
Patients, Practitioners and Lodgers: Male Sexual Health Patients' and their Healers' Use of Location in Early Modern Medical Encounters

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The 1658 edition of sixteenth-century Zurich surgeon Felix Wurtz's treatise *The Surgeons Guid* [sic] complained that, 'Patients are like Children, still desiring such things which are offensive and hurtfull'.¹ Early modern medical literature produced by physicians and surgeons is littered with complaints about the behaviour of their male sexual health patients. They were particularly aggrieved that reckless consumption of food and alcohol, and engaging in sexual activity undermined their efforts to cure the body. As Wurtz noted, without close supervision patients made their surgeons 'accessary to the evill that should ensue'.² He therefore cautioned surgeons to monitor and regulate their patients because if 'he should not do well, then all the fault would be laid upon the Surgeon'.³ These complaints and the actions of such patients reveal that the relationship between male medical practitioners and their male patients was sometimes difficult and characterised by the tense negotiation of authority.

The patients examined here all suffered from either sexual health or genitourinary conditions such as venereal disease, kidney and bladder stones, and hernias. These men were not unique, and tend to reflect the behaviour of patients more generally. Both genders were liable to manipulate healers in order to receive treatment that accorded with their own ideas about suitable remedies and therapies.⁴ In the complex and competitive medical marketplace patients willingly and wilfully abandoned medical practitioners who did not comply with preconceived notions of treatment. Additionally, patients who remained with one practitioner could be evasive, demanding or obstinate. They could actively or passively hinder treatment regimens. Women as well as men were obstructive patients.⁵ One apothecary complained that a female venereal disease patient was irregular in her behaviour and would not be confined to her chamber, her prescription, or the requisite diet to allow him to cure her.⁶ Medical men described how they had to change their treatment plans because women were uneasy.⁷ And some practitioners were overruled by the strength of their female patient's convictions, bolstered (as men were) by disparities in social and economic status.⁸ Scholars have

explored in detail the ways in which female patients interacted with early modern healers, focusing on how ideas of modesty and the potential for eroticism shaped these encounters.⁹ Despite excellent studies by Robert Weston and Alison Montgomery, far less attention has been paid recently to men's interactions.¹⁰ Men suffering from genitourinary conditions often experienced shame and embarrassment and as such were, perhaps, more likely to end up in a fractious or contentious relationship with their healers.¹¹ They also faced moments of crisis if their ailments caused impotence, infertility, and a loss of facial hair that undermined the manliness of their bodies.¹² Their actions were then likely to be implicitly shaped by notions of manliness, as women's were by ideas of femininity, even as these conflicts manifested as negotiations of authority. In scrutinising men's fractious relationships, the article will prompt social historians of medicine to reconsider the relationship between men and their healers. To fully understand medical interactions in this era both male and female patients need to be considered.

One tool that patients and practitioners (here referring predominantly to physicians, surgeons, and apothecaries rather than itinerant practitioners, empirics, cunning-folk and other unregulated healers) used, although not always consciously, was space – in terms of particular sites. Space could be used by both groups in their attempts to exert authority and control over the patient/practitioner interaction. Male patients used space, and place (here meaning geographical location), as part of a strategy of resistance against the investigations, diagnoses and treatments recommended by medical practitioners. Medical practitioners in turn obliged patients to occupy certain spaces to enforce their treatment regimens and utilised space to negotiate the hierarchical relationship with other practitioners. Male patients did not solely rely on space to disrupt the work of their medical practitioners, and this article does not argue that if space and place were removed from the examples below that tense interactions and struggles for authority would not have taken place. Rather it suggests that space facilitated men's articulations of their desire for particular medical outcomes or exchanges. Space is therefore one element of the patient/practitioner interaction that deserves further scrutiny. As men acted in a range of ways that disrupted the medical interaction, the article begins by exploring the various complaints, like Wurtz's, that medical practitioners made about their patients. It will then consider the role of space in these contentious relationships.

The texts discussed here were published between 1658 and 1757. Printed materials discussing medicine and the body flourished from the mid-sixteenth century.¹³ Costly folios down to cheap palm-sized books were available in a way that they had not been before. Particularly during the civil wars when print censorship was suspended and there was a backlash against medical elitism, the availability of medical self-help literature increased rapidly.¹⁴ Between 1649 and 1699, 282 books on medical-chemical and astrological themes alone were registered with the Stationers' Company.¹⁵ Many of these books were translations of works originally written on the continent. These European texts connected medical practitioners and interested readers, and reveal a shared medical culture. Although specific cases might not be directly comparable to customs or experiences in England, the publishers of these works believed English audiences would find them relevant. Even though large and heavily illustrated tomes were very costly, some medical texts were relatively widely read.¹⁶ Mary Fissell has shown that numerous medical texts were sold at auctions for lower prices and so

circulated more widely, than brand-new copies did.¹⁷ Purchasing a work through the second-hand trade made them available to a wider cross-section of society.¹⁸ It also ensured that medical treatises had a long shelf-life, which helped to create a medical culture where changes of orthodoxy were slow to occur. Although Wurtz's treatise was an English edition of a sixteenth-century work, these texts largely cover practitioners working in the seventeenth and eighteenth centuries, until approximately 1740. These examples, therefore, consider the experience of medical care up until the time humoral theory began to be superseded by nervous medicine, and the time when medical consultations were increasingly shaped by the language of sensibility.¹⁹ The focus on the second half of the seventeenth century and the early eighteenth century is dictated by the fact that texts produced prior to this include few detailed descriptions of cases. These became a more prominent feature of surgical texts from 1660 to 1700.²⁰ It is also dictated by the survival of manuscript case notes which are more common for this later period. It is not the intention of this article to explore in detail whether men's actions changed over this period; however, the relative similarities in many of these cases suggest that men's actions broadly were a consistent feature of medical interactions.

Unruly and obstinate patients

In the earlier part of the period considered here, certain patriarchal ideals rested on notions of self-control.²¹ Good manners were bound to self-control of the body.²² Neglecting one's health through unregulated consumption suggested that neglect of social duties was probably not far behind.²³ Being a good patient could demonstrate self-control and self-mastery, and, therefore, patriarchal manliness. Not all men attained such mastery. Wurtz and the authors of several medical and surgical treatises published, re-published and re-printed in the seventeenth and early eighteenth centuries explained that male patients were liable to be obstinate and unruly, unwilling to seek medical advice and unwilling to follow prescriptions. The continued discussion of these behaviours suggests that self-control, predominantly displayed through obedience to the prescriptions of a medical practitioner, remained an important feature of the manliness such texts perpetuated.²⁴ Acting in an unreasonable and obstinate manner may not always have been the result of a lack of self-control, even if it was interpreted and described as such by medical authors, it may have been a deliberate strategy for asserting dominance over, or reclaiming authority over the body from, the medical practitioner.

Exploring the context of French medical letters Robert Weston has demonstrated that tensions existed between elite male patients and the physicians and surgeons with whom they consulted.²⁵ Medics were usually of a lower status than their patients and were denied the authority granted to practitioners of the law and the church.²⁶ Practitioners' authority was, consequently, sometimes weak and patients challenged them based on their own social status, wealth and medical knowledge.²⁷ British healers were in a similarly precarious position. Physicians in Britain were tainted by the feminine associations of bodily care that their work connoted.²⁸ Likewise the suggestion that they engaged in manual labour and a craft compounded surgeons' inferiority. To combat these associations surgeons emphasised their learned traditions, technical skills and the manly aspects of their work such as the 'fortitude to cut unflinchingly into flesh

and physical strength to set bones'.²⁹ Sexual health patients might well have posed a unique set of challenges because both the practitioner and patient feared that their manliness and authority was precarious. In the examples examined in this article the men range from 'young' men through to those in their fifties. Many were described as gentlemen, but others were designated with occupations, for example a senator and a surgeon. It has not been possible to consider in more depth the role that life cycle played in these encounters but that the men varied in age and status suggests that these methods of resistance and negotiation were accessible to all men, rather than specific groups.

