Beyond the Reproductive Body

Levine-Clark, Marjorie

Published by The Ohio State University Press

Levine-Clark, Marjorie.

Project MUSE. muse.jhu.edu/book/28366.

For additional information about this book
https://muse.jhu.edu/book/28366

For content related to this chapter
https://muse.jhu.edu/related_content?type=book&id=1151816
HISTORICAL explanations of nineteenth-century medicine’s approach to female health have stressed an increasing medicalization of women’s bodies founded upon the reduction of overall health to reproductive health. According to Sally Shuttleworth, “the physiological, mental and emotional economies of womanhood were all regarded as interdependent,” and stability relied upon the regular functioning of the reproductive system, particularly the menstrual cycle.¹ Both historical studies and the Victorian medical literature itself lead to the conclusion that medical practitioners understood the diseases of women in terms of reproductive processes and treated them accordingly. The medical construction of the reproductive body in this period stressed “female weakness and subordination to the body”² and supported an ideal of womanhood linked to social reproduction. Although most historians recognize that this medical and social ideal neglected poor women’s experiences, little has been done to flesh out the picture of health and illness in these women’s lives.

The emphasis on the politics of reproduction in feminist medical history has led to a neglect of women’s other health issues. As a result, historians have tended to reproduce the views of medical literature, rather than the views of patients. Likewise, the historical focus on the health experiences—reproductive and otherwise—of middle-class women has led to generalizations about the experiences of all women. It was biological fragility, and specifically the fragility of the reproductive body, that presumably rendered women incapable of maintaining their health in any but a limited sphere. Yet working women did not fit this model of the delicate body. As Lynda Nead explains it, the dominant image of corporeal femininity applied to middle-class women alone and “was set up in opposition
to an image of working-class women who were defined as inherently healthy, hardy, and robust. This assumption, however, as expressed in the parliamentary investigations, was even further limited to women of the agricultural working class. Victorians in fact were confused about female bodies and what female health dictated about women’s capabilities, particularly in relationship to class.

Case Histories

To try to understand how poor women themselves thought about their bodies, in addition to employing evidence of women’s voices from the parliamentary inquiries, I use an under-utilized source of information on female health in the early Victorian period: patient case records from medical institutions. The evidence from these patient records suggests that poor women’s perceptions of their bodies were both in tension with and in support of an image of women as biologically fragile. Because their survival depended upon their ability to work—both for wages and unpaid in their homes—these women represented themselves as able-bodied but also recognized the obstacles to achieving or maintaining their ablebodiedness.

My analysis concentrates on the patient records of three institutions: University College Hospital (UCH) in London; the West Sussex, East Hampshire, and Chichester Infirmary located in Chichester; and the West Riding Pauper Lunatic Asylum in Wakefield. I chose these three institutions both because their existing records are particularly suited to this study and because their locations allowed me to examine constructions of country and city, province and metropolis. The medical case records from London, West Sussex, and the West Riding provide an exciting source of information about poor women’s lives and address different issues surrounding female health than do materials most commonly explored by historians. Although unsystematic, the patient histories from these institutions offer rich documentation on biographical particulars and patient perceptions of their health, as well as technical medical information concerning diagnosis and treatment.

In the medical culture of the early Victorian years, asylums and hospitals were significant institutions with regard to the health care and survival strategies of poor women and their families. UCH and the West Sussex, East Hampshire, and Chichester Infirmary were both born out of the voluntary hospital movement of the eighteenth and nineteenth centuries. The mission of these medical charities was to help the sick poor, as differentiated from the destitute, who were supposed to turn to the Poor Law. As
the medical journal the *Lancet* put it, the function of the hospital was to help “suitable cases for charity, supply the wants of the afflicted, and obtain the assistance of eminent advisers with the comfort of adequate provision, whilst they are unable because of sickness or accident to follow their normal pursuits.” “Suitable cases” were, in effect, those patients who could obtain a ticket of recommendation from a subscriber to the hospital. Subscribers included known pillars of the community, charitable individuals, employers of working people, clergy, and various working-class self-help men’s clubs, among others. The tickets of recommendation functioned as signs of respectability, marking the holder as a worthy recipient of hospital care, but accidents and urgent cases usually did not require a recommendation to be admitted to the hospital. Most hospitals excluded pregnant women, persons with infectious diseases, cases of venereal disease, the mentally ill, young children, and those considered incurable. In practice, however, these rules were fairly flexible.

The West Riding Pauper Lunatic Asylum was also created for a humanitarian reason, the better treatment of the pauper insane. According to Leonard Smith, the rise of public asylums was “a direct offshoot of the voluntary subscription hospital.” But the insane, as noted above, were often excluded from the hospitals, and it increasingly became clear that separate facilities were needed. Unlike the voluntary hospitals, as well as earlier private asylums, public asylums such as the West Riding asylum were created through parliamentary acts of 1808 and 1845. These were state-supported institutions, overseen primarily by their medical directors, funded through poor rates, and specifically geared to housing the pauper insane.

