-eighteenth-century man who 'showed no signs of pain during the operation' was a curiosity, not an ideal specimen of masculine fortitude or physical invincibility.⁹²

There had, however, been room for the expression of distress even before the heyday of 'sensibility'. While a surgeon noted in an early-eighteenth-century casebook that a seventy-year-old 'being very rebust constitution bore that with abundance of courage w[hi]ch would have killed a grate many stout men', this was not a language repeated in letters written by sick men, their wives, 'friends', or practitioners.⁹³ There is little epistolary evidence of practitioners expecting men to show courage in the face of

⁹⁰ When one man 'cast of all advice' it was a kinsman who persuaded him to consult Sloane, another (Thomas Davison) who sent the case to their relative, a practitioner in London, to forward to Sloane, and Davison to whom the reply was to be relayed (BL, Sloane MS 4075, Hans Sloane consultations, ff. 49-50, Thomas Davison to Ralph Davison, 8 November 1719).

⁹¹ NAS, GD136/436/36, 38, Letters sent to William Sinclair, from George Glen, 30 June 1782, and Ben Henderson, 25 April 1782.

⁹² RCS, MS 0189/1/2, 'Records in Morbid Anatomy', Hunter, no. 51.

⁹³ WL, MS 3631, Medical case-book (c.1714-c.1747), Alexander Morgan, p. 9.

suffering even before the 1700s. Letters to patients did not chastise, or praise, the way that men dealt with pain, and those sent between colleagues never implied criticism. Accounts of the last illnesses of eminent patients were silent in both centuries, never using men's courageous bearing of pain as even a formulaic, or un-gendered, testimonial.⁹⁴ Instead, male suffering sparked sympathy, one physician describing in 1706 how the dying Viscount Hatton was in such 'tortures as would have drawn compassion from the hardest heart'.⁹⁵

Men themselves seemed uninterested in any conclusion that might be drawn from their (in)ability to tolerate pain. Those who did highlight their suffering were not emphasizing their fortitude, pre-empting suspicions of physical or mental weakness, or explaining away outbursts. It was to make a literal description of their symptoms, or to underline their severity, but not in the fear of being seen as valetudinarians (let alone effeminate ones). One or two, in line with their writing style, were silent about the sufferer within the pain-inflected body, but many highlighted the physical and emotional distress that pain was causing them, at the start of the eighteenth century, in the 1780s, and in between. Nor was it only the distance afforded by postal consultations that allowed men to express distress. Wives and relatives knew that patients were suffering but never noted, or felt compelled to report, that men tried to conceal it, or that they bore it well.

Something similar seems true of illness itself. There is no evidence in these collections that even occasional men found it shameful, embarrassing, unmanly or effeminate – or a

⁹⁴ BL, Sloane MS 3984, Letters and papers (seventeenth- to eighteenth-century), Sir Hans Sloane, ff. 282-285, Sir Hans Sloane's account of the last illness of Christopher Monck, 2nd Duke of Albemarle (1687); BL, Sloane MS 1586, Anatomical observations (seventeenth-century), Sir Edmund King, f. 112, postmortem examination of Sir John Howard (1682).

sign of weak character – to succumb to illness, even when this was long-term, immobilizing or confining.⁹⁶ Even where men refused particular diagnoses it was often because of fear, as with Mr Shafto (1728), who ‘does not Care to have it said [tha]t he has any disorder in his head’.⁹⁷ Later in the century (in face-to-face practice), Mr Laughan similarly preferred to blame a partial paralysis on the fall that preceded it, not the brain disease by which his practitioners explained his accident. His friends colluded in this.⁹⁸

If there were men who delayed seeking treatment by denying the fact of sickness this received almost no comment in these letters. A clergyman was exceptional in being described in 1723 as having been ‘very averse’ to seeking help, and it might be that he was an unusually difficult patient (or person) anyway. The practitioner’s first request, to purge him,

was granted, but was obliged to one gentle, least being ruffled by what was strong, he should refuse to repeat it... He refuseth all Chalibeal [sic] medicines, except Spaw Water... it being very different to sute his temper.

Even this patient did not, however, refuse all medicines, or all help. He had an apothecary, who was consulting Sloane at the patient’s request. Nor was it clear that he *had* been hostile in principle to seeking treatment. ‘He hath for some years been

⁹⁵ BL, Sloane MS 4078, Hans Sloane consultations, f. 177, from James Keill, [1706].

⁹⁶ Despite it being, in the seventeenth century at least, ‘widely accepted that women held little control over their bodies, but... a precept of manhood that men should’ (Elizabeth Foyster, *Manhood in Early Modern England. Honour, Sex and Marriage* (Harlow, 1999), p. 41).

⁹⁷ WL, MS 6139/2, Correspondence of James Jurin, from Jacob Johnson, 12 January 1728.

⁹⁸ RCS, MS 0189/1, ‘Cases and observations’, Hunter, no. 27.

Cachexical' (in decline), and this state 'increased upon him gradually, but was not taken notice of by him, until lately, when an Ascites was visible which increasing, convinced him of the necessity of seeking relief'.⁹⁹ Being accustomed to poor health, it might be that he simply failed to note the significance of new symptoms creeping upon him.

Knowing about the attitudes of men whose activities are not recorded in the materials left by the formal medical process is more difficult. Even diarists sufficiently interested to record their every complaint could still be silent about their responses. Samuel Jeake (1652-99) and Norris Purslow (b.1673) were both tradesmen raised as non-conformists who wrote astrological diaries recording the disorders remembered from childhood and the day-to-day complaints of adulthood. However, while Jeake left evidence of his self-treatment and purchase of remedies and services, apparently for future use, Purslow's record of the events of 1673-1737 was generally silent.¹⁰⁰ Of 117 references to Purslow's health, many of them duplicates, just two gave both the illness and its treatment, and two the fact of recovery only, while three named medical procedures but not the reason. Never stating on whose initiative these were used, Purslow recorded neither purchasing medical care nor choosing to not do so.¹⁰¹

What is absent in the consultation letters, however, is reference to men *refusing* to consult practitioners or to take medicines. There are no despairing wives declaring that they were writing in place of husbands who would not seek professional help, or correcting accounts given by men underplaying their afflictions. Similarly, nobody

⁹⁹ BL, Sloane MS 4075, Hans Sloane consultations, f. 53, from S. Dale, 6 December 1723.

¹⁰⁰ Samuel Jeake, ed. Michael Hunter and Annabel Gregory, *An astrological Diary of the Seventeenth Century: Samuel Jeake of Rye, 1652-1699* (Oxford, 1988), pp. 20-21, 50, 56-58; WL, MS 4021, Astrological diary (1673-1737), Norris Purslow.

¹⁰¹ WL, MS 4021, Astrological diary, Purslow. There was an additional statement ('My verry Ill [thi]s year') of unclear meaning.

bemoaned men who had been forced to accept a practitioner but would not *acknowledge* the need for treatment, whether personally, to a practitioner, or socially. What was actually repeatedly emphasized was men's determination to obey 'with... exactness'.¹⁰² The patient who 'would not take advice a whole month from any D[octo]r [and] at last let himselfe blood' was very different from those recorded in consultation letters.¹⁰³

Men insisting that their illness be concealed from their 'friends', or at least underplayed, are also totally absent from these letters. Indeed, this was not a particularly male thing to do. One of the rare examples was that of a married woman, who 'conseal[ed]' her suffering, '[s]ince thence no remedy, and... I wou'd not be thought fancifull, to make me uneasie to others'.¹⁰⁴ Another, in face-to-face practice, actually involved a forty-six year old surgeon. He, in the second half of the eighteenth century,

for 6 years made bloody water, which... he had taken great pains to conceal... For a year before his death, he... was evidently in ill health, but made no complaint, nor did he take any medicinal advice till a month or two before his death, when he had considerable pain... which he wished to persuade his friends was Rheumatism.¹⁰⁵

On the other hand, William Buchanan, recognizing in 1785 that he was 'Nimble full for exercise [sic]', was unique in emphasizing that 'I am far from feinging [sic] or speaking

¹⁰² BL, Sloane MS 4076, Hans Sloane consultations, f. 220, from Christopher Packe, 19 February 1739.

¹⁰³ BL, Sloane MS 1640, Medical observations (seventeenth-century), Sir Edmund King, f. 100.

¹⁰⁴ BL, Sloane MS 4077, Hans Sloane consultations, f. 232, from M. Townshend, 24 July 1721.

¹⁰⁵ RCS, MS 0189/1/2, 'Records in Morbid Anatomy', Hunter, no. 71.

groudlessly'.¹⁰⁶ No men were visibly suspected in these consultation letters of imagining or feigning sickness, or of malingering, or visibly feared this. Nor is the fear of such a suspicion perceptible in the letters that sick men sent to other recipients, whether colleagues and employers, or (often playing on the heartstrings) coveted patrons. Yet such letters also showed no anxiety that being thought sickly might jeopardize men's positions, even though employers and superiors, both prospective and current, did make such judgements.¹⁰⁷ Thus, an accountant was accused of laziness, self-pampering, and 'having besotted himself so that he is in a very indifer[en]t state of hilt', even though this superior knew that 'it is a question whether he will live'.¹⁰⁸ A clergyman similarly complained that 'I have no doubt' of Sandy Gordon's 'being in distress, but suspect there is a good deal of it due to imagination'.¹⁰⁹

Also near totally absent from consultation letters are men who refused to take any medicines, whether in its own right, for being known to need to, or in an assertion of authority.¹¹⁰ One father, suffering from swollen legs, 'wont take any Physick', but if the letter stated why it was in its damaged parts.¹¹¹ Another patient 'declares Against takeing any more' medicines 'without necessity' (1719), but this was far from an assertion of independence, for 'a Line from you will soon overrule his determination'.¹¹² Otherwise, it was particular treatments only that men refused. Viscount Hatton, suffering from a

¹⁰⁶ NAS, GD253/143/6/77/2, Letters sent to John Hope, from William Buchanan, 10 May 1785.

¹⁰⁷ E.g. NAS, RH15/123/65/1-3, Letters from Thomas Ruddiman to Lord Strahallan and James Anderson on appointing a tutor (14 November 1735-11 May 1736). However, when an excise officer in pursuit of patronage claimed to have 'had his books taken... because... disabled from attending his duty by sickness' the story was said to 'not look quite well' (NAS, GD44/43/246, Gordon family correspondence, J. Beattie to James Ross, 9 December 1780).

¹⁰⁸ DUL, BAK, Baker Baker papers, 117b, Mr Lamton to Mr Ward, 24 October 1747.

¹⁰⁹ NAS, CH12/24/312, Bishop Petrie's correspondence, John Allan to Arthur Petrie, 14 September 1778.

¹¹⁰ Although a healthy brother told an ailing sister that 'was Exercise & temperance more in vogue, there wo[ul]d be very little occasion for applying to Doctors & Apothecary's trash which am perswaded do more hurt than good' (NAS, GD237/10/25/4, Correspondence from and relevant to Gilbert Laing, Gilbert Laing to Mrs Elliott, 25 August 1772).

¹¹¹ BL, Sloane MS 4034, Hans Sloane consultations, f. 367, from M. Coke, undated.

urinary suppression, was ‘violent against’ the further use of ass’s milk, but only because he ‘thought’ it to ‘breed phlegm’.¹¹³ Others too had practical reasons, usually past experience, and while stubborn in regard to one method announced themselves eager to use alternatives. A ‘Lord Duke’ was given severe stomach pains by Sloane’s prescriptions but, while he ‘would not have any more’, had ‘nevertheless... taken all’ of them. Even though the purge also ‘made him very Sick’, he continued taking an abundance of other medicines, proposed another purge, and reminded Sloane that certain earlier prescriptions ‘[a]greed very [well?]’.¹¹⁴ No matter what the balance between the status of patient and practitioner, men were not visibly struggling to assert their authority. Indeed, some did the opposite of resisting prescriptions, one being ‘advysed’ to continue his medicines simply because ‘his mind was not satisfied unless he take more’.¹¹⁵ Mr Paterson similarly explained his insistence that Sinclair prescribe for him in person only by the fact that ‘I should be... at a loss with those that had not patience to Bear... my extream Delibrat Way... I think it shall never be at an end, my Wish to commun with you’.¹¹⁶ His need for constant confirmation was not unusual.¹¹⁷

Even needy men were not, however, setting out to emphasize their delicacy. No male patient visibly used physical sensitivity, or an emotional sensitivity to physical distress, as a way of impressing the socially and professionally eminent Sloane and Hope.¹¹⁸ The same was true of men writing to explain absence from occupational duties, while those

¹¹² Ibid., f. 287, from Barbara Calthorpe, 20 September 1729.

