Mark Jenner + Patrick Wallis eds. Medicine and the Market in England and its Colonies, c. 1450- c. 1850. (Macmillan, 2007)

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The Medical Marketplace

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In the mid-1980s, a number of Anglophone historians began to describe health care in early modern England as a 'medical marketplace' or 'medical market'. These terms were foregrounded by several scholars more or less simultaneously. The opening chapter of Lucinda Beier's 1984 Ph.D. thesis (published in 1987) was entitled 'The Medical Marketplace'.[1] In 1985, Roy Porter wrote of the premodern 'medical market place' 'where physicians, surgeons, and apothecaries ... melted into each other along a spectrum that included thousands who dispensed medicine full- or part-time',[2] and Irvine Loudon observed that one of the most important unresolved areas of eighteenth-century medicine was 'the extent of the market for medical care and how that market was satisfied'.[3] The following year Harold Cook's *Decline of the Old Medical Regime* began with a chapter entitled 'The Medical Marketplace'.[4] This terminology was not confined to scholars working on the United Kingdom. Katherine Park's *Doctors and Medicine in Early Modern Florence* (1985) contained an identically entitled chapter.[5]

Most earlier accounts of early modern medical practice had either focused on the notional three-part occupational hierarchy of physicians who advised, surgeons who operated and apothecaries who prepared drugs, or else were simply dominated by a concern with learned, 'professional' practitioners. Other healers were either denigrated as 'quackish' or simply ignored. Developing pioneering work on the diversity of medical practitioners in early modern England,[6] the medical marketplace literature was in the vanguard of a wave of scholarship that overturned all these assumptions and began to set out the characteristics of an emergent diverse, plural and commercial pre-professional system of health care. These studies stressed that the boundaries between physicians, surgeons and apothecaries were blurred to the point of irrelevance: regulation had

limited force, professionalization was anachronistic.[7] Early modern practitioners, they argued, competed for custom in an open 'medical marketplace where services were advertised and sold to those sufferers who cared to shop'. Patients had 'relative freedom to choose the medical practitioners they liked'; they were 'medically promiscuous', selecting therapies and therapists according to their estimation of the practitioner's effectiveness or manners, not to mention cost.[8] For all their intellectual pretensions, learned physicians did not command any real degree of cultural authority until the nineteenth century. As the medical marketplace literature revealed, in any year a sick person might visit a wart-charmer, get a remedy from a neighbour or bookseller, pay for a surgeon and hire a horse leech.[9]

These works marked the coalescence of a new way of describing early modern medicine and were at the forefront of a revolution in the history of medicine.[10] Medical market terminology has since been adopted to analyse contexts ranging from the Graeco-Roman world to nineteenth-century South Africa.[11] Concurrently – and not accidentally – the marketplace has become ubiquitous in political, popular and academic discussions of contemporary health policy and provision. 'Market' mechanisms and terminology now play a far more prominent role in health care in most developed countries than they did in the 1980s.[12] However, the success of the idea and language of the 'medical marketplace' has come at a price, for historians at least. As the concept has been applied to an ever-wider range of settings and employed by an ever-expanding variety of historians, its meaning has become vague to the point of confusion. Ironically, 'marketplace' language seems at times to have made it easier to avoid engaging in fuller studies of the market or the medical economy. Two decades after the medical marketplace became a commonplace, historians still know very little about the scale, scope, boundaries or internal dynamics of the market for medicine. Furthermore, the very idea of a 'medical marketplace' has also begun to attract criticism. As Margaret Pelling recently noted, the concept 'is ... overdue for revision'.[13]

This book undertakes a critical examination of the 'medical marketplace', its uses and abuses. The essays focus on the nature of medical provision and its economic, institutional, cultural and political contexts in order to develop and refine fundamental concepts and arguments associated with our understanding of medicine and the market in England and in Britain's colonies between 1450 and 1850. Together, contributors demonstrate the importance of not only analysing the relationship between medicine and the marketplace, but also historicizing key terms such as medicine, the market and the economy.

This clarification and re-examination is crucial. Social historians of medicine in early modern England took up this terminology with little discussion (and possibly little awareness) of how it had been employed in other fields, and have often used this language with little precision and sometimes in contradictory ways. Moreover, there has been little discussion of how far 1980s accounts of the 'medical marketplace' should be revised in the light of new research into the early modern economy that emphasizes the socially embedded nature of economic relationships.[14] As we outline below, one theme that emerges clearly from this collection is the need for greater consideration of the nature of exchange and value in medicine that sensitively explores this and similar themes.

The medical marketplace and the history of medicine

It is important to emphasize at the outset the achievements of the 'medical marketplace' literature. Previously, much (though by no means all) medical history concentrated on 'great figures' and on internalist intellectual history. The medical marketplace came as a breath of fresh air. It swiftly became part of the vernacular of early modern English history, a development likely facilitated by the wider spread of the language of the market since the 1980s.[15] (The first time the term 'medical marketplace' appeared in *The Times* was in a 1985 editorial commending proposals to pay doctors by results.)[16] Historians found that the term had appealing intellectual advantages. It helped demystify medical pretensions. It underlined the anachronism of standard categories and assumptions about professional boundaries, ethics and authority. It emphasized that medicine was a service that was purchased in a competitive arena at a time when contemporary medicine was largely isolated from commercial pressures. It encouraged research using a wider range of sources. It built bridges with developments in economic and cultural history, not least work describing eighteenth-century England as the first consumer society.[17] For students, it made medicine 'strange' and encouraged critical thinking. Many consider that this analytical vocabulary helpfully conceptualizes the sick person as an active consumer of medical services.[18] Above all, perhaps, scholars found that discussing medicine as a marketplace helped them undertake 'Medical History from Below', studies as concerned with laypeople as with practitioners or medical ideas.[19]

Yet the analysis of the early modern world as a medical marketplace has not swept all before it. Several recent studies of European medicine in this period have preferred different analytical frameworks. Reflecting

of general practitioners' in the early nineteenth century. This encouraged doctors to form associations designed to fix fees and helped create new professional identities.[34] However, such work is relatively rare except in the historiography of US medicine: changes in the supply, demand and price of medical care before the twentieth century remain poorly understood.[35] This approach follows a path set out by social scientists in the 1970s.[36] During that decade some sociologists of the professions developed Max Weber's discussions of monopolization to explore how physicians established 'domination over the market'.[37] Sociologists of knowledge too employed this style of thinking. Among historians the most influential was Nicholas Jewson, who suggested that the changing styles and cognitive content of eighteenth- and nineteenth-century medicine should be related to the changing social and economic basis of practice, what he called the source of patronage.[38]