Until recently, such institutional details had been the focus of much of medical history, which has concentrated on the achievements of individual practitioners, progress in disease prevention and cure, and the development of professionalism and medical institutions. This has had important implications for our understandings of Victorian women’s health, for by focusing on official accounts, historians have limited their analyses to male voices. In the last decade or two, however, there have been numerous studies of the relationships between patients and their practitioners and of patients’ attitudes toward their health care choices. For the most part, even these studies have focused on well-to-do patients, with Mary Fissell’s work on eighteenth-century Bristol being a notable exception. Additionally, even in these more recent studies, men’s health narratives have been more prevalent than women’s. The case histories from London, Sussex, and the West Riding allow a focus both on the poor and on women, expanding our understanding of patients’ perspectives on health care in the Victorian period.
There is, however, debate as to whether we can get at the patients’ viewpoints at all in nineteenth-century case records. N. D. Jewson argues for the “Disappearance of the Sick-Man from Medical Cosmology,” beginning at the turn of the nineteenth century. What the patient had to say about his (or her) disease experience became less important as medical practitioners limited their gaze to “internal organic events,” as opposed to the “total symptom complex” of the patient. Medical men relied less and less on the patient’s experience of illness in a wider context. Similarly, Mary Fissell claims the significance of the patient’s narrative effectively disappeared by the beginning of the nineteenth century. Increasing medical autonomy in the eighteenth century altered the interaction between patient and doctor, from one in which they shared common concepts and a negotiated system of diagnosis and treatment, to one in which the patient’s part was significantly diminished. According to Fissell, the patient’s narrative of illness was made utterly redundant. Hospital medicine came to focus on signs and symptoms, which provided doctors with a disease-oriented diagnosis conducive to the demands of hospital practice and reflective of its social structure. Of course, the patient’s narrative did not disappear quickly or completely, even in the hospital. But its erosion was well under way by the turn of the [nineteenth] century.17

My research questions the notion that patients’ perceptions were less important in the Victorian period. In focusing on the patient’s narrative—and particularly the relationship between the social and medical aspects of the narrative—I attempt to give voice to patients’ experiences of illness and the languages that they used to express them to medical practitioners. This voice is particularly significant with reference to female patients, whom scholars have often represented as passive victims of medical authority. In many studies, women appear as patients—for the most part passive—who are understood by the expert medical gaze. Nancy Theriot, examining women’s nervousness and insanity in nineteenth-century America, has challenged this representation, arguing that women as patients were quite involved in the process of diagnosis, and indeed “were active participants in the process of medicalizing woman.” Whether or not women were complicit in constructing the reproductive body, only recently have historical studies granted agency to patients in medical encounters and begun to recognize that agency through analysis of medical case histories.

Patients in fact are never silent in medical case notes. Case histories are produced through an interaction between a patient and medical practitioners. In the London and Sussex hospitals, the patients’ case histories
were usually written by physicians’ clerks and surgeons’ dressers, who were pupils at the hospitals. It appears that one of the chief responsibilities of these students was the construction of the patient’s case record, which meant the initial notation of the patient’s narrative of social and medical history and present illness, and the subsequent following through of the case treatment and progress.22 The language of the outpatient records at the Chichester Infirmary, however, suggests that the physician or surgeon himself made the notations in these casebooks.

The hospital cases I examined were generally organized in three broad sections: a “history” section, which contains the patient’s social and medical history; the “present symptoms” section, which describes the patient’s current experience of illness; and a “treatment” section, which encompasses the doctor’s examination and diagnosis, the course of treatment, and the patient’s progress.23 The patient is present in each of these sections, as her medical practitioner listens to what she says and notes her responses. This presence, however, varies according to the emphasis of each section. In establishing a patient’s history, a representation of illness was constructed through an interview between the clerk and the patient. Although the information was solicited by the clerk through a formula, the patient’s responses were often indicated as if in her own voice, or the language of the response can be inferred to be the voice of the patient. The “present symptoms” section reveals a more ambiguous voice: the clerk translated the patient’s description of her symptoms into a more “medical” language and noted the condition of pulse, bowels, menstrual period, and tongue. The patient’s voice, however, inserts itself in expressions of pain, patterns of sleep, and descriptions of when she felt most ill. In moving to the “treatment” section, the patient’s voice was clearly subsumed under that of the medical practitioner. Once a course of treatment was decided upon, a prescription was ordered and treatment began. The case notes record patient responses to treatment throughout the progress of the case, but the focus of the progress report is the physical signs of the patient’s reactions to various therapies and medical adjustments to courses of treatment.24