¹¹³ BL, Sloane MS 4078, Hans Sloane consultations, ff. 173-172v, from James Keill, 1703.

¹¹⁴ BL, Sloane MS 4051, Letters to Sir Hans Sloane (22 March 1730–31 August 1731), f. 181, unsigned, 3 February 1731, and f. 197, from Caleb Lowdham, 17 February 1731.

¹¹⁵ NAS, GD253/143/6/64/3, Letters sent to John Hope, report on William Bruce, 29 July 1784.

¹¹⁶ NAS, GD136/436/82, Letters sent to William Sinclair, from B.a Paterson, 4 February 1782.

¹¹⁷ BL, Sloane MS 4076, Hans Sloane consultations, f. 44, from Timothy Lovett, 21 February 1722.

¹¹⁸ Despite claims that ‘the way to rise socially was through the nerves’ (G. S. Rousseau, ‘Towards a Semiotics of the Nerve: The Social History of Language in a New Key’, in R. Porter and P. Burke (eds.), *Language, Self, and Society. A Social History of Language II* (Cambridge, 1991), pp. 213-275, quotation at p. 227).

seeking patronage or intermission in appointments, often emotively, had other reasons for emphasizing delicacy. Those desiring a 'more genteel Post more consistent with my health' (1774) chose to appeal to emphatically practical considerations when emphasizing that the 'fateague of cold nights and late hours' were not 'adapted to a tender constitution', even when claiming simultaneously to be '[o]ne that dispises a mean action and discharges his trust with honour'.¹¹⁹

Significantly, therefore, it was apparently acceptable across the first nine decades of the eighteenth century for men to express anxiety and fear about their health.¹²⁰ The absence of indications of age prevents the firm conclusion that this was possible for *all* males. However, it was not only those men benefitting from the concessions allowed of the aged who vocalized anxiety and fear, and who did so without needing to claim that these were themselves the product of some physical process. Certainly, numerous men could write of being 'newly alarmd', and practitioners report that figures as eminent as Horace Walpole were 'more apprehensive & cast down than I could account for from... his disease'.¹²¹

Nor were practitioners, *or associates*, critical, even privately, of anxious sick men, even those who allowed anxieties about other areas of life to impinge upon the body.¹²² An elderly man of the cloth was able to tell his colleagues in the 1780s that it was seeing himself described as 'on the verge of a second childhood' that had thrown him into an

¹¹⁹ NAS, GD248/353/1/4, GD248/226/4/75-76, Grant correspondence, Richard Falconer to Hugh McVeagh, 9 November 1772, 30 May 1774 and 11 July 1774.

¹²⁰ However, for apparent limitations to what men could, or did, express anxiety about in regards even to the body itself see above, p. 122.

¹²¹ BL, Sloane MS 4076, Hans Sloane consultations, f. 183, from Paul Orchard, undated; BL, Sloane MS 4077, Hans Sloane consultations, f. 136, Robert Wyntle, on Horace, first Baron Walpole, 8 January 1725.

¹²² RCS, MS 0189/1, 'Cases and observations', Hunter, 'Case of M.rs [sic] Chaf-y' (unnumbered).

apoplectic-like state, without being censured.¹²³ However, a presumably much younger man, one still terrified of disappointing his parents, was also able to announce that he had been cast into a ‘deep’, debilitating, ‘melancholy’ by a matter that even he saw ‘the absurdity of’.¹²⁴ Practitioners similarly failed to pass judgement, even with a later-eighteenth-century patient ‘of very humane feelings capable of being affected with the misfortunes of life’, whose ‘great lowness, sinkings, oppressions’ and sense of ‘dying’ ‘increase[d] upon him with his misfortunes’.¹²⁵

There is very occasional evidence of practitioners warning men against fear, but not because it was unbecoming to men. Nor did they use a potential societal association with effeminacy as the likeliest means of enticing men away. Thus, it was the physical consequences of this mental state that one man was warned of in 1689, and for which reason patients were thought to benefit from the power of ‘[h]ope though Irratinal & ill-grounded’.¹²⁶ There is no evidence even in the seventeenth century of practitioners condemning men who showed fear, or advising against letting it be seen, or of men feeling a self-imposed pressure. Indeed, there is no hint here of patients being at any time aware of any societal demand that males be (strong, robust, courageous) *men*, or of this affecting their experience of sickness.

Conclusion

¹²³ NAS, CH12/24/400, Bishop Petrie's correspondence, Robert Kilgaur to Arthur Petrie, 24 May 1782.

¹²⁴ NAS, GD427/226/23, Papers of the Gillanders family, L. Mackenzie to John Downie, late-eighteenth-century.

¹²⁵ RCS, MS 0189/1/2, ‘Records in Morbid Anatomy’, Hunter, no. 6. This was, however, part of a retrospective medical history, given to accompany a curious case and the resultant morbid anatomy, and with Hunter apparently interested in the patient's sensitivity as a potential explanatory factor. That many case records and case histories, both printed and manuscript, were silent about patient fears might, therefore, indicate that these were recorded by practitioners only when deemed to have physical effects, or blamed for the interruption of treatment (above, p. 120).

¹²⁶ BL, Sloane MS 4062, Seventeenth-century medical correspondence, f. 209, Leonard Plu[n]kenet[t] to unnamed male, 15 October 1689. Printed warnings did the same (Todd, *School-boy*, pp. 22-24).

Historians have discussed how early modern *female* bodies were not always beyond the knowledge, or touch, of others. Women were not, however, alone even in being made to literally unveil their bodies, and in being made to do so because of sexual or reproductive suspicion. Public accusations of sexual assault and private claims of impotence could similarly force the exposure of the male genitals to the literal scrutiny of practitioners and, for those of sufficient fame or notoriety, to the subsequent attentions of the reading public.¹²⁷ Age and status, furthermore, offered no protection. Accused in Star Chamber in 1638 of sexual assault, Sir Edward Seabright (b. [1585?]) had similarly had to endure being examined by practitioners searching for evidence of venereal disease.¹²⁸

It was not, however, only in criminal circumstances that men were required to unveil to outside scrutiny what in the 1780s some were still calling their ‘Privet Pairs’.¹²⁹ One man was forced in 1722 to give bodily proof that he did not have, and would not produce offspring with, venereal disease. The resultant draft certificate confirmed that

Upon viewing the ~~small~~ humours [M?].r Van hath under his chin
wee are of opinion that they are not of an infectious nature, nor...
any way likely to hinder his having children or to infect... his

¹²⁷ The proceedings and depositions (including medical examinations) of those cases brought against Robert Devereux, 3rd Earl of Essex (1591-1646) and Edward Weld (in 1730-1732) were published in full in multiple editions, with extracts or abbreviated versions also included in anthologies of notorious and sexual legal cases, both soon after and in subsequent years. See, for example, George Abbot, *The case of impotency as debated in England, in that remarkable tryal an. 1613. between Robert, Earl of Essex, and the Lady Frances Howard... In two volumes* ([1715]); Catherine Weld, *The whole of the proceedings... between the Hon. Mrs. Catherine Weld, daughter to the Lord Aston, and Edward Weld...* (1732).

¹²⁸ BL, Hargrave MS 404, Reports of Cases in the Star-Chamber. A. D. 1638, f. 75v. I am grateful to Chris Brooks for this reference.

¹²⁹ See, for example, Old Bailey Proceedings Online (www.oldbaileyonline.org, version 6.0, viewed 20 March 2011), 21 April 1680, trial of William Harding (t16800421-5); 27 April 1715, trial of Hugh Leeson and Sarah Blandford (t17150427-43). Quotation from NAS, GD136/436/79, Letters sent to William Sinclair, from George Miller, 26 January 1783.

posterity.

Sloane had similarly attested in 1708 that

Having... carefully Look'd upon the body of S[i]r James Ashe,
Bart whom I have known severall years... [I] saw no Symptom...
upon him of his having the pocks ~~or~~ French disease or any other
infectious distemper.¹³⁰

In neither case is it clear whether the ultimate source of contention was suspected sexual misbehaviour, the possession of an allegedly shameful and stigmatized disease, or the known likelihood of both its transmission to a spouse and either impaired fertility or diseased progeny. Derived from practitioners' case notes, the findings of chapter 3 suggested that venereal disease very rarely brought the risk of long-term impediments to erection, threatened the loss of the penis only in exceptional circumstances, and never resulted in the destruction of the testicles. Practitioners, furthermore, left no record of issuing warnings about the potential infection of wives and future children.¹³¹ These certificates, however, raise the possibility that there might have been at least some wives, actual or prospective, who were highly alert to the potential congenital and spousal repercussions of male venereal disease, or at least some men who imagined that women might be.

¹³⁰ BL, Sloane MS 4078, Hans Sloane consultations, ff. 306, 308, draft certificates, 27 February 1708 and 13 November 1722.

¹³¹ Above, pp. 81, 84-86, 98, 109-110, 119.

The exact spousal concern that led Ashe (1674-1733), 2nd Baronet, to seek Sloane's examination is not clear. It was, however, known by a contemporary letter-writer that Lady Ashe had left him the year before, after he 'transgressed and went astray'.¹³² '[A]ll the world beside this town' being 'full of nothing' else, it knew of James's sister having 'offered her five hundred pounds att the Birth of her next childe' (perhaps because this only son was without a male heir), of other familial efforts to have sexual relations restored, and of every literal movement in Lady Ashe's eventual departure.¹³³ Vitally, it also knew that 'never man humbled himself more than he did to her made her all the fair promises immagenable and to pleas her was fflacksed' – fluxed, the often (although not always) highly unpleasant treatment for venereal disease – 'although the Doctkers said thear was no reason for it'.¹³⁴ Evidently, even in non-criminal circumstances, and even in private, marital concerns, men's bodies, what they did to their bodies, and why they did so, could be public knowledge.

It was not, however, only in sexual and reproductive circumstances that practitioners passed on formally information on men's health. As illness impinged upon men's capacities as workers, heads of households, and makers of wills and other legal contracts, Sloane, for example, gave information about men's states of health – mental and physical – in a range of personal, professional and penal circumstances, and for various audiences, including courtrooms.¹³⁵ Many of these were spheres in which *other*

¹³² D. H. Simpson, *Twickenham Society in Queen Anne's Reign from the Letters of Isabella Wentworth* (1976), p. 13. This letter is not amongst those in BL, Additional MS 22226, Letters of Isabella, Lady Wentworth, to Thomas Wentworth, Earl of Strafford, (1711), in Letters of Anne, Countess of Strafford, to Thomas Wentworth (1711-1736), ff. 34, 72, 80, 214 b, 299b, or the collection below.

¹³³ BL, Additional MS 22225, Letters of Isabella, Lady Wentworth, to Thomas Wentworth, Earl of Strafford (1707-1729), f. 28, 28 August 1707.

¹³⁴ Simpson, *Twickenham*, p. 13.

¹³⁵ BL, Sloane MS 4078, Hans Sloane consultations, ff. 77, 78, 85, 303, 312, 356, 379, medical certificates, depositions and draft certificates, undated and March 1695-August 1731.

participants had reason to see men's bad health as mattering beyond the issue of their own, physical, welfare, and as needing to be made more than private knowledge.

Usually, therefore, men (and women) knew about other men's diseases, collecting their prescriptions in recipe compilations or informing practitioners that 'North continues... better & better, he tells me that' the statesman Sir Robert Walpole (still alive at the time) 'was y[ou]r patient in a Case... like mine', or that their afflictions were, they 'suppose[d]', 'similar to that M.r W[illia]m Innes laboured under'.¹³⁶ Yet, the knowledge that others were able to obtain was usually the product of an interest very different to that interrogative, suspicious, interest in the female (reproductive) body uncovered by historians.¹³⁷ As many sufferers broadcasted their bodily problems to the world, or saw others do this, men's bodies – and men's illnesses, medical care, and states of health – could literally be public knowledge.¹³⁸ Financial independence and the gendered distribution of autonomy did not automatically equate to medical autonomy or medical privacy, or to the desire for these.

It was not, however, only in the need to access help that men allowed their health to be known about. News of health, good and bad, was exchanged so habitually that even in professional relationships it was a perceived slight to not participate.¹³⁹ In the 1770s, for

¹³⁶ BL, Sloane MS 4034, Hans Sloane consultations, f. 305, from Timothy Carter, 7 November 1734; NAS, GD136/436/152, Letters sent to William Sinclair, from William Young, 7 November 1782.

¹³⁷ E.g. Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven, CT, 2003).