Pain and the inability to adequately complete daily activities often prompted men suffering from genitourinary and reproductive illnesses to seek medical advice and submit their bodies to the authority of a medical practitioner. However, this did not guarantee that men would not impose their own will onto a physician or surgeon, or act in rebellious ways. We should, however, be cautious of accepting accounts of unruly patients provided in printed medical and surgical texts. Lisa Smith has shown that eighteenth-century French surgeons used criticism of their patients to build 'textual authority' and a 'moral advantage'.³⁰ Wurtz fretted that surgeons would be blamed for a patient's continued ill health or death, and treatises reveal that medical and surgical writers used such stories to reinforce their own reputations of efficacy.³¹ In the case of failure practitioners suggested that the patient's unruly behaviour was actually to blame for continued or worsened symptoms, or death, thereby avoiding the implication that their own practice was ineffective.

As suggested previously, the behaviours that practitioners complained about in their patients mirrored behaviours that were already thought to make a healthy man unmanly; an inability to regulate one's desires leading to gluttony, excessive drinking, and licentious behaviour.³² Moderate alcohol consumption was beneficial to the healing body, however, excess was considered damaging. Lisa Smith has shown that one eighteenth-century French physician believed that 'persons subject to wine do not call the doctor except in extremity, because they know well that wine will be the first thing that they are forbidden to use'.³³ Barthélemy Saviard commented in his 'Remarks' on a case of suppression of the urine that he was surprised that the frequency with which the condition returned could not convince the patient to live a more moderate life. He concluded 'But he is not the first, that the most excruciating Pains could not prevail upon to quit the Passion of Drunkenness'.³⁴ While Saviard appeared resigned to such interference, other practitioners were more frustrated by patients' indulgences. In the observations recorded in the notebook of the Lockyer family, dating from 1675 to 1691, the medical practitioner who wrote the cases out explained that one of his patients – a man suffering from rheumatism in 1685 – relapsed because he drank too much ale, which made him 'very angry'.³⁵ The author told his patient 'if he used such imoderate [sic] drinking it was in vaine' for him to endeavour to cure him.³⁶

Likewise, gluttony was thought to jeopardise recovery. Disease and illness disrupted the body's digestive faculties; diet was thus a central feature of cure and recovery.³⁷ Patients were told to be temperate in their eating and drinking.³⁸ If a patient ate nourishing foods before any final purges had expelled the corrupt humours from the body they risked causing a relapse.³⁹ Jane Sharp wrote angrily in

The Midwives Book, while implicitly discussing male and female fertility, that 'I never could endure that preposterous way that most persons observe to the destruction of their Friends, that when they are sick they will never let them alone but provoke them to eat, whereas fasting is the better Doctor, so it be not out of measure'.⁴⁰ Even though Sharp was writing as a woman, her text drew on and echoed existing male-authored midwifery manuals.⁴¹ Wurtz claimed that:

... if a Patient be unruly, not caring for the Surgeons instruction, but fall on gourmandizing and drunkning, then no good is to be looked for; because the Patient refusing all natural helps, like a Swine trampling on Pearls, cannot expect any cure.⁴²

Neither Sharp or Wurtz suggested that patients acted purposefully to counteract their medical practitioners, but they did reveal that patients rode roughshod over the prescriptions they received, implying that medical practitioners struggled to impose their authority on some patients.

Inappropriate sexual activity was perhaps even more contentious for men suffering from genitourinary and reproductive disorders as poor regulation of their sexual activity may have contributed to their disorder in the first place. Wurtz was clear to point out this particular danger: 'let wounded parties not practice Venereous lusts, whereby the worst accidents are caused'.⁴³ Despite such cautions, some men were unable to bridle their lusts, sometimes with severe consequences. German surgeon Matthias Gottfried Purmann (whose observations were translated and published in English in 1706) recorded a case from 1694 of a twenty-eight-year-old draper treated for a watery swelling in his penis. He suffered a relapse after having sex with his wife before his condition was completely cured.⁴⁴ Although Purmann did not criticise the patient for satisfying his libido, he made it clear that engaging in sexual activity was inappropriate and caused the patient's relapse, and eventual death.⁴⁵ It is plausible that men returned to sexual activity as a way of asserting their belief that they had recovered. Hannah Newton has described how returning to a 'lusty' state was a feature of recovery narratives at this time.⁴⁶ Richard Wiseman suggested in several of his observations that patients' bad behaviour was inherently connected to their belief that they were recovered.⁴⁷ If this were the case then this disruptive patient behaviour was potentially a means of reclaiming possession and authority over the body. A desire to return to daily life, and importantly to work, likely also prompted men to interpret their changing condition as a return to health.⁴⁸

No matter the motivation medical writers, like Wurtz, found these behaviours frustrating and feared that bad outcomes might affect their reputation: 'the Surgeon looseth his credit and reputation, and all his pains he bestowed will be in vain'.⁴⁹ The disruptive behaviours of male patients may have been a strategy for reasserting dominance and authority, either consciously or unconsciously enacted. As will now be illustrated space provided a tool – like the consumption of food or engaging in sexual activity – for men to claim authority over and shape medical consultations and treatment. Tapping into the ways in which, as sociologist Fran Tonkiss has shown, spaces could be the objects of struggle, patients, physicians, surgeons and apothecaries determined the location of medical practice in order to claim authority over, and claimed locations as their own to dictate the medical interaction.⁵⁰

Space, place and sites of healing

Beat Kümin and Cornelia Usborne have suggested that historians need to grasp ‘Spatiality as simultaneously . . . a social product (or outcome) and a shaping force (or medium) in social life’.⁵¹ Katrina Navickas has emphasised that historians taking the spatial turn have tended to rely on the definitions of space proposed by Edward Soja and Henri Lefebvre – in which there is a tripartite division of space into the material and concrete, the symbolic and representative, and the lived as a combination of the two – and emphasise the representative element because it fits neatly with pre-existing ideas in the cultural turn.⁵² James Epstein has considered how space interacts with the performance of political authority and how the articulation of particular ideas might be shaped by and reinterpreted in spaces designated as either public or private.⁵³ Geographers have turned to notions of ‘embodied geographies’ to consider how space might interact with the performance of power and authority, and the ways in which bodies and spaces exist in a constitutive relationship.⁵⁴ The examples investigated below reveal similar notions that spaces, at certain moments, might allow patients or practitioners to articulate their own ideas about medical practice and treatment, and so achieve authority.⁵⁵

Place and space were inherently linked to health and wellbeing in the early modern era.⁵⁶ It was widely believed that environment, as one of the six non-naturals (rest, diet, mental wellbeing, exercise, environment and evacuations) should be regulated to maintain a healthy body. For many British writers, the best environment was Britain itself. It provided the healthiest climate, although certain fenland and marshy areas were thought to pose a threat to the body because stagnant standing water bred disease.⁵⁷ Likewise, the filth of towns and cities made them unhealthy.⁵⁸ This could affect those who travelled to urban areas. The death of the, supposedly, exceptionally long-lived Thomas Parr was attributed to his relocation from the countryside to London.⁵⁹ Practitioners and patients put this knowledge to practical use. They created, where possible, homes and spaces that took full advantage of healthy environments and used green spaces to combat disease.⁶⁰