Although entering an asylum was a very different experience from entering a hospital, the records produced by both types of institutions are quite similar with regard to the information about the patient’s history and lay opinions about causation of disease. Indeed, in some ways the asylum notes are even more revealing with regard to the ways doctors and patients conceptualized the interactions between body and mind, environment, and socioeconomic circumstances. Additionally, as will be illustrated below, lines between mental and physical disease were not always finely drawn. The majority of patients at the West Riding Pauper Lunatic Asylum
(WRPLA) entered the institution with an order of admission from a Poor Law relieving officer or medical attendant, in most cases the practitioner who had been observing the patient before her transfer to the asylum. The order of admission recorded the patient’s social and medical history. Upon admission, these orders were transcribed into a casebook, and the attending medical officer at the asylum supplemented them with any new information garnered from the patient, her relatives, or her friends. The early Victorian asylum director Dr. C. C. Corsellis probably was the author of the majority of the case notes, but it is possible that the clinical clerk mentioned in the annual reports after 1842 might have become responsible for taking the cases at this time. The medical progress notes in the WRPLA volumes tend to be very limited, sometimes restricted to one comment a year for patients whose illnesses required long-term confinement.

There is much similarity between the hospital and asylum patients in terms of descriptions of symptoms, assumptions about how patients became ill, and the treatments ordered by medical attendants. There are, however, some central differences between the hospitals and the asylum. First, almost all asylum patients were characterized as paupers, meaning that they were unable to pay for their own care and were supported from public funds. Some were transferred from Poor Law workhouses, although a few came from private asylums. The patients at UCH and the Sussex hospital were charitable cases, meaning that they were supported by private donations. Second, women entering hospitals would generally choose to do so; the element of choice is not so clear with asylum patients. Third, although the hospital records offer a lot of detail about the specific illness from which each patient was suffering, the asylum records offer only general categories of insanity—mania and melancholia—as diagnoses. Examining hospital and asylum records together gives a fuller picture of the physical and emotional health experiences of poor women, and is revealing with regard to the health care options open to them. The thorny question of how we hear a patient’s voice through a medical case is one that applies to all patient records, but is especially difficult with the insane, whose ability to represent themselves rationally is itself an issue. As Michael MacDonald has pointed out, “historians of insanity do not in the first instance study the insane at all: they study observations of the insane.” Most often it is the voices of medical attendants that come through in a patient case, but “in some instances it is possible to detect in [these records] the beliefs and concerns of the patients’ families and sometimes of the patients themselves.”

As my interest is in the ways female patients situated health and illness in their daily lives, my analysis focuses on the history and present illness
sections of each case record. The vast majority of cases from each of the three institutions contain biographical material that includes name, age, marital status, number of children, occupation and condition of place of work, location and condition of residence, place of birth, and financial status. The asylum histories additionally contain details of religious affiliation and, in later volumes (as required by the Lunatics Act of 1845), details about the ability of the patient to read and write. The medical information includes patient narratives of their previous illnesses, present illness, parents’ and siblings’ health histories with notes about hereditary disposition, and the causes to which patients attributed their illnesses. In cases where the patient was too ill to give her own history, relatives or friends contributed these details. All this biographical and medical information was recorded unsystematically, shifting from volume to volume, or even case to case, with the asylum cases—as state records—being generally more regularized than the hospital records. Some cases allow for extremely fruitful readings, while others prove rather barren.

The nature of my project makes certain assumptions about the medical case history as a source of knowledge. Although I do not claim that we can get at working women’s “experience” directly through an analysis of the patient narratives, I do argue that these documents can reveal how some patients talked about their bodies and represented their lives to their medical practitioners. They made choices about what to say, just as the clerks and doctors made choices about what to include in the records. Any analysis must take into account that what seem to be firsthand patient descriptions are mediated by the clerk and/or physician. As Guenter Risse and John Harley Warner point out, the historian has to tread carefully when using patient records, for there is “no doubt the history-taker frequently reinterpreted, misunderstood, or dismissed what the patient said.” Taking into account the representational nature of the knowledge about poor women contained in them, the case histories provide rich insight into various layers of the patients’ perceptions of health and illness. This is particularly important for exploring female health, as the vast majority of texts from the early Victorian period were written by men. As Jane Long has indicated, “poorer people themselves were rarely heard in ‘conversations’ about their circumstances, and this silence finds its reflection in the historical literature. . . . Working-class women . . . bore a double burden of silence in their own society, and absence from the subsequent interpretation of it, as a result of both their gender and class position.” The case records open up a possibility for “hearing” poor women. These case histories suggest how these women, their families, and their friends expressed their experiences to their doctors and what was important to them in their understandings of health and illness.
Patient Profiles

An analysis of the patient records allows us to get a general picture of the women who came to the London, Chichester, and Wakefield institutions for medical assistance. Sixty-one percent (1,490) of the cases in the UCH sample noted occupation. Of these, 951 women identified their occupation as some sort of domestic service, be it cook, charwoman, housemaid, general servant, or maid of all work. The second largest occupational group was laundresses and washerwomen, encompassing 110 of the patients, and the third largest was the eighty-seven women occupied in needlework or the needle trades (especially dressmaking and millinery). These three categories of labor—service, laundry, and needlework—made up 77 percent of all the women admitted to the hospital with occupation given. Other employments that recur in the sample are fruit sellers, nurses, and milk women. There were a few shopkeepers as well as some women who worked with their husbands in trade, as tailors or shoebinders, for example. Only thirty-one women claimed that they were solely occupied at home with domestic duties, while twenty-one indicated that they had no occupation. Nineteen women were identified as prostitutes or “on the town,” making up about 1.3 percent of those noting an occupation. Only one woman was obviously engaged in some kind of factory work. This occupational sample reflects the typical employments of London women, especially for the West End area in which the hospital was located. The occupational sample would have been different, however, for areas such as Spitalfields—a concentrated area of weaving—or other parts of the East End, where more women were engaged in industries such as match-making.

