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## Introduction: the growth of the early modern medical economy

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**“Introduction: The Growth of the Early Modern Medical Economy”**

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The papers in this section address a common question: how likely were sick people in early modern Europe to seek care from a medical practitioner? The evidence they present reveals a level of engagement with commercial medical provision that varied substantially across Europe, but that for the most part shared one striking characteristic: growth. While the likelihood that someone would turn to a medical practitioner for help was markedly higher in the urban Mediterranean than in the countryside of North West Europe, in all three of the locations that these papers study we see the use of care rising over the sixteenth to nineteenth centuries. In short, people across Europe grew ever more reliant on commercial medical practitioners—individuals earning a living from their work in health care—in the early modern period. These findings substantially advance our understanding of developments in medical consumption over time. By shifting attention from goods to services, they provide a major complement to our understanding of consumption more generally. And they also present us with the challenge of explaining how these profound shifts in the medical economy connected with and contributed to wider economic, social and cultural developments.

In turning to the task of identifying and measuring long run changes in the demand and supply of medical services, these papers move on from the essential work of uncovering the variety and abundance of medical care and medical practice that historians have undertaken in a series of studies over the last forty years. That important body of work excavated rich strata of medical practice in early modern England, France, Italy, Germany and Spain, to note only a few of the best known examples.<sup>1</sup> It showed convincingly that what previous generations of historians had often assumed was a desert lightened by a few isolated

oases of medical learning had instead been a rainforest, with a richly hued flock of medical practitioners filling the archives with their complaints, enticements and conflicts.

However, where the grand narratives of professionalization and medicalization that were overthrown by these studies had been oriented longitudinally (albeit teleologically), the florid abundance of the early modern medical marketplace lent itself instead to close readings and case studies. The problem of change over time was largely set aside. Historians' attempts to impose order took the form of hierarchies or Venn diagrams that pointed out the blurred boundaries between clusters of fauna or plotted their relative positions in the biosphere.<sup>2</sup> Inspired by the pioneering work of Pelling and Webster, historians revealed the abundance of medical practitioners relative to the population, but they did not resolve how to connect these observations over time.<sup>3</sup> The new history of the patient that emerged in the same period shared these characteristics, concentrating on dynamics within patient-practitioner relationships, not the likelihood that they would exist.<sup>4</sup> The alliances that physicians made with the state and the statute book to secure professional authority that had once supplied a convenient chronology to the history of medical practice were now refigured as part of ongoing dialogues over the recognition or reinforcement of the claims of specific tribes of practitioners. The few moments of identifiable change that survived tended to be rooted in the biological or scientific: the disappearance of plague in the late seventeenth and eighteenth centuries, or the diffusion of bacteriological thinking in the nineteenth.

We can usefully identify some of the boundaries of our understanding of the nature of medical provision and resort by considering which aspects of these early modern 'medical marketplaces' are least well-defined.<sup>5</sup> We know something of who came to sell, and the nature of their wares. But we know little of who turned to the market, how often they utilised practitioners, and who preferred other forms of recourse. We know almost nothing of how provision in one city or region compared to another, or how they grew or dwindled over time.

We know little, even, about which types of practice were more or less popular, though it is the varieties of practitioner that we have been most able to study. We are left unable to answer basic questions, such as how likely was a fifteenth century Florentine baker to call for a physician when he felt ill? Was he more (or less) likely to do so if he had lived two centuries before or later? And would a baker in Modena, Marseilles or the village that was then Manchester be more or less likely to adopt the same response? To stretch the metaphor, we see something of the marketplace, but little of the economy; we witness structure, but not change; we bear witness to the existence, but not the intensity of praxis.

The papers presented here take a common analytical focal point—the likelihood of receiving medical attendance in the period before death—to explore the probability that the sick would make use of commercial medical assistance. They examine the evolution of social responses to sickness over space and time, to appreciate the significance of medical practice within these responses, and to connect medical to institutional, economic and cultural developments. In doing so, they examine three very different contexts that capture something of the varied environments that existed across early modern Europe. Bamji’s study of Venice explores one of Europe’s largest and most prosperous cities; Pirohakul and Wallis consider southern England, contrasting London—another large and rich metropolis—with life in the countryside and small towns; Deneweth and Wallis examine the minor towns and villages of the Netherlands. Though they share a general approach, each paper is restricted by its sources to examining slightly different groups. For Italy, the Venetian death registers report medical interactions prior to all Christian deaths. For England, the probate accounts used survive only for relatively rich adults. For the Netherlands, a broader slice of middling sort adults is covered. Despite the unparalleled scope of the Venetian sources, they unfortunately convey little sense of what form this medical involvement took. For England and the Netherlands,

where we are considering debts, we get more sense of the nature and price of care, but for a far shallower sample.