Place – in terms of geographical location – could also be important for those living at a distance from a large town or city, who might have travelled to receive medical care from a physician or surgeon. Given the dangers that dirty city environments posed to the body, men and possibly also women, carefully considered this journey before undertaking such a trip. However, Ian Mortimer has cautioned scholars to be wary of the idea that people had to travel to urban centres for medical aid and has highlighted that most people in the rural hinterlands could access a medical practitioner quite readily; although people might still have travelled to large cities or spa towns to access a range of medical practitioners.⁶¹ As suggested here, certain places were also intimately connected with curative powers. Healing wells had a long tradition of being sites of medical pilgrimage, while spa towns, including Bath, Tunbridge Wells, Epsom and Scarborough were popular and fashionable healing locations throughout the period.⁶² Several medical writers throughout the early modern era produced treatises detailing the cures performed in these particular places, attributing the recovery of health primarily to the spa waters, but also on occasion making passing reference to the place itself. In his book *An Historical Account of the Wonderful Cures wrought by Scarbrough-Spaw* (1680) William Simpson implicitly suggested that the Spa in

Scarborough was a *local* centre of healing – as opposed to Bath and others to which people travelled to receive a cure.⁶³ In Mr Pala's case, who was suffering from the Jaundice, Simpson made it clear that the disease had been triggered by moving from Yorkshire to the south of the country, and that returning to 'his own country' in order to drink the waters was a crucial step in finding a cure.⁶⁴

Medical interactions, consultations, and treatments happened in a range of locations, both physical and literary. Many interactions between male patients and their healers occurred at a distance by correspondence, evidenced by the numerous letters sent to Sir Hans Sloane housed in the British Library. Aristocratic, rural gentry and urban bourgeois patients were all treated without the practitioner ever seeing the patient.⁶⁵ Despite never existing in the same space these relationships still displayed tension. Surviving letters from these encounters reveal that men experienced a moment of masculine crisis in which they spoke frankly about their bodies and revealed their medical conditions.⁶⁶ Importantly, as already noted, Weston has shown that in these literary encounters physicians' social authority was weak; this meant that imposing their ideas of treatments on patients was problematic.⁶⁷

Surgeons occupied a range of medical spaces while working. Lisa Silverman has outlined that French surgical consultations occurred in patients' homes and in a surgeon's office.⁶⁸ John Douglas wrote to Sir Hans Sloane in 1722 explaining that he would 'Cutt that Gentleman for the Stone, to morrow morning, therefore desire you will be at my House, against the Golden Falcon in Tetter Lane, exactly at half an hour after Nine'.⁶⁹ This was a substantial operation and accordingly was being conducted in the operator's home. However, operations generally took place in 'a mutually agreeable location', with minor procedures like phlebotomy being conducted at the patient's residence.⁷⁰ Surgeons also operated out of rented rooms and hospitals.⁷¹ When patients were given a say in where their procedures happened this invested them with some authority over the treatment regimen, which could be exploited if they so wished.

Hospitals were becoming a more established feature of medical practice throughout the early modern period.⁷² The hospital was another site of negotiation and the performance of gender because they imposed patriarchal standards; not only did they require patients to submit their bodily authority to others, but they sought to regulate religious, moral and behavioural values in their patients.⁷³ More than this, hospitals served as a means of isolating socially unacceptable groups, the plagued, the insane and the leprous.⁷⁴ They were thus institutions of social control. Hospitals are not mentioned very often in the examples cited below, but it is worth noting that this setting, again, provided a locus for the negotiation of authority. Hospitals did not represent a location of medical treatment entirely separate to that of the home. In part this was because domestic townhouses housed hospitals, until the institution outgrew its settings and had to move to purpose built premises.⁷⁵ Given their domestic setting it is plausible that they functioned in ways similar to what Amanda Flather has argued for middle-class domestic spaces; that they could 'express and enforce social differences between individuals and groups by the different ways that space is used and the manner in which it is controlled'.⁷⁶

Medical practitioners often worked in their patients' homes and lodgings. In histories of medicine the home has been viewed predominantly as the site of domestic medicine, sometimes termed 'Kitchen physick'.⁷⁷ There, women like Elizabeth Freke

produced complex remedies, including distillations, and used their skills to aid members of their family and local community.⁷⁸ However, recent scholarship has moved beyond the gendering of domestic spaces and domestic medicine as solely feminine.⁷⁹ Homes were multifaceted spaces. Businesses, especially small businesses, were run from locations that blended home, workshop and business premises.⁸⁰ Tawny Paul, investigating insults in early modern Edinburgh, has identified that during working-hours, homes that also served as shops were perceived as semi-public, if not entirely public spaces.⁸¹ Outside of working hours men claimed domestic spaces as their own, a sanctuary of power and authority.⁸² Men claimed authority by occupying particular spaces and their movement through spaces required bodily techniques and appropriate displays of their position.⁸³ The ability to restrict access to parts of the home also connoted authority. Certain parts of the home were not open even to those who lived in the household.⁸⁴ Masters, for example, might bestow access to certain rooms in the house upon apprentices as a favour, or restrict their access to enforce their own authority over the house.⁸⁵ There is little evidence that patients restricted the access of their medical practitioners, although it may have been that competition between different types of healers was expressed through the willingness of some groups to visit patients more freely or by providing a more open and accessible space themselves.⁸⁶ Given their need for succour this is perhaps not surprising. However, the medical consultation was a peculiar mix of the intensely personal and commercial activity and patients may well have interpreted the penetration by a non-family member (although medical practitioners could of course be family members) into the home as a relinquishing of authority. Domestic sites of medical treatment were, and are, inherently dynamic, shifting depending upon the actions of the social actors inhabiting them. The ability to claim certain spaces was at certain times a feature of authority, including during medical consultations and treatments.

Space, place and medical interactions

Practitioners visited men's domestic spaces when needed but were not on hand permanently to monitor treatment and recovery. Occasionally they may have stayed with a patient: John Wyndham who was suffering from disrupted sleep caused by 'gravel' (small kidney or bladder stones) noted that his doctor came to him on 11 April 1747 and departed on the 29th of the same month.⁸⁷ In dire or apparently dangerous situations, doctors sometimes also remained near the patient.⁸⁸ The physical separation of practitioners from their patients appears to have undermined their authority in directing medical care. The select cases of John Woodward, a physician working in late-seventeenth- and early-eighteenth-century England, were published in the mid-eighteenth century. The editor, Dr Peter Templeman, noted that 'It may be thought, perhaps, that he is sometimes tedious in his Narration'.⁸⁹ This tedious detail, while annoying to Templeman, reveals how this arrangement of visiting patients facilitated men's unruly and obstinate behaviours. Describing Mr Whitehead, a wine merchant who 'appear[ed] to be betwixt Fifty and Sixty' and suffered from nephritic pains and suppression of the urine, Woodward explained that he had ordered a lenitive and unctuous electuary. Mr Whitehead initially took the medicine as ordered but seeing that it worked and 'being averse to all Medicines, he left it off' allowing his symptoms to return.⁹⁰ Mr Whitehead, following the behaviours outlined previously, disrupted

and resisted his medical care based on his own assessment of his health. Woodward's absence from the space of medical treatment facilitated this, as he was not present to enforce Mr Whitehead's compliance. In a note from 2 August 1719 he recorded that 'visiting him this Morning, I was sorry to find he had not taken the oily Draught. He finding himself now pretty easy, being unaccustomed to Medicines, and having an Aversion to them'.⁹¹ That Woodward only visited the patient sporadically, and that treatment presumably occurred in the patient's own home or lodgings, perhaps bolstered his belief that following his own authority in such matters was preferable. As with other observations Woodward used this commentary as a means of explaining why the patient relapsed and had to take further prescriptions: 'I was sent for to him this Morning and found him in great Distress'.⁹² Woodward, like other practitioners, used stories like this to build a rhetoric designed to shame patients into appropriate behaviour. However, we can also see here that by including descriptions about the location of medical care Woodward was implicitly attempting to claim authority over patients' homes when they were used for medical treatment. It was important, he suggested, that patients remembered that even when they were in their own homes they should submit to his authority in order to secure health and well-being.