Ninety-four percent of the UCH case histories recorded age. More than 35 percent of the women who became inpatients at the hospital were in their twenties (841, 36.5 percent), and 59 percent were between the ages of sixteen and thirty-five. In the 1,334 cases that noted marital status, 511 women were married, 625 were single, with the remainder being widowed. In all, about 62 percent of the women patients whose cases noted marital status were unmarried. The patients almost universally lived in London or very close by. Many women, however, indicated that they were not London natives but had come to the metropolis in search of employment or as part of a move with a family or husband looking for employment. In her study of eighteenth-century Bristol, Mary Fissell has argued that the poor who utilized the Bristol Infirmary were primarily those who fell into dependency without local networks to support them through a health crisis. The large number of unmarried non-London
natives suggests that this might have been the case for many London female hospital patients in the early Victorian years.

With the exception of occupational information, the Sussex records reveal a fairly similar patient profile for the women attending the Chichester Infirmary. Overall, 98.6 percent of the West Sussex cases noted age. Almost twice as many Sussex patients were under the age of ten as the London patients, possibly due to the fact that the very young visiting the Chichester Infirmary were primarily outpatients (75 percent). This suggests that parents were reluctant to have young children stay at the Infirmary or, alternatively, that medical attendants did not admit children. As in the UCH sample, the majority of Sussex cases were women between the ages of sixteen and thirty-five (60 percent). About one-third of the cases contained information about marital status, and of these, 469 women were noted to be married, 407 to be single, and 41 to be widowed. This is unreliable information, however, for the patient registers only gave the option to note “married” or “single”; thus many widowed patients were most likely included under the category of married. In any event, this breakdown of marital status contrasts with that in London, where single women predominated. Interestingly, however, of the medical inpatients in the Chichester Infirmary—the group that parallels the UCH sample—almost 60 percent were unmarried, which reverses the overall proportions at the Chichester Infirmary and matches the findings for UCH.

Occupational data in the Sussex female case histories are problematic, as only 15 percent of the cases recorded female patients’ occupations. In addition to the problem of this small sample, the occupations noted cluster heavily in service and needle trades—neither of which seem to be listed in any kind of systematic fashion. For the male patients, clerks recorded occupation on a regular basis, indicating the stronger cultural associations between men and work, as well as the assumption that employment played a greater part in men’s health concerns. Many male cases recorded employment in agriculture, and I expected to find evidence of women’s agricultural employments in the records as well. Although these employments certainly existed, they are absent in the case histories as an occupational category for women. Edward Higgs has shown how absences in nineteenth-century censuses reflected understandings of what counted as work. For example, “in 1841 householders were advised that the ‘profession &c of Wives, or of sons or daughters living with and assisting their parents but not apprenticed or receiving wages, need not be inserted.’” In 1851, although the census included women’s paid occupations, “the work of women in the family economy was still defined . . . as a residual category to be left blank. . . . Since there was no guidance given as to the treatment
of part-time, casual or seasonal employment done in conjunction with
domestic tasks,” much of women’s employment was not recorded. Because women’s agricultural work was both seasonal and casual, we can speculate that its absence in the hospital records is a consequence of the same definitions of what constituted work, especially in the case of married women.

The statistical breakdown of the asylum patients differs in some significant ways from that of the hospital patients, most specifically in the age and occupational categories. Of the 1,450 cases that recorded age, 393 were in their thirties, 330 in their forties, and 328 in their twenties. Proportionately, more than twice as many women were over fifty in the asylum sample as in the hospital samples. More than 95 percent of the case histories noted marital status. Of these, about 51 percent of the patients were married, 37.5 percent were single, and about 11 percent were widowed. These numbers mirror the overall Sussex sample.

The occupational picture of the asylum patients reflects the textile region in which the asylum was located. Out of the 1,092 cases that identified occupation, 216 (20 percent) noted work with textile industries, both in domestic settings and in factories. Fifty-three cases specifically indicated women’s employment in mill or factory work. This figure, however, could be much higher, as many occupations were noted simply as weaver, spinner, or burler, and thus it is unclear as to whether the labor took place in industrial or domestic settings. The three categories of labor most prevalent in the London and Sussex samples—service, laundry, and needlework—made up only 254 of the cases, or 23 percent of the asylum sample. Almost 30 percent (308) of the patients had their occupation connected to household or family duties, and fifty-eight had no occupation listed. This large number of women whose cases linked their employment to domesticity could be a result of the greater number of married women in this sample as compared to the London sample.