In Venice, we witness the years in which care from medical practitioners moved from being common to ubiquitous among the Venetian population. Among adults, the share who had been seen by a *medico* before death rose from 62 to 95 percent between 1645 and 1796. Age, status and wealth, and type of illness leap out as the key influences on receiving care. Fevers, dropsy and tuberculosis all generated high rates of recourse, and smallpox the opposite. Children are far less likely to have seen a practitioner than adults; the poor were somewhat less likely than the rich. The effect of these factors becomes less important though. All types of sickness increasingly attract attention. Medical care for children became much more common. By 1796, the poor are nearly as likely to have seen a doctor as the rich. In this, access to care in Venice was facilitated by the city's hospitals and confraternities. By the 1700s, almost all of those who died in a hospital had received some medical attention. As consumption grew, medical practitioners' modes of practice became more concentrated, with practitioners working in a narrower space within the city. The role of midwives expanded dramatically, meeting some of the growing demand for care for young children.

The elites of London behaved in a similar manner to those of Venice. By the 1670s, medical care was commonplace among those dying in the metropolis, and it remained at much the same level thereafter. Outside the city, however, the likelihood of using a medical practitioner grew markedly from 53 to 76 percent in the eighteenth century, and the amount spent also rose. Over this broader compass, geography, particularly the urban-rural divide, stands out alongside wealth as a major factor. In England, a marked shift in who provided care accompanied the growth in consumption. Physicians were dethroned by apothecaries acting as general practitioners, as care became concentrated in the hands of a single provider.

Among the middling sorts who lived in small-town Netherlands, the use of medical care was much rarer in the second half of the seventeenth century than in either of these large cities. Just a third of those in the maritime region of Holland, and a quarter in the poorer inland provinces were indebted for medical care. As in provincial England, rates in the wealthier regions grew quickly, doubling by the early eighteenth century. The inland region continued to lag behind though. The use of care drifts upwards there, but the probability of seeking care, and the amount spent were much lower. Monetisation and wider patterns of consumption affected the use of care; farmers, in particular, remain more divorced from medical practitioners than other groups. Like England, the types of practitioner involved changed. But the shift in the Netherlands went in the opposite direction. In the nineteenth century, physicians increased their already substantial role at the expense of the surgeons, who had been very important in the maritime region, and to some extent at the expense of the apothecaries who had been the leading practitioners in the inland area before 1800.

This short sketch suggests the main axes along which the consumption of medical care varied. Geography and urbanisation mattered greatly. Rural areas and small towns were less likely to see people reaching out for medical practitioners than major cities. Individual wealth and status mattered. Age surely mattered too, although we only witness this explicitly in Venice. But the regions of Europe did not start with a common baseline. In the late 1600s, the poorest sections of Venetian society were far more likely to have seen a practitioner than the more prosperous residents of the Dutch backwaters. Over the seventeenth and eighteenth centuries, the differences narrowed. Europe's population converged towards—albeit that they did not yet reach—a common commitment to medical practitioners as a prime source of assistance in times of serious sickness.

Two fundamental processes were at work in this emergence of a shared medical culture. First, among those who had always possessed the resources to employ medical

assistance, we see a change in preferences. Most visibly in England, the rich grew accustomed to seeing the assistance of a medical practitioner as a normal part of the process of sickness and ageing; Dutch farmers took similar steps into consuming commercial services. For both, practitioners had always been available, living and practicing in the area. It was not supply, but demand that shifted. Second, among those for whom poverty would have left hiring assistance as an unaffordable luxury, the binding constraint of wealth was relaxed. This was as likely achieved as much by institutional developments as rising living standards. We see glimpses of this in Venice, where the city's hospitals and confraternities stepped forward, and a century later in the provincial Netherlands, where mutual assistance began to take up the burden.

At the same time, the mix of practitioners to whom the sick turned— at least on the surface—remained varied. The doctors of Venice, the surgeons of the maritime Netherlands (or maritime Kent), and the apothecaries of provincial England had different forms of training—respectively university and apprenticeship—that may have led to different approaches and at least distinct emphases in practice. They operated under different institutional restrictions, with the writ of Colleges of Physicians largely only running over their own cities in this period. To be sure, they likely shared certain experiences of structural change. That the scope of the practice of Venetian *medici* narrowed points to a form of general practice emerging there, much as we see in England. The diffusion and growth of shared European ideas about the institutions and governance of medicine had led to the foundation of Colleges of Physic across a range of states. Yet there is little sign of a wider homogenising tendency that outweighed the persistence of local traditions and the specific regional trajectories and endowments of practitioners.