¹³⁸ E.g. the printed dispute prompted by the death of Sir Robert Walpole (1676-1745), started by John Ranby, *A narrative of the last illness of... the Earl of Orford...* (1745). Practitioners published their own cases in books advising particular therapeutic courses, or made their experiences public as curiosities (e.g. BL, Sloane MS 1968, Letters and papers of Dr John Gaspar Schengen and Sir Hans Sloane, p. 202, 'A Breif Narrative of the Shott of Dr Rob[er]t Fielding with a muskett bullet...' (eighteenth-century), printed as Robert Fielding, 'An Account of a Musket Bullet, and the strange Manner of its coming out...', in Royal Society, *Medical essays and observations...*, vol. 1 of 2 (1745), pp. 449-450.

¹³⁹ NAS, GD136/435/88, Letters sent to William Sinclair, from John Grant, 30 September 1792; NAS, CH12/23/837, Bishop Alexander's letters, David Gathrie to John Alexander, 16 November 1753,

example, George Innes, cashier at the Royal Bank of Scotland and deputy receiver general, routinely exchanged news of health and ill-health in even the most mundane business transactions.¹⁴⁰ Ill health also gave Innes and his co-cashier an additional, more intimate, relationship as fellow-sufferers.¹⁴¹ With men not compartmentalizing their associates, or discourses, involvement in those professional worlds closed to women at the social levels recorded here resulted in male-only relationships that provided men with yet another avenue for medical assistance. In return, they willingly provided even men known to them solely in a professional capacity, or friends of colleagues, with the fruits of their own experiences.¹⁴²

Sickness and sick-time behaviours were, therefore, played out in the public sphere, yet it is difficult to see either gendered ideals or gendered social positions consequently shaping men's roles, anxieties, decisions, or self-representations, as patients. At the social levels represented here, the gendered values circulating in society did not create a distinctive male sick role, let alone a normatively *masculine* one. Nor did they visibly influence the sick man's fashioning or self-fashioning outside of the patient-practitioner dialogue and for the eyes of the world. Indeed, while the experience and resolution of sickness was managed, by multiple parties, it was not itself a stage-managed performance.

mentioning how 'I hope you are... perfectly recovered of your Tooth-ache; which... is as severe a trial of human patience, as any distress I ever experienced...'

¹⁴⁰ E.g. NAS, GD113/3/818/2, Papers of George Innes, Charles McDowall to George Innes, 15 August 1776.

¹⁴¹ NAS, GD113/3/818/6, Papers of George Innes, John Campbell to George Innes, 22 August 1776.

¹⁴² James Graham (1682-1742), first Duke of Montrose, honorary member of the Royal College of Surgeons of Edinburgh, stepped in when a friend of his London-based political ally was taken ill (NAS, GD220/5/299, GD220/6/1743/5, Correspondence of the Dukes of Montrose, James, first Duke of Montrose to George Baillie, 17 February 1713, and the diploma appointing Montrose an honorary member, 22 April 1707).

Nor, furthermore, did the elevation of paternal provisioning, the association of bodily disorder with womankind and feminine character flaws, or an elevation of male and masculine fortitude, robustness and physical strength, all of which prevailed, in various genres, across the two centuries.¹⁴³ Certainly, these did not visibly make interruptions to the male social role of familial provisioning shameful. Instead, the epistolary evidence suggests that men's sick role and their sick-time identities, relationships and experiences were free of gendered anxieties, pressures and needs, and of anxieties, pressures and needs concerning gendered image.

Combined, therefore, these findings lead to several observations about the great freedom allowed to men and youths in their dually social and medical response to sickness. Men were able to very publicly experience bodily (and even deep and constitutional) disorderliness, to reveal themselves as suffering emotionally because of physical pain, and to do so as a means of benefitting from the social assistance that this invited. Certainly, men made extensive use of those social resources that were so valued a tool for the resolution of health problems, and without having cause to visibly fear that this brought into question their male autonomy or masculine stoicism. They were, consequently, able to take full advantage of both socially-held knowledge and social networks, and, indeed, to reap the benefits of unprompted – and sometimes unknown – social, familial and filial interference. They were, furthermore, able to do this without needing to subsequently reassert their independence inside of the patient-practitioner relationship, and in a way that might have disrupted recovery. Indeed, the benevolent and enthusiastically charitable social response that greeted sick men, and the willingness of 'friends' to violate without invitation men's autonomy of both decision-making and

¹⁴³ Alexandra Shepard, *Meanings of Manhood in Early Modern Manhood* (Oxford, 2003) pp. 186-187;

financial control, suggests that the bipolar opposition of independence and dependence by which society ostensibly distinguished between men and women (or youths), and the masculine and unmasculine, was open to context-dependent relaxation.

Equally significantly, and as revealed in familial responses to sickness, it was far from inevitable that age or gender, or the associated stereotypes, would have consequences for the personal and social experiences, and fates, of sick males, in uniform ways for each age group, and in different ways at different life stages. Evidently, and whether as a position in the gendered 'patriarchal' structure or as a societal code of masculine behaviour, autonomy might have been less consequential for sick men than could be expected. Youth and financial dependence did not deny young men agency in (and control over) their medical care, and intervention was not automatically stopped by legal maturity, financial independence, and 'the age of manhood'.

Joanne Bailey, 'Masculinity and fatherhood in England c.1760-1830', from a forthcoming work; George Savile, Marquis of Halifax, *Advice to a daughter...* ([London], 1699), pp. 26-27.

Chapter 8: Conclusion

As chapter 2 revealed, English and Scottish medical authors could and did gender the male body in both the seventeenth and eighteenth centuries. They could also, and often did, imagine a gendered self within this body. While Thomas Laqueur claimed that medicine was increasingly abandoning the gendered body in favour of anatomical sex, in 1780, as in the mid-seventeenth century, medical publishing of a whole host of genres, styles, and authorial types was helping to establish prerequisites for being accepted not only as male but also as masculine, or as a man.¹

Consequently, for the male, medical print offers a very different picture to that pre-1780, “short-eighteenth-century”, English mentality described by Dror Wahrman. There is little suggestion in even mid-seventeenth-century medical publishing of a conceptual world with no expectation that the individual’s gender would or should correlate to his or her sex, no notion of sex and the body being responsible for the gendering of the mind and character, and consequently no notice taken of external bodily markers of gender (femininity or masculinity) and of gender identity (whether the person was a man or a woman).² In medical publishing, therefore, the body and gender were tied together long before 1780, and gender – and, indeed, gendered social roles, the gendered self, and gendered identity – given bodily makers and natural to, and explained by, sex.³

¹ Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA, 1990).

² Contrary to the claims of Dror Wahrman, *The Making of the Modern Self. Identity and Culture in Eighteenth-Century England* (London and New Haven, 2006), pp. 42-44, 73-76.

³ Despite claims that it was only after that alleged late-eighteenth-century invention of anatomical sex identified by Laqueur that ‘[b]oth body and mind were now sexed’ (John Tosh, ‘Gentlemanly Politeness and Manly Simplicity in Victorian England’, *Transactions of the Royal Historical Society*, 12 (2002), pp. 455-472, quotation at pp. 464-465). For Wahrman, the tying of sex and gender became the dominant stance only as the consequence of a shift beginning at ‘about 1780’ and affecting ideas about identity and selfhood much more broadly (ibid., p. 74). Quotations from ibid., pp. 44, 48.

In the eighteenth century as much as in the seventeenth there were, therefore, medical mind-frames in which a gendered character was being physically rooted in, and made a product of, the male body. There was also great consistency, across both sides of 1700, in the ascribed qualities of these physical, psychological and social masculine characters. Indeed, some of the eighteenth-century mind-frames that naturalized gendered identity were visible continuations of approaches, discourses or themes already existing in the 1600s. Others, such as the new nerve-based physiology, took seemingly novel approaches to the human body, but inscribed gender into the male form through essentially humoral principles, or by using associations, languages and properties also attached to men and masculinity in early modern medicine.

The humoral foundations that underlay early modern medical notions of the male and female did not, therefore, automatically end with the seventeenth century. Even self-consciously modern eighteenth-century medical dialogues were expressing expectations about embodied gender through a traditional language of connotations already in use in the seventeenth century (and earlier) – one of male and masculine strength, robustness and courage (and sometimes reason), established in opposition to that weakness, sedentary living and sickliness (and sometimes irrationality) cast as female and effeminate.⁴ Indeed, and although this is not visible in the small number of consultation letters about onanism (masturbation) in chapter 3, eighteenth-century European discussions of the onanist were allegedly likewise predicated on that presumption of male bodily leanness and hardness, ‘self-control’, and constitutional orderliness, and its female and feminine opposites, also highlighted by historians of early modern gender.⁵

⁴ Above, pp. 48, 52-53, 64-67.

⁵ Michael Stolberg, ‘An Unmanly Vice: Self-Pollution, Anxiety, and the Body in the Eighteenth Century’, *Social History of Medicine*, 13, 1 (2003), pp. 1-22, esp. 9-11; Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven, CT, 2003), pp. 23-25.

Consequently, while ‘erotic representations of male bodies’ were ‘susceptible to the tides of contemporary developments’, it seems possible that elements of medical publishing showed great continuity across the period 1640-1780 in their approaches towards, and expectations of, the male and men.⁶ Indeed, medical writers apparently maintained a fundamentally similar set of long-established assumptions about proper and improper, or natural and unnatural, male social roles in both centuries. Yet, while there were many medical writers confident that this gendered division – or at least the principle of it – remained secure, there were also others expressing anxiety about men’s performance of their proper gender roles long before that post-1775 perceived ‘crisis’ of identity identified by Wahrman.⁷

At the end of the early modern period and across the eighteenth century alike, medical publishing was, therefore, supporting and propagating gendered anxieties and ideals that *could* have made the male corporeal body, its masculine exteriority (and presumed interiority), and its state of health a necessary testing ground of masculinity of both body and self. That this study has found that, on the contrary, men of both centuries apparently experienced, and prepared for, illness as an almost purely bodily and physical phenomenon, albeit one inviting various social interactions in its resolution, is, therefore, highly significant.

Certainly, the existence of such bodily-oriented codes of masculinity did not make illness a peculiarly negative or anxious experience for men. Indeed, men’s use of paid and institutional medical care was seemingly unrestrained by gendered fears and values

of any kind, in either century. As chapter 7 proposed, primarily for the eighteenth century but with occasional seventeenth-century examples, a masculine status ostensibly predicated on independence was sufficiently secure as to encounter no threat from subjection to the authority and superior expertise of the medical professional, or to intervening wives, associates (of either gender) or offspring. In men's ability to accept, and to seek out, help in caring for the sick body, this chapter's findings similarly raise the possibility that the dichotomy of masculine independence and feminine reliance was not expected to be inscribed in every action, to ill men's detriment.⁸ Thus, sick men made a very visible use and pursuit of familial, social and professional help, unhindered by the existence of a bipolar opposition of masculine strength, independence and resilience, and feminine dependence, and without having any gendered sickness role thrust upon them. Certainly, their eighteenth-, and occasional later seventeenth-, century consultation letters show that men were able to be carefully obedient and placatory patients, and to emphasize this to practitioners in the desire for good will.

Furthermore, it also appears likely that in both centuries men knew that they would be able to avail themselves of professional care without this entailing being told that they or their bodies had been found inadequate on sexed or gendered terms. Practitioners were not, it appears, inadvertently encouraging insecurity about masculinity to become a barrier to men's exploitation of paid and institutional medical services in the seventeenth century. Nor, however, did they visibly begin to do so in the mid- and later-

⁶ Quotation from Karen Harvey, *Reading Sex in the Eighteenth Century: Bodies and Gender in English Erotic Culture* (Cambridge and New York, 2004), p. 145.

⁷ Above, pp. 64-65; Laqueur, *Making Sex*, p. 22; Wahrman, *Modern Self*, pp. 220, 47-48.

⁸ Contrary to claims that masculinity 'must be perpetually achieved, asserted and renegotiated' (John Tosh and Michael Roper, 'Introduction: historians and the politics of masculinity', in idem. (eds.), *Manful Assertions: Masculinities in Britain since 1800* (London and New York, 1991), pp. 10-24, quotation at p. 18, cited in Michèle Cohen, *Fashioning Masculinity: National identity and language in the eighteenth century* (London and New York, 1996), p.8).

eighteenth century, even when (English) observers were allegedly highly alert to a perceived process of physical effeminization.⁹

Certainly, manuscript case histories and the correspondence exchanged between medical colleagues suggest that men were being not assessed even privately in their behaviour as patients, their ability to physically and mentally endure pain,¹⁰ or their sick bodies, through those gendered norms of courage, strength and robustness, or embodied ‘virility’, that some members of their profession were elevating in print (as discussed in chapter 2). Indeed, the apparent honesty with which laymen considered and addressed the underlying state of the body in the self-authored consultation letters included in chapter 4 reveals that sick men themselves approached the body natural to them in a neutral, value-free, way, and assumed that practitioners would do the same, both for the whole forty year period between c.1700 and c.1740 and in the early 1780s.