Institutional Medicine and Women’s Health

Understanding how illness was documented within medical institutions and knowing who the patients were provide a context within which to explore the medical cultures of both medical practitioners and their patients. Although my analysis of the medical testimony in the parliamentary investigations stressed a seemingly unified understanding of the physiology of women grounded in the reproductive functions and a reliance on the miasma theory of disease, in the case histories we see the coexistence of
a variety of approaches to the body and to medicine in general. During the first half of the nineteenth century, professional medicine was undergoing a transformation defined by a gradual acceptance of local, organ-related explanations (what we would consider more modern explanations) of disease over humoral-systemic explanations. Patients, too, were caught in this transformation, moving from a world in which they spoke a language in common with their doctors to a world in which lay and professional medical languages began to diverge. The patient records express a conglomeration of understandings of the human body that suggests that the early Victorian period in medicine was a complex one that needs to be studied in its own right, rather than as a period of transition from premodern to modern.

The case of Elizabeth Lee, for example, a patient of Dr. Taylor’s at UCH in April 1842, reveals some of the tensions between systemic and localized understandings of illness:

Has never known uninterrupted good health of any considerable period together of her life, but has suffered from various complaints at different times from an early age, and some have been of an acute and urgent nature. Some of these she says have been “inflammations” but as to the particular seat of them or the parts affected by them she does not give any satisfactory information other than the dropsy in her legs when 19 years of age . . . and she believes she has had three bowel attacks or “inflammations” of the abdomen and attacks of her chest, that for these she had been bled from the arm 59 times and has had many leeches and blisters applied to the chest and abdomen at different times and has had her mouth made sore a few times by medicine [most likely, mercury] and besides is much prone to bilious attacks.

In this case, the patient’s and clerk’s perceptions of disease were in contention. The patient used the terms inflammations and bilious attacks to indicate nonspecific illnesses that could affect different parts of her body, while the clerk searched for a more specific disease entity to describe her ailment. In another case, Eliza Hellyer stated that she was “always subject to ‘bilious attacks.’” By setting off the woman’s language, the clerk denoted the tension between the patient’s reading of the disease and his own.

Historians have most often discussed this tension in the context of the late eighteenth century—where Michel Foucault located “the birth of the clinic”—and examined it in terms of a transition between early modern, neo-Hippocratic and modern, new clinical medicine. Neo-Hippocratic
theories of disease found their bases in the medicine of the ancients, codified and systematized by the second-century physician Galen. This was a medicine that rooted the human body firmly within its environment. The body’s elements were analogous to environmental elements, specifically air, fire, water, and earth, and were connected with qualities of temperature (hot and cold) and moisture (wet and dry). Additionally, qualities and elements were associated with the body’s four humors—blood, phlegm, yellow bile, and black bile—which needed to remain in balance in order to maintain health. Illness meant an imbalance in the body’s humoral makeup and was treated with efforts to restore equilibrium.46 Doctors relied much on patients’ descriptions of their symptoms and little on physical examination, and treatments were individualized.

Essential to this understanding of the body was the close attention paid to its various evacuations: urine, feces, perspiration, and menstrual blood, among others. The obstruction of any of these processes was viewed as a dire sign of ill health, and treatments involved the opening of the bowels, bleeding, or purging to regulate the body. In many ways, the body’s fluids were fluid themselves; a nose bleed, for example, at the time that menstruation was supposed to occur could be read as a substitute for menstrual bleeding. Although nineteenth-century doctors and patients did not speak so clearly of humors, humoral categories were still embedded in the explanatory medical frameworks and treatments shared by both. The case histories reveal that the environment, the idea of imbalance, and bodily evacuations were central to the understanding of the body for doctor and patient alike.

Simultaneously, emerging in the late eighteenth century was a new clinical medicine, based in the new teaching hospitals and premised on discovering the seat of disease in a particular organ, rather than in a holistic imbalance of the body.47 This organic reductionism was predicated upon regularized post-mortem examinations, which allowed physicians to locate the sites of diseases in a systematic manner and to base their clinical assessments of health and illness on various internal signs and symptoms. Whereas previous medical systems focused on the particulars of the individual, the new clinical medicine focused on the case as representative of a certain amalgam of symptoms. This approach to the body took away patient power in defining disease, as new more technical languages of health and illness were born.48 Additionally, medical instruments such as the stethoscope were increasingly utilized by professional medical practitioners in the early nineteenth century, further separating lay and professional knowledge. By the Victorian period, the new clinical medicine was well established in hospitals but certainly had not effaced older approaches
to the body. Through the medical case histories, we can see how doctors combined new reductionist and older holistic visions of the body. The patients’ medicine was similarly complicated, drawing on a variety of experiential and theoretical understandings.