A patient's chamber (bedchamber) was often cited as the location of medical treatment and healing. The chamber had associations in the early modern period with women's health as the final stage of childbirth and parturition occurred in the lying-in chamber; a space created by keeping the chamber dark and warm. Women confined themselves to this space both before and after birth.⁹³ A letter from Ralph Radcliffe to John Radcliffe from 1738 emphasises though that the chamber was important for men as well as women. Reporting of a friend Ralph commented that 'Mr W[illia]m Hale is confined to his chamber by a fall he had leaping in his park. But I hear he will soon be able to come down stairs'.⁹⁴ Similarly Samuel Pepys recorded in his diary for 23 October 1662 that Sir William Penn, a naval officer, was confined to 'bed' by gout; Penn received Pepys in his chamber on several occasions because of his condition.⁹⁵ Penn's chamber functioned as a permeable and adaptable space where medical men, family members, friends and colleagues came and went. This was likely not an unusual concept as traditionally, although not at some points in the era, the monarch received his courtiers and advisors in his chamber. Moreover, having a separate bedchamber was not a ubiquitous feature of early modern life. For many people their parlour was both a room for entertaining guests and a bedroom, only gradually were beds moved to a separate location upstairs.⁹⁶ Treatment regimens as well as diseases confined people to their bedrooms. Alexander Read noted that in cases of 'Hernia intestinalis *when the Peritonaeum is either distended or relaxed*' if conventional medicines did not work the patient 'must lye in Bed full forty days, applying an astringent Medicine and a Truss'.⁹⁷ Despite historians' focus on women's confinement within the chamber, it is evident that many men's medical experiences played out in the bed chamber as well.

Leaving the chamber was, consequently, intimately connected with ideas of recovery and healing. The ability to leave the bedroom and resume normal daily activities was an important step in the process of healing. Medical practitioners noted though that patients who decided this moment for themselves often got it wrong and relapsed. A patient of Richard Wiseman who was recovering from a wound to the leg had been confined to his chamber for a month. At which point 'now supposing himself well, he rid to his Country-house, (unknown to me:) but that night his Leg swelled much,

and the *Cicatrix* [the scar of a healed wound], being scarce confirmed, brake out'.⁹⁸ Wiseman's narrative allowed for the blame in this case to be attributed to the patient. However, it reveals the clear need some patients felt to experience the world outside the sick room and, perhaps, their desperation to be 'recovered'. The movement outside of the sickroom space was a breach of the practitioner's authority, and allowed the patient to reject their identity as a patient.

This location was particularly central to discussions and tensions about those who were being treated for venereal disease, as most salivations and mercurial treatments required an extended stay inside one's chamber. It is important to note here that place and space are often connected to time. In this instance it was the length of time to be spent in the bedchamber that shaped responses to illness and treatment and exacerbated the tensions in the patient-practitioner relationship. Patients could be reticent for several reasons. Stephen Hobbes acknowledged that 'busines or poverty' might prevent a patient from being able to stay at home and undergo the necessary salivation (mercury treatment designed to provoke the production of saliva).⁹⁹ Those who did confine themselves demonstrated anxiety about their business and daily activities being impeded. Hobbes attempted to ameliorate his patients' concerns by offering an alternative remedy, 'emplasters spread upon leather or upon new linnen cloth', which did not require patients to remain in their chamber.¹⁰⁰ William Salmon suggested other concessions that might appease patients' dislike of confinement. He explained that a new method of salivation by fumigation allowed men to be 'drest in his Cloaths, (as if going abroad)' and after an hour in a 'Room like a Closet' wander freely about their chamber 'without any other Observation than this Caution, to beware of taking Cold', implicitly offsetting notions of restriction.¹⁰¹ Salmon further noted that if the weather was warm the patient would be '*permitted to go abroad*', again highlighting the usual expectation that venereal disease patients would be confined.¹⁰² The concessions made by those treating venereal disease reveal that patients' demands for mobility not only conflicted with practitioners' beliefs in the benefits of the sickroom but consequently shaped their medical practice.

Patients also feared spending an extended length of time in their chamber because it might announce to others the nature of their illness. Several seventeenth-century 'quack' and unregulated practitioners who used handbill advertisements offered location-based treatment concessions. Many offered specific lodgings for those wishing to obtain venereal disease treatment in secret. This highlights that space was a tool utilised by a range of regulated and unregulated practitioners to compete in the medical marketplace. One such advertisement for a German doctor and surgeon concluded with the announcement that men wishing for private treatment of venereal disease could speak to the practitioner's son who 'can accommodate with Diet and Lodging all the time of their cure'.¹⁰³ Those not advertising particular locations of treatment offered cures that worked without requiring confinement or that worked within eight or nine days.¹⁰⁴ These practitioners used space to maximise their own potential for profits, while allowing men the ability to shape their visibility in, or absence from, particular spaces in order to maintain their reputations.

Male patients, whether or not they were ashamed of their condition, were frequently eager to return to their daily activities and particularly their economic activities. Richard Wiseman noted that at least one of his patients did not follow through with

the entire cure recommended to remedy the *lues venerea* because 'his affairs abroad hastened him away' and thus he was 'longer in recruiting his flesh than was usual'.¹⁰⁵ Likewise Daniel Turner's 1724 treatise *Syphilis* includes the case of a man who reached the limits of his patience after five weeks of treatment.¹⁰⁶ The patient complained at this point that:

... he did now believe it would avail no more than rubbing (as he express'd it) his Backside with a Brickbat; that he had already spent almost five Weeks to no Purpose, and would wait only three or four Days longer, when if his Mouth was not sorer, he would go out about his Business.¹⁰⁷

Turner partly attributed this frustration to 'some officious Pretender, who, in our Absence, had insinuated that he could have flux'd him in one half of the Time'.¹⁰⁸ In his absence the unruly patient hastened his own treatment, thereby putting himself into a dangerous condition where he 'sat drivelling' and was unable to speak; Turner feared that he was 'not indeed without Danger of being throttled' by saliva he produced.¹⁰⁹

Wiseman also recorded the case of a venereal patient, who simply did not wish to remain in his chamber. Wiseman wrote of the man that, 'He desired to be cured, but would not be confined to his Chamber. I declining to meddle with him upon those terms, he put himself into the hands of an Empirick whom he had formerly known in *Italy*'.¹¹⁰ The location of medical care for Wiseman's difficult patient was thus an important feature of his identity formation as a patient. In this case though both patient and practitioner used the 'potential' location of the treatment for their own purposes. The patient called upon the location of the treatment to bolster his decision not to employ Wiseman, and Wiseman used the patient's reticent attitude towards remaining in his chamber to avoid embroiling himself in a difficult relationship. Again though, Wiseman noted that the patient's inappropriate choice of medical location backfired and resulted in 'much disorder' in his body. Unlike Woodward who used rhetoric to try and claim authority over the patient's living space, Wiseman went further. To regulate the patient more closely when he returned Wiseman 'brought [him] to a Lodging near me'.¹¹¹ Having the patient close at hand served both practical purposes and enhanced his authority. In another case it perhaps did not give Wiseman enough authority. He complained that the patient continued to be unruly and failed to complete his treatment. When the man eventually returned for a second round of treatment Wiseman noted that 'now I lodged him in a house where there was a more strict guard of him'.¹¹² He did not specify who was doing the guarding. Wiseman was not alone in moving patients to a lodging close at hand and employing experienced nurses to help manage difficult patients.¹¹³ Some patients after initial reluctance to be confined requested that lodgings and medical care be supplied for them. Turner treated a man who initially refused to undertake salivation because he had to take a journey, but, who, six weeks later wrote a letter asking Turner to secure 'a Nurse with a Lodging, and all the necessary *Apparatus* for his Salivation'.¹¹⁴ Turner's recitation of this particular case also feeds into the idea that practitioners attempted to secure authority over choosing the location of medical care; as this patient who submitted willingly to Turner's ministrations and decisions about location was happily cured. Turner therefore implicitly suggested that men who acquiesced in such a way would be rewarded.