Each of these ways of using the terminology of the 'medical marketplace' has had its attractions. However, they are of varying utility and have quite different implications. The first 'pluralist' medical marketplace is little more than a descriptive commonplace. It serves in the main as an underspecified counterpoint to domestic and professionalized medicine, which are seen as bracketing it in a loosely stated chronology. It gives little indication of how shifts between these different structures occurred, or what determines the spectrum of practitioners. And as various contributors emphasize, it is not always helpful to equate medical pluralism with the medical market.[39] The second 'commercializing' medical marketplace provides the clearest chronological and empirical narrative, although the details remain uncertain. It has the strongest relationship to broader historical literatures in positing a role for medicine within a wider set of economic and social changes identified as occurring in early modern England. It also generally gestures to various external reasons for change, largely in terms of increasing wealth and urbanization, although as yet there has been no really satisfactory examination of the different factors in this process. The third 'structural' medical marketplace offers a more universalized emphasis on the connection between the content of medicine and the economic situation of health care. It thus highlights the relevance of sociological and economic approaches. However, in doing so it normally adopts rather than extends these disciplinary perspectives, and it carries with it some of the problems of its sister schools in assuming the priority of the material over the cultural or intellectual, understating the significance of external constraints and non-human actors and drawing unhelpfully sharp divisions between content and context.[40]

The difficulties that these co-existing definitions present can be seen in how they draw different boundaries around the medical marketplace. If one conceptualizes the afflicted person as a consumer and presents every aspect of their search for relief or assistance as a kind of shopping, then including both commercial and non-commercial curers within it makes sense. Hence, scholars who use the term to describe medical pluralism often include domestic, charitable or other kinds of unpaid therapeutic assistance in surveys of the marketplace. Lucinda Beier, for instance, presented Lady Margaret Hoby's charitable medical assistance as part of the medical marketplace. Others restrict the category to medical assistance for which the sick paid. Kevin Siena, for example, presented those selling remedies for venereal disease as part of the medical marketplace, but considers charitable treatment in hospitals and parish workhouses as outside it.[41] These ambiguities are artificial, as is the debate about the position of commercial and domestic provision in the medical marketplace. Such arguments derive from the lack of a single clear definition of the 'marketplace', and are not necessarily indicators of any substantive conceptual or empirical divergence over the sources of health care or their relative importance.

Given these divergent meanings and approaches, it might be argued that it would be best to abandon the terminology of the medical marketplace altogether. However, the resonance and familiarity of the language suggest that the chances of success for any such attempts at conceptual clear-cutting would be low. A more rigorous engagement with what is meant by the medical marketplace, while more modest, does seem an attainable ambition. In part, it is this we are urging here. More important, though, is that medical historians move beyond making linguistic nods to the economy of health and medicine, and engage seriously in the study of medicine, health and the market and reflect more explicitly on the ethical and political dimensions of using this kind of language. There is probably nowhere that this is more important than for the early modern period. For this reason, the essays gathered here concentrate on re-examining what we have described as the second of the approaches to the medical marketplace: that is the medical marketplace as a process and a period in the history of medicine.

An emerging medical marketplace?

In presenting the sixteenth to eighteenth centuries as an era of commercialization and pluralism with at best ineffective regulation, historians overturned assumptions about the inevitability of the rise of

professional structures. Instead, they depicted a market for medicine that seemingly flourished independent of its therapeutic efficacy or access to authority. However, this historiography has thrown up further fundamental questions that are, as yet, unanswered. First, given the loose sense of period apparent in some discussions, *when and where* did the medical marketplace appear and disappear? Second, *why* did it do so?

Drawing on the then standard accounts of the English economy, the earliest studies of the medical marketplace between the sixteenth and eighteenth centuries contrasted it with a largely non-market medieval medical system. Since that time, interpretations of the medieval economy have changed substantially. Scholars such as Britnell and Dyer emphasize that medieval England was strongly market-oriented, and that much production was for commercial ends.[42] Robert Ralley's chapter highlights the financial rewards of some medical work in the fifteenth century, demonstrating continuities with later periods. However, he also emphasizes that it was not a 'medical marketplace' *avant la lettre*: medical practice was far less commercialized than that depicted by Cook's *Decline*. As his discussion of 'medical economies' makes clear, the boundary between the commercial and the non-commercial in medical matters is never straightforward, and while levels of commercialization clearly grew, there was no linear progression from altruistic and neighbourly assistance to the cash nexus, or from patronage relations to the capitalist marketplace and then to professional medicine.

Ian Mortimer's recent work has mapped parts of this transformation, providing the first plausible quantitative data on the growth in demand for medical services over the seventeenth century.[43] In his chapter, he demonstrates both that specialist medical practitioners became more widely dispersed through rural Southern England over the sixteenth and seventeenth centuries and that an increasing percentage of probate accounts reveal payments for medical care over the same period. Between 1690 and 1719 half the number of higher-status males and one-third the number of lower-status ones leaving probate accounts owed payments for medical care before their death. Large parts of the English population, it seems, had been drawn into a medical marketplace; inhabitants of rural areas were only a couple of hours from specialist medical practitioners and increasingly paid for their assistance.

Such indicators are only available for Southern England, for people with both worldly goods and an ultimately fatal condition. Even without these problems of sources, it is clear that the process of commercialization was far from simple. First, not all sections of medicine were

drawn into such exchanges at the same rate. Venereal disease cures were particularly commercialized; the market in vernacular medical books expanded enormously from the mid-seventeenth century. Midwifery was, by contrast, far from straightforwardly commercial in character. Second, the growth of commercial supply did not simply supplant domestic medical provision. The informal exchange of medical recipes and remedies retained its vitality and importance throughout the eighteenth century. Third, the 'unit of consumption' is hard to define and changed over time. In seventeenth-century England, it is clear that the allocation of the costs of health care and decisions about consumption were made within the household. We should never assume that the consumer of medicine was an independent economic agent.[44] Finally, commercialization did not simply trickle down the social hierarchy. Among the poor, reliance on commercially supplied health care might, counter-intuitively, occur in advance of their social superiors. In Colonial New England, the itinerant poor, those weakest in social bonds, were driven soonest to rely on paid health care, albeit often subsidized by community funds. Only those established within communities possessed the *social* capital sufficient to delay the unwelcome shift into reliance on commercially supplied health care. In England, while many of the labouring poor could not afford commercial medicine from their own purses, they quite often received medical assistance through poor law or parochial provision or through institutional and personal charity, and the Old Poor Law was therefore a major purchaser within the economy of health care.[45] Given these complexities, it should be clear that we are still far from a convincing analysis of the economy of early modern health care.