We do, however, need to recognise two limiting aspects of these studies. First, they consider care received by those who would soon be dead. How people's desire for assistance

in what would, very likely, be situations of extreme need, might have differed from their approach to the more mundane morbidity of everyday existence—the scabs, sores and dysentery that troubled and nagged but did not imminently threaten to kill them—needs to be considered.

Second, these studies consider only commercial practitioners, even when, as in Venice, they may not have been paid for directly. Interactions with other sources of assistance, from family, neighbours, or (in England and the Netherlands) the charitably inclined, are invisible in the evidence used here. That these other sources of care mattered is unarguable. The family was, and remained, the main agency of assistance. The impact of its breakdown is visible in England and the Netherlands (but not in Venice), where women, especially widows, were more likely to look to the market for care than men. That gender was not significant in Venice is one of the surprising differences apparent in these papers, and implicates some of the marked differences in household structure between Mediterranean and north-western Europe. Either way, it is not obvious that commercial and domestic care were necessarily rivals. The vitality of domestic care could equally easily have grown in complement with commercial care. Certainly, the knowledge systems were tightly entangled, as work on recipes and the market for vernacular medical texts makes clear.

There is much, then, that remains to be addressed. Did responses to minor morbidity track those to serious illness? Did domestic or neighbourhood expertise and provision supplement, complement or substitute for commercial sources? To what extent do other regions share similar tendencies? What benefits did the sick derive? But these empirical questions are perhaps less significant than the wider questions of interpretation and causation that are raised by the emerging shape of the trend and trajectory of medical consumption we can see here. The differences that shape consumption patterns intimate some elements of a causal explanation for growing consumption: imitation, commercialisation, urbanisation, and



increasing prosperity have all been mentioned here. Yet those are largely forces that help us appreciate why one group takes up the habits of another. They are the keys to convergence, diffusion and trickling down. In a society as divided and unequal as early modern Europe, convergence does no doubt do much of the heavy lifting involved in changing aggregate levels of medical consumption. But these forces are weak guides to the movements of the vanguard. Explaining the shifting preferences of the wealthy must push us to consider what intellectual and cultural developments—attitudes to expertise, ideas of natural philosophy, expectations of female knowledge and so on—initiated these changes in resort to medical care.

And much as we need to engage fully with *mentalité* to explain responses to mortality, we should consider the implications of medical supply for society. What was the effect of the expanding role of medical practitioners on the sense of family and self that existed in these communities? Does the shift in elite and middling sort preferences towards reliance on external assistance help explain the move in welfare and charity—systems they directed but did not rely on—towards offering medical assistance to the needy? Is there a threshold at which increasing demand and corresponding growth in the division of labour in medicine turns spurs a shift from an artisanal to an industrial model, with general practice sustained through industrial pharmacy and hospital specialism? Such connections may seem too economic in nature for some. But that should not be a reason for their rejection; as analytical frameworks the cultural and the economic do not (or at least should not) exist in opposition. They are necessary complements in a richer and fuller understanding of medicine, consumption and the world of sickness and survival of which they formed a part.

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<sup>1</sup> Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London, 1998); Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London, 1987): 8-50; Harold J. Cook, *The Decline of the Old Medical Regime in Stuart London* (Ithaca, 1986); David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester, 1998); Mary

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Lindemann, *Health and Healing in Eighteenth-Century Germany* (Baltimore, 1996); Laurence Brockliss and Colin Jones, *The Medical World of Early Modern France* (Oxford, 1997); Sandra Cavallo, *Artisans of the Body* (Manchester, 2007).

<sup>2</sup> Brockliss & Jones, *Medical World*, 14-15; Gentilcore, *Healers*, 3; Robert Jutte, ed., *Medical Pluralism: Past - Present - Future*, 25-44. Stuttgart: Franz Steiner Verlag, 2013.

<sup>3</sup> Margaret Pelling and Charles Webster, "Medical Practitioners," in *Health, Medicine and Mortality in the Sixteenth Century*, ed. Charles Webster (Cambridge, 1979).

<sup>4</sup> Jewson, N. D. "The Disappearance of the Sick Man from Medical Cosmology, 1770-1870." *Sociology* 10 (1976): 225-44; Porter, Roy, ed. *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*. Cambridge: Cambridge University Press, 1986.

<sup>5</sup> Jenner, Mark S. R., and Patrick Wallis. *Medicine and the Market in England and Its Colonies, c.1450-c.1850*. Basingstoke: Palgrave Macmillan, 2007.