While some patients resided in their own lodgings, others chose to move in with their medical practitioner. This evidently influenced the interactions between patients

and practitioners. Some practitioners appear to have only taken in certain types of patient. John Westover was a surgeon practicing in Wedmore, Somerset, and the surrounding area in the late-seventeenth century. Westover recorded in-patients, those who 'came to cure', in his journal by noting the cost of their 'tabling'.¹¹⁵ Westover's in-patients were, overwhelmingly, those suffering from mental health problems (distraction, melancholy or madness) rather than physical ailments.¹¹⁶ His diary reveals that he had very few male patients suffering from reproductive or genitourinary problems. None of these resided with him during their treatment. Westover recorded very little detail about the reasons these patients ended their lodging with him.¹¹⁷ The length of patients' stays ranged from a matter of weeks to seventeen years, for one John Edwards who eventually died while in Westover's house in 1706.¹¹⁸ Patients who were 'distracted' or 'mad' were liable to have the location of their care chosen for them. A letter from John Shipton, a surgeon, to Ralph Radcliffe from 7 September 1731 shows a process of negotiation over the location of the patient, apparently suffering from mental health problems. The patient initially resided with Radcliffe, but after difficulties in his care was moved to Bethlem.¹¹⁹ The patient moved through several locations recommended by the surgeon that allowed for adequate oversight of the treatment undertaken, and presumably oversight of the patient's acquiescence and responses. These examples suggest that the type of illness might have had a significant impact on patients' ability to dictate their own setting and location. Those suffering from mental health problems were more likely to have the location of their treatment dictated to them. However, venereal disease patients, unlike those suffering from madness, were better positioned to challenge these decisions and attempt to reclaim authority by claiming or rejecting spaces.

We might consider residing with a practitioner as willing subservience to their authority. A man residing in another's house would, after all, be denied access to patriarchal authority granted to the head of the household. But this could be a strategy on the part of the patient to obtain the type of medical care they desired. Lodging in a medical practitioner's house made them both a patient and a guest. This likely shaped the relationship that existed between the two. Householders were expected to display hospitality and provide food, drink and accommodation to visitors.¹²⁰ Ilana Krausman Ben-Amos has considered the relationships between lodgers and landlords more generally and found that privacy was practically unknown for lodgers, but that this was compensated for by favours, services and goods provided by the landlord.¹²¹ Living with their healer assured priority treatment and access to the practitioner on demand. Purmann's surgical treatise noted that in 1687 a 'great Senatour' 'lodged in my House, that I might the better take care of him'.¹²² Similarly patients moved closer to their preferred practitioners. Nicholas Gaynsford remarked in his observation of Samuell Curde's treatment for a hurt scrotum, that the patient having been treated by Dr Hayler, 'Came and lay at Groombridge near Dr: Willetts to be under his Care'.¹²³ This of course could have been about access to a physician more generally, as it is not clear how far Curde travelled to receive his treatment. Richard Wiseman recorded the example of a forty-year-old man with an 'Anasarcous Swellings in Scroto' (generalised oedema in the scrotum). Wiseman worked alongside the man's physicians to release the trapped water. When this initially seemed to be progressing well 'the Patient removed from his Lodging at Lime-house into the Town, nearer his Physician'.¹²⁴ This turned out to be a wise move as the man required lengthy further treatment.

It may well have been that offering such access to their patients was a way for lower status physicians to emulate their social superiors. Steven Shapin has demonstrated that social obligation dictated that 'the private residence of a gentleman should be open to the legitimate visits of other gentlemen'.¹²⁵ He explained that seventeenth-century handbooks advocated the idea that hospitality was a sign of '*Gentrie*'.¹²⁶ Although this would suggest that offering space in this way was important for practitioners' identity formation, it likely also served more practical functions. It was expected that gentlemen would behave in a civil manner and would tell the truth when in another's house.¹²⁷ Men were expected to show thankfulness and to accept obligations placed upon them when they were a guest in someone else's house.¹²⁸ This could potentially leave patients in a difficult position when they disagreed with the treatment being suggested or were forced into uncomfortable admissions about the nature of their condition. Nonetheless guests could deliberately abuse their status to invert the power relationship between host and hosted; evidently similar actions could be employed by male patients who lodged with their practitioners.¹²⁹ Men conflicted by their desire to hide the fact that they had contracted venereal disease broke these conventions by obscuring the truth and not adequately demonstrating thankfulness and obligation.

A more direct use of space and place was to change environment, thereby ensuring that it was more difficult for a practitioner to visit and impose their will. This tied in to the widely adopted strategy in the competitive medical marketplace of willingly, and wilfully, abandoning medical practitioners who did not adhere to preconceived notions of treatment, speed of recovery or privacy.¹³⁰ Some men chose to move to a more formal medical space in the expectation that the care provided would be better in some way. The English translation of Henry-Francis le Dran's *Observations in Surgery* recounted the story of a man who suffered from a Sarcocoele (tumour of the testicles).¹³¹ The patient had initially been under the care of another surgeon and was prescribed emollient poultices, which began to cure his tumour. Nonetheless the man grew 'impatient, that he did not recover so soon as he desire[d]' and sought alternative treatment in the hospital where le Dran was a surgeon. It is unclear what motivated this move to the hospital, whether it was le Dran's reputation or simply that this was a location designated as one of medical care and healing. Once in this new location however, the patient was not gratified with a diagnosis and speedy recovery. Le Dran assessed the testicles and discovered that the spermatic vessels were hard and that the testicles were inflamed to four times their natural size. He thus confined the patient to bed for three weeks.¹³² It is possible that it was the location that gave le Dran the authority required to keep this patient immobile and in one place for three weeks. This authority though was not unlimited as eventually the patient 'was obliged to follow his Master to Camp and *Campeigne* [sic]' He was happily though in a fit state to go.¹³³ In this case the authority of the man's master still outweighed the authority of the medical practitioner, even when the patient was in a place that represented medical treatment.

Other men chose to change geographical location, more than space, and opted for physical distance in choosing their new location. One of Richard Wiseman's patients, a thirty-four-year-old man arrived in London with his wife and took up lodgings with a physician. He claimed to be suffering from an inflammation in his left groin brought on by disordered drinking. Following a sweating treatment, the patient found himself in more pain and called Wiseman for a consultation. After discussing with the other practitioners, Wiseman asked the patient if his disorder was in fact venereal disease

at which point he, apparently, 'grew passionate, and denied it to be Venereal; and a day or two after removed out of his lodgings two or three miles into the Country', and dismissed Wiseman from his service.¹³⁴ He then appointed a new surgeon who was compliant with his own desires for treatment.¹³⁵ Not only did this patient reject Wiseman's care but by moving out of town into the country he made it difficult for Wiseman to follow, given presumably his responsibilities to other patients. Mr Whitehead, John Woodward's patient, also eventually relocated 'Abroad'; this was not an explicitly acrimonious split between patient and practitioner, but it is again clear that Woodward linked the location of his patient, the ending his treatment, and the likelihood of a relapse.¹³⁶ He wrote that all of his acquaintances had observed that living in the country had improved Whitehead's appearance, he seemed 'ten Years Younger'.¹³⁷ However, he still lived 'not over regular' and, despite being in better health, Woodward lamented that 'he started out of my Care too soon; and has, I fear, left that behind, which will some time create him further trouble'.¹³⁸ Being abroad meant that Woodward had no means of re-engaging this patient and, perhaps inevitably, he recorded that in March 1721 the patient 'now begins to complain of a slight Affection of his Urine'.¹³⁹ Both of these patients regained authority over their own bodies by removing themselves from the areas in which their medical practitioners operated. Their moves bolstered their decision to terminate their employment of Wiseman and Woodward.