Some of the standard information in the case histories reflects humoral conceptions of the body. For instance, in the UCH cases, a patient’s temperament, or habit, was noted in humoral terms. The clerks described various patients as possessing a “sanguineous,” “sanguino-lymphatic,” “leucophaegmatic,” or “plethoric sanguineous” temperament, terms that recall the humors—specifically blood and phlegm. The languages in which the women described their illnesses appealed to the humoral theory’s stress on the constitutional and environmental balance of various elements and the interrelatedness of the body’s systems. One patient, for example, characterized her disease as traveling throughout her body: she “took cold and was then seized with rheumatism in the hand, which has been flying about her and attacking her joints chiefly and three days ago it settled in her hand.” Likewise, Mary Ann Pollen, a patient at the Chichester Infirmary in 1848, indicated that she “had pain in the right side 3 months ago, which then left her, and settled in the left side.”

The patient records reveal that while medical examinations and diagnoses focused on locating specific disease entities in “particular seats” and “parts,” hospital treatments such as leeching, purging, blistering, and bleeding reflected older systems of medical therapeutics that aimed to restore balance to the body. Mary Fissell has shown that by the late eighteenth century, medical diagnoses were increasingly articulated in Latin and “served to separate patients and doctors.” Therapeutics, too, Fissell argues, distanced patients from their healing process, for, like diagnosis, they “emphasized the aspects of illness most removed from the patient's own understanding,” by routinizing treatments based on a clinical reading of the body, rather than the patient’s description of illness. Yet the evidence from the patient case histories shows that doctors listened to patients’ accounts of their illnesses and previous treatments, and these accounts made up a significant portion of the case notes. Even if diagnoses were written down in Latin and results of examinations were phrased in technical terms, it does not preclude the possibility of careful conversation between patient and practitioner in order for the practitioner to arrive at the diagnosis. The case histories suggest that diagnosis and the treatments following from it were still at least partially a process of negotiation. Additionally, the evidence from the case histories I examined does not support Fissell’s argument that routine treatments divorced patients from their disease experiences. Patients’ self-treatments accorded with those...
received from a wide variety of practitioners—indicating, if anything, that hospital doctors were still to a certain extent beholden to patient expectations and shared views with their patients of how these therapies worked. Although patient and doctor may not have been speaking the same language in terms of diagnosis by the early Victorian years, they still inhabited the same world of treatment. These treatments were utilized for physical and mental ailments alike and were adopted by professional and lay practitioners.

Poor women used various strategies to get well. David Harley has recently pointed out the importance of the rhetoric of medical practice. What different types of practitioners offer are different interpretations of a patient’s health and illness experiences. Harley argues that “all practitioners, from university graduates to village wise women, had to provide explanations that satisfied those who consulted them,” and that the production of medical theory for lay consumption “can profitably be seen as competition for the control of meaning.”54 The patients in the three institutions I examined appealed to diverse practitioners to help them understand and control their illnesses. And as Harley usefully suggests, in approaching a wide variety of healers, patients sought out different meanings of their bodily experiences, “although the remedy might sometimes be detached from the explanation by patients.”55

The case histories demonstrate that many poor women tried to treat their illnesses themselves before turning to semiprofessional or professional care. For example, Mary Jane Spong was at UCH in 1842, suffering from eczema. Her hands

became sore and she scratched them a great deal, and put them in this state in water containing soda in what quantity she does not know. They did not become much sorer till 10 days after. She first poulticed them applied elder ointment, salt water &c but before they became worse some friends of her husband advised her to use her urine. She did this and found they became worse every day.56

Members of the laboring poor sought out assistance in treatment from family and friends. Mary Shawyer, a Sussex patient suffering from an inflamed bursa patella, “had six leeches applied . . . by her mistress with whom she has been living as a maid of all work.”57 Leeching was thus something that could be monitored by lay and professional persons alike. One patient at UCH, the servant Susanna Middletown, was having problems with headaches in the early 1830s, and “to relieve these she took about 9 months ago some quack medicine, at the advice of a friend.”58 The friend’s
therapy proved useful as Middletown’s headaches stopped. A side effect of the medication, according to the patient, was that her menstruation was suppressed. It is impossible to know from this record whether Middletown or the clerk characterized the medicine as “quack.”

Self-medication was popular among the patients at University College Hospital. A visit to the chemist or apothecary’s shop or a local dispensary was an integral part of self-help treatment. Sarah Green, a UCH patient in 1845, had “never applied to any one for relief, taking occasionally a pill or two obtained from a druggist’s shop.” Eleanor Wall, a washerwoman suffering from ascites, “had two powders from the Marylebone Infirmary before her admission” to UCH. In a case from the Chichester Infirmary, Ann Marshall, “says she poisoned herself 5 months since by anointing herself by a home-made mercurial ointment for . . . itch. She says she swelled and broke out and has not been well since.” Remedies were easily available from the local druggist, and women experimented with various self-administered therapies to cure their ailments.