The 'end' of the medical marketplace is equally troubling. The early modern medical marketplace has generally been represented as being supplanted by the advent of professionalized medicine in the nineteenth century, notably the advent of medical registration in 1858. Yet the impact of these changes remains contested. Michael Brown's chapter emphasizes that while there were significant changes in medical identity and organization in this period, this transition was complex and uneven: the 'victory' of the doctors was neither inevitable nor universally welcomed. Moreover, despite this notionally being the age of reform, the nineteenth-century proprietary medicine trade was much larger than that of the eighteenth.[46] The emergence of new professional identities was a protracted and much-contested process.

Much of what was captured by the idea of a medical marketplace remains relevant in the nineteenth century. Professional controls have

never been unchallenged nor have they ever embraced anything like the full range of healing practices. At the most obvious level, it is clear that 'irregular' and community healing remained significant sources of medical assistance into the twentieth century, while domestic and religious cures and the supply of care retained a major role.[47] Indeed, the nineteenth century was perhaps the heyday of thinking about medicine as a market. Whereas seventeenth- and eighteenth-century satirists presented practitioners as cynically maximizing profits, abstract discussions of medicine as a market seem to have developed in this later period.[48] With the spread of the discourses of political economy, Regency and Victorian practitioners may have become *more* inclined to think in this way. Many early nineteenth-century discussions of health issues debated free trade and monopoly. Some letters to *The Lancet* during the nineteenth and early twentieth centuries analysed medical practice in starkly commercial and market-oriented language.[49] It may be that such terminology was only felt to be inappropriate for discussions of British medicine between the late 1940s and late 1970s when the National Health Service was indeed agreed to be a national *service*.[50] Certainly there remains a need for a *longue durée* analysis of the ways in which medicine has been conceptualized and imagined through the languages of trade, market and political economy.[51]

Why the 'medical marketplace' developed in the early modern period and in the way that it did is even less clear than its chronology. The initial studies of the 'medical marketplace' were rarely specific about the processes underlying its emergence and change. It is striking that few historians of Britain have discussed how far epidemiological factors, like the presence or absence of plague,[52] or new medical techniques, instruments or goods, such as inoculation and the forceps, reshaped it.[53] Cook's discussion of practitioners in seventeenth-century London is unusual in even identifying a number of potential explanations, in particular the effect of urbanization and the general extension of the market economy.[54] Some historians have suggested that competition between practitioners was the impetus for change and medical innovations such as man-midwifery and private madhouses. Others have presented the medical marketplace as growing because of the general expansion in the English economy, interpreting it as part of the rise of consumer society. Discussing the rise of proprietary medicines, Porter even resorted to assertions about a burgeoning bourgeois 'fetishism of goods', affluence and convenience to explain the growth in supply and consumption of drugs.[55] What we have to date is more a cast of likely suspects than a convincing plot.

The limits of our understanding of the causes of medical commercialization are well illustrated by the uncertainties that surround the effect of the growth of towns and cities on health care. Urbanization is, ironically, probably the best defined of all the wider factors cited in the literature. It is clear that urbanization increased dramatically in this period: between 1500 and 1700, the share of the population in England and Wales living in towns of over 5000 people increased from 7.9 per cent to 27.7 per cent.[56] However, whether and how it drove demand for health care remains uncertain. Much history of medicine has long concerned itself with activities in urban settings, while Mortimer's identification here of commercial medicine as initially urban-centred supports the suggestion that urban growth somehow induced commercialization. However, it is a large step from identifying such a spatial pattern to determining what it was about urban life – the density of demand, the concentration of wealth, higher morbidity, weaker communities, greater distance from 'natural' resources – that caused increasing reliance upon the marketplace for medicine, let alone to being sure that urbanization is not a proxy for other more fundamental changes in wealth or taste, or even simply an artefact of our sources.

Nonetheless, while the increase in commercial health care still needs to be properly explained, it is now possible to make more refined judgements about at least some factors. First, assertions about a connection between *general* affluence and medical consumption seem increasingly implausible. While the real wages for labourers in London did rise slowly from the early seventeenth century, they did so following a fall in the late fifteenth and sixteenth centuries, begging the question of why there is little evidence of widespread demand for commercial medicine in the early fifteenth century. Interpretations of the medical marketplace as largely confined to the middling sort and the elite seem more plausible: their living standard rose faster than that of the poor during the seventeenth century.[57] It is also worth highlighting the changing content and scale of commercially available drugs, particularly those imported from abroad. Only a minor theme in the earlier 'medical marketplace' historiography, where interest in commercialization overshadowed the material culture of medicine, some scholars now view this as potentially a key factor driving changes in the form and size of demand for medicine.[58] Finally, as Fissell argues here, changes in the print trade, publicity and the public sphere seem to have contributed to the expansion of demand *and* supply.[59] Like recent work on consumption and the world of goods, these approaches link consumer desires with 'the social and economic

processes ... connected to particular commodities, their production [and] distribution'.[60]

Changes in medicine were complex cultural transformations.[61] As Wilson notes, it is implausible to suggest that supply and demand can on their own explain the *form* of a medical innovation or specialization.[62] More fundamentally other authors reformulate how we might understand 'supply' and 'demand', paralleling recent work in modern health economics on the nature of medicine as a commodity. In different ways Mutschler, Mortimer, Leong and Pennell suggest that an individual's 'demand' for medical assistance was related to their household and neighbourhood resources.[63] Wallis, Kassell, Fissell and Chakrabati demonstrate that we need to attend to the cultural and social construction of particular medical goods and services if we are to understand what was being supplied. Factors which might seem intangible to modern eyes – the practitioner's ability to manipulate occult forces, their trustworthiness or ability to call upon other practitioners, the 'exotic' qualities of a good, the readability of a pamphlet – are all shown to be inherent to the value of goods and services supplied on the medical marketplace.