Practitioners and male patients apparently had, therefore, the flexibility to discard those ideals of the male and masculine body, and of the man within this body, that some members of the medical world were elevating in print. In particular, the contents of those eighteenth-century surgical publications and manuscript surgeons’ notes examined in chapter 3 suggest that men with genital or sexual problems were free of the daunting prospect of consulting surgeons who would vocalize occasional textual beliefs that manliness was to be defined by unquestioned potency and fertility, or the unimpaired genitals. That lack of interest in his patients’ probable reproductive and sexual fortunes

⁹ Tim Hitchcock and Michèle Cohen, ‘Introduction’, in idem. (eds.), *English Masculinities 1660-1800* (London and New York, 1999), pp. 1-22, esp. 8.

¹⁰ Above, pp. 291-292.

implied in Joseph Binns's comprehensive surgical records (c.1633-c.1663) suggests, furthermore, that this was already true in the seventeenth century.¹¹

Certainly, the printed or manuscript case notes sampled in chapter 3 imply that men with genital or sexual problems would not have been obstructed from making use of formal medical care by the expectation of unwelcome, but perhaps anticipated, comment on their maleness or masculinity. This source base gives no indication as to whether or not laymen were, in either century, assessing themselves by that early modern concept of 'virility' that in medical writing persisted into and throughout the eighteenth century.¹² If they were, however, a sufficient number with venereal disease or with afflictions in or of the genitals sought recorded treatment from respectable, mainstream, practitioners in the seventeenth century to suggest that it was not to the detriment of their willingness to acknowledge and seek out confirmation of their problems. Indeed, they continued to do so in the 1700s despite that increasing premium allegedly placed on male sexual substances and desire.¹³ In neither century, therefore, were men with genital problems or venereal disease confined, whether by shame, stigma, or the fear of professional hostility, to self-treatment or but the most irregular of practitioners and medical retailers. Instead, and across the social hierarchy, they felt able to approach surgeons, general practitioners, and even physicians, of all levels of professional repute.

Indeed, and more generally, these findings also suggest that men of both centuries were free to seek medical assistance without the risk of thereby inviting professional

¹¹ At a time when male sexual failure was allegedly a great source of masculine stigma and fear (Elizabeth Foyster, *Manhood in Early Modern England. Honour, Sex and Marriage* (Harlow, 1999), p. 211).

¹² See above, pp. 70-71.

comment upon their lives and morals. As chapter 5 noted, male patients do not seem to have had to routinely struggle against the injustice – and the barriers to an effective cure – that would have occurred had practitioners had a routine tendency to automatically suspect men of imprudent lifestyle choices. Indeed, even the tone used in mid- and later-eighteenth-century clinical lectures to describe the men in receipt of hospital care, and even when such men were very young, was remarkably objective. Practitioners were not, it seems, projecting moral judgements based on gender, age and social-status upon the individual male patient. Indeed, the patient-practitioner relationship, as accessible through case histories, resisted any hardening of attitudes towards venereal disease, or in relation to masculine drinking and honour-related violence, that attended the transition from late-seventeenth- to eighteenth-century moral codes.¹⁴

The experience of having a body, and one prone to physical disruption, was not, however, confined to the patient-practitioner relationship. Yet, the social experience of being a man with a physical body experiencing health and illness was similarly free of masculine anxiety, despite its very public nature. Consequently, while the juxtaposition of male bodily self-control with womankind's disorderly sickliness allegedly bore heavily on the early modern female social experience, in 1640-1700 it was not visibly repressive for adult males, at least in the realm of health good and bad.¹⁵ It seems from the sample of prescriptive literature in chapter 6 that masculine society preferred in both centuries to keep the principle of male bodily orderliness and self-control, as it applied

¹³ Tim Hitchcock, *English Sexualities, 1700-1800* (Houndmills, 1997), p. 48.

¹⁴ See R. A. Zimbaro, 'Satiric Representation of Venereal Disease. The Restoration versus the Eighteenth Century Model', in Linda E. Merians (ed.), *The Secret Malady. Venereal Disease in Eighteenth-Century Britain and France* (Kentucky, 1996), pp.183-195, esp. 183-189; G. J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago and London, 1992), pp. 37-103.

¹⁵ C.f. Anthony Fletcher, *Gender, Sex and Subordination in England, 1500-1800* (London and New Haven, 1995), pp. 61-77.

to men, a notional ideal, one ultimately satisfied by the absence of that physical disorderliness ascribed to the sexed and gendered female anatomy.¹⁶ Certainly, chapter 6's analysis of the contents, and purposes, of laymen's manuscript medical productions suggests that in the seventeenth century men's reactions to their bodies as sites of health and sickness were already unaffected by fears about male physical distance from the female.¹⁷

As others have demonstrated, the association of 'manliness' with a duality of physical 'vigour' and 'decisiveness, and courage and endurance' both predated 1640 and survived long after 1800.¹⁸ Furthermore, and as chapter 2 argued, in the eighteenth as much as the seventeenth century medical authors had the option of making not only these physical and psychological characteristics but also the masculine beard, deep voice and robust build, and, indeed, men's laborious, outdoors, gendered social role, mutually confirming, shared products of a single cause or source, and, ultimately, mutual proofs. Yet, if laymen believed, or feared, that their masculine robustness of body might be taken as revealing their masculinity of mind, they were still able to vocalize physical fragility and disorder. As the self-authored accounts analyzed in chapter 4 reveal, men of the first half of the eighteenth century apparently allowed themselves full freedom to engage in the close, honest, self-examination of the body and its natural weaknesses, vulnerabilities and failings, and to articulate what they felt to be the truth of their cases in the pursuit of effective treatment.

¹⁶ For this male ideal see *ibid.*, pp. 48, 63-8.

¹⁷ Fears discussed for the seventeenth century in Mark Breitenberg, *Anxious Masculinity in Early Modern England* (Cambridge and New York, 1996), pp. 31, 47-48, 51.

¹⁸ Quotation from Tosh, 'Gentlemanly Politeness', p. 460.

This honesty and openness was not, however, limited to men's dealings with medical professionals. In both centuries, men freely discussed with 'friends' their encounters with illness past and present, and did so in order to pursue (or to offer) emotional support, a cure, or practical help during incapacity.¹⁹ In so doing, and as the manuscript medical compilations in chapter 6 suggest, both as individuals and as a gender men could and did take responsibility for their health, assuming this responsibility even before illness struck, and performing it in multiple ways, only one of which was the purchase of paid treatment. Indeed, individually and as a gender group men were able to make at least *preparations* for the recovery of health through domestic medical care, and, significantly, to do so with little or no involvement from women. Indeed, they retained this ability even in the rise of stereotypes of foppery, with eighteenth-century men evidently still capable of choosing to accept responsibility for their health, and to do so rather than depending on women to take illness-related precautions on their behalf. As chapter 6 suggests, there was perhaps an extensive number of laymen involved in the development, exchange, and preservation of this practical medical knowledge. Men's resultant, visible, ability to derive much of this information from apparently male-male lines of transmission argues, therefore, that eighteenth-century male participation did not have cause to be interpreted, and stigmatized, as proving a 'predilection for the company of women', which 'qualifies [one] as a fop'. Certainly, it could apparently be, for men, a very homosocial activity.²⁰

It is also significant that in order to thus prepare themselves for sickness men were able to make public the knowledge of their anticipating bodily problems, having previously succumbed to illness, and, indeed, having both needed to assist the body in its recovery

¹⁹ Even though the association of femininity with sickliness, and this with womankind's stereotyped flaws

and been reliant on the help of others to achieve this. They were, furthermore, already doing so in the seventeenth century, at a time when ‘manhood’ allegedly placed a great premium on visible bodily control but alternative, supplementary, ideals that made a virtue of physical delicacy were still to emerge.²¹ Indeed, both at the end of the early modern period and across the first three quarters of the eighteenth century there were literate men able to use their own experiences of sickness as the social currency by which to access the potentially useful past experiences of others, and of others who, apparently by choice, were perhaps sometimes primarily men.

Consequently, men’s bodies were far from a private matter and something to be experienced secretly. Indeed, the lines of frequently male-male transmission and exchange recorded in these manuscript recipe collections suggest a social experience very different to that masculine competitiveness surrounding, in the early modern period at least, certain other elements of the male body.²² They argue, furthermore, that, as anticipated sites of sickness, seventeenth-century men’s bodies were already operating as a focal point for acts of sociability capable of stretching across the genders, although perhaps sometimes by choice homosocial. A century before the mid-eighteenth-century emergence of a ‘cult of sensibility’, the male body and its health were, this argues, already a site in which men (and women) could express that mutual ‘compassion for the sentiments of others’ that would allegedly come to characterize this later, sensitive, fashion.²³

and restricted social role, survived across the period (Cohen, *Fashioning*, pp. 80-81).

²⁰ Ibid., pp. 37-38.

²¹ Foyster, *Manhood*, pp. 40-41.

²² See below, p. 320.

²³ Quotations from Elizabeth Foyster, ‘Creating a veil of silence? Politeness and marital violence in the English household’, *Transactions of the Royal Historical Society*, 12 (2002), pp. 395-415,

In polite society, therefore, men's bodies predated 'politeness' and 'sensitivity' as sites of easy sociability and empathy, not only during times of illness but also in their known vulnerability to health problems more broadly.²⁴ Furthermore, the discourses surrounding such bodies were already displaying in the seventeenth century some of those ideals that facets of 'politeness' celebrated yet failed to achieve or were increasingly suspected of distorting.²⁵ Certainly, the social dialogues and networks by which men were able to equip themselves to cure the sick body crossed the boundaries not only of gender but of status too.

Indeed, at no point do those networks by which men accessed and made use of professional help during times of actual sickness, as studied primarily for the eighteenth century in chapter 7, appear to have pre-empted or echoed 'politeness' by becoming socially exclusionary. Nor, furthermore, does this seem to have occurred, in either century, in the social discourses that produced men's manuscript recipe books. On the contrary, male compilers remained able to access the potentially useful medical knowledge associated with, or even derived personally from, deemed inferiors, and to uphold the medical functions of this discourse above the ends of social advancement.²⁶ Indeed, in the social groups and types of conversation visible here, this openness was itself achieved without any threat to the benevolent functions of these two dialogues, and without their becoming visibly voyeuristic or accusatory. With the conventions of the social discourses that surrounded men's bodies as sites of health and sickness

quotation at p. 402; Barker-Benfield, *Culture of Sensibility*, pp. xix, xvii.

²⁴ 'Politeness' is approached here in a broad sense, as 'a new code... in which outward civilities could be read as the manifestation of inner social virtues' (Philip Carter, 'Polite "Persons": Character, Biography and the Gentleman', *Transactions of the Royal Historical Society*, 12 (2002), pp. 333-354, quotation at p. 333).

²⁵ *Ibid.*, pp. 335-336, 345-378.

²⁶ C.f. Paul Langford, 'The Uses of Eighteenth-Century Politeness', *Transactions of the Royal Historical Society*, 12 (2002), pp. 311-331, esp. 314-315.

seemingly sufficiently established and respected to remain independent of the discursive restrictions that eighteenth-century 'politeness' introduced elsewhere, they also retained their separation from the resultant reactive 'morbid fascination' with 'impolite behaviour'.²⁷

Possessing certain 'polite' principles independently of, and prior to, 'politeness', the relationships that men were able to utilize in order to respond to sick and failing bodies also seem to have escaped anxieties of the kind that had come to surround this fashion by the later-eighteenth century. Men of both centuries seem, for example, to have been free of suspicions of an artificial and self-serving attention to their health that might have limited their ability to benefit from offers of assistance and support during sickness.²⁸ On the other hand, while the 1774 publication of the 4th Earl of Chesterfield's didactic letters raised concern about the sincerity of the relationship between 'inner and outer refinement' and virtue, these manuscript materials suggest that if there ever was any notion that the condition of the flesh somehow revealed that of the internal man – and they give no evidence that it did – the most corporeal elements of this mirror, or their reliability, were far from a site of individual, masculine, or social anxiety.²⁹

The picture is, consequently, one of significant continuity. While Alexandra Shepard explained the semblance of a later-seventeenth-century transformation in 'the available repertoire of male identities' by our 'not comparing like with like', the men considered

²⁷ Quotation from Foyster, 'Veil', p. 400.