As suggested previously, lodging the patient in their own home gave medical practitioners greater influence over treatment regimens. It also augmented their authority in the relationship with other healers. Patients often received help from a team of healers. The complex interplay between the status of a physician, surgeon, apothecary and patient needed careful negotiation. In one observation Richard Wiseman was called, along with a physician and apothecary, to treat a man with venereal disease.¹⁴⁰ The patient was lodging in the house of the apothecary for the duration of his treatment, and although he initially progressed well his recovery was slower than Wiseman expected. Wiseman quizzed the man about his life in the house, what he ate and drank and what medicines he was taking. It thus came to light that although the apothecary 'kept a good Table' and the patient's diet was sound, the apothecary had been giving the patient two decoctions a day instead of one and had been diluting the one recommended by the physician.¹⁴¹ When confronted by Wiseman the apothecary was unrepentant and continued to defy both Wiseman and the physician employed in the case.¹⁴² The apothecary's proximity and relationship with patient created by them living together allowed him to claim authority over the treatment plan and defy his supposed superiors. The absence of Wiseman and the physician left them with little recourse to amend the situation. In this narrative Wiseman did not, as in other cases, chastise the patient himself for deviating from his prescriptions, perhaps because the patient himself had grown weary of the apothecary's ministrations and had broken off from his cure. Wiseman was also careful to note that this was 'the only one that I ever failed in the Cure of', clearly apportioning blame to the apothecary for this failure.¹⁴³

Wiseman was not the only practitioner to express concern about the influence of apothecaries. Daniel Turner, who practiced as a surgeon for twenty years before joining the Royal College of Physicians, treated a young merchant who, initially, lodged in a 'neighbouring Tavern' whose owners provided him with water-gruel and dinner.¹⁴⁴ His physician met him there in the afternoons, but sat drinking white wine with him which had prevented the cure from working. To remedy this situation Turner made the patient

promise to 'keep house, and live regularly'.¹⁴⁵ To facilitate this the patient moved in with the young apothecary, 'being both of them single Men', who had referred his case.¹⁴⁶ Although this initially appeared a good solution to the problem, Turner noted that he 'had much ado to prevent his Apothecary's exhibiting his *Diureticks*, which by their raking and stimulating Property, would in his Case have only increas'd his Misery'.¹⁴⁷ In both stages of this patient's treatment Turner linked inappropriate living arrangements with the disadvantageous practices of other healers. In doing so he revealed that he struggled to impose his authority over the patient when faced with an interfering apothecary who resided with and had ready access to the patient.

Conclusion

A more diverse picture still might emerge by looking at a broader range of cases, beyond men with sexual health and genitourinary problems. Yet these men were, perhaps, in a precarious position as their bodies had been undermined, and possibly un-manned, by ill-health. This may have made them more likely to resist the submission of bodily authority that the medical encounter involved. As such they provide an interesting example of the exclusively male patient-practitioner relationship. The descriptions of these interactions provided in medical and surgical observations reveal that these relationships were not always harmonious. Male patients were described as obstinate and unruly, liable to disrupt their recovery with excessive gourmandising and sexual activity. In cases where illnesses caused shame, recovery took too long or had adverse side-effects patients were inclined to terminate their employment of healers or simply resume their daily lives. One tool, in addition to the food, drink and sex, men employed to resist the authority of physicians and surgeons was space. Medical consultations and treatment occurred in a variety of spaces ranging from the tavern to the hospital. Both patients and practitioners attempted to use these spaces to achieve authority in the relationship. Practitioners employed rhetoric that connected poor patient choices to leave healing spaces with relapse and death. They lodged patients in particular houses in order to guard them and enforce cure taking and lifestyle, while their absence from patients' homes and lodgings undermined their authority, and allowed it to be usurped by other practitioners, usually described as inferior. Patients wilfully changed their location to avoid practitioners – notably those who threatened to reveal them as venereal patients. Moreover, their desire for mobility shaped treatments for venereal disease. Considering how spaces were used in this way can provide a more rounded picture of the relationship between male practitioners and male patients. Looking across a broader range of diseases would help to illuminate these trends more clearly. This article therefore represents a step towards balancing out the existing historiography that has emphasised the relationship between male practitioners and female patients.

Acknowledgements

I am indebted to Katrina Navickas, Owen Davies and Tawny Paul who generously read and commented on earlier drafts of this piece and to the audience of the life-cycles strand of the Social History Society's annual conference 2015, where the research for this article was first presented.

Notes

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2. Wurtz, *The Surgeons Guid*, p. 51.
3. Wurtz, *The Surgeons Guid*, p. 51.
4. Deborah Harkness, 'Nosce te ipsum: Curiosity, the Humoural Body and the Culture of Therapeutics in Late-Sixteenth- and Early-Seventeenth-century England', in R. J. W. Evans and Alexander Marr (eds), *Curiosity and Wonder from the Renaissance to the Enlightenment* (Aldershot: Ashgate, 2006), pp. 171–92, here pp. 179, 181.
5. Wendy D. Churchill, *Female Patients in Early Modern Britain: Gender, Diagnosis, and Treatment* (Farnham: Ashgate, 2012), pp. 74–6.
6. Wellcome Library, ms 3319, sig. 45r.
7. For example see, *Medical Essays and Observations, Revised and Published by a Society in Edinburgh*. ...vol. 3. (Edinburgh, 1737–8), p. 280.
8. Churchill, *Female Patients*, p. 75.
9. Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-century Germany* (London: Harvard University Press, 1991); Edward Shorter, *Women's Bodies: A Social History of Women's Encounter with Health, Ill-health, and Medicine* (London: Routledge, 2009); Churchill, *Female Patients*; Monica H. Green, *Making Women's Medicine Masculine: The Rise of Male Authority in Pre-modern Gynaecology* (Oxford: Oxford University Press, 2008).
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14. Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven: Yale University Press, 2003), p. 17.
15. Mary Rhinelandier McCarl, 'Publishing the Works of Nicholas Culpeper, Astrological Herbalist and Translator of Latin Medical Works in Seventeenth-Century London', *Canadian Bulletin of Medical History* 13 (1996), pp. 225–76, here p. 230.
16. Sachiko Kusukawa, *Picturing the Book of Nature: Image, Text, and Argument in Sixteenth-century Human Anatomy and Medical Botany* (Chicago: University of Chicago Press, 2012), p. 50.
17. Mary E. Fissell, 'The Marketplace of Print', in Mark S. R. Jenner and Patrick Wallis (eds) *Medicine and the Market in England and its Colonies, c.1450–1850* (Basingstoke: Palgrave MacMillan, 2007), pp. 108–32, here p. 112. See also Tessa Watt, *Cheap Print and Popular Piety 1550–1640* (Cambridge: Cambridge University Press, 1991), Introduction, pp. 1–10.
18. Fissell, 'The Marketplace of Print', p. 112.
19. Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 2010), p. 107; Wayne Wild, *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consulation Letters and Literature* (Amsterdam: Rodopi, 2006), p. 10.
20. Samantha Sandassie, 'Evidence-based Medicine? Patient Case Studies in English Surgical Treatises, 1660–1700', *Medical Humanities* 34 (2008), pp. 11–18, here p. 14.
21. Elizabeth Foyster, *Manhood in Early Modern England: Honour, Sex and Marriage* (Abingdon: Routledge, 2014); see also, Karen Harvey, 'The History of Masculinity circa, 1650–1800', *The Journal of British Studies* 44 (2005), pp. 296–311, here pp. 298–9.
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23. Lisa Smith, 'Secrets of Place: The Medical Casebooks of Vivant-Augustin Ganiere, ca. 1745–1750', in E. Leong and A. Rankin (eds), *Secrets and Knowledge: Medicine, Science and Commerce, 1500–1800* (Aldershot: Routledge, 2011), pp. 213–31, here p. 225.
24. For more on obedience see Lynda Payne, *With Words and Knives: Learning Medical Dispassion in Early Modern England* (Aldershot: Routledge, 2007), pp. 89, 90, 95–6.
25. Weston, 'Men Controlling Bodies', p. 227.