Medicine as a market or an economy

This desire to historicize informs contributors' approach to other categories fundamental to discussions of the 'medical marketplace'. As Leong and Pennell observe, in the early modern period it is more accurate to write of the *oeconomy* of health care. This distinctive term, linking household management and commercial activity, better captures early modern mentalities and realities. Lauren Kassell is even more radical: fundamental to her account of magnetical medicine is a demonstration that the spiritual 'economy' flowed into the medical economy; such occult medicine was based on a bodily economy quite different from our own and quite different from the account of the economy propounded in the historiography.[64]

Such observations highlight two further questions running through this collection. How best should we characterize people's conduct within this marketplace, and what was traded within it? Economic activity is embedded within all kinds of social conventions and legal norms; the very nature and units of exchange are historically contingent. Historians need, therefore, to be wary of making sweeping assumptions about the nature of 'market activity'. Furthermore, the characteristics of exchange vary according to the kind of goods and services being traded.[65] Markets

for health care in particular appear very often to take on distinctive features related to the unusual characteristics of the products and services involved. This has been brought out most famously in the work of the economist Kenneth Arrow on the effects that pervasive uncertainty about levels of demand and the quality and efficacy of treatment have on consumers and suppliers of health care in later twentieth-century American medical markets.[66] It is precisely not our point to suggest that uncertainty is somehow essential to all medical economies. Nonetheless, many of Arrow's ideas do seem to echo some elements of the premodern medicine, and, as with Craig Muldrew's work on trust,[67] which is to an extent indebted to it, historians need to engage seriously with the particular historical construction of and response to uncertainty and related problems of information. It may well be that participants in the less regulated, more fluid and more fragmented medical economy of early modern England faced higher levels of uncertainty than modern consumers, despite the relatively narrower gap between lay and specialist medical knowledge. Certainly, the efficacy of drugs and the calibre of doctors were suspected more than celebrated in early modern England. The consequences of this are only now beginning to be explored.[68]

When thinking about the characteristics of exchange, it is obvious that one of the most distinctive elements that seemed to differentiate early modern and modern medical economies is regulation. In contemporary Western medicine the prevalence of licensing requirements for health care providers, restrictions on advertising and ethical norms that oppose direct competition all serve to limit consumers' freedom of choice in the interest of ensuring the quality of the medical services they receive. By contrast, writers on the medical marketplace such as Roy and Dorothy Porter portrayed medicine in early modern England as a *free market*, stressing that there was little effective regulation of practice. Compared with much of mainland Europe, there was indeed *relatively* less state or ecclesiastical regulation of medicine.[69] However, the language of the free market, with Friedmanite echoes, is misleading.[70] Firstly, guild, ecclesiastical, civic and other regulations were far from a dead letter for much of this period, as Cook in fact argued in his original study of the College of Physicians. Charlatans and other nostrum sellers working in physical marketplaces were subject to extensive controls,[71] while there were appreciable constraints on publishing up to 1695. More fundamentally, social pressures often curbed buccaneering forms of medical profiteering, as Ralley, Fissell and Mortimer highlight. Legal and contractual norms restricted practitioners' behaviour,[72] while

any who wished to build up a geographically defined reputation and practice had to take cognizance of less formal, but equally tangible, expectations about fair conduct.[73]

Emphasizing how medical practice was embedded in social relations also qualifies the stress on competition found in the historiography. According to Anne Hardy, 'It has become customary to speak of a medical marketplace when describing the range of treatment options available to eighteenth- and nineteenth-century patients, *because* of the number and variety of "practitioners" ... competing for their custom.'[74] Porter wrote that 'medical men of all sorts were competing for custom, recognition, and reward. Each in his own way – top physician, humble general practitioner, empiric, folk healer – made his bid to seize the moral high ground in a medical arena in which the law was acknowledged to be dog-eat-dog'.[75] In contrast, as Patrick Wallis demonstrates here, medical practice involved as much co-operation as competition; practitioners, particularly in urban areas, formed quasi-firms which facilitated their work, allowing the circulation of expertise and the effective transmission of information. A practitioner's success depended on her or his integration into social networks rather than conflict with every potential rival.[76] Similarly, Brown shows that in the early nineteenth century some 'regular' practitioners constructed alliances, despite the intensification of competition Irvine Loudon identified in this period.

Furthermore, the languages of medical conflict expressed more than the self-interested pursuit of a greater share of the marketplace. The bitterly controversial world of magnetical medicine, Kassell reveals, was grounded on differing interpretations of spiritual and bodily economies; Nicholas Culpeper's books, which, as Mary Fissell demonstrates, dominated the vernacular medical book market in the late seventeenth and early eighteenth centuries, denounced physicians as 'unnatural Monopolizers' of knowledge. But religious concerns were key to this analysis. Culpeper went on: 'The truth is, throughout the whole World there are not such slaves to Doctors, as the poor English are; most of them profess themselves Protestants, but their Practices have been like those of the Papists, to hide the grounds of Physick from the vulgar' who were thus driven to empty their purses or take dangerous drugs without care.[77] And whereas many would assume that such religious concerns would have faded by the nineteenth century, Brown highlights not only the democratic epistemology but also the ecclesiological and spiritual language of advocates of Morison's Pills.

How we think about place is also fundamental to discussions of early modern medicine. Only regional analysis can take into account

factors such as ecclesiastical licensing and varying economic structures, as Mortimer and Wilson demonstrate.[78] Indeed, as Brown shows, it was only in the early nineteenth century that we can observe moves towards a *national* professional identity. The implications of this remain unclear. Unfortunately, we still know less about the social history of medicine of northern England,[79] and, despite the rich literature on Edinburgh and on Scottish-trained medics in eighteenth-century practice,[80] relatively little about the structure of practice in early modern Scotland,[81] let alone Wales and Ireland.[82]

Early modern health care needs to be subjected to a global as well as a local analysis. The English and the continental European medical economies had a complex interrelationship that is still little understood. Work on the history of medical ideas has explored the movement of people and things across borders and language communities.[83] But, written before the emergence of the new British and imperial histories, the original medical marketplace literature now looks rather Anglocentric. It contained little discussion of the impact of imperial and 'exotic' goods on medicine, even though Cook and Porter identified the rise of specific drugs as an important factor in its growth.[84] Some commodities – tea, coffee, tobacco – moved from the medical marketplace into the wider world of goods;[85] others – opium, quinine, guiacum – transformed therapeutics.[86] The effect of the movement of people, both practitioners and laypersons, is also neglected. British subjects found themselves in revealingly different medical contexts in Asia, Africa and America, and these experiences marked the medicine of the metropole – discussions of public health, for instance, drew on imperial examples and experience.[87] Conversely, 'English' medicine and health care practices were transformed by the process of transplantation into new environments. In New England, health care operated amid greater social and agricultural interdependency than in England and confronted acute shortages of *specie*. In eighteenth-century India, the East India Company relied on the bazaar to maintain the health of its personnel, while its employees also expended immense intellectual, economic and social energy on appropriating substances from their indigenous contexts into the Western pharmacopoeia. Such case studies remind us that, particularly in the seventeenth and eighteenth centuries, British, imperial and other transnational dimensions affected medicine more than many other areas of life.