²⁸ In contrast to longstanding 'objections to the artificiality inherent in polite manners' (Tosh, 'Gentlemanly Politeness', p. 461).

²⁹ Quotation from Carter, 'Polite "Persons"', p. 335.

here were involved in similar realms of activity.³⁰ They should, furthermore, have included throughout the entire period both patriarchs and participants in ‘polite’ public spheres, the central topics of studies of early modern ‘manhood’ and long-eighteenth-century ‘masculinity’ respectively.³¹ Those whose activities, self-construction, and interactions are visible in their own or their associates’ voices were in both centuries part of a social group presumably able to afford the typical eighteenth-century consultation fee of a guinea, and often far wealthier.³² Significantly, this comparison, as far as possible, of ‘like with like’ suggests that men’s health-related behaviours and identities underwent no transformation across and between the later-seventeenth and eighteenth centuries, in great part because the responses to the corporeal body allowed to men were seemingly resistant to those bodily-related anxieties that might be expected to have existed in individual eras.

In particular, mid- and later-seventeenth-century men seem to have sought treatment sufficiently quickly as to suggest that adult males were free of that masculine anxiety about bodily strength – or an anxiety about masculinity – that could have left them reluctant to admit to having bodily problems, to being physically or emotionally unable to endure these, or to not being able to overcome such disruption by strength of mind and body alone. That early modern masculine rivalry in courage, strength, and control over the body that allegedly manifested in competitive talk and performances revolving

³⁰ Alexandra Shepard, ‘From anxious patriarchs to refined gentlemen? Manhood in Britain, circa 1500-1700’, *Journal of British Studies*, 44, 2 (2005), pp. 281-295, quotations at pp. 281, 287.

³¹ These conclusions about discourses and social representations are focused on literate society. More research is needed in order to conclude whether John Tosh’s argument that in Victorian England ‘physical vigour, courage and independence were manly values which transcended class’, yet with ‘bodily vigour... even more at a premium’ for ‘working men’, also applies to Scotland and earlier centuries, and with what implications for sick lower-sort men. See Tosh, ‘Gentlemanly Politeness’, pp. 469, 468.

³² Although there was some flexibility, according to the ability to pay (Wayne Wild, *Medicine-by-Post. The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam, NY, 2006), pp. 17, 184).

around drink, aggression, sports, sex and procreation does not seem in 1640-1700 to have hindered men's medical responses when the strength and wellbeing of these bodies was most at threat, or questionable.³³ Thus, while a similar social elevation of male and masculine strength, robustness and fortitude creates the expectation today that "[r]eal men" don't get sick, and when they do... don't complain about it, and... don't seek help until the entire system begins to shut down', surgeons and physicians treating men of a range of statuses rarely referred to treatment being deliberately delayed to a dangerous extent.³⁴ That small sample of seventeenth-century friends' and relatives' letters to sick males utilized in chapter 7 was totally free of any such expectation, the criticism of it, or any willingness (or need) to make concessions

Post-1660 'politeness' did not, it appears, subsequently transform the experience of men with bodies that were sites of health. The body was always on display, and a seventeen-year-old, wanting a horse, claimed in 1779 that the 'lose of Excercise [sic] makes me grow very fat and I am afraid of being as fat as young Capt[ain] North who is the fatest young man I ever saw'.³⁵ Whether he feared this change in physique for reasons of appearance, social stigma, or health was, however, left unstated. Yet, in terms of physical masculinity, authors of health and prescriptive writing alike had no anticipation in either century of a male readership demanding the instruction that would teach them how to maintain and develop that strong and active robustness that was a presumption of such health manuals (and other medical publications) across the period.³⁶ Similarly, if

³³ Foyster, *Manhood*, pp. 39-45, 178; Alexandra Shepard, *Meanings of Manhood in Early Modern England* (Oxford, 2003), p. 16. The extent of such performances is analyzed above, pp. 190-201.

³⁴ Series Editor's Introduction, in David Frederick Gordon and Donald Sabo (eds.), *Men's Health and Illness: Gender, Power, and the Body* (1995), pp. vii-viii.

³⁵ NAS, GD112/39/319/3, Papers of the Campbell family, John Campbell of Carwhin to Mrs Campbell, 5 May 1779.

³⁶ As suggested by the absence of such texts from the range of medical and didactic sources in chapters 2 and 6.

'politeness' drew eighteenth-century men's attention to issues of cosmetic bodily appearance and presentation in a way possibly unprecedented in the seventeenth century, the contents of the manuscript recipe collections in chapter 6 argue that this was not so all-encompassing that they were left unequipped for dealing with the avoidance or alleviation of illness. On the contrary, eighteenth-century male recipe collectors continued to take a sustained interest in the preparation for the physical experience of bodily disorder for reasons concerned with health and illness directly and in their own right, and to do so without the external driving force of anxiety about social perceptions of the body. As visible in the recipe books in chapter 6, their pre-emptive interest in the management of their material physicalities was very much a continuation of that of their seventeenth-century predecessors.

Significantly, the self-authored eighteenth-century consultation letters in chapters 4 and 7 argue something similar of the experience of sickness and injury itself. That their self-penned introductory reports and even their subsequent assessments of the satisfactoriness, or otherwise, of treatment were almost entirely silent about aesthetic needs and repercussions argues that it was not only in domestic medicine that men were able to pursue recovery without distraction from competing, non-therapeutic, concerns. Indeed, those letters about penile discharges and ejaculations in chapter 3 raise the possibility that even where it was the sexual body that was at play men's medical decisions did not have to be complicated by any need to consider the possible social perception of sufferer or body. Certainly, that facial hair and deepness of voice, and robustness of build and a muscular profile, were consistently absent from not only eighteenth-century men's consultation letters but also their manuscript compilations of bodily and medical information argues that at least the observable, external, masculine

bodily attributes were felt to be fundamentally secure. The sample of pre-1700 male recipe compilations raise similar possibilities, with early-, mid-, and later-eighteenth-century men's collections of useful bodily-related information seemingly showing no difference to their seventeenth-century predecessors.

This apparent continuity suggests, furthermore, that the topics, purposes, and interests of that social discussion of men and their health and bodies that these recipe books reveal was remarkably stable between the seventeenth and the later-eighteenth century. This discourse and its conventions seems to have been so well-established, and appreciated, that men's ability to access useful socially-held information was unaffected by cultural change. '[L]ack of restraint and disregard for the sensibilities of others... was', for example, 'the very antithesis of polite behaviour', but 'politeness' did not limit men's ability to access socially-held curative knowledge, or to exploit the help of friends and colleagues, by putting certain symptoms, processes, or body parts, out of bounds.³⁷ Nor, on the other hand, did its elevation of natural, open, discourse visibly revolutionize the social, personal, or emotional experience of sickness. On the contrary, and with the possible – although not clear-cut – exception of venereal disease, the compilations in chapter 6 show that seventeenth-century men were already speaking about and recording their experiences of the most visceral elements and functions of the body, freely and without apparent embarrassment. There was no seventeenth-century stigma or shame in (at least non-venereal) male illness for eighteenth-century cultural changes to challenge, and sickness was seemingly already a shared and open experience for late early modern men.

³⁷ Quotation from Langford, 'Uses', p. 314.

It is for similar reasons that men did not need mid-eighteenth-century ‘sensibility’s rewriting of bodily and emotional delicacy to occur before they could articulate bodily suffering in ‘sickness stories’.³⁸ They were able to express even emotional distress in the face of physical suffering, and to do so without visibly fearing that this invited the slur of ‘effeminacy’ or foppery, before that cultural ‘aggrandizement of feeling’ that Philip Carter dated to the ‘later’ eighteenth century, but which studies using medical sources regard as beginning in the 1730s (or earlier).³⁹ It might even be this that explains why, as the findings of chapter 4 seemed to suggest, aspirant and elite eighteenth-century male social groups did not need to make that identification with ‘sensibility’s’ gendered nervous conditions that would have differentiated their experience and conceptualization of the sick body from their inferiors and early modern predecessors. That, therefore, men had no need to dress up and explain away their pain or internal bodily disruption, or indeed, the emotional effects of these, might support the impression given by these letters that few men of early- and mid-eighteenth-century polite (or aspirant) society chose to identify with fashionable, gendered, illnesses. Indeed, that men were already accustomed to making visible both their physical delicacies and suffering, and the immediate emotional consequences of these, might offer one reason for why ‘sensibility’ was acceptable to eighteenth-century literate male society. Certainly, men had been capable of expressing emotional reliance upon their practitioners, and distress at pain and sleeplessness, since 1700, if not earlier.⁴⁰

³⁸ Quotation from Roy Porter, “‘Expressing Yourself Ill’: The Language of Sickness in Georgian England”, in R. Porter and P. Burke (eds.), *Language, Self, and Society. A Social History of Language II* (Cambridge, 1991), pp. 276-299, quotation at p. 278.

³⁹ Barker-Benfield, *Culture of Sensibility*, p. xix; Philip Carter, *Men and the Emergence of Polite Society, Britain 1660-1800* (Harlow, 2001), p. 8; Wild, *Medicine-by-Post*, p. 178.

⁴⁰ The sources were not available in this study to examine whether or not this was true of seventeenth-century men too.

Consequently, these findings collectively imply a comparatively relaxed relationship between gendered ideals and the body that experienced health and sickness, yet not because there was so great a separation of gender from body that men were ‘donning and doffing gender identity at will’, adopting feminine gender to express vulnerability.⁴¹ Instead, it seems that the criteria and rules for (and distinguishing between) the masculine and feminine – and, indeed, the (more) manly and (more) womanly – could themselves be flexible, realistic, and open to context-dependent interpretation. Certainly, these materials point to an area of activity and identity in which the physical and social experience of the body was apparently less self-conscious than those dictated by eighteenth-century ‘politeness’ and, significantly, dental health, both of which allegedly elevated external physical refinement as a mirror of inner character and personal identity.⁴² With the possible exception of venereal disease, both inside and outside of the consultation the male experience of the body that encountered health and sickness appears to have been one of honesty and openness, their epistolary advances to practitioners (chapter 4) suggesting that eighteenth-century men continued to be able to make the medicinal needs of the physicality their first and foremost concern during sickness. Indeed, even the extent to which men with venereal disease expected social assumptions about their characters is unclear. It does seem to have been the only health problem for which male patients sought professional secrecy, one informing the physician William Sinclair in 1782 that ‘my leg runs worse than ever, you understand what I mean’, and William Gordon asking a year later that Sinclair ‘observe privacy’.⁴³ Yet, in both the mid-seventeenth century and the late-eighteenth men with venereal disease were still evidently free to utilize the practitioners of their choice even where

⁴¹ Quotation from Wahrman, *Modern Self*, p. 43.

⁴² Foyster, ‘Veil’, p. 412; Mark Blackwell, ‘“Extraneous Bodies”: The Contagion of live-Tooth Transplantation in Late-Eighteenth-Century England’, *Eighteenth-century Life*, 28, 1 (2004), pp. 21-68, esp. 27-28.

these were friends and relatives.⁴⁴ Indeed, Gordon's request was itself a comment on what he, newly returned from London, saw as the atypically backwards outlook of this particular Scottish community, and one neither shared by the patient nor expected to be held by this family friend.⁴⁵

Outside of venereal disease, the candid and matter-of-fact tone of their epistolary self-representations during and in anticipation of sickness raise the possibility that men were confident that the masculinity of their innate, fundamental, selves would not be judged by the fallible body, and whether by its natural masculinity, its state of health, or the latter's consequences for the outer, visible, body. In particular, while many of the men writing those earlier-eighteenth-century consultation letters discussed in chapter 4 did have a notion of their bodies having innate and fixed inner attributes, they – and sick men's self-representations more broadly – did so without thereby rooting their personal identity, or the identity of the self, in that of the body. These were, therefore, societies apparently able to divorce the corporeal body from the man and his masculine virtues. Perhaps they were able to do so in the mid-seventeenth century as in the eighteenth, for the potential of a conceptual separation of body and mind and self did not have to be the creation of the later-seventeenth-century decline of *express* humoralism.⁴⁶ Indeed, there were elements of eighteenth-century medical theory that found material explanations for psychology, or presumed a physical linkage between physical and mental masculinity, just as insistently as had early modern humoralism.⁴⁷

⁴³ NAS, GD136/436/34, Letters sent to William Sinclair, from John Grant, 9 October 1782.

⁴⁴ Above, pp. 205-206, 286-287.

⁴⁵ NAS, GD136/436/31, Letters sent to William Sinclair, from William Gordon, 2 February 1783.