26. Weston, 'Men Controlling Bodies', p. 230.
27. Weston, 'Men Controlling Bodies', p. 231.
28. 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: Erasmus Publishing, 1996), pp. 101–34, here pp. 102–3.
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30. Smith, 'Secrets of Place', p. 213.
31. For a discussion of the value of surgical observations see Michael McVaugh, 'Richard Wiseman and the Medical Practitioners of Restoration London', *Journal of the History of Medicine and Allied Sciences* 62 (2007), pp. 125–40.
32. Jennifer Richards, 'Health, Intoxication, and Civil Conversation in Renaissance England', *Past and Present: supplement* 9 (2014), pp. 168–86, here p. 173 discusses the early modern predisposition for adding terms such as mediocre and moderate to discussions of food and drink; Tom Nichols, 'Double Vision: The Ambivalent Imagery of Drunkenness in Early Modern Europe', *Past and Present: supplement* 9 (2014), pp. 146–67, here p. 146.
33. Smith, 'Secrets of Place', p. 225.
34. Barthélemy Saviard, *Observations in Surgery* (London, 1740), p. 165. He later complained that patients liable to suffer complications caused by gonorrhoea were those that 'Delight in their Debauches' and were unlikely to restrict themselves. He further criticised the surgeons who worked in this area for being unwilling to prescribe sobriety. Saviard, *Observations in Surgery*, p. 169. For another example see, John Middleton, *A Short Essay on the Operation of Lithotomy* (London, 1727), p. 27.
35. Wellcome Library MS 3319. The manuscript is unpaginated, this appears on sig. 38v.
36. Wellcome Library MS 3319. The manuscript is unpaginated, this appears on sig. 38v.
37. Hannah Newton, "'She Sleeps Well and Eats an Egg": Convalescent Care in Early Modern England', in Sandra Cavallo and Tessa Storey (eds), *Conserving Health in Early Modern Culture: Bodies and Environments* (Manchester: Manchester University Press, 2017), pp. 104–32.
38. Newton, 'She Sleeps Well and Eats an Egg', pp. 104–32.
39. Newton, 'She Sleeps Well and Eats an Egg', pp. 104–32.
40. Jane Sharp, *The Midwives Book* (London, 1671), p. 89.
41. Elaine Hobby (ed.), *The Midwives Book* (Oxford and New York: Oxford University Press, 1999), pp. xvi–xix. It has been suggested that Sharp was likely a male author, see Katharine Phelps Walsh, 'Marketing Midwives in Seventeenth-Century London: A Re-examination of Jane Sharp's *The Midwives Book*', *Gender & History* 26 (2014), pp. 223–41. However, this idea is refuted by Hobby, *The Midwives Book*, p. xix.
42. Wurtz, *The Surgeons Guid*, p. 55.
43. Wurtz, *The Surgeons Guid*, p. 55.
44. Mattheus Gothofredus Purmannus, *Chirurgia Curiosa: Or, The Newest and most Curious Observations and Operations in the Whole Art of Chirurgery* (London, 1706), p. 144.
45. Purmannus, *Chirurgia Curiosa*, p. 144.
46. Hannah Newton, 'She Sleeps Well and Eats an Egg'.
47. Richard Wiseman, *Severall Chirurgical Treatises* (London, 1686), pp. 523, 537, 542–3. In other cases it would appear that treatment regimens simply became too much for some men and in the face of such pain they chose to stop rather than proceed in the hope of a cure, Wiseman, *Severall Chirurgical Treatises*, p. 552.
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49. Wurtz, *The Surgeons Guid*, p. 55
50. Cited in Katrina Navickas, *Protest and the Politics of Space and Place, 1789–1848* (Manchester: Manchester University Press, 2016), p. 15.
51. Beat Kümin and Cornelia Osborne, 'At Home and in the Workplace: A Historical Introduction to the "Spatial Turn"', *History and Theory* 52 (2013), pp. 305–18, here p. 310.
52. Navickas, *Protest and the Politics of Space and Place*, p. 15; Katrina Navickas, 'Thirdspace?: Historians and the Spatial Turn, with a Case Study of Political Graffiti in Late Eighteenth and Early Nineteenth-Century England', in Sam Griffiths and Alexander von Lünen (eds), *Spatial*