Finally, we need to move beyond the assumption made in most 'medical marketplace' literature that 'medical' self-evidently refers to therapeutics. In practice, *care* for the afflicted – nursing, washing and watching – was as essential and expensive a part of the economy of welfare as cure, as

Mutschler emphasizes. This assistance and its superficially prosaic costs, particularly payments for food and drink, consumed time and labour and were central to the cost of ill health. These expenditures reflected not only the imprecise boundary between foodstuff, drink and drug, but also the importance of diet for health.[88] This widening of focus needs to be applied at every level. For example, Jenner's examination of water and public health in 1820s London argues that commercial relations were important factors in contemporary understandings of public health. Medical historians, he therefore suggests, should concern themselves with the allocation of resources broadly defined.

Conclusion

The 'medical marketplace' was primarily introduced to describe and analyse the structure of therapeutic practice. This volume reveals that many more health-related matters and objects can be related to the market and market forces in historically specific situations. They range from medical books – which reveal medicine's interaction with the print trade and how medical knowledge was commodified – to the networks which structured the production and distribution of drugs and the ways in which they moved from bazaar and factory to apothecaries and druggists, and on to patients and purchasers. The diversity of the social and economic networks apparent in these studies suggest that historians should in future think of the *markets* for medical goods and services rather than a generalized image of the medical market or marketplace. The market for bandages surely differed from that for bagnios; the woman in labour had little immediate call for an oculist.

Furthermore, if we are to fully understand the economic workings of medicine in the early modern period we need to move away from a medical marketplace populated only by individual purchasers and individual practitioners. One of the distinctive contributions of Katherine Park's discussion of the medical marketplace of fifteenth-century Florence is its emphasis on the power of institutional, ideological and social forces within the city's medical marketplace.[89] A full account of the English medical marketplace between the fifteenth and the early nineteenth century must similarly take account of the many other sources of medical demand, such as the state, hospitals, the military and naval establishments,[90] and, above all perhaps, parochial and poor law provision, topics which we have only been able to touch on in this volume. Such a comprehensive account of the many kinds of economic exchange which paid for medical assistance would amplify the central messages

of this collection: that the early modern medical marketplace must be understood as socially embedded, and that to understand how health care developed and changed over this period we must not look to the medical marketplace for an explanation but seek to explain the medical marketplace itself. This realization not only parallels recent work in cultural and economic history and economic anthropology, but also breaks down some of the excessively sharp distinctions drawn in the historiography between the English medical marketplace and European medical pluralism. For it recalls not only Park's emphasis that the fifteenth-century Florentine marketplace was 'defined largely in personal and social terms', but also Gianna Pomata's work revealing how patients in Bologna sought recompense from medics if their treatment was not appropriate.[91]

More generally we must recognize that the marketplace is no more than a site where the broader forces of economy and society come together as people jostle to buy and sell. Yet what falls within the term 'economy' is not, in itself, stable. As historians of political economy have recently been arguing, it has to be understood in culturally specific ways. The oeconomy of the household was inseparable from the formal sector for much of this period, and medical supply and medical ideas flowed freely back and forth between the two. Even more dramatically, the economy of commodities flowed into an economy of spiritual and magical power that possessed equal or greater physical effects.[92] The resonance of the medical marketplace was, as noted above, in part due to the rising prominence of market-language in late twentieth century society. What seemed surprising initially in the 1980s historiography, with its accounts of adverts for drugs and its emphasis on fees and competition, now seems disconcertingly familiar, as Mary Fissell notes in her chapter. But as this collection demonstrates, any early modern market of medicine should be thought of as socially embedded and historically specific – a social organization of health care and exchange that must be understood in its own terms.

Notes

1. L. M. Beier, 'Sufferers and Healers: Health Choices in Seventeenth-Century England' (Ph.D. thesis, University of Lancaster, 1984), ch. 2; *idem*, *Sufferers and Healers* (1987).
2. 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 188. Porter also uses the terminology in R. Porter ed., *Patients and Practitioners* (Cambridge, 1985), 313 & 10; W. F. Bynum & R. Porter eds, *William Hunter and the Eighteenth-Century Medical World* (Cambridge, 1985), 21.