Many of the hospital and asylum patients had sought aid from medical practitioners before their institutional admissions. Perhaps this would be the Poor Law doctor assigned to their parishes, a physician or surgeon offering his services on a charitable basis, or a practitioner connected to a dispensary or infirmary. These medical men utilized therapies similar to those used in the hospitals and the asylum, and the details in the case histories of treatments previous to admission reveal that mental and physical illnesses were approached with the same remedies. Leeching, purging, blistering, and bleeding, in addition to various powders, formed the center of the therapeutic regimens for both mental and physical ailments. “Antiphlogistic” approaches to the body to reduce inflammations and fevers, as well as opening, “aperient” medicines to treat constipation, were common therapies. For example, Mercella Lacey, a servant of all work, was suffering from pains in her stomach and side. She “had some medicines from a chemist. She was seen on Saturday by a medical man who bled her to a pint, applied leeches to the abdomen and administered opening medicines, also a blister to the Epigastrium.” In the case of Maryann Hodgetts, a dressmaker suffering from paralysis, the patient’s medical attendant was called in for several attacks. “She was bled, cupped, blistered, and leeched . . . was salivated, and ordered to have her head shaved, and ice applied to it.” These treatments for physical ailments have their parallels in the asylum cases. Catherine Davidson’s medical attendant before her admission to the asylum described in detail the course of treatment prescribed for her: she had “been bled, had Emetics, Purgatives, nauseating Diaphoretics, cold Evaporating Lotions to the Head, Pediluviums and recommended the
Head to be shaved and the application of Leeches but which could not be accomplished, nor could she be prevailed upon to take medicines in any satisfactory manner.” Under the care of the surgeon Mr. Hudson, Sophia Eastwood was “bled in the Arm (16 ounces) had twelve Leeches to the Temples, a blister on the nape of the neck—Medicines Calomel: Antim Tart with difficulty got her to take enough to produce catharsis or nausea,” in the effort to cure her insanity.

Not surprisingly to us, perhaps, some patients expressed dissatisfaction with the treatments they underwent before their admissions. Anne Cheeseman, who became an inpatient at UCH in February 1846, described her path to the hospital:

She first noticed a swelling in [her throat] after a cold; it was then somewhat smaller than at present . . . she thinks it then came “all at once.” A medical man advised her to apply 2 leeches which appeared to diminish the swelling somewhat, but in about 3 weeks from the first application . . . she had 2 more leeches applied which bled very much and made her feel very weak. . . . Another medical gentleman then attended her who ordered her to use a stimulating ointment which “very nearly killed her” and to take some medicine.

Although Cheeseman’s treatment cannot be classified as successful, her willingness to attend the hospital even after these bad experiences with medical men indicates a certain faith in medical authority, or a lack of other resources. This passage also illustrates how the clerk could retain the patient’s voice in his transcription. While all the information in the passage comes from Cheeseman’s narration of her experience, the clerk put quotation marks around Cheeseman’s descriptions, singling out phrases like “all at once” and “very nearly killed her.” Although this sets off the medical from the nonmedical, it simultaneously validates Cheeseman’s interpretation by deeming it worthy to be included in the record. In a similar case, Elizabeth Barren was a waistcoat maker admitted into UCH for chronic bronchitis in December of 1842. She had begun to feel sick the previous April, when she “was bled and leeched 4 times, allowed to take nothing but Barley water or gruel for 3 or 4 weeks—some Pills and Powders were administered” under the orders of a medical man. These treatments produced constipation for which she was given “several doses of Castor oil and some draughts which cured her gradually over a period of weeks.” After returning to her employment, however, she had another attack of bronchitis “which lasted about five weeks.” This time, though, she did not “apply to a medical man, but took laxatives and applied mustard poultices and blisters to the epigastrium,” which caused her “urgent
symptoms” to subside. In the end, it was Barren herself who was best able to treat her illness.

In the above cases, it is unclear whether the noninstitutional practitioners were regular (licensed) or irregular (unlicensed) medical men. The female patients, however, clearly did turn to irregular, or quack, practitioners for health care. The evidence of quackery in the institutional records confirms that use of regular and irregular doctors was not mutually exclusive; poor women consulted both in their efforts to treat their ailments. In a case of “quackery,” Mary Ellen Tree had stopped menstruating. The clerk’s voice is clearly present in the description of what followed:

To bring on the menstrual secretion, three months ago she went to one of those abominable quack doctors, who gave her physic, and recommended her to take Hoopers pills, till she perceived a return. Well—three of these she took regularly every night for about three weeks but without benefit. They only “upset” her stomach, and induced nearly immediately diarrhea and symptoms of cholera. Still she persevered, till after the tenderness and dysentery getting worse, and no menses appearing she began to think she had enough of them, but not without them leaving her a legacy, which she has not yet exhausted.

Here the clerk passes judgment on both the quack doctor and the patient herself for being foolish enough to visit a quack in the first place and for continuing treatment when it was plainly not helping her.