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53. James Epstein, *In Practice: Studies in the Language and Culture of Popular Politics in Modern Britain* (Stanford: Stanford University Press, 2003), pp. 106–15.
 54. Nicky Gregson and Gillian Rose, 'Taking Butler Elsewhere: Performativities, Spatialities and Subjectivities', *Environment and Planning D: Society and Space* 18 (2000), pp. 433–52; Robyn Longhurst, 'Viewpoint: The Body and Geography', *Gender, Place & Culture* 2 (1995), pp. 97–106.
 55. Epstein, *In Practice*, pp. 106–15. Historians' investigations of political protest have considered how space could be used to create agency and authority. For example see Navickas, *Protest and the Politics of Space and Place*, p. 15.
 56. Andrew Wear, *Knowledge and Practice in English Medicine, 1550–1680* (Cambridge: Cambridge University Press, 2000); Andrew Wear, 'Place, Health and Disease: The *Airs, Waters, Places* Tradition in Early Modern England and North America', *Journal of Medieval and Early Modern Studies* 38 (2008), pp. 443–65; Carole Rawcliffe, 'Delectable Sights and Fragrant Smelles': Gardens and Health in Late Medieval and Early Modern England, *Garden History* 36 (2008), pp. 3–21.
 57. Wear, *Knowledge and Practice*, p. 187.
 58. Wear, *Knowledge and Practice*, pp. 189–91; see also, Mark Jenner, 'The Politics of London Air, John Evelyn's Fumifugium and the Restoration', *The Historical Journal* 38 (1995), pp. 535–51.
 59. Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford: Oxford University Press, 2000), p. 61.
 60. Rawcliffe, 'Delectable Sights and Fragrant Smelles'.
 61. Ian Mortimer, 'Rural Medical Marketplace in Southern England, c.1570–1720', in Jenner and Wallis (eds), *Medicine and the Market*, pp. 69–87.
 62. For more on healing wells see Alexandra Walsham, *The Reformation of the Landscape: Religion, Identity and Memory in Early Modern Britain and Ireland* (Oxford: Oxford University Press, 2011), ch. 6, pp. 395–470.
 63. William Simpson, *An Historical Account of the Wonderful Cures wrought by Scarborough-Spaw* (London, 1680).
 64. Simpson, *An Historical Account of the Wonderful Cures*, pp. 88–9.
 65. Weston, 'Men Controlling Bodies', p. 227.
 66. Weston, 'Men Controlling Bodies', p. 229.
 67. Weston, 'Men Controlling Bodies', p. 234.
 68. Lisa Silverman, *Tortured Subjects: Pain, Truth, and the Body in Early Modern France* (Chicago: Chicago University Press, 2001), p. 135.
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 70. Silverman, *Tortured Subjects*, p. 135.
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84. Barker and Hamlett, 'Living above the Shop', p. 318.
85. Barker and Hamlett, 'Living above the Shop', pp. 317–8.
86. I am grateful to Owen Davies for raising this point.
87. Wiltshire and Swindon History Centre, 2667/12/38, Medical Diary of John Wyndham, fol. 4v.
88. The Earl of Halifax described in 1700 how a physician had 'lain here one night' when his wife was thought to be suffering a miscarriage. Cambridge Archive K17/C/1.
89. John Woodward, *Select Cases and Consultations in Physick by the Late Eminent John Woodward M.D.* (London, 1757), p. iv.
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91. Woodward, *Select Cases and Consultations*, p. 329.
92. Woodward, *Select Cases and Consultations*, p. 330.
93. The lying-in chamber could be a site of contest and tension between women. See Adrian Wilson, *Ritual and Conflict: The Social Relations of Childbirth in Early Modern England* (Abingdon: Ashgate, 2013). The lying-in chamber was also a site of tension in some witchcraft accusations. See Lyndal Roper, *Witch Craze: Terror and Fantasy in Baroque Germany* (New Haven: Yale University Press, 2004), p. 198.
94. Hertfordshire Archives and Library Services (HALS) DE/R/ 248/3.
95. Henry B. Wheatley (ed.), *The Diary of Samuel Pepys. M.A. F.R.S. Clerk of the acts and Secretary to the admiralty. Transcribed from the shorthand manuscript in the Pepysian library Magdalene College Cambridge by the rev. Mynors bright m.a. Late fellow and president of the college* (London, 1893), accessed through Internet Archive, <https://archive.org>, accessed 13 October 2016.
96. Flather, *Gender and Space*, p. 39. For more about the transition to separate upstairs bedrooms see Sasha Handley, *Sleep in Early Modern England* (New Haven: Yale University Press, 2016), pp. 110–21.
97. Alexander Read, *Chirurgorum Comes: Or The Whole Practice of Chirurgery. Begun by Learned Dr Read; Continued and Completed By a Member of the College of Physicians in London* (London, 1687), p. 598.
98. Wiseman, *Severall Chirurgical Treatises*, p. 365.
99. Stephen Hobbess, *Enchiridion Medicum containing an epitome of the whole course of physicke: with the examination of a chirurgion, by way of dialogue betweene the doctor and the students* (London, 1609), p.117.
100. Hobbess, *Enchiridion Medicum*, p. 117.
101. William Salmon, *Ars chirurgica* (London, 1698), p. 433.
102. Wiseman, *Severall Chirurgical Treatises*, p. 52.
103. British Library, 551.a.32. [51]. See also 551.a.32. [134], C.112.f.9.[5], C.112.f.9.[7], C.112.f.9.[12], C.112.f.9.[26], C.112.f.9 [78], C.112.f.9[85], C.112.f.9[93], C.112.f.9[100]
104. British Library 551.a.32., medical advertisements seventeenth century; 551.a.32.[3], 551.a.32.[6], 551.a.32.[7], 551.a.32.[14], 551.a.32. [33], 551.a.32. [42], 551.a.32.[46], 551.a.32. [65], 551.a.32. [76], 551.a.32.[90], C.112.f.9.[1], C.112.f.9 [121]
105. Wiseman, *Severall Chirurgical Treatises*, p. 530. See also p. 548.
106. Daniel Turner, *Syphilis: A Practical Dissertation on the Disease* (London, 1724), p. 230.
107. Turner, *Syphilis*, p. 232.
108. Turner, *Syphilis*, p. 232.
109. Turner, *Syphilis*, p. 233.
110. Wiseman, *Severall Chirurgical Treatises*, p. 533. Another patient was likewise described as 'would not be confined within doors', p. 542.
111. Wiseman, *Severall Chirurgical Treatises*, p. 533.
112. Wiseman, *Severall Chirurgical Treatises*, p. 534.
113. For example, see Turner, *Syphilis*, p. 245.
114. Turner, *Syphilis*, p. 223.
115. Somerset Heritage Centre (hereafter SHC), DD/X/HALW 4, The Casebook of John Westover of Wedmore, Surgeon 1687–1700, Transcribed by William G. Hall December 1992 Revised July 1999; Somerset

- Heritage Centre, DD/X/HKN 1, Dr John Westover his journal 1686–1700, for example ‘tabling’: 79r, 83v; for example ‘came to cure’: 84r.
116. Somerset Heritage Centre, DD/X/HKN 1, Dr John Westover his journal 1686–1700.
 117. SHC, DD/X/HKN 1, 216R.
 118. SHC, DD/X/HKN 1, 216R.
 119. HALS, DE/R/C118/2.
 120. Felicity Heal, *Hospitality in Early Modern England* (Oxford: Oxford University Press, 1990), pp. 5–7.
 121. Ilana Krausman Ben-Amos, *The Culture of Giving: Informal Support and Gift-Exchange in Early Modern England* (Cambridge: Cambridge University Press, 2008). The numbers of people living as lodgers increased throughout the early modern period, particularly in urban areas. See Krausman Ben-Amos, *The Culture of Giving*, p. 62; John Styles, ‘Lodging at the Old Bailey: Lodgings and their Furnishing in Eighteenth-Century London’, in John Styles and Amanda Vickery (eds), *Gender, Taste and Material Culture in Britain and North America, 1700–1830* (New Haven: Yale University Press, 2006), pp. 61–80.
 122. Purmann, *Chirurgia Curiosa*, p.162
 123. Wellcome Library MS 6919, Sig. 12v.
 124. Wiseman, *Severall Chirurgical Treatises*, pp. 127–8.
 125. Steven Shapin, ‘The House of Experiment in Seventeenth-Century England’, *Isis* 79 (1988), pp. 373–404, here p.387.
 126. Shapin, ‘The House of Experiment’, p. 387.
 127. Shapin, ‘The House of Experiment’, p. 397.
 128. Heal, *Hospitality*, p. 194.
 129. Heal, *Hospitality*, p. 199.
 130. Harkness, ‘*Nosce te ipsum*’, p. 179, p. 181.
 131. le Dran, *Observations in Surgery*, p. 250.
 132. le Dran, *Observations in Surgery*, pp. 250–1.
 133. le Dran, *Observations in Surgery*, p. 251.
 134. Wiseman, *Severall Chirurgical Treatises*, p. 27 (1676 edn, following new pagination after p. 498).
 135. Wiseman, *Severall Chirurgical Treatises*, p. 27.
 136. Woodward, *Select Cases and Consultations*, p. 337.
 137. Woodward, *Select Cases and Consultations*, p. 337.
 138. Woodward, *Select Cases and Consultations*, p. 337.
 139. Woodward, *Select Cases and Consultations*, p. 338.
 140. Wiseman, *Severall Chirurgical Treatises*, p. 524.
 141. Wiseman, *Severall Chirurgical Treatises*, p. 524.
 142. Wiseman, *Severall Chirurgical Treatises*, p. 524. At play here might also be ideas about space and knowledge production. The need to be in a place to witness the creation of knowledge – Wiseman was excluded from this process of knowledge formation about the patient’s body whereas the apothecary was not. See Steven Shapin, ‘The House of Experiment’, at pp. 374–5.
 143. Wiseman, *Severall Chirurgical Treatises*, p. 524.
 144. Turner, *Syphilis*, p. 195.
 145. Turner, *Syphilis*, p. 196.
 146. Turner, *Syphilis*, p. 196.
 147. Turner, *Syphilis*, p. 200.