3. I. Loudon, 'The Nature of Provincial Medical Practice in Eighteenth-Century England', *MH*, 29 (1985), 2.
4. Cook's 1981 Ph.D. thesis did not use this terminology. Its equivalent chapter, entitled 'The Medical Milieu: The Physicians and the Institutionalization of Physic in Early Modern England', puts forward much the same arguments about how seventeenth-century medics adapted to the development of a market economy that his book advanced with this more resonant terminology: H. J. Cook, 'The Regulation of Medical Practice in London under the Stuarts, 1607–1704' (Ph.D. thesis, University of Michigan, 1981), 37, 372.
5. (Princeton, 1985), ch. 3.
6. M. Pelling & C. Webster, 'Medical Practitioners', in C. Webster ed., *Health, Medicine and Mortality in the Sixteenth Century* (Cambridge, 1979).
7. A few scholars working on pre-1750 medicine still foreground these categories: e.g., H. M. Dingwall, *Physicians, Surgeons and Apothecaries* (Edinburgh, 1995). Opinion on their relevance for the late eighteenth century is divided: M. Brown, 'From the Doctors' Club to the Medical Society: Medicine, Gentility and Social Space in York, 1780–1840', in M. Hallett & J. Rendall eds, *Eighteenth-Century York* (York, 2003); S. Lawrence, *Charitable Knowledge* (Cambridge, 1996); A. Digby, *Making a Medical Living* (Cambridge, 1994); I. Loudon, *Medical Care and the General Practitioner 1750–1850* (Oxford, 1986); L. Jordanova, 'Medical Men, 1780–1820', in J. Woodall ed., *Portraiture* (Manchester, 1997).
8. Beier, Sufferers, 9; Cook, *Decline*, 29.
9. See also M. Ramsey, *Professional and Popular Medicine in France 1770–1830* (Cambridge, 1988).
10. Many of these works cited each other as forthcoming publications.
11. V. Nutton, 'Healers in the Medical Market Place: Towards a Social History of Graeco-Roman Medicine', in A. Wear ed., *Medicine in Society* (Cambridge, 1992); H. Deacon, 'The Cape Doctor and the Broader Medical Market, 1800–1850', in H. Deacon, H. Phillips, E. Van Heyningen, eds, *The Cape Doctor in the Nineteenth Century* (Amsterdam, 2004). European historians have recently borrowed this approach and language, W. De Blécourt, F. Huisman & H. van der Velden, 'De Medische Markt in Nederland, 1850–1950', *Tijdschrift voor Sociale Geschiedenis*, 25 (1999); P. Rieder, 'Médecins et Patients à Genève: offre et consummations thérapeutiques à l'époque moderne', *Revue d'Histoire Moderne et Contemporaire*, 52 (2005).
12. D. Callahan & A. Wasunna, *Medicine and the Market* (Baltimore, 2006).
13. Pelling, *Conflicts*, 343.
14. One of the most influential examples of this, the work of Craig Muldrew, is directly relevant here: see Chapter 7.
15. For this explanation for the spread of the term: A. Wear, *Knowledge & Practice in English Medicine, 1550–1680* (Cambridge, 2000), 28–29; D. Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester, 1998), 2.
16. Based on a search of the *Times Digital Archive 1785–1985*; *The Times* (9 November 1985), 9.
17. N. McKendrick, J. Brewer and J. H. Plumb, *The Birth of a Consumer Society* (1982).
18. See e.g., W. De Blécourt & C. Usborne, 'Medicine, Mediation and Meaning', in W. De Blécourt & C. Usborne eds, *Cultural Approaches to the History of Medicine* (Basingstoke, 2004).

19. Porter, 'Patient's View'.
20. Gentilcore, *Healers*, 2–3.
21. L. Brockliss & C. Jones, *The Medical World of Early Modern France* (Oxford, 1997). The critique of this by S. Broomhall, *Women's Medical Work in Early Modern France* (Manchester, 2004) parallels the definitional debates described below.
22. D. Harley, '"Bred up in the Study of That Faculty": Licensed Physicians in the North-West of England, 1660–1760', *MH*, 38 (1994), 398.
23. M. Jenner, 'Quackery and Enthusiasm, or Why Drinking Water Cured the Plague', in O. P. Grell & A. Cunningham eds, *Religio Medici* (Aldershot, 1996).
24. Wear, *Knowledge and Practice*, 29.
25. It built on Pelling & Webster, 'Medical Practitioners'. See also M. Pelling, *The Common Lot* (1998).
26. Cook, *Decline*, ch. 1. For such surveys, Beier, *Sufferers*, ch. 1; Porter, *Progress*, ch. 2.
27. E.g., M. E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), 41 & ch. 3.
28. Porter, *Health*, 55.
29. There was a political historical dimension to this: Cook and Porter advanced accounts of the political and cultural development of Stuart and Georgian England which were strongly opposed to those of revisionist political historians such as Conrad Russell and Jonathan Clark, whose work was gaining much attention at the time.
30. See Chapter 9 and references contained therein.
31. 'The Place of the Physician in Modern Society', repr. in M. I. Roemer ed., *Henry E. Sigerist on the Sociology of Medicine* (New York, 1960), 65–66.
32. R. S. Roberts, 'The Personnel and Practice of Medicine in Tudor and Stuart England. Part I. The Provinces', *MH*, 6 (1962), 369.
33. *The Times* (29 October 1847), 4; (15 October 1901), 10.
34. Loudon, *Medical Care*, 208 and Part II *passim*. Also relevant here are histories which relate the construction of particular conditions to particular forms or understandings of market relations, e.g. A. Scull, *The Most Solitary of Afflictions* (New Haven, 1993), esp. 29–34, 105–10; T. Laqueur, *Solitary Sex* (New York, 2003), ch. 5.
35. The most systematic and sophisticated overview is Digby, *Making a Medical Living*. For the USA, the classic study which employs this model and language is P. Starr, *The Social Transformation of American Medicine* (New York, 1982).
36. Harold Cook recalls that the first time he consciously encountered the phrase 'medical marketplace' was in a commentary from the anthropologist, Michael Taussig, personal communication (2005).
37. J. L. Berlant, *Profession and Monopoly* (Berkeley, 1975), 49 and ch. 2; E. Freidson, *Profession of Medicine* (New York, 1970).
38. N. D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology*, 8 (1974); *idem*, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870', *Sociology*, 10 (1976). The frequency with which Jewson is cited in the medical marketplace literature is paradoxical. Although his approach was broadly materialist, Jewson never used market metaphors and presented eighteenth-century England as dominated by aristocratic patronage, not by commercial relations.