⁴⁶ Although not a separation of the kind suggested by Wahrman, who seemed to see this as a period in which bodily signs of sex and gender could be disregarded when thinking about gender (Wahrman, *Modern Self*, p.86).

Collectively, therefore, these findings suggest stability and familiarity in the masculine experience of the sick and sickness-prone body, both across the individual life course and over the period 1640-1780. Whether or not new ways of imagining sex and sexual difference did emerge, laymen's own narratives of the sick (male) body and the dangers that it faced continued to envision their bodies as being composed of constitutions, habits and temperaments, hereditary predispositions, localized weaknesses, and sets of symptoms, only. Indeed, even letters about complaints affecting the scrotum or testicles focused solely upon their immediate physical symptoms.⁴⁸ Combined, therefore, the consultation letters that they wrote, the bodily concerns recorded as having taken them to practitioners, and the medical information that they collected in manuscript form suggest that eighteenth-century men were not rooting their bodies, the identities of these bodies, or their own identities imagined through the body, in their sex in a way unprecedented in the seventeenth century.

Consequently, and in 'polite' medical and social conversation at least, there was no transition between the end of the early modern period and the eighteenth century in the anxieties and interests that laymen were pursuing or experiencing in their response to sickness. While it is possible that they felt periodic life-stage and socially-induced anxieties, their consultation letters and, in particular, their recipe books suggest that in both centuries men were confident in the basic security of their sexed attributes and functions, parts, and identities. As chapter 3 discussed, surgeons' case notes are perhaps by nature limited in their capacity to reveal the anxieties and fears expressed by patients during or because of treatment.⁴⁹ However, chapters 3 and 4 found that men's own

⁴⁷ Above, pp. 50, 65-66, 70-71.

⁴⁸ E.g. BL, Sloane MS 4034, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century), f. 312, from William Chaloner, 19 August 1736.

⁴⁹ Above, p. 120.

eighteenth-century consultation letters were themselves silent about potential threats to sexual and reproductive powers, and congenital dangers, even when discussing venereal disease or uncontrollable ejaculations, and despite male patients' visible ability to make epistolary expressions of other sources of fear and anxiety. It is this, furthermore, that argues that it is a pervasive male matter-of-fact confidence about potency and fertility that is revealed by – or that explains – the way in which many of the sample of men in chapter 6 seemingly did not access (or at least record) potentially beneficial medical information for the sexed and sexual male body.

Certainly, as chapter 3 found, men were able to admit to and seek at least professional help even for symptoms that they ascribed to sex and sexual excess. Contemporary constructions of male sexuality did not, therefore, restrict men in the complaints that, as a collectivity, they were willing to take to practitioners. Nor, furthermore, did they cause men with sexual and genital problems agonized self-recrimination, or so it appears from the silences of those occasional men who wrote consultation letters about uncontrolled ejaculation. While no men were recorded in chapter 3's large sample of manuscript practitioners' records as having sought *face-to-face* assistance before 1780 for what either party identified as the consequences of onanism, or for impotency or sterility, the above letter-writers were notably matter-of-fact. As men were evidently able to consult mainstream surgeons for another allegedly stigmatized condition, venereal disease, these findings might raise the possibility that if a pervasive masculine fear about the effects of onanism had existed its self-perceived victims would have been able to consult record-keeping practitioners, without being restricted by shame and stigma to scaremongering irregular practitioners and their publications.

Combined, the self-representations that educated men left in manuscript materials produced in preparation for, to resolve, or to make retrospective memory of, the experience of illness (and, less commonly, injury) argue that they felt no tension between masculine values that anticipated the strong and robust and the realities of a corporeality never immune to sickness and failure. The epistolary discourses about male sickness that circulated in society similarly suggest that if middling- and upper-sort men were embracing ‘politeness’ they were able to do so without any resultant embarrassment about that physical ‘effeminacy’ satirized in print as its attendant.⁵⁰ When it was the body that experienced health and sickness that was involved, being a man was apparently less anxious, and being recognized as a masculine man less necessary, than were other equally public and physical masculine performances. Indeed, and as chapter 5 argued, the manuscript medical record raises at least the possibility that such early modern masculine bodily performances predicated on drink and violence – if not those based on sex – might have been less frequent, or more restrained, by the second half of the seventeenth century. Certainly, the practitioners’ materials and publications analyzed in chapter 5 suggest that it is possible that masculinity could be achieved without men participating *en masse* in behaviours so raucous as to create injury and illness sufficiently severe to need paid assistance. The privileges of patriarchy might similarly have been paid for only in physical costs limited in both prevalence and duration, even for those who satisfied their patriarchal obligations through gendered and, indeed, military occupations.

Alison Montgomery 23/3/12 20:48

Comment: Shep/foyster

Yet, when men did succumb to injury and sickness, lifestyle-induced or otherwise, masculinity was apparently sufficiently forgiving to afford them breathing space to deal

⁵⁰ Carter, *Men*, pp. 47-48.

with the physical experiences of being ill, without distraction from anxiety about gendered body image. Indeed, and in the apparent absence of gendered cultural influences, the medical and social discussion of such men, and their bodies, that makes them visible to the historian seem to have been remarkably stable across these 140 years, the alleged movement from 'manhood' to 'masculinity', and the transition from the seventeenth to the eighteenth century. Even the decorum and conventions of the dialogue itself showed great continuity, with men able throughout the entire period to discuss, and thereby receive emotional support during, and information or practical help in, even highly visceral bodily experiences. Consequently, these findings collectively suggest that the relationship between masculinity, the living corporeality, and the discourses and interactions surrounding these was sufficiently durable as to be resistant to this period's changing masculine codes and fashions and that, in both centuries, the individual's masculine identity was sufficiently resilient, or separate, to feel no threat from material bodily failure.

Appendix: A note on medical records and statistics

Chapter 4, tables 4.1-4.4

The four professional records analyzed in chapter 4, tables 4.1-4.4 were selected according to several criteria.¹ All are of known authorship and record cases from a known practice (and this practice alone), include a large number of sufferers and provide in most instances not only notes of treatment(s) or of individual consultations but also diagnoses, and give details sufficiently frequently for the historian to know the gender of at least a majority of the patients. All are comprehensive records of the practice, whether at a certain snapshot in time, as at the Westminster Infirmary (later the Westminster Hospital), or across a prolonged period. These time periods are, furthermore, discrete ones. The cases are not scattered across the full length of the practitioner's career in the way that would suggest that there were special reasons behind their being selected for preservation.

It is, furthermore, difficult to find records meeting such criteria. Some surviving casebooks are openly labelled selections (sometimes posthumous) of cases or 'observations', not all of which necessarily come from their compilers' experiences alone. Many others contain so few cases, or cases spread across such a diffuse time period, that it seems probable that they were constructed in the same way. Clinical cases and lectures from the teaching wards would provide records of a later date but also suffer from problems of professional selectivity. Similar issues surround the use of consultation letters, particularly in the probability that the perceived severity was not the

¹ BL, Sloane MS 153, 'Chirurgical Observations' (c.1633-c.1663), Joseph Binns; BL, Sloane MS 1588, Medical receipts and cases (c.1664-c.1684), Sir Edmund King; RCP, MS 625, 'Medicinal Observations at the Infirmary in Petty France. Westminster' (1723-1724, and June 1724), Alexander Stuart and William Wasey; BL, Additional MS 45670, Accompt-book (1727-1738), Joshua Firth.

only factor determining which afflictions resulted in letters and which did not. The probability of the fragmentary survival of such letter collections, the unknown professional identity (surgeon, physician, apothecary or mixed practitioner) of senders other than the famous, and the existence of only fragments of much larger dialogues, pose further problems.

The need for manageable sets of data and clear and meaningful comparisons was also a factor limiting the number of separate items analyzed. The initial intention was to compare records generated in each section of the contemporary official tripartite division of medicine into physicians, surgeons, and apothecaries.² Yet, the medical record itself reveals that it was not only in the services offered by physicians, surgeons and apothecaries that this official division broke down. There were also, for example, mixed practitioners such as Joshua Firth, and in both countries men educated and licensed to act as physicians had the oversight of hospitals (and clinical wards) also treating surgical disorders.

Consequently, the practices selected here include those of a surgeon, a physician, a mixed practitioner, and the hospital wards supervised by two physicians. There are limitations, particularly in the absence of records from Scotland and from an apothecary, whether the latter was making up prescriptions only or diagnosing and prescribing too.³ Furthermore, three of the four selected sources depict clientele in London (although not all men treated in London were necessarily living there), and none include the period after 1730. Beneficially, however, this reduces the number of other variants. Differences in location and period (and social status) might, for example,

² See above, p. 18.

have meant significant variations in the environmental and occupational hazards to which patient bases were exposed, or in the functionality or medical technicality of the diagnoses that they expected.

It is, however, the potential existence of further variations that ensures that the conclusions reached here cannot be extrapolated to include all practitioners of each type. Even within each of the official occupational groups of physician, surgeon and apothecary there were differences in education and training, clientele, corporate status, and obedience to what various regulatory bodies tried to establish as the authorized remits and limitations of the three types of expertise. There were also variations in personal expertise. Joseph Binns (d. 1664), for example, recorded surprisingly few men with urinary conditions such as kidney and bladder stones,⁴ or with skin complaints, but so many cases of venereal disease that Lucinda Beier thought it a 'minor' specialism of his.⁵

Comparison with other surgeons would be needed in order to test whether Binns did specialize in venereal cases (and if this was by his own making or patients' lack of alternatives), or if surgeons in general treated a preponderance of venereal cases. This is itself difficult, for there are few comprehensive surgical records from the period studied here. Explaining apparent absences within individual records is similarly problematic. The absence of specific problems from individual records could have arisen from all or

³ Ibid.

⁴ Contrary to claims that he 'acted as an early modern urologist, and patients apparently sought him out for this kind of treatment' (Lucinda McCray Beier, *Sufferers and Healers. The experience of illness in Seventeenth-Century England* (London and New York, 1987), p. 60). Date of death from *ibid.*, p. 52.

⁵ *Ibid.*, p. 60.

any of such factors as, for example, deliberate exclusion from the practice,⁶ the existence of local rivals (and even specialists) with superior reputations (or lower fees) in such cases, low rates of occurrence, sufferers' favouring of more informal types of treatment, or a lay awareness of the limited prospects of treatment. Certainly, the use of specialists for surgical problems involving broken bones, hernias, kidney and bladder stones, venereal disease and, in the eighteenth century, teeth, is not something that the statistics compiled here can uncover. Nor does this analysis give any indication of the problems being treated domestically, or receiving no care at all. Problematically, however, it was not simply the case that all disorders of a certain level of seriousness, and only these, received paid, and recorded, medical assistance.

Similarly, it was not only in their medical titles that the four sets of practitioners studied here differed. They also varied in professional esteem and in educational and corporate status, although these are unknown for Firth. Thus, Binns had trained by apprenticeship, as required of licensed surgeons, and was consequently made free of the Company of Barber Surgeons in 1637 (four years after the records analyzed here apparently began). He became a warden of the Company in 1662, just before these records end.⁷ Similarly, and at Westminster, Alexander Stuart (?1673-1742) and William Wasey (1691-1757) had both graduated M.D. and, consequently, were at the time a licentiate and candidate respectively of the Royal College of Physicians of London, physic's official regulatory and corporate body. Yet, Stuart (a Scot) had also worked previously as a surgeon, as had Sir Edmund King (?1630-1709), although it is unclear whether they had also received

⁶ As, for example, some charitable hospitals barred venereal patients, while other infirmaries 'explicitly excluded fever and other so-called contagious diseases' (Mary E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), pp. 106, 137). See also Kevin P. Siena, *Venereal Disease, Hospitals and the Urban Poor: London's "Foul Wards", 1600-1800* (Rochester, NY and Woodbridge, 2004), p. 3.

⁷ Beier, *Sufferers*, p. 52.

formal surgical apprenticeships. As a physician at least, King lacked both formal education and collegiate recognition and licensing. It was only as he was compiling the record analyzed here (c.1664-c.1684) that King was awarded a bachelor's degree in medicine (May 1663), an ecclesiastic license to practise (although only outside of London, June 1663), and the title M.D. (1671). Furthermore, and in contrast to Wasey and Stuart, these degrees apparently came without attendance at a university and without subsequent corporate recognition.⁸

These practitioners also varied in contemporary repute. Binns was a 'respectable but unremarkable' "ordinary" practitioner (if such a thing can be said to exist), King a 'medical luminary', Wasey an eventual president of London's Royal College of Physicians, and Stuart a medical graduate of Leiden, medical researcher, and protégée of the internationally eminent physician Herman Boerhaave.⁹ Resultant variations in access to new discoveries, texts and techniques, or to other more informal channels of continuing medical education, might have meant that the medical knowledge displayed by some of these four practitioners was more up-to-date (for the period of compilation) than that of the others. Indeed, both diagnoses and the method of reaching such diagnoses could have been very personal. Certainly, Firth was reliant on a seemingly outdated diagnostic method, urinoscopy (urine-reading), and on a diagnostic range visibly limited in both technicality and variety. This might itself bring into question his typicality of general practitioners, even for those outside of the metropolises and of his own period.