In the hospitals and the asylum, doctors and patients seemed to agree on most treatments, but patients did rebel against certain therapies. Hospital patients were not always passive recipients of professional medical authority, and the female patients expressed independence in their medical choices. This is especially evident from the London cases. Some patients made it obvious that they wished to leave the hospital because they disagreed with the treatment or were not comfortable with hospital medicine. Eliza Price, for example, stayed in UCH for only three days before she “left the hospital saying she would have no experiments tried on her.” One patient “chose to go out rather than be examined,” and another “refused to submit to an examination and was therefore discharged.” The threat posed by “examinations” demonstrates that physical touch still raised suspicion as a tool of diagnosis. Mary Baker provided the clerk with an opportunity for sarcasm, for “a small bottle of Wine and also one of opium were found in her possession—she appears to think she understands her case better than any one else, and she was, at her own request, this day Discharged relieved.” The surgeon Mr. Liston had problems with Mary
Browne, a milliner with disease of the ankle joint. On April 2, 1836, “Mr. Liston proposed amputation, but she will not consent to it,” and by May 3, “she still refuses her consent to the operation. Mr. Liston requested her dismissal.” Elizabeth Ellis, a patient at the asylum, complained “bitterly of the shower bath but appears less unsettled since the use of them.” The patients’ expressions of antagonism suggest that some women were hesitant to submit to institutional intervention, perhaps preferring less formalized methods of treatment, distrusting professional medical practitioners, or experiencing discomfort with the close scrutiny of their bodies by medical attendants.

A few records hint that some patients viewed the medical institutions as a refuge, more connected to general welfare than to medical care. Some women wished to remain in the hospital rather than return quickly to difficult employment or poor home conditions. Sarah Gibbs, a fifty-six-year-old servant admitted to UCH in February 1836 with chronic bronchitis, was described by the clerk as “of aged appearance, indicating weakness. Has had severe illnesses as fever and the like—not particularly cleanly habits.” A month after the patient’s admission, the clerk noted that she was “sufficiently well to go out, but waits for finer weather and a little more strength,” suggesting that the hospital may have been a more welcoming environment than the one to which Gibbs had to return. Hannah Connell’s notes state that she was discharged on March 23, 1842, “but Dr. Taylor permitted her to remain for a few days and she went out on the 28th March.” Dr. Williams of UCH was not so lenient. Admitted in November 1839 for sciatica, Elizabeth Pegler, a twenty-seven-year-old charwoman, was still complaining of severe pain on January 9, 1840: “Says that she is quite unable to walk or to walk on her right leg.” The clerk, however, noted that she was “suspected to be better than she describes herself,” and she was subsequently discharged two days later.

Asylum patients also seemingly became dependent on the institution. Ann Clapham, a cloth spinner from Giesly, came to the asylum in 1837 “without any Warrant and begs she may be allowed to remain at least a few days—she appears very distressed and desponding and is labouring under Dyspepsia.” This woman had been an asylum patient for six months in 1836 and had been discharged cured. In June 1836, Mary Finney, a married woman with five children, was admitted to the asylum. Her notes from September 1837 indicate that she “continues quite well and says if it were not for her Family she should like to take up her abode in the Asylum.” As will be discussed further, a hospital or asylum could also function as a type of shelter for women suffering from domestic abuse.
The evidence in the case histories complicates the binary construction of early modern/neo-Hippocratic and modern/clinical medicine that many historians have used to understand medical history in the late eighteenth and nineteenth centuries. The case notes show that there was space for differing medical assumptions to coexist, that some notions about health were shared between doctor, clerk, and patient, while others were not. Diagnoses and treatments were not based upon any systematic adherence to either humoral or newer more reductionist approaches to the body.

The patients in each of the regions studied seem to have had a general holistic attitude toward health which drew on understandings of social, cultural, and environmental factors in relation to the body, issues which the following chapters illuminate further. Patients improvised their understandings of their bodies, drawing on a whole spectrum of cures in their attempts to become well. Doctors’ responses to their patients’ efforts at healing were ambiguous, sometimes supportive, sometimes judgmental and mocking. Nowhere, however, do treatments suggest an overemphasis on the reproductive body.

We can, however, think about the reproductive body in the context of the various medical approaches to women’s health discussed above. The significance doctors attached to the reproductive organs in determinations of female health can be seen as reductionist, locating specific ailments in particular organs. Yet, to argue, as the medical witnesses to the parliamentary investigations did, that women’s reproductive functions defined female health was to see women’s bodies holistically, in terms of questions of balance. Indeed, even as the more modern, disease-entity approach to the human body became the norm as the nineteenth century progressed, official understandings of women’s health remained rooted in the reproductive body, which in effect constructed a gendered approach to the body overall: men’s bodies were seen through the lens of specific ailments, while women’s bodies were perceived in terms of ancient traditions of the interconnectedness of bodily systems. Women themselves, as we will see, described their health appealing to the many languages available to them.