39. On medical pluralism, S. De Renzi, 'The Sick and their Healers', in P. Elmer ed., *The Healing Arts* (Manchester, 2004); M. Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge, 1999), ch. 7.
40. L. Jordanova, 'The Social Construction of Medical Knowledge', *SHM*, 8 (1995).
41. Beier, Sufferers, 28; K. Siena, *Venereal Disease, Hospitals and the Urban Poor* (Rochester, New York, 2004).
42. R. H. Britnell, *The Commercialisation of English Society, 1000–1500*, 2nd edn (Manchester, 1997); C. Dyer, *Making a Living in the Middle Ages* (New Haven, 2002).
43. I. Mortimer, 'The Triumph of the Doctors: Medical Assistance to the Dying, *c.* 1570–1720', *Trans. Royal Historical Society*, 15 (2005); *idem*, 'Medical Assistance to the Dying in Provincial Southern England, *c.* 1570–1720', (Ph.D. thesis, University of Exeter, 2004).
44. See L. W. Smith, 'Reassessing the Role of the Family: Women's Medical Care in Eighteenth-Century England', *SHM*, 16 (2003).
45. E.g., E. G. Thomas, 'The Old Poor Law and Medicine,' *MH*, 24 (1980); J. Andrews, '"Hardly a Hospital, but a Charity for Pauper Lunatics?": Therapeutics at Bethlem in the 17th and 18th Centuries', in J. Barry & C. Jones eds, *Medicine and Charity Before the Welfare State* (1991); T. Hitchcock, P. King & P. Sharpe eds, *Chronicling Poverty* (Basingstoke, 1997); S. Williams, 'Practitioners' Income and Provision for the Poor: Parish Doctors in the Late Eighteenth and Early Nineteenth Centuries', *SHM*, 18 (2005); Siena, *Venereal Disease*.
46. R. Porter and D. Porter, 'Rise of the English Drugs Industry: The Role of Thomas Corbyn', *MH*, 33 (1989); S. W. F. Holloway, 'The Regulation of the Supply of Drugs in Britain before 1868', in R. Porter & M. Teich eds, *Drugs and Narcotics in History* (Cambridge, 1995); *ODNB*, 'Thomas Holloway'; M. Gijswijt, G. Van Heteren & E. Tansey eds, *Biographies of Remedies* (Amsterdam, 2002); L. Loeb, 'Doctors and Patent Medicines in Modern Britain: Professionalism and Consumerism', *Albion*, 33 (2001).
47. O. Davies, 'Cunning-Folk in the Medical Market-Place during the Nineteenth Century', *MH*, 43 (1999); 'Healing Charms in use in England and Wales 1700–1950', *Folk-Lore*, 107 (1996); J. Bradley and M. Dupree, 'Opportunity on the Edge of Orthodoxy: Medically Qualified Hydropathists in the Era of Reform, 1840–1860', *SHM*, 14 (2001); Digby, *Medical Living*, ch. 2.
48. Cf. Ruth Richardson's discussion of the commodification of the cadaver, *Death, Dissection and the Destitute* (1988). The phrases 'medical market' and 'medical marketplace' are not to be found on the text database, *Eighteenth-Century Collections Online*, but see L. F. Cody, '"No Cure, No Money," or the Invisible Hand of Quackery: The Language of Commerce, Credit, and Cash in Eighteenth-Century British Medical Advertisements', *Studies in Eighteenth-Century Culture*, 28 (1999).
49. E.g., *The Lancet*, 60 (1852), 268; 72 (1858), 585; 121 (1883), 484; 128 (1886), 153; 179 (1912), 118–120.
50. In the 1960s and 1970s, for instance, *The Lancet* contrasted the British NHS with American 'medicine of the market-place', a contrast which was, of course, central to Richard Titmuss's work on blood, *The Lancet*, 289 (25 Feb. 1967), 427–428; 306 (27 Dec. 1975), 1293; R. Titmuss, *The Gift Relationship* (1970). For a polemical overview of recent developments in the UK, A. M. Pollock, *NHS PLC* (2004).

51. For a revealing analysis of the world of health economics, M. Ashmore et al., *Health and Efficiency* (Milton Keynes, 1989).
52. Studies which highlight this include Brockliss and Jones, *Medical World*; Park, *Doctors*.
53. On the former, D. Van Zwanenberg, 'The Suttons and the Business of Inoculation', *MH*, 22 (1978); on the latter, A. Wilson, *The Making of Man-midwifery* (1995). John Styles, 'Product Innovation in Early Modern London,' *P&P*, 128 (2000) offers a model which could be extended to other medical innovations.
54. Cook, *Decline*, 33–35.
55. Porter, *Health*, 41.
56. S. Epstein, 'Europe, 1300–1800', in S. R. Epstein ed., *Town and Country in Europe, 1300–1800* (Cambridge, 2001), 10.
57. R. C. Allen, 'The Great Divergence in European Wages and Prices from the Middle Ages to the First World War', Explorations in Economic History, 38 (2001), 427–428; P. T. Hoffman, D. Jacks, P. A. Levin and P. H. Lindert, 'Real Inequality in Europe since 1500', Journal of Economic History, 62 (2002).
58. Mortimer, 'Triumph', 110–111; D. B. Haycock and P. Wallis eds, *Quackery and Commerce in Seventeenth-Century London*, *MH*, suppl. 25 (2005); Renate Wilson, *Pious Traders in Medicine* (Pennsylvania, 2000); P. Wallis, 'Drugs and the Commercialization of Healthcare in England, 1550–1750' (unpublished paper, 2006).
59. Cf. C. Jones, 'The Great Chain of Buying: Medical Advertisement, the Bourgeois Public Sphere, and the Origins of the French Revolution', *American Historical Review*, 101 (1996).
60. F. Trentmann and M. Daunton, 'Worlds of Political Economy: Knowledge, Practices and Contestation', in M. Daunton & F. Trentmann eds, *Worlds of Political Economy* (Basingstoke, 2004), 15. See also, M. Berg, 'In Pursuit of Luxury': Global History and British Consumer Goods in the Eighteenth Century', *P&P*, 182 (2004).
61. Cf. Mortimer, 'Triumph'.
62. On specialism, K. Buckle, 'The Culture of Oculists in England 1660–1740' (MA thesis, University of York, 2005).
63. Their analyses parallel David Wright's arguments that nineteenth-century asylum admissions should be interpreted with reference to the economic and demographic circumstances of a region, *Mental Disability in Victorian England* (Oxford, 2001).
64. See her 'The Economy of Magic in Early Modern England', in M. Pelling and S. Mandelbrote eds, *The Practice of Reform in Health, Medicine, and Science, 1500–2000* (Aldershot, 2005), esp. 46–48.
65. Cf. P. Warde, 'Subsistence and Sales: The Peasant Economy of Württemberg in the Early Seventeenth Century', *EcHR*, 59 (2006).
66. K. J. Arrow, 'Uncertainty and the Welfare Economics of Medical Care', *American Economic Review*, 53 (1963).
67. C. Muldrew, *The Economy of Obligation* (Basingstoke, 1998).
68. On one aspect of this, see P. Wallis, 'Consumption, Retailing and Medicine in Early Modern London', *EcHR*, 60 (2007).
69. E.g., D. Gentilcore, 'Figurations and State Authority in Early Modern Italy: The Case of the Sienese Protomedicato', *Canadian Journal of History*, 34

(1999); M. Lindemann, *Health and Healing in Eighteenth-Century Germany* (Baltimore, 1996); Brockliss & Jones, *Medical World*.