The men consulting these four sets of practitioners varied too. While Binns and King

⁸ All details for Stuart, Wasey and King are taken from the Oxford Dictionary of National Biography.

both visibly treated patients of a range of social backgrounds, including the elite, none of the patients entered in Firth's book were given a title indicating gentry or nobility. Those recorded in the Westminster Infirmary's index had only their names, illness(s) and date given, without any indication of occupation or status. However, the men who featured in a set of lectures given two and a half decades later at the Edinburgh Royal Infirmary were, where stated, soldiers, 'a labouring man', a baker, a sailor and a seafarer, a gardener, a weaver, and a quarry-worker.¹⁰ Certainly, eighteenth-century patients at Bristol's infirmary came from the poor and the labouring, just as hospital patients had been 'invariably poor' in the previous century.¹¹

Consequently, the conclusions reached from these four sources apply only to these particular practices, only at the stated point in time, and only for the particular patients represented therein. Comparison with other practitioners of the same occupational title would be needed before conclusions could be reached as to how far each of the four practices was, for example, typical in its obedience, or otherwise, to official professional divisions. Binns, for example, was allegedly 'to some extent... operating as a general practitioner', while it is unclear as to how many of the patients contained in his records were actually part of his institutional patient base at St Bartholomew's Hospital.¹²

The records also have individual limitations. Rather than a neat casebook, the notes left by Binns are hundreds of scraps of paper subsequently bound together, the incomplete nature of some of these suggesting that others have been lost. As Beier noted, such

⁹ Quotations from Beier, *Sufferers*, pp. 51. Bibliographical information from the Oxford Dictionary of National Biography.

¹⁰ WL, MS 6888, Clinical lectures (1749), John Rutherford, ff. 66v, 69v, 42, 60, 31v, 168v, 75v, 153, 105.

¹¹ Fissell, *Patients*, pp. 95-97; Beier, *Sufferers*, p. 55.

¹² Beier, *Sufferers*, p. 60.

records are unlikely to include all of the cases treated in the several decades covered, and something similar is likely to be true of the collection of King's notes analyzed here.¹³ Certainly, there are other extant records of King's patients dating from within the period in which this casebook was being compiled, ranging from scattered notes to comparatively comprehensive collections.¹⁴ In this casebook itself, as in Binns's notes, there is inconsistency in the amount of personal and medical detail given, numerous additional names and dates added in marginalia without any indication of their relationship, if any, to the original entries, and occasional items that make no mention of either diagnosis or symptoms. Problematically, the illness names (added by an earlier author) that head the pages in which King recorded his consultations cannot always be relied on to ascertain the disorder, or even general affliction type, of patients for whom the diagnosis is unstated. As revealed in cases for which the affliction is recorded, the illnesses in King's notes do not always correspond exactly, or at all, to the header.

The section of the Westminster records that was used here is, by contrast, only an index, and seemingly a partial one. Written in Latin shorthand, its contents give only the briefest details, stating no more than 'Mart: 6 Knot[,] James Diarrheoa [sic]'.¹⁵ Containing only the overarching diagnosis, there is no reference to symptoms, occasional uncertainty with abbreviations that have more than one potential meaning, and no patient details (including ages) other than names. An author's note states that the volume in which this index is included is book C of three, with 400 cases of both genders in book A, 220 in B and 169 in C, the sheer numbers involved suggesting that

¹³ *Ibid.*, p. 95.

¹⁴ E.g. BL, Sloane MS 1589, Day-book of medical cases (1676-1696), Sir Edmund King; BL, Sloane MS 1640, Medical papers, in *Medical observations (seventeenth-century)*, ff. 67-100, *idem.*; BL, Sloane MS 1586, *Anatomical observations (c.1660-c.1680)*, *idem.*, ff. 104-9, 141-69, 180-191.

¹⁵ RCP, MS 625, 'Medicinal Observations at the Infirmary in Petty France. Westminster', Stuart and Wasey, index.

they were records of admission. However, while volume C is dated 'from June:1724 to June 30 1724', the index entries range from January 1723 to December 1724 and yet include only seventy male cases (plus those of females), out of a claimed total of 789 patients of both sexes. Exactly why it was these seventy cases in particular that were entered in this index is unclear, particularly as they cover such a wide time span.

Similarly, although outnumbering the male cases included in many other casebooks, the index contains fewer male patients than do the other three practice records analyzed here. Using percentages rather than absolute figures makes it possible to draw comparisons that are still meaningful. However, its small number of cases (and, consequently, diagnostic labels) means that this source (and, indeed, King's) has less influence upon the composite picture than do Binns's and Firth's.

Firth's is an account book rather than casebook, with consultations (and fees) recorded in the same format as were all other transactions. Positively, his methodical concern with recording these financial exchanges makes it likely that Firth did include all of his patients, visits and urine-readings. Negatively, his entries are, consequently, brief. They state nothing more than, for example, 'urin[e]:man Potterton pluretick fever pain in back & side 0/2/0 9-12th' (of September). Even when Firth saw patients in person he still recorded only 'to James Hainworth Cockan pain in body, aguish, feared, sick 0/0/6 26th'.¹⁶ Thus, the patient narrative is totally hidden, it is occasionally unclear whether Firth is describing the appearance of the patient or of the urine, names are often absent, some of his frequently used descriptions (such as 'feared') are obscure, and 'lingring ague' and other labels are used almost as set diagnoses. Usually, however, Firth recorded symptoms and signs rather than diagnoses (although this need not prove that

¹⁶ BL, Additional MS 45670, Accompt-book, Firth, ff. 184, 180v.

he was not issuing the latter). As this swells the number of labels issued it was necessary, for parity with the other practices, to limit the number of cases analyzed, and to do so by date. However, Firth's use of predominantly symptomatic labels still problematizes comparison with those practices that tended to record illness names.

Contemporary labels, pathologies and illness names have, however, been used throughout the thesis, without reference to modern medical theory. Diagnoses are, for example, never 'corrected' in light of modern medicine's interpretation of the symptoms listed. Yet, the records give no guidance as to how contemporaries might have *divided* these different types of afflictions. Firth organized his entries chronologically, in line with his account book's function, while the Westminster index entered them alphabetically, by surname. Binns, by contrast, provided an index arranged by illness name, but again alphabetically rather than ontologically, with subdivisions frequently made by site rather than by medical sub-type. King's two sets of contents pages similarly provide little guidance in categorization. The first lists diseases under body part (from head to foot) and then as subdivisions of only two illness types (fevers and '[o]utward diseases'), yet was created by an earlier owner of the book. Consequently, not all of the actual contents correspond to its descriptions. King's own index, arranged alphabetically by illness name, reaches only to 'Itch'.

Consequently, the categories in which medical conditions are grouped in the tables in this section (and, indeed, in subsequent parts) are not taken from the sources. In line with the indexing interests of both Binns and the original owner of King's book, high frequencies of illness ascribed to, or by nature affecting, particular parts are noted in the discussions accompanying each table. This analysis required, however, categorizations

that would cast light on the examination of *patients*' references to symptoms that forms the second part of the chapter. It also needed categories that could perform three functions. Firstly, they had to depict clearly the individual practice, including any very specific disorders of particular prevalence. Secondly, they had to be sufficiently consistent as to be comparable, and transferable, between four potentially very different practices. Similarly, and finally, it was necessary that they were compatible, in order to allow a composite picture of the four practices to be compiled. In all three functions the information needed to be sufficiently condensed for the general nature of the practice to be visible, and for broad trends to be identified and comparisons made.

This comparison between the four practices is an important part of the analysis. It adds to the quantitative examinations of the 'most common diagnoses' (and outcomes) of individual practices that have been given in broader studies,¹⁷ and to more qualitative examinations of the effects of both bodily and social differentiations on health and, indeed, on diagnostic tendencies.¹⁸ It also sometimes tests the conclusions reached by Beier in a dually observational and quantitative analysis of Binns's notes that divided his practice into injuries, surgical repairs and certain disease states, analyzing the afflictions, symptoms, causes, treatments and outcomes within each category. Similarly, while Beier's study was followed, in a separate chapter, by the analysis of physicians' casebooks and correspondence, the examination made in chapter four of this thesis is concerned with more direct, statistical, comparison, and with the difference between

¹⁷ E.g. Fissell, *Patients*, pp. 107-108 (quotation at p. 107).

¹⁸ E.g. Wendy Churchill, 'Bodily Differences?: Gender, Race, and Class in Hans Sloane's Jamaican Medical Practice, 1687-1688', *Journal of the History of Medicine and Allied Sciences*, 60, 4 (2005), pp. 399-444.

practices. It also focuses solely on the diagnoses issued, without Beier's interest in 'the experience of being a... patient' and the seventeenth-century surgeon's career.¹⁹

To aid comparison, some types of condition in which the crucial signs and symptoms were consistent across the contemporary subdivisions have been subsumed as single categories. This includes the various types of fevers, and different pain(s), cramps and stitches, as well as such general signs of sickness as paleness and emaciation. Injuries and the different forms of venereal disease, noted very rarely by three of the four records, are treated in the same way, not least because the different types of male injuries encountered by Binns are analyzed in chapter 5, while venereal disease receives attention in both chapters 3 and (through Binns's notes) 5. They are also each recorded in these tables as a single complaint, regardless of the number of associated symptoms and side effects.

On similar lines, illnesses and conditions that by nature stemmed from, affected, or produced symptoms unique to, individual body parts are also grouped together, as with the lungs or bowels. Because of the smallness of their numbers, other named illnesses are placed together in a single group. The categorizations are, however, alert to the particular nature of individual practices. Categories are added where required, as with Firth and 'surfet'. Similarly, conditions recorded in especially large numbers in individual practices are extracted from their group, although returned in the final figures to allow a collective overview organized by category.

The practices tend to differ in their labelling methods, with varying balances between

¹⁹ Quotations from Beier, *Sufferers*, pp. 95, 51, 55.

condition names and symptomatic descriptions shown even in individual sources. However, it is still the diagnoses and labels used by the compilers – whether as listed in indexes, entered in case titles, or named in the body of the case itself – that are utilized. Where both a condition name and the symptoms leading to this diagnosis are given it is the former that is included in the statistics. However, when a diagnosis is recorded and symptoms, apparently ascribed to (or seen as) a separate complaint, also entered, both are counted. Where symptoms are themselves used as descriptors, without an illness name, they are considered as labels in their own right. It is for this reason that there are differences, to varying extents, between the number of patients and the number of labels.

Chapter 4, tables 4.5-4.7

The postal consultations received by the physician Sir Hans Sloane are yet to be analyzed for comparison of the way in which patients, third parties and practitioners constructed and represented illness. Wendy Churchill's illness profile, drawn from Sloane's own notes (whilst in Jamaica) did search for the effects of gender, sex, class and age, but as enshrined in Sloane's own representations, diagnoses and classifications.²⁰ Lisa Smith made extensive use of the consultations sent or forwarded to Sloane, but primarily for what they reveal of the effects of gender in the management and independence of healthcare, or in understandings of the body and responses to pain.²¹ In this chapter, therefore, they are used as a way of accessing the patient

²⁰ Churchill, 'Bodily Differences'.

²¹ Lisa Smith, 'Women's Health Care in England and France, 1650-1775' (unpublished Ph.D. thesis, University of Essex, 2001); idem., 'Reassessing the role of the family: Women's Medical Care in Eighteenth-century England', *Social History of Medicine*, 16, 3 (2003), pp. 327-342; idem., "'An Account of An Unaccountable Distemper': The Experience of Pain in Early Eighteenth-Century England and France", *Eighteenth-Century Studies*, 41, 4 (2008), pp. 459-480.

narrative firsthand, in its entirety, and as it reveals men's emotional and rhetorical responses to not only pain but also other types, and elements, of physical suffering.

The data is extracted, and categorized, as discussed above for tables 4.1-4.4. This part is, however, concerned not only with how different parties classed and made sense of ailments but also with what most alarmed or frustrated them. Consequently, where authors provided both an illness's name and its signs and symptoms they are all included in the statistical analysis.