70. Interestingly, some of Friedman's early work was on the economic effects of medical regulation: M. Friedman & S. Kuznets, *Income from Independent Professional Practice* (New York, 1945).
71. See, for example, the civic licenses to mountebanks in late seventeenth-century Norwich, http://virtualnorfolk.uea.ac.uk/long18thcent/introduction/norwichcorporation/mcbshows.html (10 July 2006). On market culture, A. Randall & A. Charlesworth eds, *Markets, Market Culture and Popular Protest in Eighteenth-Century Britain and Ireland* (Liverpool, 1996); C.S. Smith, 'The Wholesale and Retail Markets of London, 1660–1840', *EcHR*, 55 (2002).
72. C. Crawford, 'Patients' Rights and the Law of Contract in Eighteenth-Century England', *SHM*, 13 (2000); Pelling, *Conflicts*.
73. Jonathan Barry, 'Publicity and the Public Good: Presenting Medicine in Eighteenth-Century Bristol', in W. F. Bynum & R. Porter eds, *Medical Fringe and Medical Orthodoxy 1750–1850* (1987).
74. A. Hardy, *Health and Medicine in Britain since 1860* (Basingstoke, 2001), 14. [Our emphasis.]
75. Porter, *Health*, 16–17.
76. Cf. L. Leneman, 'Smith v. Clark and Clark v. Smith: Eighteenth-Century Scottish Doctors in Dispute', *MH*, 46 (2002).
77. N. Culpeper, *Culpeper's School of Physick* (1659), Sig. A8v. (This was a posthumous work.) On Culpeper's epistemology, see M. E. Fissell, *Vernacular Bodies* (Oxford, 2004), ch. 5.
78. See also Anne Digby's mapping of the 1783 Medical Directory, which reveals striking variations in the ratio of practitioners to population, *Medical Living*, ch. 1.
79. Exceptions include D. Harley, 'The Scope of Legal Medicine in Lancashire and Cheshire, 1660–1760', in M. Clark and C. Crawford eds, *Legal Medicine in History* (Cambridge, 1994); *idem*, 'Bred up in the Faculty'; *idem*, 'Provincial Midwives in England: Lancashire and Cheshire, 1600–1760', in H. Marland ed., *The Art of Midwifery* (1994); S. S. Thomas, 'Midwifery and Society in Restoration York', *SHM*, 16 (2003). Rather more has been written on the late eighteenth and early nineteenth centuries: e.g. H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780–1870* (Cambridge, 1987); S. King, *A Fylde Country Practice* (Lancaster, 2001); I. Loudon, '"The Vile Race of Quacks with which this Country is Infested"', in Bynum & Porter, *Medical Fringe*.
80. These include H. M. Dingwall, 'To be Insert in the *Mercury*: Medical Practitioners and the Press in Eighteenth-Century Edinburgh', *SHM*, 13 (2000); G. B. Risse, *Hospital Life in Enlightenment Scotland* (Cambridge, 1986); L. Rosner, *Medical Education in the Age of Improvement* (Edinburgh, 1991); S. Jacyna, *Philosophic Whigs* (1994).
81. See, however, C. W. J. Withers & P. Wood eds, *Science and Medicine in the Scottish Enlightenment* (Edinburgh, 2002); R. A. Houston, *Madness and Society in Eighteenth-Century Scotland* (Oxford, 2000) and his numerous articles.
82. A. Borsay ed., *Medicine in Wales 1800–2000* (Cardiff, 2003); G. Jones & E. Malcolm eds, *Medicine, Disease and the State in Ireland, 1650–1940* (Cork, 1999); I. Campbell Ross, *Public Virtue, Public Love* (Dublin, 1986).

83. E.g., J. Woolfson, *Padua and the Tudors* (Cambridge, 1998); H. J. Cook, *Trials of an Ordinary Doctor* (Baltimore, 1994); E. A. Underwood, *Boerhaave's Men at Leyden and After* (Edinburgh, 1977); W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), 46–54.
84. L. Schiebinger, *Plants and Empire* (Cambridge, Mass., 2004); L. Schiebinger and C. Swan eds, *Colonial Botany* (Philadelphia, 2004).
85. J. Goodman ed., *Consuming Habits* (1995); R. Porter and M. Teich eds, *Drugs and Narcotics in History* (Cambridge, 1997); B. Cowan, *The Social Life of Coffee* (New Haven, 2005).
86. R. S. Roberts, 'The Early History of the Import of Drugs into Britain', in F. N. L. Poynter ed., *The Evolution of Pharmacy in Britain* (1965); S. Jarcho, *Quinine's Predecessor* (Baltimore, 1993); A. Barrera, 'Local Herbs, Global Medicines: Commerce, Knowledge, and Commodities in Spanish America', in P. H. Smith and P. Findlen eds, *Merchants & Marvels* (2002). H. Cook, *Matters of Exchange: Commerce, Medicine and Science in the Dutch Golden Age* (New Haven, 2007).
87. More generally, R. H. Grove, *Green Imperialism* (Cambridge, 1995).
88. See Pelling, *Common Lot*, ch. 2; J. O'Hara May, *The Elizabethan Dyetary of Health* (Lawrence, Kansas, 1977).
89. Park, *Doctors*, ch. 3.
90. E.g., H. J. Cook, 'Practical Medicine and the British Armed Forces after the "Glorious Revolution"', *MH*, 34 (1990); C. Lawrence, 'Disciplining Disease: Scurvy, the Navy, and Imperial Expansion, 1750–1825', in D. P. Miller & H. P. Reill eds, *Visions of Empire* (Cambridge, 1996); L. Brockliss, J. Cardwell & M. Moss, *Nelson's Surgeon* (Oxford, 2005).
91. Park, *Doctors*, 85; G. Pomata, *Contracting a Cure* (Baltimore, 1998).
92. This was true not just of the sixteenth and seventeenth centuries. Many eighteenth- and nineteenth-century regimens and therapies drew upon a spiritual economy or attributed particular power and cosmological significance to particular practices or substances, e.g., M. S. R. Jenner, 'Bathing and Baptism: Sir John Floyer and the Politics of Cold Bathing', in K. M. Sharpe & S. N. Zwicker eds, *Refiguring Revolutions* (Berkeley, 1998); D. Madden, 'Contemporary Reaction to John Wesley's Primitive Physic: Or, the Case of Dr. William Hawes Examined', *SHM*, 17 (2004); L. Barrow, *Independent Spirits* (1986).