The letters used are taken from three of the volumes of Sloane's papers most heavily composed of incoming consultation letters. These volumes contain far more letters than it was possible to use, with many lacking any indication of the patient's gender or of the author's involvement, or being concerned solely with requesting visits or prescriptions or with reporting side effects. Letters have also been excluded where the patient seems to have been a child, it is not possible to estimate the authorial type, or, and very rarely, either the subject was not within the British Isles or the writing language was Latin or French. As so many give no indication of even their author's location, all letters that provide no reason to believe that the patient was not within the British Isles have been used, including those written about the occasional men who were visibly in Wales or Ireland. Yet, only one male patient in Scotland visibly prompted letters in Sloane MSS 4075, 4077 or 4078 meeting these criteria, with the vast majority of letters that do have return addresses being about men then in England.

Although Anglocentric, the Sloane letters offer, however, a comprehensive set of consultations falling well within the period and, indeed, roughly in its middle. They also

include occasional examples from the 1680s and 1690s. Sloane's fame ensured that he received letters on matters across the physician's remit of internal medicine, as well as about certain surgical conditions.²² Indeed, other materials collected by Sloane in the same period show that he had a particular interest in urinary and kidney stones – complaints about which, as a physician, he received a surprising number of letters.²³ Otherwise, however, these letters reveal little of men's experience, and construction, of surgical complaints, without there being any equivalent collection left by a surgeon for comparison. There are also substantial differences in the numbers of letters meeting the above criteria that come from practitioners, patients, and relatives, and few references to causes, particularly from 'friends'. This might, however, reveal something of the nature of the medical letter-writing process itself.

Chapter 5, part 1

Chapter 5, part 1 makes use of two volumes of post-mortem examinations, morbid anatomies and occasional curious cases started by the Scottish but London-based hospital surgeon John Hunter (1728-1793).²⁴ These are a valuable source, there being only scattered post-mortems and morbid anatomies (primarily upon the rich) for the earlier period, which usually provide little information about the case, the patient, and even the cause of death. These collections, by contrast, give a degree of personal and

²² In various parts of the period covered by this collection of letters Sloane was, for example, president of the Royal College of Physicians of London and the Royal Society, a royal physician, a hospital physician and governor, and the recipient of a baronetcy (Oxford Dictionary of National Biography).

²³ See, for example, BL, Sloane MS 4034, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century), f. 38, undated letter from Robert Smith, offering to sell his remedy for stone, gravel, gleet and bloody urine; *ibid.*, ff. 187-189v, unlabelled recipes primarily for urinary stoppages; BL, Sloane MS 4076, Hans Sloane consultations (late-seventeenth- to mid-eighteenth-century), f. 133, letter from William Mathews, 18 January 1682, about the purchase of a voided stone; *ibid.*, ff. 270-272, letter from John Powell, 16 July 1733, sending a stone and an account of the case; BL, Sloane MS 4077, Hans Sloane consultations, f. 338, testimonial to the skills and character of Richard Smith, with mention of a case involving an unusually large stone.

²⁴ RCS, MS 0189/1/2, 'Records in Morbid Anatomy' (late-eighteenth- to early-nineteenth-century, men's dated cases 1774-1802), John Hunter; MS 0189/1/3, 'An account of the dissections of morbid

contextual information unusual in both cases and post-mortems, and which often extends to the patient's age, the outbreak and development of the illness, its ascribed cause, and its prior treatment. They also cover the full social range (and beyond) of the men featuring in this and other chapters. While many of the subjects were patients whom Hunter treated personally, in private practice or institutionally, and whether immediately before their deaths or in the longer-term, some reports were submitted by other practitioners, adding to their variety. Indeed, the accounts' conclusions, and frequent hypotheses and queries, make visible the dissectors' speculations about cause of death, while there is always reference to the illness or, where this was disputed, to the symptoms. Consequently, and as above, it is the sources' own diagnoses, explanations and language that are used.

In total, the two Hunterian collections contain 153 accounts of conditions and curious cases, post-mortems, morbid anatomies and curious findings from dissections that relate to adult males (with an occasional run over in subjects). However, of the fifty-six reports in MS 0189/1/2 only twenty-one (38%) have dates. While the fame of their subjects allows the dating of occasional other post-mortems, the absence of any chronological sequence makes this impossible for the majority of the accounts. Those that are of stated or ascertainable dates are, however, late, with the earliest written in the 1770s. These three items are, furthermore, outnumbered by the number coming from after 1780, with four of the early 1780s, seven from 1786-89, four dating from the 1790s, and three from 1801-1802. Three further records contain internal information, within the patient or case history, showing them to date from after 1772, 1779 and the winter of 1780-81 respectively.

bodies' (mid- to late-eighteenth-century, men's dated cases 1755-1784), *idem*.

Where dated, therefore, the majority of the reports in MS 0189/1/2 come from the 1780s, immediately after the end of the period covered by this study. However, it is MS 0189/1/3 that contains the largest number of adult male entries – ninety-seven – and this collection is the earlier one. Furthermore, the sustained chronological ordering allows dates (or latest dates possible) to be provided for all of its undated accounts. Consequently, all of the ninety-seven in MS 0189/1/3 come from 1782 at the latest, with at least ninety-one produced in 1781 or earlier.²⁵ Indeed, a quarter (twenty-four) date from the 1750s or earlier, and at least another 39% (thirty-eight) from the 1760s. At least sixty-two, or 64%, of those cases, post-mortems and morbid anatomies in MS 0189/1/3 were, therefore, written before 1770.

In the two Hunterian collections combined, therefore, dates are given or can be surmised for 118 of all 153 relevant items. With the larger size of MS 0189/1/3, and its greater percentage of dated or datable records, at least ninety-four (80%) of the 118 datable records, and a minimum of 61% of all 153 cases, morbid anatomies, dissections and post-mortems, come from 1781 or earlier. Furthermore, even those men who were admitted or died in the 1780s and 1790s (and beyond) were alive, and building up medical histories, in the pre-1780 period. Indeed, while the accounts are written in various hands, they had the same compiler – Hunter – both before and after 1780. Hunter died in 1793 but there is no perceptible subsequent shift in tone or interests in the accounts produced subsequently.

Chapter 5, tables 5.2-5.3

Data is extracted from Binns's case notes in the same way, and with the same cautions, as discussed for chapter 4, tables 4.1-4.4 (above). A distinction is made between the number of men and the number of cases, in recognition of those patients with venereal disease who returned to Binns's care after intervals of months or years. The statistics in each of the tables are, however, minimum figures, for the historian can know only what Binns recorded. It might be, for example, that more men had sought treatment previously, had visible symptoms, or sought treatment prior to consulting Binns than he knew of or recorded. Similarly, perhaps some of those patients whom Binns classed as cured did subsequently need to seek the assistance of other practitioners, whether immediately afterwards or because of an eventual relapse.

Binns might himself have seen more repeat patients with venereal disease than his notes makes clear, perhaps recording such returning men without their names (or with their alternative names) or in the sometimes unclear marginalia. Similarly, and if historians are correct in claiming that sufferers were ashamed to admit to having venereal disease, it might be that more of his patients were long-term sufferers, or had received prior treatment, than were willing to admit it to him.²⁶ Binns himself might not always have recorded all of the information that patients furnished him with, particularly as his notes vary in detail and in their inclusion of the patient's narrative. However, they still give a degree of contextual information that is unusual in the number of patients that it is provided for and the amount given (in many instances) per case. They are also one of the few substantial sets of surgeons' records available for any part of the period 1640-1780, while covering a wide social range, the latter of great benefit in an examination of

²⁵ The chronological ordering, maintained throughout the collection, makes it highly probable that the item dated 1784 (followed by two undated entries, another of 1782 and one that can be dated to 1782) should actually say 1781 or 1782.

²⁶ See, for example, Dorothy Porter and Roy Porter, *Patient's Progress. Doctors and Doctoring in*

the bodily effects of lifestyle. Furthermore, it was Binns's notes that Beier used in the statistical analysis by which she too commented on contemporary life, reaching conclusions that echo those of gender and social historians in referring to 'a particularly violent and dangerous period' in which 'London streets, shops and taverns were as dangerous as battlefields', occupations hazardous, and venereal disease damaging both socially and physically.²⁷

Eighteenth-Century England (Stanford, 1989), p. 108.

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Farrer, William, *A short treatise on onanism; or, the detestable vice of self-pollution. Describing the variety of nervous and other disorders, that are occasioned by that shameful practice, or too early and excessive venery, and directing the best method for their cure. By a physician i[n] the country* (2nd edn., printed and sold by Fletcher and Co., 1767).

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- Forster, William, *A treatise on the various kinds and qualities of foods: with aphorisms of health; or, rules to preserve the body to a good old age. To which is added, a compendious discourse of the diseases of children* (Newcastle upon Tyne, by John White, for the author, 1738).
- Idem., *A treatise on the causes of most diseases incident to human bodies, and the cure of them. First, by a right Use of the Non-Naturals : chiefly by Diet. Secondly, by Medicine. With the Cure of Women's Distempers. Also on the various Kinds and Qualities of foods; with an Essay on Sickness and Health; and Rules to preserve the Body to a good old Age. To which is added, a Compendious Discourse on Children's Diseases, and Tradesmen's Distemper's* (2nd edn., for J. Clarke, G. Hawkins, and W. Reeve, 1746).
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- Haworth, Samuel, *A description of the Duke's Bagnio, and of the mineral bath and new spaw thereunto belonging. With an account of the use of sweating, rubbing, bathing, and the medicinal vertues of the spaw* (for Sam. Smith, 1683).
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Jones, John, *The mysteries of opium reveal'd by Dr. John Jones Chancellor of Landaff, a Member of the College of Physicians in London: And formerly Fellow of Jesus-College in Oxford. Who, I. Gives an account of the name, make, choice, effects, &c. of opium, II. Proves all former opinions of its operation to be meer chimera's, III. Demonstrates what its true cause is, by which he easily, and mechanically explains all (even its most mysterious) effects, IV. Shews its noxious principle, and how to separate it, thereby rendering it a safe, and noble panacea, whereof, V. He shews the palliative, and curative use* (for Richard Smith, 1700).

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Mandeville, Bernard, *A treatise of the hypochondriack and hysteric passions, vulgarly call'd the hypo in men and vapours in women; In which the Symptoms, Causes, and Cure of those Diseases are set forth after a Method intirely new. The whole interspers'd, with Instructive Discourses on the Real art of physick it self; And*

Entertaining Remarks on the Modern Practice of Physicians and Apothecaries: Very useful to all, that have the Misfortune to stand in need of either. In three dialogues (printed and sold by Dryden Leach and W. Taylor, 1711).

Marten, John, *Gonosologium novum: or, a new system of all the secret infirm and diseases, natural, accidental, and venereal in men and women, that defile and ruin the healths of themselves and their posterity, obstruct conjugal delectancy and pregnancy, with their various methods of cure. To which is added, something particular concerning generation and conception, and of miscarriages in women from venereal causes. The like never done before. Useful for physicians, surgeons, apothecaries and midwives, as well as for those that have, or are in danger of falling under any such impure of defective indispositions. With a further warning against quacks, and of some late notorious abuses committed by them, shewing who they are, and how to avoid them. By John Marten, chirurgion. Written by way of appendix to the sixth edition of his book of the venereal disease lately publish'd; and done with the same letter, on the same paper, that those who please may bind it up with that* (printed and sold by N. Crouch, S. Crouch, J. Knapton, and M. Atkins, A. Collins, P. Varenne, C. King, and at the author's house, [1709]).

[Idem.?], *Onania; or, the heinous sin of self-pollution, and all its frightful consequences, in both sexes, considered, with spiritual and physical advice to Those who have already Injur'd themselves by this Abominable Practice. To which is Subjoin'd, A Letter from a Lady to the Author, (very curious) concerning the Use and Abuse of the Marriage-Bed, with the Author's Answer* (4th edn., for the author, sold by N. Crouch, P. Varenne, and J. Isted, [1718?]).

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- their remaining life, even to their dying day, by the carefull use of some prescribed meanes, and medicines* (1651).
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- Moulton, Thomas, *The compleat bone-setter enlarged Being the method of curing broken bones, dislocated joynts, and ruptures, commonly called broken bellies. To which is added, The perfect oculist, mirrour of health, and judgement of urines. Treating of the pestilence, and all other diseases. Written originally by Frier Moulton. Englished and enlarged by Rob. Turner Med. Judgement of urines enlarged Judgement of urines enlarged* (for Tho. Rooks, to be sold by Nath: Crouch, 1665).
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